Where Three Roads Meet: Triangulation in the Care Sector, A Psycho-Social View on Caring and Vulnerability

SIEBELIEN FELIX

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Faculty of Health and Life Sciences
University of the West of England, Bristol

ABSTRACT

Where Three Roads Meet: Triangulation in the Care Sector, A Psycho-Social View on Caring and Vulnerability

In this thesis I explore the effect on the lived experience of care workers and their managers in the residential elderly care sector of The Netherlands in relation to changes in and around the sector. Like in most western societies The Netherlands has to deal with ever increasing health costs. In 2006 the Dutch government opted for (semi-) privatizing the sector in the hope that competition would lead to more efficiency and reduction of costs. One of the major changes is the emergence of a powerful third party: the private insurance companies. As of 2006 healthcare and health cure providers have to negotiate with these companies about costs and services.

The research perspective is a psycho-social approach, which aims to achieve a beneath the surface understanding of the interaction between macro and micro level phenomena. In doing so I wish to avoid approaching this issue from a single perspective such as organisational studies or social policy, in an attempt to adopt a more holistic understanding, viewing it both psychologically from 'inside' this experience and culturally/politically from outside.

The data is collected through two case studies - two Dutch care homes for the elderly- where I applied three research methods: organisational observation, facilitated workshops and psycho-social interviews. The data was analysed by using a thematic, theoretical, deductive top down approach and with the help of reflection groups and postgraduate supervision.

In this thesis I argue that macro level phenomena indeed are projected into the care sector and influence the running of the organisations and the lived experience of those working in the sector. The macro level phenomena are two feelings of anxiety in wider society: The fear of death and vulnerability and the fear that society can no longer afford the cost needed to care for vulnerable elderly. As such these feelings engender social defence like reactions and leads to 'as if' behaviour. It is as if good care is being delivered but in reality abuse is around the corner.

I also argue that the sector has to learn to deal with thirdness or a form of triangulation. By given a third stakeholder – the insurance companies – the task to reduce costs etc a form of triangulation is brought into the

sector. However this form in practice turns out to create fear. Management constantly focuses on the outside world and tries to comply with rules and regulations and leaves the carers to their own devices. The third party is regarded as a punitive superego, a negative third. I argue for a different form of triangulation in which the -one-in the third is allowed to be so that a true dialogue can emerge between the three partners concerned; the care recipient, the care provider and the financier.

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Chapter 1

Where Three Roads Meet: Triangulation in the Care Sector

Introduction

Every state of affairs at a given moment is in reality merely a phase of a development: no matter how concise or static or how rigidly formed it may appear. Every one of the threads that make up the web of our knowledge goes back to distant and diverse origins and is also tied up with threads of other textures

(Arturo Castiglioni, 1978)

In 1974 The Dutch artist poet Lucebert published his Poem 'De zeer oude zingt' ('The very old one sings'). This poem contains a line which is very well known in The Netherlands: 'Alles van waarde is weerloos'. The adjective *'weerloos'* can be translated as defenceless, or helpless or naked. So the poetical line in English could be: *All things of value are defenceless -* or *All things of value are naked –* or *- All things of value are helpless.*

In the 1980s an insurance company prominently placed this line in big neon letters on top of its office building in Rotterdam as a commercial marketing tool.

This gesture raises interesting questions. Why did a commercial insurance company choose this particular line of one the famous Dutch artists? How did they see their relationship with all things naked? Who needs to be insured against nakedness and vulnerability? And what does that mean? Who is going to benefit? Does someone need to benefit? And what about profit? One of the objectives of an insurance company surely is to make profit? So are they claiming to make a profit out of helplessness?

And more questions easily occur. Finding the answer to these questions is more complex. A café in Gent, Belgium later chose this line to place on the outer wall of its location:

A café certainly also seems an interesting place to contemplate the meaning of this line. Vulnerability in a café brings up all kinds of associations and questions as well. And then there is the link with caring for the elderly and dealing with vulnerability, dying and death. How do we as a society care for the vulnerable and finance support? This is an

important question in The Netherlands since insurance companies play in important role in the healthcare system.

This thesis contains the results of a PhD project that I undertook from 2007-2016. In this research I seek to examine the lived experience of care workers and their managers in the residential elderly care sector of The Netherlands in relation to changes in and around the sector. In undertaking this project I combined a number of interests. From an early age I have been fascinated by stories about individuals who are different and who try to find a position in the group for themselves. I have always been an avid reader. As a child I could lose myself completely in a book. After secondary school, I studied English Language and Literature at a Dutch University. In literature the focus often is individuals in a context - a psychological focus. Later my interested in Sociology grew. At The University of Utrecht I got a masters in Counselling and Consulting in Context. Ever since I graduated from The University of Utrecht I have been living and working with the context in mind. When working as coach or consultant I have been trying thinking with the senses and feeling with the mind. This was the motto of the 52nd Art Biennale in Venice 2007. 'Pensa con i sensi/senti con la mente l'arte al presente'.

In 2007 or 2008 I discovered the existence of The Centre of Psycho-Social Studies at UWE. And I found out that there is a very international group of PhD students doing very interesting research there. I felt that at this centre I would be able to combine my interest in psychology,

sociology and the creative arts. At the Centre one of the focuses is on doing research below the surface with qualitative research methods inspired by art forms. And the rest is history: this project began to take shape.

I was able to start exploring how major contextual changes impact the lives of the most vulnerable in society – the elderly, some suffering from psychogeriatric illness – cared for by carers who are working in a sector undergoing constant change.

Like in most western societies The Netherlands has to deal with ever increasing health costs. Since 1980 the government and specialists in the field have been thinking about ways to keep the costs in control. In 2006 the Dutch government opted for (semi-) privatizing the sector in the hope that competition would lead to more efficiency and reduction of costs. One of the major changes is the emergence of a powerful third party: the private insurance companies. As of 2006 healthcare and health care providers have to negotiate with these companies about costs and services. With the passing of the new Acts in 2006 the government changed its role. It transferred the operational tasks and responsibility of the healthcare sector to market players (mostly not-for-profit organisations). Its own task became to safeguard public interest by monitoring the quality, accessibility and affordability of the sector. In order to fulfil this task it has established a number of independent bodies that monitor and control different aspects of the sector. Within the new

system the insurance companies have a new and much more powerful role than they had before. They have become a kind of manager of the healthcare chain. Supposedly it is their task to stabilize the balance of power between the care providers and the patients. Taken together these changes are dramatic and their systemic effects upon the health and social care system are only now beginning to emerge.

In this research I adopt a psycho-social approach, one which seeks to understand the interaction between macro (politics, policies) and micro (emotions, meanings, identities) level phenomena. The concept of 'containment' is a key psychoanalytic term. It refers to the capacity of an individual, group or organisation to 'manage' powerful feelings, which are circulating in the immediate or wider social system. Obholzer (1994) and others have clearly demonstrated that public health institutions serve to contain a population's anxieties about death and dying. This is an important function in societies. However, how much can a container take? An effective container can tolerate disturbing projections and simultaneously continue to function effectively. However what happens if the pressures on the container become too much, what will be the effect on those that work for such institutions, those in receipt of services and the wider public?

With the introduction of the new funding system the pressure on the public health sector in The Netherlands has increased enormously. On the one hand there is the new way of funding. Organizations have to earn

their own income and have to pitch for their service. Insurance companies have become powerful new partners in the field. Patients and clients have also become more demanding. They require value for their money so to speak. And then there are demographic factors that cause pressure. The population in The Netherlands is aging. Predictions are that because of this, the demand on healthcare will increase significantly in the coming decades. Society requires the sector, in fact, to deal with two opposing discourses at the same time: the discourse of the market and the rhetoric of freedom of choice, and the discourse of care.

I considered it very likely that all these developments will impact on the sector and will affect its containing role. Can it still maintain this role or are the pressures becoming too large? And is this perhaps one of the reasons for turmoil within the sector?

Insurance companies as private companies were given a public task: to financially manage care for the vulnerable. In this role they have to work with the questions that the line from Lucebert's poem raises. And they especially have to explore what these questions mean for them as insurance companies.

Research Objectives:

At the start of this research project I formulated the following research objectives: to provide an analysis of the impact of the semi-privatisation

of health and social care in The Netherlands on the lived experiences of managers and professionals in healthcare institutions and the effect this has on their values, identities and behaviours. In addition the aim was to investigate those factors that support and hinder the healthcare sector in maintaining its capacity to contain public anxieties about sickness and vulnerability.

These objectives led to research questions focussing on management, the professionals and the issue of containment.

In relation to management I formulated the following research questions:

1. In what way have the managers incorporated the discourse of neoliberalism into their work and in what way does this influence how they manage?

2. How do managers experience the role of the regional care centres, the centres for care assessment, the insurance companies, the inspection and the independent bodies, etc. that monitor the sector?

3. How do they experience the pressure of constant change and what do the changes entail? What degrees of anxiety does this evoke - positive, persecutory, or catastrophic, and what is the effect of this?

4. What images of the organisation does the management have and how does this inform their day-to-day work? E.g. how do they see their role?

5. What 'social defences' characterise the subsystem of the management and why?

In relation to care professionals I formulated the following research questions:

1. How do those in professional and service provider roles experience the role of the regional care centres, the centres for care assessment, the insurance companies, the inspection and the independent bodies, etc. that monitor the sector?

2. How do those in professional and service provider roles experience the role of management?

3. What images of the organisation do professionals and service providers have and how does this inform their day-to-day work? E.g. how do they see their role?

4. How do they experience the pressure of constant change and what do the changes entail? What degrees of anxiety does this evoke - positive, persecutory, or catastrophic, and what is the effect of this?

5. How do those in professional and service provider roles experience the role of the client?

6. What social defences characterise the subsystem of those in professional and service provider roles and why?

In relations to containment and anxiety

1. How do those in professional and service provider roles cope with the dilemma of engaging with two contrasting discourses (discourse of the market vs discourse of care)

2. Do those in professional and service provider roles feel pressure to collude with situations they disapprove of?

3. In what way are the professionals affected by the audit explosion that has become part of the sector?

4. Do the changes within the system lead to more or just to different forms of fragmentation compared to the pre-neoliberal period?

5. What form of containment do the professionals experience from the management within the organisation and what is the effect of this?

Structure of Thesis

The following chapters contain the outcomes of the research project. In chapter 2 I provide an outline of the Dutch context and history of the Dutch care sector especially for non-Dutch readers. This is indeed just an outline. Moreover the changes have not stopped since I wrote chapter 2 where I explained the AWBZ Act. As 2015 of the act WMO 2007 has been replaced by the WMO 2015. Through this act the Dutch government has distanced itself further from the health sector and has transferred budgets to the municipalities. As of 2016 Municipalities have become responsible for providing care to their citizens. This means that healthcare organisations now also have to negotiate with each municipality in which they provide care. There are situations where they have to deal with more than 20 negotiating partners. Getting paid for your services is not an easy task consequently care organisations have

been required to expand their accountancy staff at the cost of care staff. Yet the ostensible objective of all the changes is to bring care closer to the client and to place the client in the centre of it all. In other words - the story will be continued.

In chapter 3 I provide a psycho-social perspective on care for the elderly. I first describe the history of psycho-social studies as it has emerged in the UK and elsewhere. Some key concepts in psycho-social studies, concepts such as discourse, containment, and social defences against anxiety, are explained. The concept of anxiety provides a thread connecting to a second section of this chapter which situates care for elderly people in its cultural context, specifically in the context of a culture which seems to be in flight from mortality and vulnerability and which, at a policy level, embraces a shallow, functional and disempowering approach to care. Finally, in a third section, this chapter examines some of the structural determinants of care – economics, the organisation of welfare - in contemporary Dutch society and the possible impacts these are likely to have upon the practice of care.

In chapter 4 I discuss the methods I used to gather data for this research project and how I analysed the data. For two years I conducted research at two Dutch care homes for the elderly. I immersed myself into the organisations, hoping to emerge with data on the lived experiences of management and professionals and on unconscious dynamics and defences at work at those two care organisations. In order to find answers to my research objectives I decided to conduct

two psycho-socially oriented organisational case studies. This was an innovative approach. Not many psycho-socially oriented organisational case studies have been completed in the field of psycho-social studies.

In chapters 5 to 7 I present the data I gathered from the case studies. In chapter 5 I introduce the two case study organisations and I present the data gathered through observations. In chapter 6 I present data reflecting the impact of anxiety on those working in the sector. In chapter 7 I present data on the tension that emerges on the crossroads where two discourses meet: the care discourse and the business discourse.

In chapter 8 I provide an analysis of the data and link in with theoretical concepts.
In this analytical chapter I will develop a hypothesis, that feelings of anxiety in wider society are projected into the care sector and influence the day to day running of care organisations and the lived experience of management and carers and staff working at the care organisations.

I conclude with the observation that effective care requires that those working in the sector, regardless of their role, are able to manage the anxiety that the work evokes and can manage themselves in their role. Everyone working in the sector has to manage the balance between targets, standards, and protocols etc. on the one hand and kindness and attentiveness on the on hand. Just focussing on the targets and the

protocols can lead to distraction, fragmentation and ultimately to brutality. The right balance can lead to skilful and compassionate forms of work. From a psychoanalytical perspective this requires the integration of 'the one in the third' (the feminine) and 'the third in the one' (the masculine).

Chapter 9 forms the synthesis of this work.

I hope the reading of this thesis will provide food for thought and will set in motion a thought process on how to care for the vulnerable in our society.

Chapter 2

The Dutch Health Care System

In the past decade the Dutch Health care system has undergone major changes. In the decades prior to the changes the system seemed to be getting out of joint. There were problems with respect to delivery and performance. Waiting lists were getting longer and longer. There was unrest within the country about the quality of the services being offered. In addition the Ministry of Health was confronted with recurring budget deficits and ever-rising costs.

Something had to be done. The government opted for liberalizing the system in the hope that competition would lead to more efficiency and reduction of cost. In 2006 a number of Acts were passed which set in motion a whole range of changes.

A Brief Overview of the Situation Before 2006

In the beginning of the 20th century the Dutch health care system developed as a hybrid between the German Bismarck employment-related system and the UK model of a population wide health insurance system[i].

In the 20th century the funding model of the health care system The Netherlands was characterised by three following features: a relatively high share of private finding, a combination of non-governmental and

governmental provision of care and a neo-corporatist style of social policymaking. The Netherlands are often described as a pillared society. Until the 1960s there were clearly three pillars: the protestant Christian pillar, the Catholic pillar and the Socialist pillar. The fourth pillar was formed by the liberals, although they themselves would say they were not part of any pillar at all. These so-called pillars have had an enormous influence on the build-up of the Dutch welfare state. Each pillar set up its own schools and health care provisions. It was hard for the different pillars to reach agreement on regulations that would apply to the whole society. During the Second World War the German occupiers established a sickness fund for the Dutch region as a whole. Under this scheme 47-60% of the population was obliged to insure for health costs. The German occupiers did something that the Dutch governments had not been able to achieve due to disagreement between all the different groups they had to deal with. After the war the system was more or less kept in place. In 1962 it formed the basis for the so-called Sickness Fund Act (Ziekenfondswet). This act determined that there were two separate systems of (short-term) health care insurance in operation in The Netherlands: public and private. The public insurance system was executed by non-profit 'health funds', and financed by premiums taken directly out of the wages (together with income taxes). Everyone earning less than a certain threshold income was automatically insured under this system. Anyone with an income above the threshold was obliged to have a private insurance. It was agreed with the private insurance companies that not more than 65% of

the population would fall under the public insurance. The private insurance companies could focus on the remaining 35% of the population.

The churches and the guilds, like in other European countries, have provided the basis of a form of communal health care for their members[ii]. The care was organised along denominational lines, each pillar provides for its own people so to speak. The pillars established not for profit institutions and charities that were run by boards of governance whose members were respected members of the pillar in question. Many of the present health care institutions are still find their roots in one of the pillars, although the present wave of mergers have made the divisions less clear or prominent. The general practitioners and apothecaries have always been independent and established their own private practices.

Until the Second World War the Dutch government did not actively intervene in the health care sector. After world war two however the government gradually increased its control. This was partly due to the fact that the health care costs kept on rising. Successive governments have tried to strengthen their control over the expenditures of the sector in the hope that this would bring down the costs. Many factors, however, made this difficult or even impossible. The Netherlands has often been described as a 'consensus building society'. In order for governments to get their policies accepted they have to negotiate with all the stakeholders in the field. In the case of the health care sector there have

always been many interest groups that have power to hinder or delay plans.

In the eighties there was an impression in The Netherlands that the society was grinding to a halt. Unemployment was high, an extremely high number of people were officially declared to be too ill to work and received state benefits under the so-called disability act (WAO). Health care cost kept on rising. The welfare state seemed to have become unaffordable an even burdensome.

A typical way of getting a breakthrough or to prepare the society for changes in The Netherlands is to establish official committees with specialists from the field. These specialists are requested to come up with a solution, which will be supported by many if not all the stakeholders in the field. In the 1980s the Ministry of Health established the committee Dekker (named after the chairperson, W. Dekker CAO of Phillips). This committee was given the assignment to scrutinize the structure and financing of the health care sector and to advice the government on innovative ways to contain health care expenditure.

This committee suggested the following: In order to increase efficiency they advised to differentiate between primary and secondary care. The primary care sector should be given the role of gatekeeper to the secondary care providers. Access to the secondary care sector (hospitals, specialists etc.) would thus become less automatic. The idea was that this would be one way of reducing costs. It advised to establish a basic standard insurance package for all Dutch citizens, with an

income related premium. This package should only cover for the most basic form of care. All other forms of care would have to fall under a so-called supplementary insurance, which could either be voluntary or obligatory. This was for the government to decide.

The most radical part of the advice was to introduce a form of privatization or competition in the sector. Already then the committee saw a role for Health Insurance funds in achieving this. They suggested that the distinction between health funds and the private insurance companies would be abolished. Instead they suggested establishing a public (so not private) health insurance organisation. In addition they advised the government to deregulate and decentralize.

The government decided to act upon the advice. In order to be able to develop a basic standard insurance package the then Secretary of State responsible for the health sector transferred provisions from the health funds and the insurance companies to the AWBZ (Algemene Wet Bijzonder Ziektekosten, the Act for Exceptional Medical Expenses). The intention was to eventually turn the AWBZ into the public health insurance organisation as suggested by the committee Dekker.

Initially reception of the plans by the stakeholders seemed favourable. However resistance gradually built up. Especially the not for profit health funds and the commercial insurance companies feared they would lose power and influence. The First chamber (the Dutch Senate) also objected to many parts of the plan. Eventually the Secretary of State

failed to get his plans accepted. In the nineties he was forced to abandon the reforms halfway.

Approximately twenty years later, in 2006 the (semi-) privatization of the sector did take place after all. A minister who had worked as a professional in the health sector succeeded the Secretary of State in the next government. By taking small steps at the time she managed to get the plans accepted by the different stakeholders. With remarkably little resistance the chambers approved the plans in 2006 and The Netherlands now has a health care system with market-based competition.

2006 and Onwards

The plans have gone even further than originally proposed by the Commission Dekker. And since 2006 successive ministers keep on introducing more and more changes. Only recently the minister has sent a white paper to the Second Chamber with the proposal that in three years' time hospitals can become completely commercial and can attract foreign capital and pay dividends. In 2013 the health insurance companies will become responsible for the execution of the AWBZ.

Four year onwards the health care budget is still increasing. At present approximately 10% of the Gross National product of The Netherlands is spent on health care[1]. The budget in 2011 is sixty-three thousand million

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[1] In the US the expenditure on health care is 17% of the GNP – data 2012

euro, which amounts to approx. 4000 euro per Dutch citizen per year. It is very likely that expenditures will keep on rising. The Dutch population is aging. More than 50% of the clients who use long care health service are above 65. In July 2010 the CPB, Netherlands Bureau for Economic Policy Analysis published a study in which they predict that by 2040 the health care cost in The Netherlands will be at least 15 % of the GPN. Another reason for the increase is caused by new technologies. Because of new technologies there are more options for treatment. This in itself is a positive development but it also means health care will become more expensive. The discussion about whether the changes have led to more efficiency is still going on. There certainly is a lot of unrest within the sector. Professionals are complaining that bureaucracy is keeping them from their real work.

With the passing of the new Acts in 2006 the government changed its role. It transferred the operational tasks and responsibility of the health care sector to market players. Its own task became to safeguard public interest by monitoring quality, accessibility and affordability of the sector. In order to fulfil this task it has established a number of independent bodies that monitor and control different aspects of the sector. The umbrella Organisation is the NZa (Nederlandse Zorgauthoriteit), the Dutch Health care authority. It was established in October 2006. This Organisation is the supervisory body of the complete health care market in The Netherlands. It supervises both the health care providers and the insurance companies. Other important bodies are the CVZ (het college

voor zorgverzekering), the board for health insurance that advises the minister on which services should be covered by the basic insurance scheme and the CIZ (Centrum voor Indicatiestelling Zorg) the Centre for Care Assessment. This centre has to give objective advice on whether patients are eligible for long term care. And then there is the IGZ (Inspectie Gezonheidszorg), The Inspection for Health Care that investigates irregularities within the sector.

The Short-term Health Care Market

The health care sector consists of two divisions: a short-term cure sector and a long term care sector. Both have undergone major changes and are now operating within a managed competition framework. As part of this framework a system was set up which enables market players to negotiate about services and prices. Since 2005 the sector works with DBCs or Diagnostic Treatment Combinations. A DBC includes all activities and services and treatments associated with a patient's demand for care from initial consultation or examination to final check-up. Since 2005 a total of approximately 100.000 DBCs have been developed. In practice approximately 30.000 are being used.

In 2006 Parliament passed the new Health Insurance Act (Zorgverzekeringswet ZVW). Before the introduction of the act the question of demand and supply was between the clients or patients and

the care providers. With the introduction of the act a third, powerful

player in the shape of the insurance companies entered the field.

The players and markets in the Dutch public health sector

The insured/client/patient

Insurance
market

Care and cure
market

Insurance
companies

Care and cure
providers

market for purchasing
healthcare
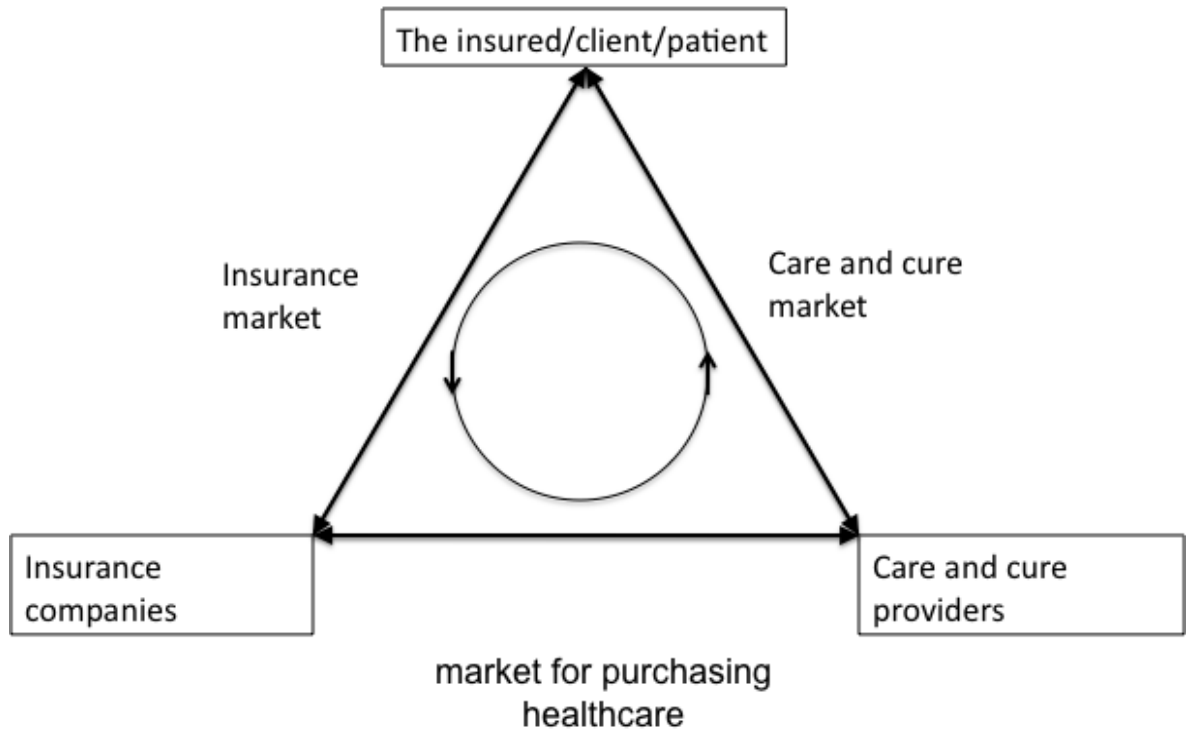
Figure 2.1

There are three major players in the field: the clients or patients, the

care and cure providers and the insurance companies. They meet in

three different markets. Patients or clients and cure providers meet on

the care and cure market. The clients and insurers meet in the

insurance market. Insurance and cure providers meet in the heath

purchasing market.

The insurance companies:

Before 2006 insurance companies already had an important role within

the healthcare system. In their comparative historical study on German,

Belgian and Dutch social health insurance systems Companje, Hendriks and Verachtert and Winddershoven (2009) describe the particular roles public insurance funds and private insurance companies have played in The Netherlands since 1770. As we have seen until 2003 healthcare insurance was a mixture of public and private responsibilities and the field of insurance was highly fragmented and complex. Within the new system the insurance companies have a new and much more powerful role than they had before. They have become a kind of manager of the health care chain. Supposedly it is their task to stabilize the balance of power between the care providers and the patients.

In the Health Insurance Act it is stated that as of 2006 all health insurance for basic and supplementary health care services will be provided by private insurance companies. The companies have to offer a basic standard insurance package for all Dutch citizens. This basic package should provide insurance for health services that are 'effective, essential and appropriate for everyone'. In consultation with the CVZ, the Ministry of Health determines which services should be covered by the basic insurance. The government also gives guidelines about the price of the premium. At the start of the new health scheme in 2006 for instance it was estimated that the community rated premium would be around Euro 1100 per year, per adult. Since 2006 the premium has risen on an annual basis.

Within the new system insurance companies are obliged to accept any applicant that wishes to be enrolled in their basic insurance scheme. Since they are not allowed to refuse clients for this basic package, the companies belong to a risk equalization scheme that will compensate those companies whose client base has a worse than average risk profile. This is done in order to insure that companies will not feel tempted to refuse 'expensive' clients, such as chronically ill people. In this way every Dutch citizen is ensured of basic care. The insurers are allowed to sell supplementary insurance for health care services that are not part of the standardized benefit package. For supplementary insurance, insurers can refuse clients and they are free to charge different risk-premiums to different clients.

Competition among the insurance companies

In 2006 the insurance companies anticipated a substantial loss of clients under the new scheme. Therefore, in order to attract as many clients as possible, most companies offered basic health care plans with substantially lower premiums than the Euro 1100 that was suggested by the government. Clients were bombarded with attractive offers etc. and in that year approximately 25% of clients switched provider. As of 2007 the situation has stabilized again. Only a small percentage of clients per year change their insurance company.

In order to attract as many clients as possible the insurance companies also offered large premium discounts for group contracts (up to 10%

discount per individual per year). These group contracts were not only employment based. Trade unions negotiated deals for their members (some with more than 1.5 million members), sport federations, a large cooperative bank, interest associations for the elderly etc. all made deals on group contracts.

All in all in 2006 not many clients paid the so-called break-even price of the administrative premium. Insurers were therefore not able to compensate losses on group contracts by cross-subsidization from individual contracts. In the first year of the new scheme losses had to be financed out of the financial reserves of the insurance companies. Not surprisingly the premiums have increased substantially ever since 2007. And this is a process that is not likely to stop in the near future.

An important feature of the new health insurance scheme is the possibility for insurers to contract selectively with health care providers, such as general practitioners and hospitals. Selective contracting is intended by policy makers to improve efficiency and quality of health care services. The assumption is that insurers will select providers that are more efficient and provide a higher quality of service. This does imply that insurers have the knowledge and skills to determine which hospital offers the best service. In reality the most important determinant seems to be cost efficiency rather than quality.

When signing up for a health scheme, clients can choose between two types of insurance policies. Under one scheme they opt for a more traditional indemnity insurance restitution policy that does not restrict the choice of provider. Or they opt for a preferred provider insurance policy that will restrict the choice of provider. If in this case, a client goes to a non-preferred provider he will have to pay extra.

Any not-for profit- or for profit health insurer meeting certain standards is permitted to offer basic health insurance coverage. In 2006 there were a large number of small and regional players on the market. They already existed under the old scheme. The first two or three years of the new scheme the insurance companies focused on increasing their market share. Many companies merged and at present there are not more than four mayor players that serve approximately 90% of the population in The Netherlands

The players are:

- Achmea/Agis   29%
- Uvit   26%
- Cx/Oz/Detla Lloyd   20%
- Menzis group   13%

The health care providers in the cure sector

Primary Care:

In The Netherlands we talk about primary and secondary health care providers. Primary care has to be accessible to everyone and is

provided by General Practitioners, dentists, physiotherapist and primary care psychologists, midwives, etc. These professionals are the gatekeepers to the rest of the sector. In order to get access to secondary care providers, patients or clients need a referral from a primary heath care professional. Without such a referral the insurance companies will not reimburse the costs.

The GP's role within the system is becoming more and more important. They determine to which provider the patient goes next. In the past GP worked out of their own private practices. Now most of them work in small health care centres. Both insurance companies and health care providers underwrite the importance of the GP as gatekeeper of the system.

Secondary Care:

Secondary care providers are specialists in hospitals, psychiatrist, and psychotherapists etc. About 50 % of the total health care budget in spent on the cure sector. Of this 50% the largest amount is spent by the hospital sector. This budget is still increasing annually. In order to contain the cost in this part of the sector all kinds of measures have been taken to stimulate competition. Slowly but steadily more and more hospital care is being privatized. In 2007 the share of liberalized hospital services was 8%. In 2009 the share increased to 34 %. And the plan is

to increase this share to 70% in the coming years.

The DBCs play an important part in this process. They either belong to the A or the B-segment. The B-segment is the unregulated part of the cure sector. The DBCs in the B-segment describe uncomplicated, elective outpatient care. This means that this form of care can be done in so-called Independent Care Centres (Zelfstanding Behandelcentrum, ZBC). An Independent Care Centre is a for profit organisation, which is usually run by independent specialists. These ZBCs are clinics that are specialized in for instance eye operations, knee operations or hip operations etc. In 2006 there were 37 ZBCs, in 2009 their number had grown up till 125. There are hardly any waiting lists for the services these ZBCs offer. And in this respect they have helped to make the sector more efficient.

As a consequence of the existence of the ZBCs hospitals end up with the patients who need more complex treatment. The present DBC structure does not allow hospitals to charge more for those more complicated treatments. This has led to complaints that hospitals are treated unfairly in this respect. At present 80 % of the DBCs are in the A-segment. The prices of these units are determined by the NZA, The other 20% is part of the B-segment and the players (e.g. ZBCs and the insurance companies) in the field can negotiate about these prices.

The Hospitals:

There are three different types of hospitals in The Netherlands: Generals Hospitals, Top Clinical Hospitals and Teaching Hospitals. The general hospitals deal with many kinds of diseases and injuries and typically have an emergency unit to deal with immediate and urgent threats to health. They provide basic hospital care and all the essential specialties are usually represented.

Top clinical hospitals differ from the general hospitals in that, in addition to all the service the general hospitals provide, they also have a number of top clinical specializations. All the teaching hospitals are affiliated with a university and have commitments to research. They are centres of experimental, innovative and technically sophisticated services and provide clinical education and training to future and current doctors, nurses, and other health professionals.

As part of the deregulating process the financial responsibilities of the hospitals have changed fundamentally. Many of the risks that formally belonged to the government have been transferred the hospitals. Likewise the ownership of the real estate has been transferred to the hospitals. The real estate now appears on the balance sheets as intangible assets. Management of hospitals has had to rethink their responsibilities in relation to strategies, financial objectives, infrastructure plans and logistics.

Medical Specialists:

There are approximately 12,000 specialists in The Netherlands. Half of

these are employed by hospitals and receive a (generous) salary, the other half work out of independent companies. They rent themselves out to the hospitals and operate as small business entrepreneurs. All specialists in teaching hospitals are employed by the organisation. This is the only option they have. Managers of the other hospitals would rather employ the specialists as well but many of the specialists think otherwise. They cherish their independence. Many of the independent specialists also work in the Independent Care Centres.

In 2007 the Minister of Health introduced a new remuneration system for specialists. As an unintended result of this system the income of many of the self-employed specialist doubled. This in its turn created huge budget deficit for the Ministry of Health. The minister is now trying to change the system again. But there are legal issues that make this complicated. The minister would rather pay the hospitals a lump sum, so that the hospitals themselves will have to negotiate about the remuneration of the specialists. In 2010 there was a precedent in The Netherlands. The specialists went on strike. The minister has won the battle. More and more specialists have to negotiate directly with the hospitals about their remunerations.
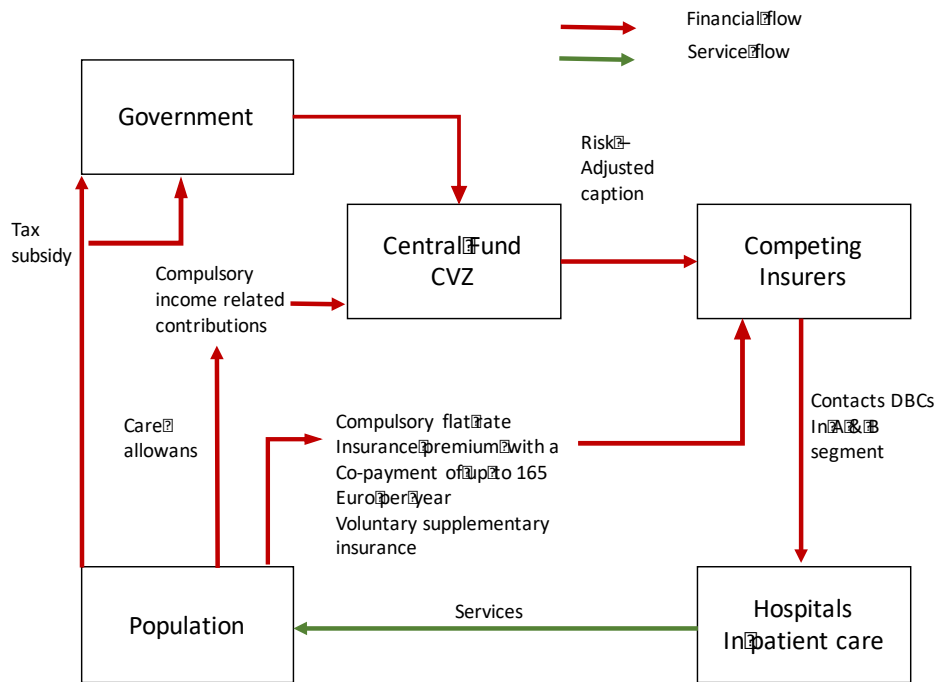
Figure 2.2: The financial flows within the cure sector

The Long-term Health Care Sector

Long-term health care is financed in a in a different way than the short-term health care. Since 1968 the Act for Exceptional Medical Expenses, the AWBZ (Algemene Wet Bijzonder Ziektekosten) has been in force. This act covers care for the elderly, for the chronically ill, for the mentally and physically handicapped, for those with somatic illnesses, psychiatric patients, etc., in other words for everyone who needs care on a long-term and regular basis.

The AWBZ is a national insurance. Every citizen in The Netherlands in need of long-term care can in principle qualify for assistance by this law. It is funded by a national insurance contributions, by taxes and by and co-payments. The amount of co-payment depends on one's income. There is not a supplementary insurance option. It is possible however to

pay extra for additional services.

Initially the act was modest in terms of the costs it covered. Overtime it became more comprehensive in the sense that it covered a very wide range of services ranging from domestic assistance, daily medical help, nursing home care, to specialized treatment etc. In an attempt to control the long-term health care costs, the act has now become more modest again. In 2006 the Act on Social Assistance, the WMO (Wet maatschappelijke ondersteuning) came into force. Under this act the Local Councils have become responsible for services that were formally covered by the AWBZ. Domestic assistance for instance now falls under this Act. Councils receive a lump sum from the government. If they exceed their budget, the risk is theirs. They have to negotiate with providers about the costs.

Other services which fell under the AWBZ are transferred to the Health Insurance Act (ZVW.) In this way health insurance companies are also gaining more influence on the long-term health care market. Those in need of long-term care need to go through an assessment in order to determine to which kind of care they are entitled. The CIZ, the Centre for Care Assessment, is responsible for this. As part of this assessment procedure the sector has developed a set of criteria or so-called severity of care packages or ZZPs. For example, ZZP 1 means that a client needs sheltered living with some assistance, ZZP8 means that a client need sheltered living with intensive care.

Purchase of care

After a client has been assessed and placed in one of the ZZPs, care needs to be bought. Depending on the service needed this is either bought by the local councils (domestic help), by a regional health centre or by the client himself. As part of the new system clients can apply for a so-called personal care budget. They can decide themselves how (within limits) they want to spend this budget. They either receive care in kind or they receive money. This service turned out to be very popular.

The regional health centres that can buy care are, interestingly enough, affiliated with the health insurance companies. They are so called non-profit units that belong to those companies. On behalf of the clients they negotiate with the care provider about the services needed.

The care providers in the long-term health sector

Care in the long-term health sector is provided by not-for profit organisations. These organisations are either specialized in a specific target group, such as the elderly, psychiatric patients, young people or they offer all the available services to all target groups. One such institution in Amsterdam for instance is responsible for domestic health care, mental health care, care homes for the elderly, care for the mentally handicapped and youth welfare in the city of Amsterdam. It employs approx. 8000 people and has locations spread all over the city. Before the changes in the health care system there were more smaller

and specialized organisations. But since 2006 many of those organisations have merged and turned into fairly big organisations.

The changes for the long-term health care providers under the new system are significant. Until 2006 all their services were funded through the AWBZ. Within their budget they were allowed to balance out more expensive service such as complex care, against more general and less complex service such as domestic home care. After 2006 this changed. Different services have to be paid out of different budgets. For some services they have to tender. The bidder with the lowest costs wins. Domestic care for the elderly used to be delivered by trained nurses. At present commercial companies specialised in cleaning and without medical background are active in this sector and win most of the tenders

Those employed in the sector also have to work with DBCs. This means they have to account for every minute of their work. As a consequence the paperwork has increased enormously. And there is less time to spend with their clients. The DBCs do not include overhead costs. This means that the organisations do not get reimbursed for back office work. These costs have to be paid out of the reserves of the organisation

Outside of the larger cities some of the long-term care organisations have to negotiate about tenders with more than 22 different councils. If an organisation loses a tender it is possible there is no employment for their workforce. Under Dutch law they are prevented from firing people

easily. It has become much more difficult for these organisations to think and plan long-term. There are signs that long-term care organisations are getting into trouble. A number of institutions were on the verge of bankruptcy. At the last moment the government stepped in to prevent this from happening.

Consumers and patients

There are a number of consumer and patients federations that actively monitor what is happening with the sector.
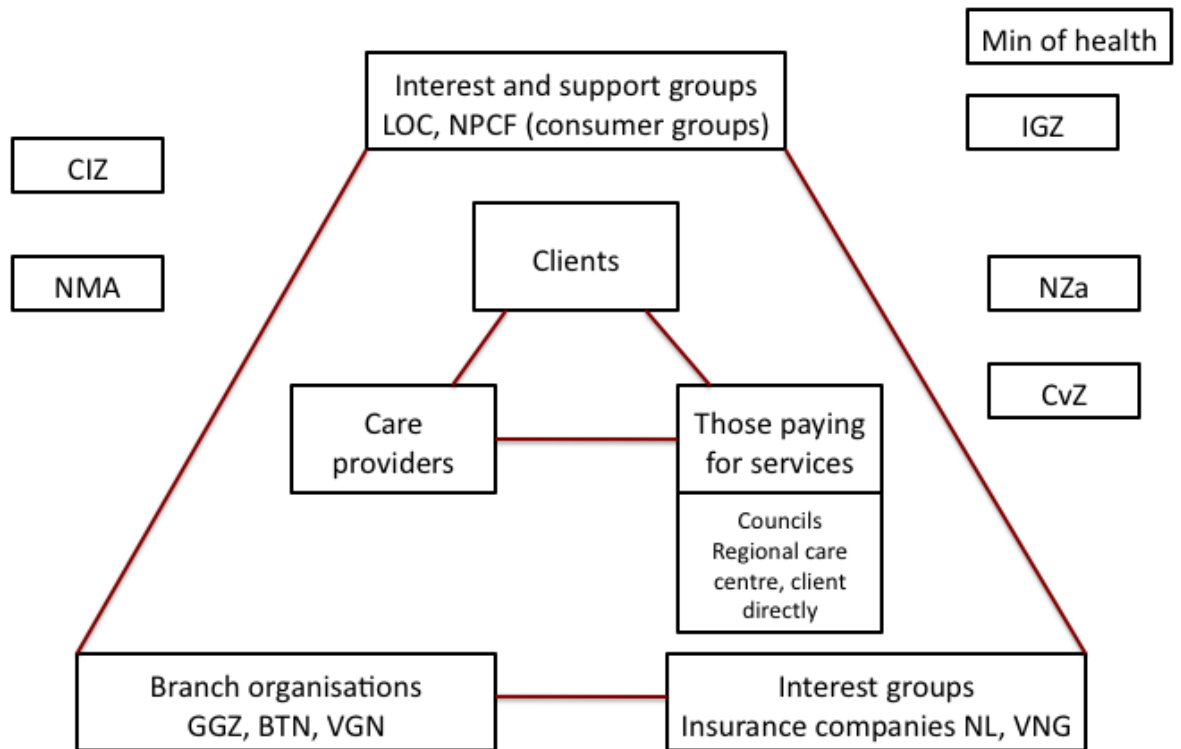
Figure 2.3: Stakeholders in the Long-term Care Sector

The complex relationships between the key stakeholders in the long-term care sector are summarised diagrammatically in Appendix 1 which also provides a list of abbreviations and summary description of them. One of the important stakeholders that hasn't been mentioned is the NMA. The NMA is The Netherlands Competition Authority, which

- oversees all industries of the Dutch economy;

- enforces compliance with the Dutch Competition Act;

- takes action against parties that participate in cartels, for example, by fixing price;

- sharing markets, or restricting production;

- takes action against parties that abuse a dominant position;

- assesses mergers and acquisitions.

All the Health Care Organisations are monitored by the NMA. Just recently the bookkeeping of a number of hospitals was seized because the NMA suspected they had made agreements with competitors and in this way hindered free and open competition about pricing.

Overall Trends

The situation in The Netherlands is constantly evolving and indeed important trends can be discerned which have emerged since the start of writing this thesis. The most important include the following:

- Within the whole sector all the organisations are increasing in scale. Mergers have become commonplace.

- The paperwork has increased enormously. Everyone in the sector has to account for every task they perform

- Those working in the sector are grumbling and complaining that they cannot spend enough time taking care of patients.

- The number of management positions has increased enormously

- In the near future there will be a shortage of personal in the whole sector.

- The sector is not popular under those looking for work

- Clients are becoming more and more demanding.

- The sector will have to economize more in the near future. Due to the present economical situation the government has to cut their expenses drastically. Predictions are that co-payment for the basic insurance packages will rise substantially.

Chapter 3

A Psycho-social Perspective on Care for the Elderly

A Psycho-social Perspective

Introduction

In this research I seek to examine the lived experience of care workers and their managers in the residential elderly care sector of The Netherlands. I wish to avoid approaching this issue from a single perspective such as organisational studies or social policy in an attempt to adopt a more holistic understanding, viewing it both psychologically from 'inside' this experience and culturally/politically from outside. This way of understanding, and the research methodologies which have become associated with it, has come to be known in recent years through the term 'psycho-social studies'.

In this chapter I will first describe the history of psycho-social studies as it has emerged in the UK and elsewhere. Some key concepts in psycho-social studies, concepts such as discourse, containment, and social defences against anxiety, will then be explained. The concept of anxiety will provide a thread connecting to a second section of this chapter which situates care for elderly people in its cultural context, specifically in the context of a culture which seems to be in flight from mortality and vulnerability and which, at a policy level, embraces a shallow, functional and disempowering approach to care. Finally, in a third section, this

chapter will examine some of the structural determinants of care – economics, the organisation of welfare - in contemporary Dutch society and the possible impacts this is likely to have upon the practice of care.

The emergence of psycho-social studies:

A large body of the literature I reviewed for this research project comes out of the field of psycho-social studies. Psycho-social studies is a fairly recent field which is finding its way into British universities, the University of the West of England being one of them. Psycho-social studies is a way of thinking and researching which is looking at the interface between the internal and the external world. Psycho-social studies is interested in the way in which the two sets of factors: the societal or external and the psychological or internal, combine, interpenetrate and influence each other. Feelings, affect and emotions are a field of research.

During the establishment of the Psycho-social studies network in the UK in 2008 Walkerdine (2008) summarised the history of the field in a succinct way. She describes three different sources or paradigms that contributed to the field.

One of its sources is in the work of the Tavistock Institute in London. In the post war period this institute attempted to apply Kleinian psychoanalytic ways of thinking and group analysis to social problems. One of their studies took place for instance in the Yorkshire coal mining industry in the 1940s. During this study relationships were investigated

between the primary work system or the nature of the work and how it was organised and the whole organisation system e.g. its culture and management structure and the place and significance of the organisation in society (Trist & Bamforth, 1951). Bion was one of the founding members of the Tavistock Institute. He first used groups with returning soldiers from the Second World War who were suffering from traumatic experiences. Later he ran groups for the purpose of learning about group processes at the Tavistock Centre out of which he wrote the influential publication Experiences in Groups (Bion, 1961). Menzies Lyth is another important member of the Tavistock Institute. In the 1950s she started with consultancy work in the British health sector. There she came across high levels of tension, anxiety and stress among the nursing staff. She wondered why this was the case and how the nurses were able to cope with this high level of anxiety. Based on this work she developed her theory on social defences (Menzies 1960).

As a second source for psycho-social studies Walkerdine mentions structuralism and post-structuralism. Important names in these schools were Lacan and Foucault as the debates in the journal of Psychoanalysis, Culture & Society (2008 Volume 13) show, this school contributed to the field psycho-social studies with its discussion on discourse (among other concepts). A third source Walkerline mentions concerns critical psychologists at British universities who are looking for a broader framework across different disciplinary boundaries than that which their own universities offered.

Walkerdine mentions two universities specifically that have played important roles in the establishment of psycho-social studies: The University of East London where Sociology and Psychoanalysis were used to develop new insights and The University of the West of England. Psycho-social studies brings the micro and the macro together. It combines psychoanalytic thinking with social scientific ways of thinking without giving either one unnecessary prominence.

The 'psycho' in psycho-social studies is about the inner and private world. As Hoggett (2008 p383) writes, psychoanalysis has brought us insight into 'the structure formation of our inner worlds'. Concepts such as splitting, projection, paranoid-schizoid or depressive position and second skin formation come out of the field of Kleinian psychoanalysis. The 'social' in psycho-social studies is about the external world with is own rules of structure formation. These are the rules that govern societies, economies and social fields such as for instance the care sector.

The hyphen in psycho-social forms the link between the inner and the outer world. Hoggett refers to the hyphen as the link that opens up thinking. It is what Winnicott (1991) would refer to as the transitional space, the bridge between the subjective and the objective. And this is what the field of psycho-social studies is about. A psycho-social perspective is neither purely psycho nor purely social, but draws upon

both, the overlapping space, the space in between, the space of the hyphen (Hoggett 2015 p.51).

In the following sections I will examine some concepts which are key to a psycho-social perspective.

Discourse and panopticism

The concept of discourse is an important and widely discussed concept. I use the concept when I distinguish between what I call the discourse of care and the business discourse during the analysis and discussion of my data. Therefore I will briefly expand on my use of the term. I regard it us useful concept because discourse can be used to analyse struggles over meaning and ideas.

The following discussion of the concept and its relation to power is indebted to Eliot's (2001) analysis of the concept and to Whinsnant (2012). According to Foucault, systems of ideas and practices (discourses) are in constant contention. There is always more than one discourse in operation. Some discourses are more powerful than others. And discourses can be said to compete with each other. As such the concept is closely related to Foucault's ideas about power and control. Knowledge is a form of power. Power can be played out by various means, such as by use of language. When someone operates from a business discourse she tends to use different language and engage in different kinds of practice than when she operates from a care

discourse. Language and practice moulds identity, and identities mould languages and practices. A discourse is created by a particular cultural condition at a particular time and place and it expresses a particular way of understanding human experience. Depending on the outcome of the power struggle a discourse has more or less power to influence and discipline individuals. Foucault analysed how in modern society power is imposed upon people with the help of bureaucratic routines. Practices such as the routine gathering of information and continuous forms of monitoring have a disciplining effect. He sees modern society in this sense as a modern panopticon. The term panopticon he borrowed from Bentham who used this term to describe a hypothetical prison design. The design was such that a single watchman could observe inmates of an institution without the inmates being able to tell whether or not they were being watched. As such the Panopticon was 'a new mode of obtaining power of mind over mind, in a quantity hitherto without example' (Bentham 1843d, p. 39)

For care organisations the present time can easily be described as a time during which panopticism is an important issue. Care organisations in The Netherlands are in the limelight. They are caught up in a system in which external powers require them to produce evidence of compliance with all kinds of rules and regulations. The computer and Internet play an important part in this system. The bureaucratic control is managed with the help of the computer. And as such the computer has

become an important entity in the lives of managers, carers and
residents in care homes.

Elliot (2001) points out that Foucault saw discourse as shaping the mind
of human subjects and that Foucault allowed human beings very little if
any individual form of agency and knowledgeability. He turned humans
into passive subjects. Here Elliot (and many others with him) challenges
Foucault's analysis. Elliot sees human beings as 'creative and
knowledgeable agents and not simply as victims of social practises of
power and domination' (p.84).

This is an important addition in relation to how I use the concept in later
chapters. Within the Dutch care sector I detect a struggle between the
business discourse and the care discourse. Managers and carers have
to decide how they relate themselves towards these different
discourses. This is not always easy and straightforward as the data
shows. I am of the opinion that managers and carers have the capacity
to play an active role in this struggle and that their actions are not just
determined by a discourse.

Containment

Through the process of containment one party may help another to
develop. The term containment, as used here, is derived from the work
of Bion (1962). He used this concept initially to refer to the way a mother

or carer helps a child to cope and deal with difficult emotions. He says that 'Learning depends on the capacity of the container to remain integrated and yet lose rigidity' Bion (1962 p.93). In other words whether containment leads to development depends on the nature of the container-contained relationship.

A mother can facilitate development and learning by by holding the emotions for the child as long as necessary, and by giving them back to the child in a manageable fashion. This allows the child to digest the emotions in a way he can handle and not to become overwhelmed by them. In this manner the mother acts in fact as a temporary container for the emotions of the child.

Containment is another psycho-social concept that is valuable for analysing organisational processes. A manager for instance offers containment for employees when he mediates relations between the inner and the outer world of an organisation effectively. Effectively means that necessary information from the outside reaches the inner world of the organisation and vice versa. If the management of the boundary is not effective, employees can either be flooded by too much information, or work in total isolation and ignorance. Too much information will hinder employees from focussing on their tasks; too little information may lead to stagnation.

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An organisation or sector as such can also act as a container. The health sector contains societies anxieties about sickness and ageing for instance. Because there are organisations dealing with this, healthy members of society do not have to worry about it. In this respect Obholzer (1994a) referred to the sector as 'the keep the death at bay service'. Implying that because the health sector took care of the dying, the rest of society could move on. This does not necessarily mean that the health sector is automatically looking after the dying in a way that is deemed proper. This depends on issues such as transparency and accountability.

Bion (1970) made a distinction between enhancing or symbiotic forms of containment and destructive or parasitic forms of containment. In an enhancing or symbiotic form of containment the two parties, the container and the contained, can transform each other and create new meaning, both can grow and develop. In destructive or parasitic forms of containment one or both parties unconsciously use the other in order to prevent development. Although Bion never provides a clear analysis of the terms he offers such as parasitic, Hogget suggests the following is what can be inferred from his writings. Parasitic is one form of destructive containment in which the container one-sidedly benefits from its relationship with its host (the contained). So a mother for whom her child is a narcissistic extension 'feeds off' the development of her child – her child's successes are her successes. But there is inevitably an element of collusion in this process, the child's egoistic needs are

partially satisfied by the mother's idealisation and so it will perform for mother. In extreme forms of emotional/physical abuse the element of collusion is almost entirely missing, the contained (the child) resembles much more the helpless victim. There are some situations however where each party colludes with the other almost on equal terms – one thinks of some forms of ethnic conflicts, like we had in Northern Ireland, where each 'side' needs the other side to contain its projections. Part of the intractability of such conflicts is the emotional satisfaction each party gains from relationship. (Hoggett 2016, unpublished reflections).

Symbiotic containment is about adequate boundary management. For organisations the organisational boundary can be a provider of containment. The boundary creates a sense of inside and outside. If the boundary is managed well enough those inside can focus on their task and think through what has to be done. If on the other hand the organisational boundary is not managed well employees do not get the time to reflect and think through how best to assist a resident for instance.

Anxiety and social defences

Anxiety is a major issue in the Dutch Healthcare sector. As I began my data collecting phase it became clear that in both case studies management and staff had to cope with anxiety on many levels. In order to understand the different forms of anxiety and to be able to analyse the effect the anxiety has on the lived experience of managers and staff

I explored the work of Bion, Jacques, Menzies Lyth and others to investigate what they have written about anxiety and social defences.

In *Experiences in Groups*, Bion argues that we as human beings are always part of a group since we are 'herd animals. Or in Bion's own words: 'there are characteristics in the individual whose real significance cannot be understood unless it is realised that they are part of his equipment as a herd animal' (Bion 1961). Bion postulated that feelings and emotions felt by an individual can sometimes belong solely to an individual, but sometimes or perhaps very often they are more than that because as human beings we have the capacity to feel and experience what others feel. As human beings we cannot not be part of a group. Either consciously or unconsciously we always have 'the group in the mind', and this influences our behaviour. Working and living in a group always creates complex group dynamics. Bion postulated that a group always operates at two levels; the sophisticated or work group level and the basic assumption or emotional, non-rational level. At the level of the working group the focus is on the rational tasks of the group. At the level of the basic assumption the focus is on emotional survival in the group. And in order to survive in a group, its members unconsciously develop shared basic assumptions. Basic assumptions are assumptions that operate on an instinctive, unconscious level and are usually not spoken about. They are forms of social defence. Social defences are functions that help keep difficult or unpleasant emotional experiences at bay. They can take various forms and shapes.

In the 1950s and 1960s Jaques (1955) and Menzies Lyth (1955 and 1960) both worked with the concept of social defences in their work as consultants. Jaques argued that organisational anxieties are a manifestation of the internal worlds of organisational members. Hoggett (2015) points out that Jaques theory was not psycho-social. Jaques saw it as form of one way traffic. The organisation was a place to which its members brought their anxieties, the organisation's work did not cause anxiety into its members : 'Individuals unconsciously or collusively concoct organisations as a means of defence against psychotic anxieties, thereby generating a fundamental cause of problems within these organisations' (Jaques 1955, p.343).

Menzies Lyth on the other hand, was of the opinion that the work caused anxiety. During diagnostic work in a hospital Menzies Lyth found high levels of tension and stress amongst nurses. She postulated that the primary task of an organisation can be a source of so much stress or anxiety that it causes its members to develop 'socially structured defence mechanism' (Menzies Lyth,1960/1988). Characteristics of such a mechanism are that they help individuals to avoid feelings of guilt, doubt and uncertainty. Menzies Lyth focused on the task. She assumed that the task of looking after and caring for suffering patients evoked intense mental pain in the nurses. And that this could not be consciously acknowledged by the nurses themselves nor by senior staff members who run the organisation. Unconscious social defence mechanisms are

a way of dealing with unacknowledged anxieties, they are socially constructed and maintained. Menzies Lyth provided the following examples of such mechanism:

* Splitting up the nurse -patient relationship.
This was done by for instance giving the nurse such a workload that she could only attend to each individual patient for a very short time. The contact with the patients was split up and reduced to a number of tasks the nurse has to perform.

*Depersonalisation, categorisation and denial of the significance of the individual. Instead of talking about a patient by using his first of last name patients were referred to by their bed number of the disease they were suffering from: the liver in bed ten.

* Detachment and denial of feeling.
Menzies Lyth came across implicit directives that implied that a good nurse was willing and able to move from ward to ward or even hospital to hospital at a moment's notice without disturbance, as such preventing a nurse from forming any deep attachment with any of the patients.

*The attempt to eliminate decisions by ritual task performance.

Nurses were instructed to perform task-lists in a very precise and ritualistic manner, even if objectively speaking such precise instructions were not necessary.

* Reducing the weight of responsibility in decision making by checks and counter checks.
The practice of checking and counter checking had become a ritual in itself. Even if a situation was not life threatening, other nurses had to be involved in reviewing decisions.

* Collusive social redistribution of responsibility and irresponsibility.
Menzies Lyth observed hat certain groups of nurses were collectively and habitually described as responsible or irresponsible. The irresponsible ones clearly needed to be supervised and disciplined. It was usually a junior category that was regarded as showing the irresponsible behaviour. Menzies Lyth also observed that many nurses complained that their seniors imposed unnecessarily strict and repressive rules and treated them as if they had no sense of responsibility. (Menzies Lyth 1960/1988 p50-58).

Menzies Lyth and Eliot Jaques both did seminal work in relation to the concept of anxiety and social defences in organisations in the 1950s and 1960s. In a recent publication in the Tavistock Clinic Series (Ed Armstrong and Rustin 2015) the paradigm of anxiety and social defences is revisited and further explored. The objective of this

publication was to investigate if the paradigm was still valid and able to produce new insights or if it had become a 'dead metaphor'. The research papers included in the volume show that after sixty years the concepts can indeed still bring new insights.

Armstrong and Rustin (2015) provide a summary of the developments since Jaques and Menzies Lyth and clarify the underlying Freudian and Kleinian theory behind the concept of anxiety. According to Freud, anxiety was experienced whenever the ego, or the rational part of the mind, felt at risk of being overwhelmed. As a result of anxiety the capacity to think is undermined. Anxiety can have different degrees. Psychotic anxiety as a severe form can confuse a mind completely for instance. Freud distinguished between fear and anxiety. Fear is of a known object, anxiety on the other hand is of a response to a situation of danger that is not understood. Melanie Klein brought a relational aspect to the concept of anxiety. Anxiety is caused by the fact that as human beings we always have to position ourselves in relation to others in our environment. In Klein's developmental model there are two distinct positions; the paranoid schizoid position and the depressive position, that we have to go through in order to be able to deal with the world around us.

The paranoid schizoid and the depressive positions

With the concept of the paranoid-schizoid position' Melanie Klein tried to capture in words what possibly happens when a baby develops and tries to get a grip on the world around him. According to Klein a child during the first months of his life is not yet able to see the world as a whole. He has contact with components, that as far as the child is concerned exist independently of each other. A child does not see his mother, but her eyes, her hands and her breasts. Because the child is not yet able to enter into social relations with individuals but only with parts of the person, Klein used the term object relations. The child has relationships with the different objects in its environment. Based on the experiences he has with these objects, he slowly builds a picture of his surroundings. Initially, the emotions of a child are primitive. If an object causes a pleasant emotion it is a good object, or if an object causes an unpleasant or painful emotion it is a bad object. A breast is good when it gives milk, bad if it does not and you want milk. This split into good and bad characterises Klein calls the 'paranoid-schizoid position'. As a grown up we can fall back into this paranoid-schizoid position. If we find ourselves in situations that remind us somehow of this first primitive period in our lives, it is possible we often fall back on our first survival mechanism. We split things into good or bad, and we project things that we can not face into others. In organisation we often find ourselves in situations that are complex and not necessary always pleasant. Splitting therefore can be observed as happening in many organisations. And example of splitting in an organisation is when all staff are regarded as

irresponsible or childlike or management collectively is regarded as incompetent.

The paranoid-schizoid position is an essential and important position and not necessarily destructive. The fact that we are able to split things into good and evil, allows us to create order out of chaos. This enables us to develop our powers of discernment at a later stage in our lives. When a child develops he actually learns to see that his mother is a complete person. Both the good and the bad things come form the same source. The child begins to realise that his mother is neither purely good or nor purely bad. He also realises that he himself has ambivalent feelings toward her. Sometimes he likes her, sometimes not. If the child's emotional development proceeds he can learn to deal with these ambivalent feelings. He then realises that he does not destroy his mother when he does not like her. Slowly but surely, the child learns to tolerate and handle his own feelings of ambivalence. This position, in which we learn that that *either-or* can actually be *and - and* Klein called 'the depressive position'. It's an important position and necessary for a child to go through. It is a prerequisite for further growth.

When as adults we find ourselves in a situation that evokes a lot of frustration, our earliest defence mechanisms come back into play. Work environments are ideal environments to evoke frustration and can trigger our earlier unconscious fantasies. Especially when an environment is perceived as unsafe and there is turmoil, irrational

behaviour can prevail. People resort to splitting for instance which is a form of either-or thinking. Something is either A or B, either good or bad. The possibility that something could be both A and B, that is complex and contradictory, is not considered. Splitting belongs to the paranoid schizoid position. Considering that something could be both A and B is a form of thinking that can emerge in the depressive position.

Projection

Projection is another important psychoanalytic concept used in psycho-social studies. Projection is the process whereby someone protects him or herself against unpleasant feelings, thoughts or impulses by denying their existence in themselves, while ascribing these feelings, thoughts or impulses to others. It is not me who is mad, you are mad.

In his dictionary of Kleinian thought Hinshelwood has included the following definition:

> *Projection of parts of the self*: Another sense in which the term projection was used by both Freud (1895) and Klein (1946) was to attribute certain states of mind to someone else. Something of the ego is perceived in someone else (Hinselwood, 1991 p. 397).

In organisations this is a particularly useful concept to understand what happens between neighbouring units or between management and staff. Each unit or group uses the other to attribute negative qualities. Staff are branded as behaving in a childish manner, management is seen as being out of touch with reality and not understanding the complexity of the work at hand.

Onwards from Klein: Borderline states and perversity

Armstrong and Rustin (2015) describe how in recent decades others have developed the concept of unconscious defences in clinical

contexts. Among others Steiner (1993) evolved the idea of narcissistic or borderline states of mind. Armstrong and Rustin explain how borderline states of mind are a form psychic retreat, caused by unbearable forms of anxiety, which can either be of a paranoid-schizoid or depressive kind or both. When in a borderline state of mind someone's ability to think is impaired.

Klein spoke about the fundamental emotions Love and Hate. Bion added a third fundamental disposition: the desire to understand, or the impulse related to curiosity. Curiosity is the impulse of the reality principle, the principle or wish to discover and understand the world around us. If on the other hand we accept something as true which is not true, than something is overriding our curiosity, our wish to find out more. If the impulse to curiosity is blocked normal development is impossible. This can happen when emotions are felt to be unbearable. This leads to an attack on thinking. Bion lists fear and anxiety as factors that can block the impulse to curiosity. A borderline state is what Bion (1967) would call an attack on thinking, or the perversion of the urge to know. And this is a dangerous state. Bion was of the opinion that this could lead to pathological situations. Cooper and Lousada, (2005) detected something similar in the UK context. They analysed that the UK Welfare system was suffering form borderline states. Borderline, they write, 'is about instinctual conflict between making or breaking contact' (2005 p.29). It is about systems of defence against unbearable pain.

Cooper and Lousada's central argument is that up to a certain time the welfare state was more or less able to provide this healthy form of containment. However due to all the changes that have taken place such as outsourcing, semi-privatisation, new public management, etc. the 'discrete containers' ('management', 'professional', 'institutions') have been broken up. Therefore social anxiety has been dispersed over a much wider field. This might be one of the reasons that welfare governance now has a double task. On the one hand it must provide the practical conditions that allow the disadvantaged to be looked after, on the other hand it must control powerful social anxieties. It must simultaneously 'disclose and foreclose'. This leads Cooper and Lousada to the conclusion that we now have 'borderline states in society'; Borderline states often operate in defensive mode, and come across as a 'scrutinising, punitive superego.' So Cooper and Lousada claim that dynamics in wider the society influence the day to day running of an organisation.

Where borderline states predominate, disturbing realities are dealt with in a very distinctive way - they are simultaneously accepted and denied. Steiner (1993) demonstrates how this is a perverse relation to the real. Hoggett (2015) points out how Steiner saw this perverse relation to reality as the manifestation of organised systems of defence, something he called the 'pathological organisation'. In doing so Steiner built upon concepts of Rosenfeld (1987) and Meltzer (1968).

Rosenfeld started to develop the concept of the psyche as an internal society. He worked with patients whom he diagnosed as suffering from 'destructive narcissism'. Rosenfeld observed when he treated such patients it was as if he was dealing with a powerful gang, dominated by a leader, implying that the self was structured like an authoritarian internal society. Meltzer (1968) worked with the notion of an internal establishment.

According to Steiner pathological organisations can be conceptualised as 1) systems of defences and 2) as highly structured, close knit systems of object relations. Hoggett takes the following points from this:

1. The Pathological organisation is an organised system of defence
2. The system can be thought of as an internal establishment which operates for the most part on the basis of consent but which is threatened, can unleash considerable violence
3. There is something perverse about the way in which the system operates, not only in terms of collusion that it invites but in terms of the tendency to be contemptuous of the patient's loving needy and thoughtful aspects (Hoggett 2015 p.54)

At this stage Hoggett is still talking about the defence system an individual establishes to cope with overbearing feelings. He warns against applying this form of reasoning to enterprises or business in a

simple way. A hospital or care home cannot simply be called a pathological organisation in the same way as this concept is used by Steiner in relation to individuals. More work needs to be done before what happens in an individual mind can be used to explore to the dynamics in social organisations. Susan Long (2008) undertook such a thinking process when she developed the concept of perverse organisations. She is indeed referring to social organisations, firms, businesses, where a culture has emerged that allows for perverse actions and processes to take place. A social organisation is formed by the people who work there. As such it is a social construct, an organisation *in-the-mind.* She described how perverse dynamics in organisations lead to processes of collusion. Members within an organisation, such as Enron for instance, acknowledge disturbing facts (for example regarding declining profitability or corruption) but at the same time deny them. Rather then facing the difficult truth, there are mechanisms in place that allow members and partners (lawyers, accountants) to turn a blind eye and to pretend that everything is perfect. Long describes how perversity procreates more perversity and how difficult it is to break this cycle. Members of the organisations become accomplices in the processes of denial that helps to construct supportive networks.

Structures of feeling

So it is possible to see how care organisations may deal with disturbing truths in similar ways to those described above – not just through

splitting and being thoughtless but through organised but unconscious systems of evasion. A final concept which may useful to my analysis originates primarily from sociology rather than psychoanalysis but it could be valuable means of understanding how powerful emotions in society are 'transmitted' into organisational worlds.

The concept structures of feeling was originally coined by literary critic and political scientist Raymond Williams (1985). Williams used the concept to describe an underlying feeling, an almost unconscious way of responding to the world that is shared by many, without consciously realising that this is the case. It is a sort of collective unconscious, a way of reacting that is quite intangible, yet it is there and it influences how many people react. He gives the following definition of the concept:

> It is as firm and definite as 'structure' suggests, yet it is based in the deepest and often least tangible elements of our experience. It is a way of responding to a particular world which in practise is not felt as one way among others - a conscious 'way', – but is, in experience, the only way possible. Its elements … are embodied related feelings. In the same sense, it is accessible to others – not by formal argument or by professionals skills, on their own, but by direct experience.' (Williams, 1993, P.18).

Developing this idea further Hoggett (2010) proposes to deploy the concept as ' a device for understanding the existence of enduring configurations of affect that characterise the subterranean sentiments of an era or epoch' (p.13).

In order to fully understand the concept of structures of feeling it is important to grasp the distinction between affects, emotions and feeling.

Crociani-Windland and Hoggett (2012) explore and discuss the role of human passions in societal phenomena such as for instance the rise of populism. They write how feelings can 'connect or disconnect from one and another in in complex, indeterminate and surprising ways' (op.cit. p.161). In other words, feelings move around, flow and circulate. Crociani-Windland and Hoggett make a distinction between affects, emotions and feelings. They place affects and emotions on a continuum: affects refers to 'more bodily based' and 'indeterminate forms of experience', emotions on the other hand refer to experiences that have 'undergone qualification' and have entered the 'discursive level'. (op.cit. p.164).

Affects are more raw, fluid and much less clearly fixed then emotions. Emotions have a strong cognitive dimension and can be thought about and reflected upon There can be a clear connection for instance between grief and the object of loss. If you lose a loved one, you experience emotions of pain and loss that are caused by this major event. It is easier to talk about emotions precisely because they have

undergone modification. They are feelings that have undergone a kind of transformation and are more conscious and can be more clearly linked to a specific event, occurrence or happening. In contrast affects are linked to somatic or bodily aspects of feeling and are less conscious. Affects as such are hard to talk about, precisely because they are unspecified, under-defined feelings that are not clearly connected to a specific event, occurrence or happening. Affects are much free-floating and are not noticeably linked to an object. In fact, they can be described as feelings that are searching for an object to hook onto or be contained by. An object is a source or event or an occurrence in the environment which suddenly becomes the focus of the affect and to which it temporarily attaches itself.

Anxiety is a classic example of an affect. When anxieties become shared by many citizens they become social anxieties and operate in this fluid and indeterminate way. As such they can easily permeate organisational boundaries. It follows therefore that particular kinds of organisations often have to contain social anxieties. Hospitals and care organisations have to contain social anxieties relating to ageing, vulnerability and dying. How they contain these anxieties, creatively or not, is therefore a key question both for recipients of services (patients, residents), for providers of care (nurses, social workers, care workers) and for society as a whole and its capacity to think about these issues.

Health, Morbidity and Care for the Elderly

Changing views of mortality and vulnerability:

The research for this study took place in care homes for the elderly. The residents in these homes are close to death. How a society treats its elderly has links with general attitudes towards death in that society. In this respect Aries' history of western attitudes to death over the last millennium is an interesting starting point to explore how modern orientations towards death have evolved. Aries (1981) relates how since the beginning of the twentieth century death has been removed from public societies in the Western world and turned into a private matter. According to Aries there was a more or less permanent relationship between death and society for 900 years, death was regarded a social matter. When someone died forms of communal mourning took place. Time stopped and the focus was on the dead and the bereaved. Dying was a public event. The traditions surroundings someone's death as it were helped to tame death. Much of the last millennium Aries describes as the period in which death was being tamed and domesticated

At the end of the nineteenth century, the beginning of the twentieth century, the attitude towards death changed. Aries refers to the twentieth century as 'the area of the invisible death', and describes how the process of dying gradually was removed from the communal home and transferred into the hospital. In the beginning of the twentieth century most people still died at home. The room of the dying was easily accessible to anyone who wanted to pay their respects. By the 1930s and 1940s, it had become more customary to have the dying transported to hospital. And after the Second World War this had

become common place. Death in this way was turned more and more in

a medical issue that was dealt with by the medical sector. Aries links

this development to new ideas about privacy and personal hygiene. He

describes how death came to be regarded as dirty and as something

that had to be avoided. People found it harder to tolerate the proximity

of death in the privacy of their own homes. The burden of care which

had once been shared by the larger community came to rest on the

shoulders of the closest relatives and specialised carers. When the

advances in medical care increased, the next step was to move

terminally ill patients to the hospital. Death became a private matter and

the hospital became, what Aries refers to, 'the place of the solitary

death' (Aries 1981 p.571). The number of people dying in hospital alone

increased. In this way western societies in the twentieth century

organised death away from every day life. The medical sector took over

the management of death. In many instances someone who was dying

came to be treated like someone who had undergone surgery.

According to Aries death was no longer accepted as a natural,

necessary phenomenon, but instead was regard as a failure or an

opportunity lost. (p. 586)

Bauman (2003) explores the presence of death in human institutions,

rituals and beliefs which at a first glance might seem to have nothing to

do with death. He attempts to uncover the 'collective unconscious' (p.

11) in relation to ideas in society about mortality. Bauman starts with

exploring Epicurus's logic that as human beings we cannot perceive or

experience our own death. We will never be able to narrate our personal death story. Once it has happened we are no longer there to tell the tale. Our own death is a an 'unknowable event '(p4). We can only imagine what it will be like and yet in our imagination we will never be able to grasp what it will really be like. Death is the end of our perception. So why fear death? According to Epicurus we should listen to reason and not be fearful or anxious about our personal death at all. What we fear is not our own death but the death of those around us. We fear the death of others, precisely because our perception does not stop after the death of a beloved one. We can perceive and experience the void that is left by the other's departure.

Yet despite Epicurus' elegant reasoning, fear of personal death is what most people feel. As human beings we know we are going to die and we cannot 'unknow' this knowledge. We can only temporarily suppress it. As human beings we all know that mortality is part of the deal. Bauman postulates that from the start culture has been the device that has been used to suppress this unbearable knowledge. He sees death, or rather the awareness of mortality, as 'the ultimate condition of cultural creativity' (p.5), since culture is a means to find the continuance that life by itself cannot offer. Through culture human beings try to create a sense or feeling of immortality. He distinguishes two strategies which present day societies deploy simultaneously: a modern drive to deconstruct mortality and a post modern drive to deconstruct immortality

Bauman links the change Aries notes between a tamed death and an invisible death to the rise of modernity which had become prominent in the 18th century. Modernity is about the domination of reason over nature, and the defeat of the unexpected. Death does not fit well in this picture. Mortality had to be deconstructed. Bauman describes how death came to be regarded as 'the major scandal', or the one issue which man could not control. And as such death became to be regarded as a denial of everything that modernity stood for. Death became a 'guilty secret', something that had better not be talked about. It came to be treated as a thoroughly private matter. The dying and non-dying started speaking a different language. Death no longer has meaning in a world where the focus is on denying that there is a limit to human potency.

Bauman notes that in the present time the living seem to have no suitable language with which to address the dying. According to him this is has nothing to do with 'delicacy of manners' but more with the fact that the living have nothing to say anymore to someone who has 'no use for the language of survival'. The language of survival focuses on action, on efficiency and effectiveness. The tasks of the non-dying is to keep fit and exercise, to eat healthy diets, to stop smoking. By sending out such messages, death is reduced to a small health hazard that can be solved. Diseases can be cured. Life can be extended. Healthy food ands sport will extend lives. Rather than admitting that death is the ultimate end, death is converted into something which can be avoided or

worked upon. If all this fails, death is being treated as infectious disease. Those suffering from it need to be isolated from the rest of society. In the end no-one dies of mortality, everyone dies because of a particular cause.

By deconstructing mortality, death has lost much of its significance. Death can be placed in the category of the Other. Bauman points out that death has always been the opposite of life and therefore the Other. Yet in modern times the Other is treated in a rather specific manner. He refers to Levi-Straus' distinction between simpler anthropophagic societies and modern anthropoemic societies[2]. In anthropophagic societies they metaphorically eat their enemies, in anthropoemic societies enemies are metaphorically vomited out. Bauman brings up this distinction to discuss different views on relationships between self and the other and how this affects ideas about kinship and affinity. Anthropophagic societies take the other inside, thus maintaining a connection between the self and the other. Anthropoemic societies see the other as something you have to get rid of. There is a distinction between the other and the self, they have to be disconnected. And this has consequences for ideas about kinship. In anthropoemic societies the focus is on separation rather than on kinship and affinity: I am different from you and not part of your kin.

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[2] When discussing anthropoemic societies vs anthropophagic societies, Bauman writes about the other with a captal 'O'.

The deconstruction of mortality has turned death into a private matter. People have started to behave as if they can control death. If they take the right precautions they can keep death at a distance. As such people have become responsible for their own death. If you die, you have not lived a healthy life, so it is your own fault. This has led to the paradoxical situation that death has become part of everyday life and that the war against it has to be fought every day. This creates feelings of anxiety. The best way to conquer this anxiety is to take action, to do things, to stay busy and not too think too much about it. Of course modernity cannot conquer death but it has managed to banished it and dying occurs out of sight and thus out of mind most of the time. Professionals are given the task to look after the dying thus freeing up the mind of the non-dying to occupy themselves with other matters.

Post modernity and the deconstruction of immortality

Alongside the modern trend to deconstruct mortality, Bauman detects what he refers to a post-modern trend to deconstruct immortality. Post-modernity as opposed to modernity focuses completely on the present. Life is now, and it is not bound by the past or the future. What counts today, may no longer count tomorrow. Memory is short, what is of interest today may be history tomorrow. The so called opposition between the short- term and the long lasting is effaced. Life is turned into what Bauman refers to as a game of 'bridge crossing'. The number of bridges to choose from seem endless and there always is a way back. What has disappeared can return in a virtual form or shape and in

his form can feel just as real: 'Time is nothing but a succession of episodes, without consequence' (Bauman, p.47). And as such immortality loses its meaning as well, it becomes 'nothing but an ongoing sequence of mortal beings' (Bauman, ibid.).

Social and cultural context or after ethics of care
Lloyd, White and Sutton (2011) explore social and cultural contexts of death in the present time and look at the work of fellow researchers who explicitly focus on end-of-life issues or dying. They provide an interesting overview of important themes that are relevant to consider when researching and thinking about end-of-life in old age.

They start by quoting Walter (2003) who points out that ideas on what is a good death are dependent on social and cultural norms. Walter lists three social factors that play an important role: secularisation, individualism and how long the death tends to take. These three factors are indeed important in Dutch Society. Since the Second World War, secularisation has been a major factor. According to the latest figures 30% of the Dutch population indicate they are part of a church community. Approximately 10% of the population regularly attends church. The role of the church as an institution is dwindling. Nevertheless there is not a one on one relationship between church affiliation and religiosity. In their study on religiosity in The Netherlands Institute for the Social Research (2012) point out that the data shows that although there is a strong decline in Church membership, the belief

in God or another higher power is not declining at the same pace. Religious trends among minority groups can be quite different from the majority. One of the case studies were the research took place was a Jewish organisation. Leichtentritt and Rettig point out that in stricter forms of Jewishness there is 'one way to die, on way to be buried and one way to turn the loss of a close family member' (LLoyd, White and Sutton, 2011. P. 387). In secular environments there usually is a multiplicity of ideas on what a good death entails. However, Seale and Van der Geest (2004) did a comparative study into what is perceived as a good death. They did find cultural difference, yet they also conclude that some ideals about dying well seem to be universal. In all the cultures in which they did research they found that a good death is 'a death occurring after a long and successful life, at home, without violence or pain, with the dying person being at peace with his environment and having at least some control over events' (Seale and van der Geest 2004 p.885).

Lloyd, White and Sutton point out that in many western societies secularisation has coincided with the growing importance of medicine and the increasing power of the medical profession. In most western countries this has set in motion a development were medicine and the medical profession have taken over the role of religion in managing death (a phenomenon also highlighted by Aries). In line with this development Timmermans introduces the term 'death brokering' to refer to the 'medical activities of authorities to render individual deaths

culturally appropriate'. (Timmermans 2005 p.993). The medical sector has been made responsible for arranging matters around death and has been given the role to form the cultural link between life and death. Timmermans follows Bauman's analysis that in modern times societies unconsciously prefer to deconstruct death and remove it from day-to-day lie as much as possible. Timmermans does not regard trends to open up discussions around the-right-to die and hospice movements as a challenge to this status quo. In fact these movements seem in fact to have reinforced the need for more specialised medical guidance. The medical sector stays in the managing role and it has effectively become almost impossible to die without somewhere in the process having contact with the medical profession.

In many western countries the hospice movement and palliative care models have become more prominent. Lloyd, White and Sutton regard this as a trend which is worth exploring further in relation to caring for the elderly. They point out that the palliative care approach was initially developed in cancer care and focussed on supporting dying middle aged people. The palliative model does not automatically work in each situation in which the elderly towards the end their lives find themselves. The complexity of their dying trajectories often make it less predictable what kind of care they need. In western countries most older people die in nursing homes, although there are trends to enable the elderly to die at home. Lloyd, White and Sutton see this as a potential positive development although they point out that this can increase the risk of

loneliness and isolation for the elderly and that it can increase the pressure on families and next of kin, if they are not adequately supported by care services.

Ethics of care framework: Tronto, Kittay and Sevenhuijsen

How can care be placed at the centre of our political life? This is a the question Tronto (2013) tries to answer in her book *Caring Democracy, Markets, Equality and Justice*. In order to find an answer Tronto explores how modern western societies deal with the public-private divide. What does society regard as belonging to the public sphere and what to the private sphere?

For centuries caring for the vulnerable, children, the sick and the elderly, was seen as the task of women and belonging to the private sphere. Tronto refers to Aristotle's *Politics* and the distinction he makes between *polis* and *oikos* to illustrate that the question 'who does the caring and where does it take place' is not a recent one. In Aristotle's time polis, or the public sphere, was the location were men could partake in socially important matters. *Oikos* or the household was the place where women and slaves provided the care necessary for the men to be able to take up their public roles.

In the present time it is not so easy to provide an easy answer to the question where care takes place. Some of the caring indeed still takes place at the home and most of the caring is indeed still done by women. But the public/private divide has become less clear. Care has been professionalized. Many women provide care as paid employees outside the home situation. Care as a service is high on the agenda of policy makers in western governments. One important public debate for instance is on whether society can afford to bear the burden of having to provide for its ageing society. So care is no longer just part of the household sphere. Tronto contends however, that many issues concerning care are up to the present time dealt with as if care is still a private matter.

In the public domain the focus is on the economical side of care. In fact the language of economics seems to be the only language which is used in the political arena. The discussion concerning care is on production, efficiency, cost cutting, competition and free choice of consumers. Citizens are treated as if they are self-sufficient, autonomous actors, who can buy the care they need on the market if and when they need any.

Care however is more than a commodity and its nature is by definition complex. And in the present society, many care needs cannot just be met by family members. According to Tronto caring 'is no longer at home'. As a result it has lost it bearings and has become detached from

the realties of every day life. It is important therefore, to rethink as a society what we mean by caring and were the responsibilities of caring should lay. In order to do this, it is important to define what caring actually is about.

As part of a scholarly tradition that concerns itself with the ethics of care Tronto and Fischer came up with the following definition of care in the 1990: 'On the most general level caring should be viewed as *a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it a well as possible* (Tronto 2013, p. 4). It is a broad definition and others have criticised Tronto and Fischer for this. But they state that an investigation into the place and meaning of care in society benefits from a broad definition. In particular contexts it will be necessary to specify further what caring is about.

Tronto and Fischer define caring as a complex process. They distinguish four phases in this process: phase one, *caring about,* phase two *caring for,* phase 3 *care-giving and* phase p.4 *care receiving*. Tronto (2013, p.35) herself added a fifth step: *caring with.* She also identifies moral qualities that align with each phase. Phase one requires *attentiveness*, the quality to notice if care is needed. Phase two requires *responsibility*, the quality of meeting the care needs. Phase three requires *competence*, the quality to be able to provide the needed care. Phase four requires *responsiveness*, the quality to observe whether the care needs have been met successfully. For the fifth phase Tronto

identified not just one quality but the following four: *plurality, communication, trust and respect and solidarity*.

The definition and the phases make clear that a relational perspective is essential when thinking about care and organising care. In this respect it is important to state the following central principles of the ethic of care framework: human beings are always in relationships and are members of a system even if they choose to operate individually. All human beings are vulnerable and fragile, although degrees of vulnerability and fragility will vary depending on circumstances and phases of life. And everyone is a care receiver and a care giver. Tronto offers her definition of the phases of care and the central principles of the ethic of care framework as an alternative to the neoliberal framework which she describes as holding a proper debate to ransom with its exclusive focus on economic issues and the belief that the 'market' will solve disputes and allocate resources. The neoliberal framework reduces humans to buyers and sellers, workers and consumers. The central principle of neoliberalism is that human beings are autonomous and independent and responsible for their own choices. Both success and failure are attributed to personal responsibility. Policies based on neoliberal principles favour/ target those who have success and are not aimed at those who are vulnerable or dependent consequently they undermine solidarity.

Kittay, another scholar who contributed to the ethics of care framework, states that dependency has become the elephant in the room. Neoliberal theories treat individuals as 'unembodied subjects - not born, not developing, not ill, not disabled and never growing old' (Kittay et al 2005 p.445). Dependency has been pushed into the realm of the private. This is unrealistic. In order to become independent everyone must first be cared for. And towards the end of one's life it is quite likely that care is needed again. The ethics of care framework does not distinguish the old from the young. Throughout the life course dependence and independence are factors of life that have to be dealt with.

Sevenhuijsen (1998 has explored the reforms in the Dutch healthcare system from the perspective of the ethics of care framework. She has taken a close look at a Dutch policy document *Choices in Health Care*, which was published in 1991 prior to the introduction of the new funding system in the Dutch healthcare sector. In this document the Dutch government presented ideas on how to organise healthcare services in such a way that the services will remain affordable and accessible to those in need of them. Sevenhuijsen analyses what the policy document says about the concept of 'necessary care' and 'normal social participation'. What is meant by social participation? She finds an answer in the example which is used in the report on 'necessary care' for women. It is argued that *in vitro* fertilisation should not be regarded as necessary care because involuntary childlessness does not hinder

women from normal participation in society. Sevenhuijsen draws the conclusion that normal social participation is equated to 'participation in the public sphere of paid labour and political participation', and that childbirth and reproduction are apparently regarded as women's individual responsibility and being part of the private sphere.

A second example she analyses focuses on what the document says about the weak and vulnerable in society. The elderly and mentally handicapped are defined as 'people who cannot take care of themselves'. It is stated that society has the fundamental moral obligation to provide necessary care for these groups in society. Sevenhuijsen points out that here the elderly are stigmatised as weak and needy and that it is implicitly stated that normal citizens are not weak and needy and can take care of themselves. She contends that this fits with neoliberal notions of citizenship. According to this world view citizens are conceptualised as self-sufficient individuals who can participate in the public sphere where labour and commodities are exchanged. The function of care is to repair citizens so that they are able to engage fully in society. In this way illness is seen as a deviation from the norm, rather than as something which is inherent to life. She states that as a result of the notion that illness is a deviation from the norm care is moved outside the public sphere and confined in 'the black box of the private realm'. And in this private realm care supposedly is provided spontaneously by women.

Sevenhuijsen argues that the focus of the document is too narrow. Looking at the policy document from a feminist perspective she observes that the report does not contain any reference to feminist approaches to healthcare. In her view the document presents a fragmented view of care and health and reduces care to a commodity. Like Tronto and Kittay she sees a 'neo-liberal mode of regulation' which is taking place in most western countries. The proposed Dutch healthcare policies will lead to the reinforcement of the market system. She predicts that care organisations will be forced to concentrate on defining uniform standards and focus on efficiency and effectiveness. As it is, the report is an 'endeavour to regulate the demand side (the patients) of the healthcare market'. Apparently this is regarded as easier to achieve than regulating the supply side (the care institutions) because, as *Choices in Health Care* argues, the power structures on that side are too strong and too resistant to political regulation.

Sevenhuijsen supports Tronto's line of reasoning that the ethics of care framework offers a better alternative for reorganising the care sector. Tronto's and Fischer's definition of care as a complex process invites us to look at care from the broadest perspective. It creates the space in which to take into consideration how social practices can influence the attitudes of staff, managers and policy makers. It provides the opportunity to explore the experience of women as carers. It allows for discussion of issues of power such as that between the provider and the receiver of care. And providers of care often have limited control over

their own working practices. Rules and regulations require them to work in ways that allow very little time for social interaction with their clients and turns care into a mechanical action.

The ethics of care framework is based on the following core principles. As human beings we are always interdependent. Care is about human interaction and interrelatedness. The liberal model of individualism is too limited and reduces care recipients to market players in a field that favours other forces. The liberal model constitutes a world of abstract ideas that is far removed from peoples' experiences in the real world.

Care and autonomy should not be regarded as dichotomous in nature. It should be acknowledged that matters of dependency are part of life and will affect the public sphere and the private sphere. In her later work Tronto pleads for a caring democracy in this respect. In such a democracy everyone has the responsibility to reflect upon the nature of care and allocation of care resources. It is about 'freedom', 'equality' and 'justice'.

Global Issues Concerning the Care for the Elderly

Lloyd (2012) uses the ethics of care framework as her starting point for a discussion on global issues concerning care for the elderly. She takes a critical look at international policy developments and explores the connections between ageing, health and care. As a start she analyses data collected by the World Health Organisation for the Global Burden of Disease project in which data is compared and examined on life expectancy and on mortality and morbidity rates world wide. Since my research has taken place in a western high income country, The Netherlands, I focus on some of the trends Lloyds discusses concerning this part of the world.

Throughout the world life expectancy of people is increasing, but especially so in western countries. In high income countries 85% of deaths occur in the age group of over 65. The first major cause of death in high income countries is heart disease. Alzheimer and other dementia related diseases are the fourth major cause of death. Gender inequalities are a worldwide issue in the care sector. Women tend to have more illnesses, yet they tend to receive less healthcare than men. Women tend to live longer and this increases their risk of developing Alzheimer or the psychogeriatric illness. Widowhood is a source of mental heath problems. Financially women are at a social disadvantage since they, on average, have lower incomes and less access to financial resources. In the sector men tend to control the heath budget and the facilities. The majority of caring is done by women.

In many countries, but certainly in high income countries, population ageing and social support is regarded as an important issue. Europe has the highest proportion of older people in the world - 22% of the population is aged 60 years or over. And the prediction is that this number will rise to more than 35% in 2050. Policy makers tend to describe social support in the context of an ageing population as a nightmare scenario. Words like 'time bomb scenarios' are used. And it is written that the proportion of over 65s will become unsustainable. These fears influence developments in policies on health and care. Lloyd argues that a closer analysis of the figures and trends is needed.

The picture is more complex than it might seem at first sight. The dependency ratios policy makers refer to tend to be used in too simplistic a manner. The figures cannot be disconnected from other demographic trends in societies and the need for care cannot be predicted on chronological age of the population alone. Economic productivity as a measure should also be looked at critically. Economically productive activities can range from paid work to activities that enable others to take up paid work, such as child care or community work. All ages participate in these kind of activities, also many above the age. It is known is that individual healthcare requirements are highest in the period to death. This applies to all age groups. The need for healthcare tends to reach its highest point between the age of 75 and 79 and then the need tends to decline.

Figures suggest that although the number of older people who use care services is higher than young people the cost per services for younger people are higher.

According to Lloyd we need to more thoroughly understand how socioeconomic determinants of health interact with behavioural and cultural factors throughout the life course. In addition it is important do develop a better understanding of dependency throughout the life course. Policy decisions and developments should not be based on crude aged-related calculations alone. Lloyd lists a number of conceptualisations of health that can be detected in society. For each model she briefly discusses what the effect of these models are on care for the elderly.

Biomedical models:

There are biomedical approaches to health. These models have a negative approach to health. Health is the absence of disease. The focus is on disease and cure. Ageing is regarded as a form of disease. Critics of this model point out that it reduces ageing to a set of individual physical complaints. It disregards the necessity to think about appropriate housing, public health, preventative care and chronic and long term care. The biomedical model is influential and has shaped ways in which care is organised. It has stimulated, what is referred to as the 'discourse of the professional helper'.

Health as the absence of illness model:

This model resembles the biomedical model in that it has a negative approach to health, as the absence of illness. It differs in that is distinguishes between objective and subjective feelings of health. Disease is seen as objective, illness as subjective. Whether one feels ill depends on the interaction between an individual and social and cultural factors. This model introduces a moral component. Perceived costs of care might influence decisions whether to consult a doctor or not. Lloyd points out that is important in relation to alarm in society about the costs of population ageing. If the dominant message is that older people are a burden on resources, the elderly may internalise this message and refrain from seeking help.

Functional or instrumental models of health:

These models see health as a means to an end. The conceptualisation of health can either be biomedical or non-biomedical. The focus is on what health enables people to do. The question is whether individuals have the vitality to achieve their goals. Functional health is associated with self-reliance and a sense of mastery and control in everyday life. Lloyd states that in healthcare, functional ageing is seen as a more accurate predictor of life expectancy than chronological ageing. The idea of functional health is valuable in relation to managing demands on health and long-term care. It fits the neoliberal agenda of linking healthcare policies to functionality. Lloyd warns that this may lead to too

strong a focus on controlling demands for services rather than on focussing on what benefits older people.

Salutogenic approach to health:

This model has a positive approach to health. The dichotomous division between health and disease is seen as incorrect. No-one is complete healthy or sick, but rather find themselves somewhere on a continuum between either state. A salutogenic environment promotes 'a sense of coherence' and stimulates people to deal with the challenges of life. This is one of the few models that focuses on balance and harmony and the interconnection between the mind and body. This approach is seen as an alternative to the biomedical approach.

Health and identity:

This model focuses on the link between individual conceptions of heath and illness and social identities. Cultural norms and expectations influence how individuals interpret and cope with biological changes in the body. Ideas regarding bodily appearance are shaped by culture for instance. In today's western world the focus is on youthful appearances. It is seen as someone's individual responsibility to remain fit and healthy and looking young. Ageing is no-longer held in social esteem.

Economic and Institutional Forces and Care for the Elderly
Global trends

In a recent study *Health and Care in Ageing Societies*, Lloyd (2012) elaborates on the challenges countries face in dealing with an ageing population and health and care. In this study Lloyd succinctly summarises major issues the care sector has to deal with. How care for the elderly is organised depends on many contextual matters. Each country has its own tradition in relation to care for the elderly. However globalisation has had its impact on the care sectors regardless of the historical and social context of the specific country. Lloyd observed how in many of the rich western countries the policies around care for the elderly have grown more alike.

Lloyd detected that in the Western countries that have elaborate welfare systems the agenda for heath care is driven by two overarching principles. The first principle is that the focus has to be on the gap between actual life expectancy and a healthy life expectancy. Policy makers focus on stimulating or increasing on what Lloyd refers to as 'active ageing'. The elderly are simulated to remain independent and self supporting as long as possible.

The second principle is that governments have to rein in the costs of care so that when the elderly no longer are able to remain self-reliant and become dependent the costs can be contained. She observes that in many countries neoliberal assumptions determine how those two principles are acted upon. Private not-for-profit parties are given a role in providing services that before were mostly delivered by public bodies,

the expectation being that they are able to deliver care more efficiently. As part of the privatisation or semi-privatisation movement in the care sector, care seekers are seen as consumers or service users who buy tailor-made care packages depending on their personal needs and choice.

Neoliberalism and public service reform in The Netherlands

In their comparative study on public management reforms Pollitt and Bouckaert (2011) compare twelve countries including The Netherlands on how they reorganised their public services by implementing forms of New Public Management (NPM). Before the 1970s, reforms were more a national or even sectoral matter. From the 1970s debates on how to reform public bodies or organisation were influenced more and more by international or global matters. One such influence was the doctrine of neoliberalism.

Harvey (2007) provides a brief history of neoliberalism. He pinpoints the start of the gradual ascent of neoliberalism as the dominant economic paradigm at the end of the 1970s. He provides the following definition: 'Neoliberalism is in the first instance a theory of political economic practices that proposes that human-well being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights, free markets and free trade'. (Harvey 2007, p2).

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Slowly but steadily the doctrine of neoliberalism has gained ground in many countries including The Netherlands and has influenced how governments have started to think about state reforms. According to neoliberal principals the state should provide a framework in which the free market can operate. In many countries the state has withdrawn from areas which before the 1970s it regarded as its task to control.

Kickert (1995) coined the term 'steering at a distance' to describe how the government in The Netherlands saw its new role. Kickert who worked at the Ministry of Education in The Netherlands as civil servant in the 1980s described almost first hand how the Dutch government started to operate as part of chain or network and delegated responsibility to other players such as the schools to organise things themselves. According to Kickert the Dutch situation was unique because the steering concept emanated from within the government and had not been suggested by external consultancy companies for instance. Kickert argues the reforms should not be regarded as a form of government withdrawal but as 'a genuine attempt of the government to improve effectiveness'. Interestingly enough teachers and others in the field of education seemed to have a different opinion about effectiveness and genuineness. A couple of years ago a parliamentary investigation was set up to find out what had gone wrong with the reforms in the Educational sector. One of the outcomes was that the ministry kept on interfering in the day-to-day business of schools, and that the bureaucracy had increased threefold.

Kickert seems to have underestimated how much the developments in The Netherlands were part of a wider global trend and had links with neoliberal principles. Pollitt and Bouckaert's study show how The Netherlands stayed in line with reform initiatives that took place in many other countries. All the twelve countries in their study implemented forms of NPM, adjusting the reform measures accordingly, depending on existing politico-administrative forms of governance.

They place The Netherlands in the group of north-western European states. These states have in common that there is a disposition towards 'a consensual, often meso-corporatist style of governance' (Pollitt and Bouckaert 2011. p.73), which has the effect of weakening of the sharper effects of NPM. There seems to be a move in The Netherlands however towards a more Anglo-Saxon approach in the last years. Pollitt and Bouckaert detect a less consociational and consensual approach since the 1990s. The present government has grown closer to the UK in its thinking about reforms.

Stein and Leisink (Stein and Leisink 2007) quote Kickert in describing the trends in Dutch public sector reforms. In the 1980s privatisation was the main trend. In the 1990s the Social Democrats participated in the coalition governments. During that time privatisation was looked upon as a less favourable solution. The trend moved towards 'self management' and outsourcing. The government placed itself at arms length without going for complete forms of privatisation. It was a more

hybrid form based on the assumptions that governmental steering

capacity in a complex, modern society has its limits (Kickert, 2000) and

that public organisations should become more market-oriented (Bovens

et al., 2001).

Assemblages

The reforms in the Dutch public sector therefore should not be regarded

as simple replacement of the state by the market. Newman and Clarke

(2009) explore the complexity and paradoxes of the changes that are

taking place in and around the public sector in West European

countries. The reforms are never solely concerned with privatisation and

promoting entrepreneurship. They are also concerned with creating new

or different forms of citizenship or social cohesion. Newman and Clarke

introduce the term 'publicness' to discuss or explore what they call the

'combination of things, ideas, issues, people, relationships, practices

and sites that have been *made public*' (Newman and Clarke 2009, p.2).

They warn against the myth that once upon a time public services were

solely there to serve the public and that these were completely funded

by public resources, only staffed by public employees, and that they

were only accountable to public bodies. For quite some time, certainly in

the UK, but also in The Netherlands with its different social pillars (see

chapter 2) the chain of connectedness has been constructed by a

variety of players and parties. What can be said is that for a period of at

least thirty years the chain has been dismantled, split up, partly

privatised, semi-privatised, contracted out, reorganised, transformed, partly handed over to private parties etc.

In The Netherlands we see much more fragmentation and different organisational forms in the care sector. Care organisations have to operate in complex partnerships and networks. Knijn and Selten (2006, p21) in this respect analyse the patterns of control that have come into existence since the Dutch governments opted for the splitting up the chain of purchasers and providers and by outsourcing services. Contractualisation has increased on three levels: the governments are contracting with providers of services that are in the general interest. In the care sector this is for instance with the insurance companies, that have been given the task to manage the sector. The government negotiates with them about the budget. Then there are contracts between chain partners who co-operate in fulfilling a general interest: e.g. the care organisations and cleaning services, and between organisations that provide public goods and their individual clients. Side effects of all this contracting are that there is less grip on the whole process of delivery and that it is much less clear who is accountable for what.

Newman and Clarke refer to these new networks and partnerships as 'Assemblages of Publicness'. Assemblages can have 'multiple sources and resources' that can have been 'dragged into complex uncomfortable and contradictory alignments that produce unstable formations and may

have unpredictable consequences' (Newman and Clarke 2009 p.175). Assemblages are heterogeneous, yet Newman and Clarke detect some dominant assumptions that tend to prevail in many of the assemblages. Markets are deemed superior to states, economic interests are regarded as strong motivational forces, being business-like is seen as a desirable quality, the public is seen as individualist and treated as consumers, and the bottom line is that what counts is what works. They also point out however that privatising public resources is not the same as introducing internal markets, and that the introduction of market mechanisms is not the same as spreading the economic discourse. Yet all these practises are related and the role and importance of markets has certainly increased.

New Public Management

Hood has done extensive research into public management reforms in OECD countries. He describes NPM as a shorthand for a set of broadly similar administrative doctrines which dominate the bureaucratic agenda in OECD countries (Hood 1991. p.3). He detects four mega trends which have helped the spread of NPM: (1) attempts to slow down the growth of governments, (2) the shift towards privatisation or semi-privatisation of core government institutions, (3) developments of automation, and (4) development of a more international agenda. The most likely answer to the question as to why NPM has become so popular and has managed to stay popular Hood finds in historical

developments in the developed world since the Second World War. One of the attractions of NPM seems to be that it is presented as a form of 'public management for all seasons', laying claims to political neutrality and universality. Hood challenges this claim to neutrality and universality. He analyses that broadly speaking it is possible to detect three sets of overarching values in public management. He distinguishes what he calls Sigma type values, Theta type values and Lambda type values. Sigma type values have as core the belief '*keep it lean and purposeful*'. Theta type values have as core belief '*keep it honest and fair*' and Lambda-type values, 'keep *it robust and resilient*'. See Table 1 for the summary of this division.

Hood points out that although the set of values overlap somewhat 'like intersecting circles in a Venn diagram', it is impossible to satisfy all values by one organising principle. NPM primarily operates from the Sigma type value system. It is about cost cutting, contracting out, compartmentalising and top slicing. It operates from the premises that that in the culture of public services honesty is a given and that services can be divided up in to self contained products without affecting the quality of the services. Hood hypothesises that these premises can be contested. Theta type values are likely to be violated in instances of dishonesty and Lambda-type values are likely to suffer from compartmentalisation. In the 1990s Hood called for further research to prove or disprove his hypothesis.

In a recent study Hood (Hood and Dixon 2015) analyses the effects of thirty years of public management reform in the UK. He points out that

remarkably little research has been done to truly measure the effects of the reforms. Debates about the effects of public management reforms tend to be rather ideological and are inclined to end up in pro or con discussions. Therefore a thorough investigation into the effects was anything but overdue. Measuring the effects on a nine point scale between the number one 'costing *the same (not less) and not bette*r' and number nine '*costing substantially more and working worse*' the outcome seem to be that the costs have risen and that there are more complaints about the workings of the government. The outcome seems to favour the NPM critics. Although Hood warns against simple conclusions and calls for further comparative research.

Figure 3.1 Three sets of Core Values in Public Management (Hood, 1991 p.11)

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Audit society

The fact that governments have placed themselves at a distance or at arms length from what formally were seen as public services, has brought into existence a phenomenon that Power refers to as the Audit Society (Power 1997). In the last decade of the previous century Power observed that an audit explosion had taken place, not just in the financial sector but in any sector you can think of. Organisations use auditing as part of the process to make professionals accountable for what they are doing. It is a means of making improvements verifiable to external parties and to provide assurances that matters are in order.

Power points out an interesting paradox in this respect, namely that the auditing process in itself 'lacks clear output based criteria of performance' and is in essence are obscure and non-transparent process (Power 1997 p27). In fact, obscurity is at the heart of the matter. Without that audits would not be able to work. Audits produce opinions and judgements. For these judgments to have impact a certain amount of non transparency is essential. As Power writes, 'audit is a craft and society must trust in the judgement of the individual auditor' (Power, 1997 p.40). However the history of audits also shows that auditing is a 'history of failure'. After each crisis in organisations, financial or otherwise, there are cries for more stringent control and more regulations follow.

At heart Auditing is a disciplinary method that changes the nature of the businesses that are being audited. In order for auditors to be able do

their works things have to be made auditable. Auditors must be able to follow a trail such a chain of transactions for instance. In general audits focus on system processes and not on outcomes. In complex environments samples are taken from what Power refers to as a 'systems surface'. In many cases these system surfaces have been designed specifically with 'audibility in mind'.

Power describes two extreme mechanisms that can take place in relation to auditing practises: decoupling or colonising. When a process of decoupling takes place organisations develop control systems, which in fact separate the auditing process from the core business. The auditing process becomes a thing in itself. To the external world the organisation presents an auditable picture or image as if everything is under control. The other extreme is a form of colonisation. When this takes place the 'auditing world spills over' into the value system of the organisation and even starts to take over the value system. The need for information gathering can supplant other needs that were more closely related to the organisational objectives of, for instance, providing quality care.

Power observes that pure forms of decoupling are unlikely to hold out, creating permanently impermeable barriers is impossible. Nor perhaps are complete forms of colonisation likely to be successful. However, audits change organisations. Power observes how with the support of audits NPM has colonised organisations and forced professionals to change their work practices in order to make them publicly accountable. Trappenburg (Trappenburg 2006) agrees with Power in relation to how

audits change organisations. She sees an audit explosion in the Dutch health care sector and interprets the focus on performance management and the audits as a form of neurosis. She observes that audit procedures have indeed changed the nature of service delivery in care organisations. If a Dutch care organisations wants to survive the audits they have to focus on reporting, monitoring and on what Trappenburg refers to as 'policing' rather than on improving performance. (Trappenburg 2006 p. 49).

Forms of gaming

Processes like audits and performance management create counter mechanisms. Power, Hood, De Bruijn and others describe how subversive counter mechanisms develop in organisations to withstand pressures which are perceived as being imposed on them by external entities such as auditing bodies. De Bruijn (De Bruijn 2003) lists the perverse effects of performance management systems in public organisations. For the sake of simplicity performance indicators focus on 'measurable outputs'. These however can only give a limited picture, they are a slice out of a complex system. De Bruijn sums up the following negative effects. It prompts gaming: it invites people to manipulate numbers or tick the 'right' boxes. It adds to internal bureaucracy, e.g. by setting up separate departments which have to make things auditable. It blocks innovation and rewards ossification, because that which already exists is rewarded. It ignores the complexity

of professional tasks. It ignores local circumstances. It punishes good performance and it kills system responsibility.

Hood (Hood 2006, & Hood and Bevan and Hood 2006) analyses the effects of performance indicator systems in the English NHS. He compares the performance monitoring system which was set up in the UK with target systems which were used during Soviet times. Experts in gaming and strategic behaviour have identified at least three types of gaming: the ratchet effect, the threshold effect and output distortion. Hood provides the following definition of these effects: The *ratchet effect* 'refers to the tendency for central controllers to base next year's targets on last year's performance, meaning that managers who expect still to be in place in the next target period have a perverse incentive not to exceed targets even if they could easily do'. *The threshold effect* refers to 'a uniform output target applying to all units in a system' giving 'no incentive to excellence' and encouraging 'top performers to reduce the quality or quantity of their performance to just what the target requires'. *Output distortion* is a 'form of output distortion or manipulation of reported results' — also described as 'hitting the target and missing the point'. (Hood 2006 p.516)

Research within the NHS provided proof that all three types of gaming took place within the system. In addition Hood detected a fourth form of gaming: namely the eagerness by central management to accept good news at face value.

Changing labour relationships.

The changes in governance of public, private, semi-private organisations in The Netherlands also effects the labour relationships. In this sense The Netherlands cannot escape from global trends. Since the 1980's labour market flexibility has gained ground, also in The Netherlands. Slowly but steadily employment protection laws are becoming more flexible, in the sense that it becomes easier for employers to make employees redundant.

Stein and Lensink (2007) describe how since the 1990's 'normalisation' of labour relations has been part of the objectives of Dutch governments to modernise the public sector. Employment conditions in the public sector have become more similar to conditions in the private sector. This has meant that social security benefits have decreased and that it has become easier to make employees redundant. In the 1990's terms of employment for all public sector workers were still centrally determined. Since the 90s this has all been decentralised. In The Netherlands sectors still agree upon collective labour agreements (CAO) in the light of legislation Wet Werk en Zekeheid in de Zorgsector (Work & Security in the Care Sector). Nevertheless employment relations have become much more flexible. This law now makes it possible for care organisations to employ staff on small hours temporary contracts. Whereas in the past care organisations worked with permanent staff, most care organisation nowadays work with temporary staff or with staff on flexible hour contracts.

Standing (Standing 2011) sees this as part of a world wide trend. He describes the emergence of a new global group: the precariat. The word precariat is a combination of proletariat and precarious. The global market systems of the twenty first century fosters employment relations that are flexible. This has resulted in the transference of risks and insecurity onto workers and their families. It has created a more fragmented national class structures in many countries. Standing distinguishes seven groups in society: 1) the elite or rich global citizens who own billions; 2) the salariat, who still have fulltime employment and work benefits; 3) proficians, professionals and technicians who possess bundles of skills they can market; 4) manual employees, the old working class; 5) the precariat; 6) the unemployed and 7) the group who are regarded as socially ill misfits.

The precariat forms a group in society which has to deal with more and more insecurities: such as labour market insecurity, employment insecurity, job insecurity, work insecurity, skill reproduction insecurity, income insecurity and representation insecurity. Not everyone who can be classed as being part of the precariat will experience all these forms of insecurity at the same time, but in the back of people's mind they lurk. Standing hypothesises that the precariat is likely to experience what he refers to as the four A's: anger, anomie, anxiety and alienation. The lack of long term contracts, or permanent positions will make it much harder if not impossible to work on building sustainable supportive networks.

Sassen (2014) links the emergence of the precariat to what she calls subterranean worldwide dynamics of expulsion. She observed that the

past two decades a growing number of people, enterprises and places has been expelled from 'the core social and economic order of our time'. She sees as the phenomenon of expulsion as going beyond more inequality and more poverty. It is a development which is perhaps not fully visible and recognisable everywhere. In Western countries it is not something which is faced by the majority. Yet worldwide there is a gradual generalising of extreme conditions that begin at the edges of systems in what she calls micro settings (Sassen, p. 29). There is a tendency towards the expulsion of non productive groups from the economy and society. This tendency is part of a trend the beginning of which Sassen pinpoints in the 1980s. Since the second world war and till the 1980s the logic was towards inclusion. The efforts were focussed on bringing the poor and the marginalized into the political and economic mainstream. As of the 1980's the tide as turned. Sassen argues that at present a narrow conception of economic growth dominates the political and economic debates. In the first decades after the Second World War growth was seen as a means of advancing the public interest. Nowadays the institutions are serving corporate economic growth. According to Sassen this is the new systemic logic. It is a logic of expulsion which has resulted in governments spending less on social services and more on deregulation and infrastructures. In the entire EU poverty is rising. Using the Eurostat statistics on risks of poverty and social exclusion in 2011 in the EU, Sassen compares the risk in different EU Countries. The Netherlands is part of the group of countries with the lowest risk. Yet the number is still 16%, meaning that

16% of the Dutch population is at risk of poverty and social exclusion (Sassen p.51).

Neoliberalism and influences on everyday life

Hochschild explores the ways individuals manage their emotions in personal life and in the American workplace and around the globe. She is interested in what happens in the intersection between the two. She describes how intimate life has been commercialised. More and more personal needs are outsourced and provided by paid strangers who promote themselves as love coaches, wedding planners, wives for hire, husbands for rent, surrogate mothers, birthday planners, elder care managers (Hochschild1983). In the recent decades Hochschild has observed how the commodity frontier has moved. Whereas in the eighteenth century slaves or servants were bought as persons, nowadays only aspects of roles are bought. When lacking a husband who can do chores, the services of someone are bought who does them, pretending for the time being he is a husband. Family activities are replaced by commercial substitutes. And those substitutes often turn out to provide better services than the real thing. And thus a vicious circle is activated. The family becomes minimised and the market jumps into the void by offering more and more services that can be bought. As Hochschild writes 'capitalism isn't competing with itself, one company against another, but with the family and particularly with the role of the wife and mother' (2003 p.37). The family is outsourcing more and more

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functions and turns into a 'post production family'. As a result personal

tasks become monetised and impersonalised. In the The Outsourced

Self (Hochschild 2012) she interviewed both clients and those providing

the services thus providing an ethnographic social account of what

intimate life looks like in market times. In her account she covers the

whole life cycle from birth to death.

The people who provide the outsourced services have to manage their

feelings while performing their duties. In an earlier work Hochschild

(1983) coined the concept 'emotional labor' to describe this aspect of

the work. She provides the following definition:

> I use the term emotional labor to mean the management of feeling
>
> to create a publicly observable facial and bodily display; emotional
>
> labor is sold for a wage and therefore as *exchange value*. I use the
>
> synonymous terms emotion work or emotion management to refer
>
> to these same acts done in a private context where they have *use*
>
> *value* (Hochschild 2003b p.7).

Hochschild's work, particularly her concept of emotional labour, has had

a significant influence on research in health and social care. Smith

(1992) has used this concept in her study of nursing in the UK and Bone

(2002) has explored the dilemmas of emotion work in nursing under

market driven conditions in the USA. Clearly we are now on a very

similar territory to that explored by Menzies Lyth in her work on social

defences against anxiety and, perhaps unsurprisingly, the sociologist

Hochschild visited the Tavistock Centre on a number of occasions in the late 1990s.

Concluding reflections

In this literature review we have come full circle from the emergence of psycho-social studies with its emphasis on the internal and external factors that bear upon the lived experience of the human actor. Lurking in the background throughout, as a kind of meta context influencing culture, economy and institutions is the spectre of neoliberalism. My ambition in this research is to be able to reveal the traces of this influence on the lived reality of care workers and their managers in The Netherlands and some of the concepts I have surveyed such as vulnerability, anxiety, fragmentation, precarity, discourse, audit and so on will, I hope, provide valuable tools for this investigation.

Chapter 4

Methodology

Introduction

In this chapter I discuss the methods I used to gather data for this research project and how I analysed the data.

For two years I did research at two Dutch care homes for the elderly. I immersed myself into the organisations, hoping to emerge with data on

the lived experiences of management and professionals and on unconscious dynamics and defences at work at those two care organisations. In order to find answers to my research objectives I decided to conduct two psycho-socially oriented organisational case studies. This was an innovative approach. Not many psycho-socially oriented organisational case studies have been completed yet in the field of psycho-social studies.

From the first encounter with each organisation I aimed to work as a psycho-social researcher. Psycho-social research is part of the tradition of hermeneutics. As such its focus is on understanding the lived experiences of individuals or groups. Alexandrov (2009) argued the case that in psycho-social research hermeneutics as such is not good enough, nor is double hermeneutics. Psycho-social research has to apply the method of triple hermeneutics. Double hermeneutics is ' the need for the interpretation the frames of reference of the observer and observed, for mediation of their respective understandings' (Sayer, 1992, p.49). It is about how the researcher makes meaning of how the individual or the organisation is making meaning of their lived experiences. Triple hermeneutics adds another layer and explores unconscious processes and relationships between the researcher and the researched that occur at the research encounter. Alexandrov points out that working with the method of triple hermeneutics is demanding yet liberating. It is demanding because you have to be able 'to think under fire' and retain a reflective stance. It is liberating because as

psycho-social researcher you can 'engage in a variety of unpredictable and anxiety-provoking situations' and explore what this tells about the affective dynamics within the research system. (Alexandrov, 209. P. 47).

In order to get access to the affective dynamics of my research system I decided to opt for a form of triangulation in data gathering. Triangulation requires using multiple data sources. This will ensure that the research account is rich and comprehensive. When using a single method it can be much harder to adequately shed light on matters, especially when the research objects are organisations. Using multiple methods can help facilitate a much deeper understanding. I gathered data using the following three different psycho-social research methods: organisational observation, psycho-social interviews and facilitated workshops.

In this chapter I will elaborate on each method separately. For each method I will explain how I worked with it. I will explore what kind of data it produced and how I worked with the raw data. I will discuss strengths and weaknesses of each method. In a separate section I will explore how I worked with reflexivity and how I dealt with the ambiguities and difficulties I encountered as researcher in a very complex and volatile environment where many people felt their way of working was under threat.

I the next section I will start, however, by elaborating on the overarching method of psycho-social case studies. It this section I will also provide a timeline and overview of the encounters I had with both case studies

Psycho-Social Case Studies

Psycho-Social studies is a way of thinking and researching that is looking at the interface between the internal and the external world. The field is interested in the way in which the two sets of factors: the societal or external and the psychological or internal, combine, interpenetrate and influence each other. Feelings, affect and emotions are a source of research. Like any other form of qualitative research, it is concerned with exploring depth. Psycho-Social research adds an extra layer of depth by researching beneath the surface. It brings the micro and the macro together. It combines psychoanalytic thinking with social scientific ways of thinking without giving either one unnecessary prominence. In doing so it unites the affective with the non-affective.

A psycho-social case study implies that the researcher gathers objective and subjective data, to explore how the macro and micro levels in organisations interact and to find out what this tells us about the overlapping space, the space in between. In my case the research objective was to explore how the changes in the healthcare system were affecting the values, identities and behaviours of management and carers. The case studies were organisational case studies. The object of research was the organisation and the people working in the organisation. How to discover what is happening at the 'space' in between at an organisation? It requires the researcher to immerse herself in the organisation, to find a way in and to slowly gather

information and data and try to stay away from premature judgements about what is happening and why things are happening as they are happening.

I opted for a form of psycho-social action research. Action research is a form of research where information is gathered through action, by doing 'things' in an organisation, and to reflect on the effect of these actions. The objective of psycho-social research is to reveal what is beneath the surface, what is not said, but yet influences the behaviour of the people who are part of a system. It is about issues which are difficult to think and talk about. For example, some matters are only stated tacitly. Tacit matters are issues which are suggested indirectly or understood rather than said in words. (def. OID). It can also be that you sense or feel something is wrong but cannot put your feeling into the right words and you cannot link your feeling to a specific event. It can also be about topics people are not allowed to speak or think about, e.g subjects that are rejected or foreclosed (Hoggett, 2000). At one of the case studies for instance one got the sense that it was not alright to talk about the past. The past was the past and now the time was to look forward. It can be about matters that are repressed by individuals. They do not allow themselves to think about matters. In this respect I got the sense that very little if any time was taken in either organisation to think about or reflect on the consequences of changes that were being implemented. Or it can be about that which is denied. As we saw in chapter 3, as a result of prevailing cultural attitudes towards mortality and vulnerability

people in western societies tend to deny that they are afraid of getting old, or afraid of death.

When issues are difficult to feel it can be an indication that they are suppressed or disavowed. Managers or carers are out of touch with the anger they feel for instance, or management acknowledges that reorganisations are difficult, yet their actions lack any emotional significance (Hoggett (non-published presentation 2011)

This was data I hoped to get access to when I planned and designed my research.

I knew I had to try to get permission from a care organisation to get an active role in the organisation so as to be able to experience the emotional life.

Finding the case studies and gaining access

It took me a few months to find care organisations that were interested and willing to allow me to do research. Through my network I got into contact with four care organisations whose management agreed to a meeting. After the meetings during which I explained the research objectives and psycho-social methodology, the managers informed me that my research had a lot of potential but that they did not want their staff to be exposed to the kind of research I had in mind. They were afraid the research would stir up too much unrest among the staff and they felt the staff already had enough to deal with. Especially the

psycho-social approach seemed to create feelings of apprehension among the managers. Then my luck changed. Again with the help of my network I got in contact with a manager of a small care organisation in Amsterdam. He had just started as acting manager. He was not employed by the care organisation, but had been hired as an external management consultant to solve some very serious issues at the organisation. He was especially interested in my research methodology as he hoped it might support him in what he had to achieve in the organisation on a very short notice.

A second care organisation (Noturos) expressed serious interest in my research as well. This was a larger care organisation in the north of the country. They were interested because they hoped the research would help them find out why one of their locations was very successful, whereas they had a lot of trouble at another location. They hoped that with the help of my findings they might be able find out what success factors there were for running a good and care location that would provide the care the residents needed. Suddenly I had the luxury to be able to choose between two very interesting options. Could I do research at both, would that be too much? These were questions that crossed my mind. It was tempting to start getting to know both organisations. The small organisation was really small. It provided care to approximately 200 elderly residents. It was a care organisation founded on Jewish principles. The organisation had avoided implementing the changes that the Dutch government had set in motion

in and around the care sector. The organisation was realising that this was going to cost it dear. The organisation was on the verge of financial bankruptcy and the National Inspectorate of Healthcare had placed the organisation under supervision because the care they offered was deemed to be bellow standard.

The larger organisation in the north was a middle-sized care organisation that had grown over the years through merging with other care organisations in the region. It had seven nursing homes, five rest homes and an intensive geriatric convalescence centre. They offered different kinds of care to around 1300, mainly elderly, clients. It employed 2144 people.

So here were two organisations, a smaller one whose rational for its existence was to provide care for Jewish elderly. This care organisation was based in a big city and it had not really started yet with implementing any of the required changes. The second organisation was larger and based in a more rural part of the country. The different locations that were part of this organisation had originally been founded on religious or socialist principles. However, through mergers these ties had been more or less cut. It was now run by a management which was fully committed to implementing the changes as instigated by the government.

I felt that it would be very interesting to explore and compare how the outer world or social context influenced the lived experience of the management and staff working in both organisations. And it would allow for psycho-social cross case analysis - an opportunity to combine in-depth analysis within case studies with breadth across case studies. I had not planned to do something like this beforehand. And I did not know for certain that this would be a realistic plan, yet I decided to try. And as I discovered along the way during the research, it was important to allow matters to happen, to allow oneself to be surprised and stay curious and not to foreclose options or possibilities too quickly.

Gathering data at the case studies

January 2012 I began gathering data at both organisations. Initially I starting by applying two of the research methods: organisational observations and free association narrative interviews. At a later stage I organised facilitated workshops as well. This method was more difficult to organise than the other two. Time is precious in the care sector. Workshops with carers could not be organised during working hours. Initially I was only able to organise a workshop with the management of Arborvitae. Later I was able to organise workshops at one of the Noturos locations as part of a consultancy project that I undertook. At this stage I was following and observing one of the location managers who was responsible for four locations. She was very taken with the attention I gave her and shared many of her thoughts and reflections with me. In consultation with the chief executive officer this location

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manager asked me if I would be willing to help out at one location as a consultant. Before I could consent to this request it was important discuss the difference between the role of researcher and consultant.

It was agreed we would make a formal consultancy agreement with objectives and a process plan before I would undertake to work as a consultant. In the mean time I would still have my role as researcher. The information I would gather as a consultant fitted with my plan to do action research. By working with the management and carers as a consultant I would be able to gather data I might not have gotten access to If I had only conducted interviews and done organisational observation. As part of the consultancy I worked with a second consultant. As a team we worked with the organisation for a period of 6 months. In this period I worked closely with the senior management, middle management, key workers and carers.

At Arborvitae I was unexpectedly placed in another role as well. Half a year into the research my parents fell seriously ill and ended up in hospital. After three weeks in the hospital they were discharged and had to recuperate in a care home. This care home turned out to be Arborvitae. They lived in Arborvitae for three months. During this period I visited them often and got to experience what it is like to be a family member of someone who has to get to terms with living in a care home and being dependent on receiving care.

To summarise, in each case study I undertook psycho-social interviews and observations and also facilitated workshops, in addition, whilst at Arborvitae I was able to be a participant observer during the time my own parents became temporary residents there. A complete description and timeline of the various research activities undertaken in each case study is given in Appendix 1.

The Psycho-Social Method of Organisational Observation

Right from the first contact with the case studies I applied the method of psycho-social organisational observation. When applying this method I built on the method as developed by Hinshelwood and Skogstad (2000) for young doctors in psychiatric training and the training programme for consultants as developed by Davar and Stern at Utrecht University. All four developers, in their turn were inspired by Esther Bick's (Bick, 1964) training method of Infant observation as developed at The Tavistock Clinic between the 1940s and 1950s (Davar, 2008).

This form organisational observation method has a tripartite structure. In the training version of Hishelwood, Skogstad, Davar and Stern the observer visits the organisation for an hour on prearranged times. During the visits the observer observes what is happening around her. She does this in an unobtrusive way without being totally disengaged. In other words, the observer is more than a fly on the wall, but less than an active participant. During the observation no notes are taken as this would prevent the observer from being in the here and now and paying attention to that what is happening around her. The task of the observer is to take in what actually happens (literal data) and to listen to the impact of what happens on her feelings and emotions (subjective data). The second phase of the method consists of the observer writing down her private account of what she saw and experienced. The third phase consists of sharing these private accounts with members of a small supervised seminar group. This seminar group reflects on the

experiences of the observer and helps her to digest what happened and gain deeper insight into what happened in the organisation.

At Utrecht University organisational observations are done in pairs. This addition is inspired by the thinking of Bion (1962). Bion stated that the smallest group that exist is a group of two. As observing pair, the observers become a small system, or working group in their own right. It is no longer an individual observer who visits an organisation but it is a system (the observing pair) visiting another system (the observed organisation). This brings a whole new dynamic in to the observational context. As a pair the observers have to work with the internal dynamic of their own system as well. Each member of the pair is likely to be attracted to different aspects of the organisation they observe and is likely to receive different projections from the organisation. The idea is that this will help to surface additional information on what is happening at an unconscious level in the observed organisation.

How I worked with the observational method

I decided that each encounter with the case studies was an opportunity for a form of unstructured observation. I did not know beforehand what would happen and I allowed myself to be open and curious as to what would occur. Most of the time I did not take notes during the encounters. I tried to be in the present moment as much as possible and observe with all my senses what was happening. After each encounter I wrote up my records. What happened, what did I recall, what struck me, was I

reminded of other situations. What did people say or do? Which of my senses were triggered? Was I struck by particular smells or the absence of smells? What emotions were evoked in me? During longer sessions or contact moments I sometimes did take some notes on the spot.

After almost every encounter I wrote up records of my observations and thoughts. When I did this I followed Hinshelwood and Skogstad's stance that writing up should be an intuitive process. I was fully aware that my notes were not accurate objective recordings of everything that had taken place. However as Hinshelwood and Skogstad (2000) point out, the words you choose, the links you make and the emphasis you place on certain events, could be indications of matters the researcher has picked up without consciously understanding yet what these matters tell him or her about the research object. Hinshelwood and Skogstad call this the 'under-life in the records' (Hinshelwood and Skogstad (2000, p.23). I saved the interpretation of the records for a later stage. In this stage of the research I focussed on gathering data.

Eight months into the data gathering phase I decided to do a more extensive form of organisational observation at the location for residents suffering from psychogeriatric illnesses at Arborvitae. From my first visit to this location I knew that at it would be possible to observe interactions between carers and residents. I arranged with the care manager responsible for the first and second floor that I would come and visit the organisation approximately ten times and observe the goings-on at

different locations at the unit under his charge. I decided to do these ten observations at Arborvitae with a fellow observer, so that I might explore if the phenomenon of two systems meeting would create a different dynamic and provide me with additional data on what was happening at an unconscious level of this part of Arborvitae. The two observers were careful not to share experiences of the observation during the observation.

In order to analyse the data I set up a small reflection group in The Netherlands with two Dutch consultants who also had experience with the organisational observation method and who where familiar with the Dutch care sector. The two observers presented their observations tot his group. This was the first time that as observers we heard how the fellow observer had experienced the observation hour.

After this the reflection group shared amongst themselves how they felt about what the observers had told them. They shared their thoughts, feelings and emotions. The observers listened to their discussion without interfering. When the reflection group felt they had shared what they had to share the observers and the reflection group worked together on forming hypotheses on what might be happening bellow the surface at the care home. In total we had four sessions with this reflection group. We shared data on six observation hours. The sessions with the reflection group were taped. During the data analysis phase I listened to the tapes again and took notes.

I also used a data analysis session during the annual Phd workshop at UWE. I shared my notes of an observation hour at the psychogeriatric unit of Arborvitae with my fellow PhD students and the course leaders of Psycho-social studies. I drew a floor plan of the unit and shared my notes from the observation. As with the Dutch reflection group, those present first listened and then shared their thoughts and feelings among themselves. At the last stage I joined in again. This session I also recorded and listened to again during the data analysis stage.

In addition I shared all my raw observations, including those of the ten sessions at the Arborvitae psychogeriatric, with my supervisors. During supervision sessions the supervisors shared their thoughts and observations on the data. During these supervision sessions I took notes on what was being said. These notes I reread during the data analysis phase.

The psycho-social method of organisational observation is a powerful way of gathering data as I hope I will demonstrate in the following chapter. However it is also very challenging. Sometimes one is inundated with so much data that it is not always possible to produce accurate and sensitive written records of the observation. Of course one has to be aware of one's own subjectivity and how this may effect one sees and remembers. For this reason the use of a co-observer and the presentation of data to the reflection group was a vital corrective.

Facilitated Workshops:

Visual methods in organisational research

During the design phase of the research I also planned to conduct facilitated workshops with participants in which I hoped to invited participants to to share what it was like to work at their organisation by means of using images, pictures or drawings.

Pictures, associations or drawing can provide different kind of insights than the spoken word. They can reveal what Bollas calls the 'unthought known' (Bollas, 1987). Bollas developed this concept in relation with his clinical work with patients. He worked with his patients on 'reliving through language that which is known but not yet thought' (Bollas, 1987, p.4). Aesthetic moments or experiences can be a means getting in contact with the unthought known. And it is possible that such moments are evoked by drawings or images.

Hutton, Bazalgette and Reed (1997) worked with these ideas when they introduced the concept of 'organisation-in-the-mind'. They defined this as 'what the individual perceives in his or her head of how activities and relations are organised, structured and connected internally. It is a model internal to oneself, part of one's inner world, relying upon the inner experiences of my interactions, relations and activities I engage in, which give reside to images, emotions, values and responses in me, which may consequently be influencing my own management and

leadership, positively or adversely' (Hutton, Bazalgette and Reed, 1997, p.114).

Armstrong reworked the concept. During his consultancy work with organisations he began to wonder if the images and fantasies located in individuals working in the organisations were indeed the property of the individual. He hypothesised instead that the images had rather to be seen as the property of the organisation: 'something that was intrinsic to the organisation as a socio-psychic field' (Armstrong, 2005, p. 5). Individuals when working in organisations pick up or introject parts of the reality of the organisation. This in its turn can influence and shape their thoughts and behaviour. This way of thinking is in line with the psycho-social approach as described in chapter 3. The societal or external and the psychological or internal, combine, interpenetrate and influence each other.

W. Gordon Lawrence developed the concept of social dreaming in organisational contexts. Like Armstrong he worked with the assumption that in an organisational context dreams are not the solely property of the dreamer. As soon as someone has a role in an organisation, he or she is part of a system. And this system will have influence on the dreams of individuals. Hence the concept of social dreaming. Lawrence saw a group of individuals as being part of a matrix. He defined the matrix as ' a space of thinking and free associations' (Lawrence, 2005, p.37). The word matrix is derived from the Latin for uterus, 'a place out

of which something grows ' (Lawrence 1998, reprinted 2005, p. 17). The idea of the matrix symbolises that as living beings we are connected. Lawrence describes a matrix as a container. In using the word container he follows Bion's (1962) thinking on this concept. 'Matrix is the 'container' of societies, groups and organisations in that in contains all the thoughts that has brought them into being and sustains them in their continuing existence' (Lawrence, 2005, p.37). Interactive workshops with participants from an organisation could be regarded as a form of a matrix. All the participants are interconnected with the organisation through the roles they have in the organisation. In a workshop setting they are away from the workplace yet still part of the organisation on which they are asked to reflect.

When thinking about methods for my research I hoped to be able to create thinking spaces for groups of managers and carers to reflect on the more implicit or emotional level of the organisation. In practice it turned out that it was not that easy to organise such events. At Arborvitae I was able to organise a workshop with the complete management. It was not possible to organise similar events with the key workers and carers at Arborvitae. Their work schedules did not allow the carers or key workers to come together for joint sessions. Even during work they hardly ever met as teams.

At Noturos I was able to organise workshops only as part of the consultancy I did at this organisation. Without the consultancy the

situation would have been similar to that of Arborvitae. The working

schedules are organised in such a way that there is very little flexibility

to organise anything outside the work rosters. It would only have been

possible to organise group sessions in the carers's own time. As part of

the consultancy I conducted a workshop with the key workers and four

workshops with different groups of carers.

Workshop with the management of Arborvitae

I consulted with the acting manager on the possibly of organising a

workshop with the whole management. He considered it a good idea to

bring the management together in a workshop setting and asked me to

invite all the eight managers to such an event.

Through the secretariat the management I sent out an invitation in which

I explained the set-up of a three our workshop and that during the

workshop the participants would be invited to share images they had of

their organisations. These images would form the basis for a shared

exploration on what they felt what was happening in their organisation

and how this impacted their roles.

The workshop took place in a meeting room of the organisation. As

working material I had brought flip-chart paper, coloured pencils and a

large stack of postcards with images and pictures. I gave the

participants the option to either make their own drawings, to choose

postcards, or combine postcards and drawings etc. in order stimulate the creative process. In chapter six I present the data which emerged from the workshop. The workshop consisted of four parts: an introduction and time to settle down, a half an hour for each participant to work with their own images, the shared reflection time to work with the images and the closing of the session. Afterwards I wrote down my own observations and reflection of the event and shared these with my supervisors who reflected back on them.

Workshops at Noturos, location Grenier

As part of the consultancy I was able to organise workshops with the key workers and carers of Grenier. In total I conducted five eight hour workshops with four different groups of carers and with a group of key workers. In two of the groups there was an opportunity for reflection with the aid of pictures and drawings. In the workshop with the key workers there was a two-hour time slot in which I used the same working method as during the workshop with the mangers of Arborvitae. I had brought the same working material: flip-chart paper, pencils and a large stack of postcards with images and pictures.

One of the workshops with the carers was with the group who cared for a group of elderly who were suffering of psychogeriatric illnesses. Grenier was not specialised in caring for elderly suffering from these illnesses. And in fact they did not have the facilities to care for these elderly very well. The workshop with the group of carers who looked

after these elderly people was the most difficult workshop I conducted. It was as though the carers could hardly express how they felt working with this vulnerable group of people. In chapter seven I present the data that came out of this session

Strengths and weakness of the method of facilitated workshops

Workshop type methods that make use of actual working groups within organisations can provide very rich data particularly where the use of visual methods can generate a matrix type structure which supports group free association. However they can be difficult to organise and employers/managers may resist freeing up the time for staff to participate particularly as, in the setting of a care home, the work of participating staff would have to be covered by others. For some, perhaps particularly those not used to reflecting, the workshop format may not be as freeing as the individual interview, they may find they have little time to reflect 'on the spot' about feelings and more 'below the surface' issues.

Psycho-social Interviews

A substantial part of the data was collected through interviews. I attempted to apply a psycho-social interview method, also referred to as interactive interviewing (Watts, 2009). The aim of the interviews is to elicit the meaning of the interviewee's social experience. The interviewer does not work with a list of standard questions but after an initial question or prompt follows the interviewee's line of thought and

encourages him or her to freely associate. The interviewer introduces the topic and invites the interviewee to elaborate or explore certain topics further. The idea is that the interviewer and the interviewee make sense of the data together, the data is co-produced.

Throughout the interview the interviewer should remain aware that a ongoing conscious and unconscious dynamic takes place between the interviewer and the interviewee. They influence each mutually and continuously. It will have impact on the data If the interviewee does not feel safe for instance or feels intimidated by the interviewer. Likewise it is possible that the interviewer feels insecure and is not able to create an atmosphere which allows for exploration.

Hollway and Jefferson introduced the concept of the defended subject (Hollway & Jefferson, 2000). They describe how interviewees can unconsciously protect themselves against unpleasant feelings or anxiety by investing in a particular discourse that supports the interviewee's idea of his own identity. During the interview this can manifest itself through the fact that the interviewee makes light of issues you would expect to be deeply affected by. He may resist sharing his deeper feeling with the interviewer on this subject and answer with platitudes for instance.

Hoggett (Hoggett, 2008) points out that the interviewer can be defended as well. The topic under discussion can create feelings of anxiety in him

or her, so much so that it prevents the interviewer from really listening what is being said. The interviewee may sense this consciously or unconsciously and feels that there is no real interest in him and his story. As a result the interview may fall flat.

In order to prevent this the interviewer must be aware of the interview process and be ready to explore his or her personal responses to what is being said. A psycho-social approach sees the interview as a dynamic process in which interviewee and interviewer take up different positions in the coyrse of the conversation. Thus the researcher needs to be aware of who is talking in what voice at any given moment, what is the interviewer invoking in the mind of the interviewee and vice versa. As researcher you try to make sense of how the people you are engaged with structure their experiences and make meaning of their lives. They will do this consciously and unconsciously. As researcher you might be able to detect something of the unconscious dynamic through their reactions to what is happening in the here and now in the interview. In contact with each other we unconsciously project thoughts, fantasies, ideas into others. As interviewer you might feel how you are being 'used' in a particular way by the interviewee. And this might give you information on more hidden issues that are at stake.

After each interview the researcher reflects not only upon what was said but also what may have been communicated at a more unconscious level. Interview transcripts are painstakingly analysed using a grounded

theory approach (Glaser & Strauss, 1967). Wherever possible researchers should fully transcribe all research interviews personally so that they are immersed in, and thus completely saturated by, the material. This both elicits researchers' own potentially informative free associations and helps them to make appropriate theoretical connections.

I interviewed 24 individuals in the two case studies (14 at Arborvitae and 9 at Nutoros). At Arborvitae I interviewed the acting manager at the start of the research and when he had just left the organisation. I also interviewed the previous manager and four care managers, two of whom I interviewed twice. There was an interval of a year between the first and the second interview. At Arborvitae I also interviewed two key workers and seven carers. One key worker I interviewed twice. There was an interval of a year between the first and the second interview. At Noturos I interviewed two care managers, a facility manager and six carers.

In both case studies I found that most of the carers were very ready to talk and take me into their world. Some of the mangers seemed more cautious. The care managers at Arborvitae that I interviewed twice seemed more open during the second interview.

Reflexivity - working with the data

As a psycho-social researcher who aims to explore what is bellow the surface reflexivity is key. Finlay (2002, p. 532) defines reflexive research as 'research (that) encompasses continual evaluation of

subjective responses, intersubjective dynamics, and the research process itself. It involves a shift in our understanding of data collection from something objective that is accomplished through detached scrutiny of 'what I know and how I know it' to recognising how we actively construct our knowledge.'

During the data gathering phase I immersed myself into the two case study organisations and while doing so I had different roles. As psycho-social researcher it is crucial to remain aware at all times of what is happening to you as researcher and engage with the research in all its forms and complexities. During the data analysis phase reflexivity is vital and the focus has to be on disentangling complexities and trying to find patterns. It is about finding answers to questions such as: what position(s) had I taken as researcher and what position what I been placed into by those working at the case studies?

Cummings (2012) depicts the research system and the position of the researcher in the system as follows:

Figure 4.1

Research systems

Researcher
Research team

Organisation
or agency

Research
participants

- The researchers is part of the researched system and its political processes

A 'research-in-the-mind' made up of

- Orientation to the project of research
- Research interests
- Choice of methods

In this Venn diagram the circles of researcher, the organisation and the research participants intersect in various ways and on various places. In order to untangle it all double and triple hermeneutics are needed. Double hermeneutics is about how the researcher is making meaning of how the research participants are making meaning of their lives. Triple hermeneutics adds another layer and explores unconscious processes and relationships between the researcher and the researched that occur at the research encounter. In relation to my research it was about making sense of what was happening during the encounter with the other persons during the research interview, the observation or the workshop. And it can also be done by working with the data with the help of doctoral supervision and reflection groups.

Working reflexively as a researcher

Vignette: Observation and Analysis of the Start of an Interview that went Wrong:

Dominique works as a care helper at Arborvitae. She has been working in this position since 1996. The function of care helper is probably similar to domestic and maintenance staff in the UK. They help residents with getting washed, getting dressed, and they are allowed do simple medical acts. She works 36 hours per week.

She was the first respondent who did not allow me to tape the interview. She gave the impression of wanting to do everything by the book. She said she likes to know what to expect. She added that she knew what the interview would be like, because a year ago she had been interviewed as well by two persons. These interviews were conducted by a consultancy organisation. Arborvitae had asked this organisation to help them look at their work schedules in order to decide how things could be run more efficiently.

I had given her the consent form to sign. And while she was reading it I was installing the recording

device I though I saw her ticking the boxes on the

form which give me permission to record the

interview and to use the data anonymously. However

when I was about to push the record button she

pointed at the no box with her pen. I was totally

surprised and taken aback when this happened.

I explained I had a different objective than the other

interviewers and that I was an independent

researcher. She remained adamant however, and did

not want the interview to be taped. I felt a sense of

frustration and for a moment wondered If I would

stop the interview. But I also felt sorry for her. I did

not want to disappoint her. I also really wanted to

hear her story. I decided to go on with the interview

and write down as much as possible and work out

my notes after the interview.

After she had signed the consent form she said that

it was important to show it to her manager. 'We have

to account for our time you know'. I told her I would

not show the form to her manager and explained the

purpose of the form once more, but she did not really

seem to listen and repeated that it is important to be

able to account for one's time.

Reflection on Vignette:

I have reflected about this incident a lot. I was a meeting with a carer who seemed to be under a lot of strain. She clearly felt she had to protect herself and did not want to run a risk of anything being held anything against her. She placed me in a role of authority and attributed great powers to me. Yet she also managed to turn the tables in her favour. The way she used her pen to point to the 'no' box made it very clear what she meant. It was a powerful gesture. And then after this refusal she was very eager to be interviewed as well. She became more and more talkative and shared a lot of information. And the more she shared, the more frustrated I became, because I could not record the interview and she said so many interesting things. I checked once if she would change her mind, but no, she would not.

She was one of the carers who moved me a lot emotionally. I felt for her, I wanted to protect her, I was interested in her story, I was angry, I was frustrated. As researcher I was initially disappointed, yet in hindsight this incident helped me to detect the undercurrent of frustration and fear which was felt by carers at the case study. And it also made clear how easy it is to be placed in different positions as researcher, in this case by the interviewee who placed me in the role of an authoritative person who would protect her.

The most challenging experience in relation to my position as researcher was when my parents were staying in Arborvitae. My role as

researcher and family member almost merged. Both my parents were ill, but my father especially. It was a nightmarish time for them. I saw they were suffering while they lived in the care home and they were hugely relieved when they left Arborvitae to go home after three months. I also saw staff running around trying to provide care around the clock. Yet it is very painful to experience someone you love who is not able to keep in body fluids and has to wait for more than an hour before a member of staff is able to help out. Incidents like this made painfully clear how care can be about very basic but important needs. And it is a thin line between feeling treated as a human being or as a burden.

During those three months I attended a PhD workshop at UWE, Bristol. During a role analysis session I disused my position as researcher and family member. This session made me realise I had distanced myself from my role as researcher at the main location of Arborvitae. Instead I had started to focus my attention as researcher on the location of for residents suffering from psychogeriatric illnesses. During the period when my parents were staying at the main location I started the more extensive organisational observation sessions at this secondary location. One of the analysands of the role analysis session pointed out that in doing so I had in fact moved closer to death. The residents in this location were in even more vulnerable positions than my parents. Most of them were no longer able to fend for themselves. For the observation sessions I had arranged for a fellow observer to attend. I had clear methodological reasons to choose for this option. But I think that

unconsciously I also wanted support from a fellow observer. Perhaps it was too scary to observe at an organisation where vulnerability and death was very close at hand. And perhaps I also felt the need to bring someone along to check that what I was seeing really was happening to my parents and was not just part of my own imagination. Initially I did not think about this consciously at the time.

During a data analysis session with the Dutch refection group, one of the analysers expressed his surprise at the fact that I had not openly referred to the fact that my parents were staying at this location when I shared my observations with the group. This made me think. I became aware that during the first observation sessions, I had had fairly harsh thoughts about the carers I saw doing their work. I noticed a lot of incompetence and neglect. Later this made we wonder if this had a something to do my personal feelings of powerlessness and anger in relation to what I could do for my parents. The answer is 'yes' probably. But this is also what many family members probably feel when they have to leave their loved ones in care homes. And in many cases this anger is projected into carers.

Vignettes: Learning from the carer
As Jessica Benjamin (2004) has noted one of the basic arts of psychotherapy is to facilitate a relationship of mutual recognition, this means the therapist learns as much from the patient as the patient learns from the therapist. The same can happen in the research

interview where relations of trust have been established. What follows are extracts from two interviews with Karin, a key worker at Arborvitae

From the first interview:

It is change upon change. Why do we have to change: For the good of the client? I have asked myself this a 100 times… and then something new has to be introduced and all the care homes bring in all kinds of people. I have always found this very annoying. – They are going to clock you… Also in this house they are introducing the lean project …. They are going to clock you… At a certain moment I said… I do not want to be involved in this.. I am dealing with people… The same happened in the home I worked before. We had to fold aeroplanes. And they said: '*Well you can fold so many in an hour, how can you translate this to your work*. And I told them: *Yes, here I do not have a phone and no one asks to go to the toilet'.* Such a production you cannot compare to caring for someone who is bedridden. Two, five minutes to give someone a shower. It is something to be terribly ashamed about. This goes against my convictions. You lose sight of the human factor. And such a consultancy firm costs a few thousand euros. That is where the money goes. And that happens much too often. Someone is asked to come and see if we can change things. And

in many instances the staff could have explained themselves what has to be changed. The knowledge is there. And often the staff has to make readjustments to the plans that those firms have come up with, or once they have left all the changes are dropped again. The money is spent on the wrong things. Use the knowledge from within the organisation!

From the second interview:

We work with a lot of temps and flex workers. And over the weekend a lot of things go wrong. On Friday there is a temp for the weekend, evening and night shift. And if she makes a mistake on Friday – things go wrong the whole weekend. It is a kind of domino effect. On Monday morning for instance I hear that a resident has had pain, pain, pain throughout the weekend. And then I ask the carers 'why did not anyone go to him to and ask him what the matter is? So I go to him on Monday - to ask him if I can have a look at his medication. This resident keeps his medication in his own room. So I immediately see that the opiates are not there. I ask him about this. He informs me he never got them over the weekend. I go and look in the central medicine chest - and there they are. So he suffered severe pain the whole weekend and no one bothered to take action. So that is how it goes. One mistake and bang, bang, bang, the mistakes accumulate. And I am afraid that this will happen a day longer till Tuesday if I am no longer

work on Mondays. Because continuity cannot be guaranteed. I
often leave on Friday with the fear that things will go wrong over
the weekend.

I interviewed Karin twice with an interval of more than a year. Both
during the first and the second interview Karin was more than willing to
talk. Initially during the first interview she felt a bit awkward, but that
soon changed. Karin seemed pleased to be listened to and to be able to
share her story. Once I set her off the stream of stories, thoughts and
reflections hardly stopped. The predominant undercurrent was one of
anger and frustration. She saw things going wrong and felt she was
involved in a constant race against the clock. She was working with
residents who were in the last phases of their lives for whom time had a
completely different connotation. Both during the first and the second
interview the issue was not about whether the interviewee or the
interviewer were defended and if my attention had been focussed on
what had been going on beneath the surface I might have undermined
the relation of mutual recognition which enabled Karin to provide such
vivid and insightful thoughts.

While listening to Karin I was reminded of the Red Queen in Alice in
through the Looking class. Karin and her colleagues have to have to run
twice as fast to stay in the same place.

Observing as a pair

Observing as a pair did bring in another dimension. As a pair we tended to stick together. Whenever we came to observe, we choose to sit somewere were we could place two chairs next to each other and could see – and perhaps – almost touch each other. On one occasion my colleague suddenly moved to another room and sat down in a comfortable chair in the sitting room area. Before I new it I moved to that room as well and found a place to sit down as well. Reflecting on this, I think it had something to do with feelings of anxiety or fear on our side. It felt safe to be together, to be able to look someone you know in the eye whenever something uncomfortable happened in front of you. Thinking about the reactions we got from the carers during the observations sessions I think they were scared of us as well. As a pair they did experience us an representatives from an external organisation who came to check upon them. We were regarded as a judgemental party who come to visist to check if what they do is alright.

During one observation session my colleague could not be there. And that impacted the dynamic. During that observation session I joined a group session of residents under the guidance of an activity facilitator. They did not have enough people to wheel all the residents downstairs to the room. I was asked to help out, which I did. During the activity session I observed but afterwards I had an friendly chat with the activity facilitator and the volunteers. They approached me as if I were a coach. It really made a difference compared to when we observed as a pair.

Action Research as a Consultant

The consultancy was dynamic and not necessarily easy. We experienced the tension the different hierarchical layers: location manager, care managers, key workers, carers, facility workers. The mistrust between them was also projected into us. During the course of consultancy the location manager distanced herself from the project. At the end of the project we had scheduled an evaluation session with the location manager and the care managers. We arrived at the appointed time. The care managers were there, the location manager suddenly had an other engagement and could not be there. We shared the observations of the consultancy project with the care managers and agreed that we would make a new appointment in a month time with the location manager and the care managers. The location manager was there when we arrived, but half way the meeting, she got a phone call and left. Later she poked her head around the door, to say that she would be in contact later. However that never happened. I am not sure she ever read the report we made for the organisation. I have a strong feeling that the location manager projected her feelings of paranoia into us and blamed us as as consultancy bureau for the fact that the relationship with the care managers seemed not to develop in a manner she deemed appropriate. A few month after the consultancy project had finished one care managers had been fired and one was in the middle of a legal battle about her job.

Cross-case Analysis.

The character of both case studies was completely different. Arborvitea clearly was a small house with a strong religious affiliation. In a way it was much more painful and difficult to follow Arborvitea. There was so much at stake for this organisation. And it had-has such an important role in Dutch history in relation to caring for those who survived the Second World War. There was a struggle about identity, survival, how to care for the second-generation war victims. How is Dutch Society going to react? The acting manager was convinced that no one in the Hague (the Seat of the Government) would have really dreamed of allowing Arborvitea to go bankrupt. And he was probably right. It would have been a big scandal. And yet, the last managing director was right. Arborvitae was a bird of paradise: beautiful but vulnerable in an environment that were birds of paradise usually are not found.

What was similar at both case studies is that the senior management seemed to suffer from a form of amnesia. They simply forgot or ignored that I walked around. When I phoned they remembered. And they were willing to make sure that I could interview care managers or carers. But then I disappeared out of mind again. They al said they were very curious about my findings – yet I wonder if this is really true.

Objectivity and Data Analysis

A psycho-social methodology places great emphasis upon the creative use of the researcher's own subjectivity. But one natural criticism of this approach is that it can discourage objectivity in research. Psycho-social

researchers (Hollway & Jefferson 2000; Clarke & Hoggett 2009) therefore stress how important it is for the researcher to look for different perspectives on the data that they have gathered. In my research I did this in a number of ways some of which – the use of a second 'partner' observer , observing as a pair, for some of my organisational observations – I have already discussed. Another method I used in both my observations and interviews was to present data to reflection groups – groups of colleagues or fellow students who were encouraged to offer their own independent insights. A particular feature of psycho-social postgraduate research at UWE has been regular postgraduate workshops at which students present their data using a 'role analysis' framework. This framework is used widely in Group Relations training and offers a proven method of generating diverse perspectives in a small group setting.

Naturally the postgraduate supervision experience also provides an ongoing avenue for challenging the student's preconceptions about their own data. I found that over time I was increasingly able to be my own supervisor, able to question my own assumptions as I visited and revisited transcripts and read and reread my data analysis notes. The task of translating Dutch transcripts and notes into English also offered me the opportunity to sensitise myself to double and hidden meanings and ambiguities in the data.

We can also see from the extracts provided how the interviewer, from the outset of an interview, is engaged in a sense making process, in Bion's terms, they are engaged in digesting their experience of the interview. From our perspective the issue is not whether they should share their thinking with the interviewee, we regard it as inevitable that they will, but the danger is that they do it unwittingly. The key question is how this thinking is to be shared (P.Hoggett, 2008).

Chapter 5

Two Care Organisations in The Netherlands

Introduction

In chapters 5 to 7 I present the data gathered using the methodologies as described in chapter 4. In chapter 8 I provide a theoretical analysis of this data. Going through all the collected data, I conducted a thematic analysis applying a theoretical or deductive top down approach. The theoretical approach is based on the psycho-social perspective as discussed in chapter 3 and 4. The data was collected at two different case studies: at Arborvitae based in Amsterdam and at the Noturos care group based in Friesland, a province in the north of The Netherlands. I followed both organisations for over a period of two years. In the first section of this chapter I provide background information about the two case studies and an overview of events that took place in the course of the research.

In the second section of this chapter I present data gathered during observations. I described the particular approach I took to organisational observation in the previous chapter. There I mentioned that I tried to adopt a formal method of observation, keeping notes of my observations, at every opportunity. But I also mentioned that after several months I undertook an intensive programme of observation at

Arborvitae. Over ten hourly sessions these observations were conducted with a co-observer and to facilitate data analysis our 'raw findings' were presented to a small, independent panel. The richness of this data is reflected in the detailed account of it in this chapter. Nevertheless I have also been able to generate valuable and to some extent contrasting observations at Volte-face, part of the Noturos care group, and these are included in the last section of this chapter. Where appropriate I compare the case studies with each other.

Arborvitae: Background and Description of the Organisation

Arborvitae is a Jewish care organisation based in Amsterdam. In the beginning of the twentieth century a Jewish Rabbi took the initiative to establish a foundation 'the Jewish Invalid' that had as its aim to provide shelter for Jewish chronically disabled frail and elderly men and women. Until that time they had been living in the municipal house for the poor. In 1912 the foundation opened its first building with initially housed 12 Jewish elderly invalids. It was regarded as a modern institution. The residents were not referred to as patients but as residents. The number of residents increased rapidly. Before the Second World War they moved three times to larger locations. In 1938 it moved into new premises in the centre of Amsterdam. The money for this location had come from private donations. The building was known as the Glass Palace.

In a radio broadcast about the Jewish Home it was described as a place for 'those who are past it, who are worn out and broken'. And it didn't seem at all odd that people donated money to this cause. You have to realize how different things were in those days. Most of the people who went to the Jewish Home had lived in slums, they came from the ghetto of Amsterdam, they were almost at starvation level. The Jewish Hospital and Home depended on private initiative and that's what made it so popular. At that time there was no such thing as local or central government social security, and certainly no subsidy for the Jewish community. It was private persons who gave their money. That was a question of little by little, and later there were lotteries, and theatre performances.[3]

In 1943 all the 256 residents and staff were deported. In 1945 the city of Amsterdam handed the building back to representatives of the former board. The Jewish community however no longer had the funds to look after the building. They moved to one other location before they moved to their present location Arborvitae.

When I started my research Arborvitae had two locations: the main location in the so-called Jewish quarter of Amsterdam and the second location in another neighbourhood in Amsterdam with a smaller yet substantial Jewish community. Arborvitae moved to this second location in 2011 from another building in a completely different, non-Jewish

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[3] (From *Memories of Jewish Amsterdam*, 1978). Words from the son of the pre-war director of the hospital-home, Mozes Heiman Gans,

neighbourhood in Amsterdam. The second location provided care for elderly people suffering from psychogeriatric illnesses. Arborvitae aims to be a multi-functional care centre, where residents can live according to the Jewish life-style that they are accustomed to. Much attention is given to Jewish holidays and traditions. Although the traditional Jewish practices are observed in the common areas and kitchen, residents are to make their own life-style choices in their own accommodations.

Arborvitae is a small care organisation. The main location can house 245 residents. The second location for psychogeriatric care can house 72 residents. The main location has four units spread over four floors, not including the ground floor. In The Netherlands there is a distinction between a rest home and a nursing home. Elderly living in a rest home will need some forms of care and will no longer feel safe living independently. A nursing home is for elderly who need much more somatic care and definitely cannot live independently any longer. In terms of ZZP (= severity of care packages , see chapter 2) categories: rest homes provide care until ZZP category 4. Nursing homes provide care from ZZP 6 and higher. Three units in the main location of Arborvitae are rest home units. The fourth floor is the somatic nursing unit.

The Jewishness of the organisation is not immediately visible. The signs are subtle. The painting on the lift gives it away at the main location. At the psychogeriatric location Jewish artefacts are exhibited in the

hallway. At a closer look the signs are more visible. On the walls in both locations there are commemorative tablets in remembrance of the holocaust. At the Psychogeriatric care location there is a prayer room. At the main location there is a schul or synagogue that is also used by the Jewish congregation in the neighbourhood.

Figure 5.1 Painting on the lift

Some of male the residents wear the yarmulke. In the communal areas everyone has to adhere to Jewish rules and laws. Food consumed has to be kosher. During the Sabbath it is not allowed to use mobile phones and similar devices in this areas. If you forget, someone will approach you and draw attention to the fact that certain things are not allowed in the communal area. In their own rooms residents are free to do as they like.

Figure 5.2

The communal area

During the Sabbath and other Jewish holidays the Jewishness is more visible. There is a more festive atmosphere. The dinner in the evening is more special. Most of the residents go down stairs to the dining room, whereas during the week many residents opt for having their evening meal in their private rooms.

Overview of events during the research period

At the start of the research in 2012, a lot was happening in the organisation. A year earlier in July 2011 the Inspection for Healthcare had placed the entire organisation under tight scrutiny for a period of at least six month, because the level of care was deemed unsatisfactory. They published a damning rapport with all their findings. This was common practise. Whenever a care organisation is placed under a form of scrutiny the Inspection of Healthcare publishes this data on their website.

The fact that Arborvitae was placed under scrutiny was widely written and spoken about in the media. As a result of the turmoil the Managing Director was fired and replaced by an interim manager.[4] A few months after he had started working it became apparent Arborvitae had severe financial problems as well. It was on the verge of bankruptcy. Arborvitae had failed to implement the ZZP structure that had been introduced in the sector in a few years before. As a result the organisation had been using up its capital. It received less money for care than it spent. In addition to focusing on the improvement of the care, the manager ad interim also had to make a start with restructuring the complete organisation.

When the managing director with a Jewish background had been forced to leave, there were only three staff members left with a Jewish background. From that time onwards the Jewishness of the home was represented by the board of directors who were all active members of the Jewish community. The home was also under rabbinical supervision.

The interim manager stayed with the organisation for one and a half years. After twelve months the reorganisation was implemented. The organisation had to lay off sixty members of the care staff (thirty-five full time equivalent) and the care was organised differently. A Managing Director who was employed by the organisation succeeded the interim

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[4] An interim manager is employed by a consultancy firm. Organisations hire interim managers on a temporary basis through such a firm

manager. She found an organisation in still greater financial difficulty than one and a half years before. In 2012 Arborvitae had the biggest negative financial result in its history. The new Managing Director had to focus on finding a partner for a merger. Only as part of a larger organisation would Arborvitae be able to survive. This manager stayed with the organisation for about a year. In this year she had a lot of contact with the Jewish community and the rabbis, much more than the acting managing director ever had. She had to work on detaching the care home from the Jewish community is such as way that the organisation could merge with another organisation and yet retain enough of its Jewishness for it to maintain its function as a care home were Jewish residents would feel at home.

After a very difficult year and after many tough negotiation rounds with a host of stakeholders Arborvitae managed to merge with a much larger care organisation in Amsterdam, which employs approx. 8000 people and has different kind of care locations in the Amsterdam Region. As part of the negotiations Arborvitae had to let go of the location for psychogeriatric care. The position of Managing Director was abolished. In its new form Arborvitae had a location manager who was responsible for three care homes in total. The last managing director of Arborvitae had characterised the organisation as the bird of paradise among care homes. A bird of paradise is beautiful, conspicuous and vulnerable all at the same time. The bird of paradise had not managed to survive on its own. From an independent faith based care home it had become part of a large care organisation that provides long-term and short-term care to the general population in and around Amsterdam.

The Noturos Care Group: Background and Description of the Organisation

The Noturos Care Group is a middle-sized care organisation in the province of Friesland, in the North of The Netherlands. The organisation in its present form was formed in 2006 from a merger of three foundations that all provided care in the same region. The organisation has seven nursing homes, five rest homes and an intensive geriatric convalescence centre. The care group offers different kinds of care to around 1300, mainly elderly, clients. It employs 2144 people, most of

whom work part-time. The care budget is around 65 million euro per year.

In 2008 the organisation employed a new Managing Director. She succeeded the Managing Director who had been with the organisation for twenty-nine years and who had presided over the three mergers. The new Managing Director started with the development of a strategic plan that formed the basis for the course the organisation was to follow in anticipation of all the changes surrounding the sector. In the strategic memorandum it is stated 'that the organisation has to redefine its aims and objectives in a changing environment. The sector will be financed in a different way, care organisations will be expected to show entrepreneurship, they have to compete on the market etc.'[5]

The research focused on two locations of the Noturos Care Group: Volte-face and Grenier. The two locations fell under the responsibility of the same location manager

The Volte-face location

The Volte-face site is a psychogeriatric care unit. It is located in a rural village and was built in 2010 by the Noturos Care group. The premises are spread over two buildings of apartment blocks. The ground floors of

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[5] (Bouwe en Binne, Huizinga 2009)

these building form the location. Each of the two buildings has two units that each house nine residents. The residents have their own rooms with en suite facilities and each unit has its own living room with an open kitchen. The location offers what is called 'small scale living conditions'. The nine residents form an independent group that is cared for by a fixed group of carers who try to create a homely atmosphere for the residents. Wherever possible the residents are stimulated to remain active and help out with day-to-day activities such as preparing dinner and folding the laundry.

The location was presented as the flagship of the Noturos Care Group. By many within the Noturos Care Group and outside of the organisation it was seen as an example of good care. During the research period Volte–face was awarded the top score in several audit programmes.

The ground floor of building is the unit for psychogeriatric care. The floors above are regular owner-occupied apartments.

Figure 5.3 The ground floor Volte-face

The Grenier location

The Grenier location is situated in a middle size town in the province of Friesland. It is a residential care centre with 85 living units dived over four floors. Adjacent to the location are 184 semi-independent apartments for elderly people who feel safer living closer to a care centre, but can still live independently. On the ground floor of Grenier are the communal areas: the reception, a dining area, a gym, a shop, the hairdresser and a room where a group of elderly people who no longer can be on their own, spend the day together. They were called 'The Group'.

Grenier is one of the oldest locations of the Noturos Care Group and one of the oldest care homes in the town. It present location was built in 1956 and renovated in 1985. The initiative the build the home was taken in 1948 by the town council. The home had to replace the 'poor house' that dated from 1795. In that house men and women lived in different quarter and had to share their living spaces with other residents. Grenier had to become a location where residents had their own private living spaces. It took eight years after the first initiative for the doors of Grenier to be opened. In 1957 there was an official opening by the then prime minister of The Netherlands William Drees. As prime minister he was responsible for the introduction of the Old Age Pensions Act of May 1956 that entitled Dutch citizens to receive universal flat-rate old age pensions. Grenier was not affiliated to any church and fell under the responsibility of the council. In 1992 Grenier was privatised and became

part of an independent foundation. In 2006 this foundation merged with The Noturos Care Group.

Figure 5.4 Grenier in 1957

Figure 5.5 Grenier in the present

Three years before the merger with the Noturos Care Group, Grenier was part of an organisation or foundation that had been in the news a lot. Staff had been complaining about working conditions and the quality of care. This foundation had attempted to prevent staff and trade unions from bringing this news into the open by means of a court case, which they lost. The relationship between management and staff has been difficult since then. Ever since that time there has been a change of management approximately every two years.

Overview of events during research period

Grenier was indeed regarded as the troublesome organisation within the Noturos Care Group. When I started with the research a new

management team was about to be installed. A manager who already had three other locations under her charge, amongst which was Volte-face, became the new location manager of Grenier. She fired the facility manager. The care manager decided to resign herself. Their replacements started in the summer of 2012. This new management aimed to get the location up and running. It had to face the mistrust of the staff who had become sceptical after the umpteenth management change. Two years later one care manager and the facility manager had been fired. The other care manager was in the middle of a labour dispute and later that year decided to leave the organisational as well.

Due to the changes in the sector fewer elderly will be admitted to care homes. At Grenier the number of beds will be reduced from 88 to 44 beds. In this new form it will need only one care manager.

It terms of organisational structure both case studies grew more alike in the period I followed them. Grenier and Volte-face are part of a middle-sized care group. Arborvitae has now lost its independence and is part of a large to middle sized care group as well. Both organisations have a Headquarters which is housed in a separate building. They are run by a managing director who is employed by a Board of Trustees. Both organisation have a large HR department and location managers are responsible for at least four locations. Care managers are responsible for organising the care processes at the different locations. Facility managers are responsible for house keeping and food. The food is no

longer prepared at the locations but in a central kitchen somewhere else.

Observing the Psychogeriatric Unit at Arborvitae

Entering the organisation: A hidden and closed world

Nothing on the outside of the building gave away the fact that the psychogeriatric location of Arborvitae was situated where it was. On my first visit to this location I had trouble finding the place. What follows are the observations I wrote down after my first visit:

> I left early because I wanted to be on time. The meeting would take place not at the main location of Arborvitae in in the so-called Jewish quarter of Amsterdam but at the second location in another neighbourhood in Amsterdam with smaller yet substantial Jewish community. This location provides care for elderly suffering from psychogeriatric illnesses.
>
> It turned out this location was not so easy to find. The street where I had to be was in an office area. There were hardly any people walking on the street. I started to look for the address number 9. The offices and buildings did not advertise their street number very clearly. I saw someone walking. I approached him and asked if he knew where Arborvitae was located. He did not know. I got very nervous because the clock was ticking. I phoned the general number of Arborvitae and the woman how answered the phone told me I had to be opposite the hospital. Opposite the hospital was an anonymous looking

building without any sign or name. The address read number 97. I was supposed to be in number 7. I approached someone who was stood close to some kind of side entrance and asked if this was Arborvitae. She confirmed it was. I later discovered Arborvitae shares this location with another care organisation. That care organisation is located at number 7, Arborvitae is located at number 9. The two number are place closed together in such a way it is possible to mistake the address for number 97.

I entered the building and was in a large open empty space where you can look right up to the glass ceiling four floors up. On the right and left were sliding doors. I had to go to the right: the sliding doors to enter Arborvitae. I moved to the doors, they did not open. On the right side of the doors there was a small window with a horn. A sign read that you could use this horn during the Sabbath. 'But it is Tuesday I thought, I do not have to do this now, do I. Where is the bell?'. It turned out to be on the left side. Through the glass sliding doors I had already seen the receptionist on the other side. He had seen me as well, but only after I had rung the bell did he open the first set of doors. Once they are closed the second set of doors opens. I was inside. Again I was in an open space. I faced a steep stairway that seemed to be going up for ever. The floors of this location are built around a large open empty space. Large glass walls go up to the fourth floor, the ceiling is glass as well. The place felt

strange somehow. It reminded me of a prison building where all the cells face the open space in the middle so that the guards have a good overview of what is happening.

I asked the receptionist where the management meeting took place. He did not have a clue. He said he was not aware that a meeting was taking place anywhere in the building but he would check. He found out I had to be on the fourth floor. You have to take all those stairs. He emphasised the word 'all'. Then he said I could also take the lift. I asked if this would be faster. He thought it would be. I walked towards the lift, which turned out to be on the other end of the open space. A cleaner informed me that only one of the lifts was working and but that right now this one was stuck on the third floor. I decided to run up the stairs after all. Out of breath and not on time I knocked on the door where the management meeting took place. I entered, quickly took of my coat and shook hands with those present and apologised I was late. I explained I had had trouble finding the location. 'Don't' worry', they said,

Once you were inside the psychogeriatric location of Arborvitae you became aware you had entered a different world. And it felt like a world where a lot was not as you would like it to be. It started with the receptionist who was not very welcoming. Was he there to prevent people form entering and leaving rather than providing a warm welcome to whoever wanted to come and visit? During one of the reflection sessions the image arose of Cerberus, the hellhound who guards the

entrance to the underworld. He prevents the living from entering and the dead from escaping.

The residents certainty could not escape. In fact, the design of the building was such that it prevented residents from freely moving about on the inside. After the entrance there was a kind of atrium. In order to get to the different floors you had to use a steep glass stairway.

Figure 5.6 The stairs at the psychogeriatric location of Arborvitae

These stairs were definitely not there for the residents. They were too steep and too high. Taking all the stairs to the fourth floor would be too much for many if not all the residents. They had to resort to the lift, at the far end of the building. And in order to reach the lift they had to traverse the whole ground floor towards the other end of the building. All access doors to the units could be opened from the stairway but once you where in they automatically locked. In order to get out of the units you needed a key or ask someone to open the door for you.

Occasionally I saw staff members use the stairs if they needed to go up. But I never saw a resident on the stairs.

Inside the organisation

Being inside the location and observing interactions between residents and staff was not easy. It evoked strong feelings and emotions. After the first observation my fellow observer sighed that during the whole hour she had been thinking about the 'pill of Drion'. This is a fictitious suicide pill named after H. Drion, a former Dutch supreme court judge and professor of civil law. In 1991 he started a debate in The Netherlands about the right of people above the age of seventy to determine for themselves how they wanted to end their lives. It was confronting to watch elderly people who were losing the sense of themselves. And it was confronting to see how they have to cope with living in a care home.

Dark images often came to mind during the observations. The residents reminded me of caged animals. They were trapped in their bodies that had betrayed them. Their minds had gone and they were no longer in control of their own lives. Many hours during the day residents who could still walk, walked in circles along the corridors behind their Zimmer frames. They were called the 'little walkers' by the staff. For hours they would walk around with expressionless faces. When they came up against a locked door or another obstacle in their way they stopped a few inches before bumping against it and then turned around. They were like hamsters in a cage that walk around in a wheel. They walked for miles but never got anywhere.

It was not always possible to see if residents where aware of their surroundings. There certainly were moments when they seemed to know they were not happy to be where they were. During one observation I saw a resident who clearly felt she did not belong at Arborvitae

I approached the activity supervisor and checked if it was all right to join them and observe what would happen. She did not object. I followed the group to the lift. There were three residents in wheelchairs and two who walked by themselves.

One resident in a wheelchair was in great distress. As she passed me while I held the door to the lift area, she asked my help. 'I am not crazy; I do not want to be here. Why are they doing this to me? Please, can you, please, help me? I do not belong here.' She was almost in tears. It was a shocking experience. I did not know what to do or say. She addressed the activity facilitator in the same manner. The activity facilitator answered that she could not do anything about this and tried to comfort her a little. The lift arrived and the woman and another resident in a wheelchair were driven inside, facing the wall. I joined them to go down stairs. The woman was still in great distress. When we had all left the lift, the activity facilitator tried to comfort her again. In order to give her a bit of time to do this I wheeled the other resident to the activity room. The facilitator followed almost immediately, without the woman in distress. On the way to the activity room she had bumped into

someone she referred to as the hostess. The hostess was now

with the woman trying to comfort her.

Halfway during the session the woman in distress entered together

with the hostess. She looked more composed, but clearly was not

happy yet, far from it. Very reluctantly she joined in with the next

activity, moving a ball across the table to each other. 'I am not like

them, I am not off my rockers like they are.' And yes, she did look

much more sane and alert then the others. She also seemed much

more alert than the volunteer who was helping out during the

session. She was not institutionalised yet. The hostess had

remained sitting next to the woman in distress. She seemed to

have true contact and took the time to be with the woman.

(8th observation session)

It was one of the more painful scenes to observe during the sessions.

Once residents are completely in the twilight zone and are no longer

fully aware were they are, living in a place like Arborvitae was bearable

perhaps. But if you were still aware of your surroundings not many

people could bear to live there. This woman must have felt she had

entered a lunatic asylum and was living in a nightmare.

She was not the only resident who felt she had entered the lunatic

asylum. On another occasion a resident tried to get our attention. The

following interaction took place:

The elderly man who had just entered before the manager came in was still in the room. He was in for a chat. He looked outside and asked us if we knew what they were building across the street. 'Perhaps', he continued, 'they are building something for the complete lunatics. We are the half lunatics you know'. Than he showed us the article he was reading. I think it was the Readers Digest. 'Look he said pointing to a picture, 'refugees from East Germany'.

(2nd observation session)

This resident seemed less lucid than the woman. We saw him during several observations. He seemed to work hard on maintaining a sane appearance. However when he spoke the line between clarity and confusion always was a bit blurred. I met him again during another observation session. We were about to go out and he was part of a group of residents who were going down stairs to the activity room. He passed me and he asked me if I was a prison guard. I have not checked but I assume he was one of the Jewish residents who had survived the 2nd World War. Apparently living in a closed PG unit, reminded him of a prison camp.

Staff members also let us know that things are not as they might seem in this location and that it is a world of its own. During the fifth observation for instance one of the staff members informed us in that indeed 'the house is a world of its own you know. Everything here is

quite different from the outside world.' He spoke in a lowered voice, as though he was revealing something he was not supposed to reveal.

Both residents and staff apparently experienced the locations as a kind of closed world with its own rules and regulations. Data coming out of the observations seemed to indicate that the psychogeriatric unit of Arborvitae indeed was a closed system that in addition evoked images of a prison.

I was certainly reminded of a prison when I began to notice that many of the residents were tied in their wheelchairs. They could not get out independently however hard they tried. On one occasion one resident tried for a whole hour to get out of her chair. After each failed attempt she briefly resigned herself to her fate, but then she tried again and again. During this time a staff member never attended her to.

A Panopticon–like atmosphere

On more than one occasion I was actually reminded of Foucault's panopticon. The architecture of the building had something to do with it. The atrium like design brought with it that all the internal walls are made glass. Wherever you were sitting in the building you could see a lot of what is going on. Anyone taking the stairs saw the residents sitting in the communal areas, you could see the staff cleaning the floor, you saw the staff chatting with each other, you saw the residents passing up and down the corridors walking behind their Zimmer frames. And when you

are inside the units you noticed immediately if someone, the acting manager for instance, was going up the stairs to attend a management meeting. Initially the transparent architectural design of the building might seem to contrast with the feeling of entering a closed world. Everything anyone did could be observed by others as if there was nothing to hide. But rather than creating a sense of openness however the transparency worked like Foucault's watchtowers.

As soon as you were in the building you knew you were being watched and you were on the alert and the observations provided me with data that staff were also on the alert for external eyes and felt like being watched all the time. Our observations coincided with visits from other observers: the IGZ or the Inspection and consultants from an organisation specialised in lean management, a form of efficiency management that had been developed by a Korean car manufacture. The staff had the experience that observations were anything but neutral. As an observing team we were seen or regarded as part of a group of outside observers who could change the running of the organisation. On several occasions carers checked directly or indirectly what we were looking for and if we were satisfied.

> A staff member we had not seen before, approached us and asked us who we were and what we were doing. We again explained. She shook hands and explained a bit about the workings on the floor. She drew our attention to a floor plan that was hanging on the wall. She explained they had just rearranged the room on the

advice of a psychologist. He or she had rearranged the room in order to create more rest. Every resident has been assigned his or her own seat at a table. Apparently there had been a lot of unrest in the afternoons. In the afternoon all the residents used to become restless she said. 'They want to go home or see their children or start annoying each other.' She left and continued with her work. On reflecting I felt she had wanted to show us that they do things with a reason and to show us that they know what they are doing.

(2nd observation session)

And

The young volunteer started to polish the nails of the woman she was sitting next to. I was reminded of a little girl playing with her doll, the doll being the elderly woman in this case.

While she was busy polishing a staff member approached her and requested not to polish the nails at the table. She explained the table was for eating and that polishing nails was not hygienic. She pointed to us, indicating we were observing. I wondered if she was afraid of us.

The young woman was surprised. She said no one had ever told her this before. She said she would go and sit somewhere else. But she stayed were she was after the staff member left. The staff member did not return to check if she indeed had moved.

(2nd observation session)

And

When we left, a carer opened the door for us. On leaving she

asked us what we were doing exactly. When I explained we were

observing as part of a PhD research project she immediately

asked if the aim was to investigate if they could work more

efficiently…

Again proof I think that the staff have a sense of being watched

and feel pressured to work more efficiently.

(3rd observation session)

And

We entered the communal space on the second floor. We went

into the space in which the kitchen of the floor is located and

notified a staff member of our presence. It was a new face again (I

think, although I am not quite sure). We decided to sit in the

corridor again, facing the glass walls in the middle (the vide)

I am reminded more and more of Foucault's panopticon. If you sit

in the corridor, facing the glass walls, you have the impression you

can see a lot. And in a way you can, but at the same time it is also

obvious that a lot remains hidden. There are many doors in the

building, so a lot will happen behind those doors you cannot see or

do not have a clue about. Yet the staff might very well have the impression that they are regularly being observed, that they work in a glasshouse

Life in a closed unit.

The contact between residents and staff had a kind of mechanical quality to it most of the time. Warmth seemed to be missing. It was a though staff were following a list and checking boxes. They did the duties they had to do but somehow their heart did not seem to be in it. Staff and residents moved along side each other and hardly touched. On occasions residents were treated as if they were annoying children who you plonk in front of the television, for instance, in the hope that that will shut them up. This happened with a resident who had wanted to go outside and let everyone in her surrounding know about this:

> The woman who was sitting at the table having breakfast greeted us and asked if we were waiting for someone. We said we were. She started a conversation with the man facing her. She asked him if he would join her for a walk outside after breakfast. He did not react, she kept on asking. It sounded like a married couple having a conversation they have had millions of time before. Then she asked if we were going out and if she could join us perhaps. We said we were not going out. A staff member came to the table with tea and coffee. The woman immediately asked her if she would go out with her. The staff member more or less ignored the question and asked her if she wanted to have something to drink.

Whenever someone new entered the room the woman told them she wanted to go outside. She said she needed fresh air and that she was suffocating. Another staff member who walked through the space promised that she would go out with her later. She explained that she could not do it right away because she was busy helping other residents getting up and getting dressed etc. The woman never the less became more and more persistent. It was actually very painful to observe. I had the impression I was watching something that had become some sort of daily routine.

The man who had been sleeping leaning against the wall woke up. He was annoyed by the woman and told her to shut up.

Another staff member passed by and again the same pattern: 'Please help me. I want to go out'. I had not noticed yet that the woman was sitting in a wheel chair. The staff member spoke to the woman and said that she could not go outside at this moment and that was too cold outside. She pulled the woman away from the table and made her face the television, which she switched on. It reminded me of busy parent who switches on the television for her children in the hope that they will stop bothering her. It did not really help. The woman kept on saying that she wanted to go out, because she was suffocating. A woman entered who did not look like a staff member. She walked toward a woman who was sitting in the reclining chair.

The woman who wanted to go out, asked her if she could go out with her. She asked the next staff member who passed by. This

staff member answered that she did not have the key to the door.

At times I had the impression the woman was hard of hearing. However when she heard a something that seemed to interest her, she picked up on it. She asked others about the key.

A male resident who had been sleeping in a chair woke up and became really annoyed and started swearing and told the woman who wanted to go out that she had to shut up.

The woman who wanted to go out again addressed another staff member who passed by. This staff member suggested she would push her towards the balcony door, which she would open for a while. And so she did. She explained that she could not go outside because that was too cold and that the door could not be left open too long because that would be too cold for the others. She put a blanket over the legs of the woman. This action seemed to do the trick. The woman became more restful. After five minutes the door was closed and the woman was wheeled back in front of the television. She now realised she was watching the programme called 'Coffee time'. She stared saying the name of the programme out loud. And added where is our coffee? I want coffee. A staff member informed her that she already had had her coffee and that she would get coffee again later.

The woman was very persistent; she just would not 'shut up' until she had gotten her way. The staff were not unkind but they seemed 'absentminded' as if they had found a way to 'work around' the problem. They were talking at her, not with her. The

staff member who wheeled her to the door was the only staff member who gave the impression of truly listing to her. What she did gave some relief to the woman and therefore also to the others.

(1st observation session)

On another occasion a resident was wheeled to communal area at around 10: 30 so that she could have her breakfast

> The carer rolled the resident out of the room. She parked the wheel chair without saying anything to the resident. She went back into the room and came out with two plush animals that she placed in front of the woman, again without saying anything. She then rolled the woman to the communal area and placed her at a table in front of a plate. I could see the table from where I was sitting. Another staff member had already placed the plate on the table ten minutes earlier. The two plush animals were placed on the table, facing the woman.
>
> 'Here you are, your breakfast', the carer said and immediately left. The woman did not react much. She did not say anything or do anything either for that matter. She looked at her plate, but did not start eating. She just sat and hardly looked at the plate in front of her.
>
> (3rd observation session)

This interaction also had a mechanical quality to it. The carer did what had to be done and nothing more. There were moments when carers stroked residents. But that did not always give the impression of a sign of warmth. It was almost as residents were dolls or objects you played with.

It being a Jewish house I had expected to find a world more infused with a spirit of warmth and closeness. However, what I saw was a kind of processing model of care. Occasionally there were glimpses of something more, of some real contact. A resident who wanted to have a paper, got one in the end. The woman who needed fresh air was eventually wheeled to a door that was briefly opened. But this only happened after a lot of dogged persistence from the resident.

Signs of neglect and inattention

I observed smaller and bigger signs of neglect or inattention. The small signs had to do with not removing a bib after a resident had finished eating, or putting on the wrong shoes or waking a dozing resident in a rough manner.

> Another resident stopped in front of us when she saw us sitting in the chairs. She apparently had finished her breakfast. Her bib was still hanging around her neck. She seemed to be looking for something or someone. She was clearly puzzled. She asked us something but it was not clear what she asked. She moved on

mumbling that she did not understand. She too passed us several times during the hour. I wondered why no one removed her bib. It actually irritated me that no one took the trouble to do this.

Across the corridor a woman entered, accompanied by a young man. She turned out to be the physiotherapist and the young man turned out to be her son. She had asked him to come and help her because her colleague was away on holiday. She had appointments with two residents.
On her way to these residents the physiotherapist passed the woman with the bib. She greeted her and asked how she was doing. And she immediately said that she would remove the bib. '*Because that is much more comfortable is it not*'. I felt relieved that at last someone had done this.

The psychotherapist discovered that her client was wearing the wrong shoes. They were too small apparently. She went looking for the right shoes. She found them in his room and explained to a carer why these shoes were the right shoes for this resident. The carer listened and nodded.
(3rd observation session)

And

A male resident who had woken up had become annoyed by the woman who persisted in saying she wanted to go out. He started swearing and told the woman she had to shut up. He took off his shoes, stood up and started walking through the corridors. He walked fairly straight without the aid of his Zimmer frame. A staff member who was passing by saw him walking without this frame and asked where it was. She warned him that he had to be careful and use his frame. She left it at that however. His frame remained were it was and he kept on walking.

And

Later the carer walked towards the woman who tried getting out of her chair. He asked her where her glasses were. She did not really give a clear answer. He left, apparently to look for her glasses in her room. He came back however without her glasses. He glanced around in the room and left again. He did not inform the woman that he had not found her glasses.

A few minutes later he returned to the communal area, he walked towards a woman who was sitting on her own at one of the small tables near the windows, nodding off. She was leaning on her arm while nodding. The carer approached her, shook her arm and woke her up, by pulling on her arm. She woke up with a start. In an almost accusatory tone he told her she was falling asleep. He then asked her what she had done with her hearing aid. 'Why

are you not wearing it?' She answered with a defiant tone that it was all right like this. I could not help agreeing with her.

A bigger sign of neglect happened during the fifth observation: It was the most shocking incident during all observation session:

> We walked up the stairs and on entering the unit we bumped into a resident who was sitting on a chair in the middle of the passage. She was barelegged and barefooted and only wore a t-shirt or sweater. She looked bewildered and angry. A clean nappy was hanging over the back of the chair. Due to the glass walls she was visible from almost everywhere in the building. She was just sitting there, and there was not a carer inside who tried to help her to get dressed. After an hour she was still sitting on the chair looking angry and bewildered. It was an utterly degrading sight.

I never found out why no one paid attention to the woman and tried to get her out of the chair and tried to get her dressed. There were at least three staff members present during that hour. One was busy distributing medication, one was helping a volunteer who had come to make toasted sandwiches for the residents and one was attending to residents. For whatever reason however this resident was not attended to.

A sanitized world without enticing smells

As observers we were struck by the fact that our senses were not stimulated in any way when we were inside. We smelled nothing, no old people, no food, nothing. In the morning residents were supposed to eat their breakfast. However there were no smells, no smells of bread, eggs, coffee, nothing. The residents were dawdling over their food, and hardly eating anything.

The domestic staff were constantly busy mopping the floors. During one observation I observed two staff members cleaning the stairs. It took them about the whole hour to mop the landing and part of the stairs. On another occasion a volunteer came to help out with making toasted sandwiches. However this did not stimulate the senses either.

> Half way during the observation session a woman entered the room. She had a sandwich toaster under her arm. It turned out she was a volunteer who was there to make toasted sandwiches for the residents.
> She created a lot of hassle around herself and it took ages before she started making any sandwiches. She could not find a spot were to make the sandwiches, she did not have the right extension cord. It took ages for the cheese to arrive. In the end however she did manage to produce some toasted sandwiches. Again I was struck by the fact that there was no smell. Even the toasting of sandwiches did not produce an interesting fragrance.
> (5th observation session)

Perhaps the staff were aware as well that smells were not 'allowed'? We

discovered that as a joke they had subtly renamed a room. On the

ground floor there was special room where people could rest, according

to the sign on the door. It was the 'rustkamer'. Someone had stuck a

small letter 'f' over the 's'. The sign now indicated that the room was the

'ruftkamer', a place where one could 'fart'. For weeks this small,

subversive sign remained as it was. Smells can give a sense of time. It

can tell if it is time for breakfast of coffee. But at this location this

sensory stimulation had been removed.

Figure 5.7 Room Name

A location lacking heart

The location was lacking heart, so to speak. The care manager confirmed that this was the case.

When this location was opened it was praised for its openness by the external experts. However, soon after Arborvitae was opened they discovered working in the new location was not that easy. At the opening they wrote that people would be able to go outside and sit on the balconies. But now the doors were locked and it was not considered safe to let the residents sit outside on their own. During an interview a care manager indicated that they had forgotten to look at the work processes when they designed the building. 'The building is not convenient. It is not handy that everything is spread over four floors. They have forgotten things'.

> This is a nice new building, but during the designing they have not thought about the work processes enough. And during the move, they just picked up everything and parachuted us into here. The ideas were all right, but the building is wrong. They have forgotten things. Here we have four floors, at the former location everything was on one floor. In terms of work processes you have to do things in a completely different way.
> (Care manager Simon)

One thing for instance that did not work, was the heating system.

The office of the care manager was very warm. He explained that he was not able to regulate the temperature in his room, due to a technical fault in the system. The overall temperature on the floor has to be a warm for the residents. But the system was supposed to make it possible to regulate the temperature in certain individual rooms, among which his own room. But the system did not work. So his room always feels like a sauna. And since his room is on the first floor he cannot open a window either. The windows on the first floor cannot be opened, because of safety issues. He explained all this in a sort of fatalistic humorous fashion. Jokingly he commented that conversations in his room never last long and never surpass the scheduled time.

(2nd observation session)

The intention had been to create a homely atmosphere it the building. However the atmosphere, as it was, was rather impersonal. The furniture was functional rather than nice or comfortable. The tables looked like tables in a standard hotel breakfast room. There were a few plants but they were not very well attended to and residents used them to discard unwanted objects, such as crusts of bread.

On walking out I noticed the plant behind my back. There were five plastic spoons in the plant pot and a number of bread crusts. It looked as though they had been there for some time. Apparently

no one had noticed or at least no one had bothered to take them out of the plant.

(1st observation session)

In the communal areas there were open cupboards with shelves. They were filled with bric-a- brac, which did not seem to belong to anyone. Each communal room had a television, which was placed on the bottom shelves of the cupboards. The televisions were always on either with sound or without. I noticed attempts to so something about it but somehow the attempts were not successful:

> There was new furniture on the floor. Not new in the sense of newly designed but new in the sense that it had not been there before. In front of us was an old-fashioned coffee table; it had a glass cover. Under the cover was a lace tablecloth. It should have been placed in the middle, but it was not. The table looked out of place.
>
> I noticed there was another table in the communal area as well. It seemed to belong to the same collection as the coffee table. It was the kind of table that could have come out of the home of one of the residents. I wondered if a family had left their parent's furniture to Arborvitae? Was it an attempt do something about the atmosphere? I do not know exactly why, but something felt wrong. It felt like a failed attempt to create a nicer ambiance. It failed because the furniture was not quite right and it was not looked after properly.

(7th observation session)

Unrest among the staff

On several occasions I noticed signs of unrest among staff. During the second observation for instance staff were constantly accosting each other checking if they already had had their coffee break and if they had spoken with the manager yet.

> The staff members present were not paying much attention to the residents. Two or three hovered close to the kitchen. There was a lot of talk about breaks. 'When is your coffee break? Have you had your break yet? Who is taking over from you when you have your break? Do you have cups for tea? When is the break?
> I also heard someone asking if 'so and so' has had her meeting with the manager yet?

Right after this we had a brief meeting with the care manager in his office space. And he confirmed that I had heard correctly that staff were talking about meetings with him. A day before all staff of Arborvitae had received a letter from the management in which the staff was informed of the financial situation of the organisation and that as a consequence people would loose their job. So no wonder the carers seemed preoccupied and more focused on themselves and each other than on the residents.

> He informed us that he was having meetings with the staff today, to inform them who could stay and who could not. Not very nice

work, but it had to be done, he said, while shrugging his shoulders. 'Desperate cases require desperate remedies. Better do it right now so that you can start building again'. So yes, I was right in assuming that the employees had been talking about the letter and redundancies.

(2nd observation session)

Two weeks later when we came for another observation session. Instead of the stairs we decided to take the lift upstairs.

On leaving the lift on the first floor I noticed the panel with the names of the carers and helpers. I counted seven carers and seven assistant carers, and a nametag for the key workers.
It is such a panel where you can slide your name tag to the left or right indicating if you are present or not. Interestingly enough the only name tag that was shifted to the right was the tag of the key worker. None of the carers or assistant carers had moved their nametag. So based on the panel, one would get the impression that none of carers or helpers were present. During the observation I saw two however and heard two more. So at least three or four carers or assistant carers were present. Had they forgotten to move their name tags or were they temps. I know from other data gathering session at Arborvitae that there has been a lot of changes among staff. After the announcements that staff had to leave, a number of staff members decided to leave on their own

accord and find a job somewhere else. As a consequence Arborvitae has to work with employment agencies to get the care organised. I wondered if the name tags were a sign of times gone by.

(4th observation session)

Figure 5.8 Whos in/out

Moments of warmth

During one observation I observed a moments of rich and warm contact between a carers and residents.

> Another care worker entered the communal room accompanying one female resident. On previous occasions she had been walking around on her own with her arms behind her back. Now she did not seem to feel so well and she needed the support of the carer. And the carer gave her the support. She offered her a cup of coffee. The woman took it, but then did not feel well enough to drink it. The carer supported her back to her room.

Later they came back to the communal area again. The carer

guided the woman to the empty seat at the table near the window.

The woman sat down and put her head on the table. The carers

started to massage the neck and shoulders of the woman. The

woman gave a sigh of relief and clearly enjoyed what the carer

was doing. When the carers stopped because she had to attend to

something else, she let her go with regret. The carer promised she

would come back later.

While this carer was massaging the neck of the female resident, I

also heard staff members laughing together with residents in the

other communal room. I realized this was the first time I heard this

his informal friendly contact between a group of staff members and

a number of residents. It was good to hear.

Distribution of medication

After their first visit to Arborvitae the inspection of Healthcare (IGZ) had

notified Arborvitae that they were lax in reporting on the use of

medication. They could not trace in the computer when and what kind of

medication residents received. The organisation was now working hard

on trying to improve this. During two observational sessions I noticed

that medication was being distributed.

One staff member moved through the corridors with a trolley, which contained the medication for the residents. She regularly left the trolley unattended when she went in and out of private rooms of the residents. I saw residents looking at the unattended trolley. Or perhaps this was just my imagination.

(1th observation session)

Later, during a reflection session I related the fact that I had been surprised that one of the carers had left the medicine trolley unattended. One of the analysers commented that by doing so the carer might have unconsciously been giving opportunity to the residents to gratify their death wish. This certainly was an interesting thought.

We were sitting in the sitting room area. One carer was standing behind the trolley on wheels from which she was distributing medication. She is wearing a green fluorescent jacket. Like jackets road workers wear so that they are less conspicuous, in the hope that this will prevent motorists from hitting them. On the back of the jacket it said: 'Do not disturb, distributing medication'. However this did not seem to have the desired effect. She was not approached by other carers directly, but they did constantly phone her. I heard her saying she was distributing Oxazepam,[6] she explained to a colleague that this was the same as Seresta. He apparently did

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[6] Oxazepam is a short-to-intermediate-acting benzodiazepine. Oxazepam is used for the treatment of anxiety and insomnia and in the control of symptoms of alcohol withdrawal. It is a metabolite of diazepam, prazepam, and temazepam, and has moderate amnesic, anxiolytic, anticonvulsant, hypnotic, sedative, and skeletal muscle relaxant properties compared to other benzodiazepines (Wikipedia)

not know this. She gave a slight shrug when she discovered this and continued with her work.

(5th observation session)

Observing at Volte–face

Observing at Volte-face provided me with a different kind of experience then the psychiatric unit of Arborvitae. Volte-face is more homelike. The location is built for the residents. From the start the care manager of this location had consulted with the architects on the design of the units.

Observations from the first unit

The following vignettes are from two observation sessions at two different units at this location. Here are some observations from the first unit.

> I was accompanied to the unit where I would observe today. We walked through the corridor to the communal room of this unit. The communal room has a sitting area, an eating area and an open kitchen. Five residents were sitting around the dinner table, drinking coffee and eating cake. Two of the cares were drinking coffee in the sitting area, waiting for me. We shook hands and they poured me cup of coffee. I felt a bit uncomfortable at first. In fact I felt like a visitor in a zoo. I realised I even felt somewhat scared. I have not been around elderly people who suffer from dementia a lot.

I was seated in such a way that I could see the residents who were sitting around the table and could talk with the carer. I had a brief conversation with them. One of the carers has been working at Volte-face since the start. She enjoys the work very much: 'It is much better here than at the main location where I used to work. Here care is provided as it should be provided. We follow the residents instead of the other way around. If someone does not want to get up in the morning but wants to have a lie in, that is all right.'

I had the impression the carers felt they had to stay with me, so after a while I told them they could just go on with their work and ignore me. I was all right, although I still felt like an intruder. I decided I would feel I bit more comfortable if I would stand in the kitchen area. The carers walked over to the table where the residents were sitting. There were four women and one man. He was a new resident. He started walking around a bit with the support of a Zimmer frame. He has a somewhat wild look in his eyes and seemed a bit lost.

Another resident constantly wanted to get up and go. She knew she was going on an outing. A number of residents were going to visit a farm in the neighbourhood where you could touch the animals etc. Another resident constantly wanted to get up and bring her spoon to the kitchen. In a friendly way the carer urged the residents to remain sitting and drink their coffee. When it was

time for the resident to leave on the excursion she was accompanied to the door. The woman who was busy with her spoon, came to me and wanted me to place the spoon in the washing machine. And then she seemed to want to go for a walk. I gave her an arm and we walked out of the communal space through the passage. She talked to me in Frisian, which I cannot understand very well. And I am not sure what she said made any sense even if she had not spoke Frisian. But it seemed all right that I accompanied her and just answered by nodding in a friendly manner.

After this contact I felt less afraid, less of an intruder. The personality of the woman still peeked through. It felt like she had enjoyed life and had had a sense of humour. I accompanied her back to the communal space. She seemed quite happy. She sat down again at the table.

Observations from the second unit:

The kitchen area clearly is the central meeting place in each unit. It is from here that carers work and attend to what is happening around them. A carer was working in the kitchen preparing stew. The design of all four units in Volte-face is similar yet each unit has a different atmosphere. The colours are different, the furniture is different, and arranged differently, the light is different.

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Four residents were busy in the living area. One of them was ill and had to stay in bed. They had rolled her in her bed into the living area. She did not seem very happy, but she did seem to enjoy that others were around her. A man was pacing up and down. He gave the impression of being a caged animal. A woman was sitting at the table, and another was sitting on the couch busy with her knitting work.

At a certain moment I sat down next to the woman who was busy with her knitting work. I thought: 'can I talk to her, will she understand me, will I understand her, or is she completely bonkers?' And of course, yes I could talk to her. She spoke perfectly lucidly about her work.

I spoke quite a while with the carer who was busy preparing the meal for the evening. The carers prepare the meals themselves, and where possible let the residents help. It is not fancy food. But they try to prepare the food the residents are used to. Once or twice a month a professional cook comes to prepare a meal and to teach the carers new tricks etc.

The carer said. 'We are never ready, time is not an issue here. Of course we have to do certain things every day, but we do not have to do everything on a fixed moment. Time does no longer have meaning for most of our residents, so why should we try to push

them in a fixed schedule. We follow their rhythm as much as possible.'

I stayed in this unit for an hour. I had the impression I was present in a private home, rather than a care centre.

Concluding Reflections

Although both Volte-face and the psychogeriatric unit at Arborvitae are housed in new buildings the contrast in their atmosphere was striking. At the latter residents tended to be treated as objects to be managed rather than subjects to be understood and whilst this task was mostly undertaken in a kindly fashion there were moments of shocking neglect towards the resident's physical and emotional needs. In contrast, at Volte-face staff followed and responded to the residents, respected them as human beings still with some capabilities rather than pitying them in a well-meaning way. The experience of observation was also different at the two locations, at Arborvitae there was a paranoia in the system which was linked to the difficult transition the organisation was going through, one in which its very survival had been at stake. As we shall also see in later chapters, Volte-face has been fortunate in having a thoughtful manager who has been able to shield the staff (and hence residents) from anxieties in the wider system. Consequently I will argue, particularly in chapter 8, that despite the forces and constraints acting upon the care sector in The Netherlands it is possible to maintain

responsive and high quality forms of provision ('intelligent kindness') as

Volte-face demonstrates.

Chapter 6

Anxiety and Defences Against Anxiety in Care Organisations

Introduction

In this chapter I present data in relation to feelings of anxiety in my two case study organisations.

During the two years I was present at Arborvitae and the Noturos Care Group I observed that feelings of great anxiety influenced the actions of everyone in the organisation. I noticed that anxiety had a spiralling top down effect. Anxiety in the wider context of the society is brought into the healthcare system. Managers from both organisations had great difficulty containing this anxiety and in various ways this anxiety permeated deep into the work processes of the organisations. It had an effect on the management style and led to the development of hierarchical control mechanisms, which in its turn had a large effect on how the care process was organised.

Sources of Anxiety

Anxiety caused by societal pressures and external bodies

There is a lot of pressure on professionals in the long-term care sector. The staff and management from both case studies were aware that

many eyes were watching what they are doing. Arborvitae discovered that the attention of the media can suddenly be on the organisation, as happened when Arborvitae was placed under tight scrutiny for a period of at least six months. This event was widely written about in major Dutch newspapers. The Acting Managing Director who came to work at Arborvitae after this had happened to help the organisation get back on track was keenly aware that all eyes were on the organisation and that this was affecting the staff.

> The other part of the story is that society and politicians keep on pressing for better and better quality of care. Nowadays there are so many possibilities. We can do anything… and everyone feels entitled to everything. And the other has to take care of it. And if they don't than there has to be someone else who checks this out: politicians and the inspection. I have experienced this at other organisations as well where I worked. And this mood is also stimulated by all kinds of consumer programmes on television. And we have to deal with this as organisations … Today you do something, and tomorrow it is in the newspapers and they day after tomorrow Pauw and Witteman (a current affairs talk show on TV) give you the third degree on television. It all goes much, much faster. You have to solve it all and it is as if you as professional are to blame for it all. (Acting Managing Director John, Arborvitae)

He saw it as part of a wider trend in society. The expectations of the care sector are high and mistakes are not tolerated. He noticed a tendency in society to look for scapegoats. Professionals easily get blamed for the slightest faux pas and it is quite possible that a mountain is made out of a molehill. When you work in the care sector you have to be very alert.

Anxiety caused by inspection- fear of exposure and closure
Many official bodies are monitoring what is happening in care homes. Care homes have to meet numerous requirements set by various organisations. One important organisation is the inspection of Healthcare (IGZ). The IGZ has the official task of promoting public health through the effective enforcement of quality of health services, prevention and medical products.[7] It has the authority to impose corrective or coercive measures and when necessary it can institute disciplinary or criminal proceedings. The IGZ regularly visits residential care homes to check on quality. Their visits can be announced or unexpected. If the inspection identifies any risks a phased form of supervision will go into effect. All the reports produced by the IGZ are made public and can be assessed by anyone wishing to do so.

The insurance companies oblige care organisation to meet all kinds of financial requirements. As John, the acting manager said, a lot of time and effort is required to meet the demands that are being made, not just

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[7] Website inspection: www.igz.nl

by the IGZ and the insurance companies but by many other organisations or institutions as well. And it is not just the work that is involved; it has an emotional impact as well:

> But for every care organisation that focuses on the elderly or the disabled it is quite a job to make sure that you meet all the requirements that are demanded of you these days. And the requirements keep on increasing, then it is the government, then it is another organisation or another, then it is the inspection, and then, …everyone has an opinion. Everyone comes to visit and you have to do this and that and then the regional care centre (insurance company) has an opinion as well. And if it is not one of them, it is a TV production or a consumer programme or the client council or the workers council. Everyone has an opinion. And as an organisation you have to know how to deal with this, especially the management of course but certainly the staff as well. They feel it as well.

His last statement was confirmed during interview with carers. Assistant carer Nicole said for instance that 'it was a quite a shock, you know, when Arborvitae was placed under supervision. It is not nice to read about yourself in the newspaper or to see yourself on television.' She was one of two carers who did not want the interview to be taped. She seemed fearful that her words might be used against her. She also pointed out several times that you need to be able to account for your

time towards the management, implying that you need to be able to prove that you are working efficiently and are not wasting any time.

The trend towards increasing surveillance cannot be resisted. The former managing director of Arborvitae had tried to ignore the external pressure to comply with all kinds of demands but he had experienced to his cost that he was fighting a losing battle. Under his management Arborvitae had been placed under supervision resulting in his forced resignation.

> I have set my face against this trend. And I have been mistaken in this. But when you go for welfare you do not want to write everything down. At home you do not write everything down either. It is a breach of privacy. But you have no choice nowadays. And that is why the inspection is now breathing down our neck. I have misjudged the importance of the rules and regulations. In my opinion the care has bureaucratised enormously. But then Care is just a mirror of society. We are afraid we will be judged on our mistakes and there for we have to register everything. Of course you have to commit things to paper as a care organisation but we have become fearful, like in the USA. The fear of being sued is ever present. And they put this fear into us. When the inspectors walked around I told them I had question marks by the way they did things. The chief inspector answered he had no choice because politics required him to do this and otherwise we will be called to account… so we do things we do not believe in out of fear

for the inspection who does it because they fear the politics. We live in a culture of fear. And as soon as you live in a culture of fear, we have seen that in the eastern bloc countries…. There everything is committed to paper. And that is what we see in the world of care. It has been a gradual process. We have been forced to commit more and more to paper. (Former Managing Director Arborvitae)

This manager felt perhaps very strongly about this because of his Jewish background. He had been the Managing Director for seventeen years. His aim

had been to provide a safe place for the elderly in the Jewish community: 'The Jewish tradition is the sole rationale of the existence of Arborvitae. We are the only large Jewish care home in The Netherlands so we have a national role to play in the Jewish Community.' However this role was now under attack. Arborvitae had to comply with the general rules which applied to every care home in The Netherlands.

One of the care managers of the psychogeriatric unit of Arborvitae subscribed to the view that the IZG became stricter and stricter because of political pressure:

> And yes, the inspection feels pressure as well. They feel under attack from the politicians. And because of that they become more and more strict. In the past 90% was good enough. Now they want to see 100% so to speak. But the healthcare sector is about people, staff members and clients. And that is difficult. There needs to be a grey area.
> (Care manager Simon, psychogeriatric location Arborvitae)

In the end everyone at Arborvitae, from management to staff, was very much aware that the inspection was a force to be reckoned with that could not be ignored, although it had taken some time for this to fully sink in, as pointed out by care manager Simon:

A couple of years ago we won the award for best care home of the year two times in row. But that was for the welfare side. What happens in such a situation is that people come to visit. And then people start resting on their laurels. That has been one of the problems. And in addition, and that is part of the Jewish culture of the house, the organisation was very inward looking. The house did not keep up with the developments in the world of care homes. Even at the time the organisation got the awards, care homes already had to start focussing more on the medical side of their services. But the house did not do that at the time. During that period they had a visit from the inspection as well and the inspection pointed out that they had to do something about the medical side. But they ignored these recommendations. And this is the reason we are now placed under severe scrutiny by the inspection.

They told us we have to make much more progress and much quicker. 'We look at welfare but we judge you on your medical and nursing skills'. And that development had not gotten off the ground so to speak. Here they had become complacent. They thought they were doing a good job and that it would not come to a head. But they were wrong. …. And after a while everyone understood what had to be done. Everyone understood that when the inspection is there, it means alarm bells should be ringing.

Another care manager at Arborvitae had foreseen that the organisation was running the risk of being placed under supervision. At the time it happened she was not yet a care manager, but she was responsible for the correct implementation of care processes. In this role she had noticed that Arborvitae was far behind in implementing ways of working that were already commonplace in other care homes. She had the impression she had gone ten years back in time when she started working at Arborvitae.

> I noticed fairly quickly that things were not all right. And then the inspection arrived. I was closely involved with the story of the inspection, because all the care plans had to be changed. And that fell under my responsibility … I know what it is like when the external world is looking at you, especially when it is the Inspection who is standing on your doorsteps. Then you are an open book for everyone. And everyone can throw anything at you. And that is exactly what happened.
> (Care manager Cecilia, nursing unit Arborvitae)

So it is not surprising that managers in care homes do their utmost to keep the inspection at bay. The time Arborvitae was under supervision was regarded as a dark moment in the history of the organisation. When I started with the research it was still an open wound. It had been a wake-up call for the organisation that 'business as usual' was no longer an option. Many were aware that they had failed to adjust to the

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changing demands in the world around them in relation to care. They were forced either to catch-up or face the risk of closure. Two years later when I interviewed Cecilia again it was still very much in the top of her mind that Arborvitae had to increase the quality of its care services and that if they would fail to do so this could still mean the end of the organisation.

At the Noturos Care Group I also experienced a fear for the inspection. On several occasions I heard the location manager impress the fact on the care managers that a bad review could lead to visits from the inspection and that was 'the last thing we should want to have happen.'

Anxiety caused by requirements of the insurance companies or the regional care centres

The insurance companies created another source of anxiety. Care homes have to negotiate with care centres about the amount of care they can provide. Insurance companies have divided up the country into regions. Each region has a care centre that is run by a particular insurance company. In name of all their insurance colleagues this company negotiate with the care organisations in their region. A year in advance the insurance companies estimate the amount of care they think will be needed in a specific region. And then the care homes have to try to get their share of the pie. Once the pie has been cut care organisations do not have much space to manoeuvre with their budget. They receive their money afterwards, based on the data they sent to the region care centre about the care they have actually provided.

It was clear that it was very important for the location manager of the Noturos Care Group that all her four locations had their ZZP structure in order. She needed this information in order to receive the funding from the regional care centre. I noticed that she was worried about the implantation of the ZZP structure at Grenier. I was present at an informal meeting with the staff where she gave a presentation on this topic. It was a very puzzling and strange event on which I wrote down the following observations afterwards:

Data from an Observation Session at Grenier:

In June 2012 I was present at a get-together between with the location manager and the staff of Grenier. The location manager had been responsible of this location for six months. In this period she had appointed a new middle management team: two new care managers and a new facility manager. She had the impression there was still a lot do at this organisation and that it would be a good idea to organise a kind of informal meeting with all the staff. She invited an external consultant she worked with a lot, and me to be present as observer. Initially she said she wanted to organise a session that would give a positive momentum to this location. She said she was puzzled by this location and did not understand why there still was so much resistance among the staff.

On the day of the get-together was to take place I received the PowerPoint presentation the location manager intended to use. It turned out that the objective of the session has been narrowed down extensively. The location manager had obtained the impression that the staff of Grenier did not understand the ZZP structure. She had decided she would use the session as an opportunity to educate the staff on the ZZP structure and the vision of the Noturos Care Group

I arrived at the location two hours before the session would start. The location manager had asked if I would go over the afternoon with her. When I arrived however she seemed to have changed her mind about this. She instead presented me with her work she had to hand in for her master study and requested I take a look at that. In the meantime she herself kept on answering her phone. This came across as completely off task. I felt at a loss what to do. I glanced at her paperwork but could not concentrate on what was written. The fact that she was constantly on the phone did not help either. I told her I would look at her work at another moment and went to the room were the meeting was the take place.

Half an hour before the get-together was to start the room was not ready yet. The meeting would take place in the communal dining area of the residents. Some were still sitting there. It turned out there was no lap-top, no projection screen for the PowerPoint

presentation, no clear programme for the session. Together with the external consultant I started arranging the room. I was afraid that if we did not do this nothing would come of the session. There turned out to be no real projection screen. I found a tablecloth. Together with someone else I put this up, standing on a table while doing this.

In the mean time the staff trickled into the room. They looked with curious expressions at what we were doing on the table. They sat down at the tables in the room. I sensed a wait and see mood. I heard them ask each other if they knew what the programme of the afternoon was. Fifteen minutes later than planned the location manager started with her presentation. She came rushing in ready to give her show. The more I saw the location manager operating the more I had become aware that she tended to create a lot of buzz and movement around herself. She reminded me of a butterfly that hopped from flower to flower to sniff and then quickly moved on. The afternoon turned out to be a one-woman show. She went through the PowerPoint slides and seemed at a loss what to do next. She looked to the external consultant for help. On his suggestion the staff were divided up into groups to answer questions on how they would be able to provide tailored care to clients based on the ZZP structure and how they could reduce work pressure.

I walked around to listen in on group discussions. The wait and see attitude had turned in to a more sceptical attitude. The information on the ZZP structure they regarded as old hat. And instead of them answering the questions they would rather have heard more from the complete management team. They commented on the fact that the location manager did not seem to know all their names and that she only joined one table to listen in on a discussion. They wondered what my role was and the precise role of the external consultant. They recognised the external consultant because he had done some team sessions with them two years before. Some had seen me before when I had been at the location for earlier observation sessions in my role as researcher.

The groups were asked to present suggestions of flip charts. The external consultant facilitated this part of the session.

It was a curious event. The location manager had not thought through the programme at all. She did not include the middle management in the programme. They had no role during the whole afternoon; they could just sit and watch. She turned it into a kind of ineffective one-woman show. At the end of the programme she gave all the staff a bag containing shampoo and hand cream as a token of appreciation.

On the way back I wondered what I had observed and what kind of event I had been attending. I had seen a presentation by a manager who was out of touch with her staff, who had not taken the time to think through what she had wanted to achieve and who had not prepared the programme properly. She started something and left it to others to finish it. She created a kind of chaotic energy around her. It was as though there had been some kind of explosion and people around her felt inclined to clean up the damage.

Why did I as an observer feel compelled to stand on a table and put up a projection screen? Why had I felt compelled to arrange the room? I had allowed myself to be pulled out of my role of observer completely. I have observed at other moments that this location manager is very good at this, pulling people out of their roles. And then why had the original idea of creating momentum been turned in to a presentation on the ZZP structure? She is a manager who acts on impulse and who thrives on chaos. She had picked as a topic for the presentation something she probably felt anxious about and which would affect her as a manager most directly. She has to be able to account for financial results of her locations and in order to be able to do this the ZZP structure needs to be in order. Was that one of the reasons?

It was clear that it was important for both the Noturos Care Group and for Arborvitae to have the ZZP structure in order. The chief Managing Director of the Noturos Care Group would certainly judge the location manager upon the financial results of all her locations. The location manager did not feel she had Grenier enough under her control yet. And apparently her anxiety about the running of this location had led her to change the objective of the meeting.

What can happen if your ZZP structure is not in order could be seen at Arborvitae. This organisation had been lacking behind with the implementation of the structure and that was another reason why organisation almost had had to close its doors. John, the acting manager, not only found an organisation that had to improve the quality of care, he also found an organisation that was on the verge of bankruptcy. They had delivered more care then they were paid for by the regional care centres and because of this they were in big financial trouble:

> In the care sector we now get paid more directly for what we
> actually do. Or you can put it like this: the ZZP structure is like a
> kind of menu. This is the menu and if someone is suffering from
> this or this he will be served Menu A. And Menu A has three
> courses, Menu B has four courses etc. But if someone has menu
> A and you serve him four courses without receiving payment for
> this extra course than things will go wrong eventually. And that is

what happened here. The focus was on serving all the courses to

everyone. And the idea was that they would somehow be able to

sort it all out in the end … That was the atmosphere. This has a

positive side as well of course … the urge was to do as much as

possible for everyone. In fact it is not negative at all…but you

need to take make sure you get the money as well. And they had

failed to do that.

(Acting managing director John, Arborvitae)

Anxieties caused by further reforms instigated by the government

At the time of writing the reorganisations of the healthcare sector were

far from over. In 2015 a new law came into effect that once again

changed the funding structure. The changes go hand in hand with more

cuts. As a result care homes have to adjust their business case. Only

the very vulnerable will still be allowed to go to nursing homes. The

somewhat less vulnerable will have to organise care at home.

Grenier at the Noturos Care Group was in the middle of adjusting to this

change. At present this location has 88 beds, in the very near future this

will be reduced to 44 beds. This will have an effect on the number of

staff needed to run the organisation. The changes have had an effect

upon the so-called organisational boundaries. They have become very

flexible. What is part of an organisation today might no longer be part of

it next month. This flexibility created feelings of anxiety. At Grenier staff

members had received official information on redundancy plans. It was very much in the mind of carers that their jobs were in danger.

The Impacts of Anxiety

The internalisation of control

Both at Arborvitae and at the Noturos Care Group I observed the existence of internal control systems or mechanisms that had panopticon-like effects. Managers and carers were anxious about stepping out of line and did their best to adhere to written and unwritten rules. At the psychogeriatric location of Arborvitae the panopticon-like structure had been brought into the building by its architecture. Many internal walls were made of glass. Anyone taking the stairs to the fourth floor could see many interactions between carers and residents. On several occasions I picked up signs at this location that carers were aware that their actions were being watched and observed. (See chapter 5 p.154. for a more detailed description)

Interviews revealed that carers had internalised signs of being watched continuously. Two carers did not want me to record the interviews. Carer Nicole gave as a reason that you never knew what would happen with the information. She started by saying she knew what the interview would be like, because a year ago she was interviewed by two people. These interviews were conducted by a consultancy organisation that works with the so-called lean concept. It is a method to eliminate waste within a manufacturing process. It aims to make the work simple enough

to understand, do and manage by anyone. Many organisations in The Netherlands are experimenting with the concept, including Noturos and Arborvitae. Arborvitae had asked the consultancy organisation to help them look at their work schedules in order to decide how things could be run more efficiently. I explained to Nicole I had a different objective as an independent researcher. She remained adamant however, and did not want the interview to be taped. She signed the consent form and said that this was important to show her manager. 'We have to account for our time you know'. I told her I would not show the form to her manager and explained the purpose of the form once more, but she did not really seem to listen and repeated that it is important to be able to account for one's time.

She was not alone in feeling that she had to be able to account for her time:

> Now you are just a few minutes with a resident. And everything is being written down you know. You just do a few things then the rest the clients have to do themselves. You have a lot more administrative tasks and paperwork. It is logical in a sense. Because of the Inspection we have to write everything down. You must be able to proof everything in black and white.

> You are always looking at the clock. When you are in the middle of something you cannot just leave someone. You need to finish what

you are doing. But if you are with someone who you cannot make go faster you have to remain relaxed. Right now we are busy checking how much time we should spend by each resident. How much care can we give, how many hours, and how many minutes.

Last week I saw them walking around on the second floor checking with a list how much time it takes to put on support stockings, washing or helping someone go to the toilet. It will be our turn next. It is fine with me. Than we know how long it take to care for someone.

(Carer Denise, Arborvitae main location 1st and 2nd floor)

At the Noturos Care Group the vision was that everyone's action had to be 'open, honest and transparent'. On more than one occasion the location manager tried to install this idea into the Care managers of her locations. The idea seemed to be that once all actions were transparent no one could complain any longer and tasks would then be picked up automatically.

Transparency at the Noturos care group also meant that all managers had to take part in 360^0 feedback procedures. Instead of creating a sense of openness however this created a sense of fear and anxiety. I observed that this was the case during a coaching session with the care managers of Grenier. The Managing Director of the organisation had to collect information for her 360^0 feedback session with her location

manager. She had invited the care managers to an informal meeting. She called it a 'lets put our feet up on the table session'. Over a glass of wine she wanted to hear from all the care managers who fall under the responsibility of the location manager what they thought about the location manager. The location manager herself would not be present. The managing director would use input from the care managers for her appraisal session with the location manager. The two care managers from Grenier location felt really uncomfortable about this session. They felt little respect for their location manager and had great difficulty in working with her. They were afraid however to discuss this matter in a 'lets put our feet up the table session' over wine in the presence of care managers of the other locations. They were thinking up strategies on how to be present and pretending to participate and at the same time not sharing their true thoughts and feelings.

At both organisations the so-called wish for openness or the need for transparency had the effect that issues were pushed bellow the surface.

Audits as part of a culture of conformity and impression management
Audit controls have become an important factor in the quality control systems in the healthcare sector. Auditors weigh the perspective and appreciation of clients and they check if an organisation has systems in place to improve quality. Depending on the outcome of the audit, care organisations receive a bronze, silver or golden hallmark. An organisation needs to have such a hallmark in order to be included in a

quality register. The regional care centre uses the data in the quality register to make funding decisions. Based upon a set of predetermined criteria and norms auditors check if organisations structurally and demonstrably meet all the requirements. Both Arborvitae and Noturos regularly had auditing bodies check their services.

During the time I followed The Noturos Care Group it became clear that audits take up a lot of time and attention of the management. The organisation worked together with several organisations that deliver audits. The location manager informed me that his rationale behind this decision was that the information that came out of the audits supported The Noturos Care Group to reach its objectives in relation to delivering quality. They used it as a method to stay ahead of the Inspection of Healthcare. Auditing bodies copy the working methods of the Inspection of Healthcare. Hopefully if an auditing body does not find anything wrong, there is not reason for the Inspection to come and pay extra visits. Since care homes have to compete with each other for clients, they also use positive outcome of audits in their marketing directed towards prospective residents. Placards with golden hallmarks are put up next to the entrance doors of locations and the positive outcomes of audits are posted on the company websites.

From my first contact with the location manager I observed many indications of the impact of audits. The location manager saw it as her task to make sure all the four locations she was responsible for gained

the gold status in various audit programmes. During the time I was present at The Noturos Care Group she indeed succeeded in this goal. Initially two of her locations received gold, then number three followed and later number four followed as well.

When her third location received gold I received an excited text message informing me that she had been invited to the 'Oscar nomination' of the audits awards organised by the auditing body. Once a year the auditing body organises this event where the awards are presented in presence of the press and other interested parties.

The audits influenced the day to day running of an organisation in many different ways. During a visit to the location Volte-face of The Noturos Care Group I encountered the care manager in her office, busy with her support staff reorganising all the binders based on the audit control system. 'In this way it will be easier to prepare for the next audit. And the auditors will be able to see immediately if we are still on track', she informed me. The care manager of this location had trained the staff to really understand the auditors' method so that they knew exactly how to deal with all the paperwork.

The different audit bodies regularly visited Noturos to check if everything was still all right. In my role as researcher I was present at two such visits.

The first audit I attended was a minor audit focusing on the hospitality of organisations. One important criterion prospective residents might check is the hospitality of a location and the quality of the meals they serve. An organisation called 'Hospitality with Stars' visits care homes and checks how accommodating they are to the needs and wishes of their clientele. Audits like this are voluntary. Care homes decide themselves if they wish to participate.

The Noturos Care Group had enrolled the location Volte-face for this audit. Volte-face was regarded the flagship of the organisation. And the expectation was they could come out favourably in the category of 'small scale living'. The location manager and the care manager had prepared the day as much as possible. All the staff were informed and instructed. I noticed this when I arrived. I was greeted by someone who had not seen me before. She assumed I was from the auditing organisation, informed me about which room the auditors were inspected to convene in and directed me to it. The location manager had provided me with the programme of the day beforehand. She had explained that care homes get extra points if they have a restaurant where residents can eat. Volte –face does not have a restaurant but they work closely together with a care organisation that organises day care activities for elderly living at home in the neighbourhood. This organisation does have a communal eating space that could pass for a restaurant. This sister organisation occupies a building next to Volte-face and it could easily be mistaken for belonging to Volte-face. It is

located next to Volta face in a similar building. If you did not know better you would think it was one organisation. The lunch for the auditors was organised in the restaurant of the neighbour.

The following abstract is from the account I made after this observation.

In agreement with 'Hospitality with Stars', Volte-face had made a programme for the day. The auditors would start with talking with the management, then they would talk with the client advisory board, they would have lunch in the restaurant and they would be shown round the whole location. The visit would end with an evaluative talk with the management.

The first auditor arrived. He was a corpulent man in his sixties with a moustache. He reminded me of a character in a Dutch television series that was very popular in the sixties: the grumpy village policeman. He turned out to be very kind and friendly. The second auditor arrived in due course. They introduced themselves. Both of them were retired and they do these audits as volunteers. The auditor with the moustache had had a career in the care sector. He had worked as male nurse and as manager. Now he is working as a volunteer at a funeral home, and he advises client advisory boards in the health sector. The other auditor had worked in the royal air force in the care department. At present he is chairing a number of advisory boards, one of them is in the care sector. As

volunteers of the organisation 'Hospitality with stars' they visit four of five care institutions per year as auditors.

At 10 o'clock the location manager and the care manager arrived. In typically Dutch fashion the meeting started with coffee and Dutch cookies. The auditor who had arrived first took the lead. He explained that they had a number of lists with questions regarding a fixed set of criteria. During the day they would collect the answers to their questions. After the visit they would write their report and send this to the organisation 'Hospitality with Stars. There a jury would look at their report and decide if Volte-face would be nominated for an award yes or no. Prior to their visits they had sent questionnaires to the management and the client advisory board. The answers they had received they used as guidelines for the conversation. The management was questioned on their vision on care for the elderly and on how they translated this to the running of the organisation. The management enthusiastically explained everything. They clearly had done things like this before. Volte-face is often presented as the flagship location of The Noturos Care Group and as a consequence receives many visitors who need to be shown around.

The session with the management lasted an hour. During the next hour the auditors met with four members of the Client Advisory board of Volte-face and at another location of The Noturos Care

Group in the village. The four members were: the husband of a resident of Volte-face, a volunteer, whose husband had lived in Volte-face , and two women whose mothers lived in the other Noturos location. The location manager had briefed them on what to expect and on what to say. The board members whose wife lived in Volte-Face spoke full of love and warmth about the way his wife is being looked after. He lives in one of the apartments above Volte-face and can visit his wife whenever he wants. 'All the nurses are wonderful, they are all qualified and know what to do.' One member of the board recounted a moving story about one of the activities Volte-face had organised for its residents. There is a resident in Volte-face who hardly ever says a word. At a certain moment the activity coordinator had organised a trip to his home village for him and a number of other residents. When they arrived in village the man started talking, talking and talking. He could hardly stop. The board member said that whenever she spoke about this she got goose pimples, because this story affected her so much. The two auditors were also moved by this story. Later in their conversation with the management they referred to it. On a scale of 1-10 the client Advisory Board gave Volte-face an eight or nine.

Lunch was served in the restaurant and after lunch the auditors got a tour of the house. In the first living unit we visited, we saw a woman sitting on the coach with a huge soft teddy bear. In another

unit, one resident almost attached herself to one of the auditors and drew him into her room. Her room was full of dolls, which she started showing him one by one. The location manager and the care manager knew this would happen. Like two schoolgirls they were giggling around the corner while they looked on.

The last part of the programme consisted of an evaluation with the management of the day. The auditors said they were impressed. They had had a pleasant and informative day. They explained that they would write their report and send this to Hospitality with Stars. There a jury would decide if Volte-face were to receive a reward. That was not up to them. At two thirty they were ready with their investigation. I remained with the management. They were relieved. They had the impression it had been a good day. They were interested to hear my thoughts. Unlike them I had been present during the whole audit. So they were curious if I had heard anything that might be of interest to them.

During the day I often had the impression I was watching a show or play. Volte-face certainly had carefully orchestrated the whole day. Everyone knew the audit was talking place and had been instructed, the lunch had been carefully arranged. The care manager afterwards said that she had not been afraid for this audit. The audit that had taken place the week before had been much more important. The week before they had had an audit by

an organisation that checks the day-to-day running of an organisation. They had checked al the files and paperwork of the organisation etc. 'You have less control over such an audit, but this one is more about the outside, the face you show to the world and it feels less threatening therefore'.

A few weeks later the Volte-face was informed that they were placed on the short list of the category 'Small scale living' and they ended in the top three of this category.

The second audit I observed was part of a series of audits that are undertaken to check if a care organisation can maintain its bronze, silver or golden hallmark. A year before Volte-face had been informed its golden status would be extended for another three years. In this period of three years the auditing body visits the organisation two times to keep their finger on the pulse. The audit I attended was one such in between audit. After attending this audit I wrote down the following observations:

> I had received the programme of the day beforehand. The audit would start at 8:30 in the morning and last till 12:00. I arrived half an hour before. The location manager and the care manager of Volte-face were already present when I arrived. They were not looking forward to the event. Especially the care manager was weary of it all. Preparing for audits takes up a lot of her time. The auditing body send out questionnaires that need to be filled out

and all the files need to be in order. During the audit she and the location manager need to be around and cannot attend to other work. Preparing for the first audit did provide them insights on how to improve work processes, but the constant scrutiny is felt to be more like a strain.

Both the location manager and the care manager seemed a bit nervous. They were confident they would pass, but then you can never be a hundred percent sure. Both the location manager and the Care manager would regard it as a personal failure if they were not to pass. And not passing might have consequences for the negotiation power with the regional care centre. The location manager was ready for it all. She informed me that she is very good at presenting the right picture or to give the auditors the right sort of information. We saw the auditor arrive in her car. The location manager went to greet her and showed her to the room were all the meetings would take place. The auditor wanted to have some time for herself to prepare, so the location manager left her in the room and came back to us. The location manager informed us that the auditor was a severe looking woman. The atmosphere reminded me of the final exam period at secondary school. There was an excited tension in the air. The first meeting started at 9:00. The morning stared with a meeting with the representatives of the organisation (the location manager, the care manager and the chair person of the client council). The auditor

introduced herself. She started by saying that she ran her own private practices as a judicial advisor. The auditing was a freelance job. She had experience of working in the care sector. She explained the objectives and programme of the day. The focus of this audit was on the professional organisation. So she would speak with the management, the educational coordinator, the general practitioner, members of the workers council, members of the clients' council and again with the management. At the end of the morning the auditor would deliver her verdict.

The auditor's first serious comment was on the use of the hallmark logo. Once an organisation has obtained a hallmark the auditing body expect the organisation to use the logo on all their communication with the outside world. Apparently The Noturos Care Group had not been doing that properly. I was struck by this comment. I wondered for whom this was really important, for the auditing body or for The Noturos Care Group? After this initial comment the focus turned to the work context. There was an extensive discussion of the use of the computer. What does The Noturos Care Group do to make sure that all the data from the residents is entered properly and in such a way that the staff have easy access to the necessary data whenever needed. The location manager is in charge of the introduction of a new computer portal. So she was able to explain that The Noturos Care Group intends to introduce a system allowing staff to work with iPads. This will

give them greater freedom to move. They no long need to sit on a fixed spot when entering data etc.

Other topics of discussion during the audit where human resources policies, staff training, management development opportunities, security at the location, health and safety training, risk signalling the use of anti-psychotic medication etc. Most of the discussion seemed pretty straightforward. The auditor throughout maintained a distant approach I had the impression she did not want to allow herself be influenced by gestures of kindness. She presided over the day as a benevolent but severe teacher or judge. She hardly smiled and remained very serious. She had all kinds of suggestions for improvements. She built up the tension. Is she satisfied or not? It was hard to tell. During a break I met the location manager and Care manager in the canteen. They were joking with the members of the client council. They were a bit like school children laughing behind the teacher's back. They were complaining that it really was a waste of time and they agreed that the auditor appeared to be not so very nice.

After the break the auditor met with representatives of the workers' council. This was the part of the programme over which the management had had least control. In three of the five sessions either the location manager or the Care manager or both had been present. The members of the client council know what to say and

not to say during councils and they have a very good relationship with the management. The management have another kind of relationship with the workers' council. The members of the worker's council come not just from Volte-face but represent The Noturos Care Group as a whole. The management did not know beforehand which members the workers' council would send. It turned out that there had been some serious issues concerning intimidation of staff at The Noturos Care Group. The members informed the auditor that lately the council had been receiving an increasing number of complaints about intimidation, rebuffs of staff by the management and of staff not feeling safe. They have contact with the labour union on this topic. They also reported on an increasing sense of unrest among staff due to the reorganisations taking place at The Noturos Care Group in general. The auditor seemed not so much interested in the content of the story, but rather seemed to check if the council was able to do its work properly.

At the end of the programme the management was requested to come back in. The auditor gave her verdict. She had not seen or heard anything that gave her reason to withdraw the hallmark. The management breathed a sigh of relief.

Just like during the other audit I attended I was left with a somewhat ambivalent feeling. The management wants to pass and does it utmost to make this happen. There is an aspect of window

dressing in it all. How do you present yourself at your most favourable? One way you can influence the process is by suggesting who will be present during the sessions. The auditor knows this of course so she in her turn tries to be clever and ask difficult questions. There is a game of hide-and-seek going on.

Audits like this were a kind of ritual dance. Both the Noturos Care Group and Arborvitae had their organisations scrutinised like this. The location manager of the Noturos Care Group seemed to believe firmly in the value of audits. Care managers who were closer to the work floor were more sceptical. Just before she resigned I interviewed a care manager of Grenier.

> I have problems with the fact that the quality of care is judged by means of hallmarks and that the regional care centre forces you to meet criteria based upon hallmarks. If you do not meet these criteria they cut back on your budget. I have a lot of problems with that. I think quality of care amounts to much more than just paperwork.

> My ideal would be that we could do with a lot less rules and fewer hallmarks. The government and the care centres pretend that if the paperwork is in order the quality is good. But it does not mean that. It means you are good at writing reports and that you have your files in order. That is an art as well, I do not deny that, but I think it

is more important that the carers treat the residents in the right way.

(Care manager Marianne, Grenier)

She sounded cynical and during the interview it became clear she had lost her enthusiasm for her work. Approximately eighty percent of her time she was busy with paperwork and audits accounted for a large part of this eighty percent. A Care manager from Arborvitae had the same experience. She saw audits as a necessary evil that the higher management needs in in order to be able to justify itself:

We have just had an audit again two weeks ago. 'Quality for Care', or something like that. I have forgotten the exact name. We have gone through the mill once more, so to speak. We had to show a lot of stuff again. And they wanted to talk to me, a key worker, a carer and everyone and everybody. And we passed again. So we are all right once more for another year.

What I think about it all? I do not think a nice sign near the entrance means that your care is actually in order. We had another sign. That was removed because of the inspection. And now we have this one. But you know, it is nothing more than an indication at a certain moment. They come for a few days. They want to see the protocols and talk with everyone and it has cost a lot of time. And of course everything is in order, we make sure of that. But a

week from now it is quite possible things will not be in order. A sign downstairs is no guarantee whatsoever.

Why we do this? Because higher up needs proof that they are doing well. And this is how they check it. But if this provides them with real proof? I doubt it, I am sure it does not. It is time consuming. They expect I do not know what from me. ... It provides me with extra work, new protocols we have to develop and ... etc. etc.

The staff gets asked questions they do not like. They are asked what they think about their manager. Some find these questions hard to answer. They are afraid I might see their answers. So they will never give honest answers. So what it is you are asking? Does your manager listen to you, does she help you when you have a problem? Of course she does. For imagine that she blows the lid and I come to hear of it. So they do not do that. It is all for appearance sake. Such a hallmark does not say anything. When you get visitors you vacuum your house and mop the floor. That is what we do when we expect the auditors.

(Care manager Cecilia, Arborvitae, nursing unit, 2nd interview)

Higher management needs the outcome of audits for their negotiations with the care centres and to prove to the inspection that their organisation is delivering high quality care services. Most of the

preparatory work for audits is done by care managers and key workers.

Making sure that all the paperwork is in order is time consuming. The

time needed for the paperwork cannot be spent on delivering care. Care

managers point out that there is no clear link between having your

paperwork in order and delivering good care. The audits are part of

culture of conformity. Managers and staff need to tick the right boxes in

order to meet external requirements. Audits are part of a form of

impression management. A golden hallmark might give the impression

that a high level quality is being maintained. Reality however can be

quite different. Audits require management to look backwards instead of

forward. The paperwork is regarded as proof that you have done things

well in the past.

Bureaucracy as method of managing anxiety

At both organisations managers and staff had a lot to say about ever

increasing forms bureaucracy. Part of this bureaucracy seemed to be a

form of defence, an attempt to hold the anxiety at bay.

At Nutoros no-one disputed that issues need to be recorded. But care

manager Marianne for instance was convinced that there was an issue

of overkill in the amount of paperwork required. She stated that it kept

the carers away from the residents. And that it prevented management

and the carers from addressing issues around the delivering of care that

were perhaps harder to face. She said that instead of on putting the

focus on paperwork the focus should be on the way care was provided.

In a previous position at another care organisation she had worked with a project called 'Care from the perspective of the client'. This had been a long-term project where with the assistance of training actors and cameras carers saw the effect of their own behaviour. Everyone who had contact with residents: carers, facility staff, receptionists, was involved in this project.

She gave the following example of issues they addressed:

A resident is eating his dinner in the restaurant and he pushes the button for assistance. A carer approaches him from behind and pulls the wheelchair away from the table and says' Ah you want to go to bed.' If you see this acted out you realise you should have had established contact with the resident first and ask him what he needed, instead of thinking for the client and deciding he wants to go to bed, because that is what happens every day. That is what we did there.

At the Noturos Care Group they had chosen a different route that produced more paperwork:

Here we do it like this. Each year we have client consultations with the resident, the key worker and the care manager. During this consultation it is checked what kind of care the resident would like

to receive. And later we ask an external body, *Hospitality with Stars* to conduct a survey to check how hospitable we are.

On the amount of paperwork Marianne had this to say:

Paperwork requires a lot of time and that means that in your job and as an organisation you spend an enormous amount of time writing reports, developing improvement plans, making care plans and that is a lot of paperwork I can assure you. And putting it on paper is one thing. But you also need to execute the plans, you need make sure that the plans are embedded in the working procedures, you need to prove you have actually executed the plans, etc.

As a care manager paperwork is eighty percent of my time. The key workers have four hours every two weeks to do this work and that is not enough. Adjusting the care plan, talking with the client, securing the follow up takes up so much time and that is a shame I think. In our case the key workers have to do most of the work, they have to talk with all the clients about dental care, about incontinence, about re-animation, about decubitus, about client satisfaction. They have to hold talks on almost anything you can think of. And they have to write it all down and they have to organise the follow up. It takes an enormous amount of time, especially if you want to do a good job.

Once all the files are in order and all the data are in the computer, the office looks neat and clean. And this might give the impression that everything is transparent and that the care process is under control. On a visit to Grenier, I once found the personal assistant of the location manager surrounded by empty folders and piles of paper. She had been requested to reorganise all the paperwork. The former care manager (Marianne) had not used the right filing method and the location in this way was not ready to meet the auditors. This discovery had caused a panicky reaction in the location manager. After the resignation of Marianne, the location manager had appointed two new care managers. These two managers would have benefited from sessions with the location manager in which they would have discussed and analyse how to run Grenier. However the location manager hardly ever took the time to focus on this task of her role. She spent more time on organising bureaucratic systems than on listening to her care managers and staff. By doing so she stayed away from addressing urgent and difficult management matters relating to interpersonal issues and accountability.

At Arborvitae the frustration about bureaucracy was present as well. No one in the organisation could escape from the computer. Carers had to spend a lot of time behind the computer, time they could no longer use for residents.

And then the bureaucracy that is being pushed down into the system! All right that everything needs to be transparent, but if you see the amount administration this requires. In the hospitals they work with the DBCs (Diagnostic treatment combinations), we have to work with the ZZPs or severity of care packages. This involves administrative work that comes on top of everything else. This requires a lot of time. There are days when staff members spend several hours in front of the computer entering all the data. And this is time they should really spend on caring for the residents. Yes, what it comes down to - No lets approach it from the positive side - We need to deliver the same amount of care, or actually more, with the same number of people but in less time. This is the inheritance we have to deal with.

So our psychogeriatric clients, for whom structure and continuity is very important and who need personal care, we are no longer able to provide them with this. You notice that residents do not get what they need. And that has an effect on their sense of well-being. (Care manager Simon, Psychogeriatric unit, Arborvitae).

The computer screen has become between the resident and the carers and keeps carers away from paying attention to the most vulnerable in society. The computer work carers are required to do prevents them from having proper conversations with the residents and to really attend to their needs. No one disputes the fact that reporting is useful and

essential. However as of yet, bureaucracy is experienced as a burden rather than as a help.

The impact of anxiety on team relations

The anxiety in the organisations had an effect on everyone. It impacted on both the management and the carers. For one thing it seemed to cause everyone to keep on running and being busy. It prevented managers from taking a step back to reflect on what they were doing and whether they ought to change how the care was organised.

In the first few months of the data gathering process at Arborvitae I had invited the managers to a workshop called *The Organisation in the Mind*. The aim of the workshop was to explore the more implicit ideas and images the managers had of Arborvitae. The workshop revealed forms of tension and stress that the managers experienced.

Data from the workshop

In May 2012 I held 'an organisation in the mind' workshop with the eight managers of Arborvitae: the acting manager, the manager welfare, the manager HR, the facility manager, and the four unit managers of the organisation. In preparation of the workshop I had a meeting with the acting manager. I had explained the purpose of the workshop and agreed to write an invitation to the managers for a three-hour interactive workshop. In the invitation I used the following explanation of the objectives of the workshop and the working method:

During the workshop I will ask you to share the implicit images and ideas you have about Arborvitae. The assumption behind this question is the notion that in each organisation there is a more visible explicit level and a less visible implicit level and that they influence each other. The aim of the workshop is to explore what is happening at Arborvitae on this more implicit level. I will invite you to reproduce your images on paper. This material will then form the basis for joint reflection and discussion on your views of the organisation and your experiences in your role as managers.

John, the acting manager thought it was a good idea to have the workshop. Since he had started as acting manager, the managers had not met as a team to reflect on or discuss the situation at Arborvitae so he saw the workshop as a useful team building opportunity. All the eight managers were invited: the acting manager, the welfare manager, the HR manager, the facility manager, and the four unit managers.

The workshop was planned from 2.00 to 5.00 pm. I arrived with all my materials at around 1.30 pm. The atmosphere in the building was different from other days. It was sort of more festive. On the counter of the reception were trays with appetisers. It turned out they were celebrating international nurses day. As part of the celebration they had organised a communal lunch which all the managers attended.

The reception had not been notified of my coming, but because I knew the names of the managers I was allowed into the room where the workshop would take place. The room clearly had been used earlier that day and had not been cleaned yet. There were dirty cups all over etc. Catering was busy with the lunch sand had not time to tidy up the room so I did that myself.

Even somewhat tidied the room, which was the meeting room for the management, was gloomy and dark. The furniture was in a decrepit state. The flipchart stand was falling apart. All in all, the room did not invite creative thinking. But anyway, I displayed the material I had brought with me: picture postcards, crayons, pencils, markers etc. and I prepared some introductory flipcharts.

When I was doing this, John, the acting manager came in. He asked how long the workshop would last. I was a bit surprised by this, because I thought we had agreed upon the time. He explained that the management team had met earlier that that day to discuss finances. The financial situation of Arborvitae is far from rosy so to speak, and during the meeting in the morning they had been discussing the implications of this. Some of the managers present had indicated that they would not be able to stay the whole afternoon. John, the acting manager had considered calling me to suggest postponing the meeting…. but on second thought had decided against it because finding a new date would be difficult.

I felt the hectic atmosphere in the building. While walking around in search of sellotape, I ran into the manager welfare, whom I had interviewed two weeks before. She had looked forward to the workshop but informed me now that she would not be able to attend. As part of the international nursing day they had invited a cartoonist into the building. As manager welfare she had to accompany him during the afternoon while he would be making caricature drawings of anyone who would be willing to sit for him.

At a quarter past two the first unit manager arrived. She did not seem very enthusiastic. She said she could not stay longer than four o'clock. I got the impression that the meeting in the morning had been planned at the last minute. So work she had meant to do earlier that day had not been finished yet. She clearly wanted to do other work right now, rather than have a workshop.

Slowly but steadily more of the participants arrived. One of the unit managers would not be there, because Wednesday was her day off. We started with a group of five. I had met all of them before, except the manager HR. I started by referring to objectives that I had sent to them as part of the invitation. I sensed right away that what I was saying came as a surprise to most of them, in fact to all, except to the acting manager. I did not check, but either they had not received the information I had sent for distribution or if they had received it, they certainly had not read it. They had expected

me to share findings of my research. Apparently they were under the impression that I already had been able to come up with some relevant findings for them. I felt I had to start more slowly. I said I felt resistance, was I right in this? 'Well no' one of the unit managers said, 'it was not resistance as such, but it was all a bit too unexpected.' I started chatting a bit about the research and what I had been doing, here at Arborvitae and in the North.

After approx. 20 minutes (it might have been sooner, but it felt long) they seemed prepared to start making drawings or collages. During the instructions the unit manager somatic care entered. I had not met here before. She also was clearly surprised about what was going on. Her face spoke volumes.

Luckily I had brought a whole stack of post cards that they could use for their collages, because that helped them to make a start. They all gathered around the table with the pictures and selected cards. And they all started working on their individual sheets. I had asked them to picture or visualise the images they had of their role and how it is influenced by the context. During my explanation one of the participants said that it sounded like Freud. I replied that there was indeed a link. I could not detect if his remark was positive, negative or neutral. I still thought at that time that that participant was Jewish, and was thinking about Freud's Jewish background.

It was a totally new way of working for all the participants. There was a lot of giggling around the table with postcards and a lot of comments about not being able to draw. It quietened down when the participants started working on their own sheets.

Figure 6.1. Overview of the Collages

Once the sheets were ready we placed them all together on the table. I explained that we would first look at them. Then we would look at each paper individually and give our reflections. Then we would ask the member who made the drawing or collage to reflect on what he had heard. Either I did not explain this properly or it was not understood or heard. What happened was that the participants did walk around all the sheets and gave a few comments and then wanted to know from each other why they had drawn what they had drawn, etc.

I let it happen. I felt I would be pushing too much if I were to ask for more reflections. Somehow the collages did not call forward very deep thoughts in me either at this stage.

The facility manager commented that all the sheets expressed a hectic atmosphere. The others agreed. One of the unit managers said she saw a lot of similarities. I asked her if she could elaborate, but she could not. When the managers started sharing their personal histories through the pictures, the atmosphere in the room changed. They drew more together and started to listen to each other.

Figure 6.2 Collage of the Acting Managing Director

The acting managing director was the first to explain his picture. His collage was fairly general. He had not drawn or written anything that showed any connection with Arborvitae. But then as Acting managing director he saw himself as someone who shovels up the earth and disrupts gardens and
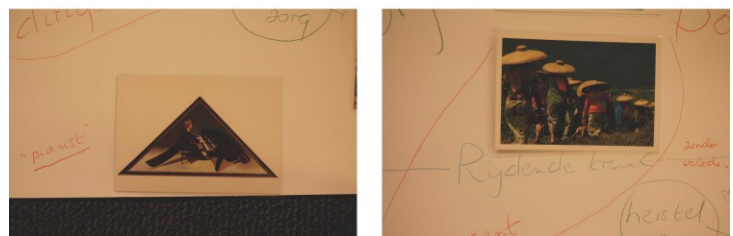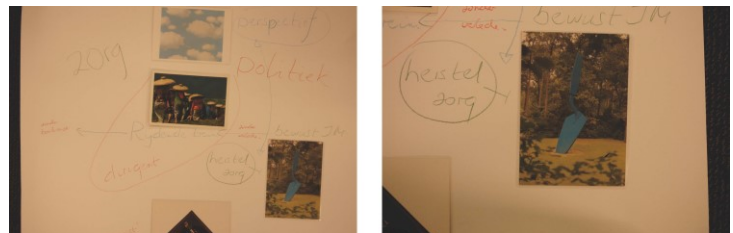
creates chaos. It is up to his successors to embellish the garden again. The picture of the lonely pianist symbolised that as well. He turns up somewhere to give a performance and then moves on to another place for the next concert. He said he was used to jumping on moving trains and to create chaos. His role as acting manager, coming from outside, requires him to take drastic measures. He also said that the fact that he is a man, influences his behaviour. The manager HR, (female), blurted out that that was obvious, for if he had been a woman he would have been ready much sooner. As a conductor who only works with orchestras once, he is someone who has no history and no future with an organisation. His plan was to leave the organisation again in five months time. I asked how the other managers would feel if his drawing were to be removed from the table, as kind of mind game contemplating what it would feel like if he had left. They said that the orchestra would start playing out of tune fairly quickly. The Acting managing director immediately played down his own role. I am the conductor perhaps, but a conductor needs an orchestra. An orchestra can exist without a conductor. I openly wondered if that was truly the case. The best orchestras have close relationships with their conductor and they develop together. An orchestra without its own conductor might lose its special tone and colour.

The chaos he mentioned was not clearly expressed in his picture. When he spoke about it, however, the other managers nodded in

agreement and said they felt he was putting pressure on them and that many things had to change.

Figure 6.3 Collage of the Care Manager,

Psychogeriatric Unit

Care manager Simon had drawn a blowing storm cloud in his picture as a representation of the pressure he experienced. There is a severe storm blowing in the world of care and in and around Arborvitae. The sun is also rising at the horizon, but the road towards it will not be easy. At the right-hand side of the picture he drew an almost transparent fragile figure who is looking toward the storm cloud. 'That is me', he said. The pictures with the pillars and the penguins on top represented Arborvitae for him. Each penguin has its own pillar and therefore they or cannot huddle together as they would do if they were all on level ground. Penguins are survivors. They can survive under extreme conditions and they survive because they work as a team. But he said they could also be mean to each other if their own survival is at stake. He still saw Arborvitae as an inward looking organisation with a lot of islands.

There was not enough contact between the islands although he saw signs of improvement. The picture with the different herbs collected in square boxes represented the diversity in the care for him. He meant that not every resident or client is the same and can be treated the same way.

In the middle of his explanation his phone rang. One of his employees had fallen ill and he had to return to his unit at the other location.

Later when I reflected on the session his picture of with the pillars and the penguins reminded me of the Jewish war memorial in Berlin.

Figure 6.4 Collage of the Care Manager (Hetty)

Care manager Hetty stated that the unrest in the organisation was bothering her. She feels like a runner who constantly has to anticipate the hurdles that are coming towards her. In the picture the runner moves away

from the arrows. The picture would have been a better representation of her feelings if the runner had been facing the arrows, she said. A lot was being thrown at her and she had to try to catch it all. She was not quite sure yet which route to follow hence the choice of the signpost with the all the sings saying 'This
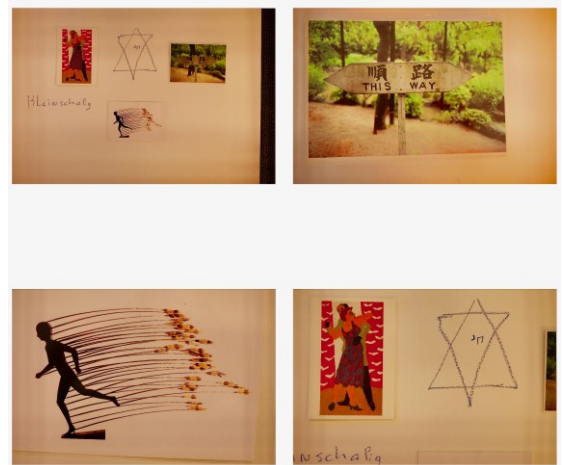
way'. The picture of the dancing couple reminded her of her time as location manager of the psychogeriatric unit of Arborvitae. She had held that position before the unit moved to its present location. At that time she said we were very close, we had a good time together although it was not always easy. We were like the dancing couple. It was a colourful time and we were like a family. She sounded nostalgic. She continued by saying that they had been too close perhaps. Dancing together is positive, but it also carries a risk. It is risky when colleagues are too close.

She had written one word on her collage: small scale. That is the kind of care she preferred to offer; care organised on a small intimate scale in a quiet and peaceful surrounding away from the contestant moment and commotion. Hetty is Jewish and this identity is very important for her.

Figure 6.5 Collage of the Facility Manager

Jacques had been with Arborvitae for more than twenty years. He grew up in a protestant Christian community (in the Dutch Bible Belt). His first picture of the elderly men and the small boys copying them reminded him of

his youth. He had grown up in a traditional Calvinistic community were people felt responsible for each other, where people looked after each other and that provided protection. These values were important for him. In relation to Arborvitae he had chosen the card with the phrase: 'Nothing is forever except change'. Next to it he had written the words resilience and multiplicity. He said they had to accept that everything was changing and that in face of this they had to show resilience. If they would succeed in doing that the outcome could be an interesting variety of new options.

Next to the third picture of the woman in a rowing boat he had written 'rowing in a changing world'. This picture symbolised the work the management team had to do. They were rowing on a rough sea in a tiny boat.

Figure 6.6 Collage of the Care Manager (Cecilia)
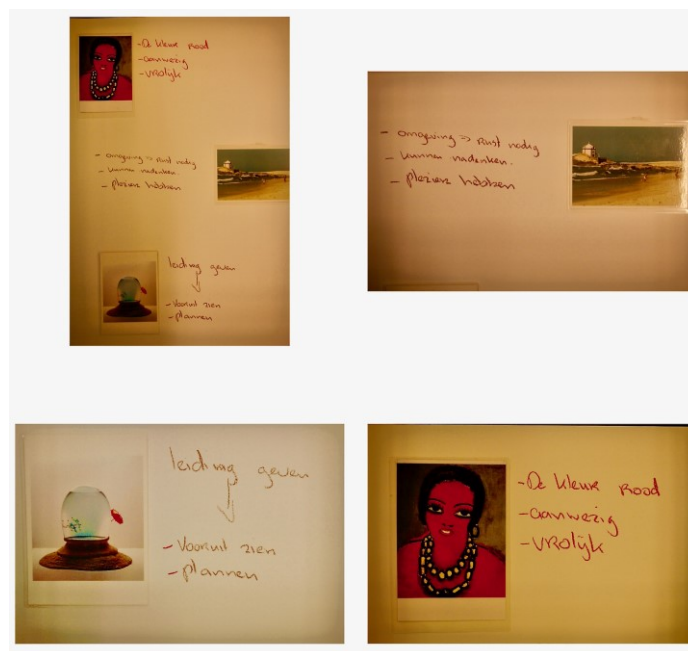
Cecilia had been Care manager for three months. She had difficulty including the context in her collage. All

three pictures expressed something more personal. The first picture of the red woman represented her passionate nature. The second picture of the house on the beach stood for her need for a peaceful environment. Such an environment she regarded a perquisite for the ability to think.

Good management meant looking ahead and planning. She remained somewhat evasive when she talked about her collage.

Figure 6.7 Collage of the HR Manager

Susan was the last manager present to explain her collage. After she had made her collage she had had to leave the session for some time. She has missed the explanations of the others. But she had come back to give her own explanation. Everyone fell silent when Susan spoke, probably because of her composed way of speaking. Her Jewish identity is very important for her. Her mother had survived a concentration camp and had lived in Arborvitae. She said it was important for her that she was being seen and that she was allowed to be who she

was. It is vitally important for her that there is a good atmosphere in the place where she works

She had chosen the picture of the blind folded woman because she wanted to be impartial in her work as HR-manager and be there for everyone. Therefor she indicated that good and fair rules and regulations are important. Rules should never be a thing in itself however. Her values were recognition, equality and justice. Since the former managing director has left, Susan and Hetty represented the Jewish identity in the organisation. When Susan spoke about her mother, Hetty said. 'Ah, the second generation syndrome' , referring to the fact that many children of war victims feel very responsible for their parents' well-being and do their utmost to look after them.

After everyone had given their explanations they had drawn together more. They started discussing problems they come across, for instance between care and facilitation. Two managers suggested it might be useful to organise a teambuilding session with nursing staff and those responsible for catering. I got the impression that disagreements are normally dealt with in one to one sessions and are regarded as something between individuals, rather than as an issue that should be regarded as an organisational matter that could be discussed in a management meeting.

I could not keep them much longer past four o'clock. They all wanted to finish some pressing issues before going home. I agreed to take pictures of their collages and sent those to them by mail, which I did the next day.

Reflections on the session

Right after the sessions I had mixed feelings about it. It had been a chaotic session and it had something intangible. A lot was left unsaid. They had not really wanted to take the time to reflect and explore what was on their minds. They had been running in and out and were almost out of breath. Despite of the obvious resistance at the beginning, they had however started making collages and after that the atmosphere had changed. They discovered things about each other that they had not known about.

After some more reflection on the session and looking at the collages the managers had made, I wondered about the following issues: were they constantly running as managers because things are not alright at Arborvitae or is it the other way round? Were things not all right at Arborvitae because they do not take the time to step back and reflect on what they are doing and why they are doing it? I did not see a management that operated as a team. I got the impression they were micromanaging. Why did the welfare manager herself have to accompany a photographer? Why had a unit manager needed to run away when a staff member had fallen ill?

All the managers were under strain, not surprising probably because they had heard about the financial situation earlier that day. Probably that announcement was still reverberating in their minds. It cannot have come as a total surprise however. Because the facility manager, when he explained his images, said that when he started working at Arborvitae there already had been issues around finances but that at that time they had had more access to funds and hidden 'nest eggs'. The other managers reacted as though this was new information for them. They were not very willing to explore and discuss deeper lying issues. They played on the safe side.

No time to think

My data from the workshop and from observations and interviews provided me with a recurring panicky feeling one would get from being on a fast moving train with different people wrestling with the controls and in the background all the time, particularly at Arborvitae, feelings of loss, including loss of hope. The short termism, rapid stopping and starting and the frenetic pace seemed to be partly a flight from feelings of any sort other than fear and panic.

Over the course of time the pressure on the managers was not lifted. After he had left, the Acting managing director John, wondered if he had not put too much pressure on the other managers.

I wonder if I did the right thing. Did I force the pace too much? I hardly gave them time to breathe. There was no time for reflection. In hindsight I think we should have taken more time to do that. The inspection even asked me if the managers could take it all on board. 'Can they cope?' they asked. They noticed the managers were under a lot of pressure. But did we have another choice? Where do you start with a neglected organisation? You just begin and you act and you do not take the time to sit down and discuss matters. And if you do not run, people think your have time on your hands and you are not doing anything. The staff was constantly running – so as a manager you have to run as well. I had to create a sense of urgency. People needed to understand that the situation was very serious. The next sanction after tight scrutiny is closure. There were signs that the Minister of Health was willing to consider closure or partial closure of the organisation.

So we were in the casualty department, so to speak, and when that is the case people have to run. But still, in hindsight it would have been good if we had built in two hours for reflection once a month.

Under his successor the situation did not improve. From the casualty department the organisation had ended up in intensive care. John had stayed much longer than the anticipated six months. He had stayed more than one and a half years and his fee had been high. He was in the top three of the highest earners in the healthcare sector of that year.

As a result the debt of the organisation had spiralled even further. The next managing director Patricia soon realized she had become a player in a very complicated game of simultaneous chess. She had to focus on the financial situation, quality of care, the reorganisation of the organisation and survival. The only option for survival was merging with a bigger organisation. Because of its deficit and substantial levels of debts Arborvitae had very little negotiation or manoeuvre power. Patricia felt she was a bus driver who had to manoeuvre the bus over a very narrow ridge with steep drops on both sides. What made the situation even more complicated was the fact that everyone in the bus attempted to get his or her hands on the steering wheel as well. During her term of office she had to take a lot of decisions that affected managers, staff and residents. An example was a deal she struck with the regional care centre. Another care home in Amsterdam had been forced to close by the inspection. The residents of that care home were therefore forced to leave that location and find a new place to live. Arborvitae had many of unoccupied rooms, which meant no income. The Regional Care Centre allowed a large number of the residents of the other house to move into Arborvitae, which improved the financial situation. However it all had to happen so fast that there was no time for proper preparation. The residents moved in and settled. A few months later however they had to move again to other rooms. As part of the deal with the Carebus group it was agreed that a closed unit from another Jewish care organisation would move in with Arborvitae. This created a lot of unrest because it

also involved renovations. In her second interview the care manager Cecilia said the following:

> Twenty-five residents with high ZZPs arrived from the other house. So suddenly the second and third floor where fully occupied and then it turned out the closed unit from the other Jewish organisation would move in as well. So since January we have had nothing but turmoil. The client council did not agree, relatives of residents arrived on the doorsteps with lawyers. If only we had thought things through beforehand this would not have happened. That is what I still miss. Planning, where do we want to go, what are our objectives? But that is what always happens here. We put up the walls, but the foundation is not there yet. Go and prepare the foundation before you put up the walls… that is how it should be done. Now the residents from the other house had to move for a second time in a very short interval.

The constant feeling of pressure had created a very hectic atmosphere. Plans were made and almost immediately put into action without thinking them through thoroughly enough. And still the management had not taken the time to create a sense of unity. After two years the island culture had not disappeared either, as Cecilia said:

> It is chaos in the management team. We have had many clashes, so to speak. Everyone is running his or her own shop, so to speak.

We do everything for our own unit and we do not care about the rest. One of us tries playing the Good Samaritan and to bring us together but it is not working. And the new location manager from the Carebus group does not take enough initiative to bring about change. He listened to us and he organised a coach. And finally at the end we have a one-off management away-day. But I have no idea about the programme and the follow-up.

Management by Fear

The emotional impact of all the external pressures expressed itself in a different way at the Noturos Care Group. The location manager of Grenier and Volte-face was not a manager who was able to deal with stress in a constructive way. When she was under stress she had a tendency to react very emotionally and accuse others of wrongdoing. This happened for instance when Grenier scored lower on a consumer quality index than the three other locations she was responsible for. She was disappointed about the results of Grenier. The measurement had been taken around four months after the new care managers had started working at Grenier. The location manager organised a session with the representatives of the organisation that had conducted the survey, the two care managers and two key workers. During this session she reprimanded the managers and key workers and demanded they accounted for the differences in scores between this year's survey and the one from the year before. Her other locations had scored between 6.9 and 10. Grenier had scored between 4.9 and 9.9. Afterwards I was informed individually by key workers and

the managers that they had felt intimidated and belittled. One and a half years later during a labour dispute the low score was held against one of the care managers and seen as proof of her incapacity to operate in that role.

Figure 6.8 Grenier Performance Measures: Consumer Quality Index

Blue Grenier 2012 vs Red Grenier 2011   Blue Grenier 2012 vs Noturos Group

Redacted due to copyright

2012

When looking at the figures, Grenier scored somewhat lower than the Noturos group in two categories: quality of food and cleaning. In the other categories, the results were not that different. For the location manager however the differences were far too big and the managers were instructed to work on the improvement of the meals. This was taken up. However, the way this was done resulted in a lot of unrest and commotion amongst staff and residents. Like at Arborvitae new projects were quickly taken up but not thought through enough to be implemented correctly. Many things were started at Grenier but finishing things turned out to be difficult.

Conclusion

My data reveal the many sources of anxiety impinging upon Arborvitae and Noturos from outside. These included fears of public exposure and shame arising from increasing surveillance and the inspection system, threats of merger, reorganisation and closure arising from financial pressures and the rationalisation of the care process through the ZZP system. Rather than being able to shield staff from these anxieties my data indicated that management tended to act as a lightening rod for them, often acting in chaotic and persecutory ways towards staff. The chaos and uncertainty paradoxically accompanied the internalisation of more and more controls as a result of which the care organisations began to rigidify and become increasingly inflexible. Bureaucratisation was evidenced by the increasing role of the computer as reporting, accounting and box ticking replaced face to face contact with residents. The appearance of care seemed to become more important than the reality, something I noticed being supported by the audit process which gave rise to various forms of impression management. The long term impact of all of these trends upon relations between staff and between staff and management seemed to be one characterised by increasing fragmentation as individuals and units stuck more narrowly to their own specific tasks for protection. Finally, with fewer resources but more bureaucratic tasks to undertake, the pace of working life increased to something quite frenetic, something which ensured that there was no time to think about the resident, their care and the care process.

Chapter 7

Crossroads of Two Discourses: The Care Discourse Versus the Business Discourse[8]

In this chapter I present data around the dynamics of two clashing discourses that are prominently present in the Dutch healthcare sector, the business discourse and the discourse of care. I argue that both management and staff at Arborvitae and at the Noturos Care Group were impacted by these two distinctly different discourses. They shaped their behaviour and language in different ways. For the management the business discourse was more dominant while the carers operated more often from the discourse of care.

The Care Discourse

Both at Arborvitae and the Noturos Care Group more had to be done with less money. During the observations and interviews I could not escape noticing the struggle between the wish to provide good care to residents and the necessity to economise and organise work processes in a different way. The management was mainly forced to focus on the care process from the perspective of the business discourse. Carers preferred focussing on the care process from the perspective of the discourse of care. Key workers were forced to keep both perspectives in their mind.

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[8] See chapter 3 for a discussion on the notion of discourse and the care discourse of care vs. the business discourse page 41

When listening to the carers during interviews I noticed that they often used words associated with the discourse of care. Most of them had chosen to work in the care sector because in one way or another they enjoyed working with people. And most of them had also consciously chosen to work with the elderly.

The stories from the carers

During the interviews I asked the carers and managers why they had chosen to work in the care sector. These are their stories.

Domestic assistant Nora was from Suriname-Hindustani descent. As a girl of eight she moved to The Netherlands from Suriname. When she was 16 she was married off. Later she divorced. In order to support her family she started working in the kitchen at Arborvitae and moved on to become a domestic assistant. Until her divorce she had not had much contact with Dutch society. Through her work at Arborvitae her horizon widened. She saw herself as someone who was there for others 'I am just a worker, I like working. If somebody needs my assistance I come and help them. That is my way of life.'

Denise entered the sector as a volunteer. She had come to The Netherlands from Indonesia with her husband. She had been sitting at home and had not had much contact with Dutch people. She felt lonely and wanted to be among people. At that time she lived close to

Arborvitae. One day, when her husband was away for business, she decided to knock on the door of Arborvitae to check if they needed volunteers. They indeed needed volunteers and in this manner her first contact with the organisation started 15 years ago. Through the internal training programme at Arborvitae she became a carer and has been working at Arborvitae ever since. She felt very loyal to the organisation, because she had been able to build up a professional life and get access to Dutch society. She liked being with people and caring for them, 'We used to do everything for the residents and when the weather was nice we took them outside and that was nice'.

Sylvia was a key worker from Suriname descent. She grew up in Suriname as the ninth daughter of a family of eleven. She moved to The Netherlands when she was eighteen and started training as a nurse.

> In my culture it is the mothers who do all the caring. Women have to be strong and able to support themselves. From a very young age I knew I wanted to work in the care sector. Caring is in our blood, in my culture. I loved my grandmother. She lived with us, when she became older. My mother looked after her. That is what we do in our culture. I was one of my grandmother's favourites. … In our family, as a girl you could choose between study or becoming a house wife. I opted for studying. I have always wanted to be able to look after myself financially.
> (Sylvia, key worker Arborvitae, main location, 3-4th floor)

Joyce worked as a carer. She was from the Dominican Republic. When she was young she did not immediately knew what kind of work she wanted to do. A friend helped her to make up her mind:

> I decided to start working in the care sector because of the stories of a friend. She worked as a carer and because of her I became enthusiastic. I either wanted to work with young children or older people. My friend worked with psychogeriatric patients, older people who go back in time and become like children again. I chose for this direction because I would also have to learn about more medical issues and that interested me… What is good about the caring profession is that your can truly help someone. You really help someone when they are covered in their faeces and you clean them. This is important and makes me feel good. It gives me a good feeling if I can help someone who is no longer able to look after him or herself…I am brought up like us. In our culture, the Dominican Republic, your look after each other. My grandmother now lives with my uncle, her son. That is how it should be done. That is part of life. I like to care for people and help them. I often do things for them when they ask me something. … Here, at this location I am told off for doing this. Because sometimes I give people more care then they are entitled to. I do

not really think a lot about the ZZPs. That is the responsibility of

the key worker. I want to give the care the residents need.

(Joyce, Carer, Arborvitae. Main location, 3-4th floor)

These four women were all first generation immigrants. They had grown up in societies where there were no extensive healthcare systems and where family and relatives had to look after each other. The different generations were more dependent on each other. At the time they came to The Netherlands the healthcare sector needed carers. It was relatively easy for them to find employment in the sector. Other sectors in Dutch society might have been more difficult for them to get access to. Sylvia spoke Dutch very well. The level of Dutch of Joyce, Denise and Nora was more intermediate. During the observations session I conducted at the psychogeriatric unit of Arborvitae I noticed that most of the carers who work there had an immigrant background.

Nicole who also worked at Arborvitae was Dutch. She described that she came from a family of doers. Her parents ran a shop. And from a young age she was taught to help out whenever necessary. In her words:

I am the eldest of a family of two. Helping is in our blood.

Whenever we can we help someone. From a young age I knew I

wanted to care for others. And when I was twenty I started working

in this organisation. …. I come from a caring family. That is how I

was brought up. We look after our grandparents for instance.

The lives of these women were closely interwoven with Arborvitae. They had started their professional careers at this organisation and they had received their training there and they felt very loyal towards Arborvitae. Through their work they had learned about the Jewish culture. There weren't any carers at Arborvitae with a Jewish background.

In Friesland the carers were all were women from the Frisian descent. Many times I heard people say Frisians look after Frisians. In the care sector this meant Frisian women look after the other Frisians. At Arborvitae there were a few male carers, but at the Noturos Care Group all the caring staff at all levels were female. When I asked Aafke what it was that had attracted her to the care sector she said she came from a family where everyone chose a profession in which you worked with people and that that might have been a reason:

> I am not quite sure why I wanted to work in the care sector. When I was in secondary school working in the care sector seemed attractive. Although you do not have a clue at that age what working in the sector really entails …I cannot quite recall why I made the decision to become a carer in the sector. Everyone else at home trained to become a teacher, except me. I think it is about working with people though. It is important for me that I am there for the residents, that I act with their interest in mind. That is very

important, that they feel well. And if that is the case they will give you things in return. When you can give them your love you will get it back. It is just a form of reciprocity. And that I consider to be very important.

(Aafke, Key Worker at Volte-face)

For Helen it was just destiny as she said:

I was destined to work in the care sector. From the moment I could play with dolls it was clear - A doll with one arm or leg, they had to stay. I was the nurse and from an early age it was clear. I thought a long time about whether I wanted to work in maternity care or with elderly people. This is more than thirty years ago, you know. But because maternity care is more about short-term contacts. And I get attached to people so that is why I chose for nursing homes. I am a carer. I want to look after people. And looking after elderly people who suffer from psychogeriatric illnesses, that is my thing, that really is my thing. I have tried other jobs in the care, such as home-based care, but that is all about short-term contacts, you give eye drops, you help them to put on their support stockings. That just is not it. So now for more than eighteen years I work in the psychogeriatric care.

(Helen, Carer at Volte-face)

In addition to interviewing carers in Friesland I spoke with all the carers from Grenier during workshops and I spoke with many carers who worked at Volte-face during observation sessions. They were all 'doers' who liked to work with people. Many said they felt guilty when they were sitting in front of the computer and could not be with the residents. Except for one key worker, all the staff were Friesian women. The woman who was not from Friesland came to The Netherlands as an immigrant from former Yugoslavia. The majority of staff I had contact with had been working at the locations for many years. They all worked part-time, the majority were not the breadwinners of the family.

Two Care managers I interviewed who had started at a young age as carers before moving up to become managers had similar stories on how and why they entered the healthcare sector:

I have always had a special feeling for the elderly. I remember going on holiday when I was eight or nine years and seeing old people. It made me feel sad how they were being treated. Ever since that time I have wanted to do something for them. It is a sort of Florence Nightingale idea. You need to have a vocation for this work. You do not do it for the money, because the salaries are bad … I have always wanted to work with the elderly. On the advice of my grandmother I started with training in nursing. She advised that that would be a good basis and that I could decide later if I really wanted to work for the elderly'.

(Care manager Hetty, Arborvitae, main location)

And the Care manager from Volte-face remembered it like this:

I had very good contact with my grandmother. I was here favourite grandchild. And I was impressed by the white dresses of the nurses. The nurses in the care home where my grandmother lived were very kind. And all this made a huge impression on me. And from that moment onwards it was clear for me, I had only one objective. I was going to work in the care sector. So there I was eighteen years old working as a carer

(Care manager Joan, Volte-face)

The former care manager Marianne of Grenier also started young:

I started working in the care sector when I was 16, because of my sister. I did not quite know what to do when I left school. My sister worked in the sector already. She advised me to do the same. I applied for an in-service training position. I started in a nursing home right away and grew up fast

(Care manager Marianne, Grenier,).

The women from both locations entered the sector at a fairly young age, between 16-18 years old. The family context they grew up in clearly influenced their choice of work. Grandmothers seemed to have played

an important role in many instances. What appeared to connect their stories was that as a child they experienced being part of a community where it was taken for granted that you took care of each other, where there had been contact between the different generations. This was the case for all the women whether they come from another cultures or whether they grew up in Friesland.

Behind the words of some of the carers also was a sense that as the girl in the family they might not have had that many other options to choose from. One key worker from Arborvitae mentioned this explicitly. She had wanted to attend university just as her brother, but that that had not been an option for her as the girl in the family.

> I grew up in the country. I had never intended to do this kind of work. I wanted to become a vet. But my parents told me that that was no profession for a girl and they pushed me in another direction. And in those days that is what you did. And at a certain moment I even started to like it. Initially I thought it was not my cup of tea, but I am still doing it and I still like it.
> (Key Worker Karin, Arborvitae, main location 1, 2nd floor)

At the workshops with the carers of Grenier three women in their late forties and early fifties also said that as girls they had not had many other choices. If you were lucky you could choose between a domestic science school and the nursing profession.

Listening to all the women I got the sense that for many their work was a kind of vocation, a calling almost. In the words of a care manager: 'Many who work in the sector start with a sort of Florence Nightingale idea. It needs to be a kind of vocation… Work in the care sector is badly paid in general. And if you no longer have a bonus for unsocial hours you will not exactly make a fortune. If you work for the money you had better find another job in another sector. Most staff are dedicated. People never go on strike, you know'.

People never go on strike and they run the risk of going too far in their dedication at the cost of their own health:

> During that time I did not look after myself enough. I just went on and on. When I was pregnant from my second daughter I crossed my own personal boundary. I did not listen to my body enough. I could not work for two years and I even thought I had to leave the care sector. I had to undergo some operations because I had a hernia.
> (Sylvia, key worker Arborvitae, main location, 3-4th floor)

Carers did not speak of economic necessity openly, although most probably many worked also because they needed the income. The carers at Arborvitae from Suriname decent in many cases were the breadwinners of the family. And many carers could not afford working

fewer hours. During the time I followed Arborvitae the contracts of many carers were reduced as part of the reorganisation. For some carers this meant they had to supplement their income by accepting a second position at another care organisation or by working for another employment agency to make up for the lost hours.

What carers consider to be good care — mourning for a lost world
At Volta-face carers were proud of their location and they enjoyed their work. At this location carers talked about their work with a sense of pride.

> I do not want to work at organisation where you hardly have any contact with residents. Here at Volte-face things are great. Here we work with the concept of small-scale living. Not more than nine residents in a unit and you always are with two carers. That is so pleasant. You can be there for everyone. And we have contact with the relatives of the residents. It is much closer. And this is how it should be. Here you can give your love to the residents. And they return their love to you. It is a matter of reciprocity – what you get and what you feel- and that is very important for me
> (Carer Aafke, Volte-face)

During an observation session I spoke with a carer of one of the unit who had been at Volte-face from the beginning in 2009. She enjoys the work very much. 'It is much better here than at the other location of

Noturos where I used to work. Here care is provided as it should be provided. We follow the residents instead of the other way around. If someone does not want to get up in the morning but wants to have a lie in, that is all right.' And her colleague said 'We are never ready but time is not an issue here. Of course we have to do certain things every day, but we do not have to do everything on a fixed moment. Time does not any longer have meaning for most of our residents, so why should we try to push them in a fixed schedule. We follow their rhythm as much as possible'.

The units at this location all had a homely atmosphere, which gave me impression whenever I visited this location I entered a home and not a care unit. Carers were busy preparing food and enticed the residents to help them with small things. One resident was ill and his bed had been rolled into the communal sitting room so that he had company around him. The carers drank coffee together with the residents and there was a genial atmosphere. There was no sense of pressure.

I also attended a teambuilding session with the carers of one of the four units. At a certain moment during the session they were asked what made them proud. They mentioned the collegial atmosphere, that they were proud of the way they could provide care. They listened to each other and were listened to. They were proud of the location as a whole. These carers felt authorised and taken seriously and supported by the Care manager. The Care manager had been at Volte-face from the

start. Her vision was behind everything. She knew all the residents and their relatives. She had been present at the job interviews of everyone who worked at this location. She followed her teams closely and tried to create an atmosphere that allowed the staff members to grow.

I asked her how she did this.

> I do a lot by intuition, I observe people, I talk with them, I observe how they operate on the work floor. How precise to they fill in the care plans. Are they task focused or people focused. If you only have staff who are people focused, nothing happens at team level. So you need people who are task focused as well. I have always found this interesting. How do you create the ideal team? I worked in such a team once. That was a once in a lifetime experience. But that is what I am constantly aiming for. How can you create together. How do you make it happen - that we say what a good team we are and our work is fun. Because that what it is about: that you enjoy your work.
> (Care manager Joan, Volte-face)

She seemed to have succeeded. Volte-face was a location where the carers were able to remain focussed on the residents and see them as complete human beings in all their complexity.

Carers at other location of the Noturos Care Group and at Arborvitae spoke wistfully about what they considered to be good care. There was a sense of loss. In the past they had been able to do provide a different kind of care to the residents. They regarded being able to have a proper conversation with a resident and to accompany them outside and to alleviate their sense of loneliness as being part of good care:

> I would like to be able to take residents outside. But we just cannot do that anymore; we do not have the time. It used to be different. We could take residents for a walk, we had excursion by mini-bus. We had activities. But that is all gone. Residents get lonely; there are too few activities. The residents are sitting in their chairs in the common space and sleep. …And you try to listen to residents when you help them, but you are busy with other things. You do not have the time to talk with them and have a proper conversation. There are people with traumas who would like to talk for 15 minutes for instance, or discuss something with you. But you cannot do this anymore.
> (Nicole, Assistant Carer Arborvitae, Main location)

When they talked about the present situation the carers mournfully looked back at former times. This was for instance the case during a group interview with three carers from the psychogeriatric unit of Arborvitae. This interview took place three months after a major

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reorganisation during which they had had to take leave of a number of colleagues.

> Before the cost cuttings and the move to this location it was much better working at Arborvitae. We were with more staff and the atmosphere was better. We could pay a lot of attention to the residents and there were many activities. That is different since we are housed in this location. And now you have to – you see- you can no longer sit next to the residents and pay them attention. Because there are more tasks you have to do, you know. And yes I think it is a pity. You are here for the residents but you cannot give them all the attention you would like…. Accompanying a resident to the hospital is not part of a ZZP packets, nor is a moment of one-to-one contact.

More than once carers said they regretted that they no longer were able to do other activities with the residents besides performing 'just instrumental care routines'. They had regarded those other activities as an important part of their work through which they had been able to provide a good caring environment for the residents.

Carer Joyce from Arborvitae had a whole list of issues that she regarded as a deterioration of care. Good care was the opposite of what she experienced she was able to deliver. On the top of her list was the issue of trust, 'Trust is very important. You experience that the whole day'. A

relationship between carers and resident is complex. It is about support and control and about dependency and independency. Joyce indirectly said that building up a relationship of trust is a prerequisite for being able to properly deal with this complexity. The fact that they no longer had the time to work on this, for instance by having a chat with people took away the pleasure in her work, 'Sometimes I wonder why I am doing this. You cannot deliver the care you want to deliver. Having a chat with people is also part of care, but most of the time we do not have the time for that'. In her eyes time for observation was too scarce as well: 'When you care for people you need to have the time to observe them to see how they are doing, what they can do themselves. But we do not have the time for that'. As a result Joyce experienced more unrest among the residents.

> When I started I working in at Arborvitae with psychogeriatric patients it was completely different. We had enough staff. We had a great team. … It all works best when you can work with a fixed colleague. But this is not always the case. Many days you have to work on your own. But if this is the case, residents get restless, especially the residents who also have psychological problems. They start calling and become angry because the help they need comes too late - structure is important for many residents.
> (Joyce, Carer, Arborvitae. Main location, 3-4th floor)

The Business Discourse

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In 2006 the changes in the healthcare sector were presented as a form of privatisation. Management of care organisations had to be more entrepreneurial and run their organisation using standard business procedures and techniques. Concepts like measurable standards, measurable output, efficiency, clients, competition, financial targets, financial incentives became more mainstream. I noticed that both at Arborvitae and at the Noturos Care Group it was mainly the management who was operating from what can be called the business discourse.

Before 2006 care organisations received a lump sum that, within limits, they were able to spend as they saw fit. In 2006 this changed. Care organisations were funded on the basis of quantified care they actually provided to individuals. In order to make this possible the ZZP structure was introduced. The ZZP structure turned care into a commodity that could be sold and bought and traced.

The former Managing Director of Arborvitae saw the ZZP structure as a method that enabled the care centres to follow how the money or care was spent.

. The ZZPs, I understand the background. We used to have nursing homes, care homes and care homes with nursing facilities: three categories. But then we became afraid people would get more or less than they were entitled to and now we have 10 ZZPs. The idea is that everyone just gets what he or she needs. And

theoretically speaking that could save money. But the whole

system costs so much so that you can wonder if it will indeed lead

to cuts in expenditure

(Former manager director Arborvitae)

Since the implementation of the ZZP structure there was a direct link

with the kind of care and the amount of care a resident was entitled to.

The regional care centres required Arborvitae and The Noturos Care

Group to be able to account for how they spent the care:

> The new rules and regulations require us to account for everything
>
> we do. If someone is entitled to a ZZP 6, you need to be able to
>
> prove that someone really gets the care he or she is entitled to.
>
> (Care manager Grenier, Marianne)

So in the wake of the ZZP structure both organisations had to organise

the work processes in such a way that whenever necessary they could

produce evidence of care delivered. In order to be able to do this, the

care process had to be minutely described. Carers were required to

enter details about the care process in the computer. The ZZP structure

created new forms of bureaucracy. The Regional Care Centres

determined what kind of information they needed and how it had to be

delivered. This is another reason why the bureaucracy has increased in

the care sector – far from reducing bureaucracy the introduction of

market principles has increased it.

Increased distance between seller and end-user

The negotiations between the regional care centres and Arborvitae and the Noturos Care Group were conducted by the higher management. The rules and regulation were such that higher management had to estimate a year in advance how much and what kind of care they estimated they would need. These estimates formed the basis for the negotiations with the care centre. So the care was bought a year in advance on a partly hypothetical basis. The locations received the money when they sent proof to the care centres that they had actually delivered the care they had budgeted.

The resident has to follow the ZZP

Both Arborvitae and the Noturos Care Group organised their care along ZZP lines. At Arborvitae this was very clear. The first three floors, units 1-3, were for residents up to ZZP category 4. The fourth floor was for the very vulnerable residents (ZZP 6 or higher). This could mean that residents had to move up to this floor if their ZZP status changed. Carers had mixed feelings about this. Management were more resigned to the fact that this had to happen. Efficiency was more important in that respect than the well being of the resident. Efficiency saved money. Or at least that was the hope.

Here we have a resident on the 3rd floor who has to go to ZZP 6. Which means actually that she should move to the 4th floor. But is

it humane to move someone like that. I do not think so. She is 95 or 96. You should not want to move someone at that age. That is really terrible.

Residents on the fourth floor need more and different care than those on the third floor. That does mean that if there is a change in care needs residents sometimes have to move up a floor or move down. This is not easy for them. You should not replant an old tree. It does happen however. We have one resident who used to live on the fourth floor but now lives on the third. He still goes upstairs during meal times and gets his medication on the fourth floor. Another resident had to move to the fourth floor. She keeps on coming back to the third floor.
(Key worker Karin, Arborvitae, main location, third floor)

A care manager put it like this:

Residents are asked to move rooms. And that is very difficult of course. The care team has problems with this. Because Mrs Jones has been living in that room for years already. But I say, suppose we can create the same space a floor below or up then it should not matter should it on which floor she is living. Because she will have the same kind of room with the same view. Mentally however this is difficult for Mrs Jones and for the staff,

… But I have to do this. I have to take action. If you sit back it will not get any better. And I am truly afraid that if we do not do this, the Carebus group will say in two years' time: 'sorry we tried it but it did not work. We are going to close the house'. I would not be surprised.

(Care manager, Cecilia, Arborvitae, nursing unit)

Performance culture and targets

In the wake of a more business-like approach care homes have become more result oriented. Management and staff have to work toward reaching targets that have been set earlier in the year. In principle care managers were not against targets, but they observed that the target culture led to an increase in bureaucracy on the one hand and to a climate where there is less tolerance for mistakes. Care manager Marianne had seen the emergence of a changing mentality in the course of the time she had been working in the sector.

It is becoming more and more result oriented. We talk about targets. We have year plans. We need to make personal development plans. I need to discuss this with my manager and my team leaders have to discuss their plans with me. It is all about efficiently, and staying within the framework … and it has all hardened, not just here at the Noturos Care Group, but in the sector in general. The Location Manager and the Managing Director, for them it is all about performance culture. And they

expect things from you. And that is fine, but pressure has
increased enormously. Mistakes are not tolerated, although we are
all human. … One mistake and you are out. When I got my
training, there was a different approach towards mistakes. It was
accepted that you were a human being and that it was possible
you made a mistake or perhaps even more than one… but then
you were not immediately fired.

(Care manager Marianne, Grenier)

Marketing the organisation – (window dressing)

Neither Arborvitae nor the Noturos Care group could afford to have
unoccupied rooms. Unoccupied rooms meant no income. So attracting
prospective residents was important, and being selective was no longer
an option. This was a change for Arborvitae who could no longer afford
just to accept residents with a Jewish background:

For me the biggest change is the privatisation. This means that
you have to market yourself in order to get clients. In former times
you had to be a member of one of the three Jewish religious
communities. You had to be 100% Jewish. But that is no longer
the case, 20% does not have to be Jewish.

(Care manager Hetty, main location Arborvitae, Units 1-3)

John, the acting manager, explained Arborvitae had no choice. Care homes competed with each other for residents and each care home had to do its utmost to attract as many residents as possible.

> In general in Amsterdam there is competition for clients between care homes. There is a lot of care space available. So there is an increasing number of vacancies. Due to specific demographic developments and due to changes instigated by the government people are expected to stay in their own home much longer – so we are getting overcapacity in terms of nursing and care - so yes if I have vacancies I will try to tempt clients away from other care homes.

At the Noturos Care Group they used the outcome of all the audits to differentiate their organisation from other organisations. They presented this data in various forms on their website. On first looking at the website one might be mistaken for thinking one is looking at a website for a supermarket. It contains pictures of smiling people with their thumbs up who are quoted as saying everything at the organisation is wonderful.

Figures 7.1

Marketing pages of

the website of the

Noturos Care Group

Language of the markets

The changes have led to a change of language. Care managers have noticed the change:

> And now we use language such as: production and high
> productively. And that is difficult for me. It sounds as if I am
> working in a biscuit factory and I have to produce biscuits. For me,
> that went against the grain for a long time. I am dealing with
> people and I had to be productive. Accepting new clients, it does
> not matter whom. It is the money what counts. I am not against
> change. But I do have problems with the commercialisation. We

are a not-for-profit organisation. And now all the focus is on targets

and earning money. It it's people we are dealing with and not

biscuits.

(Care manager Hetty, main location Arborvitae, Units 1-3)

Or

On Monday we ask the weekend staff 'How was the production',

instead of 'did you have a pleasant or nice weekend.' And it is

regarded unprofessional if you allow a resident to hug you and say

'dear' to you and even more unprofessional if you say 'dear' in

return. My location manager told me off for doing so when she saw

this happening.

(Care manager Kelly, Grenier).

One manager spoke about how they had 'leaned the unit'. 'Leaned' is

not an existing Dutch word. What she meant was that they had looked

at all the work processes with the help of consultants specialised in the

'lean concept' as developed by the Japanese car manufacturer Toyota.

This had enabled her to 'steer on hours', meaning that she could

exercise a form of leadership based on time control:

The new structure means that you can steer on hours. I now make

work schedules based on three-four hours shifts. We used to have

eight-hours shifts. So initially the implementation took some doing.

People wondered what it would entail … We no longer have eight-hour shifts for care assistants for instance. That meant for a number of them who had thirty-six hour contracts that could not work here any longer on such contracts. So they had to give up hours. And that has had a huge impact on many staff. …

(Care manager Davis, PG unit Arborvitae)

Delivering care was compared to buying and selling bread. Care manager Hetty had resented the fact that she sometimes felt care was treated as if it was comparable to producing biscuits. In an interview two years later her colleague explained that she compared delivering care to selling and buying bread:

I try to explain to the staff time and time again that this is what it is. It's like going to a bakery: you have to pay for your bread. And the residents, they have to pay their care. And if you don't pay at the bakery, you do not get your bread- and this resident should not get any care because he is not paying. It is very black and white but this is how the government has organised it

(Care manager, Cecilia, Arborvitae, nursing unit)

At the Noturos Care Group the higher management had fully integrated the language of the market into their way of speaking. At the first meeting I had with the location manager she informed me that her aim was that all her locations would get a Triple A status, as if the Noturos

Care Group was a bank. The Managing Director of the Noturos Care group defined the context of the organisation in relation to markets.

> The care sector has to deal with more and more markets that all have their own dynamics. We need to understand these markets because they strongly influence our work. There is the market of clients, the market of products, the labour market, the capital market and the insurance market
> (Strategic document of the Managing Director of the Noturos Care Group)

Since 2008, the year the present managing director of the Noturos Care group took up office, residents of the various locations are called clients, rather then for instance senior citizens. The motto of the organisation was that 'The Client is Centre Stage'. Managers had to operate like entrepreneurs looking for all the opportunities in the market to improve the business.

Efficiency

Both organisations hoped that through organising the care in a more efficient manner they would be able to increase the quality. In order to achieve these aims both organisations worked with consultancy firms that were specialised in lean management. The interim manager introduced lean management at Arborvitae. However when he left the

project was immediately abandoned. The new parent organisation was going to introduce it again.

> I had worked with Lean before. It is a good system but if you want to work with it you need to educate your staff first. It was introduced too quickly without a thorough preparation. The steps were too big and when it was introduced, we as care managers had other things on our mind such as the inspection. Plans had to be drawn up; everything had to be set right. We had an MRSA infection. There was too much going on to introduce the Lean concept properly. We did not manage to implement it. I do not say it cannot work in the care sector, but it is a laborious process. If you put petrol in a car it will drive and when you are ready you cannot say to a resident, here is your petrol and go for a drive. It does not work like that …

> From the moment they (the consultants from the lean concept) arrived I knew what was going to happen. So I was very sceptical. I told the interimmanager, but he told me I was wrong. However we had to reorganise. And the data gathered for the lean project was used to determine who had to go. Because we could do the same with fewer people.

> So Lean did not work - it was a waste of money. Because it did cost a lot of money this lean project. And now we wait and see. At

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Carebus there is also talk of lean management … so perhaps this

is going to be the third time I have deal with it. I will wait and see. I

would like to know the objectives first, but they are very good at

skirting around stating those clearly.

(Care manager Cecilia, Arborvitae, nursing unit)

Care manager Joan from Volte-face had to introduce the concept as

well. Over time I noticed her getting more burdened. During a visit she

sighed she now had to look at the lean concept and check if it contained

aspects she could incorporate. 'But we do so much already. Some of it

might be useful but I do not need a complete overhaul'.

Key worker Karin had the following observation about the lean concept:

In this house they are introducing the lean project … They are

going to clock you… At a certain moment I said… I do not want to

be involved in this. I am dealing with people… The same

happened in the home I worked before. We had to fold aeroplanes.

And they said '*Well you can fold so many in an hour, how can you

translate this to your work* ...' And I told them '*Yes, here I do not

have a phone and no one asks to go to the toilet'.* Such a

production you cannot compare to caring for someone who is

bedridden … 2.5 minutes to give someone a shower. It is

something to be terribly ashamed about. This goes against my convictions. You lose sight of the human factor.

Two years later the concept had indeed been abandoned. It had not brought them what they had hoped for. Although it had been used to determine how many people could be fired as part of the reorganisation process.

Staff are like pawns on a chess board

Along with the introduction of the ZZP structure staff contacts had changed. Flexibilization had increased. Whereas before staff worked on eight hour shifts for instance at Arborvitae, now staff were scheduled to work in three or four hour shifts. As part of the reorganisation most of the staff contracts had been reduced in hours. Some staff at Noturos had 3-4 hour contracts. This meant that they would be asked to come and work for just 3-4 hours a month. If the organisation needed more staff they might be requested to make more hours. At the Noturos Care group there was a hiring freeze. It was not possible to hire new staff and temporary staff had to come from other locations. At Arborvitae there still was a risk that many short-term contracts would not be extended. The care manager had to determine who to let go and who to keep on.

> The flex workers and staff with short-term contracts are at risk. I try to organise this as best as I can. I am not going to replace food assistants. Care assistants can do this work as well. So in the

evening we no longer have a food assistant. And the care
assistant works a bit longer …

May be it has some influence on quality, but that is my dilemma. I
go for quality, but my boss tells me to organise it like this …

According the ZZP criteria I still have too much staff. So I have to
do something about this.
If I go for quality I have to keep the nurse, the key workers and the
carers and then you are going to focus on the care assistants and
the food assistants. However tough it may be. I will start with the
food assistants. And it is really unfortunate because for them it is
more difficult to find a new job. It is very tough. A carer will find a
new place, but a food assistant will not get a new job, and certainly
not when they are older. The educational level of food assistants is
too low and other organisations will not employ them. It is a
dilemma. You play with people and it will affect them personally.
Some have small children, some have older ones… But this is the
reality I have to deal with. A few years ago it troubled me a lot. But
that is no longer the case. I have gotten used to it. It is part of the
job …

It is like a game of chess, which pieces do I hold on to, which
pieces will I let go. And you do away with a pawn much sooner
than with a king, because you have more of them. I need to go for

quality and the pawns have lesser quality. It is really unfortunate. It
is something I had always wanted to stay away from but…. I have
no choice

The mould does not quite fit. This morning someone reported ill,
and then you have a problem. Because staffing is very tightly
arranged. When one staff member is ill, six residents have to wait
a couple hours. They might not be able to get up before noon. And
that is not as it should be. But it is reality. The staffing is based on
our income. This is our income - this is what we can spend.
(Care manager Cecilia, Arborvitae, nursing unit)

Assembling the weekly work rosters had become a complicated and
time-consuming task. It was not possible to have much overlap between
work hours of different staff members. It all had to fit very precisely. If
one staff member fell ill and was not able to come to work it was acutely
felt how lean the work rosters had become. Care managers and staff
experienced the pressure of having to do more with less. Both care
managers and staff were aware that jobs were not as secure as they
once had been.

The bottom line is money.
Location managers and care managers in both case studies were aware
that staying within their budgets was vital. Money was scarce and they
had no other option than working within budget constraints. When I

interviewed care manager Cecila for the second time, Arborvitae had

been part of Carebus for six months. She had experienced many

changes since I had interviewed her the first time. Arborvitae had

survived and had a future again as part of a larger organisation. It was

very clear for her that the organisation clearly could not afford to go over

budget again.

> Everything has become more business-like and this organisation is
>
> business. It is about the money and if there is no money the
>
> business cannot run. It is like this everywhere. It used to be
>
> different in the world of care. Somehow it was always possible to
>
> find some money here or there or to do something else to get
>
> things in order. But that is no longer the case. And yes, you work
>
> with people perhaps, but - we are not the only ones who do that.
>
> The difference is that here we work with vulnerable people, that is
>
> the difference.

Earlier in the interview she had said this:

> We are a unique house (as a Jewish organisation). If that had not
>
> been the case, Carebus would not have taken us in… but money
>
> is another important factor. At this moment they have put a lot of
>
> money in this small building: renovations, new IT, new computers.
>
> There are going to be a lot of changes. And that costs a lot of
>
> money. So they want to see a return of investment in the near

future. They are not doing this for nothing. The bottom line is finances. We have to be very realistic about that. I think that in two year' time we need to be able to show that we can support ourselves financially.

Money is the bottom line. Managing director Patricia who succeeded John, the acting manager, found an organisation with a deficit of 1.3 million euros. John had focused on improving the care or the organisation. The care had indeed improved. But hiring him as an interim manager had increased the deficit to such an extent that the next managing director had but two options, closure or finding an organisation that Arborvitae could merge with. After tough negotiations with banks, regional care centres, Jewish organisations and Carebus a deal was struck, Arborvitae was saved for the time being.

Care at the Cross Road of Two Discourses: The Position of the Key Workers and their Experiences

The role and position of key workers

In an attempt to be able hold residents in mind in the midst of all the changes care organisations in The Netherlands introduced the position of key worker. Key workers are carers who have to coordinate the care for the residents. A key worker can be responsible for 15 to 40 residents. Both at Arborvitae and at the Noturos Care Group the position of key worker had been introduced approximately a year before I started gathering data. The key workers were still in the middle of finding their roles.

At both organisations it turned out to be an important position. They were the professionals in both organisations who knew the residents best, who had an overview of their medical needs and who knew the relatives of the residents. They were responsible for the care plans and checked if their care colleagues worked according to the care plans. The key workers at Arborvitae had had a bit more time to settle into their roles than the key workers at Grenier.

The key workers at Arborvitae liked the responsibility that came with the position.

> I like the position of key worker because you have more influence on how you want to work. I enjoy bringing the parties together. I always listen to all sides of the story. There always is another side. Sometimes the family complains, sometimes the staff, sometimes the resident. I listen, consult with the doctor and see what we can do. The doctor and I are often on the same line. … It is important to think strategically, to keep the big picture in mind and take conscious decisions on what to do next. This is part of your job as key worker. You always have to place your decisions in a larger context. If I do this now, what will be the effect in the long run. (Sylvia, key worker Arborvitae, location 1, 3-4th floor)

The key workers at Arborvitae were able to take a step back and to observe the effect of all that is happening in the sector on the residents. They had an eye for the bottlenecks in the care process and expressed their concern. Sylvia experienced that all the professionals were working under pressure and that the work was very hectic:

> We have to do much more with fewer people. Now we do with two what we used to do with four. And today for instance when two colleagues are ill, you are running around like a chicken with it's head cut off. You have to be everyone and do everything. … I am happy when at the end of the day I can say that I have at least done one thing well, although ten things might not have gone well.

She was aware that residents were feeling the effects. She noticed that carers were less precise in in order to gain time. Articulate residents probably would not let carers get away with this. But Sylvia was worried about the less articulate and quieter residents:

> Residents have changed over the years. When they come to Arborvitae nowadays they need a lot of care.[9] There is a group of people here who are very good at letting us know what they want. I am not so worried about them. They somehow make sure they get the care they need. I am much more worried about the quiet group. They see that we are very busy and they do not want to impose on

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[9] As a result of new rules and regulations new residents will only be admitted to care homes if they fall in ZZP 4 category or higher.

us. So they do not call us. But this can be dangerous. If for instance we do not attend to a wound one day, it might have gotten worse the next day. Your really have to think about how you communicate with this group. We must not project our stress onto them. We should not say I am too busy and I cannot attend to you now. We need to explain that we will definitely come and help them, then and then. We might not be able to stay too long with them, but we will come and do what we have to do. And structure is important for many of our residents. A fixed structure is beneficial for them.

This group of residents is getting larger (the quiet people). You really have to be very alert and explain things in such a way that they will not be afraid to ask for help. There are colleagues who take at it face value when a residents says he or she does not need anything, because in that way they can save time. But it should not be like this. We always have to double check and see what we can do.

She noticed that ordinary carers did not take enough time to properly observe the residents and provide her as key worker with the right sort of information she needed to determine what kind of care a resident really required. As a consequence she tried to gather this information herself most of the time.

With the ZZP structure we have to evaluate properly what kind of care a resident needs. We observe every new residents for 6 weeks and sometimes longer, to determine how much care they need. Some new residents need a lot of time to adjust. They do not speak a lot and are very quiet. You need to observe them very well. The notes of my colleagues are often not specific enough. They write such things as Mr X washed himself or he ate his food. What I need to know is how he washed himself, how is his coordination. Did he eat all his food, does he have an appetite. So I often have to do the observations myself. That is why we as key workers need to be able to do everything. I do not have much time with each resident. But when I am with them I do as much observing as possible.

I had two in-depth interviews with the key worker Karin, once when she had been working at Arborvitae for six months and again two years later when Arborvitae had become part of the Carebus group. Two years later she had become more cynical. During the first interview she had said that her work was cut out for her at Arborvitae. There was a lot that needed to be done in relation to work processes and protocols. She did not necessarily see this as something that was unique for Arborvitae. It had not been that much different at the organisation where she had worked before. Over the years she had experience that the pressure on the carers had steadily increased.

Oh, there is a lot what needs to be done here. Many things are unclear. There is a lot of miscommunication at this location. Many things are unclear. Nothing is put on paper. So my work is cut out for me. But to be honest, it is not just here. The whole sector is at a standstill. All those ZZPs that have had to be implemented. It is like running a race. We knew it was coming, but no one was ready for it really. And then you see that everyone makes a false start. That is the strong feeling I am having. If it had been introduced more gradually and if people had been informed better…. If they had said 'pay attention this is what is going to happen and you have better start preparing' – if that had happened… It was the same at the home where I worked before.

But it has to do with the work pressure I think. Because it has been very difficult. When I started working in the sector we worked with ten people on a unit. That number has been halved if not more. And if you are going to implement changes you have to prepare people. Give them training, do something and do not step on board at the last moment, because then it is too late. But that is what has happened. It happened from one day to the next, That is how I experienced it. They see it coming but they jump on the train too late. And then they are behind the facts and do not have the time to organise things properly.

Karin experienced that the continuity of the care process was affected by the staff reductions. She listed a number of examples where this had led to very unpleasant situations for residents.

I do not work in the weekends. When I am back on Monday I am often busy picking up the pieces of the weekend. Well picking up the pieces is perhaps too strong an expression but I do have to correct stuff. We work with a lot of temps and flex workers. And over the weekend a lot of things go wrong. On Friday there is a temp for the weekend, evening and night shift. And if she makes a mistake on Friday – things go wrong the whole weekend. It is a kind of domino effect. Last Monday for instance I hear that a resident had pain, pain, pain throughout the weekend. I ask the carers 'why did not anyone go to him to and ask him what was the matter? So I go to him - to ask him if I can have a look at his medication. This resident keeps his medication in his own room. I immediate see that the opiates are not there. I ask him about this. He informs me he never got them over the weekend. I go and look in the central medicine chest- and there they are. So he suffered severe pain the whole weekend and no one bothered to take action. So that is how it goes. One mistake and bang, bang, bang, the mistakes accumulate. And I am afraid that this will happen a day longer till Tuesday if I am no longer work on Mondays. Because continuity cannot be guaranteed. I often leave on Friday with the fear that things will go wrong over the weekend.

Since Arborvitae had become part of the Carebus group they had to use flex workers that were part of pool of supernumerary staff to fill gaps in the planning. Karin's face spoke volumes when she talked about this. Often the organisations had to accept the flex workers who were available and could not chose who came to work for them. Karin was not pleased with this development because it was another source of unrest and opened up more possibilities for mistakes.

> Every weekend there is a problem - also in terms of staffing at the units. Carebus has a large pool of flex workers. People are drawn from this group and placed here… and Yes- No, I think it is a pity. You should have two permanent well-qualified staff members, a fixed team during the weekend. It will be easier to talk things through. And the residents will know them and don't have strangers on their bedside. Because that is another problem: strangers. It is such a pity—that is no longer the case that we work with a fixed team in the weekend

Frustration about lack of continuity and quality was the major theme during the second interview with Karin. The list of what went wrong became longer and longer and she pointed out that there had been moments when the mistakes had become life threatening.

I see a lot of things going wrong. I am a member of the
commission that checks on incidents that have happened. And I
see loads of mistakes with medication. And all of the mistakes
happen in the evenings. And I am not surprised. Because there is
only one nurse for the evening, night or weekend shift and she
also has to distribute the medication. And it is not possible to do
both: to be the nurse on duty for whatever is needed and to deliver
medication. This can be life threatening.

Communication across hierarchal lines was difficult. Trust in the
management was not altogether great. She often had the feeling that
she was banging her head against a brick wall. She observed that
managers were often absent and she had the impression the amount of
time they had to spend away from the location had increased now that
Arborvitae was part of a bigger organisation. In her role as key worker
she was confronted with the effect of short term planning. She
confirmed care manager Cecilia's opinion that many projects were
started without a proper foundation. And as key worker she saw the
effect of this on residents as the following story illustrates:

A lot of decisions here are taken at an ad hoc basis. Now that we
have lost the psychogeriatric location the plan was to make a
psychogeriatric unit in this location … But for all kinds of reasons
this has been postponed for another six months. In the meantime
we had a women living here who should go to a psychogeriatric
unit. We have spoken with her relatives and informed them that

their mother would be much better off in a psychogeriatric unit somewhere else. There she will get the care she needs … And now she is not allowed to go because the boss says we will get a psychogeriatric unit here … but that decision has just been postponed for another six months. So that woman just has to wait …. Well I ask you … My manager can go and explain this to her son. We told him that his mother needs more care. If I were in his shoes I would kick up a row. I actually hope that what they will do. We speed things up so that she gets the right ZZP indication for her to be able to go to a psychogeriatric unit and then, when all is said and done, it does not happen - because we are not ready yet with our plans … And then I cannot help but thinking … come on boys. Why do you not think things through properly? Everything is bam, bam bam and in the end we are back were we started! You know I cannot explain this to the family anymore. I informed the son that is his mother has an advance stage of dementia. And that she needs specialised care and that we in the rest home cannot give her this care and now she is not going. So If I were her son, I would ask ... *and where is the care you said she needed?* … And you know it is up to my manager now to solve this. I cannot do this anymore. This is so frustrating. And you know things like this happen all the time. This is not an exception. When you start with something you should bring it to an end and not just start something light-heartedly and do it like that.

As key worker she saw directly what the effect of all the austerity measures were on residents. In her opinion the threshold of what is still humane was about to be crossed or had already been crossed. Care was cut up too much and the approach has become too instrumental. She illustrated her point with the following example:

We have a new resident with a ZZP 6 indication. He is suffering from cancer —he needs specialised care. So I stay with him longer, I do not run away. Because I want things to go right. And I cannot ask a care assistant to do that. And I cannot say either you go in first and wash the patient then I will come later to take care of his wound. You cannot do that with someone who suffers from this illness. You cannot cut up the care. Because he is tired. He has no energy. He does not have the energy to tell his story to a care assistant and then again to the nurse or the carers who attends to his wounds. You cannot have too many people bothering him. And this is what is happening- the care people need is becoming more complex – so you need different kinds of staff.

Because of the new rules fewer people will be admitted to care homes. If they come they really need care, specialised care and that means you cannot cut up the care … But what is going to happen? In this house we still have food assistants. I am afraid they will go next. Other houses in the Carebus group do not have food assistants any longer so they are bound to go here as well.

Although they are very important, they are a pair of extra eyes for me and they check if all the supplies are in stock for instance. So I do hope they can stay for a while. But they are bound to go… Another group we have to say good-bye too. … And then who knows ,the care assistants might be next.

When more and more staff are removed from the care process, the key workers have to focus themselves on non-related care issues. And thus the vicious circle continues. Care professionals have to spend more and more time behind the computer and cannot attend to the residents in person.

All the procedures have become too involved and everything has to go through too many channels. You lose sight of it. And still you feel you need to check. It does not feel right. I cannot go home if I feel the problem has not been solved. Things are getting out of sight – it becomes more and more anonymous.

The emotional experience of key workers: the effect of having to juggle with conflicting discourses
Key workers felt sandwiched between management on the one hand and their fellow carers on the other. During team coaching sessions and workshops with key workers at Grenier in Friesland I noticed the emotional strain this put them under. Decisions taken at a higher level in the organisation at a certain stage would reach them as key workers

and they had to make sure that their non-key worker colleagues would carry out the changes. They experienced they were the funnel through which all the changes had to pass. And at times this felt like a form of forced feeding. During a team coaching session I had with the key workers of this location they bombarded me with feelings of frustration and anger. These were among the things they said:

> I feel sandwiched between the management and the other staff. I feel like a garbage can. Somehow everything that needs to be done, or changed is dumped on my plate. I feel sucked empty

> We are drowning. But instead of throwing us a life buoy, they tell us we have to do fend for ourselves and just swim to the shore

> We are in a moving train, we are in the locomotive and we would like to get out, but it rides too fast. Yet at the same time we feel we are running out of fuel. The end is near.

During a workshop with the key workers at Grenier I asked them to express how they felt in relation to their work with the help of pictures. Figure 7.1 shows an overview of the flip charts of a number the key workers present.

Figure 7.3   An overview of the flipcharts

A closer look at the images and the explanatory texts they wrote next to

the pictures showed that the carers felt exhausted. They used strong

images and words to express their feelings.

Figure 2   This shows the picture chosen by key worker BZ. She had

chosen a picture with a decapitated broken head to symbolise her

feelings of emptiness and tiredness. A picture of a bus stop in a strange

location symbolised her feelings of disconnectedness and loneliness.

She had the impression she was in her own cubicle, whereas she would

like to work in her unit as a team. The third picture was an image of her

as key worker. She saw herself as a kind of conductor of her team. The

carers from her unit or team knew where to find her. The book on the

picture was still empty. She was conducting with an empty score. She

explained that Individual team member knew where to find her but her

team did not function yet like an orchestra. She wrote she felt

supported by her fellow key workers.

The key worker F was full of frustration. She used two images to show

she is exhausted, the two sleeping boys on bike and the man sitting in a

chair. She felt her spirit had been broken, broken by the constant fight.

She felt lost in the wood. Two of her images depicted children. She

indicated she felt treated like a child. Like key worker BZ she felt

isolated on her own island. She also expressed that it was not easy to

Figure 2 key worker BZ

I feel safe among my key worker colleagues, We can share things together

find a proper a balance between home life and work life. The picture of

the baby that is being weighed stood for the increasing bureaucracy and

for the fact that she had the impression that the higher management

found fault with everything.

Figure 3 key worker F

Redacted due to copyright

I feel washed out, brought down and feel GUILTY towards home

I need to let the Managers Care know WHERE MY BOUNDARIES ARE

This shows the picture of the third key worker. She only chose one image, a man moving boxes to the other side of the ditch. Next to this she wrote that the boxes she has to move each time are too many. It is too much work that cannot be done in 24 hours. She too felt treated like a child. She wrote on the flip-chart that managers do not really listen, but just tell you to grow up and solve the problem yourself.

Figure 4 key Worker I.

Redacted due to copyright

I am I, and that should be GOOD ENOUGH

I have to move too much luggage within 24 hours. I have to learn to protect my boundaries and not carry all the responsibility by myself

I feel insecure

Managers treat me as if I am a child: They say things like : this is a new way of working. You still have to learn how tot do this. This simply is part of the job. You need to solve this yourself. You need to grow up. This is just how it is

The next picture is from key worker G. She indicated as well she was exhausted and that her spirit was broken. She felt the organisation saw her a simple pawn, 'They play dice with me. I feel snowed under. I feel like a child who has to confront angry grown-ups'. She too has an image of luggage that is too heavy to carry.

Figure 5 key worker G

Redacted due to copyright

They play dice with me.
They trifle with me

Redacted due to copyright

I have too much to carry

Redacted due to copyright

My spirit has
been broken.
I am so tired

Redacted due to copyright

Too much information and too little time, I feel like a child

Redacted due to copyright

I feel snowed under

Figure 6   These are the images from key worker E. She said she chose pictures representing how it should be. She said she would like residents to be well looked after. She would like them to feel indulged and to live in a nice and clean environment. She saw colleagues who were too casual in their work ethic and for instance did not shave the male residents properly or left residents sitting on the toilet far too long. She expressed a sense of frustration and was unhappy about the fact that her carer colleagues of her team would not listen to her and instead complained to the residents about their work.

Figure 6 key worker E

Redacted due to copyright

This is how it should be taking pride in caring for each other and making sure that the rooms are tidy so that the residents feel happy

But there is a lot of miscommunication and complaining.
I am bossed around by the manager and by my colleagues. I need to learn to protect my boundaries

Cares complain to residents about their work hours and the work
The rooms are not cleaned properly

Colleagues do not react when a residents needs assistance when they are using the toilet. IT takes far to LONG!!!!

Figure 7   These are images from key worker N. She was struck by the first picture she chose. 'This is our work. We have to clear up this mess all the time and we are never finished.' Like key worker G she had chosen one picture representing an ideal state. She hoped that one day everyone in her unit would work as a team. Like key worker BZ she said she felt supported by her key worker colleagues.

Figure 7 key worker N

This is my work as Key worker:
sorting and cleaning up and it is
never finished

I wish we my unit was at team in which we all
worked together. But there is a lot of resistance

I feel supported by my Key
worker colleagues

Themes emerging from the team coaching and the images produced in
the workshop confirmed each other. The key workers at Grenier felt
powerlessness. In different ways they expressed feeling belittled by the
management and treated as children. They did not experience a
management that worked with them to make sure that the residents got

the care they needed. They felt they were left too much to their own devices, hence the feeling they were living on an island, or were working from their own private cubicle. They experienced their work as a constant fight, as a boxing match and this made them feel very exhausted.

This team of key workers did not feel empowered enough to motivate carer colleagues to change their work attitude and do things differently.

> I have no real influence over the other carers. Some are nice to work with and then it is alright to work with them, but some carers don't want to listen to me.

> If extra tasks need to be done, I rather do it myself then ask others to do it.

> We would like to make a binder containing all the work protocols. We know this will not solve the problem but at least we can point to the book to explain what they should do. We have to explain the same thing over and over again to our colleagues; they always pretend they do not know. I write down everything in the care plan of each resident but no one reads them and does the things in the way they think is best. (Comments made during a team coaching session by key workers N, E and BZ)

The data on the key workers of Grenier indicated there was a lot of uncontained anxiety at this location, which the key workers internalised. The key workers did not experience containment from the levels above them. They were able to support each other as key workers on a horizontal level, but along vertical lines there was disconnection. They felt not supported enough from above and they were not able to support their carer colleagues enough. In their opinion they had not been granted suitable forms authority. As key workers they had to organise and coordinate the care process but they were not given the authority to manage their colleagues and to address them on matters of unacceptable behaviour. That was the responsibility of care mangers. The anxiety among key workers at Grenier was deep and it had a paralysing effect. They were hardly able to focus on the caring process and had become inward looking.

The frustration of carers - the impossibly of providing tailored care – and the effect this has on residents

The carers on the units at Arborvitae also saw the care deteriorate. And during many interviews they expressed their frustration and anger.

> The money is no longer there --- and that is the problem. The
> clients and the staff are the victims. I would like to send an
> anonymous letter to the minister--- why do you not come and

deliver care for a day. Just watch how we walk around with our legs, hands and brains. Show your face and look around for a day. (Carer Denise, Arborvitae main location 1st and 2nd floor)

During a group interview with three workers Sharon (key worker), Maria (carer) and Jane (assistant carer) I got the following question:

Are you going to the Prime Minister with your results? I hope so. I wonder what he will do when someone in his surrounding is in need of care. Up there they sit and make plans but they do not see that theory and practice are miles apart. When we are old will there be anyone to look after us??

The carers who worked at the psychogeriatric unit at Arborvitae gave examples of situations that they thought came close to forms of negligence. They had trouble for instance making sure that the residents got enough to eat. In the mornings it was not uncommon that people started with their breakfast around eleven or twelve o'clock. The following experiences were relayed by Sharon, Maria and Jane in the group interview:

Yes, you notice that we work with fewer people. I work in the morning shifts. We now work with one carer and two or three assistant carers, and that is it. The last residents get out of bed at twelve. And then he or she still has to have breakfast. We often

ask a domestic helper to give them breakfast in bed so that they have at least eaten something. But you know this is not tailored care. The vision of Arborvitae is not in keeping what the government expects from us. The government expects us to deliver tailored care. But we cannot give this, because we do not have the staff and time to do that. If someone says he does not want to have breakfast in bed the alternative is no breakfast at all. We have to tell him it is not his turn yet and at the moment we cannot bring him any food because one of our colleagues has fallen ill for instance, and that there is no one to take her place.

During the evening shifts they had trouble making sure that residents managed to eat as well.

Many residents need assistance with eating. And when you have an evening shift you indeed count many you need to help – but we do not always manage. So no wonder that people lose weight. We have to feed nineteen people and we are with one carer and one assistant carer. And you also have to distribute the medication. And you are supposed to take a break. It is not uncommon that you cannot take a break, so at the end of your shift you are dog-tired.

Then they also noticed that looking after the residents was not becoming easier. Residents tended to stay home longer. They did not

see this as a positive development and linked it to an increase of aggression they experienced from residents:

> And then the aggression nowadays, aggression because residents stay home too long. Then they have received all kinds of helping hands from all kinds of people, home care, volunteer aid and that sort of stuff. And at the moment we try to bring structure into their lives they get confused. And then they become aggressive. Because at home, well if you do not want to get washed… you do not get washed.

This made caring more demanding and less predictable. It was not easy to stay within the time limits they had for each residents based on the ZZP criteria. The words ZZP actually made them rather angry.

> You constantly bump against things, you know, such as residents who have made a mess. They are very good at that. Urinating. And of course you have to clean it up. Or you find one of them emptying a closet because he thinks he is moving. You come across things like this a lot.

> Sometimes you have to entreat for half an hour or more to get someone to accept to put on clean clothes, because his clothes are wet through with urine. Please, please, you cannot stay like this, but 'No, No'. Yet you cannot let someone walk around like

that. Sometimes they hit you. Yes the other day I was hit or they

suddenly kick you out of the blue

And then a woman from the regional care centre comes for an

intake. And she writes such things as Mrs Williams gives a brisk

and social impression. But they do not see all that happened

before. And at the time she is here and we have been able to

observe her … Only then can you begin to see what her situation

really is. And then the ZZP turns out not to be correct.

This illness is a process you know. If they come in walking or in

wheel chair, they all get a 5 but the illness is progressive you

know. They all end up in stage four of the illness. But the ZZP

indication does not adjust for that. The system is too rigid. It has

been invented by people in an office and it is not right.

The work pressure at the psychogeriatric unit at Arborvitae was

experienced as high. The last reorganisation had been experienced as

painful. Carers had had to say good-by to colleagues they had worked

with for years. And the reorganisation came at a time when lots of other

important issues had to be paid attention to as well.

You cannot do this and this and this and this and this etc. We had

to start working with the ZZPs. We had to move to a new building,

we had to work on the improvement of care and we had to

reorganise. It was quite a lot you know. The reorganisation was the

toughest bit. You had to say good-bye to colleagues who you

could rely on blindly. One word was enough. And they left.

As a result of the reorganisation the care processes had become very

lean. Carers had shorter shifts. Instead of eight hours shifts, many now

had four-hour shifts. When one of their colleagues had fallen ill she was

often not replaced by someone else, because at the time someone

would have been found who could come, the shift would have ended.

> Especially during the latest reorganisation people were crestfallen.
> That is not unusual during a reorganisation but at present there is
> little room for manoeuvring left. And as a result there is an
> increase in absence through illness. And now with the short shifts
> they do not arrange replacements. When you hear at 7:30
> someone is ill – they cannot find a replacement till nine o'clock and
> then it is too late anyway

And as a consequence the reorganisation more people left than

anticipated. For some carers the amount of hours they could still work at

Arborvitae was too little and they chose to work for a temporary working

agency instead. The carers who stayed were confronted with the fact

that they now often had to work with temporary staff who did not know

the residents.

We have to work with a lot of temporary staff. And they also do the

evening and night shifts

The just come to earn money. They do not know the residents.

They do not know anything. They are here to bring people to bed

and that is it. And you need to explain a lot of things to them. So in

fact you work for two.

And carers get irritated towards each other. Instead of helping each

other out they ignore calls for assistance.

Sometimes when you ask colleagues to help you they do not react,

as they should. Everything is too much for them. Because of the

work pressure we irritate each other. Yesterday for instance I was

helping a resident to shower. When we do that we cannot leave

the resident alone of course. Suppose something happens. I got a

call but I could not attend to it so I phoned a colleague to help me

out. But she reacted angrily and refused to do as I asked. She

said: 'you are with two at your unit, are you not, so do it yourself.

…. You can count on some colleagues but not on everyone.

(Carer, Joyce, Arborvitae. Main location, 3-4th floor)

Working with psychogeriatric residents was experienced as being

demanding, it impacted on carers physically and mentally. Joyce had

been working at the psychogeriatric unit before she moved to the main

location of Arborvitae. She had been one of the carers who had been

offered a shorter contract at the psychogeriatric unit as part of the
reorganisation. She could not afford to work fewer hours and had almost
left Arborvitae completely to work for an employment agency. Then
Arborvitae had approached her again and had offered her a bigger
contract at the main location of the organisation, which she had
accepted. When she compared working at both locations she said that
working at the psychogeriatric unit had been more difficult

> Working at the location for psychogeriatric care had been tough. It
> was heavy on both body and mind. My joints were inflamed at the
> time because of the work. And mentally it is difficult. Residents ask
> the same thing over and over again. And even after you have
> explained things to them they keep on asking. That tests your
> patience. And you see them deteriorate. They get worse and
> worse and that is painful to watch. When residents come to the PG
> location they sometimes are still aware who they are. They try to
> hide the fact that they suffer from dementia. They say things like, I
> have a short memory. But then you see them decline
> I can cope because of my religion. Without that I would not be able
> to do the work. I have seen so many, many, things.

Carers felt they could not provide the care they wanted to provide. They
clock was constantly in the back of their mind and the care had
delivering care had turned into something much more mechanical.

> You are constantly looking at the clock. We no longer have to time
> to develop a relationship. We deliver the care we need to deliver
> and have to move on to the next.

Joyce noticed that because of, among other things, the pressure carers felt some of them lost their patience with residents and treated them rudely.

> Both here and at the other location you see staff members who are
> rude to residents both to psychogeriatric and non-psychogeriatric
> residents, because of the pressure. The work is demanding and
> we do not have the time breath.

Residents from the main location of Arborvitae who do not suffer from psychogeriatric illnesses articulated their discomfort with certain carers. For residents at the psychogeriatric unit this might be harder to do.

> Here at the main location of Arborvitae some colleagues are more
> involved with the residents than others. And the residents sense
> this. They tell you; 'no I do not want to be helped by her.' Today for
> instance there was a staff problem, two colleagues were ill. So
> there were carers hired through an employment agency. One
> resident said: 'I do not want her, I want you' … Trust is very
> important you know. You experience that the whole day.

Concluding Reflections

My data demonstrates how an ethic of care is rooted in the biographical experiences of this overwhelmingly female workforce. It was this ethic which drew my interviewees into care work. For some, particularly the largely immigrant carers at Arborvitae, working in the care sector also provided a bridge into Dutch society, whereas at Nutoros 'caring for one's own' was closely bound up with one's fellow identity of place as a Frislander. Much of this data appears to accurately illustrate the reflections about the ethic of care of Tronto and others that were examined in chapter 3. Interviewees gave emphasis to meeting the relational and emotional needs of the frail and elderly people in their care and were committed to taking the time that meeting such needs implied.

The move from a needs-based to a finance-based system of care had a significant impact on the working lives of these carers. Interviewees gave innumerable examples of the way in which the introduction of business models such as 'lean production' prioritised quantity over quality and focused upon the physical rather than relational or emotional needs of 'clients'. There clearly was a lot of tension between the care discourse and the business discourse at both case studies. They key workers were in the middle of this struggle. But all the carers felt they could not provide the care they wanted to provide. They were constantly working against the clock. They can no longer see the residents in all

their complexity. Instead the residents are turned into objects. And when

this is the case the risk of abuse is around the corner.

Chapter 8

Analysis of Findings

Introduction

In this analytical chapter I will develop a hypothesis, that feelings of anxiety in wider society are projected into the care sector and influence the day to day running of care organisations and the lived experience of management and carers and staff working at the care organisations.

As I noted in chapter 3 in modern western society death causes feelings of anxiety. Aries (1981) refers to the twentieth century as the era of the invisible death. Bauman (1992) postulates that culture is the device which humans use to suppress unbearable knowledge, such as the fact that we all have to die. He attempts to uncover the collective unconscious of modern western societies and explores how since the rise of modernity in the 18th century, death has come to be regarded as a denial of everything that modernity stands for. He explores how society has deconstructed mortality so that society can pretend that death is 'simply' a private matter and as such is not significant for society as a whole. Simultaneously with the trend to deconstruct mortality Bauman detects a postmodern trend to deconstruct immortality and turn it into something inconsequential.

In their work Aries and Bauman provide accounts on how splitting and disassociation work at a societal level. They explore in what way societies find ways of dealing with the unthinkable. This links their thinking to the psycho-social way of theorising about how the societal or external and the psychological or internal, combine, interpenetrate and influence each other. When anxieties, feelings, emotions or thoughts are too complex or difficult to handle we tend to project them outside ourselves into others. In doing so we can deny their existences in ourselves, while ascribing these feelings, thoughts or impulses to others. This allows us to move on and not be overwhelmed by those difficult anxieties. Bion (1962) developed the concept of containment. Social theorists influenced by Bion (Armstrong 2005) have theorised how society as a whole needs containers: societal institutions that unconsciously function as the receptacle into which society deposits that about which it is too hard to think and talk. The healthcare sector as such is the container in which society can project its anxieties related to dependency, dying and death. Because there are organisations dealing with this, healthy members of society can get on with their lives. In this respect Obholzer (1994) referred to the sector as 'the keep the death at bay service'.

But what if the pressure on a societal container is so big, that it no longer can maintain its containing function? Cooper and Lousada (2005) and Cooper and Lees (2015) detect subterranean sentiments in the British welfare system. They write that as result of external ideological

and financial pressures there is a 'structure of feeling' that is characterized by 'fear and dread' and they hypothesise that anxieties arising from the managerial and political environment often are perceived as persecutory and as such engender 'secondary anxieties', or social defence-like reactions within welfare organisations (2015).

Evidence from my research suggests that something similar was happening at the two case studies where this research took place. The data in chapters 5 to 7 shows that feelings of acute anxiety were present and were influencing the behaviour of management and carers.

As Aries and Bauman describe, fear of death has always been present in society, it is part of human existence. And societies have always found ways to deal with this. So why is it that at the present time institutions have taken on the function of managing this anxiety for a society which no longer seems able to maintain this function itself?

I postulate that there are two major configurations of affect in Dutch society that cause these feelings of anxiety to influence the day to day running of care organisations such as Norturos and Arborvitae. Management and carers of both organisations responded to societal structures of feeling that bring subterranean societal anxieties into the organisational systems.

Fear of Dependency, Vulnerability and Dying.

At the end of the nineteenth century, the beginning of the twentieth century, the attitude towards death changed. Aries (1981) describes how the process of dying gradually was removed from the communal home and transferred into the hospital. Death was turned more and more into a medical issue that was dealt with by the medical sector. Aries links this development to new ideas about privacy and personal hygiene. He describes how death came to be regarded as dirty and as something that had to be avoided. The medical sector took over the management of death. In this way western societies in the twentieth century organised death away from every day life.

Bauman (1992) links the change Aries notes between a tamed death and an invisible death to the rise of modernity that had become prominent in the 18th century. Modernity is about the drive for control of reason over nature, and the defeat of the unexpected. Death does not fit well in this picture. Bauman describes how death came to be regarded as 'the major scandal', or the one issue which man could not control. And as such death came to be regarded as a denial of everything that modernity stood for. Death became a 'guilty secret', something that had better not be talked about and came to be treated as a thoroughly private matter. The dying and non-dying started speaking a different language. Death no longer had meaning in a world where the focus was on denying that there was a limit to human potency.

Along side the modern trend to deconstruct mortality Bauman detects what he refers to as post-modern trend to deconstruct immortality. Postmodernity as opposed to modernity focuses completely on the present. Life is now, and it is not bound by the past or the future. What counts today, may no longer count tomorrow. Memory is short, what is of interest today may be history tomorrow. The so called opposition between the short- term and the long lasting is effaced. Life is turned into what Bauman refers to as a game of 'bridge crossing'. The number of bridges to choose from seem endless and there always is a way back. What has disappeared can return in a virtual form or shape and in his form can feel just as real, 'time is nothing but a succession of episodes without consequence, immortality is nothing but an on-going sequence of mortal beings' (Bauman 1992, p. 47).

In western societies individualism is the dominant trend. The task of individuals is to discover their personal interests without necessary taking societal structures or ideas into consideration. Individualist societies tend not to look favourably upon dependency. The Netherlands is indeed a western society where this is the case. Verhaeghe (2012) describes how the meritocracy of the sixties has developed into a society in which there is a tendency to see both success and failure as something personal. Success is someone's own merit. Failure is someone's personal fault. Independence and autonomy are the norm. In her global study on health and care in ageing societies, Lloyd (2004) describes how the focus on individual success and

personal failure has resulted in a loss of status for those who become

dependent and vulnerable such as the elderly towards the end of their

lives. She states that 'death fits uneasily with the emancipatory models'

that are current in many of today's societies (Lloyd 2004, p.235).

Dependency is frowned upon and equated with weakness. A Dutch

General Practitioner seems to subscribe to this view in an interview in a

newspaper: in our society 'we hate old people. If you work in a nursing

home, then you are on the side of the losers'.[10] Society would rather not

be confronted with decline. Lawton (2000) relates this to the liminal

character of the dying process. In western society death is seen as the

end of the individual. The rational belief is that there is no life after

death. As a consequence the state of liminality has been brought

forward and is now linked to the time just before death: the state of

decline, vulnerability and deterioration. Lawton states that in western

societies individuals in this position are looked upon as 'polluting and

dangerous'. The status of individuals in this stage has become 'highly

ambiguous and the longer this period lasts the greater the fear and

anxiety it provokes' (Lawton 2000, p.174). Gilleard and Higgs (2000)

introduced the concept of the fourth age or the period of deep old age.

They observed that the very old are treated as a group who lack the

ability to operate as agents in their own right and are turned into

'depersonalised subjects' of the health and welfare systems. The fourth

age can be regarded as a kind of social or cultural black hole. Many

problems associated with this period of life are projected into it by

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[10] Quote in a Dutch local magazine, 14 Feb. 2015

society, 'in the 'social imagery' it is a place where society's greatest fears reside' (Gilleard and Higgs 2010, p.126).

Anxiety About the Collapse of the Welfare State.

In The Netherlands there is anxiety about the welfare state. Can we as a country still afford to have a social and financial safety net based on solidarity? This is a question that is regularly asked in the media. The global financial crisis has stimulated the idea that this is no longer possible and certainly not in the form in which it existed till the 1980s.

As early as the 1970th consecutive governments in The Netherlands have focussed on reforming the welfare state. Pollitt and Bouckaert (Pollitt and Bouckaert 2011) describe how since the 1970s debates on how to reform public bodies or organisation are influenced more and more by international or global forces. One such influence is the doctrine of Neoliberalism.

Slowly but steadily this doctrine of Neoliberalism has gained ground in Netherlands and has influenced how governments have started to think about state reforms. According to neoliberal principals the state should provide a framework in which the free market can operate. In The Netherlands the state is withdrawing from areas which before the 1970s it felt responsible for. The reforms in the Dutch public sector should not be regarded however as simple replacement of the state by the market. The government placed itself at arms length without going for complete

forms of privatisation. It is a more hybrid form based on the assumptions that governmental steering capacity in a complex, modern society has its limits (Kickert, 2003) and that public organisations should become more market-oriented (Noordergraaf et al., 2001). It has led to a system in which the chain of connectedness has been constructed by different players and parties. In a period of at least thirty years the chain has been dismantled, split up, partly privatised, semi-privatised, contracted out, reorganised, transformed, and partly handed over to private parties (Newman and Clarke 2009)

The reforms are publicised as necessary reforms to keep the welfare state in place. However policies are introduced by using language of division and fear. Politicians use sentences such as 'the welfare benefits are there for the hard working Dutchman', implying that if you are not working hard and are not Dutch you do not really deserve to live off the state. As such the reforms can be seen as an attack upon citizens' dependency needs. There are lots of signs in Dutch society that they are regarded as such and that they have unleashed persecutory anxieties.

In their study Polllit and Bouckaert (Pollitt and Bouckaert 2011) show how The Netherlands went along with the international trend to reform its public services including the healthcare system to promote a more business-like governmental approach. Pollitt and Bouckaert however recognise the language of division and fear that is being used and they see this as an expression of what they refer to as the 'politics of fear' in

their comparative study on Public Management Reforms in a range of European countries including The Netherlands, North America and Australasia. They noticed in the 1990's and early 2000's the formation of the following vicious circle in the countries in which they did research: politicians play on the fear of collapse of the pension system, the healthcare system or other key state systems. This in its turn instigates a loss of public trust in institutions, which prompts a governmental response to promise more transparent and responsive public services. Parallel to this trend new freedom of information legislation is implemented, which leads to more openness about miscarriages in the public sector. This again leads to ever more demands for reforms and transparency (Pollitt and Bouckaert, p.8). The debate seems to become more and more toxic. Politicians and citizens use stronger and stronger language. There is regularly uproar in the media over new scandals for instance in the care sector. July 2016 the Ministry of Health published a black list of care organisations whose performances were below par according to the inspection of Healthcare (IGZ). The organisations were openly blamed and shamed. After the list was published, it turned out to be incorrect and outdated. The Secretary of Health was called to the Chamber to explain the situation.

Effect of Anxieties

The anxieties circling around in society have to go somewhere. Crociani-Windland and Hoggett (2012) describe how it is common these days to distinguish between an affect and an emotion. An emotion such

as fear or jealousy has an object. We are frightened for instance of what will happen to us financially when we have just been informed that we will lose our job. This is a fear caused by an actual message you have received. Emotions as such have a strong cognitive content and they operate mainly at a conscious level. An affect on the other hand does not have an object. It constantly seeks different objects to attach itself too in a restless way. It can be described as primarily somatic and operating at a less conscious level. It is much harder to give words to an affect like anxiety than to fear, e.g. to explain what caused it, why you feel anxious.

Williams introduced the idea of a structure of feeling (Williams, 1993) to describe something in society that he saw as operating on the affective level: an almost underlying unconscious way of responding affectively to the world that is shared by many, without consciously realising that this is the case. It is a sort of collective unconscious, a way of reacting that is quite intangible, yet it is there and it influences how many people react. This is what Cooper and Lousada refer to when they write they detect a structure of feeling in the British welfare system that is characterized by fear and dread (Cooper and Louasda, 2005).

Affects are free floating and look for an object to attach themselves to. We see for instance that in public life underlying affects attach themselves to specific objects. However the attachment is temporary because the object never represents the affect in a satisfactory way.

Populist politicians are clever at using this phenomenon. They know how to find 'objects' for underlying anxieties, asylum seekers or migrants with Islamic backgrounds for instance. These objects then become the focus of emotion such as fear, resentment, etc. around which public opinion can be mobilised.

In relation to care for the elderly, there are structures of feeling in The Netherlands that float around: anxieties about dependency, vulnerability and dying and about the collapse of the welfare state. The deeper and more fundamental anxiety about death strengthens the anxiety about rising costs and turns the idea of an ageing society into a nightmare scenario. The rising healthcare costs are often mentioned in the same sentence in which it is observed that the Dutch population is ageing. It is as though the elderly are blamed for the fact that as a society The Netherlands might not be able to provide good care in the near future. As Lloyd (2012) points out, the elderly are frequently characterised en masse as an economic problem. Words like 'bomb scenario' are used and it is written that the proportion of 65 year olds will become unsustainable. These anxieties attach themselves to the sector that focuses on care for the elderly. They are projected into the sector, and management and carers working in the sector somehow have to deal with those projections.

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Care homes such as Arborvitae and Noturos are examples of care organisations or locations in which these anxieties are projected. Managers and staff in both organisations have to deal with what Williams (1993) refers to as the 'embodied related feelings' of society. These unconscious pressures placed on managers and staff are high indeed. They have to operate under difficult circumstances and this poses the risk, as Hirschhorn writes, of the emergence of primitive psychological cultures. He compares the building of a modern organisation to performing a difficult circus act:

> Building a post-modern organization is …like walking across a trapeze. Facing greater market risks, the enterprise asks its employees to be more open, more vulnerable to one another. But in becoming more vulnerable, people compound their sense of risk. They are threatened from without and within. …Thus the stage is set for a more primitive psychology. Individuals question their own competence and their ability to act autonomously. In consequence just when they need to build a more sophisticated psychological culture, they inadvertency create a more primitive one. (Hirschhorn 1997: p 27)

The pressure on management and staff in both case studies was indeed high. The social anxieties fuel fantasies of control and this has created a panopticon-like situation for care homes. As the data in chapter 5-7 shows management and staff had the feeling that external parties were

constantly and meticulously observing their moves and actions and that they had to be able to account for everything they did.

From a Dyadic to a Triadic Form of Cooperation: A Process of Triangulation

For years successive Dutch governments have been trying to curb the costs of the healthcare system. The healthcare system is complex and changing the system is not easy. It is like attempting to change the course of a mammoth tanker. With the introduction of new legislation in 2006 the balance of power within the healthcare sector was changed in the hope that this would to prevent healthcare costs from spiralling out of control. Insurance companies were given the role of financial watchdog. They have to make sure that healthcare organisations compete with each other and do not overcharge for their services.

The new relationships between the major players in the healthcare sector in The Netherlands can be depicted in the shape of a triangle.

Figure 8.1   The triangular relationship in the Dutch care sector (Adaptation from Post, 2009)

The model allows us to explore the relationship between the three major players in the field and the dynamics within the system. It shows that there actually is an inner and an outer triangle. The outer triangle is the relationship between the insurer, the entrepreneur and the insured. The inner triangle is the relationship between the care seeker, the care provider and the purchaser of care. Both triangles represent different worlds or modes of thinking. The focus of the outer triangle is on financial matters and represents the business discourse; the focus of the inner triangle is on care and represents the care discourse. The latter is encompassed by the business discourse. Each player in the

field has to deal with an internal split and to decide whether they focus on the economics or on care. The government is an indirect participant in the field, yet an important one. The Ministry of Health keeps on introducing new forms of legislation that influence the power structure within the system.

A closer look at triadic relationships

In psycho-social thinking triadic relationships are a focus of research. From the start of our lives we deal with establishing dyadic and triadic relationships. Initially the main focus is on a dyadic relationship between the child and one nurturing parent, usually the mother. This first, dyadic relationship is symbiotic in nature and is a nurturing relationship. The child is completely dependent on the mother for food and sustenance. The other parent, usually the father, can turn the dyadic relationship into a triadic one. Britton describes how by entering the relationship this third party can create space for separation and room for thought. Britton refers to this space as ' a triangular space' – i.e. a space bounded by three persons of the Oedipal situation and all their potential relationships (Britton 1989, p 86). The triangular situation breaks open the dyadic situation and creates the opportunity to develop creative thinking about matters in a more abstract manner, thus reducing the risk for enactment. In a triangular space it is possible to be a participant in a relationship and be observed by a third party as well as being an observer of a relationship between two others. Dealing with a triadic relationship is never easy. Waddell characterises a triangular relationship as one in

which 'over and over again … matters of love, hate, possession and separation have to be negotiated' (Waddell 2002 p.65).

As a generative metaphor[11] the concept of triangulation is a worthwhile concept to analyse the dynamics between different players in a systemic setting such as the Healthcare system. Cooper and Lousada (2005) do this when they talk about the third position as the missing link in organisational life, '(A)s with the infant, so with social policy, the move from the dyadic relationship of provisions into a more triangular configuration is undertaken neither smoothly nor without anxiety and confusion and fear. … Oedipal themes are as crucial to organisational life as they are central to individual psychic development' (Lousada 2005, p.119). It is important for individuals to deal with complex and multifaceted relationships. For successful organisational development it is vital as well. As in personal life dealing with triadic relationships in an organisational context is complex and requires careful working through. If triangulation is successful it can be a source of creative thinking in organisations as well.

Benjamin (Benjamin 2004) has taken up the concept of triangulation and thirdness in an interesting way. And she precisely highlights this source of creating thinking. In discussing how the Lacanian and Kleinian view of the third has been developed by among others Britton, Benjamin adds the fascinating dimension of the 'one in the third'. Whereas Britton

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[11] Schon: A generative metaphor carries over of frames or perspectives from one domain to another (Schon, D. A. 1979)

describes how the other parent can turn the dyadic relationship into a triadic one, Benjamin contends that 'the early origins of the third (are) in the maternal dyad' (Benjamin 2004, p.16). She parts with the Lacanian interpretation of the Oedipal view that the father is the sole representative of the third. The father can bring in speech, thought and recognition in the triangular relationship, but before that there is the mother who also communicates but non-verbally, or as Benjamin puts it, 'the experience of sharing a pattern, a dance with another person' (Benjamin 2004, p.16).

If for what ever reason this first and early dance cannot be experienced in the maternal dyad, there is a risk that the idea of the third can develop into a persecutory one, or 'the negative of the third' (Benjamin 2004, p.9). When this happens it is very likely that a destructive process will take shape. The relationship becomes a complimentary relation of two where one acts as a doer and the other feels done to; it is a controller/controlled relationship. Benjamin contends that this form of thirdness 'privileges laws as boundary, prohibition and separation' (Benjamin 2004, p.18) rather than its facilitatory and liberating aspect and this is too narrow an interpretation of the Oedipal triangle. The third in the relationship takes on the form of the punitive super ego: the internal voice that tells us that what we do is wrong. In this form of relationship, the 'element of symmetry and harmony' is missing. Harmony and symmetry can emerge when there is space for the 'one in the third' to develop in the maternal dyad. When that has happened the

dialogue with 'the third in the one' can emerge and this can be the

prelude to a constructive dialogue with the third partner in the triadic

relationship. The 'third in the one' represents the moral and symbolic

forms of thirdness that introduces differentiation. This is the form of

thirdness that can develop in a constructive and creative dialogue with

the third person in the triangle, such as for instance a truly observing

father with an open eye.

In other words, Benjamin states that all the relationships in the triangle

have to be dyadically connected to each other, before a true dialogue of

three can emerge.

What does this mean systemically or psycho-socially for care

organisations?

Before 2006, the relationship between the Dutch care providers and the

care receivers was more or less dyadic in nature. The care provider and

the care recipient agreed upon the sort of care needed. Money was not

an issue that was discussed, since the bill would automatically be paid

afterwards by another entity. This other entity was the government who

distributed the money through the fragmented field of insurance

companies. A dyadic relationship is not necessary always healthy. As

Dartington (2010) points out with reference to the organisational

healthcare contexts, the relationship can be delusional and inward

looking. A third party can provide an alternative perspective and can

open up a discussion for instance. In the present formation in The

Netherlands the insurance companies represent the healthy perspective that money is an issue and that care is not an unlimited resource.

But now that there are three players in the field instead of two, does that mean that a form of successful triangulation is taking place? Evans (2015) describes how the caring profession can benefit from a situation where someone takes up the third position. Carers need to maintain their capacity to separate their own personal anxieties from the anxieties of those they care for. In other words, they need to be able to keep a healthy balance between their own internal reality and the external realty. If this balance is not maintained carers run the risk of identifying too much with those under their care. This can either lead to 'manic or heroic attempt' on behalf of the other that could result in feelings of defeatism. They want to do everything in their power to cure the patient, or in case of Arborvitae and Noturos, the resident. In the case of the residents, no cure is possible however. The best carers can do is care for the resident in such a way they have a more or less comfortable last phase of their lives. Feelings of defeatism can also lead to despair and withdrawal. This in its turn can lead to neglect and even maltreatment of the patient. A care manager who is engaged with the care process can take up the third position in the resident-carer relationship and support carers dealing with the complexity of the caring process and support them in keeping a healthy balance and stay in touch with reality. But that requires a care manager who has the capability and time to think through what it means to take up this third position. And evidence from my research suggests that taking time is exactly what is lacking. It was

striking how little time was taken to think actions through. During interviews and observations at both case studies the metaphor of a high-speed train frequently popped up. Both management and professionals had the feeling they were passengers in this train, that they did not have a clue where the train was heading to and that they had no influence whatsoever on the engine driver. The acting manager of Arborvitae with hindsight wondered if he should not have built in moments of reflection with the management team of at least two hours a month (chapter 6, p. 227). The Managing Director at Arborvitae who took over from the Acting Managing Director said she felt like a bus driver trying to pass a narrow ridge and that the situation was made more complicated and dangerous by the fact that all the passengers attempted to get their hands on the steering wheel as well.

Working through the complexity of a triangular relationship requires time and courage. Management and carers at Arborvitae and Noturos however were trying to cope with survival anxieties. Feelings of anxiety do not support the process of working with complexity. Instead this calls forth defence like reactions.

The triangular relationship in the mind

In figure 8.1 the three mayor players were depicted as though they had the same power. The triangle is depicted as an equilateral triangle. This is not a proper representation of how those working in Arborvitae and

Noturos perceive the other parties. The depiction in figure 8.2 is a better representation of how relationships are experienced.
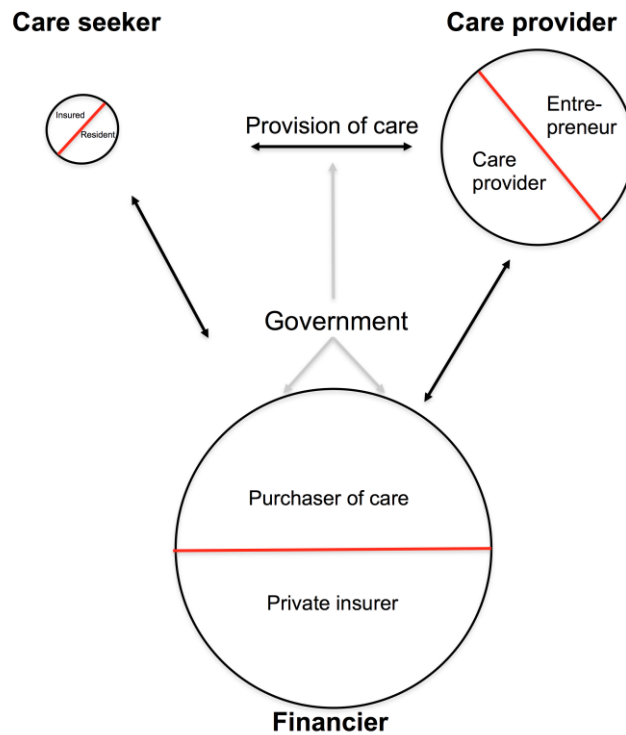
Figure 8.2 The triangular relationship in the mind.

The financier as punitive super ego

Evidence from my research suggest that in the triangular relationship the financier is perceived as the punitive super ego in whose wake a whole secondary system of controlling mechanisms has been developed which now dominates or controls the sector. The financiers are experienced as persecutory. As financiers they want to be able to follow the money and to verify that the money is spent on the right matters. As a result managers at Noturos and Arborvitae spend a large amount of their time meeting the demands of external auditors. And they spend a lot of time on making sure the ZZP structure is in order. They

have made the 'surface auditable (and have) installed systems and performance measures necessary to make verification possible' (Cummins 2002, p.105). Arborvitae experienced to its cost what the consequence could be if this was not the case. As described in chapter 5 (p.138), this organisation narrowly escaped bankruptcy.

With introduction of semi-privatisation came financial constraints. The managers at Arborvitae and Noturos have had to economize, downgrade staff, reduce the number of hours staff can be available, fire food assistants, bring in organisations that help look at how the care process can be organised more efficiently, change shift patterns. All in all this has led to a care process which carers give the impression that they are doing production line work. The changes lead to fragmentation. The ZZP structure is a form of fragmentation in itself. The needs of residents are divided up in care packages that are bought by the care homes from the regional care centres in name of the residents.

Instead of negotiating with the financier about effective forms of spending money and agreeing upon constructive forms of cooperation, it seemed managers at Arborvitae and Noturos felt they had no choice but to yield to the pressure they experience from external parties. In this sense it is not possible to speak of a successful process of triangulation. The time is not taken to think and work through how constructive forms of cooperation could be developed. Instead experience of the players in the field is that the most powerful take over.

At many levels in both Arborvitae and Noturos the metaphors of the market gained prominence. As the data shows (chapter 6), the managers at both organisations often used the vocabulary of the market, almost as though they had 'succumbed' to incorporating the language of the victor. The residents were referred to as clients or customers or as a ZZP number. 'He is a number 5, she is a number 4, we need more number 7s'. After the weekend a manager checked how 'the production' over the weekend had been. Managers used expressions such as 'the Client is King', 'the Client Centre Stage'. A location manager wanted to obtain a Triple A status for all her locations, as if she was working for a Bank. And at both care organisations there were frequent discussions of performance management systems, audits, benchmarks and targets.

The care seekers depersonalised

At Arborvitae and Noturos the residents are vulnerable elderly in their fourth age, moving towards the end of their lives. At two of the four locations where the research took place, the residents were suffering from psychogeriatric illnesses. These residents especially were totally dependent and could only express their needs by indirect means. They were no longer in the position to negotiate about the kind of care they needed and wanted. As such they were not active and articulate participants in the process of triangulation. The care organisations and the financiers make decisions for them and transform what should be a

triadic relationship almost back into a dyadic one again. They take up a 'parental position' and take decisions on behalf of the resident who is no longer articulate enough to speak his or her own mind.

The data emerging from the observations at Arborvitae (chapter 5) and from the interviews with carers and managers (chapter 7) shows that the residents were turned into 'depersonalised subjects'. Managers did this by referring to the residents as clients. In doing so they transformed the caring relationship into a provider-purchaser relationship and simplified the complexity of the care process. In a provider - purchaser relationship goods or services change hands. Providing care is seen as a market transaction, a form of exchange. Tronto (2013) points out that by using the language of exchange the fact is ignored that caring is a intimate matter that involves emotional attachment.

By referring to the residents as clients it is less painful to decide that they have to move to a different room if, for organisational purposes, this is more convenient. In both organisations it happened that the resident had to follow the ZZP rather then the other way round. It will be more difficult to move a resident if you accept that he considers his room as his home and not as a hotel room he rents for the night.

Unsuccessful forms of triangulation causes thick skinned behaviour and as-if like reactions:

Management and especially higher management of both organisations gave the impression of suffering from Attention Deficit Hyperactivity Disorder syndrome or ADHD. Signs of the syndrome are: difficulty in paying attention, difficulty in following through on actions, frequent problems with organising tasks or activity and seemingly being in a state of constant action. The mind of someone who suffers from the syndrome is constantly searching for stimulation and they experience silence as oppressive. Management indeed seemed addicted to action. One plan was dropped into the organisation and the another immediately followed. Care managers and key workers were frustrated by the fact that many such actions were taken without constructing proper foundations. It happened frequently that projects were started up and then aborted before the desired results had been achieved. (See the example of the introduction of lean management in chapter 7 p. 257-263 and comments of the care manager Cecilia in chapter 7 p.185).

Avoiding thinking

The ADHD of the management was contagious. It resulted in a situation where, as one carer said (chapter 7 p. 266), everyone was running around like a headless chicken and avoided thinking. Lawrence and Armstrong (1998) hypothesise that for managers and staff in present-day organisations it becomes more and more difficult to discriminate between thinking that is non-psychotic and psychotic. Psychotic thinking is,

'thinking that is out of touch with psychic reality and is in this sense erroneous. Such thinking is based on a hatred of reality, both in the inner and the outer world. The source of this hatred is the point where reality is felt to be construed as catastrophic chaos of utter unpredictability' (Lawrence & Armstrong, 1998, , p.56)

Psychotic thinking occurs when the inner and outer world cannot be integrated. When the context in which organisations have to operate produces so much anxiety for role-holders this anxiety is often felt as being catastrophic. They have the feeling that a disaster is about to happen, something that cannot be got in perspective or seen in its proper proportion. As a reaction people resort to psychotic like forms of behaviour. Managers can for instance resort to hubristic forms of leadership and start acting as though they are omnipotent. An example of such behaviour was provided by a location manager at Noturos. A substantial amount of her time she focussed on winning gold in audit contests and going to prize-giving ceremonies (chapter 6 p. 196-201). She avoided exploring what was really happening at the locations that fell under her responsibility. When she visited her locations she repeated mantra-like phrases such as that everybody had to realize that 'the Client was King' and that everyone had to stick to the organisational motto that everything they did had to be 'Open, Honest and Transparent'. It sounded like a form of magical thinking. If you say something often enough it will somehow happen. This brings to mind Freud's thinking about the power of groups and primitive religious

groups in particular. In his work Group Psychology and the Analysis of the Ego he cites from Gustav Le Bon's book The Crowd:

> Reason and arguments are incapable of combatting certain words and formulas. They are uttered with solemnity in the presence of groups, and as soon as they have been pronounced an expression of respect is visible on every countenance and all heads are bowed. (Freud 1922, quoting p117 from the Crowd)

The location manager who resorted to this magical form of speaking was not able to work on building sustainable relationships with her middle management. Three care managers and two facility managers either resigned or were fired within a time frame of two years. The blame for the unsuccessful working relationships was placed onto the middle management.

Splitting Management and Staff

In a reaction to the Francis Report (2013) which was published in the UK after major failures in British hospitals Evans (2015) wonders what has gone wrong in the health sector and how come management and staff were reported to 'be beyond caring'. Evans detects fragmentation of authority and an erosion of clear lines of accountability and he sees survival anxiety being pushed into the system. The pattern Evans (2015) detected in the UK seemed to be present at Noturos as well. Survival anxieties seemed to be pushed down from management into the rest of

the organisation. And this created a split between the management and the carers. At Grenier the carers felt no containment and support from the higher management. Instead the staff had the impression that they could not do much good in the eyes of the management. They felt not listened to and withdrew to their own island. The staff room was turned into a location from which subversive actions were undertaken. The bulletin board in the room contained newspaper clippings and other articles against the changes in the care sector. During the night shift more subversive actions took place. It emerged that the night shift ignored many of the directives on how to deliver care and what to write in the care plans.

The survival anxieties are not just fantasies; they have a clear basis in reality. This fear for survival creates a spilt within the organisation. Managers have to focus on meeting the needs of the financiers; they have to focus on keeping the organisation afloat and meeting the demands set by external parties, they are caught up in the social panic about ever increasing costs. The carers are left to deal with the deeper cultural anxiety related to fear of dependency and dying, an anxiety embodied in residents and their families as well as the wider society. Both at Arborvitae and Noturos staff felt overwhelmed by the changes arising from management's attempts to address the social panic around costs. They had seen it all before and with every change they saw deteriorations. The change in shift patterns, for instance, had left them with very little overlapping time between shifts. This made it harder to stay informed about the residents. At Noturos they had abolished the

weekly meeting during which they shared information on all the residents. This information now had to be retrieved from the computer. When they complained that this was poor replacement for the staff meeting, management interpreted this as a form of irrelevant complaining. Higher management showed little empathy with the staff, as a result the staff showed little empathy with the management. One can only fear what the consequence will be for the residents. The carer Joyce noticed that carers were rude to residents (chapter 7 p. 291). This could be regarded as a first step to saying: I am beyond caring. I did not observe any neglect yet in the shape or form as discussed in the Francis report, but the risk was there. The anxiety in both organisations was creating an 'as if' culture. We pretend we deliver good care, yet we all deep down know we are not. Malcolm described the 'as if' phenomena as: '… the outward impression of understanding and progress, while in fact the whole process lacks something real, does not feel genuine and seems to be going nowhere'. This 'as if' behaviour is 'like any other defence or resistance against insight' (Malcolm 1992, p 114).

Evidence from the research suggests that there was considerable impression management. The pretence went something like this: 'if we run the care home as an efficient business, meeting our objective targets and the demands set by the external auditors and the inspection of Healthcare (IGZ) we deliver good care'. However, whilst it might look as if the organisation is delivering good care in a subtle and perverse

way it is weakening the very thing it says it seeks to improve. Management and staff in the organisations consciously or unconsciously resort to gaming, adapting behaviour to meet the requirements that they experience as voices from the outside telling them what to do, the super ego voice, coming from the negative third.

The Business Discourse Triumphing over the Care Discourse

At three of the two locations where the research took place the care discourse was losing in its struggle with the business discourse. Carers saw the time that they could spend with residents decrease. The time they had to spend behind the computer increased. Carers have to fill in detailed forms and care plans. However they are apparently not trained to analyse the data and make it work for them. Key workers noted that carers did not take the time to observe residents properly (chapter 7. p. 268). This provided key workers with insufficient data to make proper judgements regarding the care that residents needed. It is almost as if the care plans had become a kind of fetish, a thing in its own right, an obsession almost.

In the Munro Review of Child Protection (2011) Munro calls the approach to endlessly collect data and put it into the computer a 'rational-technical approach'. She states that this approach created the belief that a 'good enough' picture of the patient or resident can be formed from the computer records. She points out that however important recorded data might be, it does not contain any of the thinking

of those working in the care profession. The reliance on the computer has created the misconception that the most important work of the care professional is carried out on the computer. If you were to talk with residents and their families however they would say that the most important aspect the carer's work is the relational aspect.

The Munro Review focussed on the childcare sector. However many aspects that Munro observed in the childcare sector also happen in the healthcare sector. The key workers that were interviewed complained about the computer work and noticed that the data in the computer did not paint the complete picture. According to key worker Karin, the care process had been cut up too much and had become too instrumental. In her opinion the threshold of what is still humane was about to be crossed or had already been crossed (chapter 7 p. 269-273). Carers had the impression they only had time to focus on the psychical well-being of the residents. They had to rely on volunteers or relatives of the residents to focus on the emotional well-being of the residents. The complexity of care is denied in this way. Care is treated as if it is an instrumental process that just has to be organised as efficiently as possible. Once that has been done, the problem has been solved.

Tronto and Fischer (Tronto, 2013) define caring as a complex process. They distinguish four phases in this process: phase one, *caring about,* phase two *caring for,* phase 3 *care-giving and* phase 4 *care receiving.* Tronto herself added a fifth step: *caring with.* She also identifies moral

qualities that align with each phase. Phase one requires *attentiveness*, the quality to notice if care is needed. Phase two requires *responsibility*, the quality of meeting the care needs. Phase three requires *competence*, the quality to be able to provide the needed care. Phase four requires *responsiveness*, the quality to observe whether the care needs have been met successfully. For the fifth phase Tronto identified not just one quality but the following four: *plurality, communication, trust and respect and solidarity*. The key workers and carers at three of the four locations where the research took place could only really focus on phase 3: care-giving, yet without proper attentiveness, with unclear lines of responsibility, without time to have a proper chat with the residents, without trust and respect, the deliverance of care can hardly be done in a competent way. According to the definition of Tronto/Fischer this form of care can only be regarded as dysfunctional.

To use Benjamin's phrase (Benjamin, 2004) key workers and carers at both organisations felt that they were 'being done to'. They felt their working circumstances were bad and that this was affecting the quality of their work. They felt drained, emptied and squashed. The phrase, *feeling being done to*, brings to mind Benjamin's question how we can get 'beyond doer and done to' relationships to something more symbiotic. As she states this requires another view of intersubjective thirdness: a form of triangulation where 'the one in the third' is allowed to be.

The Care Discourse Triumphing over the Business Discourse

At one location at Noturos, at Volte-face, the care discourse (still?) took precedence over the business discourse. At Volte-face the atmosphere was different from the atmosphere at any of the three other locations where this research took place. At this location key workers and carers were proud of their work and able to provide quality care to the residents. What was different at this location compared to the other three locations and how come carers at this location did not succumb to the feelings of fear and anxiety to which carers at the other locations within the same organisation had succumbed to? The care manager at Volte-face knew all the residents and knew their background. She made sure that she was present at every intake with new residents. She knew all her staff. She made sure she was present at every interview of new staff. The carers knew they were in her mind and that they could approach her if they needed her. This did not take the form or shape of dependency. I saw carers at this location who took up their own authority and were there when the residents needed them.

Nevertheless Noturos was putting pressure on the care manager to spread her attention to other locations. They were spreading her thin, by requesting her to become care manager of a second location. One day I found her sighing that everything was becoming too much for her and that she was feeling out of breath and did not have enough time to think matters through properly.

Intelligent Kindness

At this location I saw what Ballat and Campling (Ballat and Campling 2011) refer to as 'intelligent kindness'. Intelligent kindness is a form of care that places kinship and kindness at the heart of the care process. It focuses on the interdependence of people. Ballet and Campling regard the acceptance of interdependence as the 'glue' of cooperation, echoing Tronto, Kittay, Sevenhuijsen and Lloyd. It is a plea to bring moral aspects into the care work and not just to focus on the instrumental and business-like aspects of the care process.

But this is not just kindness but intelligent kindness, and this requires a balance between providing good care on the one hand and at the same time not losing sight of the fact that efficiency and effectiveness are important a well. It is a plea for integration. In the following figure they bring the whole concept together:

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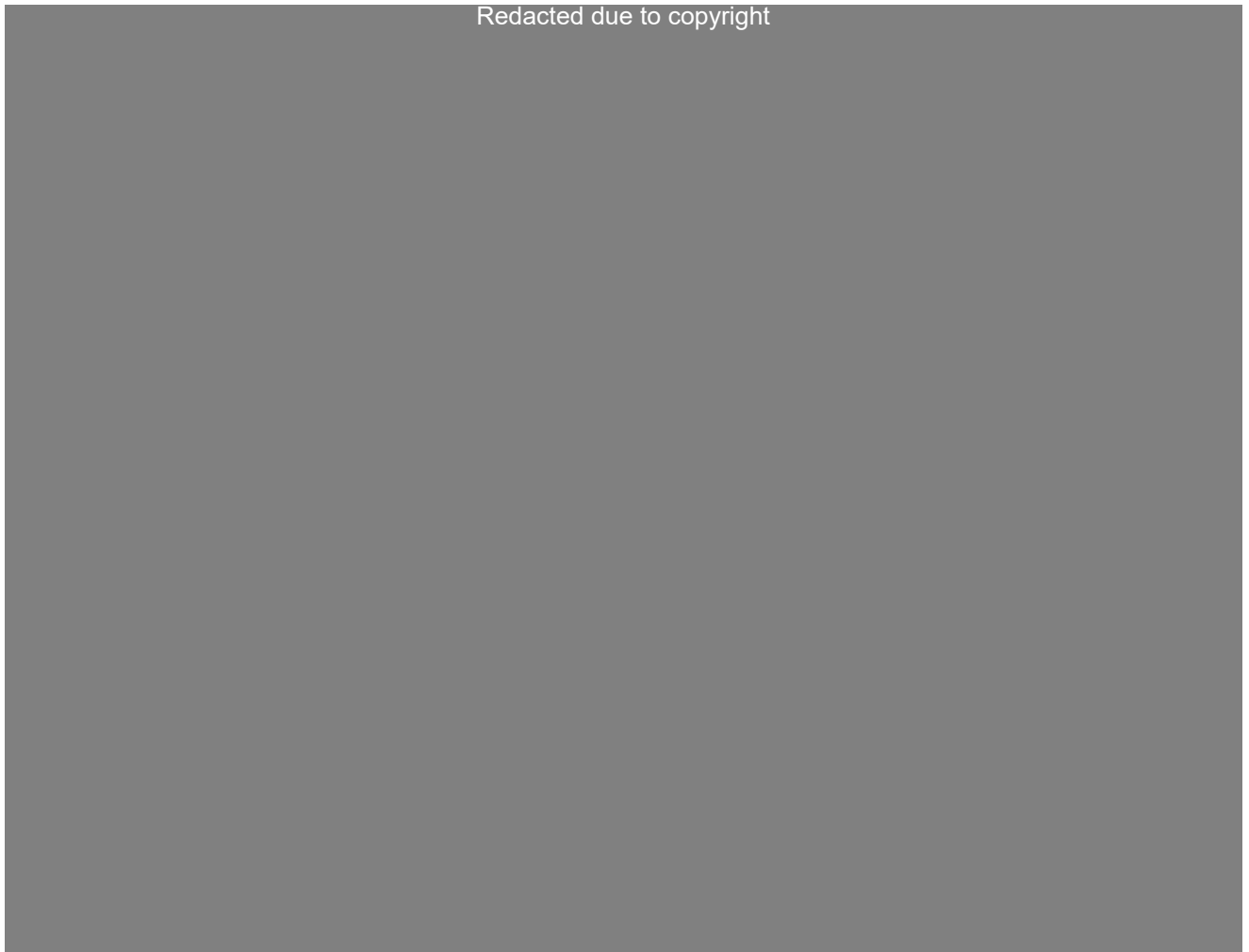
Figure 8.3 Intelligent Kindness

Effective care requires that those working in the sector, regardless of

their role, are able to manage the anxiety that the work evokes and can

manage themselves in their role. Everyone working in the sector has to

manage the balance between targets, standards, and protocols etc. on

the one hand and kindness and attentiveness on the on hand. Just

focussing on the targets and the protocols can lead to distraction,

fragmentation and ultimately to brutality (the red arrow). The right

balance can lead to skilful and compassionate forms of work. This

requires the integration of 'the one in the third' (the feminine) and 'the third in the one' (the masculine).

Volte-face was proof that it is possible, even in the present climate in The Netherlands, to work like this. Leadership was a crucial factor in this. This location was the brainchild of the care manager. She had been involved with the location from the moment it was conceptualised. She had worked with the architects on the design of the location. She had hired every staff member herself and she still managed to be present during every intake meeting of new residents. The care manager was able to hold the whole location in all its complexity in mind. She was able to keep on thinking and to focus on the residents as complete human beings. During each intake the focus was on getting to know a much as possible about the personal history of the new resident and his or her context.

This location had a secure boundary and the care manager was aware that she had to work on keeping this boundary secure. Systemically it helped that the managing director of Noturos and the location manager of Volte-face loved the location. They regarded it as the jewel in the crown of the care group. The care manager left the marketing of the location to them. She did not attend external ceremonies where the location was held up as an example to others. The location manager went to these. The care manager focused on balancing internal and

external requirements. Key workers and carers felt supported by her and respected her highly.

Volte-face is proof of the importance of a positive and secure form of containment. Britton (1992a) describes how secure enough forms of containment are a prerequisite for being able to hold things in mind. Being able to hold things in mind is a prerequisite for the ability to keep on thinking and developing. At this location the complexity of care was not lost sight of.

Ballat and Campling (2011) write about how teams can only put their mind to staying in touch with these aspects of care if they are cared about themselves, when they are supported as a team and can work through their team issues. They refer to research done by Haigh (Haigh, R. 2004) on the needs of staff in healthcare settings. Haigh lists five prerequisites for a strong team:

1) Teams need a sense of attachment or a culture of belonging where staff are encouraged to be part of things. At Volte-face they had formed fixed teams. Each team was responsible for the running of a unit. There was just enough overlap for the team members to see each other around shifts.

2) Containment: or a culture of safety were staff feel supported. This was the case at Volte-face. Staff rarely left, and staff members who had worked at other locations experienced it as a relief to work at this location.

3) Communication or a culture of genuine openness. At Volte-face I observed two team-meetings where team members communicated with each other in an open and creative maker.

4) Involvement or a living and learning environment in which it is possible to discuss difficulties and where mistakes can be talked about. Again teams seemed to be able to discuss with each other what could be improved and how they could learn from past mistakes.

5) Agency, or a culture of empowerment in which staff are involved in a part of the decision making process. The care manager held weekly team meetings with all the units and took them seriously.

At this location the focus was on the discourse of care - the internal triangle of figure 8.1, the outer triangle, the business discourse, was not the primary focus. The triangular relationship in the mind at this location is as represented in figure 8.4:
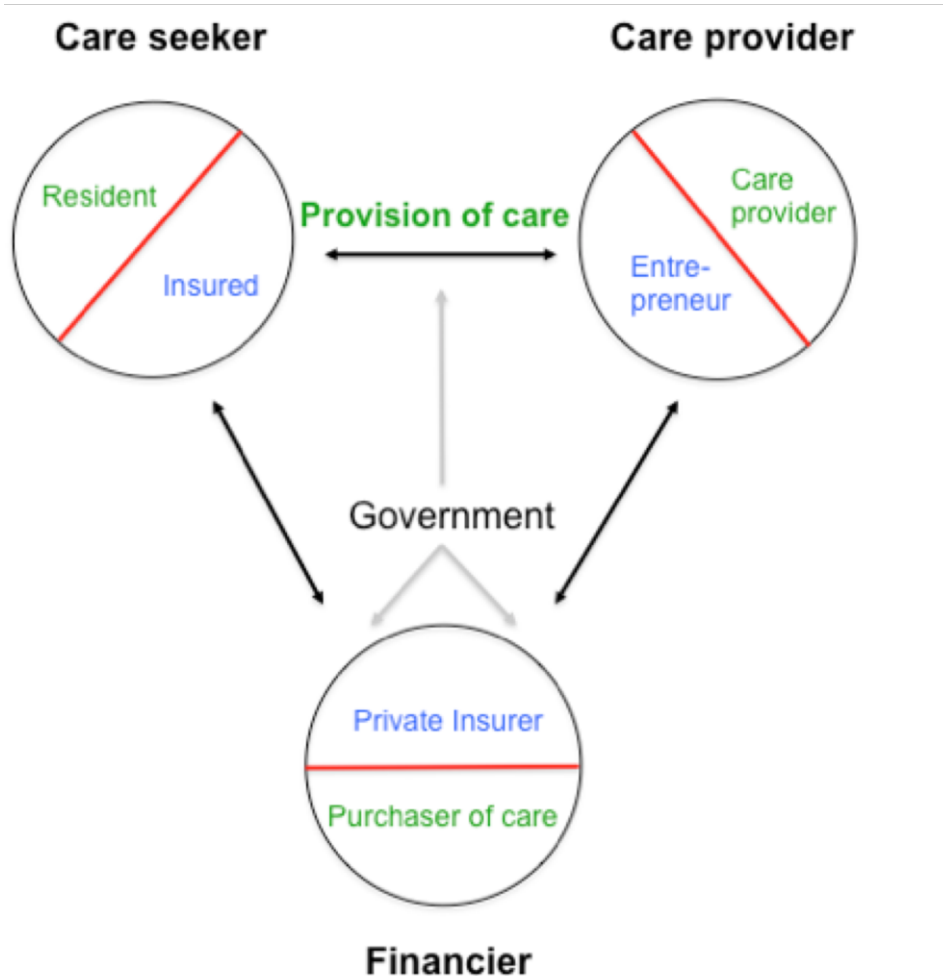
Figure 8.4 The triangular relationship in the mind at Volte-face

The research at Volte-face revealed that the role of the care manager was vital in this. She involved the staff in external requirements where she considered this helpful for the improvement of the care process. She protected them as much as possible form the anxieties that audits provoked. The fact that her role was so vital also revealed the vulnerability of the situation. The care group tried to copy what happened at this location in other locations and held the location up as an example to everyone else. But it cannot be a matter of copy and

paste. It requires working with complexity, working through the complexity of care. In requires daring to face vulnerability, the vulnerability of the residents who are in their fourth age, the period of deep old age, and who perhaps no longer are able to grasp what people say to them. They will probably understand music though. Research and experience has shown that patients suffering from psychogeriatric illness light up if they listen to music or hear songs from their youth. It also requires that management and carers listen to their own anxieties, fears and insecurities and dare to discuss these without fear of being punished for making mistakes. And above all it requires a management who negotiates with the financiers on an equal footing. The focus has to be on the discourse of care, the discourse of business should only take up a supporting position. And this means that all the sides of the triangle have to be dyadically connected to each other. Only then can a true and free dance between the three come into existence. This implies that financiers, managers and carers have to go beyond dualism. Triagulism has to come in its place. And this requires time to reflect and think. Based on the research which came out of infant observation as described in chapter four, the conclusion was drawn that a child can only start to think after it has been thought about enough by its parents and carers – if they have thought about it as a subject in its own right. In the 1820s Alexander von Humboldt observed that 'with knowledge comes thought and with thought comes power.' (Wulf 2015, p. 193). So, again when we transfer this to the care sector. When those working in

the sector take the time again to think and reflect, they will be able to take up their authority.

These conclusions can also be transferred to carers providing care to the vulnerable. Only when those working in the sector take the time again to feel, think and reflect and know that their managers (or others who could provide containment through their role) have thought about them enough as carers in their caring role can they begin to see the residents as true subjects. Only then can the three roads meet.

Chapter 9

Synthesis

At the start of this research project I formulated the following research objectives: to provide an analysis of the impact of the semi-privatisation of health and social care in The Netherlands on the lived experiences of managers and professionals in healthcare institutions and the effect this has on their values, identities and behaviours. In addition the aim was to investigate those factors that support and hinder the healthcare sector in maintaining its capacity to contain public anxieties about sickness and vulnerability.

These objectives led to research questions focussing on the management, the professionals and the issue of emotional containment. In chapters five to seven I have presented the findings collected at two Dutch care organisations that provide care for the elderly. In this chapter I will discuss and analyse these findings and answer the research question.

In relation to Management I formulated the following research questions:

1. In what way have the managers incorporated the discourse of neo-liberalism into their work and in what way does this influence how they manage?

2. How do managers experience the role of the regional care centres, the centres for care assessment, the insurance companies, the inspection and the independent bodies, etc. that monitor the sector?

3. How do they experience the pressure of constant change and what do the changes entail? What degrees of anxiety does this evoke - positive, persecutory, or catastrophic, and what is the effect of this?

4. What images of the organisation does the management have and how does this inform their day-to-day work? E.g. how do they see their role?

5. What 'social defences' characterise the subsystem of the management and why?

In relation to care professionals I formulated the following research questions:

1. How do those in professional and service provider roles experience the role of the regional care centres, the centres for care assessment, the insurance companies, the inspection and the independent bodies, etc. that monitor the sector?

2. How do those in professional and service provider roles experience the role of management?

3.	What images of the organisation do professionals and service providers have and how does this inform their day-to-day work? E.g. how do they see their role?

4.	How do they experience the pressure of constant change and what do the changes entail? What degrees of anxiety does this evoke positive, persecutory, or catastrophic, and what is the effect of this?

5.	How do those in professional and service provider roles experience the role of the client?

6.	What social defences characterise the subsystem of those in professional and service provider roles and why?

In relations to containment and anxiety

- How do those in professional and service provider roles cope with the dilemma of engaging with two contrasting discourses (discourse of the market vs discourse of care)

- Do those in professional and service provider roles feel pressure to collude with situations they disapprove of?

- In what way are the professionals affected by the audit explosion that has become part of the sector?

- Do the changes within the system lead to more or just to different forms of fragmentation compared to the pre-neoliberal period?

- What form of containment do the professionals experience from the management within the organisation and what is the effect of this?

In chapters 5-8 I have tried to find answers to these questions. I do not claim to have found all the answers. More psycho-social oriented research will definitely be needed to explore these important questions further.

I do think my research has shown that the pressure on those working in the sector is large. Both management and carers are required to contain a lot for society as a whole, without them receiving the containment needed for them to do their work in a way that would really support the elderly under their care. I draw your attention to two important publications: *The emotional labour of Nursing Revisited, Can Nurses still Care?* By Pam Smith (2012) and *Leading Good Care, the Task and Art of Managing Social Care,* by John Burton (2015). Due to unexpected time restraints, I have not done these publications justice yet in chapter 3. I do hope that the importance of the emotional labour will be picked up more and more in the Dutch care sector. John Burton shares his inside knowledge with managers in the care services. His words are worth listening to and more than that.

This research project has been a personal learning curve as well. I have enjoyed enormously working on this project for seven years. Slowly but

steady I found my way into the research role. Supervision was vital in this. Both my supervisors Paul Hoggett and Mathew Jones, each in their personal way, taught me how to approach this project and to learn to trust my skills and judgement. I felt contained by my supervisors and they helped me to grow. Last summer (in 2016) Paul and I caught up in Amsterdam. Full of enthusiasm Paul spoke of the publication *The Invention of Nature* by Andrea Wulf that he had been reading while traveling on the Hurtigruten, or Norwegian coastal express. I am now reading this book. In no way I am comparing myself to Alexander Humboldt, whom this book is about. What is fascinating about Humboldt however, amongst many things, is that he came to see that we can only understand the world around us if we see it with both our head and heart. Scientists have to integrate the subjective and the objective. I hope that with the ideas on triangulation, as discussed in chapter 8, I have started a creative thinking process that, those working in the care sector, can use to start working with the complexity of their work.

Part of the data gathering was done with the help of my colleague and close friend Marijke van der Heijden. Together we founded the consultancy business called Zoom Consulting. Our motto was that you have to do your work by thinking with the senses and feeling with the mind. This was the motto of the 52nd Art Biennale in Venice 2007. 'Pensa con i sensi/senti con la mente l'arte al presente'.
This is how we approached the consultancy work at Noturos. This is how I tried to work gathering the data for my research.

Both Marijke and I have had the privilege of being taught by Erica Stern. Her thinking and feeling is behind the masters programme Coaching, Consulting in Context at Utrecht from which both Marijke and I graduated. Erica Stern also did consultancy work occasionally and she said that she always prided herself in the fact that people in the organisation realised that matters were much more complex than they thought they were before she came. I hope I have achieved the same thing with my research. Working in the care sector cannot be a matter of copy and paste. It is not just one discourse that has the answer. It requires working through difficulties and dealing with complexity.

During the cause of the research my father died. Two years after his short stay in Arborvitae he died at home, as he would have wanted. He died of mortality at the respectable age of 88, almost 89. He was very interested in my research although he never quite seemed to follow what I was doing exactly. He was more into physics and astronomy. I don't think he has ever read the work of Oliver Sacks. Yet I am sure he would have full heartily subscribed to what Oliver Sacks writes in his essay *The Periodic Table:* 'I Have tended since early boyhood to deal with loss … by turning to the nonhuman. When I was sent away to boarding school as a child of six at the outset if the Second World War, numbers became my friends.' (Sacks 2015, P.26). My father turned to the stars. As a young boy he lived in Rotterdam during the Second World War. During the night all the lights were out. So he had ample

opportunity to sit in the window at night and look up at the sky and learn all the galaxies by heart. In 2005 we visited South Africa as a family (my parents, my brother Gerard and his wife Hanneke, their two daughters Bella and Quita, Leo, my soul mate and partner in life, and I). There we saw the galaxy of the Southern Hemisphere. I will never forget the evening when my father, Gerard and Leo and I spotted the Southern Cross also known as the Crux. It felt like a moment of great connection with life.

Only a few weeks ago I heard I will most probably die of mortality as well pretty soon. This process is accelerated by the fact that I am suffering from a form of Non-Hodgkin's disease that turns out to be immune to chemotherapy. The medical sector has not found any form of alternative treatment yet that can combat this disease.

My illness gave me direct contact and experience with the health care sector. I came across very good doctors and nurses dedicated to their work. I also was able to experience as a patient, that you are part of a complex system. It is very easy for things to go wrong. I am proof in fact of Lloyd's observation that people in between their 50s-60s cost the health sector much more money that people in their 80th.

My father no longer saw the need for extensive care. In the end he felt he had lived his life. It was time for him to go. He died in his sleep. He

felt that society no longer had room for him. 'There is no place for old people in the present time', he said.

He was my parent who could dance. We could dance together. Although not very proficiently and perhaps we should have tried more often. My mother now has to face her own vulnerability without the support of her life partner. And that is difficult, but she is working hard.

I do not feel like dying yet. Life has so much to offer. But then, the odd thing is that deadlines do help. They help you to find focus and to pay attention to what is really important and it gives clarity. Bion wrote that we have to deal with uncertainty and not knowing. Both Paul Hoggett and Elisha Davar shared their observations that Bion never explicitly wrote about these matters in relation to illness. Elisha Davar shared that Melanie 'Klein thought that being in touch with good objects through difficult times has survival task. So the Bionic task would be to keep in order that the good objects are kept in order'. (Davar 2016, unpublished e-mail). So this is indeed what I am trying to do right now.

In this PhD, I tell a psycho-social story. I have always loved stories. In the book The Crane Wife by Patrick Ness, two main characters discuss the art of storytelling.

> The extraordinary happens all the time. So much so we can't take it. Life and happiness and heartache and Love. If we could not put it in a story -

'And explain it -'

'No, she said suddenly sharp. Not explain. Stories do not explain. They seem to, but all they provide is a starting point. A story never ends at *the end.* There always is an after. And even within itself, even by saying that this version is the right one, it suggests other versions, versions that exist in parallel. No, a story is not an explanation, it is a net, a net through which the truth flows. The net catches some of the truth, never all, only enough so that we can live with the extraordinary without it killing us' (Ness 2013, p. 141-142).

My first university degree is in English Language and Literature. I studied at The University of Amsterdam and for one year the graduate school of CUNY, New York (as part of my Dutch degree). George Eliot and Samuel Richardson and Virginia Woolf became my favourite writers. I wrote my thesis 'An owl in the desert' on Samuel Richardson's amazing novel Clarissa. My supervisor was Marijke Rudnik Smalbraak. Her publication on Samuel Richardson is called *Samuel Richardson: minute particulars within the large design (1983).* Marijke Rudnik knew I had started on this PhD journey. And she was following with interest what I was doing. Unfortunately Marijke left us too soon as well.

Somehow I feel that things are coming full circle: it is indeed about minute particulars in the large design.

Leo, my soul mate and partner in life has always felt very close on my journey. We have been travelling together for more than 30 years and will do so till the end is there. I feel as though we met only yesterday. Time flies when you are having fun. But then it can also suddenly feel infinitely beautifully long and eternal.

Siebelien Felix

Amsterdam 2016

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Lucebert

Verzamelde Gedichten, © 2002, First published in 1954,

De Bezige Bij, Translation: 2011, Diane Butterman

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Appendix 1

Overview of the Actors in the Dutch Health Care Sector
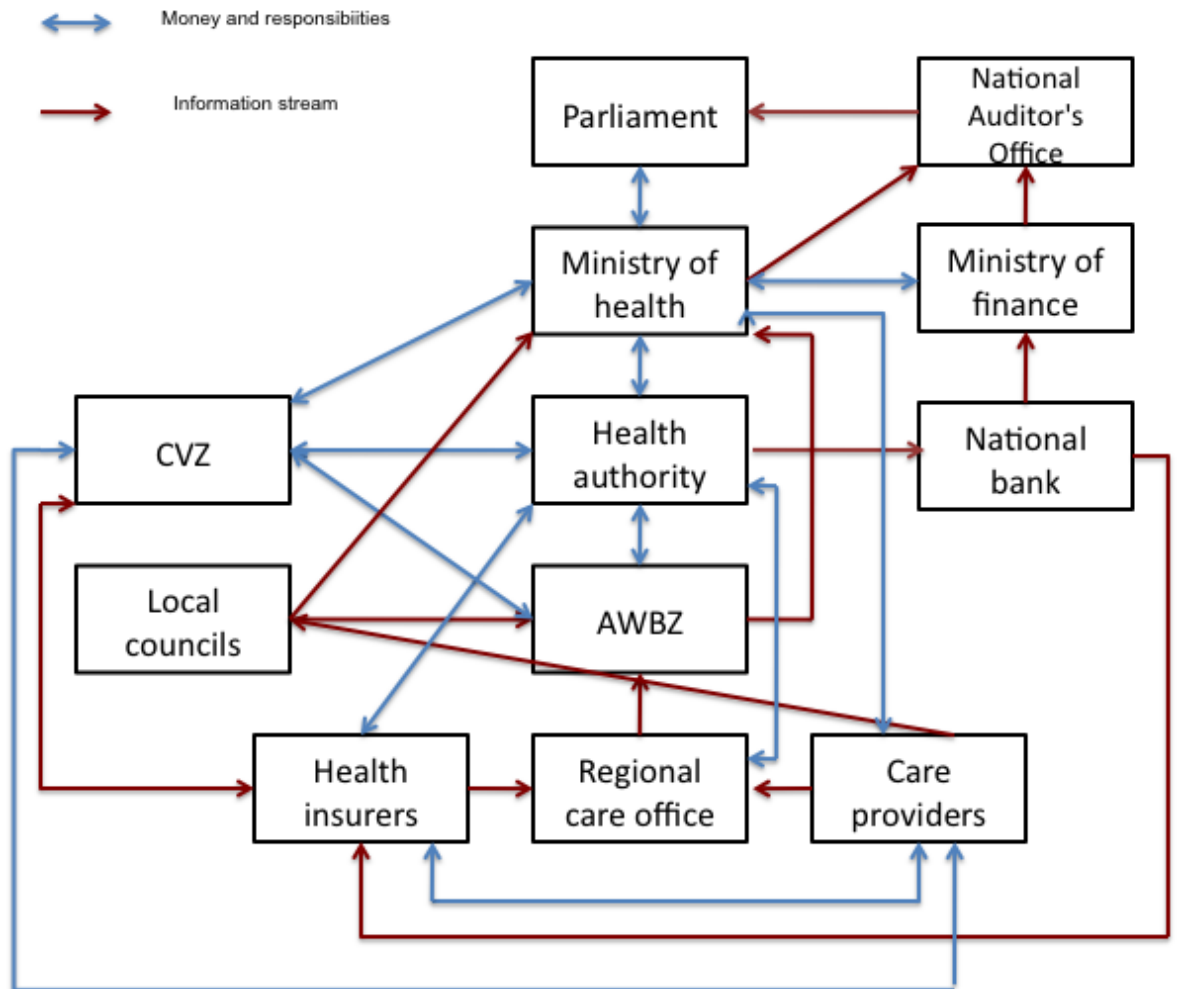
List of Abbreviations

ZVW	Zorgverzekeringswet	Health Insurance act
WMO	Wet maatschapplijke ondersteuning	Act on Social Assistance
AWBZ	Algemene Wet Bijzondere Ziektekosten	Act on Special Health care Costs
NZa	Nederlandse Zorgauthoriteit,	Dutch Health care authority
CvZ	het college voor zorgverzekering	Board for health insurance that advises
CIZ	Centrum voor indicatiestelling Zorg	Centre for Care Assessment.
IGZ	Inspectie voor Gezondheidzorg	The Inspection for Health care
ZBC	Zelfstanding Behandelcentrum	Independent Care Centre
DBC	Diagnostische Behandel Combinatie	Diagnostic treatment combinations.
ZZPs	Zorgzwaarte Pakket	Severity of care packages
NMA	Nederlandse Mededingingsauthoriteit	Netherlands Competition Authority

Consumer Groups and Branch Organisations

LOC	Landelijke clientenorganisatie in zorg en welzijn	Client Organisation
NPCF	Nederlandse Patienten Consumenten Federatie	Dutch Patients and Clients Federation
GGZ	Geestelijke Gezondheidzorg	Branch Organisation Mental Health care
BTN	Branchebelang Thuiszorg Nederland	Branch Organisation for providers of Domestic Care
VGN	Vereniging Gehandicaptenzorg Nederland	Foundations for care of the handicapped
VNG	Vereniging Nederlandse Gemeenten	Foundation for Dutch Councils

Appendix 2
Timeline and Overview of Research Encounters at both Case Studies

1. Noturos Care Group:

- 28 nov 2011 first meeting with CEO of Noturos care group and Head of Personnel to explore if I could do research at the organisation.
- 6 January 2012 approval to come and do research
- 12 January 2012 first meeting with Josephine, location manager of four care locations at Noturos: Volte-face, Grenier, Minte and Mylen . A tour around the care home Minte and introduction to staff members and carers.
- 7 February 2012 interviews with two managers care Minte and Grenier
- 6 March 2012 interview with a manager care Grenier
- 13 March 2012
    1. meeting with CEO and the Location manager a
    2. Lunch with location manager
    3. Request is I could do consultancy work at Grenier
    4. Interview manager care
- 22 March 2012 observing and audit at Volte-face
- 6 April 2012 CEO and Josephine accept proposal on consultancy job at Grenier
- 11 April 2012 interview interview with manager care Volte-face and meeting carers of Volte-face, visiting units
- 17 April 2012, being present at meeting of Josephine and a member of the personal department and a consultant on developments at Grenier
- 15 May 2012 observing at an information and working session for al the staff member of Grenier during with the location manager gave a presentation and introduced two new managers care
- 11 June 2012 observing at Grenier morning and afternoon
- 15 June 2012observing at Volte-face morning and afternoon
- 18 June2012 observing a team session at Volte-face morning and afternoon
- 4 July 2012 start of consultancy - first coaching session with two new managers Care
- 28 August 2012 meeting in at Minte with Josephine, location manager to discuss consultancy process at Grenier
- 6 September 2012
- supporting new managers Care with the application process of new key workers
- 16 October 2012 coaching session with managers Care and observing a team meeting manager Care and key workers, carers and support staff
- 12 November 2012 team coaching key workers
- 27 November 2012 meeting with the location manager and coaching session with managers Care
- 3rd December 2012 team coaching key workers
- 8 January 2013
    1. meeting with location manager

2. Coaching managers Care
- 12 February 2013 observing audit at Volte-face
- 26 February 2013 team coaching key workers
- 6 march 2013 meeting with location manager
- 19 March 2013 first of five full day team workshops with key workers, carers and support staff
- 20 March 2013 2nd workshop
- 3 April 2013   3rd workshop
- 9 April 2013   4th workshop
- 10 April 2013   5th workshop
- 17 May 2013   coaching managers Care
- 28 May 2013   meeting with location manager
- 25 May 2013   evaluation consultancy process with managers care
- 26 August 2013   closing of consultancy job
- 4 November 2013 interviews two carers and support staff at Volte-face

2. Arborvitae:
1. 21 November 2011 meeting with acting manager to discuss if I could do research at Arborvitae
2. 10 January 2012 meeting the management team Arborvitae
3. 23 February 2012 interview manager Care
4. 26 February 2012 interview acting manager
5. 15 March 2012 interview manager activities
6. 27 March 2012 interview former manager
7. 30 March 2012 meeting with acting manager to preparer organisation in the mind workshop
8. 24 April 2012 observing a memory training for residents
9. 10 May 2012 Organisation in the mind workshop with management
10. 3 June 2012 observing a meeting were residents and their family were informed about the future plans or Arborvitae
11. 14 June 2012 interviews manager care, key workers, and two carers
12. 30 August 2012 till 30 November parents living in Arborvitae
13. 8 October 2012 observing at psychogeriatric unit
14. 16 October 2012 meeting with acting manager
15. 25 October 2012 observing at psychogeriatric unit
16. 29 October 2012 observing at psychogeriatric unit
17. 6 November 2012 observing at psychogeriatric unit
18. 20 November 2012 observing at psychogeriatric unit
19. 27 November 2012 observing at psychogeriatric unit
20. 3 December 2012 observing at psychogeriatric unit
21. 10 December 2012 observing at psychogeriatric unit
22. 7 January 2013 observing at psychogeriatric unit
23. 21 January 2013 observing at psychogeriatric unit
24. 25 January 2013 interview acting manger
25. 31 January 2013 Meeting new CEO Arborvitae

26. 15 march interview manager care
27. 18 march 2013 meeting CEO
28. 15 april 2013 group interview 3 carers
29. 2 July 2013 meeting CEO
30. 7 October interview key workers and carers
31. 6 december 2013 last meeting CEO
32. 7 april 2014 meeting new location manager. Arborvitae has become part of a large care organisation
33. 3 June 2014 Interview two managers care
34. 16 july 2014 interview key worker

Appendix 3: Informed Consent Forms

Informed Consent Form: Interviews (Translation from the Dutch version)

Research into the effect of the (semi-) privatization in the Dutch Healthcare sector and how these changes are affection those working with the sector

> You are being invited to take part in a PhD research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part or not. Thank you for reading this.'

The purpose of the study

> The aim of this research is to investigate the impact of the (semi)-privatization of the Dutch health and social care sector on the emotional experience of those in professional and service provider roles

What you will be asked to do in the research?

> Are you willing to participate in this research? I am approaching you to see if you would be willing to be interviewed. There will be two interviews, each lasting approximately sixty minutes. During the first I will interview you on your life story and focus on possible biographical sources that motivated you to work in the healthcare sector. During the second interview we will focus on your professional role and explore how the changes in the sector are influencing your work.

Do you have to take part?

> It is up to you to decide whether to take part or not. If you do decide to take part you will be given this information sheet and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What are the risks involved in taking part?

> As a participant you always have the right to call a halt to your involvement at any time during the research process. If you decide to withdraw your data will be destroyed.
> You also have the right to receive transcripts of the interviews or any summary of the emerging findings.

> If the interview turns out to be stressful and you feel you need to talk things through with a independent professional counsellor your can contact mw. M van der Heijden : 020-25008834. This consult will be free of charge.

Will what I say be kept confidential?

As a researcher I will treat anything you say with the utmost confidentiality. The information gathered will be stored on a stand-alone computer that is password protected and is situated at location where no one of your organisation has access to. All the data gathered will be generalized and no data will be attributable to a single source or person.
The data will be kept for six years, after which period everything will be deleted.

What will happen to the results of the research study?

The findings will lead to a PhD thesis and might be published in journals. If you wish so you can receive a summary of the results.
You will most probably also have the opportunities to hear about the research findings, for example by attending a meeting. During this meeting I will again not attribute anything to a direct source or person.

Who can you approach when you have complaints?

In case you have complaints about the researcher you can contact my director of study Paul Hoggett,. Professor of Social Policy, Director of the Centre for Psycho-Social Studies
University of the West of England, Bristol: paul.hoggett@uwe.ac.uk

Contact detail researcher:

Siebelien Felix, ████████████████████

Thank you

Thank you very much for taking the time to consider getting involved in the research.

CONSENT FORM

Research into the effect of the (semi-) privatization in the Dutch Healthcare sector and how these changes are affection those working with the sector

Siebelien Felix Phd researcher at the University of the West of England
Contact address: ██████████████████████
██████████████████

	Please <u>tick</u> box
1. **I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions**	☐
2. **I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason**	☐
3. **I agree to take part in the above study**	☐

Please tick box

YES   NO

4. **I agree to the (group) interview / consultation being audio recorded**	☐ ☐
5. **I agree to the use of anonymised quotes in publications**	☐ ☐

_____   _____   _____

Name of Participant   **Date**   **Signature**

_____   _____   _____

Name of Researcher   **Date**   **Signature**

Informed Consent Form: Group interviews (Translation from the Dutch version)

Research into the effect of the (semi-) privatization in the Dutch Healthcare sector and how these changes are affection those working with the sector

> You are being invited to take part in a PhD research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part or not. Thank you for reading this.'

The purpose of the study

> The aim of this research is to investigate the impact of the (semi)-privatization of the Dutch health and social care sector on the emotional experience of those in professional and service provider roles

What you will be asked to do in the research?

> Are you willing to participate in this research? I am approaching you for a group interview.

> During a group interview you will be part of a group of 4-5 members of your organisation involved in similar work to yourself. This interview will last 1,5 hour. The focus during this interview will be on your professional role and explore how the changes in the sector are influencing your work.

Do you have to take part?

> It is up to you to decide whether to take part or not. If you do decide to take part you will be given this information sheet and asked to sign a consent form. If you decide to take part you are still free to withdraw from the discussion at any time and without giving a reason.

What are the risks involved in taking part?

> As a participant you always have the right to call a halt to your involvement at any time during the research process. If you decide to withdraw your contributions will not be included in the data analysis.
> You also have the right to receive transcripts of the interviews or any summary of the emerging findings.

If the interview turns out to be stressful and you feel you need to talk things through with a independent professional counsellor your can contact mw. M van der Heijden : 020-25008834. This consultation will be free of charge.

Will what I say be kept confidential?

As a researcher I will treat anything you say with the utmost confidentiality. The information gathered will be stored on a stand-alone computer that is password protected and is situated at location where no one of your organisation has access to. All the data gathered will be generalized and no data will be attributable to a single source or person.
The data will be kept for six years, after which period everything will be deleted.

What will happen to the results of the research study?

The findings will lead to a PhD thesis and might be published in journals. If you wish so you can receive a summary of the results.
You will most probably also have the opportunity to hear about the research findings, for example by attending a meeting. During this meeting I will again not attribute anything to a direct source or person.

Who can you approach when you have complaints?

In case you have complaints about the researcher you can contact my director of study Paul Hoggett,. Professor of Social Policy, Director of the Centre for Psycho-Social Studies
University of the West of England, Bristol: paul.hoggett@uwe.ac.uk

Contact detail researcher:

Siebelien Felix, ███████████████████████

Thank you

Thank you very much for taking the time to consider getting involved in the research.

CONSENT FORM

Research into the effect of the (semi-) privatization in the Dutch Healthcare sector and how these changes are affection those working with the sector

Siebelien Felix Phd researcher at the University of the West of England

Contact address: ███████████████████████████

███████████████████

Please <u>tick</u> box

1. **I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions** ☐

2. **I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason** ☐

3. **I agree to take part in the above study** ☐

Please tick box

YES   NO

4. **I agree to the (group) interview / consultation being audio recorded** ☐ ☐

5. **I agree to the use of anonymised quotes in publications** ☐ ☐

_____   _____   _____

Name of Participant   **Date**   **Signature**

_____   _____   _____

Name of Researcher   **Date**   **Signature**

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Research into the effect of the (semi-) privatization in the Dutch Healthcare sector and how these changes are affection those working with the sector

> You are being invited to take part in a PhD research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part or not. Thank you for reading this.'

The purpose of the study

> The aim of this research is to investigate the impact of the (semi)-privatization of the Dutch health and social care sector on the emotional experience of those in professional and service provider roles

What you will be asked to do in the research?

> Are you willing to participate in this research? As part of this research I will be observing meetings in your organisation. I will be observing without taking any notes. I will only observe during a meeting if all the participants agree to my being there.

Do you have to take part?

> If you do object to my being present as an observer, I will leave the room. If you do not object to my presence you will be given this information sheet and asked to sign a consent form. If you have agreed to my presence and yet halfway change your mind, I will leave at that stage.

What are the risks involved in taking part?

> As a participant you always have the right to call a halt to your involvement at any time during the research process.

> You also have the right to any summary of the emerging findings.

.

Will what I say and draw be kept confidential?

> As a researcher I will treat anything which happens utmost confidentiality. The information gathered will be stored on a stand-alone computer that is password protected and is situated at location where no one of your organisation has access to.

All the data gathered will be generalized and no data will be attributable to a single source or person.
The data will be kept for six years, after which period everything will be deleted.

What will happen to the results of the research study?

The findings will lead to a PhD thesis and might be published in journals. If you wish so you can receive a summary of the results.
You will most probably also have the opportunities to hear about the research findings, for example by attending a meeting. During this meeting I will again not attribute anything to a direct source or person.

Who can you approach when you have complaints?

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University of the West of England, Bristol: paul.hoggett@uwe.ac.uk

Contact detail researcher:

Siebelien Felix, ██████████████████████

Thank you

Thank you very much for taking the time to consider getting involved in the research.

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CONSENT FORM

Research into the effect of the (semi-) privatization in the Dutch Healthcare sector and how these changes are affection those working with the sector

Siebelien Felix Phd researcher at the University of the West of England
Contact address: ████████████████████████
████████████████████

Please <u>tick</u> box

1. **I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions** ☐

2. **I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason** ☐

3. **I agree to take part in the above study** ☐

Please tick box

YES   NO

4. **I agree to the (group) interview / consultation being audio recorded** ☐ ☐

5. **I agree to the use of anonymised quotes in publications** ☐ ☐

_____   _____   _____

Name of Participant   **Date**   **Signature**

_____   _____   _____

Name of Researcher   **Date**   **Signature**

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The purpose of the study

> The aim of this research is to investigate the impact of the (semi)-privatization of the Dutch health and social care sector on the emotional experience of those in professional and service provider roles

What you will be asked to do in the research?

> Are you willing to participate in this research? You are invited to participate in an 'organization in the mind' workshop. During the workshops you will be asked to draw the images you have of the organization. Through group discussion this material will be used to reflect on and analyse what is happening at the organization. The researcher will take notes during the discussion phase.

Do you have to take part?

> It is up to you to decide whether to take part or not. If you do decide to take part you will be given this information sheet and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What are the risks involved in taking part?

> As a participant you always have the right to call a halt to your involvement at any time during the research process. If you decide to withdraw your drawings will be destroyed and your answers will not be included in the data analysis.

> You also have the right to receive a copy of notes taken by the researcher or any summary of the emerging findings.

> If the workshop turns out to be stressful and you feel you need to talk things through with a independent professional counsellor your can contact mw. M van der Heijden : 020-25008834. This consult will be free of charge.

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Will what I say and draw be kept confidential?

As a researcher I will treat anything you say with the utmost confidentiality. The information gathered will be stored on a stand-alone computer that is password protected and is situated at location where no one of your organisation has access to. All the data gathered will be generalized and no data will be attributable to a single source or person.
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Contact detail researcher:

Siebelien Felix, ██████████████████████

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CONSENT FORM

Research into the effect of the (semi-) privatization in the Dutch Healthcare sector and how these changes are affection those working with the sector

Siebelien Felix Phd researcher at the University of the West of England
Contact address: ███████████████████████████
███████████████████████

                                                                              Please <u>tick</u> box

1. **I confirm that I have read and understand the
    information sheet for the above study and have   ☐
    had the opportunity to ask questions**

2. **I understand that my participation is voluntary
    and that I am free to withdraw at any time,   ☐
    without giving reason**

3. **I agree to take part in the above study**   ☐

                                                                              Please tick box

                                                                              YES   NO

4. **I agree to the (group) interview / consultation
    being audio recorded**   ☐ ☐

5. **I agree to the use of anonymised quotes in
    publications**   ☐ ☐

_____   _____   _____

Name of Participant   **Date**   **Signature**

_____   _____   _____

Name of Researcher   **Date**   **Signature**

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