



A Living Intervention – Anthropology and the Search for Person-centred Teamwork in a Hospital Ward in Sweden

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ABSTRACT This article draws on a long-term, team-driven project in a Swedish hospital ward to provide an ethnographic description how anthropology can be used in practice to support healthcare providers in their everyday work. I argue that ethnographic research, by affording participants in the ward an outsider's view of their workplace and routines, can facilitate healthcare providers' own process of reflection, communication, and the development of solutions to problems. The project aimed at facilitating change in relation to three challenging circumstances identified by the hospital ward management and staff: better-functioning communication on the ward, closer and more collaborative inter-professional teamwork, and deeper and more respectful integration of the patients in what was termed *person-centred care*. As an anthropologist I moderated a series of workshops in which I presented fieldwork insights, organised small-group work, and facilitated dialogue. The workshops enabled co-learning and collective reflection across professional boundaries, empowering the healthcare professionals to identify steps for better teamwork and patient care.

Keywords: facilitating change, collaborative reflection, healthcare, Sweden, teamwork, person-centred care

Introduction

Drawing on a long-term, team-driven project, initiated by the nurses' ward management leader at a medical emergency ward in a Swedish hospital and carried out by anthropologists in collaboration with the management and various healthcare professionals, this article gives an ethnographic description of how anthropology can be used in practice to support healthcare providers in their everyday work. I argue that ethnographic research, by affording participants in the ward an outsider's view of their workplace and routines, can facilitate healthcare providers' own process of reflection, communication, and the development of solutions to problems.¹ The project aimed at facilitating change in relation to three challenging circumstances identified by the hospital ward management and staff: better-functioning communication on the ward; closer and more collaborative inter-professional teamwork; and deeper and more respectful integration of the patients in what was termed *person-centred care*. The method developed in partnership between the ward management leaders and the research group entailed arranging drama workshops for collective reflection and learning and three sets of follow-up workshops on communication, teamwork, and person-centred care.

¹ Thanks to the anonymous reviewer for this formulation, that neatly describes my argument in this article.

Since the drama workshops have been described elsewhere (Skott et al. 2013; Dellenborg and Lepp 2018), I focus here on the follow-up workshops held on staff days, in which the management and the staff worked to improve communication, teamwork, and person-centred care on the basis of the results from the drama workshops and the long-term collaborative project. In these workshops, I as an anthropologist had the dual role of researcher and moderator, which presented some challenges, described below. The workshops sought to raise awareness of the structures that influenced everyday work on the ward, and help participants to see the workplace from the perspectives of the various healthcare workers. By means of collaborative action and reflection, the researchers and participants went through an open-ended learning-process together.

The setting

The medical emergency ward was divided into an intensive care unit for the most critically ill, and a post-acute unit for patients who were in rehabilitation or whose condition had been diagnosed as not critical, although many of them were old and very sick and their status could quickly change to critically ill. The ward was a high-tech environment, prioritizing a biomedical perspective and marginalizing a care-giving perspective. The treatment regimen included full supervision of the patients and readiness for emergency intervention by the personnel. The ward had high numbers of patient admissions and discharges. Coupled with daily rotation of staff and high turnover rates of different care professionals and students, this meant many people passed through the ward on any given day. Both healthcare providers and patients experienced communication challenges due to this high circulation.

The healthcare providers and professionals in the project were nursing assistants (NAs), registered nurses (RNs) and senior and junior physicians. A senior physician is a specialist. A junior physician, called a resident, might be a medical student practicing to gain their licence, a newly certified physician or a physician in specialist training. An NA has two years of high school education and in this ward, did the ward's 'household chores', such as the linen, ordering and serving food, and making beds, and performed most of the caring, although caring (Sw. *omvårdnad*) is the RN's professional competency (Leksell and Lepp 2019). In Sweden, RN is a legitimation earned after three years of academic study. In this ward, an RN was expected to be well-informed about vital signs and the patient's medical problems and treatment, and technically skilled in reading electrocardiograms and recognizing various heart rhythms and respiratory problems with a stethoscope. As described elsewhere, the nursing perspective received little attention in the ward, which made the RNs uncomfortable (Wolf et al. 2012).

There were many other healthcare professionals working in this setting, such as physiotherapists, occupational therapists and dieticians, and cleaners. At the time, the three first-mentioned were not considered to be members of the team, but functioned as 'consultants.' Cleaners were not even seen as part of the ward's work force, although they were present all days of the working week and their task was crucial for the hospital (cf. Messing 1998).

Teamwork and professional boundaries

The healthcare professionals worked in many different teams. The RNs and NAs worked closely in a nurse team, and the physicians (specialists and residents) in a physician team.

Every morning on the ward round, they met in a multi-professional team consisting of two RNs and two NAs caring for ten patients, a senior physician, and one or two residents caring for the same ten patients in the ward. In the multi-professional team, each profession performed their tasks parallel to each other or in sequences. During the project, the clinic wanted more intensive and collaborative inter-professional teamwork.

Inter-professional teamwork unlike multi-professional teams, entails a collegial and equal relationship between the participants, with shared decision-making procedures (D'Amour et al. 2005). In the hospital setting, it demands a fundamental change of professional relations and ordering of knowledge, and moving away from parallel work processes. The circumstances complicating teamwork in the ward were three-fold: first, the social construction of biomedicine as the primary knowledge of healing (cf. Good 1994; Lupton 2007); second, physicians who were trained to be autonomous decision makers (cf. Baathe and Norbäck 2013), contra nurses who were trained to cooperate (cf. Leksell and Lepp 2019; Coombs 2003); and third, healthcare organizations that were operationalised in terms of the medical gaze, and awarded physicians the authority to define and solve problems in the treatment of patients (cf. Wikström 2008).

The biomedical perspective is based in a disciplinary knowledge tradition according to which physicians are trained to discover the illness in the patient's body, separate it, name it, and correctly treat it using a *medical gaze* (Foucault 1975). Epistemologically, biomedicine focuses on "the solitary body of the individual sick person" (Kleinman 1995: 37), thus constructing the patient as someone experiencing illness in a vacuum of social relations. While medicine concerns the pathogen perspective, nursing also considers the salutogenic perspective (Antonovski 1987), focusing on health and the possibilities for maintaining health and understanding illness holistically, in the wider context of a person's life situation (Jansson 2010).

Healthcare's hierarchy of "hospital workers with curing (doctors) at the top, followed by caring and healing (nurses, therapists, and attendants), and hygiene (cleaners, sterilizers, and launderers) at the bottom" (Messing 1998: 168) is well-documented. However, although the biomedical perspective was prioritized in this ward, and the physicians located at the top in their team status, the physicians did not experience themselves as being in a power position. They felt seriously curtailed agency in relation to their hospital management's healthcare organization (Dellenborg et al. 2019) and the general hospital steering system, New Public Management (NPM). With its prioritization of efficiency and economical aspects of care, NPM has turned healthcare towards increased administration and manual control (Bornemark 2018: 14, see also Kaufman 2005).

At the same time, the physicians' status was visible through their understanding of themselves as *the ones responsible* for a patient's life and death. Medical responsibility was constructed as *the decisive* responsibility, even though research stresses the importance of nursing knowledge (Aaiken et al. 2014; Griffiths et al. 2016) and professional collaboration in teams (Lyubovnikova et al. 2015) for reducing patient mortality. This hierarchical polarization between care and cure has a long history; the professions are socialized into these epistemologies and identities (Wikström et al. 2018; Coombs 2003). The different value attached to the disciplinary knowledge traditions in contemporary healthcare is detrimental to care, and creates conflict in the healthcare team (Wallström and Ekman 2018). Making visible these structural dimensions of professional identity and disciplinary knowledge in the healthcare organization was an essential first step for improving teamwork.

Person-centred care – a contested concept

Parallel to inter-professional teams, the hospital was implementing person-centred care. Researchers define person-centred care as an ethic that urges healthcare professionals to change the focus from the disease within the person to the person with the disease (Edvardsson and Nay 2008; McCormack and McCance 2010; Ekman et al. 2011; Zhao et al. 2016), an approach that has been shown to increase care quality and decrease the length of stay in hospital (Ekman et al. 2012; Olsson et al. 2009). Fundamentally, medical signs and the ill person's experiences of symptoms should be considered as *equally important* in person-centred care (Wallström and Ekman 2018). Care decisions should be made in partnership between the person with the disease and the care providers (Ekman et al. 2011). This challenges the priority given to the biomedical perspective and the physician as the main decision-maker, and the generally hierarchical relations between patient and healthcare practitioner (McCormack and McCance 2010).

In this ward, the concept of person-centred care evoked strong emotions. The meaning of person-centred care differed both between and within the various healthcare professions, and caused confusion and frustration that complicated everyday care practice and relations in the team. The physicians particularly questioned the hospital management's aim to implement person-centred care, wondering if their motivation was patient empowerment or cost effectiveness, as management emphasized person-centred care as a way of reducing the number of hospital beds in use and length of stay (Dellenborg et al. 2019).

Practicing anthropology on the ward

Our practice of anthropology during this project was informed by Ingold's vision of anthropology (2017) and Kiefer's of action anthropology (2007). Ingold writes that anthropology is generous, open-ended, comparative and critical. It is generous because it helps us understand other people's way of living from their perspective and encompasses gratitude on the part of the researcher for having been let in, often generating a desire to give back. It is open-ended because it does not seek final solutions, comparative because nothing is given (life can be lived in many ways), and critical because we cannot be content with things as they are (Ingold 2017: 58-59). Ingold sees change as central to anthropology, and widely critiques the modern era, focusing on ecological aspects, and discrimination against local knowledge. He also emphasizes participant observation as a learning process with the ability to be transformative. More than a method, it is "an ontological commitment" (ibid.: 23), about learning *with*, not about, people.

Kiefer describes action anthropology as "far more than just a technical skill. It is, in a very real way, a moral position..." (2007: 201). The action anthropologist is an "outside helper in promoting the process of empowerment" (ibid.: 200), one who "helps people create the conditions for self-discovery and independent action" (ibid.: 202). The "goals are set by the community under study, and the results of [the anthropologist's] work are made available to the community to use as they see fit" (ibid.: 200). Like Ingold, Kiefer sees the learning position as central. The anthropologist is a student who learns from those whose life situation they aim to understand, not an expert on others' life situation. The research participants are the experts and teachers. Kiefer sees curiosity and courage as central to action anthropology. Courage means putting yourself in situations where you might be

seen as clumsy and inappropriate. I would add that this opens up the possibility of being transformed through a process of critical questioning of your own pre-understanding.

Methods

Fieldwork for this project stretched over eight years, from the end of 2009 to the beginning of 2018.² Long-term fieldwork, entailing long-term relationships, understanding the context for change, and understanding resistance to change (Tax 1975; see also Loup 2005), was crucial. I conducted participant observation with, and interviewed all three categories of healthcare providers in the team: RNs, NAs, and junior and senior physicians, plus the management leaders and patients. Data included fieldnotes, formal and informal interviews, and group discussions that were transcribed verbatim, photographs of architecture, machines, devices, signs, and consenting staff, and drawings of the professionals' and patients' position in the room during rounds and care encounters that I used for reflection in interviews and workshops. As the medical anthropologist Kaufman says of her fieldwork in American hospitals, the field was broader than the physical setting of the hospital. It was also "found in the structural fabric of the health care system and its institutions, the powerful and tenacious values and traditions that support individualism and biomedical progress, and the taken-for-granted, everyday activities that constitute bedside medicine" (Kaufman 2005: 328).

The project involved a cycle of planning-acting-observing-reflecting-re-planning, with critical reflection as an important step in each cycle (Kemmis and McTaggart, 2005). The team of anthropologists planned action along with the ward management, who were themselves trained nurses and physicians.³ We co-created the workshops together and co-owned the results, albeit not the data. I was the field-working researcher building relationships with the staff and the management, and therefore the one appointed as moderator at the workshops. As such, I facilitated bridging between researchers and practitioners and between the different healthcare professionals. In this context of strong professional boundaries, my dual role as field-working researcher and facilitator of change was at times challenging. In classical anthropological research, the anthropologist follows various social actors and dynamic processes in the field. As one seeking to facilitate change, I also had to *respond to*, and *act* in relation to these to "make things happen ... or at least be catalysts" (Tax 1975: 515). This demanded a high capacity for improvisation and serendipity (Watson 2019).

Every set of workshops was conducted twice, as one part of the staff had to stay in the ward taking care of the patients, and the others went to the staff day. In the workshops, I presented preliminary research findings and guided the inter-professional discussions. These discussions could become rather heated, demanding sensitive navigation on my part as the moderator. The staff presented results from group discussions on large sheets of paper and in verbal presentations that I tape-recorded and transcribed. I took fieldnotes which, along

² The fieldwork was divided into two research periods. The first involved intensive fieldwork including participant observation on all working days of the week for one year and two months (December 2009 - February 2011) and then periodically from March 2011 to December 2012. The second entailed shorter periods of fieldwork conducted between October 2013 and January 2018.

³ The study comprised five action research cycles starting in 2008 with focus groups on communication in the ward. For a detailed description of the first four action research cycles (see Dellenborg and Lepp (2018)). Both the nurse and the physician management leaders were exchanged in this period: the first-mentioned twice and the latter once. These changes in management did not cause us any problems since all showed great interest in the project.

with the transcribed staff presentations, I subjected to analysis before presenting them to the research group. After each set of workshops, I wrote a report that was first discussed in the research group, then given to the management for comments. After reworking, the management leaders asked me to circulate the report in the ward, present it at different staff meetings, and at times to the hospital management. Observation was conducted in each encounter with the practitioners and reflection was an essential part of the whole research process.

Building confidence

To facilitate the staff's reflections and dialogue in the workshops, I had to study communication, teamwork, and person-centred care from the perspectives of each professional group. Creating confidence and acceptance and attaining access were methodological challenges, given the strong professional identities and boundaries. I had to use my role as researcher flexibly, depending on the profession with which I was performing participant observation. I had to place myself in this hierarchical order and negotiate my own belonging there, in order to gain trust with each profession, and at the same time retain the trust of all. This demanded that I chop and change, and not stay consistent, rather like a trickster (van Meijl 2005). Because building the confidence of all four groups of healthcare providers was crucial for the project (cf. Tax 1975), I describe the process in detail.

The nursing staff were a relatively stable group working closely together in the ward. It was relatively easy for me to enter this group. Each time I arrived, the nurse management leader welcomed me publicly and announced to the nurses in the morning meeting that I was to spend the day in the ward. Frequently, one or several nurses invited me to be in their team, or I asked the one closest to me if I could join them during the day. To be recognized as someone who genuinely wanted to learn about the nurses' working conditions, I had to work in close proximity to the patients. This included comforting, washing and drying patients, combing their hair, fetching plasters, water, food trays, blood-pressure cuffs, bedpans, blankets and clean clothes, sorting and folding washing. It was not possible for me to participate in the RNs' more specialized work, such as administering medication, documentation, care planning, and contact with relatives; I could only "shadow" and observe them. Nonetheless this gave me significant understanding of their everyday situation.

Gaining acceptance among the physicians was harder. Unlike the nurses, the physicians moved around the clinic and often worked alone. I had to approach them one at a time. I could only follow the physicians around in their daily work; I couldn't examine patients, listen with a stethoscope, make diagnoses, decide upon or carry out treatments, write or respond to referrals, approve medications, or lead rounds. However, I could fetch blankets, hold an anxious patient's hand, and actively listen to the physicians' discussions. Through this I learned a great deal. I noted the hope in a patient's eyes as they looked at their doctor and later asked them, "What do you do with all the hope that is pinned upon you in your professional role?" I understood that physicians, like nurses, are subject to many expectations. I emphasized my role as researcher among the physicians. I discovered that many physicians knew about anthropology and were interested in the subject, which opened doors.

Learning from all professions in the team gave me the opportunity to explore misunderstandings and gaps in communication. By following first nurses and then physicians, I gained bodily experience of these gaps and the professional boundaries became visceral

to me. For instance, before I began participant observation with a physician, I had only met physicians during the ward rounds. These were organized according to a strict pattern in terms of both embodiment and speech. Working with a physician, I now saw myself positioned in this structure: the physician's body in front of the rest of us, a silent cluster, the physician's body turning back to us to say something. I realized that I must demarcate myself from the rest of the silent group if I was to earn the physician's trust as a researcher. If I dressed as the nurses commonly did, in blue, I would be associated with the 'other side'. Yet if I began dressing in white, would the nurses regard me as a deserter? Fieldwork in this setting was a balancing act. In hindsight, I realize how revealing of the clinic's professional hierarchy my worries were. Maintaining the trust of the various groups of professionals required delicacy. The way in which they viewed one another and pulled together depended upon the context. Privileges were always pointed out by those who lacked them: NAs in relation to RNs and physicians, nurses in relation to physicians and, after I had earned their trust, junior physicians in relation to their seniors.

When I shifted groups, conflicts of interest between the physicians' and the nursing staff's duties became clear. Time and space took on entirely different meanings. For instance, when I was with the physicians, the round just suddenly seemed to happen. With the nursing staff, I would already have been on the go for many hours when the round started. Further, the nurses mainly stayed with their ten patients in the ward, while the senior physicians' duties spanned the whole clinic. Marching quickly through the clinic with the physicians gave me a feeling of autonomy, and the physicians' better-fitting clothes made me feel slimmer. When I was with the nurses I often had to bend over for long periods of time in a single place – over a bed we were making, over a patient we were washing, while a patient was sitting in bed having blood tests taken, while we picked up the washing, took clothes from low shelves in the cupboards, prepared trolleys, fetched food from the fridge, or helped a patient to get dressed.

The junior physicians were in-between the nurses and the senior physicians, attending different tasks in the clinic and staying for long times in the ward. This middle position frequently put them in difficult situations. They had a great deal of responsibility in the ward but were dependent on the senior physicians for decisions on treatment or discharge. Waiting for these decisions created a work 'bottleneck', which gave rise to irritation in the team and often set nurses against junior physicians.

In spite of these differences, I noted an embodied solidarity among the staff on the ward. Emergencies, severely ill patients, and anxious relatives all prompted a cooperative spirit. At staff parties, there was laughter, dancing, and fun activities. Professional boundaries became more blurred, and a sense of common belonging to the ward more pronounced. Some of the nurses told me they thought the parties had a positive effect on teamwork in the subsequent week. "But then it's gone and we're back in this formal division again", one nurse said gloomily.

Fieldwork demonstrated the extent to which the work environment enhanced the hierarchical order (cf. Messing 1998). As noted, the physicians did not experience themselves as prioritized; they often expressed feelings of powerlessness in relation to the healthcare organization and its management. They often found themselves facing the nurses' violent criticism regarding a lack of communication or routines not being followed. A young junior physician told me, "I have tried to tell [the nurses] why, but they accuse

me of defending myself, they are not interested in my situation...” At the same time, the nurses clearly experienced a strong hierarchy in relation to the physicians, and felt that their time, duties, and knowledge were not valued. Patient overload and financial cutbacks only strengthened the hierarchical relationships between disciplinary knowledge bases and between professions. The staff experienced tension in the team, yet the organisational and structural aspects creating the tension were usually invisible to them. They were seldom given time for reflection and feedback, and conflicts and misunderstandings were rarely addressed. Making these circumstances visible to the management and the staff became our main approach to improve communication and teamwork in the ward.

The workshops on communication, teamwork, and person-centred care

The three sets of workshops on communication, teamwork, and person-centred care followed inter-professional group discussions and drama workshops on various aspects of communication and teamwork in the ward.⁴ Co-developed with the management leaders, the workshops intended to bring about change by helping the healthcare workers to ‘see’ themselves, to discuss what they had learnt, and develop their own solutions. The research team never presented solutions that we developed based on our research; the staff were the experts in their working environment and best suited to finding solutions to their problems. My role was to give an outsider’s view on their working situation and support them in problematizing what they took for granted. I now turn to the three sets of workshops, presenting them in chronological order.

Workshop on communication: All encounters are cultural

The first set of workshops were in late 2010. At the time, I had been doing fieldwork for over ten months and had held several drama workshops. I saw presenting professional relations and the complexity of the working environment without misrepresenting any of the professions as ethically challenging. I had observed their actions, choices, and communication patterns in situations of great uncertainty, in delicate and often painful encounters, and in emergencies, when any posturing in front of the observer was lost. After weeks of torment, in reflection with my research colleagues, I finally found support in the ethnographic stance itself: the non-judgmental, profound curiosity, and relativistic approach of truly wanting to understand what is going on ‘on the ground’ (D’Andrade 1995; Kiefer 2007). Remembering this ‘ontological commitment’ (Ingold 2017) helped me clarify my role in this new, and sometimes awkward situation of being both anthropologist and facilitator of change.

I started my presentation by describing the workshop as co-operation between researchers and healthcare workers, with the aim of finding solutions together for problems *they* defined. I explained my role as an outsider observer who was seeking to understand their situation, not as an expert who would tell them what to do. This statement raised interest in the staff, and many nodded their heads in approval. To link my presentation to the learning process, I reminded them that we had taken the first step in 2008, when

⁴ The results from the group discussions that focused on transcultural care and communication in the ward are described in Dellenborg et al. (2012), and the drama workshops with the healthcare providers in Skott et al. (2012), and also in Dellenborg and Lepp (2018).

the ward management and researchers had arranged for a workshop where the staff had discussed communication in transcultural care in the ward, in inter-professional groups. Most present remembered that day well. I explained that we would continue this work on improving communication in the ward, but with focus on the staff as ‘the other’ this time. To help them think of themselves as ‘the other’, I compared my fieldwork in Senegal, West Africa to my fieldwork in the ward. I showed pictures of what I had initially found exotic and unfamiliar in Senegal and then in their ward, explaining my journey into learning the local norms in both settings. I intentionally took time to describe cultural practices, norms, and perceptions that I needed to learn in order to understand and adjust to Senegal, and how it had been confusing at times, but also a beautiful, fun, and surprising experience. My purpose was twofold: to familiarise the group with the anthropological methodology of fieldwork and participant observation and to help them get to know me as a person better, not as a detached researcher. My presentation was also an icebreaker, helping the participants focus on something other than their workplace for a short while.

After the pictures from Senegal, I showed the participants pictures which were more familiar to them. First was a photograph of the ward round being done. I asked them to reflect briefly on whether their positions in relation to each other might influence communication patterns. Next came a photograph of the naked hospital corridors and another of devices in the ward. I joked that I had expected R2D2 from Star Wars to come around the corner at any minute, and commented on how tired I was initially because of all the sounds. I talked about the different beeping tones, and how curious it was to see that different categories of staff reacted to different alarms. I showed them a list of medical terms that had flooded over me, saying that it had taken me weeks to be able to hear anything else during the round, so overloaded was I with this eccentric medical lingo. I intentionally used words such as “rituals”, “altars”, “sacred space”, and “secret language” when describing pictures of the staff’s familiar milieu. They laughed at how this classic anthropological terminology made them sound exotic.

I ended the presentation by saying, “All human encounters are cultural; we constantly interpret each other’s words and body language”. I clarified that we usually take our own cultural context and its codes and norms of behaviour for granted; we rarely perceive ourselves as cultural beings. If misunderstandings happen in transcultural encounters, we tend to explain these as *the other* being cultural, strange, and complicated. In making the group exotic to themselves I hoped to support them in self-discovery (Kiefer 2007) and break down the perception of *differences* between Us and Them that was the main finding from the 2008 discussions (Dellenborg et al. 2012). Their laughter and comments revealed an amused recognition that the organization of people and relations, language and practices in the hospital actually were quite special.

Next I presented the results from the transcultural communication discussions and the drama workshops. There, the staff had highlighted difficulties in communication with patients and their families, as well as between healthcare providers, and had pointed to difficulties within the team and the organization of care. The results showed how staff struggled to do the right thing, following their conscience and conviction, and that they did not always succeed because of stress, routines, language difficulties, lack of communication, misunderstandings, and hierarchical relations that silenced them. I made sure to give examples of situations that they could identify with and emphasize the staff’s strong ambition

to provide good care. This included demanding themselves to solve problems autonomously (Dellenborg et al. 2012; Dellenborg and Lepp 2018).

The staff listened attentively, with the nurses smiling and nodding, and posing short questions. I felt they were with me, but the physicians' silence made me uneasy. I could not figure out whether they recognized the situations, or whether my presentation interested them, surprised them or made them critical or uncomfortable.

After a break, I divided the participants into inter-professional groups. Each group was given a theme that we had construed from analysing the drama workshops and asked to develop three suggestions for improvement to present to the entire group.⁵ I urged them to be constructive, to work as anthropologists, and take the opportunity for curious inquiry.

The response

The staff were intrigued by the outside perspective on the ward and themselves. They described the pictures and comparisons as a revelation, spurring reflection on how they worked and how they could work differently; for instance, how they needed to be more patient with new junior physicians and nurses on the ward. They reflected on the difficulties for patients and their families to navigate the hospital, realizing that signs were often confusing. Months and years afterwards, the staff repeatedly told me how this presentation had affected them and made them see themselves and the care environment with different eyes. Two junior physicians I met much later laughed at the fact that the hospital staff did not greet each other in the elevator. Reflecting about the atmosphere that this promoted, they commented that the hospital being a big work place was no excuse – tram drivers, for example, greet each other as they pass, and there are hundreds of these drivers spread around the city.

During the first workshop day, mostly physicians reported from the small groups. I realized this was because I had given the paper with the written instructions to the physicians. On the second day, I therefore handed out the instructions to the NAs in each group. This time, rapporteurs came from all the professions. They identified barriers to good healthcare encounters and teamwork, such as lack of knowledge about the individual patients due to high circulation of staff and a lack of documentation, and the need for extra physicians in the team and a greater presence of the senior physician in the ward. An area of concern was the lack of patient perspective and how to involve the patient in the care process from the start. They also realized that they were unfamiliar with each other's tasks and daily work. One suggestion to remedy this was for the different categories of care providers to "shadow" each other during a working day. At times the discussion became heated, typically when nurses complained about physicians being unprepared and late for the round. As the moderator, I tried to open up the discussion by providing arguments for "both sides" from my observations, but the physicians mainly remained silent.

When the day ended, I was unsure of how the physicians as a professional group had received my presentation. Afterwards, however, several physicians expressed interest in my research and those who had not attended had heard from colleagues about the presentation. One senior physician commented, "It's fun to be cartooned – it makes you recognize yourself." Although pleased, I noted the word *cartooned* with ambivalence. Nevertheless, my presentation seemed to have achieved something among the physicians.

⁵ The themes were: improving teamwork, routines and flexibility, the patient's voice, improved relationships with patients' families, improvement of communication, and transcultural encounters

Based on the staff's suggestions, several routines were changed. A simple routine that facilitated teamwork was to write the phone numbers of the physicians on duty that week on the whiteboard, as well as the number of the nurse coordinating places for incoming patients. Another change was organising checks, such as taking the temperature of all patients every morning, and checking patients who were simply waiting to go home. The NAs told me this was an important change in care practice, as it freed up time to be with the patients. Still another new routine entailed adding a brief period in the afternoon for nurses and junior physicians to give feedback and reflect on the day's work.

Workshops on teamwork

For the second set of workshops, which took place in 2012, the management leaders were interested in formulating ethical guidelines for conduct in the ward and the team. Initially, they asked the anthropology team to formulate these. We argued that a key approach in action research was seeing the staff as the experts. The staff needed an opportunity for deeper conversation about what they saw as the aim of teamwork, and the opportunities and barriers they faced in fulfilling this aim. On the basis of such a conversation, we suggested, the management could formulate ethical guidelines for conduct, or let the staff do it. The management leaders agreed it could be a good idea to explore the team's aim and their scope for teamwork before writing rules. We drew on our experiences from the communication workshops to rethink how to stimulate productive dialogue. We wanted to avoid, for instance, silence on the part of the physicians. This time, we organized the workshop participants into profession-specific groups, with the aim of providing them a safe space to explore opportunities and obstacles to teamworking in their profession, and to consider how to promote inter-professional teamwork.

As during the communication workshops, I started with a presentation of preliminary research results from fieldwork and a short recapitulation from earlier interventions. I then talked about teamwork and started with a comparison with general knowledge from transcultural studies: when people from different parts of the world work together, they need to learn about each other's background, norms and perceptions; this awareness makes us more open-minded when misunderstanding and conflict occur. Teamwork researchers argue that this approach is needed in multi-professional healthcare teams as well, as the members have different professional formations, with different historical background, epistemological traditions and ontologies, and perspectives on the patient. I reminded the participants that they had discovered this in the 2010 workshops; one of their suggestions to improve teamwork was to shadow one another during a working day. I then gave a short lecture on different theories and definitions of teamwork, identifying as a challenge that organisations and enterprises often take for granted what teamwork implies. Using Lind's and Skärvad's (2004) playful metaphors of different sports to illustrate different healthcare teams, I described how teams ideally should be organized differently depending on aim, and that the team aim is one of the fundamentals of successful teamwork (Otis-Green and Cohen Fineberg 2010).

On the whiteboard, I wrote down the different teams they were actually working in, i.e. the multi-professional team that met each morning, a separate nurse team and physician team, and teams for competency development, among others. I drew pictures illustrating that in the competency development teams, the same people were working together over

time. For care teams, however, *functions* were represented and these were rarely occupied by the same person for any length of time. Each of the care teams consisted of one senior physician, one junior physician, two RNs and two NAs with shared responsibility for ten patients. Although the management aimed to keep the same individuals in a team for as long as possible, nurses were commonly exchanged every two or three days, and senior and junior physicians every Monday. Team members were not considered *persons* with relationships to the patients and to one another. Patients encountered so many different care providers during their hospital stay that they mixed them up. I gave examples of how this organization caused discontinuity and fragmentation in care, breaches in communication and increased tension in the team. I highlighted the nurses' frustrated catch phrase, "Where is the physician?" as symptomatic for the tension in the team and the tendency to confine organizational problems to a single profession. To further illustrate structural and organizational aspects that influenced teamwork, I used pictures of communication flow during the round which I had drawn during observations, illustrating that time was mostly consumed by physicians' internal interchange, with nurses briefly responding to physicians' direct questions. I asked them to reflect on the implications this had for communication and relations in the team, as well as knowledge of the patient. In this way I prepared them for small group discussions, laboriously urging them to consider ward structures and how these structures influenced them. I asked them to be specific and to give examples – simply saying "more resources" or "improved communication" was too vague.

The response

Again, the staff appreciated the outsider view of the different teams in the ward. There was instant emotional recognition of the illustration of team members as *functions* rather than persons. One participant reflected on the absurdity of being expected to work with person-centred care without themselves being considered persons in the organisation. The sport metaphors prompted laughter and were pedagogical: the staff used them frequently in their presentations to make visible for themselves how they worked differently in different teams. Some structural and organisational factors that impeded teamwork were highlighted; others seemed too complex to formulate in the moment. The participants pointed out the extent to which the nurses and the physicians worked parallel to each other rather than in cooperation, noting that this was neither bad nor good but depended on the aim of the particular team. The nurses said it was important to make the patients members of the team, while the physicians preferred to talk in terms of a holistic understanding of the patient, and identifying patients' needs.

This set of workshops was a real breakthrough. Power dynamics and hierarchy that I had identified during fieldwork and that made the healthcare providers uncomfortable when I brought them up, were suddenly formulated in plain words when participants reported from their group discussions. The senior physicians, who were understood by all as the undisputed team leaders, pointed out an impossible situation: they could not be team members as they had too many missions outside the ward. The physician management leader then explained that the senior physicians were actually scheduled 60% in other parts of the hospital. Suddenly, the nurses' frustrated question "where is the physician?" was answered. The senior physicians were lacking support 'from above' in providing continuity for their patients and the team. The junior physicians reported that the absence of senior physicians

in the ward meant that they bore significant responsibility for the running of the ward. They identified a lack of communication with the senior physician and with the nurses, which complicated their task.

The NAs expressed difficulties in 'being heard' and 'being seen', with several talking in terms of 'not daring to speak' during the round. They pointed out their competency was omitted from the team. When I asked one NA what hindered NAs from speaking, she said hesitantly, "I don't know what's medically relevant or not". The RNs also reported 'not being heard': they were obliged to repeat themselves to get the physicians' attention, and their knowledge was not valued. These reports produced disagreement among the nurses. As soon as one mentioned 'not being heard', another protested emphatically, declaring that it 'depends on the person; I say what I have to say'. This resulted in the nurse who raised the problem falling silent. Further, the senior physicians did not understand why the nurses felt this way. They emphasized the importance of nurses' perspectives on the patient and underscored that they expected the nurses to speak up during the round. Ultimately, the nurse reports led to a common conclusion that they needed competence building in verbalising caring perspectives. To me, this was yet another example of individuals and professional groups being blamed for structural circumstances. The nurses' complaints mirrored the biomedical culture on the ward, where 'the voice of the lifeworld' was generally inhibited by 'the voice of medicine' (Mishler 1984).

Given the opportunity to discuss their situation without having to explain or defend themselves, the healthcare providers had formulated core barriers to fulfilling their roles in the team, and an important discrepancy in the aim of the team, i.e. to provide patients with the best care based on the competencies of all involved professions. When it came to discussing these reports together, tensions rose. Evidently, the issues were sensitive and occasionally explosive; they stirred emotions in all of us. Most of the participants, not least the physicians, spoke hesitantly, searching for words, anxious not to step on any mine fields. All the professions tended to disguise their meanings between the lines, which made my task as moderator trying. I had instructed them to give examples and not to be abstract. Reading the transcriptions, I can see that I unwittingly put the participants in an uncomfortable situation, as I urged them to put their experiences into plain words.

Reception of the report

The management leaders appreciated the report, and I was invited to present at various levels and in different situations in the ward and in the hospital. The physicians' management leader commented with satisfaction that although some of the suggestions were impossible to follow because of inadequate resources (for example, the senior physicians' situation and the discontinuity this caused), much could be adjusted. They incorporated the report in an information sheet for patients and their families concerning what they could expect from care and how the staff worked in teams. The report later led to the junior physicians being scheduled two consecutive weeks in the ward for better continuity, instead of one as with the senior physicians. Finally, the nurse management leader used the report to help formulate ethical guidelines for the ward.

Workshops on teamwork and person-centred care

The last set of workshops on teamwork and person-centred care occurred in a different context than previous occasions. This time, I had conducted fieldwork periodically and was less anchored in the participants' everyday context. I was worried that this might lessen the staff's confidence in me, as circumstances change quickly in hospitals. All the senior physicians and the majority of the nurses knew me from before. There were however quite a few junior physicians that I never had met. In addition, after two years of implementation work in the ward, there were still voices questioning the feasibility of person-centred care, especially among the senior physicians. The majority of the nurses expressed the importance of providing person-centred care, and many of the junior physicians also saw a value in that approach. I expected heated discussions.

As with previous workshops, I began by highlighting how the work on person-centred care was part of a long-term effort to improve teamwork and include the patient's voice. I recounted that I could see improvements since I first entered the ward in 2008. I then presented the concept of culture and the possibility of changing the structure, followed by a few words on the challenges of work according to their own definitions of the team aim from 2012. I spoke about the epistemological differences between biomedicine and nursing, the priority of medical aspects in the team and the nurses' experiences of not being heard.

In presenting my field observations on their work to implement person-centred care and formulate care plans together with the patients, I highlighted the finding that patients generally appreciated being more well-informed. The NAs witnessed that patients now took more interest in and responsibility for their own treatment. RNs and NAs felt that the plan gave them greater independence in fulfilling their tasks. However, physicians reported a heavy increase in work. In-bed time had been reduced, causing more work for the already overburdened junior physicians. I also reported that my interviews with patients indicated that they went home with big questions unanswered. For example, one elderly woman wondered why the heart problems that she had been experiencing for many years had now suddenly worsened. Was it because her husband was suffering from dementia and this made her home situation difficult? I knew the physicians had answered her question several times, but always standing during the bedside round, with other patients waiting and the whole team around them, and never in dialog in a calm setting.

Drawing on the success of the last set of workshops, I divided participants into groups separated by profession. They were given the same questions as in the previous workshop about the team aim and their role in the team, plus a new question on how their profession could promote the patient perspective.

The response

The presentation and the theme for discussion spurred the healthcare providers' interest. They participated energetically in the small group discussions, and came forward with interesting insights. My worry that they would lack confidence in me proved groundless. During the breaks, the junior physicians in particular sought me out to continue the discussion. Presentations in the larger group were animated, and the atmosphere was mostly friendly, although there were some heated moments. For example, it emerged that the junior physicians and the nurses had different strategies for handling the round, which complicated teamwork and presented barriers to good care. A marked difference from the 2012 workshops

was that both junior and senior physicians raised concerns about the patients' perspectives and experiences, and stating that they needed more time with the patient. In 2012, the physicians had not addressed the patients' perspectives, only the nurses. Now the physicians complained about the lack of time and space for a real conversation with the patient. They identified problems with the lengths of the various rounds. They explained that the overall ground situation was not suitable for conversation, standing as they were by the patient's bed, surrounded by the team and other patients in their beds. As one physician exclaimed, "There isn't even a chair for me to sit down on!" Ever since my first fieldwork, the physicians had complained about lack of time with patients, and of course, the added question on how their profession could promote the patient perspective influenced the discussion. However, the emphasis on the patient's *experiences* and also the focus on "real conversations", both of which can be said to be central to person-centred care (i.e. patient experiences and narrative, see for instance Ekman et al. 2011), were new.

Clearly counteracting the ethics of person-centred care was the lack of inter-professional co-operation and co-production of knowledge about and together with the patient. The physicians talked in terms of the other team members giving them information so that they themselves could form a holistic picture of the patient as a basis for the medical decision. Significantly, the most important relation for the physicians was with the patient, not as a team member, but as their patient deserving the best treatment. In contrast, the nurses focused on the patient as a team member, and the importance of improving relationships between the professions in the team and the collaboration of different disciplinary perspectives for the best care. In other words, the physicians promoted a multi-professional team with themselves as the decision-makers, whereas the nurses (as in the previous workshop) rather promoted an inter-professional team and the co-production of decisions. The workshops revealed staff engagement with the patient, but strong professional boundaries within which medicine remained the prioritized knowledge, and the other team members' competency was understood as information adding to biomedicine, not as knowledge in itself. Further, the patient was understood by the physicians as 'theirs', not the whole team's responsibility. Overall, the participants in this process realized that their efforts to achieve their ideal of person-centered care were impeded by aspects of their own institutional organization, such as the division of labor, spatial and temporal organization. In various ways, they put the hierarchical ordering of relations between members of different professional groups (nurse assistants, registered nurses, senior and junior physicians and also the management and the administration) into words.

Conclusion

Better communication, improved inter-professional teamwork, and person-centred care in the ward require epistemological and ontological changes. The healthcare providers' efforts at positive transformation were hampered by circumstances they could not control, such as the senior physicians working 60% outside the ward, staff cut-backs, and reduced time for care. As described elsewhere (Wolf et al. 2012), Sherry B. Ortner's (1996) concept of *serious games* can be used to understand the possibility for change in hospital organizations. Social life can be understood as a game with rules that limit action, but the rules may also be stretched and interpreted differently. In addition, there is never only one game, but a "multiplicity of games in play, both at any given moment, and across time" (Ortner 1996: 20). Participants

in these serious games play with “skill, intention, wit, knowledge [and] intelligence” (ibid.: 12): we are neither completely tied down by the structure, nor completely autonomous agents, but act and are constructed by multiple simultaneously-existing games. From this perspective, critical collective reflection and raising awareness are important strategies for inducing change. How every individual healthcare provider acts in relation to patients and their families, and in relation to colleagues and other team members *matters*.

Still, if there are no efforts made to change the context, transformation through collective reflection and learning cannot reach its full potential. Change within healthcare is also a question of curriculum; how nurses and physicians are trained into conventional professional identities that create boundaries, rather than as team members co-producing knowledge (McCormack 2018). Significantly, in the current era of NPM, with its focus on efficacy as the prime objective for care, a change in hospital organization for improved communication, inter-professional teamwork and person-centred care is a societal issue and a question of political will.

I recently met one of the management leaders at a conference on person-centered care. She told me that whenever they as management leaders are asked how they work for a person-centered care in the ward, they present their many years of collaboration with anthropologists as a method for improving the conditions for person-centeredness such as communication and teamwork. Of course, I was delighted to get this confirmation that anthropology in the clinic matters. Like the action anthropologist Mark K. Watson, I see anthropology’s most important contribution to the ward as being “a more complex and nuanced awareness for the *context* in which action, conflict, life occurs” (2019: 27, emphasis in original). As I have described, the healthcare providers and management leaders often got stuck in a pattern of blaming individuals or individual professions for problems caused by structural and organizational circumstances. The workshops gave them the opportunity to conduct a “collective self-reflexive enquiry” (Kemmis and McTaggart 2005: 1) into their circumstances of communication, professional identity, teamwork, and patient care, making reflexivity a social practice (Watson 2019).

Research colleagues who have worked in this same ward referred to my role there as “a living intervention” and say that its echoes are still found in staff discussions of ward circumstances. The anthropologist’s intensive presence in the everyday life of the ward prompted staff reflection; posing questions had incited dialogue on things sometimes so ordinary that they did not see them until the anthropologist poked her finger at it. Our collaborative reflections during the workshops allowed the staff to identify new perspectives that supported them in their work for change. Our collective reflections particularly allowed us to transcend professional boundaries, at least to some extent. These moments of co-learning and co-producing knowledge are at the heart of what anthropologists can contribute to healthcare professionals’ work for transformative change. They are what enables ethnographic research to become “a living intervention”.

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