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Doctoral Thesis

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**Copenhagen
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HANDELSHØJSKOLEN

Responsibility Flows in Patient-centred Prevention

Kathrine Hoffmann Pii

Doctoral School of Organisation
and Management Studies

PhD Series 03.2014

KATHRINE HOFFMANN PII

Responsibility Flows in Patient-centred Prevention

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Kathrine Hoffmann Pii
Responsibility Flows in Patient-centred Prevention

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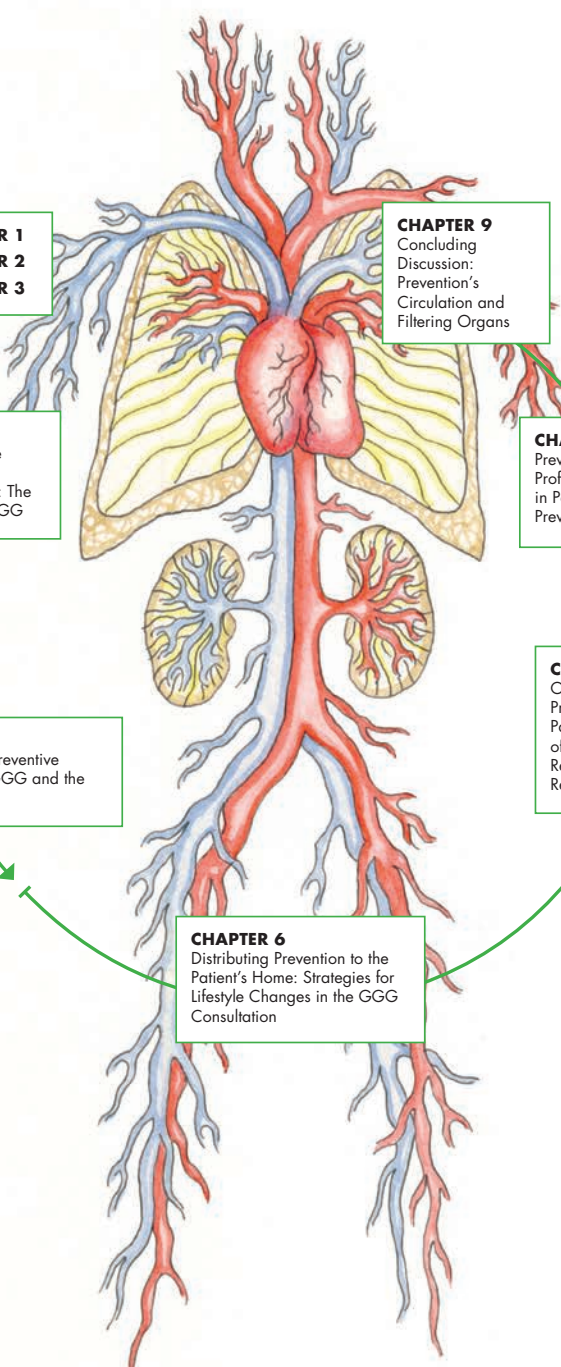
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CHAPTER 1
CHAPTER 2
CHAPTER 3

The diagram shows a human figure from the waist up, with the internal organs and circulatory system visible. The heart is centrally located, with red arteries branching out to the head and lungs, and blue veins returning blood to the heart. The lungs are shown in yellow, and the kidneys are shown in brown. The legs are also visible, with red arteries and blue veins branching out. The callout boxes are connected to the diagram by green lines and arrows, indicating a flow from top to bottom and then back up to the right.

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Concluding
Discussion:
Prevention's
Circulation and
Filtering Organs

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Building Preventive
Pathways into the
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Material and arguments from Chapter 6 appears as:

“Den forebyggende indsats” in *Ledelse gennem patienten – nye styringsformer i sundhedsvæsenet* (Kjær & Petersen 2010).

Likewise material and arguments from Chapter 8 appears as:

”Sygeplejerskers arbejde med patient-centreret forebyggelse” *At skabe en professional: Autonomi og ansvar i velfærdsstaten* (Järvinen & Mik-Meyer 2012).

Furthermore, material and arguments from Chapter 7 appear as:

“Protect the Patient from Whom? When Patients Resist Governmentality and seek more Expert Guidance” *Social Theory and Health* (Pii & Villadsen 2013)

“Forebyggelse på tværs af det offentlige og private: Når patienter trodser myndiggørelse og efterspørger mere professionel involvering” (Villadsen & Pii 2012) in *Tidsskrift for forskning i sygdom og samfund*.

CHAPTER 1

Entering the Building

Entering the Building

INTRODUCTION

The hospital is a construction site at the moment; building material, containers, ramps, barriers, and mud tracks left behind by big trucks. These are the temporary conditions during the modernization of the hospital, which was initiated four years ago to fit the demands of modern healthcare as it states on their homepage. "The NEW Gentofte [Hospital]", it says promisingly on a big sign outside the hospital. The head nurse that I am meeting has already warned me about the mess; "We might be a bit difficult to find," she has told me on the phone and has emailed me a map and directions. The map comes in handy, as the entrance is hidden behind some containers that work as temporary offices and clinics.

Outside the entrance, two men are sitting in shapeless white hospital gowns with blue prints that reveal they are patients. One is in a wheelchair and has a drip-stand beside him, and the other is sitting on a bench. They do not seem to know each other; they do not talk. They are just sitting, staring into space, and smoking a quiet cigarette. Since the so-called Smoking Law was passed by Danish Law in 2007 in order to protect people against passive smoke, the sight of people smoking outside public buildings is quite familiar. Despite this familiarity, the sight of the two men captures my attention, as I am here to begin my research on the preventive work that goes on inside the hospital – including the issue of smoking cessation.

The doors open automatically as I approach them and I enter

the hospital building. The information sign inside tells me that the vascular clinic I am looking for is on the first floor. I take the stairs, as it is not a long climb, and the lift in the centre of the stairway is not that appealing anyway: its windows are covered by a metal grid, giving the impression of a mine cage rather than a lift for people. But all these things are exactly what the hospital is renovating. The hospital building is changing its form to meet its patients in a more welcoming way: Walls are to be painted white, new art is being installed, and the old signs with impossible Latin names are being replaced with Danish words – the first hospital in Denmark to offer this friendly service.

On the short climb to the first floor, I am met three times by a pair of other signs. The first sign welcomes me to the hospital in large letters. The second sign thanks me for not smoking in the hospital area and informs me about the smoking politics of the hospital: If patients need to smoke, they should contact staff, who will then direct them to a special smoking room. The sign further informs me that all patients are offered smoking cessation courses and that the staff members do not smoke during working hours and have also been offered smoking cessation courses. At the bottom of the sign, I am thanked again for supporting the anti-smoking politics. Despite the clear visibility of the preventive attempts made within the hospital - its politics, information and smoking cessation courses- the sight of the two smoking patients outside the hospital building signals that this has not had its intended effect. It seems there is still work to be done in order to realise the preventive project.

PREVENTION'S MANY BUILDINGS

This thesis deals with prevention within healthcare – the efforts made in order to hinder illness or delay its development. More specifically, it investigates a Danish preventive programme within the medical specialty of vascular surgery. Prevention is not a new thing. It has a long history both as a political project aimed at improving the collective state of health by means of different technologies and interventions and as a moral programme of individual self-conduct; that is, the actions taken by individuals to privately protect oneself or one's loved ones against illness and to maintain good health. Many preventive efforts are so integrated into our daily lives that we do not notice them as prevention aimed at protecting our health and well-being – organized sewage, tooth brushing, added iodine in salt, traffic lights, and so on. Other preventive efforts are more difficult to blend into individual everyday life and are met with resistance or indifference and thus require more work or new approaches.

Prevention as a political project dates back to the late 18th century, where state populations became objects for political governing and began to be treated as productive state resources to be protected and nourished in increasing competition with other states (Foucault 1997). Over time, various strategies and technologies have been invented and employed to direct collective and individual health conduct. These have been developed in relation to the kinds of diseases that have put the well-being of collectives and individuals at risk. In the 18th century, the control of contagious diseases was attempted by establishing sewage in cities and by isolating infected individuals. In the early 19th century, strategies such as compulsory vaccination programmes and public health campaigns aimed at educating the population were initiated. What these different strategies have

in common, besides their aim to reduce illness and promote health, is that they have been developed in pace with the expanding knowledge about the correlations between our way of living and the condition of our bodies – the specific characteristics of diseases and epidemiological patterns. So, even if the issue of prevention in itself is not new, the focus and ways of doing prevention have changed over time, and new preventive strategies continue to be developed. This continuous development reflects a persistent topicality: The interest in promoting health perseveres and constantly defines new areas for preventive interventions as well as initiates the development of new techniques that direct us to behave in more healthy ways. Today, preventive strategies continue to work through law enforced regulation, city planning, vaccine programmes, and general health information and campaigns, but also through more individually-oriented approaches, which seek to make preventive intervention fit the individual's specific life conditions, personal values, and motivations. This trend can also be seen as related to the diseases that are currently challenging the individual's and population's health, namely, the so-called 'lifestyle diseases', which are caused by unhealthy diet, alcohol and tobacco consumption, and physical inactivity leading to chronic diseases and complications such as cardiovascular diseases, type 2 diabetes, chronic obstructive pulmonary disease, stroke, obesity, and different types of cancer.

Whereas some preventive strategies (the traffic light, organized sewerage, the ionized salt) seem to work without much controversy, preventive efforts regarding lifestyle diseases have proven to be more difficult. Denmark follows the international statistics regarding the increase in lifestyle related diseases and morbidity rates. The increasing costs that this implies for the public healthcare budget is a concern that is often evoked in Danish health politics. The issue of 'lifestyle' has been of great political attention both in liberal and social

democratic governments' health programmes (Valgård 2003). In Danish health politics and within the health sector, the lifestyle issues go by the acronym "KRAM", which stands for: Diet, Smoking, Alcohol and Exercise (the word KRAM also means 'hug', which embraces a grave issue in a friendly way). The difficulty of influencing these KRAM-factors is explained in different ways: First, the factors touch upon issues that deal with our personal perception of a good life – what we like to eat and drink, the stimulants we indulge in, and the activities we enjoy – and thus require essential changes in our likes and priorities, which prove to be rather stubborn qualities in people. Second, the persistence of unhealthy behaviour in relation to these factors is related to their bodily or cultural embeddedness – the active practice of smoking cessation, for example, often requires perseverance through the physical discomfort of withdrawal symptoms. Similarly, dietary changes may require a radical break with habits and pleasures taught in childhood. Unsurprisingly, therefore, preventive strategies aimed at lifestyle diseases have proven to stir controversies. A recent example of such controversy were the debates that followed the Smoking Law (Act of Smoke-free Environments) from 2007, which forbid smoking at workplaces, schools, public institutions, and restaurants, except for rooms made for smoking only. A critical campaign sponsored by the popular Danish folk musician Kim Larsen was launched with posters and postcards stating, "*Congratulation with the new Smoking Law – Gesundheit macht Frei*", aligning the new law with the Nazi regime's brutal efforts to create a clean and healthy Aryan society. Despite such protest from one of the best-loved artist, critical voices are rarely heard today. Six years after the law, it seems impossible that smoking in offices, at restaurants, in hospitals, and trains used to be part of everyday life such a short time ago. Today, areas outside buildings, train platforms, and other open public spaces are discussed as new territories for preventive intervention and protection against passive smoking.

Accordingly, the issue of prevention holds a number of challenges and controversies that cuts across political and moral questions. It is simultaneously viewed as an issue that has to do with personal choice – the fundamental right to choose how to live – and as a problem that is linked to structural circumstances – that people do not have equal conditions for making personal choices regarding how to live. This leads to a basic tension: Is the problem of prevention located within the individual or societal body? The problem of prevention, however, may also be framed in a more practical way focusing on how to ‘do’ something about it, rather than being stuck with the more ethical questions of choice and equality. Viewed from this angle, prevention can be viewed as a range of actions and programmes, each reflecting different political or professional understandings that imply different means or strategies to manage unhealthy lifestyles. Some are regulated by law and work through penalization if individuals do not submit to the legislation; other strategies are informative and base their intervention on the promises of human rationality and thus work on the assumption that humans will generally do what is healthy for them as long as they have the right (medical) knowledge. Yet other strategies work through a more individualized orientation which adopts different logics than the legislative and medical approach and through psychological motivation and counselling attempt to take the individual’s specific social, cultural, and practical situation into consideration so as to inform the design of the preventive intervention. This orientation is sometimes described as the ‘patient-centred’ approach, and it is this kind of prevention that I deal with in this thesis.

PATIENT-CENTRED PREVENTION: HOPES OF AUTONOMY AND EFFECTIVENESS

The concept of patient-centred care was established in the 1980s and 1990s, especially within family medicine (Hudon et al. 2012).

Although definitions of patient-centred care vary, the key tenet is to take the point of departure in and organize care and treatment in accordance with the particular patient. This approach is often defined in opposition to the ‘doctor-centred’ (or professional-centred) approach (Byrne & Long 1976) and the ‘disease-centred’ approach (Steward et al. 1995). This can be perceived as a consequence of the numerous critical accounts regarding medical practice and power relations between health professionals and patients, which for decades have been expressed especially within the social sciences. Talcott Parsons (1951) was one of the first to voice this critique and conceptualise medicine as an institution of social control (Conrad 1992). Also, the critique of medicalization brought forward by Irving Zola (1983), which claims that everyday life becomes more and more subsumed under medical domination and influence, can be seen as an influential critique of modern healthcare. In relation to this critique, the patient-centred approach can be perceived as a response to institutional practices that subject patients to medical hegemony and paternalistic authority and reflects an ambition to foster active, responsible, and competent patients.

Patient-centred care thus promotes an understanding of the patient as the key-actor in the definition of ‘what’ the problem is and ‘how’ to manage it. The definition of patient-centred care is often referred to the model defined by Steward et al. (1995), which identifies six interconnected factors: (1) Exploring both the disease and illness experience; (2) understanding the whole person; (3) finding common ground; (4) incorporating prevention and health promotion; (5) enhancing the doctor-patient relationship; and (6) ‘being realistic’ (Mead & Bower 2000; Hudon et al. 2012). These factors convey in different ways both the ‘what’ and ‘how’ of care and broaden the perception of disease as well as the patient. First of all, the approach includes both the biomedical understanding of disease and

the patients' subjective illness understanding, what is often termed the "biopsychosocial" dimensions of disease (Engel 1977), i.e., psychological and social factors that may influence the patient's understanding and resources for managing the illness. Furthermore, with the call for prevention and health promotion, the approach expands the focus on the patient's current condition by incorporating a long-term perspective on the disease's development. Moreover, the approach describes the optimal relationship between professional and patient as a collaborative effort that strives for pragmatic solutions. The patient-centred approach implies an understanding of the patient as an actor that is actively involved in the definition of the disease and in the decision-making regarding the treatment and care plan. Although the patient-centred approach has a background in family medicine, it has been adopted in various medical and nursing fields and has become a prefix in many care practices and methods. Recent examples include "Patient-centred culturally sensitive health care" (Tucker et al. 2011), "Patient-centred care in chronic disease management" (Hudon et al. 2012), "The Patient-centred medical home" (Braddock et al. 2012), and "Patient-centred goal-setting" (Levack et al. 2011). The patient-centred approach resonates with a range of preventive and health promoting health educating initiatives such as 'patient education', 'self-management', 'self-efficacy', and 'patient empowerment'. Common for these different notions is the ambition to enable patients to make decisions regarding their way of living by informing them about the relationship between their lifestyle and their disease and to support them in actualizing these decisions. One of the core values and key concepts of patient-centred approach is that of 'autonomy'. The patient-centred approach thus formulates an ambition of ensuring individuals' fundamental right to choose.

But intertwined with this concern for patient autonomy, the pa-

tient-centred approach has also been argued as being a more effective way to engage patients in preventive activities and lifestyle changes. Based on behavioural psychological theory, it is argued that preventive interventions are more sustainable when they are based on patients' personal motivation (Prochaska et al. 1994). This alleged effectiveness of a patient-centred approach has been established more broadly and measured as patient satisfaction, patient safety, and decrease in healthcare utilization (e.g., Australian Commission on Safety and Quality in Health Care 2011, Bauman et al. 2003). Also in Danish healthcare, the patient-centred approach has emerged as a central topic in the last ten to fifteen years within treatment, care, and prevention (Kjær & Reff 2010, Valgård 2003). The continual actuality of the approach was expressed in a recent article in the Danish Weekly Newsletter for Doctors, where spokespersons from the Danish Cancer Society accounted for the need to strengthen a patient-centred approach in order to improve quality in Danish healthcare. This was more specifically understood as better communication, continuity, and coordination that the authors argued entail a higher degree of patient satisfaction and reduction of adverse events (Knudsen & Olsen 2012).

The patient-centred approach is thus both oriented towards a concern regarding patient autonomy and a concern about increasing the efficiency of prevention. However, these admirable ambitions have not been left undisputed. Within the medical field, the issue of effectiveness has been disputed for example by questioning the methodological premises for evaluating patient-centredness according to evidence-based criteria and the problem of inconsistent definitions of patient-centredness (Mead & Bower 2000, Hudon et al. 2011). Also, it has been argued that the 'evidence-based' and 'patient-centred' rest on incompatible paradigms that are difficult to merge (Bensing 2000, Lacey & Backer 2008).

Furthermore, critiques formulated outside the medical field, by social theoretical scholars, have especially challenged the understanding that the patient-centred approach promotes autonomy. One kind of critique argues that the ‘empowering’ ambition neglects those people that are not able to actively engage in or adhere to self-caring preventive interventions and therefore only manage to empower those whom are already taking responsibility for their health (Anderson 1996, Wilson 2001, Wilson et al. 2007). Another kind of critique points out that the kind of autonomy that is being fostered only includes autonomy which complies with biomedical values, and that although the patient-centred approach is based on the individual’s motivations and values, the trajectory of the health promoting intervention is still formed by a medical authority and public health rationality (Levack et al. 2011, Coveney 1998, Nielsen & Grøn 2012). This delicate balance between expert dominance and citizen autonomy is recognized not only within healthcare but also in other public areas, where welfare work is defined in dialogue with citizens and based on their understanding of their situation and needs – what is referred to in parallel terms as ‘client-centred’ or ‘citizen-centred’ approaches (Cruikshank 1999, Rose 1999, Dean 1999).

A major source of inspiration for this type of critique is the work of French historian of ideas, Michel Foucault, who has addressed what he characterizes as the key governing concern of liberal societies, namely, “a wish to govern without governing too much” (Foucault 1997). Through Foucault’s concept of governmentality, patient-centred and other responsabilizing preventive and health promoting approaches have been analysed as subtle power strategies that work through individuals’ and communities’ identities and self-regulation. In the early uptakes of Foucault’s work, medicine and health care were described as part of regimes for social control (Armstrong 1983) that exercise power by shaping individuals’

self-understanding and self-conduct in refined ways that links up with societal regulation (Turner 1997). Although the tone of these critiques has been modified, recent governmentality-inspired studies still point to the critical transgression or blurring of the public/private boundary that modern health promotion and preventive strategies perform (Larsen 2011, Fox et al. 2005, Finn & Sarangi 2008, Ryan et al 2010, Rous & Hunt 2004). In these studies, the issue of responsibility comes across as a central point for discussion. Not only do governmental strategies for health promotion and prevention intensify individuals' responsibility for their own (and the nations) health and well-being; the strategies also specify the conditions for exercising personal health responsibility.

However, what seems to be less investigated in relation to these neoliberal health promoting and preventive strategies is the impact it has on the health professionals that work with such patient-centred approaches and how these affect professional responsibility. In this study I explore this issue further and shed light on the managerial and organizational challenges that emerges with patient-centred prevention - both in relation to the implementation of prevention within the vascular specialty and in relation to the preventive encounters between health professionals and patients.

"GET-GOING-A-GAIN": A SPECIFIC PREVENTION PROGRAMME AND ITS OBJECTIVES

The prevention programme that forms the empirical case of this thesis is called "Get-Going-a-Gain" (GGG)¹ and was developed at

1 In Danish the preventive programme is called Gang-i-Gen, which translates into "get going again" but also forms a pun referring to the name of the hospital where it was developed Gentofte. When the programme was implemented at Rigshospitalet it was called Gang-i-Riget, which refers to the nickname of Rigshospitalet "Riget", which translates into Kingdom.

the vascular clinic at Gentofte Hospital in 2001 and further implemented at the vascular clinic at Rigshospitalet, the region hospital, in 2004. The programme is aimed at people with *atherosclerosis*, one of the major chronic diseases causing serious and potentially fatal coronary heart diseases and stroke. Atherosclerosis is a condition where fat (at later stages *plaque*) builds up on the inside of arteries and thereby inhibits free blood flow. If this constriction (*stenosis*) is left untreated, it may continue to build up and completely close off the passage (*occlusion*). Patients in the GGG programme suffer from atherosclerosis but are not (yet) heart patients. They are referred to the vascular specialty because they suffer from painful muscle cramps in the lower legs, the most common symptom of atherosclerosis, which is caused by decreased blood flow to their leg muscles. This symptom is called *claudicatio intermittens* or “window watcher syndrome” in Danish layman terms because the pain forces the affected person to stop and ‘look at windows’ when walking. After pausing, when the blood has reached the calf muscle, the cramps cease and the person is again able to walk for a while. The painful leg cramps and the intermittent walks are not the only problems of reduced blood flow to the legs; another major problem is that small wounds on the peripheral limbs may have difficulties healing due to the inadequate blood flow and may ultimately lead to gangrene and the need for amputation. The programme’s name, “Get-Going-a-Gain”, reflects the symptomatic problems of the disease, which is that people with *claudicatio intermittens* have come to a halt, and the programme is thus aimed at getting them ‘going again’.

Atherosclerosis cannot be cured, so treatment consists of relieving symptoms and hindering the exacerbation of the disease. The surgical interventions that are performed within the vascular specialty include: *Atherectomy*, where narrowed arteries are stripped of the obstructing plaque; *Angioplasty* (in Danish: Balloon operation), where

a small deflated balloon is inserted inside the artery and inflated to push away the plaque and recreate the passage again – sometimes stabilized by a small metal grid (a *stent*) to uphold the enlargement. *Bypasses* are also part of the surgical solutions for obstructed blood flow. If an artery is completely closed, a new artery (either made by a prepared vein or synthetic Gore-Tex material) is inserted and sewn on either side of the occlusion to create a new passage. Operations are, however, not without risk and have limited durability. Therefore, preventive treatment is the preferred and first intervention.

The preventive treatment consists of prophylactic medicine (antiplatelet and cholesterol-lowering medicine), which changes the properties of the blood by reducing the clot formation and lowering the cholesterol levels in the blood so that they do not develop into atherosclerotic plaque. Furthermore, patients that are enrolled in GGG are offered individual nurse-conducted conversations that focus on smoking, diet, and exercise, the so-called lifestyle factors that have a major influence on the condition. The GGG course typically consists of five individual conversations over a period of approximately one year. The conversations have an informative scope, where patients are educated in how smoking, exercise, and diet influence their condition and the development of atherosclerosis. Patients are offered smoking cessation support, and are given advice about healthy diet and exercise. The programme stresses that the conversations are based on the individual patient's particular life conditions and personal motivation. The programme is built on psychological theory on behaviour change and uses the method of *Motivational Interviewing* (developed by Miller and Rollnick in the 1980s), which has become widely used in prevention within the Danish healthcare system and which aims to clarify patients' motivations for lifestyle changes and handle relapses in the process of individual behaviour change. The main focus of

the programme is to provide patients with knowledge on which they can act “according to their own motivation”, as the expression goes among the nurses. The conversations are supported by specially developed software (GGG software) in which different measurements and notes on the patient’s progress are entered and which allows for the monitoring of the individual patient as well as the preventive programme’s effect (the details of the knowledge forms and technologies will be further described in the analytical chapters).

When GGG started in 2001 at Gentofte Hospital, it was the first vascular clinic, not only in Denmark, but in Europe to offer vascular patients a formalized preventive concept, which supplemented the medical treatment and monitoring with focused conversations on lifestyle issues. Within the vascular community, this was thus viewed as pioneering work and a reorientation of the vascular object of attention and professional responsibility. In 2004, the managing surgeon and the project nurse, who had played major roles in the development of GGG, moved to the vascular clinic at Rigshospitalet and initiated the implementation of the programme in this clinical organization. In 2008, as a consequence of a major structural reform in Denmark in 2007, the two vascular clinics at Gentofte Hospital and Rigshospitalet, were merged but remained at two different locations while referring to the same managing team.

The empirical foundation of this thesis is the ethnographic fieldwork I conducted at Gentofte Hospital over two months in 2009 and over two months at Rigshospitalet in 2010 as well as my ongoing contact with the clinics over the years 2009-13, where I have followed the development of the preventive work and the GGG programme.

THE THESIS' ANALYTICAL APPROACH: PREVENTION AS SOCIOMATERIAL PRACTICE

In this thesis I study prevention 'in practice'. This attention to practice, what some also call the "practice turn" (e.g. Savigny et al. 2000), is contrasted to other social theoretical accounts that understand 'the social' in terms of for example individual lifeworlds, language, systems, or institutions (Savigny et al. 2000:13). A practice approach does not assign any of these any explanatory status, but explores instead how they are practised and how they come into being through practice.

The practice turn is however not a unified approach, and there are variations of which kinds of practices are attended to. In my work I attend to sociomaterial practices. This approach draws on theoretical resources located in the cross-disciplinary field of Science, Technology and Society (STS) and especially inspired by Actor-Network Theory (ANT) (primarily associated with French anthropologist and philosopher Bruno Latour, French sociologist Michel Callon, and British sociologist John Law) and scholars that sympathetically and critically debate with ANT, a community often labelled Post-ANT (e.g. Dutch philosopher Annemarie Mol, British anthropologist Marilyn Strathern, American sociologist Susan Leigh Star, and John Law). Despite differences in their analytical interests (which I will return to in greater detail in Chapter 2), what connect them is a close attention to the relationships between the human and non-human, which constitute 'the social'. This attention is often referred to as "material semiotics", which Law describes as an approach that "takes the semiotic insight, that of the relationality of entities, the notion that they are produced in relations, and applies this ruthlessly to all materials" (Law 1999: 4). This means that entities are made up of their relations and are effects of these relations and implies

that I will attend to how prevention is enacted in heterogeneous relations between human and nonhuman actors.

Latour describes ANT as “a very crude method to learn from the actors without imposing on them an a priori definition of their world-building capacities” (Latour 1999a: 20). He points to ethnomethodology, which engages in studying actors’ everyday methods for producing social order, as a major source of inspiration and further states that ANT has a central interest in enabling actors (human and non-human) to “build their own space” and “to define the world in their own terms, using their own dimensions and touchstones” (ibid.: 20). This approach thus implies a certain relation to the field and actors that are being studied, which may be described as one of engagement rather than opposition. This is also described in the introduction to the anthology *“Health Promotion and Prevention Programmes in Practice: How Patients’ Health Practices are Rationalised, Reconceptualised and Reorganised”* (Mathar & Jansen 2010). The work in this book is contrasted to the work of medical sociologists and anthropologists, which the editors of the book argue have focused on the social dimension of health and illness in *opposition* to the medical system, often criticizing the biomedical system for being ‘paternalistic’, ‘objectifying’, and suppressing lay belief and the nursing profession (ibid: 15; also Pols & Moser 2009 and Jensen 2010 present similar critiques of medical sociology). In contrast to this attitude, the book’s editors claim that the attitude in their book and more generally in STS, is one of engagement with medicine rather than opposition. My study of how patient-centred prevention is practiced in line with this approach.

TOWARDS A RESEARCH QUESTION

ANT’s interest in actors’ “world-building” (Latour 1999a: 20; Callon 1986b: 22; Callon & Latour 1981) resonates with the Danish word

for prevention ‘forebyggelse’ (from German “vorbauen”), which literally means ‘to build in front of’. This expands the meaning of the English word ‘prevention’², which means ‘to come before, anticipate, hinder’ and thus solely focuses on the act that hinders something from happening. In Danish, the preposition ‘for’ is the same as the English ‘pre’, something before or in front of something else. The second part of the word ‘-byggelse’ means ‘building’. ‘Forebyggelse’ (noun) is the building in front of something in order to protect it. “Forebygge” (verb) is the building of this defence.

The Danish word for prevention thus bears other connotations than the English word. The Danish word focuses on the construction made in order for something not to take place. The action, described by the word, is not just about hindering something from happening; it is the establishment of something that hinders. The word draws attention to the action of building and thus the actors who build the building, but also to the building itself, the building material, that which holds it together and defines its strength. It thus reflects the co-construction of different actors. In this thesis, I am inspired by the image of the building of prevention and ask questions such as: What is this building? What material is it made of? What is its form? Who builds it? What does it contain? And how durable is it?

But where to look for these constructions that aim to hinder particular actions? In my thesis, I study prevention in relation to patients who are already suffering from atherosclerosis. As the disease is chronic, the prevention is thus aimed at hindering its progression and the consequential vascular complications. The location

2 From Latin *praevenire*: a constellation of *prae-* meaning ‘before’ and *venire* meaning ‘to come’.

for preventive work and the ‘building’ that goes on may therefore first of all be placed at the hospital: This is where atherosclerosis is identified and patients are enrolled in a preventive treatment programme. At the hospital, several kinds of preventive constructions take place. The GGG programme is one of these. It consists of a range of procedures, measurements, medical prescriptions, and planned check-ups – an organizational infrastructure for handling the prevention of atherosclerosis.

In the clinical setup, another kind of building is going on, a more bodily kind. In the medical treatment, blood properties are changed and thus one can say that the preventive building takes place within the body, at the molecular level. The blood is reconstructed in a way that prevents it from adding to the progression of the disease. Another bodily reconstruction in the preventive work involves injecting, cutting, inserting, and sewing – the vascular constructions performed on patients’ bodies by surgeons and their tools. Some vascular complications are possible to prevent by building new passages for blood or cleaning blocked passages. However, not all patients have their vascular system reconstructed. There are earlier stages of atherosclerosis where surgical reconstruction is not yet relevant.

Here, yet another kind of construction is attempted in addition to the medical prevention. This is aimed at patients’ lifestyles. If patients are able to make certain lifestyle changes – quit smoking, eat healthier, and exercise, they can prevent the disease from worsening and even improve their general condition, that is, reduce pain and gain mobility. This construction, one could argue, takes place inside the head, in the mind, in building a new mindset, one that will enable a healthy life by preventing actions that induce the progression of the disease. Yet the preventive ambition does not rest within the

mind and body of the patient. It strives to enable action outside the mind, in the doing of prevention in everyday life, and in patients' homely spaces, where the active quitting of tobacco, of exercising, of preparing and eating healthy food is to be built into everyday routines and homely spaces in order to have an impact on the body.

THE THESIS' RESEARCH QUESTION

Taking my point of departure in the field of vascular surgery and the case of the preventive programme GGG, the question I seek to explore in this thesis is:

How is preventive capacity and responsibility built and distributed in patient-centred prevention practices?

The question consists of two word pairs: The nouns 'capacity' and 'responsibility' and the verbs 'building' and 'distribution'. 'Capacity' and 'responsibility' reflect the joined practical and ethical concerns of patient-centred prevention. I have chosen the word 'capacity' because it may both refer to the abilities of humans and nonhumans. The issue of responsibility is motivated by the controversy that patient-centred prevention creates, and which I wish to engage in and contribute to by describing how patient-centred prevention is practiced in social-material practices. As described above, the concept of 'building' is inspired by the Danish word for prevention 'forebyggelse', which both refers to the verb, the building activity, but also to the noun, the materialised building and thus draws attention to a wide range of actors that contribute to this simultaneous product and process. Combined with the verb of 'distribution', what I seek to explore is how the building of prevention moves across dif-

ferent spaces and how preventive ambitions are distributed across clinical and home spaces.

MAPPING THE BUILDING: THE STRUCTURE OF THE THESIS

In the clinic hallway a colourful commercial poster from Gore, the company that produces the durable material Goretex for shoes, motorcycle jackets, as well as vascular products for the medical world, is hung on the wall. It is a typographical roadmap with blue and red highways and illustrations of the landscape's formation, hills, and lakes. Hiking routes are depicted in organic lines on the map and marked by the icon of backpack carrying people. In contrast, resident areas are illustrated in square formations. With a closer look on what appears to be a map over a geographical area (perhaps the area where the Gore factory is placed?), strange names appear on the high ways, roads and towns: Abdominal Aorta, External Iliac A., Inf. Epigastric A., Lateral Circumflex A. These are not names of geographical places, but belong to another atlas, that of the body. What the poster shows is a specific part of the vascular system, the part from the stomach to the legs, for which Gore produces vascular products to be inserted by surgeons in the vascular specialty. Other parts of the vascular system do not appear: The pumping heart, the blood flow, the capillaries, kidneys, liver, or lungs. These have been cut off, so that the main pathways, the larger arteries and veins stand alone. The analogy of the road map is not unfamiliar to the vascular specialty. Vascular surgeons and nurses also talk about the main arteries as "highways" and bypass operations as "diversions". It is not the only metaphors used to describe the vascular object of interest

and intervention; they also talk about their work in plumbing concepts, such as “replacing the piping” or “problems of pumping”. In fact, some of the tools invented by vascular surgeons were inspired by plumbing tools. It is not only the vascular system that goes by allegorical comparison, also the patients on whom surgery is performed get new names upon their arrival – they go by the names “new arteries” or “new veins”, depending on the locality of their ailment.



My focus on the simultaneous building and distribution of prevention is framed by the image of the vascular system. This framework was developed through my fieldwork as well as in the reading and writing process of my thesis work. It was not only inspired by the empirical object in focus within the vascular specialty, but also in ANT literature, where it is evoked at occasions. This overlap between the analytical concepts and empirical object is evoked through this thesis as a map -or angiography- of the building and distribution of preventive capacity and responsibility. Furthermore, it initiates a heuristic exercise in which vascular form, properties, functions, complications, and interventions add new dimensions and expand the analytical resources I draw on by formulating new concepts. Thereby, I engage in the task of enabling the actors 'to build their own space' and describe the world in their 'own dimensions' as described by Latour. The five empirical chapters in this thesis evoke different locations in the vascular circuit: The heart, arteries, capillaries, veins, kidneys, and lungs, all through which we follow the circulating flow and distribution of prevention.

THE THESIS' CHAPTERS

In the following chapter (Actor-Network Theory: An Approach to Studying Strategies and Multiplicity), I introduce my analytical setup in more detail. I combine both classical ANT and critical developments of ANT, which are identified respectively as 'strategy-oriented' and 'multiplicity-oriented' ANT. Combining the two approaches allows me to map relations that create strong preventive actor-networks as well as follow prevention's multiplicity as it

is enacted in practice. I unfold the metaphorical resources of the vascular system, blood and fluidity, which are found in the ANT literature and which I develop further through my empirical chapters by introducing vascular properties and functions that expand the analytical imagery further.

Chapter 3 (Research Practice: Empirical, Theoretical and Methodological Intertwinements) presents the research process behind the thesis. Besides describing the practicalities of the project's onset and methodological approach, I point to some of the crucial decisions I made regarding the framing of the project including the occasion that led me to evoke the vascular system as an analytical heuristic.

In Chapter 4 (Building Preventive Pathways into the Vascular Specialty: The Development of GGG), I describe the building of prevention as a professional task within vascular surgery and the development of the GGG programme at Gentofte Hospital and I show how prevention is translated into a vascular concern by linking it to existing interests and problems of surgeons and nurses within the vascular specialty. The chapter describes the strategic work in mobilising prevention as a vascular task and points out the new roles and responsibilities that GGG imply for the professionals in the field. In vascular terms, I focus on the *heart* that generates the preventive flow and the *arteries* that form the passages for prevention within the vascular specialty.

Chapter 5 (Complications in the Preventive Pathways: Adjusting GGG and the Preventive Flow) follows the further development and translation of GGG as it is implemented at Rigshospitalet. I describe two challenges that obstruct the preventive flow and diverts from the initial strategic mobilization of prevention within the vascular field. One regards the surgeons' neglect of referring patients to

the preventive programme. The other regards a decrease in preventive enthusiasm among the nurses who work with prevention. These challenges are managed with different organizational interventions that ensure the preventive flow by creating *bypasses* around the occluding doctors and by creating new preventive tasks that ensures a richer *vascularization* of the preventive work.

In Chapter 6 (Distributing Prevention to the Patient's Home: Strategies for Lifestyle Changes in the GGG Consultation), I focus on the preventive encounters between nurses and patients. I explore how patients' preventive capacities and responsibilities are built and distributed from the clinical space to patients' home spaces by different motivational practices. I show that the distribution depends on an openness in the preventive consultation where patients provide information about their life situation and personal motivation for lifestyle changes, which enables the nurses to create passages for the preventive capacity and responsibility to flow into the patients' everyday lives, practicalities, and concerns. The chapter draws on the image of *capillaries* - the complex network in which the metabolic process takes place. The blood flow that is delivered to the capillaries through the arterial passages carries nutrients and oxygen, which are *perfused* into the cells of the tissue in the metabolic process.

The focus in Chapter 7 (Overflows in the Preventive Encounter: Patients' Re-distribution of Preventive Responsibility and Redefinition of GGG) also focuses on the GGG consultations between nurses and patients. I show how the openness, which the patient-centred preventive consultation depends on, also forms openings for the patients to return issues, demands, and expectations, which 'overflows' GGG's scope and formulates new types of professional responsibilities for the nurses. Although nurses attempt to frame these overflows, the issues and demands put forward by the patients

still continue to concern the nurses. This, I propose, resembles another part of the metabolic process in the capillaries, namely, the exchange of *waste products* and deoxygenated blood, which are returned via the veins.

In Chapter 8 (Prevention's Backflow: Professional Responsibility in Patient-centred Prevention Work), I focus on nurses' reflections on the preventive work, what I propose as the *backflow* of the preventive work. I describe the experiences and challenges that nurses express about the preventive work and how they try to deal with these. The preventive work is experienced as a demanding practice that requires that the nurse 'use herself' as a central tool in the preventive work, which at times blurs the boundary between her professional and personal responsibility. Furthermore, nurses also express the challenge that lies in the conflicting values in the patient-centred approach; namely, the value of ensuring patient autonomy and at the same time providing effective preventive outcomes.

Chapter 9 (Concluding Discussion: Prevention's Circulation and Filtering Organs) summarizes the findings across the empirical chapters and relates this to the thesis' research question regarding the building and distribution of preventive capacity and responsibility among health professionals and patients across the clinical/home boundary. After this summary, the chapter discusses the values of autonomy and effectiveness which patient-centred prevention is articulated and evaluated according to. I draw on the image of the *filtering organs* that connects to the vascular system and which cleanses the blood as it circulates. I describe prevention's ideals as such filtering organs, which cleanses patient-centred prevention in specific ways by redistributing some qualities of the preventive work while discharging others. In the discussion, I argue that the ideals of autonomy and effectiveness are inadequate to discuss and evaluate

prevention according to the way that it is being practised. I thus propose that other ideals, or filters, may be formulated in order to provide other understandings and criteria for evaluation of the preventive work. Furthermore, I specify the thesis' contributions to two fields of audiences, the 'practice-oriented' field of prevention and health promotion where ANT's analytical approach and empirical finding expands the common understanding of prevention within this field. The other field that the thesis contributes to is STS and especially ANT where I point to the productiveness of combining the two analytical approaches within the tradition and furthermore discuss my use of the vascular system as an analytical imagery and relate this to the debate within STS regarding the relationship between the conceptual and empirical.

CHAPTER 2

Actor-Network Theory: An Approach for Studying Strategies and Multiplicity

Actor-Network Theory: An Approach for Studying Strategies and Multiplicity

INTRODUCTION

As briefly introduced in the previous chapter, this study looks at prevention as sociomaterial practices and is especially inspired by Actor-Network Theory (ANT). ANT is primarily associated with the work of French anthropologist and philosopher Bruno Latour, French sociologist Michel Callon, and British sociologist John Law, all of whom have, since the 1980s, developed ANT's analytical approach in a collective that includes a wide range of authors both sympathetic and critical to ANT. In this thesis, I draw on the 'classical' repertoire of ANT, especially concepts and empirical cases described by Latour and Callon, as well as insights from what has been labelled "Post-ANT" or "After ANT" – the critical reflections and conceptual developments of ANT – where I focus on the work by Dutch philosopher Annemarie Mol and John Law. The distinction between ANT and Post-ANT may convey an understanding of two incompatible strands. However, in my work I draw on insights from both sides, arguing that they complement each other. This is inspired by an alternative way of distinguishing between the two approaches; namely, by defining them according to their different analytical interests and possibilities. Here, classical ANT has been defined as "strategy-oriented ANT" and post-ANT as "multiplicity-oriented ANT" (Vikkelsø 2007). In the following, I describe the two approaches and their different conceptual and metaphorical resources, which together have inspired my analyses of prevention practices both as a strategic project and as a phenomenon that multiplies into various ontological versions. Furthermore, I draw atten-

tion to the use of blood and vascular metaphors that are evoked in both approaches and the curious overlap it has with the empirical object of the vascular system in this study. I discuss this conceptual/empirical overlap and propose the vascular system as a heuristic analytical form, which I develop and draw on throughout the analyses in this thesis.

STRATEGIC ANT: CLASSICAL CASES AND CONCEPTUAL REPERTOIRE

ANT is often described as a material-semiotic approach, “that treats everything in the social and natural worlds as a continuously generated effect of the webs of relations within which they are located” (Law 2009: 141). The figure of the actor-network conveys the analytical principle that all actors are constituted by their relations: An actor never stands alone or isolated but depends on relations to other heterogeneous actors. ANT operates with the principles of “generalized symmetry” and “free association” (Callon 1986a: 196), which respectively implies that all phenomena are explained by the same analytical vocabulary and that any a priori distinctions between the natural and the social are abandoned. An ANT approach implies that humans and non-humans are assigned the same possibility for agency instead of assuming pre-set relations of who acts on whom. Actors are sometimes also termed *actants*. This concept is taken from French semiologist Algierdas Julien Greimas’s semiotic analytical model (1966), in which agency is not only assigned to humans but also to objects. Since ‘actor’ is often associated with humans, the term ‘actant’ is used to include non-humans and their agency (Latour 1999b: 303), permitting the synonymous use of actor and actant in ANT analyses.

ANT was developed in the 1980s based on ethnographic studies of laboratory research (Latour & Woolgar 1979) and was inspired

by social studies of science that pay attention to the social factors that influence scientific work (the so-called ‘social construction of science’), which had unsettled the natural sciences’ objectivity claims in the 1960s and 1970s. Latour and Woolgar, however, took the constructivist approach further, arguing that scientific facts are constructed in socio-technical processes that involve ‘social’ human actors, as well as technologies and materials. The approach thus describes the construction of scientific facts as the meticulous work required for the ‘world’ to be transformed into ‘facts’, or “packing the world into words” (Latour 1999b: 24). The descriptions follow the work of the sampling of different materials, whether in a laboratory set-up (Latour & Woolgar 1979) or the Amazonian rainforest (Latour 1999b), then the processing of these samples through the use of different “inscription devices” – the various technologies and apparatuses that transform material substances (whether laboratory rats or soil samples) into figures, diagrams, or numbers, and finally presents the crafting and writing of reports and papers at the scientist’s desk. This constructivist approach that ANT performs differs from social constructivism. Latour states:

“When we say that a fact is constructed, we simply mean that we account for the solid objective reality by mobilizing various entities whose assemblage could fail; ‘social constructivism’ means, on the other hand, that we replace what this reality is made of with some *other stuff*, the social in which it is ‘really’ built.” (Latour 2005: 91)³

‘Construction’ in the ANT sense takes its point of departure in

3 This difference was represented in the change of the subtitle of their book *Laboratory Life*, which in the first edition was labeled “The social construction of scientific facts” and later changed to “The construction of scientific facts”.

the commonsensical understanding of something being built or crafted. Saying that something is constructed means that it is not a “mystery that has just popped out of nowhere” (ibid.: 88), but rather that something has come into being by a range of practices, materials, skills, and knowledge, regardless of which enterprise is being made or ‘world being built’; this being the opposite of both natural and social scientists’ understanding of constructions as something artificial, made-up, or false (ibid.: 90). The word ‘construction’ was thought of as ideal to describe “a more realistic version of what it is for anything to stand” (ibid.: 89) Latour states and draws attention to the construction site (which is also pictured on the cover of *Reassembling the Social: An Introduction to Actor-Network Theory* (Latour 2005)) as an ideal vantage point for observing the connections between humans and non-humans, which every construction requires. The use of the word ‘construction’ implies questions of how well, durable, and stable those constructions are, as well as the costs they incur.

Although ANT departed from laboratory studies and an interest in studying science in the making, it has expanded its scope and has especially, through the work of Latour, Callon, and Law, become a broader social theoretical and philosophical approach, particularly within the cross-disciplinary field of Science, Technology and Society studies (STS). This broadened approach also implies engagement in a multitude of other empirical fields such as medicine and healthcare (e.g., Mol 2002/2008, Singleton 2005, Pols 2012), engineering (e.g., Akrich 1992, Law 1988, Latour 1996), IT (e.g., Berg 1997, Jensen 2010, Vikkelsø 2003), teaching (e.g. Verran 2001, Sørensen 2005), and organisations and markets (e.g., Law 1994, Czarniawska & Hernes 2005, Callon 1998/1999). In its broader orientation, ANT was formulated as a provocative alternative to the dominant social theory and established truths

and ‘grand theories’ in sociology⁴. ANT’s emphasis on sociomaterial relations unsettles a range of sociological dualisms – human and non-human, social and technical, micro and macro, science and society, and refutes that there are ‘deeper structures’ such as culture, power, or society that in themselves determine specific events and relationships. As Latour formulates “society is not what holds us together, it is what is held together” (Latour 1986: 276). This does not mean that society or the social does not exist; it exists in its continual practice as a performative sociomaterial effect. The argument is rather that ‘the social’ does not in itself explain anything but is something to be explained just like any other phenomenon. It has been argued that ANT is thus more a method or an approach to studying the social than it is a theory of the social (or any other entity) (Latour 1999a: 19, see also Law 2004:157). The ANT slogan, “Follow the actor!” (Latour 2005: 12), conveys the key interest and attention to actors’ movements (Latour 1999a: 17), which is often described as *circulation*. Following entities or actors as they circulate allows for the recording of how they come into being in various relations and the changes they undergo in this movement. Latour proposes that following the circulations of actors and entities (whether “scientific facts”, “the social”, “organizations”, “the body”, “power”, etc.) allows us to expand our understanding than merely defining entities, essences, or provinces (ibid.: 29). This, he states, is inspired by an ethnomethodological approach, which allows one to learn from the actors that are being studied and to take their terms, conceptualizations, and understandings ‘seriously’, while refraining from

4 Whether ANT still holds this position is a question currently being debated, as it has been argued that ANT has become its own grand theory especially within the field of STS (Wyatt & Balmer 2007), where it has been noted that ANT’s once radical claim of generalized symmetry has become redundant.

“explaining away the actors’ behaviour and reasoning with social scientists’ powerful gaze and methods” (ibid.: 19).

An ANT approach thus implies that one pays close attention to how worlds, objects, or phenomena come into being. It is an act of description rather than an act of “filtering” according to pre-established concepts and understandings (Latour 2005: 55). The ambition to learn from the actors of the field by following their “world-building activity” not only refers to the spoken statements and conceptualisations of the human actors, but (as quoted in Chapter 1) also refers to the ambition to learn from the fields’ “dimensions” and “touchstones” (Latour 1999a: 20), which may include the fields more material substances and actors; an issue I return to later in this chapter.

Building Networks through Translation Processes

A central focal point in an ANT approach is on the processes that bring an actor-network together. This process is described as *translation*, and, accordingly, ANT is often described as the “sociology of translation” (Callon 1986a). The processes of translation imply the forging of relations between actors and materials, and it leads to the momentary stability of the actor-network and the constitution of agency. The concept is taken from French philosopher Michel Serres (1974) and his work on order and disorder (Law 2009: 144) and is further developed by Callon (Callon 1986a/b). In its classical sense, to translate is an attempt to make two words equivalent, but since no two words are ever equivalent, translation comes to work both as a transferring and transforming signal – ordering and disordering at the same time (Law 2009: 144). This keeps the outcome of the translation open and unpredictable: How it is possible to stabilise the network and how long it is possible to sustain this stability is therefore an empirical question.

In Callon's seminal analysis, "Some elements of a sociology of translation: domestication of the scallops and the fishermen of St Brieuc Bay" (Callon 1986a), he develops the concept of translation and distinguishes between four "moments of translation", which he terms "Problematisation", "Interessement", "Enrolment", and "Mobilisation". This categorisation is not meant as a general model for all types of translations, but is an attempt to describe the translation process in greater detail by pointing to the different (overlapping) elements of the translation process he has followed. Callon follows the scientific and economic controversy regarding the decline in the scallop population in the St. Brieuc Bay in France and the attempts of three marine biologist researchers to develop a conservation strategy that would increase the population of scallops. This strategy implies new scientific knowledge, which in this case is the latest cultivation technique from Japan where the scallop larvae are anchored to collectors placed in seawater. This technique protects them against predatory fish as they grow until they are big enough to become 'sown' along the ocean bed to develop further for a couple of years before they are harvested.

In order to actualize the strategy, the biologists need to build relations with a range of actors, which include their scientific peers, the local fishermen, and the scallops. This implies the act of "problematisation", where the researchers try to convince the implicated actors about their understanding and solution to the problem by defining these actors' various interests and concerns. The researchers thus define the fishermen's interest as being economical and thus interested in conservation of the scallop population to ensure profit; their scientific colleagues are defined as being ignorant about the issue about scallops' anchorage and thus interested in advancing their knowledge; the scallops' interest is defined as a basic interest in survival. In the process of problematisation, the

researchers define what Callon terms an “obligatory passage point” to which all implicated actors have an interest, and which becomes the reason for them to join the researchers’ network; the research project and conservation strategy becomes the obligatory passage point for all implicated actors to meet. However, the solidity of the researchers’ problematisation and obligatory passage point is still to be tested⁵. The identity and interest of each actor as defined by the researcher can both prove to be something that the actors submit to or refuse. This is tested in the process of “Interessement”, which are those actions, techniques, or mechanisms that are used to stabilize the actors’ identities and internal relationships as well as to cut off actors and relationships that may destabilize the network. For example, in order for the scallop larvae to develop, other potential relationships need to be cut off, such as the predatory fish that will eat the larvae. The collectors in which the larvae are anchored serve the purpose of protecting the larvae while they grow and thus come to act as a “device of interessement” that locks the network allies into place and exclude competing actors. The concept of “Enrollment” refers to the further negotiations of and transformation of the initial interessement into active participation. The defining of roles, including devices of interessement, is not enough, but requires constant maintenance. A range of different techniques is used to continually define and coordinate the actors’ roles and internal relationships. With the concept of “mobilisation”, Callon draws attention to the fact that in the process of interessement and enrollment, it is only a few representatives for each implicated actor-community that are directly involved. The researchers have only enrolled a few individuals that have come to represent the larger masses: A few individual fishermen, some colleagues in the scientific community, and a few larvae on a col-

5 Also described as ‘trials of strengths’ (Callon 1986b: 30).

lector all act as spokespersons for their community. The question still remains whether these chosen spokespersons, and the entities that they speak on behalf of, can sustain their ascribed identities. Is it possible to mobilise the greater masses of fishermen, scientists, and larvae of which the spokespersons represent? And for how long? In the case, Callon shows that the mobilisation of the actors is stabilized for a while. The larvae anchor and grow and are set out to sea, where they are to mature. However, the mobilisation of the fishermen is more fragile. On Christmas Eve, a group of fishermen tempted by the outlook for the big catch set out to harvest the scallops and thus subvert their spokespersons.

Callon's description points to the continual and meticulous work of holding a network together. The notion of translation recalls the work and the necessary consent that is granted from the implied actors in order to achieve a strong actor-network. Callon demonstrates how effective translations depend on both material and social displacements by taking us through the discursive and material arguments and negotiations, as well as the violence and seductions, used to establish the actor-network (Callon 1986b: 28). Furthermore, he shows how translation is an endeavour that may be achieved but which also may fail completely by the desertion of a single actor.

The reestablishment of broken networks is taken up in Callon's later work on economic markets, however, it is by evoking a different set of concepts. Here, Callon uses the concepts of "framing" and "overflowing" to describe how economic markets are defined in order to establish a temporary order by defining different agents, objects, goods, and their internal relations (Callon 1999: 188). Framing is the establishment of a boundary or disentangling of an entity from its wider network of heterogeneous entities, which is bracketed to

achieve this temporary order (Callon 1998: 249). Within economic theory, this is captured by the notion of externalities, which cover those connections and relations that agents exclude from their calculations (Callon 1999: 187). However, this very establishment of externalities is also the establishment of relations that make the boundary permeable, constituting a “leakage point” where overflows can happen (ibid.: 188). Thus, framings are always incomplete and subjected to overflows as the framed entities may not conform to the identities ascribed to them and may form new networks that overflow the framing. This again calls for a re-framing, which Callon describes as an internalisation of externalities (ibid.: 188).

The translation process is thus described in different terms in ANT analyses, as the empirical translation processes vary and imply different actors, actions, and goals. For example, Latour uses the concepts of “programmes” and “anti-programmes” to describe the strategic translation and mobilisation processes. The concepts are described in the case of a hotel manager who attempts, by different means, to get hotel guests to leave the hotel key at the front desk, instead of taking it with them when they leave the hotel (Latour 1991). This wish is not something that the hotel guests are willing to grant. Latour describes the manager’s wish for the returning of the key as the manager’s “programme” and the hotel guests’ reluctance to do so as “anti-programmes”. The friendly reminder that the hotel manager puts on a sign is not enough to discipline the guests into submitting to his wish. Subsequently, the wish becomes materially “loaded” with a heavy and clumsy key ring that has a more persuasive effect and that comes to work as a technology to remind the hotel guests to return the key at the front desk when leaving. It is only once the hotel manager has accounted for the various anti-programmes of the hotel guests that stability is achieved and guests finally obey the order. But the order is not the same as the initial.

The programme ‘Please leave your key at the desk’ is translated into a key ring. It is no longer the same; it has been displaced from the original programme: “Customers no longer leave their room keys: instead they get rid of an unwieldy object that deforms their pocket” (ibid.: 105). They submit to the order, not because they read the information that reminds them to do so, nor because they are well behaved, but because they cannot be bothered to carry the large object around. Leaving behind is not as much a conscious choice as it is a compulsion. In this translation process, it is not only the statement that has changed, but also the key, the customer, and the hotel that have changed (ibid.: 105). Latour points out that the transformation always has a price: The simple programme or wish that keys are to be left behind is translated into first a sign, then a key ring with a sign, and then finally the large metal object. The reduction of anti-programmes thus also has a cost in terms of finances, energy, intelligence, and friendliness.

A central point in the classical ANT analyses is to illustrate the role technologies and materials have in carrying out specific programmes of action and their importance for producing social order and stability (cf. the title “Technology is society made durable” (Latour 1991)). Many ANT analyses have therefore described how actors achieve power or strength in sociomaterial relations. The symmetrical approach and free association is put forward as a better way to understand the establishment and development of power relations, i.e., “the capacity of certain actors to get other actors – whether they be human beings, institutions or natural entities – to comply with them depends upon a complex web of interrelations in which Society and Nature are intertwined” (Callon 1986b: 201). One of the classic concepts used to describe how stability and power are obtained is the notion of the ‘immutable mobile’ (Law 1986; Latour 1987), which was developed to understand how it was pos-

sible for European colonial empires to exercise control over long distances - how power could hold its shape and function over wide spaces. The concept of the immutable mobile was developed by observing the European empires dependence on ships, enabling long-distance control by moving and holding together the power-network required for colonial rule, which included orders, people, technologies, weapons and so forth. The argument put forward is that long-distance control was possible because immutable mobiles circulated in networks that allowed them to hold their shape. If people, technologies, papers, and texts are able to hold their relational shape as they spread, then it is possible to have control at a distance.

The Strategic Approach to Studying Prevention

The classical ANT conceptual repertoire draws attention to how strong actor-networks are established through the strategic acts of building relations to supportive actants and cutting off those that may undermine the network. In studying prevention through the case of GGG, I pay attention to the strategic work of building GGG's network – the problematisation process which identifies relevant actants in the network, the identification of anti-programmes that need be omitted, cut off, or circumvented in order for the programme to become strong and durable, and the price paid for this establishment. I thus follow how GGG becomes distributed in networks, and the role that technologies and materialities play in this distribution. The approach both demonstrates the successful translation of prevention, in terms of GGG, into a relatively stable order with certain fragilities where the network's stability is threatened. The description of the strategic establishment of networks is not a neutral, retrospective exercise but may contribute to, in Callon's words, the existing framing process in the studied field "by improving the visibility of various efforts to keep track of overflows as well

as the visibility of the disagreements and agreements to which they give rise” (Callon 1998: 263).

MULTIPLICITY-ORIENTED ANT: CRITIQUES AND METAPHORICAL DEVELOPMENTS

ANT has been met with different kinds of critique regarding the kind of analyses it produces and the implications of its analytical and metaphorical form, the actor-network. These critiques, which are formulated by outsiders as well as ANT’s instigators, are gathered in *Actor Network Theory and After* (Law & Hassard 1999), most polemically by Latour himself, who states: “I will start by saying that there are four things that do not work with actor-network theory; the word actor, the word network, the word theory and the hyphen! Four nails in the coffin” (Latour 1999a: 15).⁶

One of the main critiques concerns ANT’s tendency to focus on the fate of a single project, programme, or network and has subsequently been criticized for being “managerialist”, “Machiavellian”, or “male” in its approach by foregrounding strong actors at the expense of marginalized and “othered” actors and networks (Lee & Brown 1994, Star 1991, de Laet & Mol 2000). Critics point out that there has been a tendency to centre upon human actors, who, through their intentional and strategic abilities to mobilise others, succeed in realizing their various projects. However, in a counter-position to this critique, it has been argued that the classical ANT analyses do the exact opposite and make an effort of demonstrating that the success of a project or its personification (as in Latour’s portrayal of Pasteur (Latour 1988)) is a cumulative network effect rather than the product of

6 In his book *Reassembling the Social: an Introduction to Actor-Network Theory* (2005), which came out six years after this critique, he apologizes and takes the exact opposite position of defending all elements of the Actor-Network Theory – including the hyphen! (Latour 2005: 9).

a single genius (Law 2009: 150). Despite this counter-argument, the critique brought forward has produced a range of critical reflections about the other networks that the strategic networks relate to or cut off and other ways to conceptualise these.

The critiques regarding ANT's metaphorical form (that appear in Law & Hassard 1999; Mol & Law 1994; de Laet & Mol 2000; Law & Singleton 2005) point to some problematic outcomes of studying objects as networks. Latour especially finds the expression 'actor-network' problematic because it bears connotations to the debate regarding agency/structure and the related dichotomy micro/macro. The idea with ANT was not to settle the debate about whether structure beats agency or vice versa, but rather to investigate empirically the conditions that make the disagreement between the two possible (ibid.: 17). He states:

"if there is no zoom going from macro structure to micro interactions, if both micro and macro are local effects of hooking up to circulating entities, if contexts flow inside narrow conduits, it means that there is plenty of 'space' in between the tiny trajectories of what could be called the local productions of 'phusigenics', 'sociogenics' and 'psychogenics.'" (Ibid.: 19)

"Nature", "society", and "subjectivity" do not define what the world is like, but are rather the concepts that circulate locally and to which the actors of the field subscribe. The empty space in between the network lines or passages is the most exciting aspect of ANT, Latour states, because they show the extent of our ignorance and the wide reserve that is open for change (ibid.: 19). He points to the new conceptual work that has been developed within ANT: Mol and Law's concept of the 'fluid' (Mol & Law 1994), Adrian Cussins'

concept of ‘trails’ (Cussins 1992), and Charis Cussins’ concept of ‘choreography’ (Cussins 1996), and Law and Singleton’s later developed concept of ‘fire objects’ could be noted as additional metaphorical and analytical forms (Law & Singleton 2005).

One of the clearest voices in the development of the ANT vocabulary is Annemarie Mol, who proposes an understanding of ontology as ‘multiple’. This is proposed in her book *The Body Multiple: Ontology in Medical Practice* (2002)⁷, where she studies how medicine ‘practises’ the body and its disease in different ways through different technologies, medical departments, and medical specialists. She argues that when one studies practices, reality multiplies ontologically (ibid.: vii). That the world comes in multiple versions is not the same as the claim put forward by perspectivalism: that the same world can be viewed from multiple perspectives, Mol argues. In Mol’s understanding, perspectivalism multiplies the observer “– but leaves the object observed alone. All alone. Untouched. It is only looked at. As if it were in the middle of a circle. A crowd of silent faces assembles around it” (ibid.: 12). What Mol draws attention to is that in practice, the *doing* of an object, and the technologies and knowledge that is involved in this doing, changes and multiplies the ontology of the object. However, this does not mean that the object becomes fragmented; by describing how the body is practiced in different ways, she convincingly demonstrates how different versions of the body exist, while still remaining singular. The interesting questions that a multiple ontology raises are then, how is this multiple object held

7 The disease Mol explores in this book is atherosclerosis, which is the same disease that the preventive programme GGG that I study is aimed at. This overlap of empirical object was not intentionally pursued as the case for my research was established prior to my involvement (this is described in Chapter 3). In relation to Mol’s work, which demonstrates the various practices of atherosclerosis in the operation theater, the consultation, and the laboratory, my work on the prevention of atherosclerosis may add to the multiple ontology of atherosclerosis.

together? And how does it manage to stay the same and yet be different? By elucidating the multiplicity of objects, it becomes possible to point to the consequences, risks and opportunities, and what Mol terms the “ontological politics” of the different versions of an object as it is being practised in different ways; and how a certain version of the object always happens on behalf of its other versions (ibid.: viii; see also Mol 1999).

Fluidity – a Figure for Handling Complexity

In Mol’s earlier work, her proposal for multiplicity also comes across, however in a slightly different way, namely, in a discussion regarding topological understandings of the social. In a text from 1994, “Regions, Networks, and Fluids: Anaemia and Social Topology”, she critically addresses, together with John Law, the centrality of the network metaphor for understanding ‘the social’ in spatial terms. Here, she and Law propose the fluid as a supplementing social topology to social theory’s regional and ANT’s network topologies. In their text, they investigate the object of anaemia and show how it unsettles “topological spaces” and topological presuppositions that frame the performance of social similarity and difference in social theory (Law & Mol 1994: 642). In addition to a ‘regional’ and a ‘network’ topology, they develop a ‘fluid’ topology.

Whereas objects are clustered together within set boundaries in the regional space, the network space spreads across boundaries, as it consists of a range of variable relations between different elements. The regional topology of anaemia is, for example, performed when the problem of anaemia is attributed to different geographic localities or to different population characteristics (gender, age, race) in which similarities are set within boundaries and differences across boundaries (ibid.: 647). The network topology of anaemia, which ANT performs, points to the relations

that make up a regional boundary. It argues that boundaries do not exist in themselves but are effects of numerous, related elements. The regional topology of anaemia depends on the production of blood values to be compared across regions. This implies that similar lab set ups across geographical localities are able to produce values for comparison and thus implies a network of machines, blood samples, and human competencies, all of which are held together while being spread across physical space (this is also captured in the concept of immutable mobile) (ibid.: 649). In addition to these social topologies, Law and Mol develop the concept of the fluid space, which neither exists within set boundaries nor in specific relations, but where “boundaries come and go, allow leakage or disappear altogether, while relations transform themselves without fracture [...] [where] the social space behaves like a fluid” (ibid.: 643). The fluid topology of anaemia is developed by observing the differences between how anaemia is practised in Africa and the Netherlands. Anaemia is “here” and “there”, but they are not necessarily part of the same stable network. This does not make them separate like regions, Law and Mol argue, for there are no clear boundaries between them and they still relate in some ways – some actions, procedures, and symptoms may take place and be practised at both places in similar or slightly different ways. What we are observing, they write, is “variation without boundaries and transformation without discontinuity” (ibid.: 658).⁸

The fluid form is also found in a later text from 2000 by Marianne

8 The permeable structure that Mol describes resembles Callon’s image of “leakage points” in his concepts of “frames” and “overflows” presented earlier. These constitute the point where a frame enters into a relation with its surrounding world – a necessary opening in order to enter relationships, but also a point that results in overflows, which then again requires frame-working. However, where Callon’s concepts of framing and overflow points to the unstableness of framing processes that constantly require maintenance, Mol’s concept of flow and the permeable structure of the capillary that she and Law refer to entails stability.

de Laet and Mol, where the issue of technology's durability is discussed and the understanding of strong technologies as "immutable mobiles" is challenged. Here, de Laet and Mol analyse the success and durability of the Zimbabwean bush pump as it travels across sites, and they observe that the durability of the bush pump does not reside in its immutability, as proposed by the concept of "immutable mobile" developed by Law and Latour, but rather in its mutability. The Zimbabwean bush pump continues to work, not because it manages to hold together a pre-established network in its spatial distribution, but because it is able to change and adapt to various sites. When the pump breaks down, it is repaired by the local actors, and broken components are replaced with what is at hand locally – a piece of tire, tree branch, or scrap metal. The pump's function is thus sustained by its non-dependence on components from a distance and by its ability to vary. The stability of the object is thus not due to immutability, but to mutability, what de Laet and Mol articulate as *fluidity*. The pump is in this way understood as a fluid technology; it changes its shape slowly as it moves. The metaphor conveys an undisturbed viscous flow that gently reshapes as it moves, both staying the same and changing (Law & Singleton 2005: 338).

The Multiple Approach to Studying Prevention

Whereas strategic ANT analyses often focus on the fate of a single project and on the way its network stability is established, including the price of this stability and how it is threatened, the multiplicity-approach explores the ontological multiplicity of an object as it is enacted through different practices and how it is simultaneously part of many network formations. Where the strategic ANT approach focuses on the GGG programme, the multiplicity approach draws attention and explicates those networks that are cut off or 'othered' (in terms of not being articulated) in the process of establishing the GGG network.

Summing up: Combining Strategy and Multiplicity

Keeping the two approaches together allows for an exploration of both the strategic work of building a strong network and of following the proliferation of other networks - the multiple versions of prevention that are practised in relation to, in opposition to, or alongside the 'dominant network'. This dual task implies the simultaneous depiction of the network and its fluidity and leakages, which together may resemble a vascular system and its blood flow. In the following, I therefore present the vascular system as a heuristic analytical form that is anchored both in the empirical field of my study (the vascular specialty, whose main concern is the condition of the vascular system) and in the conceptual resources I draw on from ANT, where both Mol & Law (1994) and Latour (1999b) draw on the imagery and properties of the vascular system and of blood flow.

EMPIRICAL AND CONCEPTUAL OVERLAPS: THE VASCULAR SYSTEM AND BLOOD FLOW AS HEURISTIC ANALYTICAL FORMS

In Mol and Law's text on social topologies from 1994, presented above, they introduce their paper by stating that it is about blood and about space, and what follows in the paper is a new way of understanding social spaces by drawing on the empirical object of blood. Blood, the authors claim, disturbs the "spatial securities of anatomy" as it moves through the body in a widely branched network that ignores the internal bodily boundaries (Mol & Law 1994: 642). In anatomic representations of the body, it is mainly the larger veins that are depicted (arteries drawn in red and veins drawn in blue), whereas the larger network of smaller vessels, the capillaries, is left out. This conveys the image that the blood moves within these passages in a closed circulating system. However, blood does not keep within the boundaries of the arterial and venal passages.

The vascular system branches out in smaller capillaries, which have more permeable structures, that allow white blood cells to migrate into the tissue (ibid.: 642). This provides an image that is developed to propose and conceptualize the coexistence of different social topologies. Blood's movement can say something about social spatiality and makes it possible to understand that the social can both be a region and a fluid. Mol and Law write in their last footnote:

“Blood vessels themselves [...] suggest another interesting way to be both a region and a fluid. In some measure vessels are well-bounded regions that keep their constituents inside them. Large arteries have solid walls. But the small hair vessels in most organs (except the brain) are permeable to endless chemical substances and many cells – a form of imagery that suggests that the network metaphor is taken from the technology it is used to talk about, while we tap biology's body for fluid metaphors.” (Ibid.: 671, footnote 54)

This “body's fluid metaphors” propose the existence of permeable structures. Flow is directed in a wide branching network, but it also leaves the vessel, as it leaks into the bodily tissue – or *perfuses* into the tissue as the metabolic vocabulary defines it.

The image of blood flow is also found in Latour's book from 1999, *Pandora's Hope: Essays on the Reality of Science Studies*, where he analyses scientific work and the construction of scientific facts. In Chapter Three, called “Science's Blood Flow: An Example from Joliot's Scientific Intelligence”, the image of the vascular system is evoked in the story of French atom-physicist Frédéric Joliot's work on devel-

oping the atomic reactor in the 1940s⁹. Latour writes that:

“By following the ways in which facts circulate, we will be able to reconstruct, blood vessel after blood vessel, the whole circulatory system of science. The notion of a science isolated from the rest of the society will become as meaningless as the idea of a system of arteries disconnected from the system of veins. Even the notion of a conceptual “heart” of science will take a completely different meaning once we begin to examine the rich vascularization that makes the scientific discipline alive.” (Latour 1999b: 80)

The purpose of Latour’s allegoric description is to argue against the understanding of science as a separate and pure domain from the rest of the world. It is to show how scientific work is comprised of a network that includes political and economic stakes in the specific laboratory work of controlling neutrons. Joliot’s work required him to move between mathematics, law, and politics, and required him to deal with the neutrons in the morning and the ministers in the afternoon, as Latour writes. Joliot’s scientific work was thus comprised of holding together the threads of neutrons, colleagues, politician, industries, all of which had an interest in his work to develop the atomic reactor (ibid.: 90). The driving force of science, the heart, is not separated from the rest of the world, as epistemologists would have it, Latour writes (ibid.: 109). Rather, it is connected to the world with both an input and an output. Studying the con-

9 The imagery of the vascular system is most likely to be inspired by Mol and Law’s work. In Latour’s critical account of ANT in *ANT and After* from 1999, he points out Mol and Law’s text from 1994 and their fluid concept as an exemplary way of developing the conceptual vocabulary within ANT inspired by the empirical field of investigating (Latour 1999a: m19).

struction of scientific facts then requires that the whole “bloody, throbbing, tangled mess, the entire vascularization of the collective effort”, is treated (*ibid.*: 109).

Although Latour and Mol & Law draw on the vascular system, they do so with different focuses. Latour pays attention to the structures and vessels of the vascular system and how they form both inputs and outputs into “the heart of science” and how these passages are related; thus, he pays attention to the structuring conduits that lead the blood flow. Mol and Law, on the other hand, focus on the properties of the flow and the substance of the blood; its movements inside the vascular networks as well as the possibilities of its spreading into regions.

In this thesis, I attempt to combine both imageries as I follow the strategic building and distribution of prevention, as well as how it is practised as multiple versions and how these relate. I take the image further by emphasizing the circular movement of prevention’s circulation; thus, I first describe how prevention came into the vascular specialty and mixed with political, economical, and other interests of the profession, and how it was mobilised through different paths that distributed the preventive flow into various organizational, professional, and patient spaces. I show what type of flows these conduits allowed and what happened during the circulating movement in the different locations of the vascular system: metaphorically speaking, in the heart, arteries, capillaries, veins, filtering organs, and lungs. Finally, I draw attention to the surgical procedures and the different materials that are inserted as hybrid objects in the vascular system to allow the continual flow.

This overlapping relationship between the empirical and concep-

tual is not uncommon within ANT. We have seen how the concept of fluidity is anchored in the empirical object of blood, but also in the Zimbabwean bush pump, which deals with another fluid (water). However, other objects, which work conceptually, are known within the ANT repertoire, for example, the concept of “obligatory passage point”, taken from military strategy or “the black box” used to describe undisputed scientific facts – a metaphor taken from the field of engineering, where the term refers to a device or machine which appears to ‘run by itself’, where the focus is on its input and output and its internal mechanism and complexity is left undisputed and unexamined (Latour 1987; Latour 1999b: 304). Both examples indicate that the relationship between the empirical and conceptual is of a more intertwined matter. This relationship between the conceptual/empirical has been addressed and discussed in recent anthropological and STS debates and is an issue I return to in Chapter 3, where I discuss methodology.

The strategy-oriented and multiplicity-oriented approaches evoke different analytical figures in their analyses; the image of the network and of flow. Combining these two figures (network and flow) conveys the image of the vascular system, which both approaches occasionally draw upon implicitly and explicitly. To me, the vascular system is a form that allows me to keep together both the strategic network alliances of prevention and the multiplicity and the flow – it is not thought of as a way to settle the discussion between the two approaches, but rather to hold together the empirical exploration of prevention in a form that comprises both the stability of the network and the movement of fluidity.

SUMMING UP:

COMBINING STRATEGY AND MULTIPLICITY

- TOWARDS AN ANALYTICS OF NETWORK AND FLOW

By combining the two analytical approaches within ANT, I strive to map the network of prevention as it is distributed in political, organizational, professional, bodily, and homely spaces. I will show how health political priorities, professional and organizational concerns of vascular surgery, and patients' homely practices are linked in various ways. I follow the translations that this linking requires; the temporary achievements and the ongoing, meticulous work; the overcoming of obstacles that keep the network durable; as well as the price to be paid and inevitable, unexpected outcomes of prevention's building process. Furthermore, I endeavour to follow the multiplicity of prevention, the coexistence of multiple versions of prevention (as a political agenda, organizational decision, professional status project, and a process of lifestyle change¹⁰), and the ways in which these interact with each other – in conflicting or quietly coexisting ways.

Combining the two approaches evokes both the image of network and of fluidity. This combination overlaps with the vascular system, which consists of a network in which blood flows, the concurrency of and connectedness between stability and movement. In this thesis, I draw on the image of the vascular system as an analytical heuristic that makes it possible to hold together the two analytical approaches and thus both map the strategic network distribution of prevention and follow the fluidity of prevention. By evoking the vascular system as an analytical form, I continue a tradition both

10 All of these having their own multiplicity to explore – however, I hold my focus on prevention.

found within ANT and anthropology, where the relationship between the empirical and conceptual have contributed in different ways to discussions both regarding the empirical object in focus as well as theoretical and disciplinary debates. More specifically, I draw on and add to the way that the vascular system and 'bloody' properties have been evoked as analytical resources by Latour and Mol, as well as Law and de Laet. In the following analytical chapters, I draw on the different ways that the vascular system and blood have been used, and I develop the vocabulary and imagery by adding vascular properties and functions that have not been explored by following the movement of prevention through the entire vascular circuit. In the following analytical chapters, I will therefore describe prevention's 'vascularization' as it moves from 'the heart' of central actors through specific pathways into the vascular specialty (Chapter 4); the obstacles met on the way that reduce the preventive flow; and the various 'operations' performed to ensure the continuation of the flow (Chapter 5). I follow prevention's flow into the smaller capillaries in the preventive encounters between nurses and patients and see how prevention is perfused into the 'tissue' of the patients' home (Chapter 6). In these encounters, however, I will show how the distribution of prevention not only flows in one direction, but is also characterized by an exchange process where patients put forward issues, concerns, and demands that overflow the intentions of the preventive programme (Chapter 7). This backflow is carried back via the veins in terms of the challenges that nurses' experience regarding their preventive work (Chapter 8). These challenges may strain the organism if it is not filtered and re-oxygenated before further redistribution into the system (Chapter 9). By evoking the vascular system as both network and fluid, I explore the relationship between the two approaches within ANT; not to settle the debate between them, but by pointing to the productivity of joining them.

CHAPTER 3

Research Practice: Empirical, Theoretical, and Methodological Intertwinements

Research Practice: Empirical, Theoretical, and Methodological Intertwinements

INTRODUCTION

In the two previous chapters, I presented the research interest of this thesis and defined the research question, which has guided my exploration of the practice of patient-centred prevention in the empirical case of the preventive programme, GGG. Also, I have presented the analytical resources I draw on in the empirical chapters, hereunder the vascular system as a heuristic analytical form that relates both to the empirical field of vascular surgery and Actor-Network Theory, where the vascular system provides a joined imagery for both the strategy and multiplicity orientations within ANT. In this chapter, I describe my research practice – the curious empirical, theoretical, and methodological intertwinelements that make up this particular framing of my research project. In the following, I present the occasions of puzzlements, choices, coincidences, and practicalities that led me to the material I will analyse and to the analytical framing I decided upon.

Marilyn Strathern, a British anthropologist who has worked in Melanesia as well as the UK, describes ethnographic practice as having a double location: that of ‘the field’, in which ethnographic data generation takes place, and that of ‘the desk’, where the production of text happens (Strathern1999). The relationship between ethnography’s two locations is more complex than simply ‘writing up’ what happened in the field. She writes:

“The relationship between the two fields can thus be de-

scribed as ‘complex’ in that each is an order of engagement which partly inhabits or touches upon but does not encompass the other. Indeed, either may seem to spin off on its own trajectory. Each point of engagement is thus a replacement or a reordering of elements located in a separate field of activity and observation altogether. And the sense of loss or incompleteness which accompanies this, the realisation that neither can ever match up to the other, is common anthropological experience.” (Ibid.: 2)

Strathern further describes how research ambitions prior to the fieldwork are often overshadowed by the observation of completely different concerns and stakes observed during fieldwork. However, after fieldwork, the task of the ethnographer becomes to handle both fields, which requires both recalling the theoretical conditions and motivations for the research, as well as taking into account the events and ideas that emerged during fieldwork. The ethnographer’s practice may thus be portrayed as a “movement” (ibid.:2) between these two fields or locations, which of course happens when the ethnographer travels to the physical location of the field, but which also happens intellectually in the writing process, when the experiences from fieldwork and theoretical conceptualisation are brought together. In what follows, I portray my movement between ‘the field’ and ‘the desk’, and the research process that has led to this thesis. I present the initial motivation of the project, its practical execution, and the eventual delimitations that were made both during fieldwork and in the writing process. I end this chapter with an ethnographic description of the occasion that sparked my use of the vascular system as a heuristic analytical form.

THE PROJECT: ONSET, METHODOLOGICAL DESIGN, AND EXECUTION

The relationship between ‘the field’, in terms of the research site at the vascular clinic and the GGG programme, and ‘the desk’, in terms of the research project’s institutional affiliation to Copenhagen Business School, was initiated in 2005 by the head nurse of the vascular clinic at Rigshospitalet, who was studying for a Master of Public Administration at Copenhagen Business School. During her studies, she had been inspired by various critical social theoretical perspectives and the issue of power and governance in relation to the preventive work at the vascular clinic she was leading. During her oral exam, she proposed that the GGG programme and its implications called for further critical social theoretical research. This suggestion was responded to by her supervisor and associate professor at the research group regarding political management at the Department of Management, Politics and Philosophy at Copenhagen Business School. He wrote the initial project description and funding application to the Danish Council for Independent Research under the title “Preventive Strategies in the Danish Health Care System”. Here, the purpose of the project was described as to gain a better understanding of the managerial problematics that preventive strategies produce by focusing on the social processes between management and health professionals, nurses and doctors, and health professionals and patients and, furthermore, to focus on preventive technologies, including forms of organization and professional logics. The application granted funding for a PhD project, which I applied for and was granted in December 2008.

The project and empirical case and field site were therefore prearranged prior to my involvement. It was to take place at Rigshospitalet’s vascular outpatient clinic and be about the preventive work

that was being done within the GGG programme. Speaking of the clinic in singular is misleading because it is physically located at two hospitals: Rigshospitalet in the capital, Copenhagen, and Gentofte Hospital, located 4 km north of the capital. Each clinic has its own regular staff group but is managed by the same management team (chief surgeon and head nurse). The clinics used to be separate, but were merged in 2008 due to a major structural reform in Denmark.

Although the empirical site and case were prearranged, the analytical and methodological approach was not. With my academic training in anthropology, I was approaching a new institutional setting with a key interest in political and welfare management, and, although I had focused on medical anthropology in my training, including issues of prevention and health promotion, I had not worked with these issues in terms of governance or management problematics, but more in phenomenological terms, focusing on how certain patient and social groups understood and managed their health situation in pluralistic healthcare systems (both in Denmark and Kenya). Furthermore, I knew that the research group, where the PhD was anchored, was more theoretically oriented than what I was used to from my education, and that I would have to frame my project in theoretical terms that were recognized within the institution and not only known within the field of anthropology.

In my application, I proposed that I would, inspired by the work of Michel Foucault, study prevention as a “problematic of government” and explore this particular prevention programme as a governmental technology aimed at governing patients’ self-governance. This I would approach methodologically, not as a genealogical and archive study in a Foucauldian tradition, but by conducting ethnographic fieldwork and by studying prevention ‘in practice. Furthermore, I

added Actor-Network Theory as an analytical approach, because I was inspired by its explicit sociomaterial approach, but also because it allowed me to practise ethnography under a theoretical heading. ANT's ethnographic methodological grounding thus allows for the flexibility of the ethnographic fieldwork in terms of defining the research object 'on the go' and following different analytical paths and openings as they occur.

I conducted ethnographic fieldwork at both the locations of the vascular clinic, with each period lasting two months. The first period of fieldwork was primarily conducted in May-June 2009 at Gentofte Hospital and the second in November-December in 2010 at Rigshospitalet. In addition to the two periods of fieldwork, I have been in frequent contact with the clinics by email and phone, as well as occasional follow up visits. In addition to the observations made during my fieldwork at the clinics, I have also participated in other activities such as evening staff arrangements, meetings in the cross-clinical prevention workgroup, and the annual conference for the Danish Vascular Community in October 2010, where I also presented my research project and preliminary findings. During the study process for this PhD, the GGG programme and preventive work at the clinics has undergone several changes. One of these changes is described in detail in Chapter 5. However, since the cessation of my fieldwork, GGG has been phased out and the preventive work that is being practised at the clinic has now been integrated into other types of consultations and is not performed in a separate preventive consultation as before.

In the following, I present the practical execution of my research and the central reflective occasions that led to the specific framing of my project.

DEFINING THE RESEARCH SITE AND EMPIRICAL FOCUS

As introduced, the project started with a focus on prevention as a problematic of governing and was inspired by a Foucauldian understanding of power. To begin with, I intended to focus on how patient-centred prevention worked as a governing of patients' self-governing. However, instead of studying this discursively and focusing on prevention's programmatic rationality in a genealogical manner, I wanted to study how prevention was practised in various mundane socio-material ways. Inspired by Actor-Network Theory, I planned to 'follow' prevention and was especially interested in following prevention from the clinic to the patients' homes and to explore how prevention was translated across these locations. Despite the openness of where to follow the actor, which the ANT slogan "Follow the actor!" proposes, I had already defined before the fieldwork which direction I would follow prevention and its translation; namely, from the clinic to the patients' homes. Being inspired by a range of critical analyses of preventive and health promoting programmes, I was especially interested in how prevention 'responsibilized' patients in specific ways according to biomedical categories and understandings of health. The plan was to observe the preventive consultations, establish contact with patients, and then visit them in their home environment to do interviews and observations.

Nevertheless, during my fieldwork it appeared that there were other locations where I could follow the practice of prevention. Early in my fieldwork, when I was following the clinical practice of prevention, I came to understand that prevention not only had implications for its intended receivers – the patients – but that it also had implications for the professionals working with it. I gradually became aware of prevention's effect on the health professionals working with it and came to understand that prevention as a work task also 'responsibi-

lized' the health professionals in specific ways. This caught my interest and pointed at a different research problem that I had not come across in the literature to the same degree as studies focusing on the effects of prevention and health promotion on patients. After I had conducted three interviews with a patient at their home, it became clear that if I was to focus on the patient's preventive practices at home in more than just verbal terms, it would require me spending more time at the patient's home, following their everyday preventive practices, which meant that I would have to reduce the time spent at the clinic. Furthermore, the clinic's dispersed location at two hospitals had also brought up a range of organizational issues that caught my interest and provided the opportunity for the comparison of the preventive work between the two locations. Therefore, I eventually decided to focus on the preventive practices as they were enacted at the clinic. However, this does not mean that the patients' preventive practices at home are absent in my analyses, but rather that they appear in a different way. I have not observed how patients practise prevention at home, but I have observed how their preventive practices at home are enacted in the clinic. More specifically, I have observed how patients and nurses in the preventive encounters talk about planning, reporting, and measuring patients' preventive practices at home. Whether patients actually do engage in preventive practices at home and to what extent is thus not the interest of this project. Rather, the interest is to explore how preventive capacity and responsibility is built in sociomaterial practices and distributed across clinical and homely spaces with implications for both patients and professionals working with prevention.

THE PRACTICAL EXECUTION AND APPLIED METHODS

Observations

The main methodological approach used to study the sociomaterial practices of prevention was ethnographic observation. During

the two periods of fieldwork at Gentofte Hospital and Rigshospitalet, I followed the daily clinical routines at the outpatient clinics from 8 am to 4 pm Monday to Friday. I made two kinds of observations: Observations focusing on prevention and general observations. The observations focusing on prevention included the clinical appointments, which were allocated to preventive purposes (GGG consultations and Preventive Conversations), as well as appointments that would possibly include preventive issues and potentially refer to preventive appointments. I also followed four meetings within the prevention workgroup (which included doctors and nurses from both hospitals and was responsible for maintaining and developing the preventive work at the clinic), which took place after my fieldwork. In addition to the observations that focused on prevention, I also made more general observations, where I followed other types of clinical work and consultations in the outpatient clinic, such as regular check-ups performed by nurses and doctors as well as doctors' pre-examinations. I also spent a great deal of time in the staff room, where I observed the various interactions between the health professionals. During my various observations, I openly jotted down notes by hand. These were written out (also by hand) during the day, when I withdrew to an office. Some of these notes have been rewritten electronically and appear as unfolded ethnographic descriptions (they appear as centred text in this thesis), but the observational data also sometimes appears in the body of the text as general descriptions, as direct quotes (which appear in quotation marks), or in paraphrases where I have not noted the statements verbatim.

In my general observations, I focused on the ways in which different clinical tasks were carried out, including the technologies and various objects involved in this. I wrote down dialogues, statements, and expressions regarding different issues that were being

discussed among the health professionals, patients, and relatives. This was carried out without predetermined strategies for my observations but with the aim to get as much down on paper as possible and to get a general insight into the clinic's daily routine, tasks, work organization, and professional logics. These observations gave an insight into the other networks that prevention was a part of (in both compromising and supportive ways), such as the vascular specialty's relations to other competing medical specialties, prevention's role in relation to the doctors' and nurses' other central tasks, and the 'cultural' differences between the two clinics, issues I attend to in Chapter 4 and Chapter 5.

The observations that focused on the preventive work were more structured: They were bounded in time, they were directly oriented at prevention, and they followed GGG's particular structure of clinical measurements and conversational issues¹¹. Here, I especially focused on the 'translation processes' of prevention in terms of the ways that different kinds of knowledge were generated through clinical measurements and in conversation, as well as how this was linked to the preventive agenda. Most obvious was the inclusion of the material technologies (which ANT studies often tend to focus

11 I have also made video-recordings of GGG consultations in three cases. These recordings provide rich information, in that they are able to capture the various details of interaction; not only the words that are being said, but the tone of voice, accompanying body language, and the atmosphere between the nurse and patient. Furthermore, they make it possible to freeze and rewind to crucial moments in the interaction. The recordings have been helpful later in the research process, providing an opportunity to re-experience the consultation, atmosphere and interactions, however, the additional opportunities that this methodological approach provides in terms of going into the details on atmosphere and interaction have not been pursued in this thesis. Instead, I have used this material in the same way as other non-recorded observations.

on) such as the scanners, stethoscope, scales, and computer software used in the preventive consultations. Besides these preventive apparatuses, there were also psychological models and theories (sometimes in materialized on paper) that formed part of the preventive practice and translation work. Furthermore, I observed that prevention was translated into more mundane practical attempts to organize the patients' everyday lives at home according to preventive goals. These observations are dealt with in Chapter 6, where I draw particular attention to this less articulated knowledge form, which comprises an important part of the strategies used to engage patients in preventive work but which are often overshadowed by the medical and psychological knowledge forms. The observations I made of the preventive consultations included situations where patients aligned with the preventive agenda in terms of expressing preventive wishes, strategies and self-reflections, which resonated with the values of the GGG programme. However, I also observed situations where patients translated prevention in other ways and attempted to reformulate the GGG programme according to other understandings, needs, and wishes, which I deal with in Chapter 7.

My observations were supplemented by informal conversations and interviews with the health professionals, patients and relatives I was observing. During preventive consultations, the nurse sometimes left the room, which gave me the opportunity to chat with the patients and ask them about their opinion with regard to the preventive consultation and health promoting recommendations and their experience with engaging in preventive activities at home. After the preventive consultations, I talked to the nurse about the consultation and asked her which issues and concerns she found central. I also asked about issues, procedures, and situations that I did not understand or that had puzzled me. Often the nurses also asked me what I had noticed in the consultation, not so much in terms of

evaluating their work, but more as a reflective occasion for them to get “other eyes” on their practice, as several of them expressed it. They generally expressed that it was a positive experience to have their work observed and described from an outside position and that my “strange” questions had made them reflect on issues they took for granted (an issue I return to under my ethical considerations).

Interviews

Although my main method was observation and the informal interviews that followed, I also conducted and recorded a few formal semi-structured interviews with health professionals and patients. Whereas the observations focused on the sociomaterial practices of the preventive work and the subsequent informal interviews on nurses’ and patients’ reflections on specific situations, the formal interviews regarded more general reflections about prevention in the vascular specialty and the development of GGG.

I conducted four formal interviews with health professionals: The management team’s managing surgeon and head nurse, as well as a senior surgeon and a nurse specialist. These interviews were conducted with the purpose of getting descriptions of the introduction of prevention into the vascular specialty and the initial development of GGG, which was a matter that emerged as a reappearing narrative during the fieldwork in the informal conversations I had with the health professionals in the clinic. The management team, senior surgeon, and nurse specialist all played major roles in the introduction of prevention into the vascular specialty and the development of the GGG programme. In these interviews, it became clear that the preventive work was not only a problematic issue in relation to getting patients engaged in preventive activities, but that prevention, although being aimed at improving the patients’ situation, also implied possibilities and challenges for the professionals and the

vascular specialty, a theme I unfold in Chapter 4 and Chapter 5

As presented shortly above, I conducted three patient interviews at patients' homes that regarded the ways patients had used the information from the GGG consultations, how they practised prevention in their daily routines, and their opinion regarding the GGG programme. These interviews gave insight into the patients' understandings of and motivations for engaging in the GGG programme – also in ways that challenged the purpose of the programme and, together with observation material from the clinical encounters, is the focus in Chapter 7.

Furthermore, I have conducted a single focus group discussion with seven nurses at Gentofte Hospital. The focus group discussion was conducted with the purpose of allowing different voices to be heard, and observing internal discussion and disagreements about prevention. This was supposed to be supplemented by a focus group discussion with the nurses at Rigshospitalet. However, due to practical circumstances, this was not possible because the scheduled time for the focus group discussion collided with some major cutbacks and the reorganization of the clinic, which occupied the staff practically and emotionally. This means that the material from the focus group discussion that I use in Chapter 8 only draws upon the opinions of the nurses at Gentofte Hospital. However, the dilemmas and challenges that the nurses from Gentofte Hospital describe have also been voiced in conversations with nurses during my fieldwork at Rigshospitalet.

Documents

I have analysed a range of documents that appear in this thesis: Internal reports, meeting minutes, education material, PowerPoint slides, patient information material, scientific articles written by

health professionals at the clinic, and newspaper articles. These documents appear as data in terms of texts with discursive manifestations. This data have been used to focus on formalized and programmatic values of GGG and the preventive work, which I have related to my observations of other preventive practices. Sometimes these discursive statements appear as an explanatory background that aligns with my observations of practice, and, at other times, they reflect a contrast between the ideals expressed discursively and the way they are being practised in other ways.

Ethical Considerations: Engaging with the Field of Study

I consider two issues in relation to my research ethics. They both revolve around my relationship and engagement with the field's actors, but in different ways. One ethical consideration regards issues of access to the field, informed consent, and ensuring anonymity; the other regards the product of my research and the kind of contribution my research provides to the field of study.

Access to the clinic was initiated by the head nurse and formally by the clinical management team. In terms of the more formal ethical arrangements, my research project had to be approved by the management team and the research manager at the clinic. Here, the main ethical concern was to ensure informed consent from the involved professionals, patients, and their relatives and to ensure their anonymity in my work. One thing is formal access provided by the management, but my research also rested on the acceptance and the granting of access from the professionals' and patients' side. In relation to the professionals, I introduced my research project at staff meetings prior to the fieldwork. The project was received well and mainly caught the interest of the nurses, who are engaged the most in the prevention work. Both doctors and nurses were used to having students with them during consultations and seemed re-

laxed about my presence. In relation to the patients, I introduced myself and my project prior to the consultation and asked if I could observe their consultation for my research project regarding the preventive work at the clinic. I informed them that I would write notes and that all information would be anonymous. All the patients and relatives I asked allowed me to observe their consultations. I have ensured the involved actors' anonymity by changing names and identifying details (such as gender). However, the names of the hospitals and the managing team have not been changed. I have discussed this with the management team, who argued that the anonymity of the hospitals would only be of a formal character as all professionals within the field of vascular surgery in Denmark would know which clinics I was describing and would also be able to identify the management team. Therefore, the hospitals where the clinic is located and the management team, chief surgeon Henrik Sillesen and head nurse Margit Roed, appear with their own names while all others have been anonymised.

Another ethical consideration regards the product of my research. It has been important for me to ensure that the way I have portrayed the health professionals and their preventive work was recognisable to the field's actors. I have been concerned with the issue regarding the difference between how the two clinics practise prevention. Although my description of the differences resonates generally with the narrative that the nurses and doctors use regarding the two clinics, it is a simplification which overlooks the fact that individual nurses and doctors at both clinics are more or less interested in working with prevention; the differences I point to are thus more a portrayal of general differences within and across the health professions than differences solely tied to the two clinics. I have sent drafts and final copies of my publications to the clinics and the management team. Moreover, different nurses from both clinics

have commented on and corrected various details. Here, there have not been any big disagreements, but rather they have expressed that the case has been well described and unproblematic, also in terms of the differences between the two clinics. However, the change of research site and focus, which meant that I did not follow the patients' preventive practices in their home environment, has to some degree disappointed the nurses, who would have liked to learn more about what patients "actually get out of" the preventive work and what "actually happens when they go home". This wish has been articulated as a kind of evaluating parameter to judge the preventive work by, which reflects the current focus and value of 'user' evaluation on a range of welfare services. Instead of contributing with this kind of knowledge, I engage in a more fundamental discussion regarding the conditions under which prevention is being practised and evaluated and the kind of responsibility that follows from this. Within this discussion, 'the patient's perspective' is one among other relevant perspectives. Instead of appointing the patient's perspective as a 'gold standard' for evaluating prevention, I point to the various co-existing ways – and the accompanying perspectives – that prevention is being practised and evaluated by. This approach is inspired by theories and discussions within the field of STS, which shaped my engagement with the field in particular ways and thus also became part of my ethical considerations regarding my engagement with and contribution to the field. The decision regarding my theoretical approach is elaborated in the following section.

DECIDING ON THE THEORETICAL APPROACH

Besides my modification of research site and focus, the theoretical approach of the project also changed over time. As described above, the head nurse of the vascular clinic initiated the research project and provided the site and preventive programme to be studied. In her MPA studies, she had worked with various critical social theo-

retical perspectives that she used when reflecting about the preventive work. As such, she was already problematising the preventive practice with social theoretical concepts and approaches. This posed a challenge in terms of what I as a ‘researcher’ could contribute with to ‘the researched’ field of study, when the field was already doing what I was supposed to do and with the same theoretical resources as me (this problematic regarding the relationship between the ‘the researcher’ and ‘the researched’ is also described by, for example, Riles 2000 and Ratner 2012). Although the existing critical reflections within the field provided an invitation and an opening up for further elaboration, it also seemed somewhat redundant, as the field was already discussing the moral and political implications in terms of “power relations” and engaged in self-critical reflections about “how far they could interfere in people’s lives”. This was not only expressed by the head nurse due to her MPA training, but also resonated with a general concern in the more academic discussions within the Danish nursing profession, which had started in the 1990s¹². Within the discussions about health promotion and prevention (which within Danish nursing was related to the academic field of health pedagogics), social theoretical perspectives and especially the work of Foucault and Foucauldian concepts such as ‘governmentality’ formed an important part of the critical reflections. This literature, as presented in Chapter 1, critically explores how ‘empowering’ and ‘patient-centred’ approaches work as subtle governing techniques that subject patients to biomedical, global, and public health agendas.

However, the methodological approach used to study prevention in practice and not only as discursive manifestations in, for exam-

12 In the 1990s Danish nursing developed into a more academic discipline, including changes in nurses’ education and making the nursing education into a Bachelor’s degree in 2001.

ple, preventive programme descriptions, policies, and professional literature, turned out to provide other findings that, to some extent, challenged the established critique within many governmentality-inspired studies. During the clinical encounters I observed between nurses and patients, I not only saw how patients came to understand themselves and their lifestyles according to biomedical categorization and psychological understandings, but also how patients actively challenged and reformulated the preventive programme according to their own understandings. These observations challenge to some degree the critique put forward by numerous governmentality studies. I have dealt with this issue elsewhere (Pii & Villadsen 2013), where my observations are used to point to other analytical possibilities with Foucault's work, more specifically the concept of 'biopower'.

However, in this thesis I have decided to deal with this issue in another way. Here, I do not draw on Foucault's work analytically as such, but rather engage in a debate with people who do and the critiques they formulate. Although my project was initially inspired by the work of Foucault and drew on Foucauldian concepts, which framed my project as a governing problematic, I have decided to frame my thesis within an ANT tradition (which is undisputedly inspired by the work of Foucault) and the discussion within this theoretical field. One of the reasons for this is precisely the implicit or normative critique that the concept of governmentality carries, although it has been pointed out that the concept as such is not meant to represent a settled critique (Pii & Villadsen 2013, Greco 2010, Jensen 2010). Instead, I work with concepts or – perhaps more precisely – imageries within ANT (as presented in Chapter 2) and try to combine and develop these with inspiration from the empirical object of the vascular system. This, I argue, forms part of the contribution to the field of study, as it expands the analytical

vocabulary that already exists within the field. The occasion that initiated this exercise is presented in the following ethnographic description.

THE VASCULAR SYSTEM AS ANALYTICAL HEURISTIC

While I am waiting in the conference room for Margit to get ready for the interview, I look around for something that can entertain me. The conference room is the place where the staff meets for morning conferences, hold meetings, and eat lunch. It is not the most inspiring room: brown and grey colours, heavy wooden furniture, a large oval table and chairs with brown upholstery and armrests. On the middle of the table, besides a stack of white plastic cups, a plastic bag with fruit – one of the health promoting efforts at the hospital – has been opened. The only obvious amusing thing in the room is the poster placed on one of the white boards. I noticed it earlier: A young smiling soldier with a helmet on his head, holding a metal field cup in his hand and above him a clear-cut recommendation: “How about a nice big cup of shut the fuck up”, and further explained in the subtitle, “Think before you say something stupid”. Even after just a few days into my fieldwork, the tone of the poster seems characteristic for this place – unrestrained, sarcastic, and unsentimental.

My eyes wonder to the metal bookshelf: brown covered medical journals and books. Only one of them has a remotely interesting cover that compels me to take it down: A black background and, written in dramatic blood red letters, BLOOD FLOW IN ARTERIES. It even has an illustration of the heart and arteries drawn in red. The name of the author, Donald McDonald, makes me think of the fast-

food chain MacDonald's and their clown mascot, Ronald MacDonald; I am amused by this silly association and think that it is rather unfortunate for a cardiovascular doctor to have a name that evokes such unhealthy connotations. I open the book, not expecting it to bring me further entertainment, nor an understanding of what is written in it. However, a typed letter has been placed inside the book. It was written by Chief Surgeon F. R. Mathiesen and dated 21.11.1974. The letter is a book review written in Danish, and it reflects the same tone I have found characteristic of the clinic. Dr Mathiesen states that this 400-page book on the mathematical and physical laws of blood flow might leave the reader at a "higher stage of confusion". He adds, however, that it is a comfort that even the author of the book has found the material "sophisticated", as stated by Dr McDonald. He praises the book for providing very useful information on the very complex problem of blood flow and promotes it as an essential work for cardiologists and vascular surgeons. He closes the review in English: "But you have been warned."

The warning spurs my interest and I look further into the book. On the left-hand page, the author and co-author are pictured, not in photographs but pencil drawn portraits. The older McDonald (1917-1973) in a dark suit, wearing horn-rimmed glasses, with white hair and a serious, but not grave, facial expression. Underneath him, the younger Womersley (1907-1958) in a dark suit, with dark hair and a mild, almost boyishly cheeky facial expression. On the opposite right-hand page, Donald A. McDonald (with the modest title M.A., D.M. (Oxon.), D.Sc. (Lond.) Professor of Physiology and Biophysics at the University of Alabama)

has inserted a poem by T.S. Eliot on the title page of his book. It reads:

“The dance along the artery
The circulation of the lymph
Are figured in the drift of stars”

T.S. Eliot, *Burnt Norton*

(From collected Poems 1909-1962, Faber & Faber Ltd).

What a curious thing to do. No context or explanation of why he has inserted the poem in a book on the mathematical laws of blood flow. My only guess is that he fell upon the words and felt connected to them due to his professional interest. I cannot help smiling at the image of him reading this poem and recognizing the description of pulsatile flow curves and arterial pressure waves in the drift of stars. This stage of preoccupation, where you see whatever is on your mind in everything else in the world, reminds me of what one of the surgeons said the day before: With great enthusiasm he described to one of his colleagues how the road works that were being done outside his home looked exactly like a huge vascular operation with the blue and red tubes, water and gas pipelines, all exposed underneath the open ground.

Dr McDonald, has caught my interest and I turn to the acknowledgements, which I expect to be understandable prose and which I always like to read so as to get a peek at the person behind the author name: Who is being thanked? Colleagues for inspiration, spouses for enduring the writer during a frustrating writing process, or children

for simply being there and bringing a healthy perspective into the author's time consuming work life? No, not Dr McDonald. The first person he mentions in the acknowledgements is the goddess of Chance, who is rarely thanked on occasions such as this, he writes. He continues, "I am sure that this is not so much due to ingratitude of scientists as to the fact that she plays some part in starting almost any research. In my case her interventions have been so helpful and so perfectly timed that I feel I must pay her homage" (ibid. xi). My stereotyped conception of the rational 'hard' scientific persona is put to shame. (By the way, in the Preface, Dr McDonald does thank his colleagues, two children, who have been an active part of the work on the book as typist and artist, and his wife, who "has borne the burden of the moods and strains of tending a struggling, fractious author" (ibid. X). These acknowledgements are written in a very personal and beautiful way, which touches me.)

I am falling a bit for this Dr McDonald; he surprises me, but he is not done with me yet. As I go to the index of the book, I get swept away by the words of the chapter headings: "Turbulence and disturbed flow patterns in the circulation" and "The velocity profile in pulsatile flow" and "The relation between pulsatile pressure and flow". Of course I do not understand the content that these headings refer to, but the mere sound of them and the images they produce in my head have a hold on me.

Margit enters the room and I am brought back to the research situation and the interview I am to begin. I show her the book. "Oh, that old thing." She smiles, however, when I show her

the letter by Professor Mathiesen, 'Fritz' as she calls him; an institution in himself it seems. I ask if I can borrow the book and she says I can as long as I return it.

After the interview, I bike home, thinking about the themes that came up in Margit's account of GGG: How it all began, the changes it has been through, and the present challenges they are facing in the preventive work. During the interview, she described that there was a sense of fatigue among the staff working with prevention and that they needed to do something to boost engagement again. The poetic quality of the index in Dr McDonald's book is also on my mind. The concepts of fluidity and circulation resonate with concepts in the ANT literature I am reading into. I begin to think about the preventive strategy as a flow that may be directed in different passages and that may be hindered, intensified, decreased, or redirected.

This occasion, a coincidental discovery of an old book, initiated my use of the vascular system as an analytical hueristic. As such, the book has nothing to do with the preventive work or the GGG programme, but it sparked the idea that perhaps there would be interesting commonalities between the empirical object of the vascular system and the conceptual imageries of network and fluidity found within ANT and thus comprise a curious overlap of 'the empirical' and 'the conceptual'.

The relationship between 'the empirical' and 'conceptual' (or 'theoretical') has been widely discussed across various disciplines and is also an issue in recent discussions within anthropology and STS (Riles 2000, Maurer 2005, Henare et al. 2007, Stengers 2011, Hansen

2011, Ratner 2012, Jensen 2014 forthcoming). Within anthropology, there has historically been an interest in the empirical field's own concepts and understandings in contrast to the ethnographers' ethno-centric understanding and conceptualisation from the outside. Bronislaw Malinowski's famous tenet for ethnographic researchers to understand "from the native point of view" captured this ambition as early as 1922 (Malinowski 1922). Also, linguistic anthropology's distinction between 'emic/etic' (i.e. theirs/our) concepts reflects a concern regarding the difference between 'the researcher's' and 'the researched's' conceptualisations and understandings. This historic anthropological interest in local ways of understanding and critical stance towards conceptualisations from the 'outside' is recognized in recent work within anthropology and STS, where not only local concepts but also local objects or 'things' are evoked as vehicles for analysis (Henare et al. 2007, Hansen 2011).

This approach, which uses local concepts and objects analytically, is often portrayed as a way to 'overcome' theory's superior position to 'the empirical' and instead allow 'the empirical' to speak for itself instead of being 'explained away' with theoretical abstractions (Henare et al. 2007, Hansen 2011, Stengers 2011). Latour's description of ANT as inspired by ethnomethodology and his call for allowing "the concepts of the actors to be stronger than that of the analyst" (Latour 2005:30) by using the field's concepts, touchstones, and understandings (as presented in Chapter 1) thus also resonates with this approach¹³. Another way that the relationship between 'the empirical' and 'the conceptual' has been portrayed is in terms of a "collapse" (Riles 2000:20), arguing that theoretical conceptualisations are no longer perspectives from 'the outside' but have become

13 However, it may be argued that Latour not only draws on the vocabulary and touchstones of the studied actors but also draws on concepts developed from other empirical theoretical sources (Gad & Jensen 2010).

part of the field's 'inside' and part of the field's own vocabulary and self-reflexivity (Riles 2000). This approach then does not problematise the relationship between the empirical and conceptual as a hierarchical order to be overcome, but rather points to the similarities between the empirical and conceptual (also Ratner 2012).

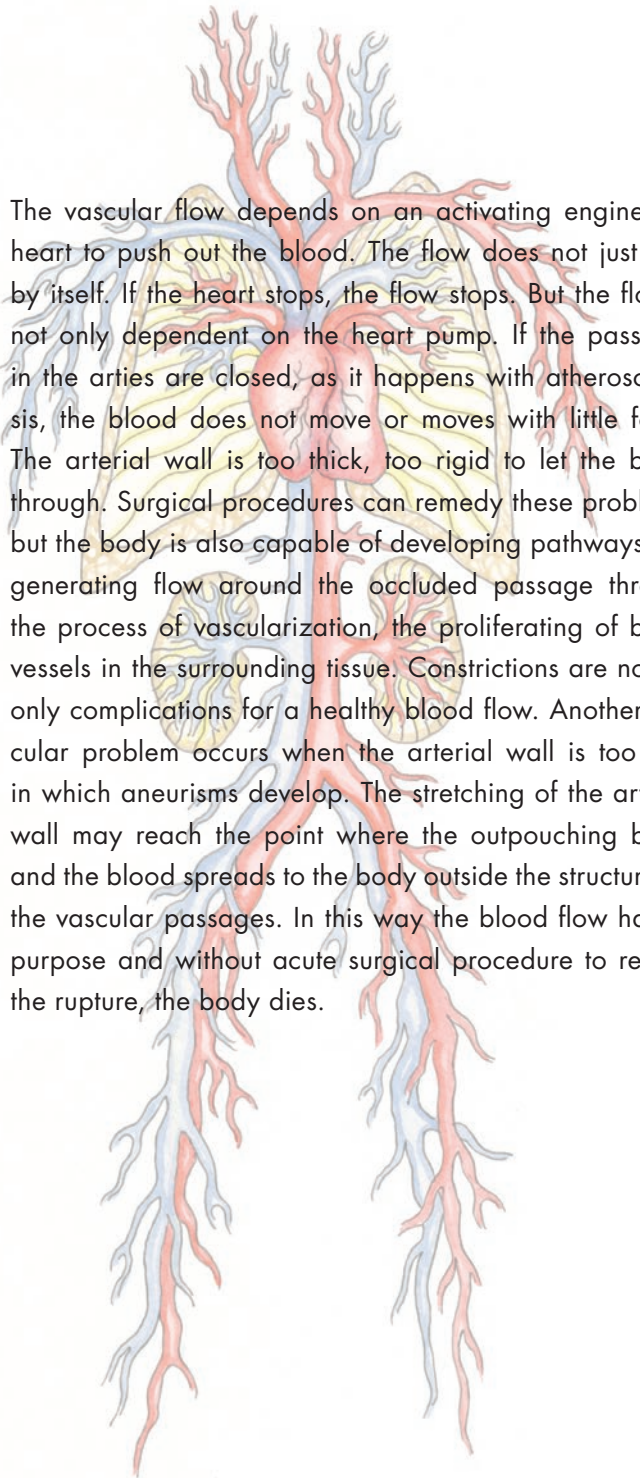
What then to make of the vascular system as I use it in my work? I take the vascular system to be a heuristic analytical form, which is related to both the empirical field and the theoretical resources I draw on. This means that I do not evoke the vascular system with a particular political ambition to turn over theory's superior position and free 'the empirical' from theoretical conceptualisation. Nor do I argue that there is a collapse between the empirical and conceptual, as this would imply a prior separation between the two (as argued by Ratner 2012:76). Rather, I take a more pragmatic stance and see the empirical/conceptual relationship as a mutually generative one and that may take many different forms, of which the vascular system in my project is one of these variants (Jensen 2014 forthcoming). One may argue that conceptual thinking (whether theoretical or mundane reasoning) has always been inspired by 'the empirical' and that this is not so different from the everyday use of imageries or metaphors 'we live by' (Lakoff & Johnson 1980). In Clifford Geertz' classical book, *The Interpretation of Cultures*, from 1973, he describes the metaphor as "the power whereby language, even with a small vocabulary, manages to embrace a multi-million things" and he further explains that: "In metaphor one has, of course, a stratification of meaning, in which an incongruity of sense on one level produces an influx of significance on another" (ibid.: 210). Referring to American author Walker Percy's short story (1958), "Metaphor as Mistake", Geertz points out that the basic trouble of the metaphor is that it is 'wrong' and that:

“[I]t asserts of one thing that is something else and that it tends to be most effective when most “wrong”. The power of a metaphor derives precisely from the interplay between the discordant meanings it symbolically coerces into a unitary conceptual framework and from the degree to which that coercion is successful in overcoming the psychic resistance such semantic tension inevitably generates in anyone in a position to perceive it. When it works, a metaphor transforms a false identification [...] into an apt analogy; when it misfires, it is a mere extravagance.” (Ibid.: 210-11).

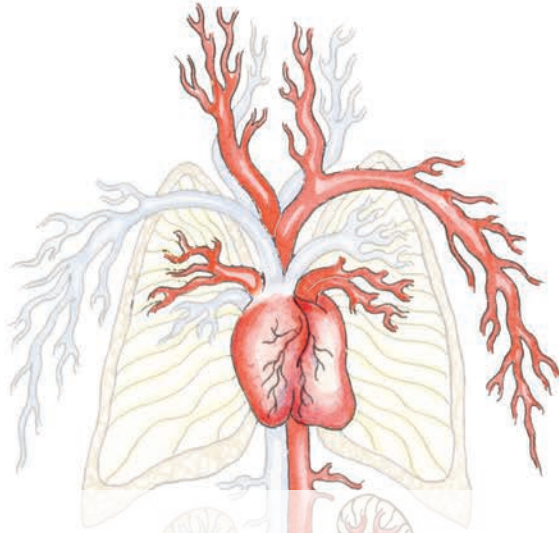
In the following chapters, I draw on the vascular system as an image that ‘embraces’, if not a multimillion thing, then, the complexity of the practices of patient-centred care. The vascular system forms the background map that keeps us on track when following the distribution of patient-centred prevention. Its varying form and functions are evoked differently in the following chapters; how well and productive this heuristic exercise is performed through the thesis is something I reflect upon in the last chapter. My hope is that it does not come across as mere extravagance, but that it manages to relate the various practices of patient-centred care in a productive way.

A Tour in the Vascular System

Unlike the flow of a river, the blood moves within a closed system. Unless a trauma appears, the blood does not leave the body. It is the same blood that moves within the body. However through its movement, the properties of the blood change. The movement is initiated by the heart muscle that pushes out the blood via the arteries. At this stage, the blood is full of nutrients and oxygen which are delivered to the life sustaining metabolic processes in the body's organ and muscle tissues. The arteries spread throughout the body in a network of different sizes – the large aorta runs from the heart through the abdominal region and divide into smaller arteries that reach the upper and lower extremities. The larger arteries spread into smaller branches called arterioles, which further divides into capillaries, the vascular system's smallest blood vessels, which are only 5-10 micrometer in diameter. It is in the capillary networks that the metabolic process happens in which the nutrients and oxygen from the blood is perfused into the cells of the tissue. What happens is an exchange. Oxygen and nutrient are supplied and the gasses and waste products from the metabolic process are absorbed into the blood stream and directed away. The capillaries are interwoven networks that connect arterioles with venules, the smaller veins that branch into larger veins by which the deoxygenated blood and various waste products are returned to the heart. Reaching the heart, the blood is then distributed to the lungs to become reoxygenated in the pulmonary circulation system. And in its further distribution, waste products are cleansed in the filtering organs, the kidneys and liver.

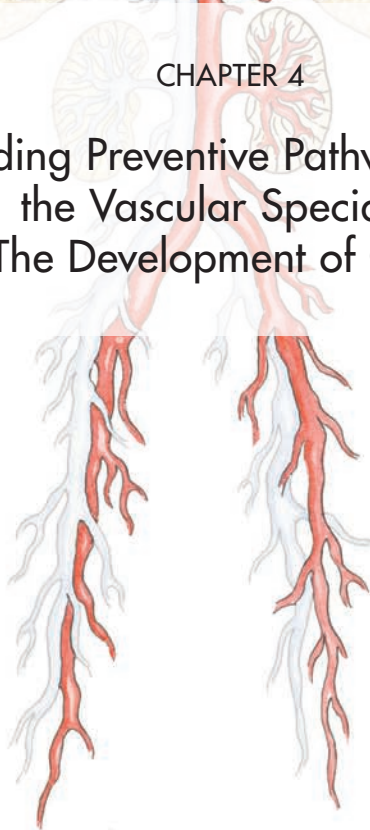


The vascular flow depends on an activating engine – a heart to push out the blood. The flow does not just flow by itself. If the heart stops, the flow stops. But the flow is not only dependent on the heart pump. If the passages in the arteries are closed, as it happens with atherosclerosis, the blood does not move or moves with little force. The arterial wall is too thick, too rigid to let the blood through. Surgical procedures can remedy these problems, but the body is also capable of developing pathways and generating flow around the occluded passage through the process of vascularization, the proliferating of blood vessels in the surrounding tissue. Constrictions are not the only complications for a healthy blood flow. Another vascular problem occurs when the arterial wall is too soft, in which aneurysms develop. The stretching of the arterial wall may reach the point where the outpouching bursts and the blood spreads to the body outside the structures of the vascular passages. In this way the blood flow has no purpose and without acute surgical procedure to restore the rupture, the body dies.



CHAPTER 4

Building Preventive Pathways into the Vascular Specialty: The Development of GGG



Building Preventive Pathways into the Vascular Specialty: The Development of GGG

INTRODUCTION

The general integration of preventive strategies in our daily lives – clear-cut warnings on cigarette packets, stamps of approval on health food products, exercise initiatives at work, and so forth – as well as the highly prioritized status that prevention has in health politics today makes it difficult to imagine that introducing preventive treatment into the vascular specialty would demand much effort. However, as we shall see, the preventive programme GGG, which developed at the vascular clinic at Gentofte Hospital and later implemented at Rigshospitalet, required the cooperation of a wide range of actors and their efforts.

Drawing on the image and insight of Latour's *Science's Blood Flow* (1999b), presented in Chapter 2, I intend to show how the development of GGG occurred in relation to specific actors and concerns within the vascular specialty and the local vascular clinical organization at Gentofte Hospital, as well as in relation to general political debates. Thus, what I follow in this chapter is the “rich vascularisation” of prevention, the various arterial passages that directed the preventive flow into the vascular specialty and which made it “alive” (ibid.: 80) within the vascular specialty. By drawing attention to this expansive network of prevention, it thus becomes possible to transgress an understanding of prevention as either an isolated, local organizational practice or as an example of a ‘global’ structuring phenomenon in society. Instead we come to understand how ‘the local’ and ‘the global’ are related by following the conduits that connect them and thereby avoid jumping between these different scales (Latour 2005:173).

In this chapter, I follow the development of GGG in relation to the emerging preventive focus within the Danish vascular community in the late 1990s and early 2000s. Up until this time, the preventive efforts within the vascular specialty were to prescribe antiplatelet medicine (such as aspirin or in Danish “hjertermagnyl”) and recommend smoking cessation, which was known to worsen atherosclerosis. Besides these few preventive efforts, the treatment of vascular diseases mainly consisted of surgical procedures such as atherectomy, angioplasty, and bypasses. However, the dominating surgical approach was challenged by the preventive effort and medical innovations that were occurring in cardiology in the 1990s and which started to ‘flow’ into the vascular specialty.

I draw on the analytical framework of what, in the theoretical chapter, I called a ‘strategy-oriented’ ANT approach, which is occupied with mapping out the mobilisation of heterogeneous actors and entities in order to create strong actor-networks. The preventive flow into the vascular field did not move ‘by itself’ nor did it flow undirected, but was rather introduced through specific pathways and pushed forward by certain actors. In this chapter, I use insights from Callon’s description of the process of ‘translation’ (Callon 1986a) to understand how prevention was introduced and built within the vascular field by relating prevention to existing local stakes and concerns within the vascular specialty and how prevention became ‘an obligatory passage point’, where vascular surgeons’, nurses’, and patients’ interests and concerns were met. In addition, I describe the various roles, responsibilities, and opportunities that prevention implied for the vascular professionals, respectively the surgeons and nurses, and the different kinds of stabilizing techniques that were used to maintain the professionals’ roles and responsibilities.

The initial mobilisation of prevention took place in the late 1990s and early 2000s, before my fieldwork, and this chapter therefore attempts to elucidate the development of GGG by retracing the central events, polemics, and issues, all of which the actors in the field have articulated in their narratives (interviews and conversations) about this period and which are described in various written documents (meeting minutes, Power Point presentations, newspaper articles, scientific papers, and internal educational material used at the clinics). Firstly, I describe the difficult acceptance of prevention among the vascular surgeons, and the efforts made to engage them in the preventive approach in general. Secondly, I describe the development of GGG and how prevention mainly became a task for the nurses and which engaged them because it implied professional development and status in the clinic.

PREVENTION FROM 'THE HEART'

In this section, I present the accounts of the management team, chief surgeon Henrik and head nurse Margit, which include the motivations behind and onset of GGG in order to find out how prevention flowed into the Danish vascular specialty. One could argue that prevention came into the field 'from the heart', implying literal and metaphorical meanings. In literal terms, the preventive focus and idea for GGG was inspired by the work that was being done in the heart specialty. At the neighbouring cardiology clinic, they had since 1992 worked with a concept called 'Heart-Healthy-Again', which combined medical treatment (cholesterol-lowering and antiplatelet medicine) and lifestyle-oriented conversations between nurses and patients. In more metaphorical terms, prevention also came 'from the heart' of the managing surgeon and main catalyst behind GGG, Henrik, who stated in an interview that prevention "is something that lies very near to my heart," something he told me that was not the case for most surgeons.

According to Henrik, bringing preventive medical treatment into the vascular specialty was a rather controversial subject among vascular surgeons. Henrik described it as a totally unknown territory, “a town in Russia”, and said that the dominating presumption within the field (also internationally) was that “no pill could ever help [treat]” atherosclerosis. It could only be treated when it was so advanced that the only option was to operate. The reason for this poor reliance on medicine, he explained, was that the vascular field, unlike other surgical fields, is not joined by a medical specialty¹⁴. The treatment of vascular diseases is thus solely performed by surgeons, whereas surgeons and medics in other surgical specialties join forces. However, this sceptical perception of medicine in the vascular field underwent a change in the 1990s; Henrik explained in an interview:

“In the mid-late 90s, studies began to appear that showed that it [medicine] did probably help, after all [and that] it was probably the same disease [atherosclerosis] that caused blood clots in the heart. And here it was well known that if people with blood clots in the heart were treated with antiplatelet medicine, then they got fewer blood clots and if they got cholesterol-lowering medicine, then it also made them better. They also got better when they quit smoking, if they exercised and suddenly if one made parallels then it became quite clear, that of course this must also benefit our [the vascular specialty’s] patients, right.”

The problem, Henrik explained, was that there was no place to send

14 At least, this is not the case in Denmark. In other countries, such as France, the Netherlands, Switzerland, and the USA, vascular surgery is joined by its medical equivalent angiology/vascular medicine.

their patients to get this medical treatment. The atherosclerosis patients that were referred to the vascular clinic had complications in their legs and not (yet) in their hearts, and they were thus not (yet) heart patients that could be sent to the preventive treatment, which the cardiology clinic was offering.

“And then it became quite obvious to say, ‘well how the hell do we get such an offer for our patients?’ [...] [A]nd then we had started talking about all of this and nursing had started talking about this holistic nursing, it was very popular 10 years ago, and then I thought what about holistic patient treatment? Why can it only be nursing? Why can’t it be all of it?”

At the vascular clinic at Gentofte Hospital, the idea was to get it all together in one place, that is, in a preventive outpatient clinic, and develop a prevention programme that was inspired by Heart-Healthy-Again but with a modified clinical part that suited the vascular patients. Here, they would take care of the medicine monitoring as well as patient education and information on smoking cessation, exercise, and dietary issues. According to Henrik, the idea to build a holistic and preventive programme was mainly his (however, this was stated in a hesitant tone of voice). This perception was backed up by other surgeons and nurses at the clinic, who referred to the concept as his “great idea” (or ‘kingly idea’, as it is expressed in Danish: “kongstanke”). However, as the above quotation specifies, the idea was developed in relation to “the talk about holistic nursing”, indicating that the thought was not defined in isolation within the medical rationality of providing patients with the best medical treatment, but also in relation to considering the health educational part of preventive treatment. Combining medical and nursing approaches was something that came out of the

collaboration between Henrik and Margit, who together started the vascular clinic at Gentofte Hospital in 1998. They had struck a blow for closer collaboration between the medical and nursing professions in the vascular specialty. Among other initiatives, they had advocated and achieved the invitation of nurses – as peers – to the annual meetings in Danish Society for Vascular Surgery in 2000.

Although Henrik was recognized as the main actor behind the idea of GGG, he stated himself that he did not invent the programme. First of all, it was inspired by the heart specialty and, furthermore, the development of the idea into practical terms was executed by others. A nurse specialist¹⁵, Marie, was hired to develop the pedagogical part of the programme and a young surgeon, Louis, who was doing a PhD on prevention's impact on surgical procedures, took care of the more medical responsibilities in the development of GGG.

Parallel to Henrik's account of the onset of GGG, head nurse Margit also pointed to "new knowledge" as the motivation behind the preventive approach. In an interview, she explained that she and Henrik had talked about prevention for several years and that they "actually felt bad" about not doing anything about patients' lifestyles when they knew this was the major cause of their condition. She said:

"Perhaps we made a small comment about it, but we operated on them, did their bypass and helped them with their acute problem. But it wasn't really where the problem was. If they go home and smoke on or

15 A nurse specialist is a nurse who besides the clinical work also works with the professional development of certain areas within the clinic and who for example engages in research projects and initiates education of the other nurses.

eat fatty food or don't exercise, then the operation we have performed, it won't work after 4-5 years maybe, or even for a much shorter time perhaps. So partly we wanted to do something to affect them so they also helped themselves, so that they got better after the operation but also that there might be some of them who didn't need the operation at all if they changed their lifestyle. And those were the things we had talked about and then when new knowledge and new medicine, the statin area [cholesterol-lowering medicine], [...] when that came about and became more available and could be monitored and used in common practice [then it started].”

In addition to these motivations, that is, the new knowledge and availability of new medicine, Margit also added that the strategic possibility to develop the idea into practice came in the heated political debates of the early 2000s about the general problem of long waiting lists for treatment within the Danish healthcare system.

“In Henrik's and my position we also have to talk about when to put something on the agenda [...]. That is also part of our job, to be strategic about it and say right now this is 'hot' and gets a lot of attention and we have a patient group here who has a problem and is overlooked, how can we get them on the agenda? We could because there was all this waiting list talk and heart talk and there was a lot of political focus on people dying while they were on the waiting list. So we brought it up publicly: so are our patients! And we tried to get some numbers on it.”

In order for the preventive approach to materialize, funding was needed for the team that was going to develop it. In Margit's account, a crucial opportunity appeared as an intense political debate was going on regarding hospital waiting lists. The management team's interest in developing a preventive offer for their patients was "combined", she said, with the media debate that was going on and which especially focused on the waiting lists for heart patients. The focus on heart patients became an opportunity to draw attention to the vascular patients, who suffer from the same underlying disease (atherosclerosis) as the heart patients, even though atherosclerosis in the legs may incorrectly be understood as being less dangerous than when it is around the heart. So not only were patients with atherosclerosis in the legs as seriously ill as heart patients, they were also overlooked and therefore in an even worse position than the heart patients, which was an argument that was used in a range of articles written by Henrik between 2000 and 2001. "The numbers" that Margit refers to above regarding the consequences of long waiting lists for patients with atherosclerosis in their legs appeared in September 2000 in an article at the news agency *Ritzøus Bureau* under the heading "Patients with Atherosclerosis are Severely Undertreated" (*Ritzøus Bureau* 2000, September 20). The article referred to a study made by three doctors at Gentofte Hospital, including Henrik, which showed that only 7% of the heart patients with atherosclerosis in their legs were in relevant cholesterol-lowering treatment. In the article, Henrik stated that in the prioritization of treatment of heart patients within the Danish healthcare system, patients with atherosclerosis in their legs and coronaries had been overlooked, despite the known excess mortality of this group. In a later article published in the Danish Week Letter for Doctors in May 2001, Henrik and his colleagues also published the review article "Lipid Lowering Treatment of Patients with Atherosclerotic Disease in Peripheral Extremities", where they

drew attention to the importance of treating patients with atherosclerosis in their legs with cholesterol-lowering medicine due to the excess mortality rate – of up to 50% – among patients who have undergone revascularization in the legs in the first four to five years after surgery (Bismuth et al. 2001).

In the above narratives about the onset of prevention within the vascular specialty, prevention stands out as a matter coming ‘from the heart’ in two senses: Firstly, as a matter that was inspired by knowledge, medicine, and preventive technologies developed within the heart specialty; and secondly, it also stands out as a ‘heart matter’, that is, carried forward by engaged and passionate prevention spokespersons and strategically linked up to a heated political debate about heart patients dying on waiting lists. However, prevention was not ‘taken to heart’ straightaway by the larger mass of the vascular specialty. The pathway for prevention into the vascular community had to be built by other arguments and concerns more closely connected to the specialty’s actors. This work had begun in the late 1990s, where a thematic meeting in the Danish Vascular Community regarding the specialty’s future in relation to its organization and specialist education was a pivotal event, and where prevention was put on the agenda as a central issue in relation to the specialty’s future.

PREVENTION IN DOCTORING

According to Bent, one of the senior chief surgeons, prevention came into the specialty as a solution to the specialty’s challenged position. In an interview he recalled:

“I remember that we had a meeting in the Danish Society for Vascular Surgery over in Middelfart, where we had assembled with exactly the purpose of how to re-

spond to taking that part up (prevention) and opinions certainly differed [...]. But the underlying issue was in reality that it appeared that if we didn't take it up, then others [specialties] would and then we would get this divided approach to our patients [...]. This we thought was a bad, bad thought. And the other underlying issue was that it in the long run, it appeared that there would probably be a decrease in the surgical part, because all that with the stents [a surgical procedure conducted by another specialty, radiology] was increasing, so one could imagine, somebody had calculated on this, that one or three guys were probably going to be sacked. So it was with these two arguments that it was sold and it was Henrik, among others, who sold it."

In Bent's account, prevention was "sold" to the vascular surgeons by presenting prevention as the solution to the challenges that the specialty was experiencing. Surgical procedures concerning vascular diseases were increasingly being performed by radiologists with the development of endovascular intervention, such as angioplasty. The need for open surgery on vascular diseases and thus the competencies of vascular surgeons were thereby declining. If the preventive medical approach was not taken up by the vascular surgeons, they would lose even more patients to other specialties, and the decrease in patients and production would lead to employment reduction.

Thus, prevention became not just a possibility due to the medical developments within the heart specialty and the discovery of the connection between atherosclerosis in the legs and heart diseases, but it was also construed as a necessity if vascular surgeons were interested in protecting their profession. Broadening the vascular responsibilities by including preventive medical treatment into the

vascular field would secure a sufficient number of patients to uphold the specialty's production; not on the surgical part but rather by increasing the number of medically treated patients.

Going through the minutes from the above-mentioned meeting in the vascular community in Middelfart in May 1999, the discussion and disputes about prevention among the surgeons that Bent refers to are clear. A representative from Sundhedsstyrelsen (The Danish National Board of Health)¹⁶ spoke at the meeting on the issue of the organization and education of the vascular specialty in the future. In his presentation, he prepared the ground for prevention by relating it to the vascular specialty's future survival. A future that depended on the identity of vascular surgeons, he proclaimed:

“It is important to make clear, when discussing the future of the surgical area of specialization, whether one generally perceives oneself as a technician or whether one perceives oneself as doctor.”

The representative explained that if the vascular surgeons continued to think of themselves as technicians then their existence would solely depend on the treatment technologies available. And with the development that these technologies had recently undergone, this would imply a threat to their function. The representative stated that the technological development within the next ten to twenty years would “make the knife unnecessary.” However, he continued, if the vascular surgeons perceived themselves as doctors, then it would be the general patient pathways and not the surgical procedures that mattered.

16 The supreme authority in Danish healthcare, which assists and advises the ministry of health and regional and municipal political authorities with the development and administration of healthcare services.

“Try to think, well could we go “upstream” instead of standing downstream in the river and tossing the patients up on the banks again, and find out who or what it is that tosses them in the river. You, as doctors, will discover that it has to do with the lipid metabolism, there is something about tobacco smoking and there is something about diabetes and all in all something regarding our lifestyle.”

This, however, posed the question, he continued, “Are you interested in this as a doctor?” The motivation to answer yes was offered with force, formulated as a dramatic question of life and death: “Can we continue accepting that so many people die from diseases that we very well know are possible to intervene in much earlier?” But the focus would require a special interest and effort from the actors in the field. He proclaimed: “It will demand that you rise up and tell the population that a great part of our diseases are consequences of something that we can avoid, if we want.”

He argued for the expanded approach, both by evoking the argument in favour of the patient and the argument in favour of protecting the specialty against competing specialties:

“You can say that ‘we won’t put up with this’ and fight those [other specialties] that want to steal the patient pathway from you by entering the technological areas that work [radiology]. But besides the procedure that is directed towards the stenosis in the artery, you must think more on the human being that carries the vascular disease. How does he live with it? How does he compensate for what he misses when he hasn’t got sufficient blood supply to parts of his body? Think about

how to help the patient to compensate so that he can live a better life with his handicap. If you don't do it, somebody else has to do it."

He continued:

"[I]t is actually only the good Lord who has the responsibility for the pathway [now]. Therefore, if you want to make the patient group with peripheral atherosclerosis yours, it will be yours when you take the overall responsibility for the course of things. Not in the old fashioned paternalistic sense, where we are supercilious and want to teach the patient how to live their life. It's more that as a doctor, one considers what awaits the patient and shares one's knowledge with the patient, so that he or she can act in a sensible way."

Due to the development of new and gentler endovascular interventions, the representative said, patients' hospital stays have shortened, which means that contact with the patient has been reduced and that something "valuable" has been lost, "namely that the patients feel that we are interested in them and give them the care values that lie in the doctor-patient relationship". He advocated that the vascular specialty should try to get that back "somehow". The "somehow" he put forward was to change the specialist education so that the pathway approach would become a formal part of the surgeon training; "I think the doctors are the key to such changes. Knowledge, attitude, and behaviour are closely connected." At the end of his speech, he concluded:

"Regarding the education of future vascular surgeons, you probably need to help The National Board of Health to understand what the right thing to do now

is – is it the patient pathway or the technology that the vascular surgeon is to take responsibility for? If it is the technology, then you must choose that technology which looks to be most progressive and stake everything on it. If it is the doctor, the surgeon, who wishes to take responsibility for the patient pathway, then one must presume a more differentiated content in the vascular surgeon's workday. In reality, I think it is about finding the balance in both.”

The next morning, the representative's speech was followed up by a discussion among the surgeons. The main points made the day before were summarized by the vascular community's president:

“Those patients who come early, those with claudication, where we just say, ‘that's no big deal; you must just quit smoking and go out and exercise.’ Those we don't see again. Those were the ones that we should throw our resources on and then maybe give up on some of the wrecks that we burn all the money on. It may very well be that there will be a demand that we do it. That means that we must exert ourselves in trying to get people to quit smoking. Not just say it but make them do it! We must initiate walking therapy [...]. And finally there's the medical aspect. It's totally foolish that there is nobody who is interested in whether our patients would gain from cholesterol-lowering medicine when all other atherosclerosis patients do. I'm sure our patients would too!”

“It's also important to make clear that when our patients come due to pain in their legs, then it's perhaps

even more important to regard this as a signal for that they soon will have a problem with the heart. And then it doesn't suffice saying to them that they should just go home. It doesn't matter with your legs, you won't be amputated, only 1% [of the patients] do. But they all, by and large, get an AMI [Acute Myocardial Infarction/blood clot in the heart] at some stage. Just look at the mortality rate on the ones we operate on with bypass, over half of them are dead after 3-4 years [...] because of an AMI caused by their atherosclerosis."

"We have an obligation to handle the medical counterpart to the vascular specialty. We don't have, and we have always been happy about that, the medical counterpart angiology. We don't have the cardiologists making the indication of who to operate on, like the thorax-surgeon. But on the other hand, we have an obligation to be interested in much more of the medical aspects; we must take responsibility for the patient pathway."

Critical voices from the audience responded to the president's summation. "A younger surgeon", as it is stated in the minutes, said:

"Is it really so that we all now agree that all aspects of atherosclerosis are our business? [...] Then major changes have happened in this society. Five-six years ago the society's chairman said at one of the annual meetings that all that about measuring cholesterol, that was the most stupid thing he had ever heard and all applauded enthusiastically with their small hands. That was only five-six years ago."

Another surgeon, not specified in rank, also expressed his scepticism:

“I think it’s really interesting that we’re sitting here quite a lot of vascular surgeons talking about diabetes, talking about cholesterol lowering. Are we that idealistic? Is it really so that surgery, as the representative from the National Board of Health says, that we belong to a losing specialty?”

Another surgeon confirmed this grave outlook, pointing to the problem of recruiting candidates to the specialty:

“Isn’t the whole recruitment problem caused by the candidates that have smelled the rat? That it’s too dead a specialty? We are dying, we can’t bother doing the PTA [angioplasty], nobody bothers doing anything, not even giving them some pills against high cholesterol. The heart doctors are barrelling forward and we do nothing!”

Other voices uttered in favour for the expanded ‘doctor approach’ as opposed to the solely ‘technician approach’, as defined by the representative. One of the surgeons who argued for taking responsibility of the patient pathway said:

“Well, I think that one best solves one’s tasks as a doctor if one has all the treatment that is applicable. Both the ones who only need a pill and have their cholesterol lowered [pills] over the balloon treatments and the most outrageous of the operations we are capable of performing. I think it should all be on the same shelf in order to have an overview and to take down whichever one, one thinks, suits the individual patient.”

But expanding the vascular specialty's treatment raised questions regarding the concrete organization of the specialty in relation to other competing specialties.

“How should we take care of this patient with these vascular diseases? We can end up in a destructive battle around these patients and we can end up in a constructive cooperation and work together on it. [...] As it's run right now, nobody can be content with that many patients feel neglected”

This cooperation especially referred to the radiologist specialty. A surgeon stressed:

“Another important thing is the relation to the radiologist, the intervention-radiologist. How is the future going to look? There's no doubt that the intervention radiology or endovascular surgery is one of the things that will remain for years to come, but enrolled in our department, or are we to take over the procedures or go about it as hitherto?”

Another surgeon responded to this issue by arguing in favour of keeping medical specialties apart and upholding the historical separation of them:

“I think it's wrong that the vascular surgery should take care of it all. I think one has to view it from an organizational point of view and say, now we have moved the content of the vascular specialty quite a lot with our discussion today and constructed a more complete view on what offers there must be. But the offers must be placed

in a way that show respect for the specialties' development through time and the know-how that has been acquired in the different specialties. [...] [I]t's the organizational model that should solve the vascular treatment, by having different specialties with respect for each other, participating in the treatment offer [...] it isn't a must that the radiologist is employed in the vascular clinic."

Another surgeon refuted this by saying:

"I think it's a bit disheartening to hold on to this old fashioned structure, where we have a diagnostic department and a therapeutic department. I think the time is ripe for hospitals to be arranged according to the patients and not how some specialties were invented 200 years ago."

Another surgeon claimed that the decision to expand the specialty's work task was out of their hands and part of a larger political agenda:

"We shouldn't forget that the structural change that is intruding on us now, it isn't generated in a medical professional point of view. It's generated with political, economical aspects, where the motive is to reduce the number of specialties and thereby the opportunity to change the hospital structure, so that they can smack things together and run units that are cheaper."

Another surgeon also expressed that the decision had already been made:

"If we are to have that pathway responsible senior

doctor, which he [the representative] very much wants, then it doesn't matter that we're sitting here wasting our time talking flatology [hot air]!"

In the résumé of the minutes dated August 1999 and signed by the president of the Danish Society for Vascular Surgery, it is stated that there are no final solutions, but a lot of problems have been put forward. However, there is agreement that "we must be interested in the pathway to a greater degree and not just care for the surgical or interventional aspect of patient treatment. We must take responsibility for the pathway."

In an article in the medical journal *Dagens Medicin* (Daily Medicine) March 2000, called "Vascular Surgeons on the outlook for New Tasks", the disputes at the meeting a year earlier were reformulated into new visions for the specialty. The president for the Danish Society for Vascular Surgery stated that the specialty was on the look out for new tasks and perhaps also a new professional name. He stated that the vascular specialty would look out for the entire patient pathway, "an unusual thing in a surgical specialty," (Brob-erg 2000: 3). This new approach, he explained, was a consequence of the recently changed needs for vascular surgery, which had required a discussion about the future of the specialty. The meeting at Middelfart was referred to as an event where the specialty's "identity crisis" was discussed and where there was agreement that the specialty had to reorient its course if it was not to stall. At this occasion, it was also stated that the professional title of the doctors was to change from vascular surgeon to vascular specialist. The article ended by stating that the Danish Society for Vascular Surgery in the fall of 1999 had oriented the National Board of Health about their visions and future wishes for the specialty and the requirements to ensure the doctoral capacity to fulfil these visions and wishes. A

year after the Middelfart meeting, the disputes had been translated into set visions to be taken into consideration with regard to the specialty's education.

Linking Prevention to Better Surgical Outcomes

Although prevention in this way became part of the specialty's official tasks and responsibilities, it still required an effort for the vascular surgeons to take the task upon themselves. In the interview with Henrik, he told me that, although most of his surgical colleagues thought that the preventive approach sounded "swell and cosy" (imitating their mocking tone of voice), most of them had no real interest in engaging in it themselves. And with a sigh, he said that it had taken quite a few years before it had been fully "accepted". He further explained:

"Meaning that people understood their responsibility in relation to referrals and in relation to respecting what goes on. And that I think most of them also did acknowledge that it was clearly favourable to place it [prevention] with us. But that isn't the same thing as being interested in it, 'that's not why I became a vascular surgeon, to sit and talk smoking cessation and green salad' and so on. But that's also something we must accept and that's the way it is. But, but, but, people still need to know their position and respect that it [prevention] exists and need to know why it's necessary and that took some time!"

The interests that Henrik referred to, and which were put in contrast to the preventive treatment, are the surgical procedures that occupy the surgeons to a great degree. He further explained that some surgeons felt that the preventive approach "diluted the fun part with

something more ordinary”. Henrik stated this as a problem both in relation to referrals, because the doctors had a responsibility to refer patients to the preventive treatment and GGG programme (an issue I return to in Chapter 5), and in relation to “respecting” the preventive treatment. Pointing to prevention as a necessary solution for their challenged specialty did not necessarily endorse respect about the preventive approach or create engagement among surgeons into practising prevention; but other factors contributed to the gradual acceptance of it. Henrik explained:

“It always helps when the boss is doing it, right. But they could also see that it wasn’t just some little local enthusiastic group, you know. They could see that something was happening around us in the world and I got involved in some big international projects, which were about that kind of thing, where they could see that publications were raining down on the department. And we got the money to do it and it created a whole lot of publicity [...] in the daily press and we were reaping a lot of credit for our holistic approach. Ehm, so one thing led to another, time was working for us and, moreover, we became aware that it also made our patients much better when we also took care of this.”

The publicity Henrik refers to included articles in the journal *Dagens Medicin* (Daily Medicine) under headings such as “Vascular Therapy is Much More than an Operation” (Brunsted 2001, February 22) and “Healthy Living Instead of Operation” (Langer 2001, November 22) as well as in the national newspaper *Berlingske*: “Change: Success when Nurses Prescribe Medicine”(Pedersen 2003, June 6). The preventive work that the clinic engaged in interested various

actors, including the Copenhagen County (later Capital Region), who granted funding for the development of the preventive treatment and the GGG programme.

However, the most convincing issue for the surgeons regarding the integration of prevention in the field was when prevention was related to surgical outcomes; Henrik told me:

“When we started GGG, it wasn’t so much with an eye to getting patients to live longer; it was more selfish, that our treatment would improve. It’s actually stated if you read our original project description, it states that the main objective is to improve the operation outcomes in the long run. [...] Later we discovered that the patients also lived longer [laughs]!”

He further explained this difference in outcomes:

“If you think about it, we operate on patients in their neck and on their leg; it doesn’t necessarily have anything to do with how long they live. But if that bypass operation we make to avert an amputation, if that works longer, then you also postpone the amputation, and [...] if there is something that vascular surgeons like, it’s when their patients arrive on two legs; when they arrive with one leg, then we can see that we have failed to do something: My operation didn’t last or we started too late or something. So basically, those things were actually the main purpose when we wrote the first protocol.”

This main interest in prevention’s effect on operation outcome

was also expressed by Bent during my interview with him. With a straight face, he said:

“Numerous studies show that prevention, whether you quit smoking slash take your statins slash one thing or the other, [implies] that they live longer, our patients. And that’s a fine goal in itself, [but] the upmost important goal is, in fact, that what *we* do surgically is more durable if they adhere to those prevention things that we recommend. To quit smoking prolongs the lifetime of a bypass by about 10-15%.”

The effort to relate prevention to surgeons’ major professional interest in surgery continues to be important and more and more attention is given to the area of pre-operative prevention. During my fieldwork, one of the younger vascular surgeons was engaged in researching the effect of smoking cessation on surgical procedures and was writing a PhD on the topic. Despite this, there continued to be an ambivalent attitude towards prevention in the specialty. Although prevention was taken on board in the vascular field in order to secure a challenged specialty, the preventive approach in itself also works as a threat because the focus on prevention in the long run means fewer operations, which is what attracted the surgeon to the specialty. As one of the surgeons jokingly said during a conversation, “Some of us young surgeons are a bit worried about all this prevention. It’s like shooting yourself in the foot. [To an imagined patient:] ‘Go out and smoke for God’s sake!’”

Summing up

In this section, I have shown the introduction of prevention into the vascular field. I have shown how prevention is configured as an obligatory passage point that becomes a solution for many concerns:

It emerges as a solution for better patient treatment both regarding effectiveness and coherence (patient pathways). It is articulated as part of a larger strategy for the survival of a challenged specialty and a means to ensure a steady flow of patients, money, and a new generation of young surgical candidates to the specialty, and it is related to the surgeons' core interest in surgery. I also showed that the mobilisation of interest among surgeons rests upon a fragile foundation: It is acceptable only so long as their core activity, surgery, is still a prominent feature and in practice we shall see that prevention is mobilised into the vascular specialty because nurses are defined as the main actors to carry out the task.

In the following section, I look at the further distribution of prevention and its translation into the concrete GGG programme, which took place in the period 2000-2001. Although prevention depended on a passage into the vascular specialty and acceptance by vascular surgeons to legitimize its presence in the vascular specialty, it was the vascular nurses who become the main preventive actors in the vascular clinic.

PREVENTION IN NURSING

The GGG programme started up at the vascular clinic at Gentofte Hospital, which was established in 1998 with Henrik and Margit as a joint management team. The development of GGG drew upon several interests and concerns among the young and newly recruited nurses at the clinic. In Margit's account, two issues stood out. Firstly, the preventive approach fed into the general professional interest of holistic and patient-oriented care that dominated the nursing discourse at that time (which Henrik also mentioned above). Secondly, prevention was seen as an opportunity for nurses to strengthen their professional status in the clinic.

New Professional Responsibilities with GGG

According to Margit, the preventive approach, and more specifically the idea to develop a preventive programme, was seen as an opportunity to define the nurses' professional identity and status in the clinic. She recollected:

“I could see an opportunity and a challenge for the nurses to take this field on themselves. I'm very concerned when nurses take on new areas that traditionally have been a doctor area, that there must be something independent to it, so that they develop within nursing too. There are many blurred boundaries where doctors and nurses work together and agree on a division of labour. And then there are things that develop mono-professionally. And I think it's great that one can do things all the way around, but there also has to be some things within one's own profession, where one can develop.”

This was not only a personal matter for Margit but also something that reflected the general debates in the Danish nursing profession in the 1990s. As Margit expressed, this was part of a more general battle for professional legitimacy: “We were fighting the nurses' fight”, she said.

In the beginning, the medical treatment with cholesterol-lowering medication required “something more” from the nurse, Margit stated. The medication had to be meticulously monitored and regulated and thus required some “hardcore knowledge”, as she termed it, referring to the calculation of dosage and adjustment according to blood samples and the clinical guidelines for which the nurses re-

ceived special training. The management of medicine thus became a nurse responsibility enabled by the delegated right to manage medication, which allows specially trained nurses to adjust medication according to clinical guidelines (however, a doctor's signature is still required on the prescription). This medicine management had been practised at the bed units, where nurses especially managed the medical treatment of pain; however, for the nurses at the outpatient clinic, the management of cholesterol-lowering medication broadened their field of responsibilities.

“We placed these prevention conversations with other consultations, like, if they had had an operation, then we placed the conversations with the check-up consultation on their operation. Then we decided on some criteria so that we could decide whether to end them, refer them to other treatment, or talk with another surgeon. So the nurses could actually take the entire consultation and this was actually what excited me. This was new and the consultation could include it all. We were very attentive to whether patients thought it was strange that they didn't see a surgeon. In the vascular field, we've always been used to patients having a strong doctor association. We really did a lot so that the doctors would start treatment by saying that all this prevention is part of the treatment in this clinic and that it's the nurses who manage it. This was a way to reassure the patients that the doctors had approved it and that they expressed that 'I also think this is important, but it's the nurse who takes care of it.'”

The strategic use of the media to mobilise prevention generally within the vascular specialty was also used to promote the GGG programme

and the preventive efforts at Gentofte Hospital. In the above-mentioned article in the Danish newspaper *Berlingske* “Change: Success when Nurses Ordinate Medicine”, the preventive work at the clinic and the related increase in responsibilities and expansion of the nurses’ work tasks were portrayed as a way “to optimize treatment production and quality”. In the article it was stated that between 40% and 50% of the patient consultations were attended by the nurses, who were supported by special software to monitor and ensure the quality of the treatment. At the end of the article, the preventive work at the vascular clinic was exemplified as a case that corresponds with the agenda of the Danish Nurses Organization for delegating nurses with more responsibilities within the Danish healthcare system in order to “get more health for the penny” at the hospitals (Pedersen 2003).

Defining the Pedagogical Approach: Motivational Interviewing

In addition to the excitement about new responsibilities and enhanced professional skills, Margit explained that the pedagogical considerations in the preventive work especially engaged her and the nurse specialist, Marie, who was hired to develop the GGG programme. They were particularly concerned with how to approach the patients, such as: “What are we supposed to talk about with the patients? How do we approach them? What is our role? How can we intervene in their lives?”

This interest was part of a general debate that had begun in the Danish nursing profession in the 1990s, Henrik and Margit explained. Margit said that they talked a lot with the heart department and a preventive clinic at Bispebjerg Hospital, which had been appointed to be a model hospital for prevention in 1994, an initiative made by the Copenhagen municipality and as part of a larger WHO collaboration between European hospitals entitled “The Health Promoting

Hospital”. Their role was to develop, establish, and evaluate preventive practices so that other hospitals could learn from these. At Bispebjerg Hospital, all patients had, from the late 1990s, been asked about their alcohol and smoking habits and had been offered preventive conversations if they smoked or consumed alcohol above the national guidelines (Valgård 2003: 208; Fredslund 2001; Dahlager 2005). The preventive conversations at Bispebjerg Hospital built on the method of ‘Motivational Interviewing’, which also became one of the methodological sources of inspiration for the GGG programme. Margit explained the approach and the implied considerations that were taken into the GGG programme:

“It’s about starting with where the patient is and to get them to talk about what the problem is. And at the same time, to give them some actual guidance and help them make up their mind about what they should do. So already at that time we talked about power relations: How far can we go? What is my role? What can I tell them to do?”

The pedagogical considerations and the discussions about the nurse-patient relationship, “the power relations,” as Margit stated, was something that the newly hired and young nurses were excited about.

“Here was something that they were really interested in: all these things regarding prevention – the talk about smoking – and here you must remember what time it was. It was really hot to talk about smoking. Smoking prohibition at work or at least in the offices – this existed even in the late nineties, totally inconceivable today! There was a lot of debate about how far you could interfere in peoples’ private lives and

questions like ‘Can I have cigarettes in my pocket if I promote smoking cessation?’ and ‘If I am overweight, is it then appropriate for me to say that somebody else must eat healthy?’ came up. So they were very, very interested in all this.”

In Margit’s account, getting nurses involved in the preventive work was not difficult because it already appealed to them due to its topicality, both within the nursing field but also generally in the public debate. In Chapter 6, I describe the principals of Motivational Interviewing, as well as other theories of behaviour change that inspired GGG, and unfold how they are practised in the GGG consultations between nurses and patients. The purpose here is to illustrate that the translation of prevention into the GGG programme happened in relation to specific concerns in the clinic, as well as more broadly, by translating prevention into a network that was expansively spread in the Danish healthcare system, where Motivational Interviewing was an approach that was generally articulated, discussed, and circulated in relation to prevention and health promotion (Valgård 2003). Several reports on the issue were produced and published by the Danish Medicine and Health authority “Sundhedsstyrelsen” (e.g., Mabeck et al. 1999; Dalum et al. 2000), which were also used in the internal educational material for nurses at the clinic at Gentofte Hospital. Apart from being educated in the principals of Motivational Interviewing by external educators, the nurses were also trained as smoking cessation instructors at the Danish Cancer Society. Furthermore, a range of “reflection-sessions” were arranged to ensure nurses continual development regarding the preventive work. Here the nurses shared their experiences regarding the preventive work and gave feedback to each other.

GGG SOFTWARE: MONITORING AND MEASURING PREVENTION

GGG adopted the special software that had been developed for the Heart-Healthy-Again programme, which was used to document and record the preventive treatment. The software was developed in cooperation with the medical firm Pfizer, who produces the cholesterol-lowering drug Zarator; however, the clinic did not only use this drug in their treatment. The GGG software was established as a central tool to support the preventive work in several ways. The software was to be used in the GGG consultations in order to monitor the preventive work with the patients and also included the possibility of monitoring the preventive performance internally among the nurses and later comparing the preventive intervention across the clinic at Gentofte Hospital and Rigshospitalet. The GGG software was welcomed by the nurses as it made it possible for them to document their practice, which was (and continues to be) an issue that relates to a general concern within the nursing profession where documentation is part of the agenda to increase professional legitimacy by systematically define and record core areas and tasks within nursing and define nursing in a more scientific way¹⁷ (Svenningsen 2003, Bowker & Star 2000).

In the manual (GGG Handbook 2002) the purpose of the software is described and reflects a range of organizational interests that the software is designed to support in its data generating function. These are listed in the introduction (*ibid.*: 2):

17 This is an issue that not only concerns the nursing profession in Denmark but internationally (Dansk Sygeplejeselskab & Dansk Sygeplejeråd). Here the words of nursing informatics pioneer Norma Lang are often quoted: "If you can't name it, you can't control it, finance it, research it, teach it or put into public policy" (Clark & Lang 1992).

- To ensure consistent documentation of relevant data.
- Provide the opportunity to illustrate treatment data to the patient.
- Deliver documentation to the patient record, which is only written in at the first consultation where the examining doctor writes down the motivation for his/her treatment plan. With the choice of conservative [preventive] treatment, it is marked down at the end of the note that “the patient is referred to the GGG outpatient clinic incl. statin treatment according to table”. The latter formulation is to document that the treatment in this way is delegated according to guidelines under existing laws [i.e., the delegated right to manage medication].
- To assure treatment quality through Practitioner Reports.

The first purpose reflects a traditional positivistic scientific purpose, namely, to ensure that data are comparative. The categorisation provided by the software ensures a homogenization of the patient data, which is essential in the different evaluating, auditing, and research-oriented practices. The “relevant data” are defined in six parameters that are generated and entered at every GGG consultation: cholesterol level, ankle-brachial index (ABI)¹⁸, weight, walking distance, blood pressure, and tobacco consumption. The first purpose mentioned reflects the importance of the documentation work in the clinical praxis, which is backed up in the introduction section in the manual, where it is stated that the main purpose of the first version of the software is to get started on the data production and registration of the new preventive treatment. This ambition later materialized in various reports and articles, which were generated by the GGG software to document its effect. One of the results was the article “Organising a Nurse-driven PAD Rehabilitation Clinic

18 The ABI is the ratio of the blood pressure in the lower legs to the blood pressure in the arms. Lower blood pressure in the legs compared to in the arms is an indication of reduced blood flow due to atherosclerosis.

within the Vascular Surgical Department: What is Required and are Treatment Goals Reached? – A Prospective Study”, which was published in 2007 in *European Journal of Vascular and Endovascular Surgery* and authored by Henrik, Margit, Marie, and another surgeon from Rigshospitalet. Here, they showed that GGG had successfully managed to increase the proportion of patients taking antiplatelet and cholesterol-lowering medicine: The proportion of patients in antiplatelet treatment had thus increased from 63% to 87% and the proportion of patients in cholesterol-lowering treatment had increased from 27% to 84%, which had resulted in a significant reduction of patients’ cholesterol levels. The mean of the total cholesterol had decreased from 6.2 to 4.9 mmol/l and the mean of LDL cholesterol from 3.9 to 2.6 mmol/l, proving that patients had taken their preventive medicine and that the preventive effort at the clinic had been successful in reaching its medication targets. Furthermore, data on smoking cessation was also presented, which showed that after a year, the proportion of smokers had been reduced by 12.5%, which was however evaluated as less successful (Sillesen et al. 2007).

The second purpose refers to the prevention strategy’s more pedagogical aim and relates to the strategy’s main purpose of ensuring that patients are well informed about their disease and can make grounded decisions regarding their lifestyle and preventive practices. The software makes it possible to illustrate the course of the treatment and the development of the above-mentioned six parameters as diagrams, which gives the patients a visual representation of the state of their health and the effects of the preventive treatment and lifestyle-related behaviour. This feature, nurses expressed, had a “motivating effect” especially on the male patients.

The third purpose is that the software works as an extra page in the patient’s record, where the treatment course and development

can be written down and thus makes place for other data that are not covered in the set categories and selected parameters for monitoring. Moreover, under this point a very precise instruction is given in order for this extra page in the record to work as documentation for following the legislation regarding the delegated right for nurses to manage medical treatment.

The fourth purpose refers to the possibility of generating reports on the practitioners', i.e., nurses', performance in the preventive work. The aspiration was that the nurses' individual work and results on the six parameters could be compared to ensure the treatment quality in the clinic. However, this individual-based monitoring and quality assessment was not technically possible. Instead of statistics on the individual nurse, it was possible to generate more general statistics about treatment results and production at each clinic and compare these.

Generally, the software was presented as the infrastructure designed to support the preventive work in the clinic so that this work appeared responsible in scientific, pedagogical, legal, and medical terms. In the earlier mentioned article in *Berlingske* (2003), the software was also portrayed as a tool that enables the monitoring of the preventive treatment and thus legitimizes the nurses' expanded tasks and responsibilities within the field of vascular surgery. To begin with, the software was perceived positively by the nurses in relation to the more general concern for documenting their work. However, over time the enthusiasm for GGG software gradually decreased because it became outdated and also because a number of other information systems were implemented. Although, the nurses recognized the importance of documenting their work, some of them also expressed that the computer work disturbed the intimacy of the preventive work. In 2010, it was

decided to end the use of the separate GGG software and instead document the preventive work in a descriptive manner in the general electronic patient record.

SUMMING UP

In this chapter, I have described the initial building stages of GGG and the mobilisation of prevention within the vascular specialty. Following Callon's portrayal of the process of translation (Callon 1986a) as presented in Chapter 2, I identify prevention as an issue that was gradually and strategically developed into an 'obligatory passage point' for the various actors in the vascular field. This chapter describes how prevention was related to existing local stakes, concerns, and interests in the field through the act of 'problematization', where specific roles, motivations, and internal relations between the various actors in the field were defined by the developers of the programme, and we thus see how prevention ascribes certain identities, fates, and possibilities for the professionals in the field. An attempted stabilization of these roles was made by different 'devices of interessement', which were enrolled to keep the different actors in place and lock them into their specific roles and responsibilities. For the surgeons, prevention became an obligatory passage point in relation to the survival of their challenged specialty. Taking responsibility for the patient pathway would ensure that patients were directed and kept within the vascular specialty and were not taken over by other specialties. This survival strategy regarding the preservation of patient numbers and staff retention was accompanied by different devices of interessement or stabilizing arguments to keep surgeons in place: Besides the moral argument or obligation regarding patients' excess mortality, feelings of neglect, and long-term health status, vascular surgeons' more specialized interest and passion in the surgical procedures was also used as a device of interessement,

where new knowledge on prevention's positive effects on surgical outcomes and durability was used to maintain surgeons' support of the preventive approach. For the nurses, prevention became an obligatory passage point in order to gain more responsibility and professional status in the clinic. The stabilizing devices here were partly the pedagogical part of the programme, which held the nurses' interests and partly the GGG software, which played a major role as a technology for documenting the preventive work and producing scientific facts, which implied a legitimization of their preventive work and expanded responsibilities.

What this chapter points to is that the building of prevention within the vascular specialty consisted of a wide range of materials, including scientific facts, political debates, professional interests, and local organizational concerns. The development of GGG was thus made through scientific, political, and professional alliances. As Latour writes about 'science's blood flow': "these alliances do not pervert the pure flow of scientific information, but are what make the blood flow much faster and with a much higher pulse rate" (Latour 1999b: 104). This chapter demonstrates how prevention became part of the vascular field, not merely by implementing new medical knowledge, but through the meticulous work of relating this knowledge to the stakes and concerns of the field's actors and by stabilizing these through different strategies and in different devices. However, the image of a singular heart that beats at a steady rhythm, as Latour portrays it, is challenged in this chapter, which rather conveys an image of different hearts beating in different rhythms and for different causes. How these different heartbeats evolve beyond the initial problematisation and intersement of prevention is the issue of the next chapter, where the strategic building of GGG is challenged by different obstacles and dissident actions.

CHAPTER 5

Complications in the Preventive Pathways:
Adjusting GGG and the Preventive Flow

Complications in the Preventive Pathways: Adjusting GGG and the Preventive Flow

INTRODUCTION

In Chapter 4, I focused on the initial strategic building of prevention's pathway into the vascular specialty. I also described how the GGG pathway was built by mobilising surgeons and nurses through their specific interests and by involving a range of heterogeneous actors to establish prevention as a vascular task and responsibility. In this chapter, I continue to follow the development of GGG and describe some of the challenges that arose in its further spatial and temporal distribution. More specifically, I focus on the 'occlusions' that build up in the GGG pathway which decrease the number of patients enrolled in GGG, and I follow the operational interventions and adjustments that are made to maintain a preventive flow in the vascular clinic.

In the years after the launch of GGG at Gentofte Hospital in 2001, the clinic received a lot of positive attention from the national and international vascular community praising the programme as a pioneering approach. The programme was presented at national and international conferences, and visitors from other clinics in Denmark and Scandinavia came to Gentofte Hospital to learn about GGG's principles and organization. In 2004, Henrik changed position and became managing surgeon at the vascular clinic at Rigshospitalet, the largest hospital in Denmark and located four kilometres from Gentofte Hospital near the city centre of the capital, Copenhagen. Here, he initiated the implementation of GGG, which expanded spatially to the new clinic and thereby also expanded in the sense that more patients with atherosclerosis were offered structured preventive treatment. However, GGG's success at Gentofte Hospital

was not easily transferred to Rigshospitalet, where it did not catch on among the nurses as it had at Gentofte Hospital.

At Gentofte Hospital, GGG was also changing and expanding in the sense that the preventive approach and lifestyle-oriented consultations were not only offered to outpatients enrolled in GGG but also to patients in the bed unit, where patients were educated in groups during their admission¹⁹. The GGG programme thus became a sub-programme under a broader strategy, which was called “Healthy Lifestyle”.

In 2008 the two clinics merged due to a large structural reform. Henrik and Margit formed the managing team for both clinics, which continued to be located at two separate addresses in Copenhagen and Gentofte. In this new setup, the differences in practicing GGG and prevention between Rigshospitalet and Gentofte Hospital now became more salient in the efforts to standardize treatment offers and practices at the two clinics.

During my fieldwork at Gentofte Hospital in 2009 and Rigshospitalet in 2010, GGG was going through a reconstruction, and new initiatives to revitalize GGG were being discussed and developed. Both clinics had experienced a decrease in patients enrolled in the programme, which was explained in different ways, referring both to “societal matters” and “organizational matters”. In this chapter, I describe how the decrease in GGG patients was explained and how a new type of prevention consultation, the ‘Prevention Conversation’, was introduced in an attempt to reverse this decrease. Thus,

19 This approach was inspired by the so-called Patient Schools, where patients would receive information in groups and share their thoughts and experiences in a community with other patients suffering from the same disease. This approach was upcoming generally within the Danish health care system (see e.g., Nielsen 2010).

this chapter shows that although prevention had since the early 2000s become part of the vascular specialty, prevention continued to require mobilisation and came to modify professional responsibilities in this process.

GGG IN COMPETITION WITH OTHER PREVENTIVE OFFERS

One explanation the health professionals came up with regarding the decreased number of patients enrolled in GGG was that prevention had become a general focus “in society” compared with the period when GGG started and patients with atherosclerosis in their legs were an overlooked patient group. One of the nurses said, “It takes up a lot of attention in society, it’s a trend to speak about prevention, and when you open the newspaper, there is always something about prevention.” This general expansion of the preventive orientation in society was further organized in connection with a national public sector structural reform in 2007, which had merged municipalities (from 271 to 98), reduced 13 counties into 5 larger regions, and changed the organization of healthcare tasks between them. This meant that the responsibility for preventive, health promoting, and rehabilitation services was moved from the counties (now regions) – and thus the hospitals – to the municipalities, where new health centres were established to provide these services. At the centres, a number of preventive and health promoting offers such as smoking cessation, exercise, diet counselling, and healthy cooking classes were provided and facilitated by different health professionals such as nurses, dieticians, and physical therapists. Such offers had not existed to the same extent in 2000, where patients with atherosclerosis were an overlooked group in regard to preventive treatment. Furthermore, the general practitioners had also become better at monitoring the cholesterol lowering medicine, which had become easier to monitor, and they were also

to a larger degree taking care of prevention and health promotion issues together with more disease specialized initiatives. This general spread of prevention was seen as a reason why the number of patients in GGG had decreased – patients were already enrolled in other preventive programmes. In the interview Henrik explained:

“[T]he need in our field has also decreased, the patients are much better ‘prevented’ when they come from their general practitioner and the general practitioners have a whole other assortment of offers they can send the patients to, [which] was practically nil in year 2000, no municipal offers and therefore we have also begun a reassessment of GGG [...] because the need simply is different [now]. There are many more diabetic schools that we are not to compete with. All heart departments also have a prevention department now and there is a convergence of our patients, some of them [our patients] are heart patients, right, and a lot are diabetic patients and are already enrolled in such places and then we don’t have much to offer.”

Henrik saw this as a “natural part of the development”; he said that they had had some “enormously interesting development years”, but that the need had changed and therefore they also had to re-organize their preventive work to better fit and make sure that the offer was provided to the ‘right’ patients, which primarily was understood as those patients who were not already enrolled in other preventive programmes, as well as focusing on those patients who were “motivated” to actually make lifestyle changes. A key issue was therefore to make sure that the referral procedure was effective and well defined.

The changed conditions for working with prevention and the need to rethink the preventive setup especially in relation to referrals was also something Margit described in the interview:

“When we started this, there was not as much information out in society [as now] [...]. A lot of things have changed the last five years – like the Smoking Law²⁰, has meant a lot because people, even though in the hard way, have been informed about or know the political message, that it is not a good thing to smoke. But also the healthy messages, people know, they know ‘six a Day’²¹ [...], they know that one has to exercise and they know what happens when you smoke, so the knowledge level is increased in the population, so that’s why the [preventive] need is not quite the same. [W]hat we want to try is to get it sharpened a bit, so that we don’t just have a lot enrolled without really knowing whether it helps or not, [but] to ensure that those we spend time on are people who are interested in it and that we know we can help.”

This, Margit explained, needed to be better assessed in the referral process in order to be more precise about the individual patient’s needs. This was not sufficiently clarified in the present screening process, which largely depended on the doctor’s assessment and referral to GGG.

20 “The Smoking Law” refers to the Act of Smoke-free Environments, which was passed by Danish law in 2007 and which forbade smoking outside designated rooms at both private and public workplaces, see also Chapter 1.

21 ‘Six a day’ is a National health promoting campaign that began in 2004 and which encourages people to eat six pieces or 600 grams of vegetables and fruit every day.

DOCTORS' NEGLECT OF REFERRALS

The explanation of the decreased number of patients in GGG was thus not only explained as an effect of other competing preventive offers external to the organization; it was also seen as an internal problem, regarding the referral procedures and especially doctors' responsibility to refer relevant patients to the GGG programme. The procedure had so far been that patients who were referred to the vascular clinic would get an appointment with a doctor, a pre-examination, where the doctor examined the patient to make the diagnosis and treatment plan according to the patient's condition, whether this implied operation, medication, monitoring, or preventive intervention. In the pre-examination, the doctor was supposed to assess whether or not a patient was a relevant candidate for GGG. However, there was a common understanding that some doctors neglected this part of the job. A nurse explained that some "simply forget it", and others "don't see the purpose of GGG", indicating that it was both a matter of inattention and of lack of interest that led to the decreased referrals. Henrik confirmed this interpretation, adding that the decreased number of patients also could be a question of:

"[...] how much we have made an effort to convince the patient that it is a good idea, right. [...] [Imitating in a sluggish way to an imagined patient]: 'You don't really want to come for prevention, do you?' [...] It might also have to do with prejudice, that one looks at the patient history and says: 'You don't look like somebody who would benefit from this – waste of time!' But that might not be right and if you look in the health legislation, we are not permitted to have such prejudices."

In Henrik's account, it was not only doctors' attitudes towards the preventive offer that could influence the referral procedure, but also their sceptical attitude regarding the patients' abilities to actively engage in preventive activities.

DECREASED MOTIVATION AMONG NURSES

A third issue that came up regarding the decreased activity in the preventive work and enrolment of patients in GGG was a decrease in the nurses' motivation to work with prevention. This demotivation had different causes at Gentofte Hospital and at Rigshospitalet. At Gentofte, the demotivation among the nurses was explained as a "natural" deflation; what once had been exciting and new had now become mundane and had lost intensity. At Rigshospitalet, GGG and the preventive work had not caught on among the nurses when it was implemented in 2004 as it had done at Gentofte Hospital due to other interests, as we shall see in the following.

Gentofte Hospital: How to Maintain Motivation when Working with Prevention?

At Gentofte Hospital, the decrease in the nurses' motivation to work with prevention was explained by Margit, who said that one of the biggest challenges in working with prevention was to keep focus on the long-term goal:

"Because there are no immediate results – so I think the biggest challenge about the preventive work is that one cannot see here and now that it has helped. And it is not always easy to keep the staff, keep the motivation, when you cannot see a direct outcome. It is difficult. It is much easier to see that a surgical operation has worked, if it has worked, [...] or a wound that heals quickly because you have used some principals

you know are the right ones and then there is a direct payoff, right? When you give a pain relieving injection and five minutes later they are able to walk out in the corridor – there is a payoff with a lot of our other tasks, also the softer fields like conversation, information, guidance, where you can see that there is a content patient in front of you and that he feels secure. You know a worried, scared patient that has calls throughout the night, well if you see them fast asleep at five in the morning; that feels great, when you are on night shift. It's not the same with the preventive work. Here you have to believe that it helps in the long run [sighs] and have that ideological approach and that is especially difficult for a group of professionals that have chosen a surgical specialty, it's a challenge for them and for me as a manager, to keep on believing that it is the right thing we are doing and not just passing it all on to the general practitioners and say 'enough!' [laughs], and it demands a mutual pep up."

Whereas other parts of the nurses' work tasks have immediate results, the preventive work in Margit's understanding needs to be related to its long-term goals, which requires a more "ideological" engagement and a belief in "the right thing". In Henrik's account, he also mentioned the difficulty of seeing the immediate results of the preventive work as a problem that affected the health professionals' motivation to work with prevention: "it is really difficult to measure the effect of prevention because it doesn't come tomorrow [sighs]". This was also an understanding that was shared by the nurses. One of the nurses explained that in the beginning, when GGG was developed, it excited the nurses because it offered so many new tasks and opportunities. They went to courses

and became smoking cessation instructors; the topics they had to cover in the consultations with patients expanded; they also got new responsibilities in relation to medicine and had to learn about cholesterol-lowering medicine and how to monitor it. “The parcel grew and we grew along with it [i.e., rose to the occasion]”, the nurse said and further reasoned that the decrease in motivation that they were experiencing was a “natural” part of the process after a period of exciting development. She said that changing the programme in different ways was a way “to catch people [their interest] again. It has to be exciting and relevant [...] and we have perhaps experienced that some of our work tools are not that good anymore and need updating, right”. Aligning with Margit’s understanding, she said that getting new professional “input” and “perspectives” on the preventive work could boost the motivation among the nurses. A second nurse added that another important part of maintaining motivation was “standard-bearers, who burn for prevention”. This was confirmed by a third nurse who said that “fireballs” could influence the “attitude” among colleagues towards prevention, but that there is also the “practical” consideration, that there was time for getting new input, reading on the subject, and having time to reflect and develop the content of the preventive work.

Another practicality that influenced the motivation for preventive work was the GGG software, which had gradually become outdated since its introduction in 2001. Nurses complained that it was old fashioned and rigid, and that it also disturbed the intimacy with the patients in the consultation. Also, more and more computer programs had been introduced into the clinical practice, which meant that nurses spent more and more time on “checking boxes”, “opening programs”, and “remembering passwords”. What had been seen as a tool for support to begin with, had turned out to be a burden

that took attention away from “the human work”, as one of the nurses said. The GGG software, which had been mobilised as a way to document and show the effects of the preventive work and thereby legitimize the preventive work, had not worked quite as well as imagined. One problem was that while it made it possible to show the effects of the medical treatment (as published in Bismuth et al. 2007), other parts of the preventive work did not show it in as quite a convincing way. For example, the parameters ‘Smoking Consumption’ and ‘Walking Distance’ were based on patients’ self-reported information and therefore did not count as much as the other objective measurements, which meant that these results could not be used in scientific articles. In an attempt to bring forward other effects of the preventive work than the merely medical measurements, Marie, a nurse specialist, initiated a survey in 2003, which evaluated patients’ knowledge about their disease and the influence of lifestyle issues before and after the GGG course. However, the responses did not show any statistical significant results due to an inadequate response rate, and thus the results were reduced from ‘proof’ to ‘indication’, stating that patients already knew quite a lot before they engaged in the GGG course. This reflected what was already known regarding preventive work: That those patients who engage in preventive interventions are often those who already are knowledgeable and therefore take part in preventive activities.

Margit further commented that the character of the preventive work and the need to believe in its effects had consequences for the kind of staff they wanted to recruit to the clinic.

“You probably need to be a little ‘green’ to continue to believe in it, right, also in your private mindset. So you can say that this [affects] the kind of staff we hire and who is to work here [...]. I actually believe that it’s

a little necessary that you believe in ‘the good cause’, in ‘the preventive’, in ‘the healthy’, right. Because if you in your own lifestyle don’t believe in it and think it’s great to drive around in a petrol guzzling car and always take a new plastic bag in the supermarket and don’t care about smoke, noise and fumes, then I don’t really know whether you can honestly go into it [...]. It’s part of the discussion, where do you have to be in all this [i.e., what is required when working with prevention]? It’s easier at Bispebjerg Hospital in their prevention team, when they hire people there, to stress the importance of that part of the personality than here, because we stress the importance of other things as well – other professional skills that appeal to other more natural science kind of people [who choose the surgical specialty].“

In her perception, prevention was not only an issue that required specific professional skills and interests but also touched upon the professionals’ personal lifestyle and attitude (an issue I take up again in Chapter 7 and Chapter 8).

Rigshospitalet: Other Professional Interests

At Rigshospitalet, the nurses’ lack of motivation to work with prevention was not something new; rather, it had never caught on in the same way as it had among the nurses at Gentofte Hospital. When Henrik started at Rigshospitalet in 2004, he wanted to implement GGG and continue its success as a preventive offer for atherosclerosis patients at Rigshospitalet. Despite the success of GGG at Gentofte Hospital, Henrik expected that the actual implementation at Rigshospitalet would nevertheless be difficult, especially among the senior surgeons. However, to his surprise they accepted

it “as quick as lightning”. This, he explained, was probably due to the success at Gentofte Hospital and all the publicity they had gotten. The vascular surgeons had seen how the patients got better and there was a lot of focus on prevention generally, “time worked for us”, he said. A few months after his shift, Marie, the nurse who had developed the GGG concept together with a junior surgeon, was hired at Rigshospitalet, and the premise for implementing GGG at Rigshospitalet was thus in place. However, the implementation of GGG among the nurses at Rigshospitalet turned out to be a different story to that of Gentofte Hospital. Henrik explained in an interview:

“It was up hill with the nurses here, because they were a group of outpatient-clinic nurses who had been here for 15 to 20 years and who thought that, ‘Well, prevention that is fine, but can’t it be done somewhere else?’ They liked the ultrasound scans, the circulation measurement; and sitting next to the doctor during the consultation.”

Ultrasound scans had become part of the vascular specialty’s diagnostic method around 1998 in relation to locating stenosis and determining its size. This diagnostic work had previously only been possible with angiography and had thus been part of the radiographic specialty. With the introduction of ultrasound scans, the vascular specialty could therefore perform certain diagnoses independently and gain independence from the radiographic specialty. Henrik explained that it took quite a lot of work from the head nurse at the time to convince them that it was part of their job and that prevention was not up for debate. Prevention had with time become accepted to some degree, but there was still a difference between the nurses’ attitude to prevention at the two clinics; he said:

“We can see that there are fewer prevention consultations here [at Rigshospitalet] than at Gentofte and you know, somebody has to [...] evaluate if there is a need [for prevention]. And I can imagine that sometimes here [at Rigshospitalet] the evaluation is: ‘Ahh, that’s something that the general practitioner can figure out. That’s probably well taken care of at the general practitioner’, where somebody at Gentofte, perhaps not all, says: ‘That’s something I would like to take care of’ and then makes the offer to the patient.”

The difference between the nurses’ engagement in the preventive work at the two clinics was openly discussed at both clinics among the nurses, doctors, and management team. There were different stories and explanations about the differences in the preventive work and the preventive performances at the two clinics. One of the explanations given by a nurse at Rigshospitalet was that prevention was “imposed on them from the outside”, when Henrik started at the clinic. Where prevention had been a task to position the nurses and expand their professional responsibilities and define an independent mono-professional area at Gentofte Hospital, the nurses at Rigshospitalet had focused on developing their technical skills in relation to ultrasound scanning and strengthening the position they have in their close working-relationship with the doctors, which the organization of work at Rigshospitalet implied, as most of the consultations included the joint participation of the doctor and the nurse.

It was often mentioned by the management team, but also by nurses and surgeons at both clinics, that the nurses at Rigshospitalet were not interested in prevention because they defined their professional skills through their scanning expertise and had become extremely

good ultrasound scanners. One of the surgeons at Rigshospitalet expressed that the Rigshospitalet nurses' skills were so good that it was a potential problem for the surgeons, "We have to be careful that they don't get too clever", she said, because it could leave the surgeons "lazy". Instead of performing the scans themselves, the surgeons at Rigshospitalet would often let the nurses perform them, which then caused problems when the surgeons were on their own during night shifts and had to perform the scans. The nurses' scanning skills at Rigshospitalet had already given them a central position in the consultations and the clinic and made them reluctant to define their position through prevention. As one of the nurses at Rigshospitalet told me: "We have not had the same need to do so [define the professional position through prevention] here because of the scanning." The nurses at Rigshospitalet had enhanced their professional responsibility through internal special education, and they had thus acquired not only diagnostic responsibilities, but were allowed to discharge some of the outpatients on their own. In a conversation with one of the nurses at Rigshospitalet, I was told that their enhanced responsibility meant that they were very careful when performing the scans and followed the procedures more thoroughly than the doctors. She explained that "when you put out your neck [and get something for the it], you want to maintain it and not just be like the doctors [she imitated a sloppy scan on the neck, moving up and down] 'Oh well that looks fine' ". The nurse further said that the scanning skills also had a higher status than the "softer" "nursing blipper-blapper" (the more communication-oriented nursing skills), as she put it. She saw this as a major problem that jeopardized some important parts of their professional expertise and responsibilities:

"We are not good enough at documenting all the other good and important things we do – like the nursing

anamnesis – ‘Do you eat? Do you take your medicine?’
If we were better at that, we would spare a lot of time
for the people down at the bed unit – but the nursing
‘blipper-blapper’ is not prioritized [in the outpatient
clinic].”

The prioritization of technical skills and scanning over the preventive work continued to be an issue and came across in several situations during my fieldwork at Rigshospitalet in 2010. In one situation, where I asked a nurse after a screening consultation (a ‘Prevention Conversation’, which I introduce later in the chapter) about her thoughts on referring the patient to GGG, she said that she would probably not refer the patient even though the patient smoked and thus was a relevant candidate for GGG. She explained that smoking cessation would require a much more intensive programme, which they could not offer at the clinic. She said, “They do that much better out in the municipalities in the health centres, where they [the patient] also can meet up with people they know and go along with them to the conversations”. She further said: “I was very ambitious in the beginning, I was on a smoking cessation instructor course, but I only saw them [the patients] three times during a year and in the beginning I blabbed on and on about it, but when you only see them a few times...” With this she indicated that she did not believe that the limited number of consultations that GGG could offer (approximately five consultations a year) was sufficient.

Prioritization of the scanning work over preventive work was not only explained as a lack of interest or status, but also as a task that some of the nurses did not feel they managed well enough compared to other healthcare institutions. One of the nurses, who was known for avoiding GGG consultations, said that she did not think

she was any good at doing preventive work. She explained that she was too impatient and got annoyed by patients' bad excuses and that there were so many others who did much better than what she and her colleagues could actually do at the clinic. They could only offer a couple of "conversations", whereas preventive offers at the local healthcare centres were much more expanded and performed by people who had specialized within the relevant areas. Another nurse confirmed this, saying that times had changed since GGG started in 2001 at Gentofte Hospital: "We have been overtaken by other offers – like training facilities [at the municipality healthcare centres] that are more socially and locally anchored – we can't offer that here", she said.

Another reason given by the nurses at Rigshospitalet to explain the difference between the preventive performances at the two clinics was that the two hospitals were placed in different geographical locations and served different kinds of patients. Rigshospitalet is placed in the city centre, "we see a lot of different people here", a Rigshospitalet nurse said and contrasted this with the patient group at Gentofte Hospital, located "up north", in the wealthier area of the region, which goes by the nickname 'the whiskey-belt'. The nurses at Rigshospitalet explained: "We also see the patients who sit on the bench in the park", indicating a greater diversity among the patients in the city population, among these, marginalized groups such as alcoholics and drug addicts. At Gentofte Hospital, the Rigshospitalet nurse explained, patients have other conditions for engaging in the preventive work. The Rigshospitalet nurse described the stereotype patient from the Gentofte Hospital area as a retired doctor from the north, who is bothered by his atherosclerosis when he plays golf, the "golf-claudicant", as the term went. This group of patients was perceived to be in a better position to undergo lifestyle changes than patients who deal with other social and economical problems.

The difference between the numbers of patients enrolled at the two clinics was also explained by most of the nurses at Rigshospitalet, who said that they actually did cover prevention in their work, but in another way due to the different consultation setup at Rigshospitalet, where both the nurse and doctor went into the consultation together. This meant that prevention became a more “integrated part of the consultation”. This was an advantage, they explained, because they could talk about prevention when the doctor was present and thus stress the importance of the preventive issue through the doctor’s authority. However, this preventive intervention did not register as the preventive work did in the GGG programme, and because it was not documented, it did not appear in the statistics that the GGG software generated.

This way of practising prevention as an integrated part of the regular consultations was not the only difference in the preventive practice at Rigshospitalet. Also, some of the GGG consultations were practised in ways that did not follow the GGG procedure (which I unfold in Chapter 6), for example, keeping to the delimited number of consultations to be offered. During a day of observation, I followed a nurse who had a GGG consultation with Mrs. Nissen. Mrs. Nissen, I came to understand, was a well-known patient at the clinic. The nurse I was following received friendly, albeit teasing, comments about her continual check-up of her patient: “Oh you have a visit from Mrs. Nissen today, how cosy”, one of the other nurses commented, implying the familiarity with Mrs. Nissen. The nurse I was following explained that Mrs. Nissen had been coming to the clinic for biannual check-ups for the last eight years. She was enrolled in GGG, not because the consultations were focused on prevention, but because they worked as check-ups on the condition and general support and comfort of the patient. The nurse told me that the patient was a very nervous and fragile person and that

she was worried about her: “Who will take care of her, if I don’t?” she asked rhetorically. This was not the only patient she was ‘taking care of’ in a way that went beyond the GGG programme. The nurse was known among her colleagues as “our social worker”, who takes care of the “hard cases” or “characters”, and her colleagues talked about her effort in a respectful and lenient way. One said, “We don’t really understand why she bothers. But she is very social and very embracing and she might be the only contact those people have.” Her colleague continued in a defending tone: “Prevention is very much about the social and perhaps there is a managerial opinion that she shouldn’t spend so much time on it [those kinds of patients], but...” she said and shrugged her shoulders.

Another nurse I followed had a similar case. During a patient’s tenth GGG consultation, the nurse went through the measurements and themes in the GGG programme (details on this in Chapter 6), and they talked in a familiar way about the patient’s everyday life and his interest in art, something that the nurse also shared an interest in. During the consultation, she said: “And I know I can’t convince you about quitting the pipe, I have tried God knows!” The patient confirmed that smoking his pipe was too much a matter of “life quality” for him to consider quitting. After the consultation, she said that although he was not willing to quit smoking, she had managed to convince him about the importance of walking every day and changing his diet, which he had determinedly engaged in. He walked a lot and had managed to increase his walking distance and had changed his diet, especially regarding the importance of eating fish. She said that she kept seeing him for her own “selfish reasons”. She explained that he was “interesting” and “able to reflect” about his situation and other issues; “He is one of those patients that makes it bearable for me – who gives something back to me”. She said that she could end the course,

but she continued to follow him in the GGG setup. When I asked why he was not followed as a normal check-up consultation, she said that the doctor would probably end the course and refer him to check-up with his own general practitioner. But she wanted to follow him to make sure that he kept on track with the walking and the diet. She said that she was well aware that she did not treat the patients equally by doing this, but that she felt she needed to have some “good cases” as well, so that she did not burn out.

So, to sum up the situation at Rigshospitalet, the implementation of GGG there had turned out to be more difficult among the nurses than what Henrik had expected due to the different local interests and stakes. Whereas GGG in its initial stages at Gentofte Hospital was defined in relation to the nurses’ professional interest in the pedagogical aspects of nursing and in their interest to create an independent professional positioning in the clinic, these concerns were not of primary interest among the nurses at Rigshospitalet in 2004. The problematisation that had rendered prevention as a solution for the nurses at Gentofte Hospital, and so successfully enrolled and mobilised them, did not have the same relevance for the nurses at Rigshospitalet, where the question of their professional authority, status, and interest were related to scanning skills and the close working-relationship with the doctors in the consultations. Despite this lack of general interest, GGG and the preventive work was still being practised to some degree according to the GGG procedures but also in different ways that made other practices of care possible: The unintended continuation of patients in the GGG programme thus came to work as both a way to offer extended care for fragile patients whose treatment would probably have been ended and as nurses’ ‘self-care’ in relation to their work life by holding on to interesting patients and tasks that made their work “bearable”.

INTRODUCING THE NEW SCREENING PROCEDURE: THE 'PREVENTION CONVERSATION'

At the time of my fieldwork at Gentofte Hospital in 2009, the prevention workgroup (which was one out of six workgroups that had been formed after the merging of the two clinics and which included the management team, nurses from both clinics, and a surgeon from Gentofte Hospital) had developed a new preventive setup that could respond to the above challenges. This consisted of a new screening consultation, the "Prevention Conversation", which made it possible to make a more focused referral procedure that would ensure that all relevant patients were offered preventive treatment and made aware of the GGG programme.

The inspiration for the new Prevention Conversation came from Bispebjerg Hospital, Henrik said. The preventive chief physician at their cardiology department had been invited to a staff meeting to talk about how they had organized their preventive work. They had had good experience with keeping the preventive work in a separate consultation and even held the preventive consultations in a different physical setting outside the heart department. Henrik did not see the purpose of sending the patient to different places and believed it was smarter to keep the consultations in the same place in order for patients to see the same healthcare professional and if necessary, have check-ups that required the clinical setup. However, what inspired him was the division between the pre-examination and the introduction of the preventive treatment in a separate consultation with a few days in between. Henrik explained:

"We had the original concept where you came in once and then we would just deal with it all together. But it turned out that when the patient had heard the

word ‘operation’, or something, then they closed off. You couldn’t get through to them with other things. So you could talk about diet and exercise and they didn’t get it. So the idea to separate it and make it a set component, [...] not something where we would ask ‘would you like to?’ No, no – you just get it [the Prevention Conversation].”

Not only was the Prevention Conversation an opportunity to focus on prevention and make a more clear referral procedure, it was also a way to increase the clinic’s production. The clinic was facing cut-backs due to economizing in the Capital Region announced to take place in 2010. Henrik explained:

“In relation to the first cutbacks in 2010, the new Prevention Conversations worked as a ‘cost reduction’, as they generated a small profit that could be put in [in the clinic budget] as a cost saving. [...] [I]t is so fortunate that with the Danish accounting system [in the hospital sector], that is the way we are financed, that it [the accounting system] doesn’t distinguish who makes the service. That means that when we get payment for a prevention consultation, the system is actually designed as if it is a doctor, who is sitting there [in the consultation], and the price is calculated in relation to that [...] because mostly it’s a doctor who is sitting there in the consultations. When we then have a nurse in there then it’s actually slightly cheaper and we get the same refunding as if it had been a doctor, [...] it isn’t a poor business [to offer prevention].”

The new referral was practically organized by giving patients two

appointments instead of one. In the old setup, the patient would only receive one letter with an appointment for a pre-examination, after which the doctor would refer (or neglect to refer) the patient to GGG. In the new setup, the referral procedure for preventive treatment started earlier, when patients' referral letters from their general practitioners or other clinics were received at the vascular clinic. Here, the charge nurse would read through the referral letters and evaluate which patients were relevant for preventive treatment based on the varying information that was provided in the referral letters. The criteria for this evaluation were not quite set from the beginning (as I will show below), but some types of information excluded patients from the further referral procedure, for example, if the patient was a resident at a nursing home. Those patients who were perceived as relevant for preventive treatment would get two letters: one with the appointment for pre-examination with a doctor and one with the appointment for the Prevention Conversation performed by a nurse, which was booked approximately a week after the first consultation. Accompanying the letter with the pre-examination appointment was a sheet of paper, the 'Information Form', which was to work as a "joint work tool" for the doctors and nurses to ensure the preventive treatment. One part of the form was to be filled out before the first consultation by the patient. The other part was to be filled out by the doctor and nurse in the pre-examination consultation and in the screening conversation. The part of the Information Form that patients were to fill out consisted of yes/no questions under a range of categories:

- ALLERGIES (MEDICINE, IODINE, PLASTER, CONTRAST MEDIUM).
- DISEASE HISTORY (HEART CRAMPS, BLOOD CLOTS, HYPERTENSION, DIABETES, LUNG DISEASE).

- PREVENTIVE MEDICINE (ANTIPLATELET, CHOLESTEROL-LOWERING, HIGH BLOOD PRESSURE MEDICATION).
- MEDICINE.
- SMOKING (CURRENT/FORMER SMOKER).
- DIET (LOW FAT DIET, 6 PIECES OF FRUIT/VEGETABLE A DAY; FISH TWICE A WEEK).
- BODY MEASUREMENTS (HEIGHT, WEIGHT).
- ALCOHOL (MORE THAN 4 UNITS A DAY).
- EXERCISE (MORE THAN 30 MINUTES A DAY/TYPE OF EXERCISE).
- SOCIAL (ACCOMMODATION: OWN HOME, SHELTERED HOUSING, NURSING HOME; RECEIVER OF HOME CARE OR HOME NURSE SERVICES; LIVING ALONE).
- EARLIER ADMISSIONS (REASON AND YEAR).

The part of the form that the health professionals were to fill out was categorized as “Treatment Plan” and consisted of a range of boxes to be crossed:

- MEDICAL TREATMENT
- ARTERIOGRAPHY
- ADMISSION FOR OPERATION
- PREOPERATIVE PREVENTION
- GGG
- SMOKING CESSATION CONVERSATION
- PREVENTION IN OTHER DEPARTMENTS
- PREVENTION WITH GENERAL PRACTITIONER
- IN RELEVANT TREATMENT
- DOES NOT WISH PREVENTION CONVERSATION
- PATIENT HAS RECEIVED PRESCRIPTION FOR STATIN
- THE PATIENT HAS RECEIVED PRESCRIPTION FOR MAGNYL/PLAVIX [ANTIPLATELET MEDICINE].

At the bottom of the Information Form, a box with the text: “The patient is referred to preventive treatment in GGG, including anti-platelet and statin treatment according to table” with a line for the doctor’s signature and the day’s date to allow for the delegated right that nurses have to manage medication (see Chapter 4).

The Information Form was understood as a way to make it possible to keep together all relevant information during the referral procedure and make the referral process more transparent in order to ensure that all relevant patients were in preventive treatment. Furthermore, instead of primarily placing the referral responsibility and generation of relevant information for the selection process with the doctor, the new form involved more actors to contribute to this.

In April 2009, a joint meeting for both clinics was arranged by the prevention workgroup to discuss the new Prevention Conversation. In the written presentation sent out prior to the meeting, it stated:

“We know that patients with peripheral atherosclerosis have a considerable excess mortality, and we also know from numerous studies that smoking cessation, exercise, healthy food and medical treatment (like aspirin and statin) work if you want to prevent the development of cardiovascular disease. In the vascular department, the preventive intervention has been focused on the outpatient clinics [at Gentofte Hospital and Rigshospitalet] in GGG, which has been running for respectively 9 and 4 years and there has been a total number of approximately 1700 patients through a preventive course at the clinics. At both clinics there is also work going on regarding the establishment of patient education during admission.

In the last couple of years, the number of patients who are already in statin treatment at the time of their referral has increased due to the greater focus on preventive treatment among general practitioners. Furthermore, new municipal offers for patients, for instance, the health centres, focus on rehabilitation and lifestyle interventions for chronic diseases such as cardiovascular diseases, type 2 diabetes and chronic obstructive pulmonary disease. When we compare this development with the last six months' decrease in referrals to GGG, we think it is time to get a fresh look at the prevention offer at the clinic."

The presentation further stated that the prevention workgroup therefore proposed the introduction of the 'Prevention Conversation' for all patients with arterial disease. It described the consultation, which was to take place in the outpatient clinic with a nurse and last about 30 minutes and would be booked approximately a week after the doctor's pre-examination and treatment plan. The purpose of the visit was described in the following points:

- The pre-examination should only regard the referral cause.
- The Prevention Conversation devotes prevention to a patient who has hopefully been clarified on the treatment plan for the main disease and that all relevant information, including blood sample results, are available and that a suitable amount of time is reserved.
- The Prevention Conversation ensures that all get their risk factors assessed and that the right treatment is ensured.
- The preoperative prevention intervention could be included in this visit [the Prevention Conversation].
- The competence to assess the need for prevention is placed with a nurse who has experience from her work in GGG.

The purpose was thus described as a way to focus on prevention after patients had had time to adapt to the diagnosis and treatment prospect. During the conversation, the relevant data would be collected in a structured way. And nurses were positioned as the main actors for the assessment of the patient's preventive treatment. The purpose was further explained:

“At this visit [the Prevention Conversation], the patient and nurse are to find out together which risk factors the patient has in relation to diet, smoking, exercise and medical treatment and if possible what he/she is motivated to change. Together they are to assess whether the patient needs a follow-up in GGG, is ‘self-propelled’, or is to be referred to other offers at for example a health centre.”

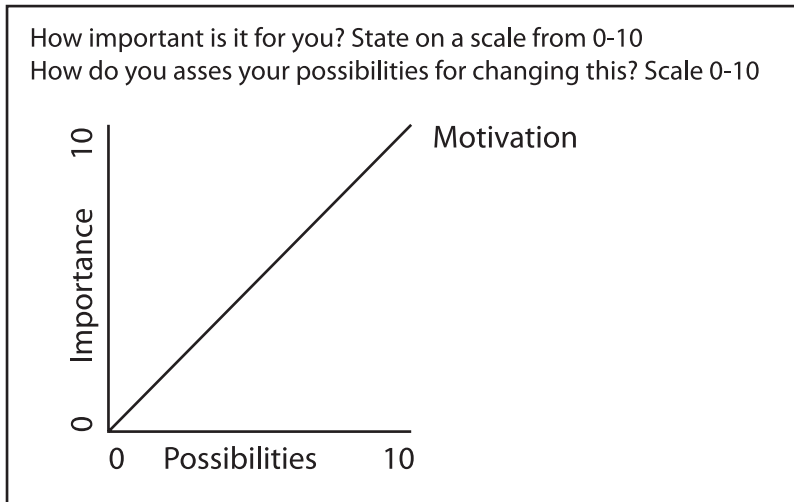
The Prevention Conversation thus reflected a continual focus on the patient-centred approach known from the GGG programme, emphasizing patients' individual situations and personal motivations for planning the preventive treatment. Furthermore, it also made it possible to make a more focused selection of GGG candidates, including patients who were not already in preventive treatment elsewhere and who were motivated to engage in lifestyle-oriented prevention. In order to support this work, a form had been developed, which was to be used during the Prevention Conversation. Here, the lifestyle issues of smoking, diet, exercise, body measurement, alcohol, and cholesterol level were listed as issues to cover during the conversation. Under the issues, it stated “Need for Change” followed by a “yes” and “no” box to tick off, as well as some lines to write down patients' “Motivation/consideration for changing”. The form also included the “Wheel of Change” model and a description

of the different stages of behaviour change: Pre-contemplation, Contemplation, Preparation, Action, Maintenance, and Relapse, where the nurse could tick off at which “stage” the patient was in his behaviour-change process (This model is further explained in chapter 6). In addition to the “Wheel of Change”, other models such as the Analogue-scale and the Balance-diagram were on the form, which could assist during the conversation in order to assess the patient’s need for preventive treatment and management of this.

I was not able to attend the meeting where the Prevention Conversation was presented to the staff from both clinics; however, I received the Power Point presentation prepared by a nurse from the prevention workgroup who had presented at the meeting. Here, the purpose of the new setup was mainly presented as a way to make sure that all relevant patients got the preventive offer, but also that the new Prevention Conversation was a way to make the preventive work more attractive and exciting for the nurses to work with. Thus, in a similar way to the first introduction of prevention into the vascular specialty, ensuring patients’ treatment needs were aligned with professional interests and opportunities. The new screening conversation was seen as a solution to the overlapping challenges in the preventive work. Doctors were relieved of their referral responsibility and nurses got the opportunity to work with prevention, which did not necessarily imply the extended GGG course and furthermore excluded patients that were not motivated or already being “prevented”.

In the period from September to December 2009, the new screening conversations were run in a pilot phase and were evaluated afterwards.

Analogue-scale



The Analogue scale on the patient’s motivation for behaviour change.

Balance-Diagram

Unchanged behavior	Changed behavior
Problems for me: I can’t keep up My children are embarrassed about me People think I have a weak character It’s difficult for me to find a job	Advantages for me: It’s easier to find smart clothes I’ll feel more confident I’ll have the courage to go to the beach
Advantages for me: It’s cozy when we eat together When I get home, I need to relax It’s easy to buy ready-cooked meals	Problems for me: I can’t go for runs It is expensive to go to the gym The family don’t like fish I’ve had too many disappointments

The Balance-diagram material used in the GGG conversation.

Evaluating the New Prevention Conversations

In April 2010, I attended a meeting in the prevention workgroup, where they evaluated the pilot phase of the Prevention Conversation. There were different experiences at the two clinics. At Gentofte Hospital, the evaluation was positive: out of 100 patients that had been referred to the Prevention Conversation, at least 25 had been referred to GGG. Especially the nurses' experience had been positive at Gentofte Hospital, as the Prevention Conversation made it possible to work with prevention in a "light version", as a nurse from Gentofte Hospital stated and explained that the Prevention Conversation was not "as heavy" a task as the longer consultations and courses that GGG imply (an issue I return to and unfold in Chapter 8). The nurse further said that the new setup had revealed that the prescription of medicine was insufficient. Some of the patients who came to the Prevention Conversation had not been prescribed with standard medication at the pre-examination. "The doctors don't show any interest for it", she stated; however, she pointed out that this could then be handled by the nurse in the Prevention Conversation. This information was received by the prevention group and especially the managers with surprise and discomfort; standard medication ought not to be a problem for doctors to prescribe. In order to do something about this problem, the nurse from Gentofte Hospital had tried to clarify for the doctors what their role was in the new setup. She showed the group a letter she had sent out to the doctors at Gentofte Hospital a month earlier regarding the new Prevention Conversation and referral procedures. The letter was an informal description about the preventive procedures in the doctors' pre-examination consultation. Its directive bullet points were accompanied by informal explanatory parentheses, and at the top of the form the disarming figure of the cartoon character Professor Balthazar cheerfully greeted the reader with a tip of his bowler hat.

The letter stated:

- The doctor should continually relate the patient to the lifestyle factors that influence the development of the basic condition and if possible the risk of operation. (Without moralizing or judging the patient, as this creates resistance with the patients and makes it difficult for the next motivational interview with another white-coated person. It is, of course, all right to scare the patient a bit, as long as one does not intimidate or judge, some believe it [scaring] works).
- The doctor should not fill out the "Information Form". (It did not work, I have seen three filled forms... and okay! It is probably not the best form we have made).
- We try to sort out all the non-relevant patients if by chance somebody could benefit from the Prevention Conversation; we expect that the doctor will make the referral. And vice versa, the doctor must also cancel a planned Prevention Conversation if there is no need or wish for it.

(Say it verbally or write it, then we will make an appointment or cancel one and then we're on track...).

- [...].
- If the doctor starts the medical treatment (statin), a blood sample must be made the same day. We can take care of the medical control in GGG. If the patient is seen by their general practitioner in the ongoing control, the nurses will make sure that the general practitioner gets a letter and she will control the blood sample results.

(We are the best [compared to the general practitioners], but we must as a minimum requirement make sure that the patients get their treatment controlled).

- If the nurse is to start up or change the statin treatment, the doctor must continue to write the sentence "the patient is referred to

preventive treatment incl. magnyl- and statin treatment according to table.”²² There are three options: the box on the Information Form, the stamp in the journal, or it can be dictated. (It is difficult, but if we help each other...).

The letter thus described a range of issues regarding the doctors’ tasks and responsibilities including both various practicalities as well as instructions about the preferred attitude towards preventive work, i.e., that the doctor should refrain from intimidating and judging patients and thus making the preventive work more difficult for the nurse afterwards. However, the main point of the letter was to make clear that the main responsibility for the referral in terms of the various practicalities was allocated to the nurses. Despite her effort to clarify the new procedure, the nurse later said that she was not sure whether the doctors had bothered to read it.

At Rigshospitalet, out of the 117 patients who had been called in for Prevention Conversation, only four had been referred to GGG – most of the patients had instead been referred to their general practitioner. They had not experienced the same insufficient medication as they had at Gentofte Hospital; however, they had experienced that doctors were reluctant to refer patients to Prevention Conversation (if they had been overlooked in the earlier referral procedure based on their referral letters to the vascular clinic), not because they lacked interest in prevention, as described regarding the Gentofte Hospital doctors, but because they “felt sorry” for the nurses if they got too many Prevention Conversations. A nurse from Rigshospitalet said that because they work in a different way

22 This refers to the procedure regarding nurses’ delegated right to manage medication if a doctor has given a signed approval (also described in Chapter 4).

at Rigshospitalet, where both the doctor and the nurse are present during the pre-examination, they already had the opportunity to talk about prevention at the end of the consultation and thereby already filled out some of the purpose of the Prevention Conversation, leaving the new consultation somewhat redundant. She said that if the number of Prevention Conversations was to be increased, it was important to make it clear to the doctors that it is not a waste of money and time to refer patients to Prevention Conversation. Furthermore, she expressed that there was a lot of administration in relation to the new conversations: getting the right information in different programs, sending letters, and filing documents. She asked whether it was possible to join the pre-examination with the Prevention Conversation. To this, Henrik responded that although he recognized the practical problem, “the administrative work must not become an argument against the professional”. He further said that if the problem regarding referral was that doctors wanted to spare the nurses because they heard that it was difficult to find outpatient appointments, then they should make it clear for them that the new conversations had already been “budgeted with”. Here, he was referring to the increased production and thus surplus that the Prevention Conversations produced and which had been put into the clinic’s budget. Margit suggested that doctors should work more closely with the nurses in the referral decision. She suggested that they could tell the doctors that if they did not think that a patient was relevant for prevention, they should discuss this with a nurse before cancelling the Prevention Conversation appointment. This caused some laughter around the table, indicating that the doctors would never align with this. Margit insisted that it should just be part of procedure as long as they were rehearsing on the new referral setup and definition of selection criteria, but the issue was left at that.

The nurse at Gentofte Hospital said that she did not see the issues of money and finding appointments as the primary problem at Gentofte Hospital. Here, the problem was that doctors were more interested in “admitting patients” for operations rather than “preventing” them. The surgeon from Gentofte Hospital backed her up: “I can only support that [observation] – I hear from quite sensible colleagues that they just don’t have an interest in prevention.” Margit said that it sometimes helps to show results of the preventive work. “But that’s the whole problem”, the surgeon responded, “it’s one of the most difficult things to document! It all boils down to: does it actually help, the effort we make?” Margit continued, “Maybe this is something Kathrine can show...” Henrik countered that they had already shown that for a long time, especially on the pre-operation area. He also thought it was a matter of the doctors protecting the nurses from extra tasks. The nurse from Gentofte Hospital insisted that this was not the issue at Gentofte Hospital, but that it was more about the doctors’ lack of interest in prevention. Margit commented that it did not have to take much time for the doctor to tell the patient that they should “come for prevention”. The surgeon from Gentofte Hospital added that maybe the problem was that the doctors needed “some tools to say it”. He said that they had to learn that it did not help to stand on the top of one’s toes and say that patients’ must quit smoking. “The doctors don’t have the same skills as the nurses who have been on courses and have gotten under their skin”, he explained.

Apart from the role of the doctors in the new setup, the issue of selection criteria for referral, i.e., which patients to offer the Prevention Conversation, was discussed. The nurse from Gentofte Hospital said, “If you tell a 90-year old woman who is in statin treatment and who does not smoke that she should come, then she will.” By this she implicitly questioned that all patients should be included in

the Prevention Conversation. The nurse from Rigshospitalet confirmed and said that it was important to discuss the selection criteria “because most of the patients we deal with will come if the doctor says so”; she made a salute to illustrate her point. Not only did this mean that it was important to get the doctors’ support to back up the preventive work, but it also made it necessary to be clear on the selection criteria so that they did not include patients who were already sufficiently “prevented”. The nurse from Rigshospitalet said that she had been harder in her selection to begin with; she thought, for instance, that people who lived far away would not come for the Prevention Conversation. But she had found out that this was a misguided assumption. She also said that there had been more positive responses from the patients than she had expected, and that many patients who attended the Prevention Conversation were “happy just to get confirmed that what they are doing is the right thing”, even though this did not necessarily produce more GGG candidates. Margit suggested that the nurses, who were in charge of making the selection based on their referral letters, should write down the criteria they used, so that they could discuss them further. She said, however, that they should be aware of the formulations and make sure that they did not sound discriminating. Henrik backed her up by saying that the selection had to be “qualified” and that they had learned that geographical distance was not necessarily a hindrance. However, it worried him that the Prevention Conversation was a selective offer: “It doesn’t look very nice from the outside”, he said, and he stressed the importance of the qualification of the selection: “We must define the cuts we make”.

To sum up, in the evaluation of the new setup and the Prevention Conversation, a range of different issues were brought forward. The Prevention Conversation had been introduced to handle the challenges that GGG had faced in its further distribution: the

increased competition with the general growth of preventive offers outside the clinic, doctors' referral neglect, and nurses' demotivation (Gentofte Hospital) and lack of interest (Rigshospitalet) in working with prevention.

The first challenge regarding the increased competition from other preventive offers was handled by focusing on the referral procedure to make sure that all patients were systematically screened, and that the relevance for preventive treatment at the clinic was evaluated already when the clinic received the patient's referral. This setup brought forward a discussion about the criteria for defining 'relevant' patients and thus making the referral procedure more transparent and systematic compared to the previous procedure, where patients' referral to GGG solely depended on the doctor's decision in the pre-examination; a responsibility that some neglected either due to a lack of interest in prevention or forgetfulness. However, the transparency and documentation of the referral procedure also made explicit the ethical problems in this work in terms of "which cuts to make" and the formulation of the criteria for selection.

The second challenge, which specifically regarded doctors' referral neglect, was handled in the new setup by placing the initial referral with the charge nurse prior to the doctor's pre-examination. However, it turned out that the new referral procedure did not relieve the doctors fully from their referral responsibility as they were still required to actively refer 'relevant' patients to the Prevention Conversation, specifically, patients who had not been included in the charge nurse's initial screening, for example, due to incomplete information in the referral letter. Furthermore, it may also be noted that the general ambition of making doctors more attentive to prevention was compromised with the new setup, as the preventive attention fell back on a decision made by the nurses in the selection

of referral letters. However, it still did not cancel the importance of the doctors' influence on supporting the preventive work, for example, by stressing its importance to the patients and remembering to sign the delegated right to manage medication.

In relation to handling the third challenge regarding nurses' demotivation and their lack of interest in prevention, the new setup was evaluated positively at Gentofte Hospital, where nurses experienced a motivational boost by working with prevention in a new way, which was "lighter" in its structure and which excluded those patients that were already "prevented" and those patients who were "unmotivated" to engage in lifestyle-oriented prevention. At Rigshospitalet, the Prevention Conversation had not been received as positively by the nurses, who pointed out that the new setup increased the administrative workload for the charge nurse and was somewhat redundant because the issues covered in the Prevention Conversation were already an integrated part of the pre-examination and consultations, where nurses and doctors worked together.

Despite the mixed evaluation of the Prevention Conversation, a decision was made to continue the new setup. However, not primarily as a means to refer more patients to GGG; rather, it became a more separate offer or a preventive intervention in itself. A decision was also made to phase out the GGG software due to its outdatedness and due to the introduction of new software at Rigshospitalet, which made it possible to enter information regarding the preventive treatment. At Gentofte Hospital, the notes made during the preventive consultations were instead written on paper so that they could be placed in the patient's physical record until the software was developed to a point where notes could be entered electronically. The preventive work offered by the clinics thus consisted of the Prevention Conversation, where it was still possible to refer to

the longer GGG course, however, this was not registered in the GGG software. This setup continued throughout 2010 and 2011.

In 2012 the clinics again faced reorganization due to cutbacks. The work among the clinics was divided so that Rigshospitalet would take care of all arterial surgery and related admittances and Gentofte Hospital would take care of the varicose surgery (which did not require admittance) and the arterial outpatient tasks such as general follow-up and monitoring. This meant that longer GGG consultations were directed to Gentofte Hospital, while Rigshospitalet focused on admitted patients and related pre-operative prevention. However, this plan was changed again a year later in 2013, when it was decided that the clinic at Gentofte Hospital would take care solely of the varicose area. This also meant that the preventive work that was part of the arterial outpatient work now was directed to Rigshospitalet. As a consequence of this reorganization, some of the nurses who had been very engaged in the preventive work at Gentofte Hospital resigned and found other positions.

The preventive work at the vascular clinics today is organised as part of a general quality programme at Rigshospitalet that was introduced in 2012 and which requires an increased focus on KRAM factors in all consultations. This focus is specified as a guideline under the hospital's "VIP-system", an acronym of the Danish words for Guidelines, Instructions, Politics (Vejledning, Instrukser, Politikker), which implies documentation and audit every six months. Prevention is thus an integrated part of the other consultations and requires that the KRAM factors are discussed with the patient and noted in the patient record. However, as one of the nurses noted, although the Rigshospitalet has put greater focus on prevention and health promotion by demanding for the inclusion of KRAM factors in the clinical work, in reality it mainly implies "ticking off boxes"

and using standard formulations such as “the patient has been informed about the benefits of smoking cessation”. In her view, this is a substantial reduction in the preventive work compared to the work done in the Preventive Conversation and especially GGG. However, the possibility of offering patients smoking cessation conversations or seeing them in a preventive course still remains but is rarely used. Instead, a more active referral to the municipality healthcare centres is prioritized.

SUMMING UP: ADJUSTING THE PREVENTIVE FLOW

In this chapter I have explored the further building and distribution of preventive responsibility and capacity within the clinical organizations of Gentofte Hospital and Rigshospitalet after the first initiation of prevention within the vascular field and development of GGG. The overall challenge that GGG faced over time was a decrease in the number of patients enrolled in the programme. This was explained by pointing at both external, ‘societal’ matters (the expansion of preventive offers) and internal, ‘organizational’ matters (doctors’ and nurses’ lack of interest and demotivation to work with prevention). The strategic solution to overcome these various challenges was the development of the Prevention Conversation, which not only aimed at optimizing the referral procedure (to ensure that no prevention-relevant patient was overlooked) but also aimed at enhancing nurses’ motivation to work with prevention by revitalizing and ‘lightening’ the preventive work.

The effects of the Prevention Conversation overcame some of the challenges: It made the referral procedure more structured and transparent by placing the initial referral responsibility centrally with the charge nurse instead of the individual doctors. However, doctors were not completely relieved of their responsibility, as they were still obliged to support the preventive work – stressing its im-

portance to the patient and in some cases actively referring to the Prevention Conversation those patients who had been excluded in the charge nurse's selection. In relation to enhancing the nurses' motivation to work with prevention, it mainly had a positive effect on the nurses at Gentofte Hospital, who appreciated the possibility of working with prevention in an additional and less demanding way compared to the GGG courses. At Rigshospitalet the Preventive Conversations were rather considered an administrative burden and a somewhat redundant offer. This continual lack of interest among the nurses at Rigshospitalet was to a degree handled in the reorganization of the two clinics in 2012, when the GGG consultations were directed to the clinic and nurses at Gentofte Hospital, where all the outpatient tasks, including the GGG consultations, were placed. However, in the 2013 reorganization, the majority of preventive work was redirected and gathered at Rigshospitalet, where all arterial consultations were to be taken care of. Here, the preventive work was organized according to a standardized and general guideline that focused on KRAM factors.

In terms of a strategic ANT analysis, we have followed the dissident actions and collapses of the GGG network and the strategic attempts to overcome these and re-establish the GGG order (Callon 1986 a/b). Drawing on Callon's later conceptualization of this process in terms of overflows and reframing (Callon 1998; Callon 1999), we may add elements and surgical procedures from the vascular specialty to illustrate the operational interventions made to reframe and thereby ensure the preventive flow: Introducing the Prevention Conversation with its new referral procedure can thus be understood as a bypass built around the occluding doctors, who had obstructed the preventive flow by neglecting their responsibility to refer patients to GGG. With a strategic ANT approach, we see that the initial motivation to work with prevention among

the human actors is not enough, but requires a more durable infrastructure in terms of new materially-distributed procedures which can form pathways for prevention's flow. Furthermore, we also see that the strengthening of the network not only required additional actors and actants, but also required cutting those off who endangered the network – as it was done by directing the GGG conversation to Gentofte Hospital and thus amputating the GGG work at Rigshospitalet in the reorganization in 2012.

Approaching the story and development of GGG from a strategic ANT approach, we have seen the efforts to build GGG by enrolling different actors and actants and the adjustments required to overcome a range of challenges. We have thus followed the establishment of prevention in terms of the temporary order of GGG – but also, how GGG eventually became integrated in a larger preventive network in terms of the general expansive preventive offers outside the clinic that was initiated by the structural reform in 2007 and locally at Rigshospitalet with the introduction of the KRAM policy. In this translation, we see that although GGG becomes a part of a larger network, it also has a price; namely, that the ambition to provide patients with a thorough preventive course has been replaced with “checking boxes” and “standard formulations” to document and thus satisfy the auditing of the KRAM policy. The ambition of GGG to work with prevention in a patient-centred way has thus been replaced with standardized information.

In terms of a multiplicity approach, the analytical focus is different. This approach draws attention to the other networks that exist, connect or disconnect from the central network that the strategic approach follows. The multiplicity approach is thus not solely focused on GGG as the main actor, but rather explores its multiplicity and explicates how different ways of practising GGG enacts

different versions of reality; the reality of GGG is not the only reality at stake, but connects to and carries other interests, objects, and concerns. This approach explicates the multiple networks that GGG is related to, and it pays attention to how these networks relate to each other in conflicting, peacefully coexisting, or supportive ways. In this approach, the chapter showed how prevention was transformed when it was distributed to Rigshospitalet, where nurses' professional interests and authority were defined along their technical scanning skills, which had a higher status in the clinic than the preventive work. The initial problematisation that had mobilised nurses to work with prevention at Gentofte Hospital (as a strategic possibility to define and expand their professional task, responsibilities, and status) in the onset of GGG did not connect to the nurses' interests and established position at Rigshospitalet in 2004. This not only resulted in fewer GGG consultations compared to Gentofte Hospital but also meant that prevention and GGG was translated and practised in different ways at Rigshospitalet: Here, prevention was thought and practised as an integrated part of the regular consultations, and we also saw that GGG consultations were used by individual nurses to offer other long-term care practices and hold on to 'interesting' patients that could enhance the individual nurse's job satisfaction. These translations of prevention and GGG are understood in different ways according to the strategy-oriented and multiplicity-oriented ANT: Where a strategy-orientated ANT approach may focus on the breaks GGG's specific network-order and the failure of mobilising the masses and enrolling actors in the network, the multiplicity approach propose another understanding or judgment by arguing that while the purpose of GGG is not fully complied with, opportunities for other practices are enabled by GGG such as offering other care practices and enabling individual job satisfaction.

Besides the translation of GGG at Rigshospitalet and the challenges of implementing GGG in relation to the specific interests, dynamics, and concerns among nurses at Rigshospitalet, this chapter also described the challenge GGG faced in relation to the general expansion of prevention 'within society' (including general practitioners' increased attention to the disease and the preventive offers at municipality healthcare centres were offering). Where the expansion of the preventive network may be seen as a success, we however also see how it poses a challenge for the local GGG programme. The classical argument of ANT proposes that an actor acquires strength through its expansion of the network. The more actors enrolled in the network, the stronger and more durable it is. However, in this case we also see that the expansion of the prevention network 'in society' also implies challenges and weakens the local GGG programme in terms of a decreased number of patients enrolled. Where the image of the network conveys an understanding of strength as achieved by expansive relations through more strings, passages, wires, the image of the vascular system comprised of as both a network structure and fluidity may help to understand that, with expansion, the flow may also lose its intensity when distributed in a wider network.

Whereas the present and previous chapters have focused on how prevention is practised among health professionals as an organizational task, in Chapters 6 and 7, I focus on the preventive work between nurses and patients in the actual GGG consultations and explore how preventive responsibility and capacity is built and distributed further in relation to patients and their homely settings. After these two chapters, I return to the professional debates regarding the preventive work and take up some of the issues presented in this chapter.

CHAPTER 6

Distributing Prevention to the Patient's Home:
Strategies for Lifestyle Changes
in the GGG Consultation

Distributing Prevention to the Patient's Home: Strategies for Lifestyle Changes in the GGG Consultation

INTRODUCTION

In this chapter, I move into the GGG consultations between nurses and patients and explore how preventive capacity and responsibility are built up in these encounters and, furthermore, how their distribution to patients' everyday lives at home is attempted. In vascular terms, we move from the arterial structures of prevention – the organization of prevention within the vascular specialty – and follow prevention's further branching into what I propose as prevention's 'capillary form', the various and very diverse preventive passages between the vascular clinic and the patients' homes, which are developed in the course of the GGG consultations.

With the introduction of prevention into the vascular specialty and more specifically GGG into the clinics at Rigshospitalet and Gentofte Hospital, the vascular focus on atherosclerosis changed from primarily focusing on the patient's bodily ailments to a much broader locality, namely, the patient's home life. As mentioned in Chapter 4, head nurse Margit expressed that before the introduction of GGG, the vascular clinic treated atherosclerosis by remedying the patient's acute problems through various operations. However, they had come to realize that "that wasn't really where the problem was located". The problem, she argued, was 'at home', where the cause of the atherosclerotic disease, the everyday practices or 'lifestyle', took place. The purpose of GGG was thus to target these lifestyle issues and involve patients in self-care practices through which they could improve their condition, and thereby avoid or postpone risky

surgical intervention. In the clinic's information material provided to newly diagnosed atherosclerosis patients, the purpose of GGG is described in the following way:

“You will be offered to be educated in how smoking, exercise and eating habits influence the development of atherosclerosis. You will be offered smoking cessation support, healthy dietary advice and preventive medical treatment. The sessions are individual and based on what you are able to do by yourself and what you are motivated to do.” (Patient Information 2008, Vascular Clinic, Gentofte Hospital)

The GGG consultations are thus presented as having an informative scope that passes on biomedical-based recommendations in a way that relates to the individual patient's particular life conditions and personal motivation. This reflects GGG's pedagogical approach and patient-centred orientation, which is built upon psychological theories, models, and methods such as *The Wheel of Change* (Prochaska et al. 1994) and *Motivational Interviewing* (Miller & Rollnick 1991). The main aim of the GGG programme is to provide patients with knowledge on which they can act “according to their own motivation”, as the expression goes among the nurses.

In this chapter, I explore how this combination of biomedical knowledge and psychological theories is practised in the GGG consultations in its attempt to reach out to the ‘problematic’ space of the patient's home. I show that these knowledge forms are supplemented by a more ‘practical’ type of knowledge, which attempts to translate biomedical and psychological knowledge into the patient's everyday life at home. The GGG consultations are based on knowledge exchanges and translations between nurses and patients, in

which the nurse gets to know the patient through different technologies and observations that indicate the patient's bodily condition as well as his emotional and practical conditions for engaging in preventive activities. Likewise, the patient gets to know his bodily state according to biomedical knowledge and comes to understand the process of his lifestyle change according to a behavioural psychological rationality, and he learns how to translate this knowledge into practical arrangements in his everyday life.

I will first introduce the general structure of the GGG course, its themes, and purpose presented to the patient. Then I will describe how 'openness' is enacted and forms a condition for patient-centred prevention, and I will show that the knowledge exchanges between nurses and patients depend upon the patient's openness in several ways: First, the opening of the patient's body in order to describe in bio-medical terms his physical condition; second, an opening of the patient's mind in order to get to know his motivation for lifestyle changes; and finally, an opening of the patient's home life in order to relate the preventive agenda to his practical everyday life.

THE GGG CONSULTATION: GETTING TO KNOW EACH OTHER

The GGG consultation takes place in the same rooms as all other consultations. The rooms have an examination bed, scales, a small portable ultrasound scan "the pocket-Doppler" and sometimes a larger transportable Doppler ultrasound scan, which not only transmits the sound of blood flow but also enables a visual image of the arteries and the blood flow. Furthermore, there are chairs for the patient and relatives, a desk with a computer, and a mobile desk chair for the health professional. The desk is placed against the wall with a chair for the patient adjacent to the side of the desk. This allows the patient and health professional to be face-to-face

when the health professional turns her body towards the patient. Likewise, it is also possible for the patient to see what the health professional enters into the computer. There is a washbasin flanked by fluid soap, a dispenser with disinfectant, and a curtain that is closed around the door, which is drawn in order to ensure some discreteness for undressed patients if somebody should enter the room during the consultation.

The nurse goes to the waiting room to call her patient. They shake hands and she introduces herself before they walk together to the room. Sometimes this is a painful walk for the patient and may take a while, which is usually filled with general conversation about the weather, the journey to the hospital, the parking facilities, or other issues. The issue of the disease is saved for the consultation room. The nurse indicates which room the GGG consultation is going to take place in. She closes the door behind the patient and draws the curtain. She tells the patient where he can hang his jacket or she might also help the patient take it off and put it on a hanger. They sit down, the nurse starts the computer, and prevention can begin.

Although the consultations vary from patient to patient, nurse to nurse, clinic to clinic, and day to day, there is a routine for the course: certain practices, tasks, and expressions that reoccur. At the final consultation in a GGG course, the patient and nurse act in a familiar way around each other. Patients know when and how much to undress, how to position themselves during the examination, and there is a familiar tone between the patient and the nurse; they refer to issues they have talked about earlier, the nurse often asks or comments about some detail in the patient's life: "How are your dogs?"; "Did you watch the game last Sunday?"; or "Your blood pressure is much better today". This familiarity is not there from the beginning; both parts must mutually get to know each other.

Patients are guided with more words: “You don’t have to take off your shirt”; “Yes please take off the socks too”; “The scales are over there”. The patients also have to learn and interpret different codes regarding their health status: Total Cholesterol should be below 4.0 mmol/l and LDL²³ level should be below 2.5 mmol/l; BMI between 18.5 and 25; and the blood pressure measurement should be around 140/80. Nurses also have to learn their way around the patient: he has just lost his wife; she does not appreciate dietary advice; his hearing is poor; or her blood pressure measurement is unreliable because she suffers from white-coat syndrome²⁴. This knowledge of each other is acquired during the course of GGG consultations.

In the first GGG consultation, patient demographics are entered into the GGG software and the registering of information, which makes it possible to monitor the patient’s preventive progress, is initiated. Apart from the six parameters (blood pressure, cholesterol values, ABI²⁵, weight, tobacco consumption, and walking distance) that monitor the patient’s condition and progress (and which I unfold later in the chapter), the patient’s medication and the “agreements” and “goals” made with the nurse regarding certain preventive activities are entered into the computer. These numbers are transformed by the software into points on a graphical representation of the patient’s bodily condition. These graphs are part of the status report, The Patient Report, which patients get after each GGG consultation.

23 LDL (Low-density lipoprotein) is one of the cholesterol values that are measured and is often called the “bad” cholesterol.

24 A syndrome that leads to elevated high blood pressure in the clinical setting but not outside.

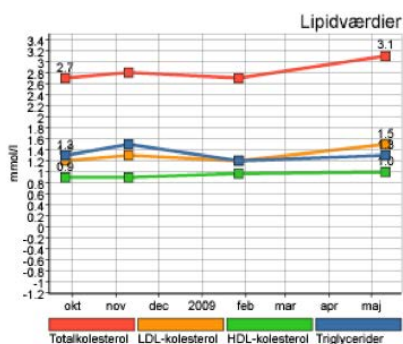
25 ABI is the ratio of the blood pressure in the lower legs to the blood pressure in the arms. Lower blood pressure in the legs compared to the arm is an indication of reduced blood flow due to atherosclerosis.

At the first GGG consultation, patients who have recently been diagnosed with atherosclerosis often request more information about their disease, its cause, and the prognosis. This information has ideally been presented by the doctor in a previous consultation, but sometimes patients have not understood what the doctor has said due to “doctors’ poor communication skills” or because patients are “too upset”, “old”, “slow”, or due to “language barriers”, as the nurses explain. Therefore, nurses often need to repeat the information about the disease. Other patients may also have questions because they have researched the disease thoroughly and need clarification on the details, which they have found on the web, or there are issues they have discussed with their general practitioner or others. Many patients with atherosclerosis fear that they may lose their legs. Nurses state that it is important to reassure the patient that amputation is very rare and that there are many interventions before amputation, among these, lifestyle changes. There may thus be many issues to talk about and get sorted before the issue of prevention is addressed.

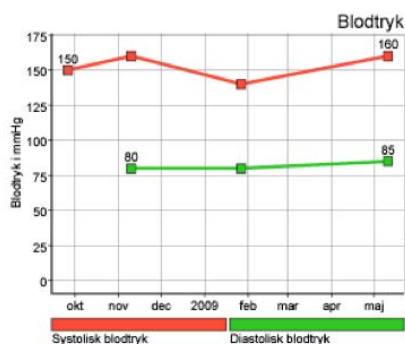
The first consultation includes an introduction to the purpose of the programme: To inform the patient about the kind of lifestyle issues that influence the condition of atherosclerosis and *claudicatio intermitens*, which is the main symptom that most atherosclerosis patients experience. Patients are informed about the importance of taking the preventive medicine (statins and aspirin) and are told that they can slow the progress of the disease and improve their condition, for example, by increasing their walking distance, through smoking cessation, healthy diet, and walking exercise. Furthermore, the introduction also emphasizes the importance of the patient’s personal motivation to make and maintain lifestyle changes. According to the psychological theory that GGG draws on, it is important that the patient defines his preventive goals according to what is “possible” and “meaningful” to him. Sometimes the Balance Score

Card is used in the first consultation to make the patient explicate his motivation for lifestyle changes. Here, the patient is requested to list pros and cons about certain lifestyle issues and habits which they consider changing.

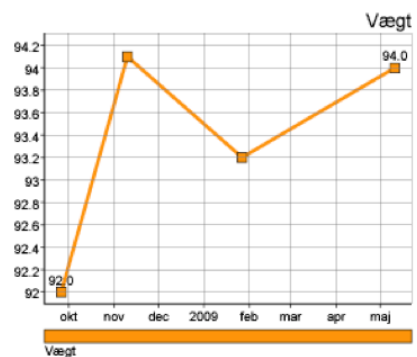
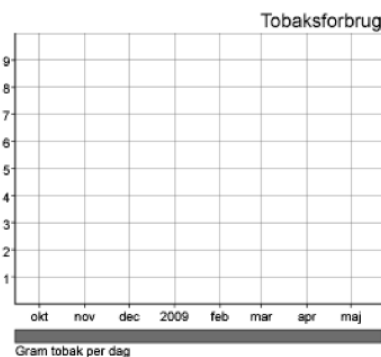
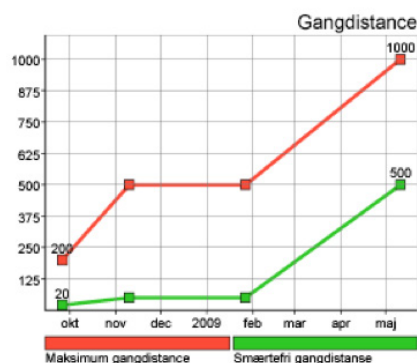
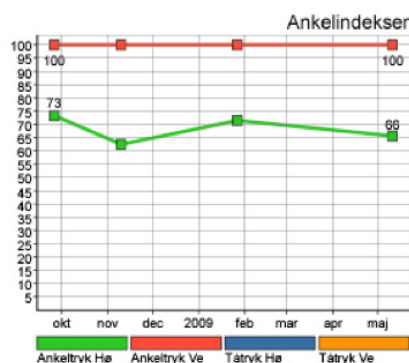
During the consultations, the nurse and patient discuss the preventive activities that the patient would like to engage in and the nurse tries to get the patient to define a clear goal: A certain date is decided upon for smoking cessation, specific dietary changes, and a concrete exercise plan, all of which will be evaluated in the next consultation. Nurses often recommend that patients focus on one or a few specific and realistic goals at a time in order to realize and maintain their preventive activities. The consultations that follow later build on the structure laid down in the first consultation: The parameters that the GGG software requires are generated and entered, Patient Reports are printed, and the process of defining preventive goals and evaluating their realization is discussed between the nurse and patient.



- Totalkolesterol bør være **under 4,5 mmol/l**.
- LDL-kolesterol, også kaldet det fede kolesterol, bør være **under 2,5 mmol/l**.
- HDL-kolesterol, det herlige kolesterol, bør være **over 1 mmol/l**.
- Triglyceridniveauet bør være **under 2 mmol/l**.



- Blodtrykket bør være lavere end 140/90, for diabetikere lavere end 135/85 (den røde kurve viser det systoliske blodtryk, den grønne viser det diastoliske blodtryk)



Din behandling

Therapy.RxName	Therapy.Strength	Therapy.RxText	Therapy.StartReason	Therapy.ToDate	Therapy.Pause
Hjertemagnyl	75	1 tablett daglig.	Blodfortyndende		
Simvastatin	40	1 tablett daglig.	Kolesterol-sænkende		
Atacand Zid	16	1 tablett daglig.	Blodtrykssænkende		

Mærk: Giv besked til lægen hvis du også bruger anden medicin

Din ABC, hvad du selv kan gøre

- A** Alt godt fra haven (6 stk frugt/grønsager inkl. kartofler/dag)
 Alt godt fra havet (fisk 2 gange om ugen)
 Af med en del pattedyrsfedt i mæden
- B** Bevægelse (1/2 times daglig motion).
- C** Cigaretter (ingen)

Screen dump from the GGG software illustrating the six parameters: Lipid values, blood pressure, ankle measure, tobacco consumption and weight. Furthermore the medical treatment appears, the patients 'ABC', as well as spaces for writing down the next appointment and which agreements the patient and nurse have made.

OPENNESS AS A CONDITION FOR PATIENT-CENTRED PREVENTION

Despite the set structure of the consultation, including the categories to be typed up in the GGG software and the ongoing process of defining and evaluating preventive goals, the consultations are also characterized by a rich flow of information that is not generated within the set criteria. This information regards the specific conditions of the patient's life, which the patient-centred preventive agenda depends on in order to distribute prevention from the clinic to the home. The patient's family situation, hobbies, housing, and work life are all issues that may help to realize preventive efforts or endanger them.

This information is not only generated from verbal communication, but may also include visual information. Nurses observe how patients look, their personal hygiene, the clothes they are wearing, and so on; anything that might reflect circumstances regarding the patient's life and which might have relevance for the preventive work. The information may also come from other observations, for instance, smell. A jacket smelling of smoke may reveal that the patient lives in a smoking environment even if he does not smoke himself. Or the smell of dog that sticks to the patient's clothes may indicate an opportunity for the patient to become more physically active. Most patients are happy to share information about themselves and their life and do not need too many probing questions to induce them to open up and talk about grandchildren, vacation plans, work, or their favourite food. The challenge this openness implies for the nurse is to navigate this information, to pick out the issues that are relevant for the preventive work in order to "go into depth" and not just be "seduced by talk", as one of the nurses expressed. The task is to get the patient to open up while direct-

ing this openness towards the preventive agenda (this is not always possible because some issues may come up that need attention of a different nature to that of the preventive agenda, and it is therefore temporarily suspended in such cases. The challenges that the unpredictability of the consultation creates are further elaborated in Chapter 7 and Chapter 8).

The main challenge of the preventive consultations is, however, when openness is not created, when patients “close off”, or are “impossible to get into”, as some of the expressions go. ‘Closedness’ is referred to either when it is difficult to get patients to talk about their life situation and give information that the nurse can relate prevention to or when patients are not motivated to engage in preventive activities. A method of dealing with the first type of closedness is to get information about the patient’s life in other ways. Spouses or other family members are often present in the consultations and may impart more information about the patient’s life situation than the patient himself. This is especially articulated in relation to the male patients: “Some men are not very talkative, but then their wife may compensate for that”. There is also another kind of ‘closedness’, namely, when patients are not motivated or prepared to engage in preventive activities, as the following example from a Prevention Conversation (the screening conversation prior to GGG) demonstrates.

The patient sits in the corner of the room, arms crossed, with a tight, silent face. She does not look like the “motivated kind”, as the expression goes. The nurse begins by calmly introducing the scope of the conversation: to inform the patient about the disease and answer any questions that she may have. She also says that the purpose is to talk about the issue of lifestyle and how it affects athero-

sclerosis, and, if the patient wishes to engage in certain lifestyle changes, what they can offer at the clinic to support these changes. The patient is quick to respond that she knows very well what they demand of her, but she is not going to quit her cigarettes. "Okay", the nurse says and asks why she does not want to quit. The patient says agitatedly that she has already tried and it was impossible. "That's fine", the nurse responds and says that it is good that she knows that they recommend smoking cessation and then asks if the patient knows why. The patient replies, "Because it's unhealthy". The nurse says that she is right but that it has a specific reason in relation to the pain people with claudication are suffering in their legs and she explains how smoking causes the build up of plaque in the arteries, which reduces blood flow, and causes the leg cramps. The patient moves around in the chair impatiently while she listens. "Can I ask you how you tried quitting the last time?" the nurse asks. "I tried the chewing gum, but it made me feel dizzy", she snaps. The nurse explains that many people experience that because they are not properly instructed on how to chew the gum. If one chews all the time, too much nicotine is released at once and this can cause dizziness. Instead, the gum should be chewed 10-15 times followed by a break. There are also other options, the nurse says, for example, tablets, e-cigarettes, and plasters. She also mentions the medicine Champix, but it is a very expensive option, she says. The patient listens but does not look as if the range of options has made her more interested in smoking cessation; "I'll think about it", she says.

The nurse continues and says that there are also other important lifestyle issues that have an influence on atherosclerosis, for instance, healthy diet and a low intake of cholesterol. She asks the patient what she eats on a normal day. They talk about the meal at lunch and the nurse asks what kind of rye bread she eats – if it is wholemeal or the traditional. It is the traditional, the patient says. She does not like the kind with all the whole seeds in it. “I’ll tell you what Kirsten Hüttemeyer²⁶ once said very well about this modern rye bread with all its seeds, not to mention green salad: What do you take me for – a horse?!” The patient laughs and the nurse smiles and says that there need not be seeds in the bread, but that they recommend wholegrain because it helps reduce the cholesterol in the blood, which is what builds up in the arteries. However, her attempt to inform the patient of these benefits does not seem to leave an impression.

This kind of closedness displayed by the patient above is handled in different ways: Either the patient will not be enrolled in GGG or the preventive ambitions are modified. One of the nurses, for example, told a story about a patient who could not quit smoking because he worked as a night truck driver and had to smoke in order to keep himself awake. She said: “Then we can work on something else, at least make sure he takes his medication. We can’t have him falling asleep and being a danger to others”. But even though some patients show closedness to begin with, nurses still try to get them to open up or “soften them” in order to promote the benefits of the preventive activities; “We want the best for you, you know”, as a nurse told her patient.

26 Kirsten Hüttemeyer (1914-2003) was a notorious Danish household teacher and cookbook writer, who introduced a cooking show to Danish TV in 1952 and returned to TV again 1995, aged 81, where she became a cult figure honouring the rather unhealthy traditions within Danish cooking.

THE BIOMEDICAL APPROACH: PREVENTION AS A BODILY MATTER

During the GGG consultations, the nurse controls a range of anthropometric (bodily) markers: cholesterol values, blood pressure, ABI, and weight. Before the consultation, the patient goes to the lab where blood samples are taken. The blood sample reveals cholesterol levels and a liver count. These are measured in order to ensure that the cholesterol-lowering medicine has the desired effect and that the liver is not harmed by the medical treatment. These counts are retrieved through the hospital's computer system during the consultation and evaluated by the nurse and later, when the patient has become familiar with the values, also by the patient.

The nurse also measures the patient's blood pressure on the arm and ankle. The comparison of these two measurements results in the ABI, or "the arm/ankle measurement" in daily speech, which indicates how the atherosclerosis has progressed. People without atherosclerosis in their legs have the same blood pressure in their arms as their ankles, but patients with atherosclerosis in their legs have decreased blood pressure in their ankles compared to the blood pressure measured in their arms. If the pressure falls below 30 mmHg, there is a risk that wounds on the feet or lower legs cannot heal and will develop into gangrenous infections that may lead to amputations. The ABI is thus part of the clinical monitoring of the disease and is an important factor in deciding whether a surgical procedure is required in order to secure sufficient blood flow to the lower limbs. Furthermore, general high blood pressure further complicates atherosclerosis, which is also a reason for controlling it.

The ABI examination has its own characteristic set of sounds. The patient is placed on a bed to relax, preferably not talking in order

for the blood pressure to fall to its “resting stage”. However, some patients find it difficult to be quiet. The silence creates a strange intimacy – a contrast to the conversation in the consultation with all its confessional and joking fluctuations. The urge to break the silence with a cough or a comment is subdued by the sound of the blood pressure measurement, which creates a characteristic rhythmic pumping sound when the nurse inflates the cuff around the patient’s arm in order to cut off the blood flow. She puts a stethoscope to the elbow joint and deflates the cuff; she notes the measurement when she can hear the blood rush through the artery. “145/80”, she says aloud and asserts, “that’s fine”, or if it is over the recommended measure, “that’s not good”, and she compares it with the last measurement. She then removes the cuff from the elbow joint with a quick movement that makes the Velcro band detach with a loud, crisp noise. She now places it on the ankle of the patient and brings out the portable Doppler scan to scale up the sound of the blood flow in the artery, as this is not audible through the stethoscope. With a small amount of gel, she moves the point of a pen-like device around to find an artery. This makes a loud distorted scratching sound until she finds the pulsating sound of blood flow that she is searching for. When she is happy with the quality of the sound, she inflates the cuff and cuts off the flow and its sound. She then deflates the cuff, watches the measurement, and notes the point at which the blood flow is re-established and the sound reappears. She repeats the procedure on the other ankle.

The patient is also weighed on an electronic scale in order to follow his Body Mass Index²⁷ (BMI). This part of the examination is often accompanied by a sigh or joking “uh” from the patient. The patient is weighed without shoes and one kilo is subtracted from the

27 BMI: the body mass in kilos divided by the square of the height in meters.

measurement “due to the clothes”, as the nurse explains – an adjustment that many patients who are concerned about their weight comment on as “courteous”. Sometimes the nurse also takes the patient’s waist and hip measurement with a tape measure to generate a Waist-Hip Ratio²⁸ (WHR). Both the BMI and WHR are indicators that convey the weight-related health status of the patient, which can be monitored in numerical values during the GGG course. Another optional measurement is the patient’s lung function, which is measured by a Carbon Monoxide Meter into which the patient blows and which subsequently produces a numerical value. This test reveals the amount of carbon monoxide in the patient’s expiration and is also nicknamed a “telltale” because it reveals whether and to what degree the patient smokes. The Waist-Hip Ratio and lung function are not set parameters in the GGG software, but are other ways of measuring the patient’s bodily condition and which may “increase motivation”, as one of the nurses expressed it. Just taking the waistband out of the drawer or letting the patient blow in the meter may emphasize the seriousness of the situation, she stated. The nurse also said that these “hard measurements” have a motivating effect on male patients especially, as “Men are often more interested in technology and numbers than talking.”

The parameters regarding smoking consumption and walking distance are self-reported measurements. Here, patients are asked how often they smoke their pipe or how many cigarettes they smoke a day, and they are asked to state how far they can walk before the pain sets in and how far they can push themselves beyond the pain until they are forced to a halt. These values are rarely stated in a straight-forward manner but often joined by longer explanations and narratives. The numerical values needed, which are to be entered into the GGG software, are thus to be found among the

28 WHR: waist measurement divided by hip measurement.

many words that patients use to describe these values in practical and emotional terms. This part of the examination requires another kind of listening from the nurse.

The nurse sits in front of her desk looking at the patient, who is sitting on a chair placed up against the wall next to the desk. "So, what about the smoking cessation, how is that going?" she asks in a cheerful and challenging way. The patient moves a bit in the chair and laughs quietly, "Well, I went to this party and I slipped up." The nurse still smiles: "So still party-smoking a bit?" she replies. She turns to the keyboard and looks at the screen and then back at the patient: "How much should we enter under tobacco consumption, 1 to 2 cigarettes?" "Yes, that sounds right", the patient replies. She enters '2' in the smoking consumption-box. She then turns to the patient again and explains in a serious tone that it is very important that he quit smoking completely. A reduction is simply not enough when you have atherosclerosis. "If you were at the lung clinic they might celebrate you if you were able to reduce your tobacco consumption, but here we promote a complete cessation." The patient, whose symptoms are located in the arms and not so much the legs, has experienced cramps in his fingers. The nurse explains that it is the atherosclerosis that is hindering blood flow to his fingers. She strokes her fingertips on her left hand and explains that besides the already reduced blood flow to his fingers, the small blood vessels, the capillaries, contract when a person smokes and this worsens the metabolic processes in an already challenged vascular system. The patient is very attentive while the nurse talks, he nods and then sums up: "So that explains why my fingers started hurting when I smoked at the party."

In this situation, we see how medical knowledge and the patient's bodily experience are related. The nurse asks on the basis of the software's categories, how the patient's smoking cessation is going. The patient explains that he "slipped up", an event that is translated into a number they agree on and entered into the software, which processes it into a point on a graphical curve representing his smoking consumption. The patient's story about slipping up is first received and formulated in an understanding tone as 'a little party-smoking', referring to a common understanding that it is especially at social occasions and particularly if alcohol consumption is involved that smoking is difficult to abstain from. But this understanding has to be entered as a numerical value in the software and the party smoking is thus translated into the number '2'. Mutually, the patient, after having been told about how smoking causes capillaries to constrict, comes to understand that the cramps he experienced in his fingers were directly related to and caused by his smoking. In the course of measuring, counting, and noting, it is not only the nurse who gets to know the bodily parameters for the monitoring part of the preventive work, but also the patient who gets to know his body along these biomedical categories and a biomedical rationality. Numbers, values, and causalities are also articulated by the patient: "Good, then I'm still below 4", "The last time it was 170/80 I think", or "Does that mean that I will need a stronger drug?"

Nurses use a range of different observations in the preventive work that reveal the patient's bodily condition, and which open up the body and make its condition visible, auditable, and tangible. The measurements become occasions to explain and repeat the importance of medicine, smoking cessation, exercise, and dietary recommendations. This focus on physiological and biomedical knowledge is, however, only part of the preventive work and, to some of

the nurses, not the most important part. “The proper prevention work”, as one of the nurses said depends on “getting to know who these patients in front of us are” and doing “the human work”, as she said and related this expression to a Danish book on health promotion and prevention (Jensen & Johnsen 2000). She described “the human work” as being crucial, as well as being very different from the preventive work, which focuses more on measuring and “just filling in tables”.

THE PEDAGOGICAL APPROACH: PREVENTION AS A MATTER OF PERSONAL MOTIVATION AND PSYCHOLOGICAL PROCESS

In addition to “the filling in of tables” and the bodily measurements and evaluations, GGG also draws on psychological theory on behaviour change and the method of Motivational Interviewing, which was developed by American clinical psychologists Miller and Rollnick in the 1980s and evolved from the counselling of problem drinkers. The method works towards specific lifestyle changes by facilitating the patient’s exploration of his ambivalence towards these goals and the formulation of his personal motivation to engage in them. Motivational Interviewing was introduced and became popular in preventive work within the Danish Health Care system in the late 1990s (as described in Chapter 4; also Valgård 2003). The patient’s formulation of his personal motivation for lifestyle changes is central to the approach, as it is argued that patients are not necessarily moved by a biomedical rationality. This is also stated in the internal educational material made by the nurse specialist Marie (Internal report 2002), which states that:

“Studies show that knowledge in itself does not make patients change behaviour, but that health advice which starts with the individual patient’s situation,

thoughts and reflections more often lead to behaviour change.” (Internal report 2002: 4)

This statement refers to the work of Swedish psychologist Aborelius’ book *Why don’t they do what we tell them to do?* (my translation) (Aborelius 1996). In the consultations, the understanding of personal motivation is that it is often located “within” the patient.

During a GGG consultation, one of the nurses, Lisa, asks her patient, Esther, a woman in her eighties, how her smoking cessation is going. Esther reports calmly and factually how she has been on and off the cigarettes in the last couple of months. As to defend these ups and downs, she bursts out: “But I talked to one of my friends at the gym, and she said, ‘just continue to try stopping, even if you fall off the wagon, just continue’, so that is what I’m doing!” Lisa confirms with a smile and comments that it is really good that Esther is motivated, and yes she should just continue as her friend has told her. Esther accepts: “Yes, I know. I know I must stop!” But at this point Lisa corrects her: “It’s actually much better if you say ‘I want to stop’. If you say this ‘I must’, then it becomes something outside of you.” She illustrates with her hands on the table: clenching one hand while curving the other hand around it in a half circle. “You see?” Then she places her hand on her chest and says, “It’s much better if it comes from within, and when you say ‘I want to quit smoking’.”

This boundary between internal and external motivation is invoked in many consultations, and nurses stress that it is important that patients make their own evaluation of what they want and what is

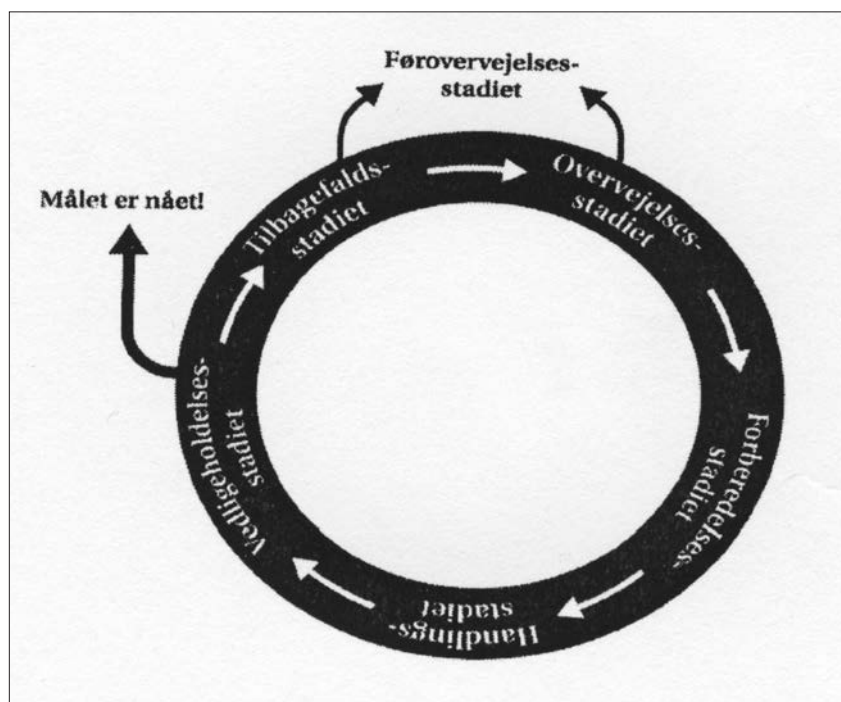
possible for them instead of trying to satisfy external expectations, whether these are formulated by their families, “societal norms”, or what they imagine the nurse or doctor expects or wants from them. The method of Motivational Interviewing is used to discover the patient’s inner motivation for lifestyle changes. In the internal educational report, the method’s basic principals are presented as: “Taking departure in the patient’s own opinions, thoughts and preferences; Identifying the patient’s resources for change; Respecting the patient’s right to self-determination”, and “Uncovering the patient’s ambivalence [towards lifestyle change] and initiating the thought that change is possible” (Internal report 2002: 13). Furthermore, the report emphasises that the concepts of “empathy, motivation, ambivalence, resistance, responsibility/respect and self-efficacy” are central for Motivational Interviewing and defined in greater detail; for example, the issue of resistance is explained as an effect “if the patient feels pressured into behaviour changes” and “is an indication that the counsellor has misread the patient’s readiness [motivation] and is not aware of where the patient is in the change process” (ibid.: 14). The issue of responsibility/respect is also explained further:

“The advisor should help the patient by elucidating the problem so that he has the best possible ground for making a decision, but the responsibility is placed with the patient. This means that the advisor must accept and respect the patient’s choice, also if the patient chooses to continue his hitherto lifestyle.” (Ibid.: 14)

In addition to the patient’s inner motivation, the “Wheel of Change” developed by American psychologists Prochaska and Diclemente in the 1980s is the central model for the behaviour change theory that GGG draws on and which is used by the nurses to describe to the patient the likely psychological process that they will experience

when they embark on lifestyle changes. The model portrays six stages that the nurses use in the preventive work to ‘locate’ “where the patient is in the process”, as they say, in order to support them in specific ways.

In the internal educational material, the model is translated into practical reformulations that the nurse can use when conducting the GGG consultation. In this material, each stage of the model implies different kinds of support from the nurse’s side.



The wheel of change as it is illustrated on material from the clinic. The stages described are: Contemplation, Preparation, Action, Maintenance, and Relapse. Outside the circle, the stages Pre-contemplation and “The goal is reached!” are placed.

At the ‘Pre-contemplation stage’, the report states that the patient needs motivation in relation to considering his behaviour. The nurse is advised to inquire into the patient’s smoking habits and how he feels about it: The nurse is told to ask the patient if he is aware of the relation between smoking and his disease and to inform him about the health benefits, for example, in relation to wounds healing, operation durability, and minimizing risk of amputation. But she is also asked to show acceptance if the patient does not want to quit smoking (ibid.: 18). Here, the benefits of lifestyle changes are described according to the health-related effects – however, it is also stressed to show acceptance towards the patient’s health-contradicting preferences.

At the ‘Contemplation stage’, the report states that the patient needs support to become aware of his often-conflicting feelings and opinions about lifestyle and lifestyle changes. At this stage, it is advisable to use the Balance-diagram to visualize pros and cons of lifestyle changes, which is often used in the first consultation. Here, the health benefits of smoking cessation are joined by other concerns, for example, the patient’s concerns regarding being able to walk longer distances, especially when he is in the company of others, for example, on family trips or in relation work. But also other benefits, such as the money he can save for other things than buying cigarettes, are put on the Balance-diagram. The downside of the Balance-diagram is that issues such as weight gain and the pleasure of smoking are often written down.

The next stage described in the report is the ‘Preparation stage’, where the patient needs help planning the smoking cessation and its consequences. Here, it is advised that the counselling regard issues such as nicotine products, planning a smoking cessation date, and talking with the patient about the kinds of situations that will be

the hardest to handle for the patients and which strategies may be applied to manage these difficult situations.

At the ‘Action stage’, the report states that the patient needs more practical advice about how to manage abstinences, weight gain, mood swings, or lack of moral support from others. Furthermore, it is stated that it becomes important to confirm and repeat the health-related gains, and it can be further confirmed by using “concrete measure results such as blood pressure, ABI and carbon monoxide measurement” (ibid.: 18). In the consultation, the Patient Reports are often put on the table in front of the patient to show the improvements that the patient has made.

At the ‘Maintenance stage’, the patient needs help maintaining the original motivation for the smoking cessation, and the nurse can do this by asking “about the patient’s feelings and thoughts about the smoking cessation” (ibid.: 19) and by recognizing the great effort required to change one’s behaviour.

The model also describes ‘Relapses’ as part of the behaviour change process. The report states that relapses are common and the patient “needs to have this turned into something positive” (ibid.: 19). The nurse is advised to ask the patient what went wrong and what went right in the attempt and is encouraged to support the patient in processing the experiences made in the attempt. It is stated that it is important to focus on the positive experiences and ask what the patient has in mind in relation to his behaviour change.

In the report, the importance of how the patient deals with the behaviour change, both rationally and emotionally, is foregrounded. The means to maintain the behaviour change are described as repeating the health-related gains, motivating through measurement

(which makes the results concrete), and asking about the patient's feelings and thoughts. The reference to the model is sometimes evoked explicitly in the preventive consultation, for example, on a piece of paper used in the first Prevention Conversation, but it is also referred to implicitly during the GGG course in the use of different arguments or formulations from the internal educational material.

"Do you have any expectations about what we should talk about today?" the nurse asks the patient, a woman in her sixties. It is their second consultation after the patient has had angioplasty surgery, a bypass operation, which has had the intended effect, allowing blood to pass to the calf muscles so that she does not experience painful cramps when she is walking. "The cigarettes..." the patient replies and looks at the nurse with a serious face, "I've gone from twenty to three – I had acupuncture before the operation. But I would really like to quit completely [...]" The nurse nods: "Three cigarettes means that it isn't a strong physical addiction. I think that what is needed is the very last bit [...] your will." She says that the patient has all the right circumstances to quit: Her family and friends support her and it seems she has "good resources" and that she also expresses that she wants to quit. The nurse suggests a new smoking cessation course. The patient looks sceptical and shrugs her shoulders. The nurse observes her reluctance and makes another suggestion: "Perhaps you could be more aware of your routines during the day. When do you smoke during the day? Is there something else you can do instead of smoking? If you smoke after eating, could you do the dishes instead or leave the table and go for a walk? It's continuous work to keep the cessation, you go through this circle". She draws on the table with her finger and ex-

plains: "First you consider, then you prepare yourself, then you set a date for your cessation, but you might slip up and start smoking again", her finger diverts from the imaginative circle, "but then you might start considering again", her finger returns back to the circle, "and you start over again. You might have to do this many times before it lasts."

Here, the nurse refers to the Wheel of Change, focusing on the continual effort it requires to maintain lifestyle changes. Apart from the focus on the patient's motivation and likely psychological process, she also draws attention to the practical circumstances of lifestyle changes that follow from the patient's initial personal motivation; a knowledge form I unfold in the following section.

THE PRACTICAL APPROACH: PREVENTION AS A MATTER OF ORGANIZING EVERYDAY AND HOMELY LIFE

The biomedical and pedagogical approach in the preventive work is supplemented by another approach, which concerns the translation of preventive knowledge into practice in the patient's daily life. The problematic and resourceful home spaces are identified in the consultations, where nurses on behalf of the information that patients share with them – explicitly or implicitly - suggest ways to organize these home spaces and relations to support their preventive activities.

During a GGG consultation, the patient, a woman in her sixties, and the nurse are talking about the patient's daily meals. The patient expresses that she likes to have mayonnaise on top of her sandwich even though she knows that it is against the dietary recommendations. She complains that her sandwich will be too dull without the topping. The

nurse suggests that she could replace the mayonnaise with something else like fresh herbs and asks the patient: "Do you have a balcony or terrace at home where you could have some fresh basil?" She explains that the dullness of the food could be overcome by adding more flavour, like fresh basil, to replace the taste of mayonnaise.

The patient's home life thus enters the clinic in different ways during the conversations. The nurse asks how the patient lives, whether there are stairs to climb, which would be an excellent exercise form for a patient with claudication, or an elevator that might challenge this preventive opportunity. The nurse suggests strategies for coping with the urge to smoke after dinner, such as leaving the table after a meal to do the dishes or going for a walk as ways to manage the urge. In different ways, the patient learns and becomes attentive to the practical circumstances that support or endanger his or her preventive activities.

Esther says during the consultation that she had maintained her smoking cessation for six weeks before she started again. "And I can tell you the reason why it went wrong! There was this detective show on the television and it was so exciting that I had to, yes, smoke", she says, ending her story with a disappointing sigh. Lisa asks if there was something that Esther thought she could do about such a situation. Esther answers promptly, "I simply have to stop watching those shows!" Lisa tries to modify Esther's suggestion. She says that Esther should not stop watching those shows if she likes them, but that she could instead prepare other snacks before turning the television on and which she can have instead while watching the show, something that can help her han-

dle the urge to smoke. She suggests chewing gum, carrots, or hard candy and says that sometimes the urge to smoke is relieved if something else is put in the mouth.

This example points to the awareness that is created around Esther's smoking habits. Esther expressed that she reflected about why it was difficult for her to maintain her smoking cessation. In the consultation she expressed that she did not feel physically addicted to the cigarettes because she had no problems avoiding them when she was around non-smokers. The need to smoke came when she was alone, sitting at home watching television. Esther showed that she was reflective about why she took up smoking and proposed that she would avoid watching the detective stories as a strategy to control her urge to smoke and thereby translate her will into a practical arrangement. Furthermore, at a later stage in the consultation, she said that she should get out more and spend time with her non-smoking friends. By moving her body to other places and engaging in other activities with non-smoking friends, the preventive activity of quitting the smokes was thus moved from an internal matter of motivation and will to an external practical matter and organization of her everyday life. Visiting Esther a month after her GGG consultation, she showed me how she had made arrangements to control her urge to smoke.

Esther shows me around her apartment before the interview. She has just moved things around; she says it should not be too cluttered and that old people tend to save and have too many things. You should be able to get around the furniture; there should be air around things. She has also moved her cigarettes, she tells me. They are no longer in the living room. They have been put away in a drawer in the

entryway. This was suggested by her nurse, Lisa, she says. She does not smoke much, 1-2 cigarettes a day, but sometimes, when she is watching a good movie, she might smoke more, so that is why Lisa has advised her to keep them out of reach. If she feels the urge to smoke, she has to get out of her chair and walk the distance to the entryway, open the drawer, and find the cigarettes. This means that she will have to leave the movie and miss out on it for a couple of minutes. If she nevertheless gets up and moves towards the cigarettes, she still has to walk a distance and during this walk she discusses with herself, she tells me. "I may reach the cigarettes and then think: 'it's stupid', Lisa is telling me so. She sits there on my shoulder and reminds me that it's stupid". Instead, Esther tells me, she has bought small liquorice sweets that are just next to her favourite chair.

In this example, we see how Esther has become aware of the practical circumstances for her goal to quit smoking. We see how Esther's will to quit smoking is distributed into a practical organization of things in her home – cigarettes have been moved and liquorice sweets are in place. Prevention is organized into these mundane homely arrangements.

The rearrangement of homely spaces and practices are sometimes also supported by additional technologies to support the various strategies for translating prevention into practice at home. Some are provided by the nurse and others are invented by the patients. In the following, I describe two technologies.

The Diet Brochure: Happy and Unhappy Smileys

One of the technologies that is handed to the patient in the consul-

tation is the brochure “*Bliv let om hjertet*”²⁹, which translated directly means, “Become light around the heart”. Phraseologically speaking, this title translates better to ‘Unburden your heart’, which in Danish means to unburden oneself or to relieve one’s mind. Under the title, a heart shaped strawberry appears (in blue colours) with a label stating, “Know your cholesterol level” and under this is typed “4.5” in big figures. A note in the right bottom corner explains further that if you have type 2-diabetes or have been admitted due to cardiovascular disease, your total cholesterol level must be less than 4.5 mmol/l. This fact is supported by a reference to The Danish Heart Foundation and “Clinical guidelines for the prevention of cardiovascular diseases in Denmark, 2004”.³⁰

The brochure is folded into three sections. When opening it, five grocery shopping tips appear: “Don’t shop on an empty stomach”, is the first recommendation. The brochure states that this can result in too many “hygge-products” with a high fat content. ‘Hygge’ is a Danish word that refers to a cosy atmosphere. The word is mentioned in a lot of tourist literature about Denmark as one of the most important concepts in Danish culture. Instead, it is recommended that one eat one or two pieces of one’s favourite fruit before grocery shopping. The next tip is, “Watch the fat content in the products you buy.” This is done by reading the informative labelling on the product, the brochure states. More specifically, it states that many foodstuffs are defined as low-fat products when the fat-content is

29 The brochure states that it is produced by chief physician Børge Nordestgaard, published in 2008, and sponsored by the pharmaceutical company AstraZeneca, who produces medicine for cardiovascular diseases.

30 This was regulated in 2010 to 4.0, where the recommended LDL level was also regulated from 3.0 to 2.5. In 2012 the recommendations from the Danish Vascular Society were regulated according to the European guidelines which recommend LDL under 1.8 for patients with atherosclerosis or that the LDL level is reduced with 50% of the initial measurement.

less than 10g/100g foodstuff. For bread it is 5g/100g and for dairy products it is even lower, preferably under 1.5g/100g. The third recommendation is called, 'The Crown-model': "Use as many [Danish] crowns (Danish currency) on vegetarian products as on animal products." This is pedagogically exemplified: "If you buy a piece of meat that costs 80 Danish crowns, you must buy fruit, vegetables, and bread for the same amount." The fourth recommendation is to buy seasonal fruits and vegetables and only in the amount that is needed. Here, the advice takes an economical turn, as it states that it is far cheaper to buy the seasonal products. It is also stated that frozen vegetables and fruit can be included. The last recommendation, or rather piece of information, is that fresh vegetables and fruits do not contain fat – with the exception of avocado, "the vegetable 'fat ball'", which contains about 20g fat/100g. This is the same amount of fat as a regularly fried 'karbonade' (pork patty), the brochure warns. Despite this, it is stated that it is all right to eat avocados as long as it is not on a daily basis.

The essence of these five tips is recognized in general biomedical dietary recommendations and is reflected by the technical values of fat-content, but they also express a local and homely atmosphere. They refer to the national concept of 'hygge', the Danish crown and 'karbonade', a traditional Danish dish³¹.

On the back of the brochure, the headline states: "Enjoy your meal!" The reader is congratulated with his new and low cholesterol level and is reminded to contact his doctor if he has any questions. It states that the brochure contains good advice, which makes it easier to eat in the right way. It sums up the dietary recommendations in bullet points:

31 This name is even sub-local, as it is the name used on Funen and in Jutland outside the capital island of Zealand, where the dish is called 'krebnet'.

REMEMBER:

- EAT 600 GRAMS OF FRUIT AND VEGETABLES EVERY DAY.
- 300 GRAMS OF FISH EVERY WEEK.
- AS LITTLE FAT AS POSSIBLE.
- AVOID OVERWEIGHT AND OBESITY: EAT SMALL PORTIONS!

Inside the brochure, when fully unfolded, a diagram with three vertical columns appears under the headline: “AVOID OVERWEIGHT AND OBESITY: EAT SMALL PORTIONS!” Above each column a smiley represents the three categories: A happy green smiley represents “Eat/drink these products often”; a yellow displeased smiley represents “Eat/drink once in a while”; and a red unhappy smiley represents “Eat/drink very rarely”. Under these columns are thirteen rows with different foodstuffs, for example, “Bread, flour, cereal”, “Fish and fish products”, “Dairy products”, “Nuts and seeds”, “Potatoes, vegetables, legumes, spices”. Products within these categories are divided under the three smileys, so that we learn how often it is advisable to eat a specific product. The total product list is impressively detailed, with close to 300 specified products. The bread, flour, and cereal category alone includes ten kinds of bread within the green category and twenty-two specific bread products within the red category.

The brochure is handed to the patient, who is advised to take it out during grocery shopping. One of the patients, John, I interviewed praised the brochure very much, stating that this was a concrete thing that “put action behind the words” (see Chapter 7). He and his wife had taken the brochure with them to the supermarket at the beginning of his diet change process. They cross-checked the products they usually bought and if the product was categorized as red,

they looked for similar products in the green and yellow categories. After a while, it had not been necessary to bring the brochure along because they had learned what to buy and what to avoid.

A Homemade Technology: The Bucket

But not all preventive technologies are handed over by the nurse. Patients also develop their own technologies and devices to support their preventive work. One patient, for example, proudly displayed a wooden mouthpiece he had cut for himself as a substitute for his pipe to manage his urge to smoke. In the following example, Jonna also makes use of such a material object to enforce her preventive effort.

Nurse Sofie and her patient, Jonna, who is in her sixties, talk about Jonna's possibility to exercise more. Jonna is scared of going for long walks because of the pain that it causes in her legs. Sofie explains that the pain is not dangerous; it is good for Jonna to go walking because the smaller capillaries will grow and expand around the blocked arteries and thus optimize blood flow so that with time Jonna will be able to increase her walking distance. Jonna says that she is afraid that the pain will make her stop in the middle of nowhere. She lives in the countryside; what if the pain gets so bad that she cannot move? Cars rarely pass on the road. No, she prefers biking into town then. Sofie says that biking is good exercise, but that walking and specifically walking "beyond the pain" will improve Jonna's walking distance. She suggests that Jonna walk her bike to town so that she can get on it in case the pain gets unbearable. Jonna comments that it would look silly to walk on the road with the bike. She then says that, in fact, she is walking more now because she has made a new system when she

is gardening. She tells Sofie that when she tends her flowerbed she now brings a small bucket for leaves instead of a large bucket. This forces her to walk to the compost container more often. She proudly exclaims that she walks many more kilometres. Sofie asks more into the system: Where is the compost container placed? How far is the distance? Does Jonna feel pain when walking to the container? Jonna explains that the compost container is about 50 meters away – no, it is no problem for her to walk the distance. Sofie says that it is a good system for getting up more and walking more, but that the distance should be longer if Jonna's legs are to benefit from it. Jonna says: "But I do walk longer, if you add up all the times I walk back and forth to the container." Sofie says that it is good that she moves around and that she should continue that, but that she should still get out and walk longer distances until she feels pain and then walk beyond the pain. Jonna at first looks a bit disheartened but then insists in a defiant tone of voice that she walks more now than earlier and that this is an improvement.

Although Jonna's homemade technology for enhancing her physical activity does not improve her walking distance according to the nurse, it shows that she actively develops and engages in practical arrangements to support her behaviour change. Moving cigarettes, arranging food on the plate instead of bringing the pots and large dishes to the dining table, getting up and doing the dishes right after the meal instead of smoking a cigarette, having alternatives to put into her mouth instead of cigarettes, and changing garden buckets constitute a range of mundane strategies, tricks, and rearrangements to put the biomedical and psychological knowledge into

practice. In addition to the view and understanding of the body and mind that the biomedical and pedagogical knowledge forms entail, this practical approach implies a new view on the patient's home and daily routines.

But the preventive activities that patients engage in do not only rearrange their homes and routines, they also include, affect, and thus rearrange social relationships to family members and friends. This is to some degree a strategic consideration within the programme, where the patient's social relations are considered as either supportive or compromising allies in the patient's preventive efforts. The head nurse Margit expressed in an interview that some preventive practices, such as cooking, may not be part of the patient's normal home activities and "Then it may make good sense to get the person who is doing the cooking in [join the GGG consultation] and talk to them about what food is good to prepare." In some situations, preventive activities may also regard other family members' lifestyles; couples are often encouraged to engage in joint smoking cessation to support each other if they both express a wish to quit smoking. However, the patient's social relationships may also be affected by the patient's preventive efforts in an unintended way. One of the male patients expressed that his preventive work implied spending time with specific people that could keep his mind off the cigarettes and he had therefore in the beginning of his smoking cessation actively contacted and spent time with a group of ladies who were very supportive and praised him for his efforts. But he had not only actively searched for supportive relationships; he had also avoided others. He explained that he usually went down to the courtyard to have a beer with another group of people in the afternoons, and this also included smoking. He had explained to his friends that he had stopped smoking due to his legs and they had also expressed support, but he had nevertheless

spent less time in the courtyard because it was difficult to abstain from cigarettes when having a beer. Preventive activities may thus have an effect on the social environment and distribute new roles and responsibilities to the patient's family and friends. This social rearrangement may be difficult for the patient's friends and family to handle as a patient's wife expressed during a consultation. She said that her attempts to help her husband lose weight by preparing healthy food were difficult because it made her feel "like a hawk watching his every move and striking down on him every time he eats something that is not good for him" and that it was difficult to support him when he expressed that "all the good things have been taken away from him".

SUMMING UP

In this chapter, I have focused on how the GGG programme is practised in the clinical consultations between nurses and patients, and I have shown that the mobilisation of preventive capacity and responsibility involves three coexisting knowledge forms: a bio-medical, a pedagogical, and a practical approach, all of which form different passages for prevention's flow between the clinic and home and which work as different, albeit supplementing, strategies for engaging patients in preventive lifestyle changes. We have seen that prevention builds on biomedical information and knowledge related to different physiological values measured by different technologies and translated through set criteria anchored in the GGG software in an opening and sorting of the body and its values. We have also seen that prevention builds on pedagogical knowledge and technologies that strive to open the mind of the patient and encourage the patient's motivation for lifestyle change. Furthermore, we have seen that prevention creates other kinds of information generated in the GGG consultation that regards the patient's daily and homely routines and values, and which constitutes a more practical

approach. The generation of this information does not rest on set criteria and technologies, such as the GGG software or the Wheel of Change, but also rests on probing patients about their home life and routines and acquiring other nonverbal information, like smell and appearance, to which preventive knowledge can be related and allied with. The preventive pathways that are built in the GGG conversations thus have a curious form; some parts are structured according to set criteria, boxes to tick, certain measurements, and criteria to follow, but other parts are characterized by an openness to issues, concerns, and information regarding the patient's home life and circumstances. In vascular terms, this resembles the form of the capillaries, which both consists of set structures or lines, but which also has a permeable structure through which molecules can perfuse into the tissue. In a similar way, the GGG consultation both consists of a bounded structure as well as a permeability in its structure, which allows for an exchange process. In order for prevention to be distributed from the clinical space to the patient's home space, the preventive work depends on an access to information regarding the patient's everyday life in order for the preventive agenda to perfuse into the patient's homely life in terms of various practical arrangements.

The different knowledge forms imply different understandings of preventive responsibility. The patient-centred approach and the psychological theory that GGG builds on, which foregrounds the importance of the patient's personal motivation for behaviour change, locates preventive responsibility with the individual patient. Emphasis is put on what is "meaningful" for the patient and thus turns prevention into an individual internal capacity, in terms of the patient's individual attitude and feelings about healthy lifestyle changes – which the (biomedical) preventive agenda strategically can link up to. However, in this chapter, we also saw that this inter-

nalization of prevention into a matter of personal motivation is supplemented by attempts to rearrange and intervene in the patient's external environment in various practical ways – something that is initiated by the nurse as well as the patient. The understanding of motivation and thus responsibility as an internal matter “within” the patient as conveyed by the psychological theory may thus be supplemented by another understanding of motivation and responsibility, which includes a wide range of socio-material elements and relations in the patient's external environment.

CHAPTER 7

Overflows in the Preventive Encounter:
Patients' Redistribution of Preventive
Responsibility and Redefinition of GGG

Overflows in the Preventive Encounter: Patients' Redistribution of Preventive Responsibility and Redefinition of GGG

INTRODUCTION

In this chapter, I keep the focus on the GGG consultation and the preventive encounter and knowledge exchange between the patient and nurse, however, with an alternative focus than the previous chapter. In the previous chapter, I showed how prevention was practised as different knowledge forms, which included biomedical, psychological, and homely-practical approaches, that formed different 'openings' for prevention's flow from the clinic to the home. Drawing on the vascular heuristic form, I evoked the capillary imagery to describe GGG's permeable structure, which enables the perfusion of prevention into patients' homely lives. In this chapter however, I focus on the situations where the preventive perfusion is challenged and where GGG's values and aims are disputed and transformed by patients. I thus show how the permeable structure of GGG not only forms strategic possibilities for linking the preventive agenda to patients' homely lives and individual motivation but also 'opens up' for the patients' possibility to challenge and redefine the GGG programme and to redistribute demands, concerns, and responsibilities in the preventive encounter. In this chapter I also show that patients actively challenge GGG's patient-centred orientation and demand more professional involvement in their preventive efforts and thus paradoxically try to re-establish the paternalistic and authoritative professional-centred approach that the GGG programme wishes to break away from. Furthermore, I show that patients may engage in GGG for other reasons than acquiring preventive capacity and that other matters may emerge in the consultations which set aside the purpose of GGG.

Drawing on Callon's concepts of 'framing' and 'overflow', I show how GGG's frame is overflowed in different ways in the GGG consultations and how nurses attempt to handle these overflows by reframing the programme's values and purpose. However, I also show that some overflows are tolerated and come to modify some aspects of the GGG programme. This I relate to Mol's understanding of 'multiple ontology' (and the associated notion of 'fluidity'), which implies a different analytical interest and expands the analytical preoccupation with the GGG programme by including its related networks and the multiple ways through which prevention is being enacted.

DISTRIBUTING PREVENTIVE CAPACITY AND RESPONSIBILITY TO THE PATIENT

As we saw in the previous chapter, GGG's pedagogical approach and patient-centred ambition assigns preventive responsibility to the patient and attempts to facilitate this by building patients' preventive capacity in different ways by providing knowledge and facilitating patients' decisions and practices regarding their preventive lifestyle changes. The patient is defined as the primary actor of prevention – simultaneously the subject who acts and the object that is acted upon – whereas the health professional is defined as being a supportive and facilitating actor. The patients are thus framed as active and responsible actors, whereas the health professionals are framed in a more reticent role, whose task is to facilitate the patients' initiatives, definition of goals, and motivation, as well as being supportive and showing respect for the patient's particular wishes and thereby moderate traditional professional authority.

This establishment of the patient's particular situation and motivation as the point of departure and the health professional's more limited role is described by the health professionals as both a con-

trast and a shift from the former paternalistic, disciplinary medical authority. The preventive outcome is still framed according to health gains as formulated from medical categories and values (cholesterol level, blood pressure, and weight); however, the way to reach preventive activity is not only based on generic medical knowledge and health information, but rather takes into account the particular life situation, opportunities, and resources of the individual patient. Prevention is framed as an ongoing process that includes different concerns and ambitions.

Although the preventive work rests on a medical rationality that identifies the health benefits of certain preventive activities, its patient-centred framing also reduces the authority of medicine as the main catalyst for preventive action. In a patient-centred framing, patients' preventive activities do not work through generic medical advice heralded by health professionals, but instead work through patients' own statements, desires, and wishes to which health promoting objectives can be related. It is argued that patients act on a range of other values that are meaningful to them; values that traditionally have been thought of as externalities to the medical rationality.

The patient-centred approach is defined as a way to foster active, responsible, and 'empowered' patients. It defines prevention not only according to medical values and objectives but also according to what is defined as meaningful and possible by the individual patient, and it works through patients' self-defined motivation. It can thus be argued that the framing of prevention is rather open, as it includes understandings, motivations, and conditions that may traditionally have been seen as "externalities" to the medical rationality, which have now been "internalized" within the framing to use Callon's vocabulary as presented in Chapter 2 (Callon 1999:

188). Despite this inclusive framing, not all externalities have been included (indeed this would not be possible) and patients may thus formulate expectations and act in ways that overflow the framing of the GGG programme in terms of its values, content, and distribution of responsibility as we shall see in the following.

PATIENTS' REDISTRIBUTION OF PREVENTIVE RESPONSIBILITY

In this section we shall see that GGG's patient-centred orientation and ambition to disclaim the traditional authoritative and disciplinary position of the medical expert is not necessarily a concern that patients share. In contrast, we shall see how patients actively request and insist on health professionals' disciplining and expert knowledge and interventions.

Asking for More Disciplining

Christian, a male patient in his fifties, is attending his third GGG consultation with Nurse Sara. In the previous consultation his blood pressure was alarmingly high. This corresponded with his explanation that he had not renewed his prescription for his blood pressure-lowering medicine. Sara had expressed her concern about this and explained the importance of taking his medicine when suffering both from hypertension and atherosclerosis. She had told him that she would like to see him in a month in order to check-up on his blood pressure. Before his third consultation, she told me that he was one of the more challenging patients. He did not seem very keen to consider quitting his cheeroots or doing more exercise. "But that's fine", she said, "then we can work on something else, at least make sure he takes his medicine". Yet, this had also been difficult. "He even asked me if he could skip it on the weekends!"

She explained that the reason was that he did not really understand his diagnosis and why he should take the medicine, “so we just have to continue explaining and repeat it again and again,” she said.

Christian’s blood pressure is measured during the GGG consultation and has dropped. “I’ve been taking my medicine every day!” he proclaims proudly. During the consultation, they talk about how exercise and reducing his smoking can improve his condition, but Christian does not give a convincing impression that he is motivated to engage in this. At the end of the consultation, Sara asks him: “So, what do you think? Is there something else I can do for you? Is there something you think I could help you with?” Christian shrugs his shoulders. She asks him if he wants to come again or if they should end the GGG course. “No, I would like to come again”, he says and continues: “Then I have something that gives me a guilty conscience!” Sara furrows her brow and replies: “But you shouldn’t feel guilty – it’s totally up to you what you want to do with all this [the GGG consultation], I’m just here to push you in a positive way – I don’t want you to feel bad.” Christian shrugs again and suggests: “No, but perhaps that is what is needed”.

This plea for discipline, which Christian expressed at the end of his consultation, contradicts GGG’s patient-centred approach, as it reflects an understanding of ‘external’ motivation and fails to subscribe to the understanding of ‘inner’ motivation, which GGG’s pedagogical approach builds on (see Chapter 6). Instead, Christian articulates a wish for a disciplinary relationship that positions Sara as the authority to whom Christian should adhere. This position

was not something Sara was comfortable with or willing to take because, as she stated implicitly, Christian should not engage in preventive activities because she told him to; but rather consider and take point of departure in what was meaningful to him. This was also expressed in a similar way by the other nurses, for example, one stated bluntly: “They shouldn’t do it for my sake, I don’t care; they should do it for their own sake.” Christian’s actions and statements display an ambiguous engagement in GGG. Although he showed up for the consultations, he at the same time seemed reluctant towards the preventive purposes of the programme, both in terms of engaging in preventive activities such as smoking cessation and also towards the programme’s ‘empowering’ approach. In his own judgment, Christian needed somebody that could make him feel guilty and in this way motivate his preventive actions. In principle, it may be argued that Christian’s definition of motivation is just as ‘patient-centred’ as other types of motivations, as it reflects his particular understanding of motivation in terms of somebody else telling him what to do. However, his disciplinary understanding of motivation is not easily aligned with the critique of the paternalistic and disciplinary attitude of the professional-centred approach from which the nurses wish to distance themselves. Therefore, we see that Sara reframes the GGG programme by rejecting the role that Christian requests her to perform and insists on the importance for Christian to define his own motivation and thereby exclude his understanding of motivation as external discipline.

Establishing an Obligating Relationship

Christian’s plea for discipline was not an isolated incident; other patients also articulated that an obligating relationship to the health professionals and the clinic had a motivating effect:

Inge, a patient in her sixties is attending her second GGG conversation after she has had angioplasty surgery. Her main objective is to quit smoking. She has already reduced her smoking from twenty cigarettes a day to three with the help of acupuncture before her operation. She says, "I would really like to quit it completely – both for your and my sake. I think I owe it to you after the operation." She continues and says that she feels stupid and ashamed. She says that before the operation she could not follow her grandchild around and go with him to the playground and now it is no problem. "I feel so privileged and happy but it's hard to let go of the last smokes. I try to do these things – like I buy the cigarettes with filter, the type that I don't like, but then I end up breaking off the filter...aw!" She says that her brother, whom she has a close relationship with, has quit smoking and that he is keeping his cessation. "But I haven't told him that I've started again, he would get so mad at me, I just haven't had the courage." At the end of the conversation, the nurse asks if they should formulate a goal for the next meeting. They agree that Inge will work at cutting one cigarette down. "I really like coming here", she says, "I look forward to it. It gives me something to live up to and it's much better than if I go to some course at home, I take it more seriously when I come here."

Inge stated that she felt she "owed it" not only to herself but to the clinic after they had performed the bypass operation on her. She also articulated that she took it more seriously when she came to the hospital than if she went to a similar preventive course at home. Inge expressed that she feels an obligation towards the health care

system and the professionals and that this entails a sense of responsibility that motivates her towards her lifestyle changes, which differs from her feelings of shame with regard to her brother, who would get “mad at her”. By this, she implies that the clinic offers a different type of support that may still engender a feeling of obligation, but not in the disciplinary sense that Christian stated above, rather in a way where she can be more honest with the nurse and get support instead of being scolded. This understanding was also expressed by another patient at the clinic who said that he thought that it was “a really good thing that one can come here and get moral support”. When I commented that some might think of it as “moral finger wagging”, he said that he did not perceive it as such, but that he thought it was positive that “One can come and get to know how it all hangs together and get to know what one can do.”

Nurses recognized that many of their patients, especially the elderly patients, claimed to have this faith in the health professionals as authorities³², but they perceived it as a problem that compromised the patient-centred approach and obstructed patients to formulate their own motivation.

Demanding More Expert Knowledge

The emphasis on professionals’ specialized expertise was also expressed by other patients. In fact, some patients demanded even more of this from the nurses and the programme. For John, a patient in his sixties, the obligating relationship with the health professional was not the key issue in his preventive work; however, he formulated other expectations in regard to the nurses’ role and

32 In Chapter 5, we also saw how the nurses articulated in the evaluation of the Prevention Conversation that the kind of patients they attend, i.e., elderly patients, have faith in authorities, “most patients we deal with will come if the doctor says so” a nurse expressed.

responsibilities, and he requested more clear-cut knowledge in relation to his prevention activities. In an interview conducted at his home, he said:

“There are good intentions in the programme, but I need action behind the words. And then you can say – well, that’s up to you. Yes, that’s true. But if the programme is supposed to be sensible, then there must be an action plan that ensures that the programme is reasonable and that it has an effect. I miss that action plan.”

He particularly asked for “professional expert guidance” about how to use fitness equipment in the most effective way. John expressed that he knew that it was for him to take action, as he was well aware of the tenets of a healthy diet and exercise. John and his wife had changed their diet dramatically in accordance with recommendations in one of the folders he had received from the clinic (the diet brochure that was presented in Chapter 6) and had found it very helpful. These clear-cut and practical guidelines were exactly what he pleaded for: “That’s a concrete action plan, one can say: good illustrations, examples, and recipes – especially a table where you can see what’s good and what isn’t.” But he lacked similar instructions in relation to exercise. He exercised several times during the week: walking, swimming, biking, and also did fitness exercise. It was especially in relation to the fitness exercises that he requested guidance: “There are so many things you can do, certain exercises and these must be specified by a professional, so that you don’t do something wrong.” John had therefore, on his own initiative, asked for professional guidance at his local gym. This had been very successful and he suggested that the programme should include physical training sessions with profes-

sional instructors. This was something his brother, who had had a heart attack, had been offered at the hospital where he was treated. This, John expressed, was much more “action-oriented” than the “words” or “talking” that the GGG consultations offered.

John’s request for more expert guidance and ‘action’ overflowed the purpose of GGG in terms of pointing to the professional’s responsibility to provide more practical knowledge and guidance regarding exercise. His wishes were not reframed in the consultation, but nurses pointed to GGG’s limitations, arguing that the programme was a “starting signal”, which could not facilitate exercise, but instead referred patients to the local municipality offers.

Turning the Preventive Gaze towards the Nurse

During the consultations, other expectations were also formulated regarding nurses’ involvement in the preventive work. Although the preventive work revolves around the patient’s lifestyle, it was not unusual for patients to enquire into the nurse’s lifestyle and health conduct, especially in situations where they rejected the nurse’s suggestions and advice for certain lifestyle changes. However, as the following example shows, the nurse reframes this overflow by drawing attention to the way that the recommended diet is closely connected to the patient’s disease and not necessarily relevant for everybody.

Nurse Louise explains to Kaj that one way to cut out a lot of fat from his diet is to abstain from using butter on bread. Kaj looks very dissatisfied and asks her in a challenging tone whether she has butter in her fridge or not. Louise replies that, in fact, she hasn’t. Kaj does not look convinced and I am also a bit unsure whether this is true or merely said to support the possibility of actually refraining from

butter on the bread. Kaj turns and looks at me, "What about you, don't you have butter in your fridge?" I am baffled by the question and unsure what to answer, but then say that I do eat butter. Louise quickly cuts in and says, "But she hasn't got atherosclerosis, Kaj!"

Patients did not, however, only refer to nurses' personal experiences with lifestyle changes as a strategy to dodge responsibility, but also in an attempt to find support and sympathy by referring to a common experience. Regarding the issue of smoking cessation, patients sometimes asked the nurse about her own experience with the difficulties of quitting, an experience that not all nurses could share with the patient, either because they had never smoked or because they had not quit. (This issue regarding health professionals' own lifestyle and the requirements that the preventive work implies regarding their own health behaviour is further elaborated in Chapter 8).

GGG's focus on patients' 'own' or 'inner' motivation proposes the patient's self-relation as central for the patient's preventive activities. However, as the above examples have shown, patients do not necessarily subscribe to this understanding of motivation but express the importance of an obligating relation (sometimes even disciplining) to the nurse or the clinic as providers of health care services. Also, some patients demand more involvement from the programme and the nurses in terms of clear-cut expert evaluations and advice or even nurses' personal experiences with lifestyle changes. The patient-centred framing of GGG in terms of its ambition to foster the patient's ability to relate to himself and to downplay the professional's authority is thus overflowed by the patient's attempts to involve professionals in their preventive efforts and their insisting on a more obligating relationship.

These cases show that the intention to responsibilize patients by getting patients to state their ‘own’ self-defined motivation, formulate agreements, and translate prevention into their daily lives and routines is overflowed by patients’ attempts to involve and engage health professionals in more binding relationships – as disciplinary authorities and intervening experts. We saw that the nurses’ reluctance to act as disciplining and directive experts does not necessarily respond to a concern put forward by the patients. Patients instead expressed a wish to engage in mutual and obligating relationships with the health professionals and subject themselves to the professional’s expertise and authority – and also in some instances even subject the health professionals themselves to the preventive logic.

REDEFINING GGG’S PREVENTIVE PURPOSE

In addition to patients’ redistribution of the preventive responsibility, patients may also overflow the frame of GGG by engaging in the programme for alternative reasons than prevention.

Prevention as a Pathway for Surgery

Jørgen is at his second GGG consultation. He is in his seventies and has trouble with his legs, which upsets him; not only is his walking hindered but he cannot dance any more and as he says, “There are so many old ladies out there to dance with”. Nurse Lotte asks Jørgen what his thoughts have been since the last consultation. Jørgen replies in a serious tone of voice: “What I’ve been thinking? I’ve been thinking damn hard about it. It’s been a tough period of time”. Lotte, who is looking through the journal, looks up at Jørgen: “Yes?” He continues: “When you put me on smoking cessation and a diet, that’s usually not something one does at once,” he says and looks severely at her. Lotte replies in an understanding tone of voice: “No, so what did

you do when you got home?" Jørgen says: "Well then I did it all, almost." Lotte smiles and questions further. Jørgen tells her that he quit smoking after the Tour de France and that he has not been smoking since, which is five weeks. Lotte praises him: "GREAT! Then you have done a lot!" Jørgen says that it has not been easy and that he has used a small plastic mouthpiece with nicotine ampoules, but he does not need the nicotine any more; he just sucks on the mouthpiece now. Lotte says that it is a good idea to have something in his hands and in his mouth to substitute the cigarette. Jørgen then informs her: "And then I've lost between 6-7 kilos". He gives Lotte a serious look. Lotte is clearly surprised: "Whow! That is really well done!" She says that taking into consideration that he has also quit smoking, which usually means that people gain weight, his weight loss is really impressive. Lotte enquires more into what he eats during the day and recommends that he add some more meat and protein, because he is mostly living on tomatoes, cucumber, and crisp bread. It is not healthy to quit eating, she tells him, and says that he needs protein from meat for his muscles – a good steak or fish, but fried on a dry pan or with a little good oil. They also talk about the importance of staying positive during the difficult smoking cessation process, and Lotte recommends that he remember the good things he is experiencing now when he finds it difficult: feeling proud, lighter, having a better taste in the mouth, and being able to breathe better. After the various measurements and reading of blood samples, Lotte ends the consultation by asking what they should agree on until the next consultation: she mentions keeping the smoking cessation, adding more protein to the diet and continuing exercising, especially walking. He

says that he is motivated to do this, but then states "Now I have done mine, what about you? What can you do?" implying a wish for surgery.

In Jørgen's case, his engagement in the preventive activities was not the sole purpose or end goal; rather, it was part of his attempt to convince the health professionals to offer him the surgical intervention he was hoping for. His prevention engagement formed part of his strategy towards surgery, although the purpose of GGG is to treat atherosclerosis by preventive means and postpone risky surgery. However, we see that his nurse complies with his surgical wishes and sets out to find a doctor who is willing to operate.

Other patients also expressed their engagement in GGG as a strategic move in order to get surgery. Esther explained in an interview at her home that she thought it was a clever idea to engage in GGG in order to get the bypass operation in her leg. She reasoned that if she attended all the sessions and showed engagement and willingness to quit smoking, this would improve her chances of getting the operation. Esther had not explicated this directly to her nurse as Jørgen above, and, despite her display of willingness for preventive lifestyle changes, her engagement in GGG did not have the outcome she hoped for. In fact, her continuation in GGG postponed the operation. The argument being that the operation should be postponed as long as possible because the outcomes of these operations have a limited durability and because surgery is always risky. For as long as the patient is able to live with the condition and engages in prevention by trying to quit smoking, by walking, eating healthy, and taking the medicine, the operation is put on hold to evaluate how these practices affect the patient's condition. In Jørgen's case, however, he expressed that his quality of life was

significantly decreased because his walking was getting worse, and combined with his preventive efforts as well as the physical placement of his stenosis, Lotte saw that there may be a high probability that a doctor would find good cause to operate on him. She therefore booked a doctor's appointment for him three months later, giving him some time to "boost his motivation" and prove that he could maintain the lifestyle changes, as she said.

This reciprocal relationship between the patient's preventive efforts and the healthcare system's surgical interventions was not only expressed by the patients, but also something that was articulated by the health professionals. One of the surgeons said, for example, that he expected that patients also made a preventive effort in order to get surgery and that he sometimes adopted a tough stance towards the patient and could, for instance, say: "Come on buddy, we have made some damn complicated surgery here and then you just continue smoking; that isn't fair. I mean, that's a bad bargain the two of us have made here, don't you think?"

Prevention as an Opportunity to Socialize

In my interview with Kaj, a patient in his late fifties, conducted at his home, Kaj revealed a rather different reason for engaging in GGG. Kaj said frankly that he saw the consultation as "entertainment". Kaj did not only have atherosclerosis, but several diagnoses, including Leukaemia, which had put him on disability pension at the age of forty-five. He was also recently diagnosed with diabetes and on top of this he suffered from depression. He attended numerous meetings and consultations at different clinics due to his various illnesses, and he explained that the conversations at the clinics essentially gave him "a purpose to get out of bed in the morning". He was especially fond of Louise, the nurse at the vascular clinic, because they had good chemistry and she even knew something about his great passion for antiquities.

Kaj is attending his third conversation with Louise. She expresses doubt whether she can do more for him. Kaj has stopped smoking and he has made some diet changes due to his diabetes, which mainly implies a reduction in his consumption of sugar. There is still the issue regarding the reduction of fat in his diet, along with the issue of daily exercise. Louise says that if it is difficult for Kaj to reduce the fat-energy in his diet, then he can exercise more in order to burn more energy. Kaj proclaims that he is simply "a lazy bugger". "I get up in the morning after a whole night's sleep – I sleep like a baby – I have my breakfast and medicine and then I almost doze off while having my coffee, I get so tired". He also explains that walking is too painful for him and that after 200 meters he screams because of the pain. Louise listens and says that doing exercise also gives him more energy. He nods but then expresses that it is too painful for him to walk. Louise then suggests that perhaps he should just be content with what he had already achieved. "I don't think you are lazy Kaj, you have achieved so much, you should feel proud. It isn't easy to quit smoking and maybe we can't do more for you". Kaj nods but then says that he really likes coming and that he feels privileged that he can come and talk; it all encourages him to think about what to do. He insists on coming again and Louise agrees to see him again in six months. As they say goodbye, Kaj holds on to her hand for a while, reminding her about the upcoming antiquity festival in his hometown.

After the meeting, Louise repeats that she does not think she can offer him any more help with his preventive activities. She says that he has a lot of other things to deal

with and refers to his Leukaemia, diabetes, and depression, and she suspects that it is his Leukaemia medicine that is making him so tired. Although she does not know what more she can offer him, she agrees to give him a last conversation, as he expressed a wish to come again. But then she says she will end the GGG course.

For Kaj, the clinical encounters with Louise and other health professionals have an extended meaning than merely being supported in preventive activities. It is not only about the information they can offer or medical control; it is to a greater extent an occasion to get out and socialize with other people and speak with a dedicated listener. Although Louise could not offer him more in relation to his preventive activities, she instead offered her ears and agreed to see him again. In Kaj's case, where his reasons for engaging in GGG were mainly social, we see that his nurse comes to the conclusion that she cannot do more for him within the preventive scope of GGG. Despite this conclusion, she grants a final conversation and thereby includes Kaj's social need within the GGG frame, however, only temporarily.

OTHER EMERGING MATTERS

In some of the conversations, other matters also emerged that did not directly regard prevention of atherosclerosis. Practical matters such as claims for insurance, divorce, legacy issues, or a family member's death were some of the issues that nurses talked about with patients. Attending to the patient's motivation and emotional and practical conditions elicited a range of issues that needed to be dealt with in addition to prevention.

Michael is at his second GGG consultation. Many issues have come up. Not only has his leg been recently oper-

ated on due to a blood clot, but he has also just been diagnosed with skin cancer. The preventive focus in the consultation has primarily been about smoking cessation. Michael is interested in trying Champix, a prescription medication for smoking cessation. The time has now come for checking his blood values. Nurse Cecilia reads the results on the computer. Michael's cholesterol levels have decreased, but could be better. He told her earlier that his general practitioner has prescribed him 20 mg Zarator, an alternative kind of statin because he was experiencing side-effects with Simvastatin, the drug that the clinic recommends initially because it is cheaper than Zarator. However, at the clinic they recommend 80 mg Zarator as a standard dose. Cecilia says that if Michael comes for check-ups at the clinic, they would like to monitor his cholesterol-lowering medicine because the general practitioner might not know enough about atherosclerosis, and the worst-case scenario is that this might lead to poor management of his medical treatment. She then reads the liver count, which is too high. This she says is something she needs to enquire about; could it be that Michael perhaps has had alcohol the night before? Michel confirms, saying that he was at a restaurant the evening before and had some wine. Cecilia asks more into the issue: "How many units do you have on average in a week?" Michael says about half a bottle of wine a day. Cecilia probes: "About 6-7 units?" Michaels says he does not know what she means by 'unit'. She says that there are 8 units of alcohol in a bottle and asks again if he has 6-7 units a day. Michael is a bit reluctant in answering. Cecilia suggests 5-6 units and they agree on 6 units as an average per day. "That adds up to 42 units a week" she states and continues, "I have to inform you that

the Health and Medicine Authority recommends a maximum of 7 units a week for women and 14 units a week for men. It has just been further reduced." Michael says, as if to defend himself, that he was able to completely quit smoking and drinking around the time of his earlier leg operation. Nevertheless, his liver count is too high and Cecilia says that she has to get a doctor's evaluation to find out what to do about his medicine and to find out whether it is advisable to increase his medicine to the recommended dose so that he can reduce his cholesterol levels further. She goes out to find a doctor and they return to the examination room after a while. The doctor greets Michael and reads the journal, some parts aloud. He turns towards Michael: "So what's wrong?" Both Michael and Cecilia start explaining. Cecilia then stops and asks if Michael wants to explain, but he leaves it to Cecilia, who informs the doctor that Michael only gets 20 mg Zarator but that she is in doubt whether the dose can be increased due to his liver count. She points to his alcohol intake on the computer screen, which she has entered in the GGG software. The doctor responds forcefully, saying that Michael's drinking is "damned dangerous", that he can get cirrhosis of the liver. He says that reducing his alcohol intake might imply that Michel has to take some sedative drugs to manage the withdrawal symptoms because "when you go from 100 to 0, the body will respond – trembling, sleeping difficulties", he explains. The medicine he will prescribe means that Michael will not be able to drive or handle dangerous machines. Michael is calm and states that he does not drive. The doctor responds, "Good, I need to tell you this." He continues, "Maybe you might benefit from Antabuse as well." Michael says that he knows people who are alcohol-

ics and who have been on it. The doctor breaks in: "But that isn't what I am saying, that's not where we are [being an alcoholic], but when you go from 100 to 0, then you will feel it." He recommends that Michael slowly decrease his alcohol intake to zero units over three weeks and keep it there for six months. Michael agrees to that plan. He is advised to stay on the 20 mg Zarator. The doctor makes a prescription on the computer for the sedative medicine and smoking cessation medicine Champix, which Michael wishes to try. Michael sees the price of Champix and notices that it is expensive, even more expensive than the Zarator. Cecilia comments, "But think about all the money you save when you don't buy cigarettes." The doctor dictates his note while we listen and looks at the patient and nurse as to confirm the information he is dictating. He ends by saying: "Have spoken to the patient about alcohol intake. Have recommended total alcohol cessation over three weeks gradual reduction. Patient prepared for this." Cecilia asks when they should book a new appointment and suggests in three months. The doctor states to Michael: "I'm a sissy; I think we should see you in six weeks for a doctor's appointment. I would rather see you 10 times too much than once too little." He shakes Michael's hand and leaves. Cecilia books appointments for blood samples and appointments both for a doctor's consultation and for a GGG conversation.

After the conversation, which has lasted two hours, we talk about it. Cecilia says that it is the first time she has talked so much about alcohol, because normally they talk about smoking cessation, diet, and exercise with the GGG patients. I say that I had not suspected an alcohol prob-

lem from the way Michael looked and from my chat with him. Cecilia says that she suspected that he was a little “psychologically unstable – no that sounds wrong”, she corrects herself, “but he has been through a tough year,” referring to his leg operation as well as the diagnosis of skin cancer. She says that he “seemed affected”. She also says that she could see it a little bit on his skin. She further explains that when she confronted him with the liver count and asked if he had had alcohol the evening before, he reacted by saying that he was at a restaurant as a way to legitimize drinking alcohol. She further says that she was a bit surprised that the doctor gave him sedatives and insisted on total alcohol cessation, but that it seemed to be all right with the patient; that is, he took it seriously and calmly, which is not always the case with alcohol. “You have to sense the atmosphere around it because some will refuse it straight away.”

In this case, we see that the standard blood sample, which is taken before the GGG conversation in order to check up on cholesterol levels as well as the liver’s reaction to medicine, confirms the patient’s overconsumption of alcohol as an additional issue to take into account; not because of its direct influence on atherosclerosis (although alcohol also increases cholesterol levels in the blood which may develop into arterial plaque), but because the alcohol strains the liver to the extent that the patient cannot tolerate the recommended statin treatment. In Michael’s case, we see that the content of the GGG consultation changes as a more important concern emerges in the consultation, and the GGG frame is thereby not re-established but replaced by another framing, which concerns Michael’s overconsumption of alcohol and the treatment of this.

SUMMING UP

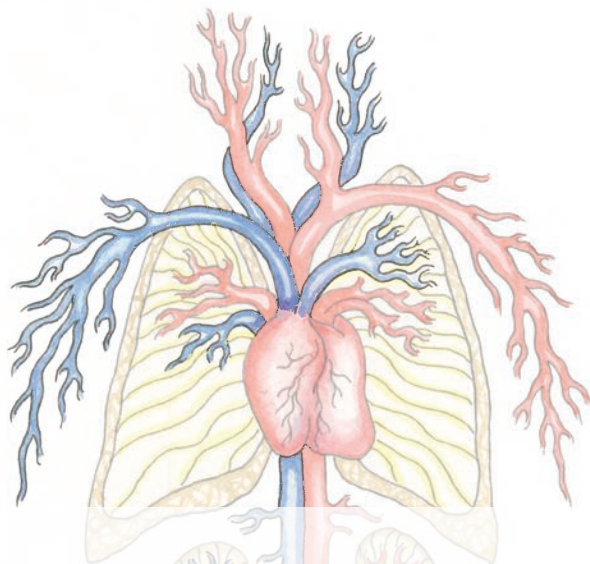
GGG's patient-centred approach defines a rather open framing of prevention, as it attempts to take point of departure in the individual conditions of each patient. It reflects an ambition to not frame prevention too tightly according to traditional biomedical health understandings and ideals. This 'openness' is intended to allow for a variety of understandings and interpretations of health, however, it also has the effect of redefining the GGG programme and redistributing preventive responsibility.

In this chapter, we have seen that GGG is overflowed by a range of issues, concerns, and demands that unsettle the programme's framing in terms of its basic values, aims, content, and division of preventive responsibility. In the first section, we saw how patients in different ways demanded more intervention and a more authoritative approach from the nurses in the preventive work. They challenged basic values in the patient-centred approach such as redefining motivation into a disciplinary relationship. We also saw that patients required health professionals to give more clear-cut advice and how patients turn the preventive gaze towards the nurses and hold them accountable for their own lifestyle and health. In the second section, we saw how patients reformulated the preventive purpose of the GGG programme by engaging in it with other goals than prevention, namely, as a strategic way to obtain surgery and an opportunity to socialize. In the third section, we saw that other issues emerged in the GGG consultation, which needed attention prior to the main preventive purposes of GGG. These various kinds of overflows were handled in different ways by the nurses. In some cases, nurses attempted to reframe GGG's values and objects. For example, we saw that Sara rejected acting as a disciplining authority despite Christian's request for this. We

also saw that Kaj's attempt to change the preventive subject of the GGG consultation by enquiring about Louise's use of butter was reframed by Louise, who related the diet recommendation to Kaj's atherosclerosis diagnosis. Furthermore, we saw how the proposal to include exercise in the GGG programme was turned down and that GGG was defined as a "starting signal" which could not offer a continual intervention, but instead referred patients to their local municipality healthcare centres. However, we also saw cases where overflows were not reframed but where some of these issues were 'left flowing'. The redefinition of GGG's preventive purpose in terms of patients' engagement in the programme for surgical and social reasons was to some degree tolerated. Also emerging issues set aside the preventive purpose for a while. This then implies a different analytical vocabulary or imagery to capture the fact that overflows are not always reframed according to a set preventive order. Mol's notion of 'multiple ontology' draws attention to the multiple versions of a phenomenon and the coexisting networks that a phenomenon may be part of and thus implies another analytical interest that does not revolve around the continual establishment of one ontological order of an object, but rather show attention to its many variations. Mol (together with Law and de Laet) also uses a fluid metaphor to describe this, however, in a different way than Callon's fluid metaphor: Where Callon's concept of overflows and reframing draws attention to the ways that a certain order is unsettled and the attempts to re-establish this order, the 'fluidity' that Mol, Law and de Laet draw attention to is its variation, which does not necessarily imply difference. What we see are various versions of prevention that relate in different ways – sometimes they conflict and other times they coexist and mix.

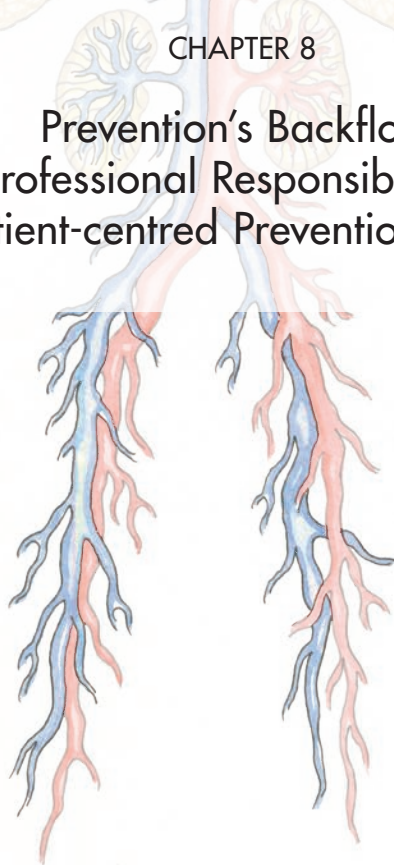
Drawing on the vascular system and the capillary form, which I suggested as imagery for the preventive encounter, we may expand

the analytical possibility of the fluid metaphor that Mol, Law and de Laet suggest. Where the previous chapter evoked the metabolic process whereby specific nutrients in the blood flow are perfused into the tissue as an image of the distribution of prevention, in this chapter, the unintended issues that emerge in the preventive encounters may then be thought of as the excess products of the metabolic process, which are absorbed by the blood flow in the capillaries and carried back via the veins. This image is further developed in the following chapter, where I deal with nurses experiences of the preventive work.



CHAPTER 8

Prevention's Backflow: Professional Responsibility in Patient-centred Prevention Work



Prevention's Backflow: Professional Responsibility in Patient-centred Prevention Work

INTRODUCTION

In this chapter, I move from the preventive encounters between nurses and patients and focus on the nurses' more general reflections about the preventive work. Drawing on the image of the vascular system, I leave the capillaries and capillary exchange and focus on prevention's backflow: its further circulation into the venal passages. More specifically, I address the issues that nurses articulate about the challenges of preventive work and show that patient-centred prevention not only assigns responsibility to the patients but also sets specific conditions for being a responsible professional.

Firstly, I describe the nurses' understanding of the preventive work as being more demanding than other clinical tasks, which implies a special involvement and which at times blurs the boundaries between professional and private responsibility. Preventive work is also perceived as more challenging because of its unpredictability, both in terms of the content of the consultations – which issues and concerns may emerge – and their outcome. I then describe the main challenge that nurses describe regarding the preventive work, which consists of handling two different values within patient-centred prevention: One regards an ambition to see patients make concrete lifestyle changes based on the information and tools provided in the GGG consultations. The other regards the concern for ensuring patient autonomy and supporting them in their individual lifestyle choices – whether they are healthy or not. These values, I show, have different and sometimes conflicting implications for professional responsibility.

PREVENTION AS A DEMANDING JOB: THE “USE OF ONESELF” IN THE PREVENTIVE WORK

Nurses describe the preventive work as more demanding compared to other clinical tasks. They describe the preventive work as a task that “fills up the head” (i.e., is a strong presence) and as “costly” because it requires more “energy”. This requirement of engagement is, however, also expressed with great enthusiasm. The longer courses in the GGG setup where the nurse follows the same patient also means that she “gets to know the patient”, “takes part in his process”, “helps him achieve his goals”, and “being a nurse with a capital N” as some of the positive expressions about the preventive work were stated. One of the nurses described the difference between preventive work and other tasks in the following way:

“You get very involved; it isn’t the same as scanning and measuring blood pressure, not for me at least. So in that way you use yourself more”. (FGD, Nurse 4)

The “use of oneself” can be understood in different ways. In the quote, the nurse describes the “use” of herself in comparison to other work tasks and technologies used to generate physiological information about the patient such as taking blood pressure and scanning. The preventive work, however, also implies that she uses herself as another kind of tool, which ‘opens up’ for other kinds of information that concern the patient’s personal motivation and home life in order to relate these to the preventive work (as we saw in Chapter 6). In this position, nurses thus work as technologies that generate information and translate this according to the preventive agenda. In contrast to the physiological information that is generated with standardized methods and measuring technologies, the information regarding the patient’s personal motivation and

everyday life is generated in a less structured way and depends on the patient's willingness to open up and share details about his everyday life and thus the nurse's ability to facilitate this opening. The sensitivity towards the particular life situation of the patient means that the consultations are very open and inclusive for whatever may come up, which requires the nurse to be able to navigate this information with the purpose of relating it to the preventive agenda. As we saw in Chapter 7, a range of unexpected and unintended issues and demands may emerge in the GGG consultation. The preventive work is thus experienced as being highly unpredictable in terms of what emerges as issues and content in the GGG consultations, what is possible, and how to relate it to the individual patient. At the same time, adjusting the preventive work to exactly these individual conditions is fundamental to the programme's patient-centred approach. The nurses describe the unpredictability of the preventive work as being more demanding, and they explain that they have to "get into the right mode" in order to do the job. On one occasion, I also observed that a nurse asked her colleague to take a new GGG patient for her, because she did not have the energy to take that task on that particular day.

The "use of oneself" may also have another meaning, which is more closely tied to the nurses' personal health-related behaviour and experiences. Although the GGG conversation revolves around intimate issues regarding the patient's life, the nurse's life is also brought into the conversation. Sometimes patients ask nurses about their own health conduct (as we saw in Chapter 7). In such situations, the nurse's own experiences with difficult lifestyle changes may be seen as an advantage in relation to the conversation and relationship with the patient. One of the nurses said that when patients asked her whether she had ever smoked, she could answer that she used to be a heavy smoker and patients would of-

ten reply: “Well, then you also know how difficult it is,” conveying a shared experience. In other situations, the nurse’s experiences or lack of experience could also have the opposite effect:

“I think most of the patients think it’s better when you say that, ‘yes, I’ve been a heavy smoker myself and I quit.’ They can both see somebody who has succeeded and somebody who knows what it’s all about, more than when I say, ‘no, I’ve never smoked,’ then they just think, ‘so, what does she know?’” (FGD, Nurse 6)

Here, the nurse expresses a concern for not being taken seriously by the patient due to her lack of personal experience with smoking cessation and the patient’s critical questions about whether it is possible for the professional who has never smoked to understand and know how to support a person going through smoking cessation. In this way, the credibility of the nurse’s preventive work is related to her personal experience and not just her professional knowledge and expertise. In a similar way, it may also be a problem if the nurse conveys an unhealthy lifestyle. Working with prevention thus involves the nurse’s own health-related behaviour and appearance. In the focus group discussion, one of the nurses expressed how working with prevention impacted her behaviour:

“I think it touches a lot [on a personal level], enormously. I try to change almost everything about my life in relation to living according to, you know, all that about being a role model, you know if the patient sits there and says, ‘But you are also too fat!’ Can a fat nurse tell you to slim down and how to go about it?” (FGD, Nurse 3)

Although the nurses are not obligated to be role models³³, the nurse expresses that the work implicitly obliges her to represent a healthy lifestyle. Another nurse, Maria, disputed this and said that:

“I don’t think that patients sit there with me because, “Maria, she is virtuous, she runs, she doesn’t eat candy.” [...] I don’t need to be a role model. I don’t need to level with them and smoke with them. It isn’t Maria in her white coat and healthy lifestyle that they refer to. I don’t think that has any influence – that they see me as a health lexicon and then they also want to [live healthy], that’s at least not what I read in the literature.” (FGD, Nurse 4)

Furthermore, she said that if patients refer to the nurse’s lifestyle, for example, her lack of personal experience with smoking cessation, it can also be understood as a bad excuse for not engaging in lifestyle changes, which has nothing to do with the nurse, but reflects that the patient is not interested or ready to quit smoking.

Despite this discussion about whether nurses are obliged to be role models or not, the nurses agreed that the preventive work implies some obligations regarding their health behaviour. At different times, in the focus group discussion, in interviews, and other conversations, different health professionals referred to an episode where the clinic had received a letter from a patient in which he criticized the fact that the doctor who had recommended that the

33 In a study of the implementation of prevention conversations and the development of the preventive clinic at Bispebjerg Hospital in 1998, there was a much stronger expectation that nurses who work with prevention also subject themselves to the healthy recommendations in order to appear as good role models for the patients (Dahlager 2005).

patient quit smoking had carried a cigarette packet in the pocket of his white coat. In all the situations where this story was told, the health professionals agreed that this was inappropriate and untrustworthy behaviour. Furthermore, the nurses had observed that healthier habits had entered the clinic with GGG.

“[W]e all gradually began to change our diet [...] and we talked about how we were standing there in the supermarket doing our grocery shopping and reading fat content and I don’t know what – we all knew that this liver paste only had 6% fat and blah blah blah. We were looking at things we hadn’t looked at earlier. So you gradually get influenced, when you sit there, day in and day out, and talk about it.”(FGD, Nurse 2)

Not only did the nurses begin to bring healthier packed lunches and increase their physical activity in their leisure time, their workplace also began to promote a healthy lifestyle among its employees. In 2005, four years after GGG started up, Gentofte Hospital launched a general project focusing on healthy employees and healthy work life. The hospital formulated a smoking policy, offered smoking cessation courses, and supplied a free fruit arrangement for all employees. At the clinic, all smokers, except one, had managed to quit smoking and the employee who had not managed was “bullied in a friendly way”, as one of the nurses said. The more or less implicit expectations that the preventive work put on the health professionals regarding their own behaviour was also something that the head nurse, Margit, expressed. Although there were no official requirements for acting in certain ways in one’s private life, Margit expressed that:

“You probably need to be a little ‘green’ to continue to believe in it, right, also in your private mindset. So you

can say that this [affects] the kind of staff we hire and who is to work here [...]. I actually believe that it is a little necessary that you believe in ‘the good cause’, in ‘the preventive’, in ‘the healthy’, right. Because if you in your own lifestyle don’t believe in it and think it’s great to drive around in a petrol guzzling car and always take a new plastic bag in the supermarket and don’t care about smoke, noise and fumes, then I don’t really know whether you can honestly go into it [...]. It’s part of the discussion, where do you have to be in all this [i.e., what is required when working with prevention]?”

She said that perhaps at the preventive department at Bispebjerg Hospital (the regional role model hospital for prevention) they could put weight on such issues when hiring people, but at their clinic other professional qualities were more important; however, she believed that people who worked with prevention have to “believe that it matters” and “believe that it makes a difference”.

A general impression that nurses give regarding the preventive work is that it is an energy demanding task that implies personal involvement from the nurse in order to establish an intimate relationship with the patient, which is needed to generate information about the patient’s everyday life and translate the preventive agenda to the patient’s individual life situation and personal motivation. On occasions, this also means that the preventive work blurs the boundary between the nurse’s professional and personal responsibility, as the preventive focus draws in the nurse’s own health conduct as a condition in the preventive work. As one of the nurses said, the healthy advice was not only good for the patients with atherosclerosis, but “something that is good for us all”. However, professional responsibility is not only an issue of being held accountable for one’s own

health conduct; it is more related to the outcome of the preventive work as we shall see in the following.

RESPONSIBLE RESULTS: PROVIDING EFFECTIVE PREVENTION

One of the challenges expressed by the nurses and also by the management team is the concern about the outcome of the preventive work. Although there is evidence behind all the elements of GGG – both in terms of the recommended medicine, the effect of lifestyle issues (smoking cessation, walking therapy, and a cholesterol-low diet), and the psychological theories and methods used (Motivational Interviewing) – the outcome of the single patient case and preventive course is highly unpredictable in terms of which lifestyle changes patients engage in, to what extent they are able to achieve them, and the effect it has on their condition. Patients who do not seem very motivated come back and report that they have made radical changes. Others who express a great will and have started on new healthy habits may fall back into old habits. Relapses are expected, nurses say, and refer to the Wheel of Change model (see Chapter 6) and behavioural change is understood as a continual process. Despite this processual understanding of behavioural change and the expected unpredictability of the behavioural change process, nurses still hope that patients succeed in concrete lifestyle changes and express great excitement when their patients are able to make lifestyle changes. One of the nurses said during the focus group discussion:

“I had this patient yesterday, where I thought, oh well he’s always a bit passive, and then suddenly he said: ‘I quit smoking April 1st.’ ‘Okay, and how’s that going?’ and it makes me happy, I think it’s super, that’s a success [...] that’s the whole point: Eliminating these risk factors of atherosclerosis [...] if you can do that, then

it's a success for the patient and the nurse!" (FGD, Nurse 1)

Although the purpose of GGG is often articulated as "providing knowledge, so that the patients can make their own decision regarding their lifestyle", and that the programme does not formally define lifestyle changes as a success criterion, many of the nurses still express that they would like the patients to transform their knowledge into preventive action. One of the nurses said that she leaves "invigorated" from the preventive conversation when she experiences that:

"[T]hey have really listened and acted. When you can see that they have reacted on several areas, then you think 'YES, damn it, it worked somehow!' After all, they did change some things and without it being a violent intervention in their way of life, right? Those things, that's the fun part!" (FGD, Nurse 2)

In this quote, the nurse states that she would like the patients to take the advice given to them, but at the same time, she also expresses that she is concerned about whether her counselling is perceived as too intervening in the patient's life. Another nurse described the difference between informing about prevention generally and having a patient enrolled in the GGG.

"As soon as you have them enrolled in the preventive outpatient clinic [GGG], then there's an expectation, in some way or the other, that they should achieve something, get healthier. That is at least what I would like [laughs]. And if they don't, well that's also alright, but *I* would really like them to get themselves together, give them that chance to make a decision and be aware

of it, so it requires more resources [from me], I think.”
(FGD, Nurse 3)

Later in the focus group discussion, one of the nurses said that it was draining not knowing what the preventive work they engage in actually results in for the individual patient.

“Sometimes I think, well, how much does it actually matter when they leave?” Backed up by another nurse who described that there was a risk of becoming “worn out” if the work they put into it does not have an effect, “they must feel, that damn, they get something out of it, those who come” (FGD, Nurse 2).

On the one side, the nurses explain that there is no formal criteria about the patients having to succeed in their lifestyle changes, but nevertheless, the cases where patients manage to change their lifestyle is experienced as great successes and motivates the nurses in their preventive work. The successful lifestyle changes become examples that the preventive effort makes a difference and that the work, which the nurses put a lot of effort and energy into and which requires that they “use themselves”, is not wasted. Parallel to that, it is wearying and demotivating when patients are not able to transform the counselling into concrete lifestyle changes, and this produces questions of self-blame regarding the nurse’s responsibility: Did I convey my knowledge in a good way without moralizing and was it relevant for this patient? Was it my fault that the patient rejected the tenets or was I too directive in my approach? Although the pedagogical approach of the GGG programme is based primarily on distributing preventive responsibility to the patient, the methodology of Motivational Interviewing also states that the counsellor bears a responsibility in terms of

facilitating the patient's self-defined motivation. In relation to the issue of "Resistance", which is one of the key concepts in Motivational Interviewing, it is, for example, stated in the internal educational report that:

"Resistance in the conversation with the patient will emerge by patients reacting defensively and arguing for his behaviour. Resistance will often emerge if the patient feels pressured to change. Resistance blocks dialogue and understanding of the problems and it expresses that the counsellor has misinterpreted the patient's readiness and is not attentive regarding where the patient is in the change process. In order to proceed, the counsellor must attack the problem from another angle." (Internal Report 2002: 14)

In these terms, the patient's lifestyle changes not only become an issue of their own evaluation and choice, but also a matter of how the nurse manages the pedagogical task of facilitating this. The outcome of the preventive work is, in this sense, not only dependent on the patient's choice, but also closely linked to the nurse's competencies. In this sense the programme depends on the nurse's personae as a social technology, which stimulates the patient's motivation, but which has to be regulated so that it does not overstimulate and thereby impose a motivation from the outside.

The focus on prevention's measurable outcome, as we saw in Chapter 4, is part of the general mobilisation of prevention within the vascular specialty. As one of the nurses said regarding the issue of how to maintain motivation for the prevention work:

"When we hear our boss get up and say that new stud-

ies show that it works and it helps especially in relation to operations, that already after two weeks of smoking cessation together with the start on statins that there's a reduced risk, so in that way it catches us again and then it makes you want to work with it, right." (FGD, Nurse 4)

Also, in the various presentations about GGG at conferences and education sessions, the kinds of results that are presented foreground the measurable effects of GGG generated with data from the GGG software: For example, that GGG has increased the level of patients receiving adequate medical treatment (number of patients in anti-platelet treatment rose from 27% to 84% and cholesterol-lowering medicine from 63% to 87%) and consequentially reduced cholesterol levels, where the total cholesterol mean was reduced from 6.2 to 4.9 mmol/l and the LDL mean was reduced from 3.9 to 2.6 mmol/l (Sillesen et al. 2007). This focus on the more "hard facts" in the GGG software was described as "political", as one of the nurses said, and she explained that it was important to document that patients were getting the right medical treatment because it can be related to other grand studies that show that the mortality rates go down by 40% just through patients getting the right medicine. But there was also an interest in the measurable outcomes regarding the lifestyle parameters; another nurse said:

"We've been asked, 'Can't you pull out some number? Can't you show [...] how many have quit smoking?' [...] but there might also be cases where they have gone from 30 to 10 [cigarettes] and that doesn't show, so we know that there might be something more to it than what the numbers can show." (FGD, Nurse 5)

In the study from 2007, the numbers on smoking cessation showed a success rate of 12.5%, which was perceived with disappointment: In the article, it is stated that this required improvement. In a later interview with the managing surgeon, Henrik, he also lamented this outcome: “We have the same gloomy effects on that area as all others”, and he explained that the difficulty of getting people to quit smoking was not only a local issue within the GGG programme, but a general problem. In another attempt to measure the effects of GGG on other parameters than biomedical values, the nurse specialist Marie had in 2003 initiated a survey that measured patients’ knowledge before and after the GGG conversations. Due to inadequate responses, the findings had not been statistically significant and could thus not conclude on this issue.

The focus on measurable outcomes and the difficulties of showing these, both due to the limitations of the GGG software but also due to the unpredictability of the course of the preventive consultations, sometimes made it difficult for nurses to mobilise strong arguments for GGG compared to the effects of surgical treatment. This came up, for example, during a joint evening meeting for nurses and doctors. Among other issues, the various research projects that were being conducted at the clinic were on the agenda and were presented. One of the new projects was presented under the title “Is our approach to claudicatio intermittens too conservative?” The presenter explained that new findings showed that the durability of surgical intervention based on a new surgical procedure had very good outcomes and were more durable, which posed the question as to whether the treatment offered at the clinic was too “conservative” or whether more surgery should be done in order to improve peoples’ lives apart from “just talking to them and handing over brochures about lifestyle changes.” Several nurses were alarmed about the presentation of the preventive work at the clinic

as 'just handing over brochures', which they felt did not do justice to the comprehensive work that had been put into developing GGG and the actual work that was performed in the GGG consultations. They were also worried about the way that prevention was portrayed as an 'alternative' to surgery. Their fear was that the presentation reflected the attitude of a broader group of doctors and that the project further spurred this understanding of GGG.

The concern for showing the effects of GGG in terms of measurable outcomes and actual lifestyle changes was, however, not the only kind of legitimization of the preventive work. When claims of effectiveness failed, other purposes with GGG were articulated, such as ensuring patient autonomy, as I focus on in the following.

RESPONSIBLE RESPONSIBILIZATION: ENSURING PATIENT AUTONOMY

Besides the value of effectiveness, nurses also expressed the value of patient autonomy in relation to the preventive work. This value was expressed by Margit as a concern regarding the "power relations" between health professionals and patients (as described in Chapter 4), which was a popular debate that started in the 1980s and especially in the 1990s, where the academic development of the nursing profession in Denmark took an especially pedagogical turn. This value came across on various occasions; one nurse expressed directly that she was "very much into patient autonomy"; others expressed this value in other terms, expressing a wish to distance themselves from "former paternalistic approaches", "finger-wagging", and "ear-pulling". One of the nurses said in the focus group discussion that she was not occupied with the ambition of whether or not the patient made lifestyle changes, but expressed that the most important part for her was to describe the health benefits that the patient could achieve by engaging in different lifestyle changes and if a patient then chose to continue

smoking despite the information provided about its harmful effect, she could still “be happy” for that patient and say:

“You know what, you’ve made that decision and you have to live with it. And if what I tell you can’t make you quit, then it’s fine with me’ [...]. The success criteria can be very different [...] you go through it with them and then they say, ‘I have made that decision – that is my [sense of] life quality’.” (FGD, Nurse 4)

However, in the preventive consultations, the upholding of this ideal of letting the patient’s own understanding and sense of life quality override biomedical advice was difficult, as the following example shows.

After a consultation, Lotte expresses that she is impressed with the progress that her patient, Jørgen, a patient in his seventies, has made. In the consultation, he had stated that “they” (the health professionals) had told him to quit smoking and go on a diet, which he had then done and with great success, managing both smoking cessation and weight loss, which was uncommon, as smoking cessation normally increased the patient’s weight at least in the beginning. Despite this success, she also says that one of the difficult parts in the conversation is how to convey the health recommendations without being too authoritative. “You have to be careful that it doesn’t turn into finger wagging. Really you want to say ‘you should do this’, but the ‘should’, you really don’t want to say that”. She says that it is difficult to keep to the ideal of “you decide what you want to do”. Some of the issues like alcohol, she says, “it sounds so self-righteous”. In the conversation, she had asked about Jørgen’s alcohol intake. He had

told her that he had almost not touched alcohol while being on diet, which she had confirmed was probably also a part of why he had lost weight. Furthermore, she had explained that alcohol often leads to an urge to smoke and that it was wise that he had kept away from it due to his smoking cessation. But, she had added, a glass of wine a couple of times a week was no harm, "it also has to be a bit nice and cosy". She reflects further on the consultation and the way Jørgen had expressed that he "was told" to lose weight. "I feel totally bad that he doesn't eat anything! What on earth did I say the last time?" Jørgen had told her that his diet had consisted of oatmeal in the morning with a banana, crisp bread with cucumber and tomato for lunch, and rye bread with cucumber and tomato in the evening. She had told him that it would be good for him to add some protein for his muscles such as some low-fat meat or fish. Jørgen said that he could only eat fish if it was coated in breadcrumbs and fried, which she had told him was not a healthy choice and which he already knew and therefore had abstained from. Now after the conversation, she expresses doubt about her strict attitude and advice: "Should I have told him that it's alright to fry that fish? But no, in principal it is unhealthy!"

Both during the consultation and in the reflections afterwards, Lotte was juggling with the way to convey the healthy recommendations without being too directive or authoritative and also to what degree she should support Jørgen's preventive engagement. Did the fried fish compromise his preventive efforts and healthy engagement in losing weight or could the fried fish be understood as part of the pragmatic and realistic attitude that meals also had to be "nice and cosy" as she stated regarding the wine.

Other nurses also experienced the difficulty of finding a balance between the two values, because the GGG consultation still included a range of clinical measurements, as one of the nurses said during the focus group discussion:

“It is sometimes difficult, that you are not supposed to be an expert, but have to be the patient’s ally [...] but then you sit there and measure the blood pressure [...] then you’re very much the expert when you are doing those clinical things, that is something that I alone can do, not the patient, it’s only me who can read the numbers and then you cannot avoid being the expert”.
(FGD, Nurse 6)

Furthermore, there might also be expectations from the patients about nurses being experts who provide clear-cut, unambiguous advice about what is best to do or even expectations about professionals fulfilling the role of disciplining authorities (as the examples in Chapter 7 described), which complicates the value of ensuring patient autonomy. In the focus group discussion, one of the nurses expressed that in order to keep up the motivation for the preventive work, it was important to emphasise that the GGG consultations were not just about achieving measurable lifestyle changes but that other values were also upheld. She said:

“It requires that somebody set up some guidelines, so that you don’t feel that it’s a failure if it isn’t every single [patient] that quits smoking. That there is a frame you can work within so that the expectations aren’t too high regarding what it is you ought to achieve and what is possible.” (FGD, Nurse 3)

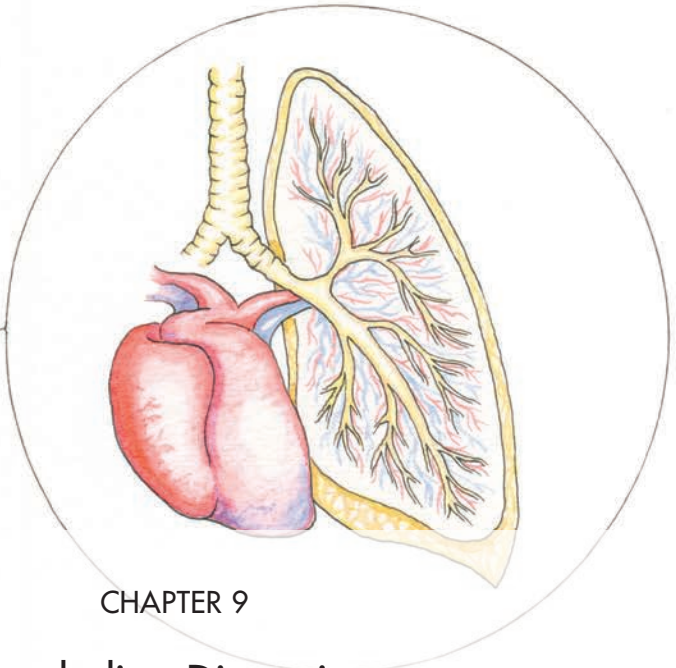
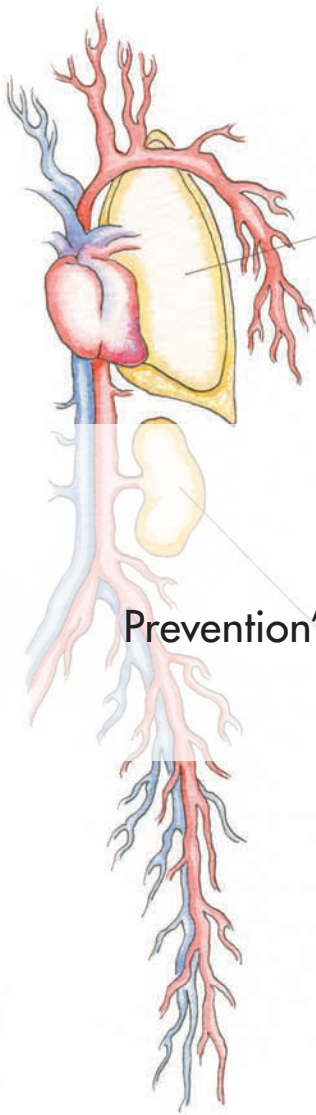
SUMMING UP

In this chapter, I have described what I term prevention's back-flow in terms of the thoughts and opinions nurses articulate regarding the preventive work and experiences from the preventive encounters with patients and thus the effects that the patient-centred preventive work has on the nurse's understanding of professional responsibility. First of all, nurses articulate that patient-centred prevention is a demanding task which requires a certain involvement and attention and which differs from other clinical tasks. The work also implies a higher degree of personal involvement, which at times also puts focus on the nurse's own health conduct and blurs the boundary between her professional and personal responsibility. Besides this understanding of prevention as a more personally demanding task, patient-centred prevention is also complicated because of its contrary values, which on the one hand emphasise prevention's measurable outcomes according to biomedical understandings of health and on the other hand stress the importance of ensuring patient autonomy and the patient's right to choose how to live, whether healthy or not. These values therefore imply different, and at times, conflicting conditions for professional responsibility in preventive work.

As such, these contradicting values and the challenge of balancing them are not exclusively tied to the preventive work but relate to a general challenge within nursing. As described in Chapter 4, the preventive work and the GGG programme were part of the "nurses' fight" in terms of the struggle to claim more clinical responsibility and enhance their professional status vis-à-vis their colleagues, the doctors. Here, the documentation of the preventive work that the GGG software enabled played an important role in accounting for and legitimizing the preventive work. However, as it turned

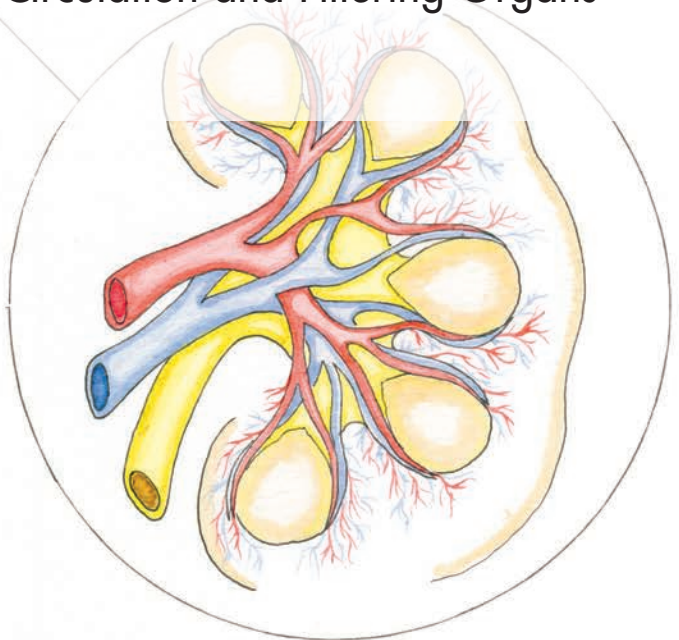
out, the documentation of prevention, which the GGG software enabled, rendered especially some outcomes of the preventive work visible, whereas other aspects of the preventive work still remained invisible. Here, patient autonomy can be understood as a legitimizing value, which can be mobilized when the preventive work fails to prove measurable outcomes.

Taking up the vascular system, it might then be suggestive to think of these values of effectiveness and autonomy as filtering organs that sort the experiences of the preventive work in different ways, either in terms of measurable outcomes or concerns regarding patient autonomy. These values, however, seem to be in conflict with each other at times and thereby imply a prioritization of that value which is the most important to uphold and to evaluate the preventive work in relation to. But are these values the only options to evaluate prevention according to? Or, may there be other filters to pass prevention through? This issue is taken up in the concluding chapter.



CHAPTER 9

Concluding Discussion: Prevention's Circulation and Filtering Organs



Concluding Discussion: Prevention's Circulation and Filtering Organs

INTRODUCTION

In this thesis, I have explored the practice of patient-centred prevention and its formulated ambition to improve healthcare in both ethical and effective terms. By involving patients to take a more active role and responsibility in their treatment, it is argued that healthcare not only becomes more ethical, as patients' personal values, conditions, and opinions are taken into consideration, but also that this results in better outcomes and provides more effective healthcare. In this thesis, I have followed these ambitions by looking at how they are practised in a specific preventive programme within a vascular clinic in Denmark. My objective has been to explore how preventive capacity and responsibility is built and distributed among health professionals and patients in socio-material relations. The distributing of preventive responsibility, I have shown, is not unidirectional, extending from the healthcare system to the patient, but one that circulates across the clinic/home boundary and thus flows back into and affects the healthcare system and its professionals. Patient-centred prevention may to a large degree delegate preventive responsibility to patients, but it does not absolve the healthcare system's or the professionals' responsibility. On the contrary, the patient-centred approach requires organizational and professional participation and sets specific conditions for managing this.

The time has come to summarise across the chapters and to point out what effects the implementation of patient-centred prevention within the vascular specialty had for its patients and professionals.

After this summary, I engage in a discussion regarding the ideals of autonomy and effectiveness, according to which prevention is articulated and evaluated. In this discussion, I draw on the image of the ‘filtering organs’ that connects to the vascular system and which cleanses the blood as it circulates. I describe prevention’s ideals as such filtering organs, which cleanses patient-centred prevention in specific ways by redistributing some qualities of the preventive work while discharging others. In the discussion, I argue that the ideals of autonomy and effectiveness are inadequate to discuss and evaluate prevention according to the way that it is being practised. I thus propose that other ideals, or filters, may be formulated in order to provide other understandings and criteria for evaluation of the preventive work. After this discussion, I point to this thesis’ contributions in relation to two different groups of audiences: One is to the ‘practice-oriented’ field of prevention and health promotion, which include a range of disciplines and epistemological traditions. Here, I argue that ANT’s material semiotics provides an analytical approach and empirical findings that expand on the dominant social and psychological understanding and problematisation of prevention and health promotion. Furthermore, I discuss the governmentality-inspired critiques of health promotion and prevention, which have had a major influence on the critical thinking among the field’s practitioners. The critiques formulated within this tradition contend that neoliberal forms of government, such as the patient-centred approach, transgress the public/private boundary by installing public health objectives in individuals’ self-understanding. This, I argue has become a somewhat normative critique, which the findings of my study unsettles to some degree. The second audience to which this thesis contributes is the field of STS, especially regarding the debate among different analytical versions within the ANT-approach. Here I argue for the constructiveness of combining the two approaches. In relation to this, I discuss my use of the vascular system as an ana-

lytical imagery that combines the two approaches and I evaluate the productiveness of the vascular system as I have evoked it throughout this thesis.

CAPACITIES AND RESPONSIBILITIES IN PATIENT-CENTRED PREVENTIVE WORK

The GGG programme that I have studied reflects a widely adopted approach within recent prevention and health promotion initiatives in Denmark, which emphasise the importance of organizing healthcare according to the patients' conditions and personal wishes and motivations. The aim of this preventive intervention is to inform patients about the relations between their lifestyle factors and their disease and thereby provide patients with the knowledge with which they can make their own decisions regarding their lifestyle. This clearly points to the patient as being the main bearer of responsibility in the preventive work. However, in my study of the various preventive practices that the GGG programme consists of, it is clear that this distribution of responsibility to the patient does not absolve the professionals from responsibility.

Although the patient-centred approach appoints the patient as the main bearer of responsibility, questions regarding who should work with and take responsibility for the preventive tasks – which approaches, techniques, and methods to use to enable patients to make healthier choices, as well as which criteria to use for evaluating the outcome and quality of the preventive work – are all questions which involve the professional and which put professional responsibility at stake in different ways. This professional responsibility in patient-centred preventive work includes formal and legal issues, for example, in relation to the prescription and management of medication. It also revolves around issues such as how to be accountable (answerable, reliable, or dependable) for the preventive work and its outcome. This

means, for example, showing responsibility in relation to using effective methods in the right way and ensuring that all relevant patients are offered the same preventive treatment. Furthermore, responsibility in patient-centred prevention also regards how to ensure an ethical relationship with the individual patient to ensure patient autonomy.

The Patients' Preventive Capacities and Responsibilities

As already described, a key ambition in the preventive work is to assign patients with more responsibility in terms of improving their health status. This responsibility is defined according to specific measures and ideals. In the GGG programme, the patients' responsibility relates to the preventive capacities that patients are educated in and thus constructs the frame within which they can take responsibility and appear responsible. GGG thus puts up certain conditions for practising responsibility. This rests on biomedical understandings between lifestyle and disease and also psychological theories and models where patients are educated in understanding and working with their personal motivation in relation to engaging in preventive activities. I have shown that both nurses and patients engage in this translation work between biomedical and psychological knowledge on the one side and the patients' practical everyday lives, concerns, and experiences on the other. Thereby, I have demonstrated how preventive capacity and responsibility is built up according to biomedical and psychological knowledge but supplemented by a practical knowledge form, which enables distribution of the preventive agenda into the patients' home spaces and routines (Chapter 6).

In the GGG programme, patients get to know their bodies, their mental motivation, themselves, and their home environment in ways that are specifically related to the preventive agenda. By acquiring this knowledge and practising the capacities that these pro-

duce (in terms of evaluating, deciding, and handling their condition and prevention), patients are assigned with a specific responsibility according to these knowledge forms. At the same time, the patient-centred approach and its call for individual definition and decisions regarding health conduct also ascribe patients with the responsibility to individually define and act upon their 'own' motivation. This means that patients both become responsible for following biomedical recommendations *and* are assigned responsibility to critically assess and make their own individual choices.

However, I have also shown that biomedical and psychological knowledge are not the only rationalities that patients practice prevention according to. I have more specifically shown that patients also redefine the purpose and the responsibilities that GGG assigns them: They require professionals to act as disciplinary authorities, give clear-cut expert advice, and provide surgical interventions. Thereby, they do not only subject to the responsibilities that GGG assigns, but also redirect the preventive responsibility to the health-care system and its professionals (Chapter 7).

The Professionals' Preventive Capacities and Responsibilities

With the introduction of prevention into the vascular specialty, we see that the object and approach of the specialty expands and assigns new tasks and responsibilities for vascular surgeons and nurses: From primarily taking care of vascular patients' acute conditions and performing surgical intervention, the specialty begins to include preventive and health promoting tasks that include medical treatment and therapeutic lifestyle-oriented conversations. By expanding its scope and approach, the specialty not only deals with acute bodily dysfunctions, but takes on a new responsibility for the entire vascular patient pathway. This new responsibility is initiated by new knowledge about the effect that preventive treatment has

on patients with atherosclerosis; it is further spurred by a political focus on the vascular patient as an overseen and insufficiently treated patient group; and it is further motivated by the challenges that the vascular specialty is facing due to developments in surgical procedures, which means that vascular surgical procedures are progressively being taken care of by a competing specialty, radiology. Taking responsibility for the patient pathway and including the preventive treatment requires new capacities within the specialty. This includes a range of organizational matters such as how to integrate prevention into existing clinical tasks and routines; deciding what kind of responsibility the professionals within the specialty are to take on in the preventive work; defining what preventive offers should include and how to upgrade the professionals' competencies and skills to meet these demands; and defining the measures according to which the preventive treatment should be evaluated.

The Doctors' Preventive Capacity and Responsibility

Although doctors are not the primary professionals to take care of the preventive conversations, they are still assigned with the responsibility for legitimizing the preventive treatment, prescribing preventive medicine, informing patients about the relationship between lifestyle and disease, and referring patient to the preventive consultations and generally supporting the preventive tasks that the nurses take care of. Although doctors do not perform GGG conversations, their preventive capacity in terms of their attitude, focus, and interest – or lack thereof – influences the preventive work in different ways, that is, in terms of the number of patients enrolled and the status of the preventive work in the clinic. In Chapter 4 we saw how the doctors were enrolled in the preventive network by different acts of persuasion that included the consideration for the overlooked vascular patient, prevention's positive impact on surgical durability and ultimately as a necessary task to ensure the secure

the challenged specialty. Despite this initial mobilisation, which led to the integration of prevention within the vascular specialty, we also saw in Chapter 5, that doctors' neglecting their referral responsibility. This was managed by a new referral procedure, which the charge nurse managed, and which thereby bypassed the 'occluding' doctors. By directing more preventive responsibility to the nurses, the original ambition to involve doctors in the preventive approach was thereby further diminished.

The Nurses' Preventive Capacity and Responsibility

For nurses, who are given the main task in relation to the preventive work by conducting the GGG consultation (and later the Prevention Conversation), their preventive capacity and responsibility are practised in two different settings: The first setting regards their formal responsibility within the clinical organization, and the second setting regards the preventive consultations and the relationship with the patients.

With the introduction of prevention into the vascular specialty and, more specifically, the development and implementation of GGG, the nurses' clinical responsibilities expand. This is brought forward by a professional interest in expanding the professional domain and responsibilities of nursing and advancing the professional status and competencies. Prevention becomes an area that they are in charge of, requires new competencies, and implies a new role in the clinic. This new task, however, also comes with a demand for the legitimization the nurses' new responsibility and the preventive work. This entails a close documentation of the preventive work in order to monitor the preventive work and ultimately show the effect of prevention according to the parameters which have been formulated. Although the purpose and general effectiveness of preventive treatment has been established and the positive outcome of medical

treatment and smoking cessation has been proven, the local preventive effort in terms of the GGG programme and especially the outcome of the lifestyle oriented conversations between nurses and patients is difficult to demonstrate and thus challenges the status of prevention and the nurses' work on this area (Chapter 5).

Furthermore, the new preventive tasks also imply a new kind of responsibility vis-à-vis the patient. The issue of the patient's lifestyle sets up certain ethical considerations regarding how to intervene into patients' private lives, personal opinions, choices, and ways of living. Most apparent, the patient-centred approach articulates a responsibility for ensuring that the patient's particular circumstances become the basis for the preventive work and that the patient's fundamental right to choose is ensured. In the nurses' accounts, this type of responsibility is especially articulated as a concern for not appearing paternalistic, authoritative or moralizing and for not transgressing the patients' limits, privacy, and personal values. In Chapter 6 and Chapter 7, we saw how the preventive encounters between nurses and patients unfolded. We saw that in order to distribute prevention to patients' everyday lives at home, the consultations required openness in terms of informative patients that could provide knowledge about their everyday life and thereby make it possible for nurses to translate the preventive recommendations into everyday practicalities. However, we also saw that the openness of the consultations challenged the nurses' work as a range of unexpected issues, expectations and demands were formulated by the patients and which put nurses' professional responsibility at stake.

In addition to the above responsibilities related to the organizational, the professional, and the interrelationship with patients, the patient-centred preventive work also implies new considerations regarding nurses' personal responsibility for their own

health conduct and their appearance as healthy role models in the preventive work. Although there are no formal criteria for their health-related appearance, nurses express that working with prevention and lifestyle issues also influences their own health-related conduct and poses questions regarding their professional responsibility to display a personal healthy appearance and lifestyle.

SUMMING UP

The empirical chapters in the thesis has shown that the implementation of prevention into the vascular specialty challenged the logics, procedures and values in the field and defined new demands for its professionals. The implementation of prevention was managed by a range of strategies that in different ways mobilised the professional groups according to their concerns and interests. Despite the effect of these strategies, the analyses have however also shown that prevention within the vascular specialty require a continual and practical translation, which not only has to relate to the motivations of the specialty's practitioners, but also needs to adapt to the developments and changes within the healthcare organization. In the lifespan of GGG, the focus on prevention has been intensified, among other things by legislation such as the Smoking Law and the structural reform, which has delegated the task of prevention to the municipal organisation. The preventive work at the hospitals has thus changed since GGG started and the GGG programme has also been phased out since 2012. The preventive work that is being done at the hospitals focuses on information on KRAM factors, including the documentation hereof. We see that the preventive objective has generally been distributed, but we also see that the local programme and its ambition to offer more than mere information – by working in a closer, processual and individualised way with the patients – has been replaced with standardised health information at hospital level.

THE VALUES OF PATIENT-CENTRED PREVENTION AS FILTERING ORGANS

In Chapter 8, I described what I proposed to be the main filtering organs within patient-centred preventive work; namely, the two dominant values – autonomy and effectiveness – in relation to which the preventive work is discussed among the nurses in the vascular clinic. Although these values coexist, they are not easily combined, for example, when patients choose to exercise their autonomy in unhealthy ways and continue an unhealthy lifestyle according to the categories that the GGG programme proposes. This incompatibility of the two values poses a general challenge to the preventive work as expressed by the nurses in Chapter 8.

The values of autonomy and effectiveness form specific and different criteria for evaluating the preventive work. The value of effectiveness evaluates the patients' ability to comply with the recommended health behaviour: taking medicine, abstaining from smoking, following a low-cholesterol diet, and exercising daily. The value of autonomy evaluates the preventive treatment by other parameters, which revolve around ensuring the patient's right to choose and independently identify personal motivation for changing or maintaining his lifestyle. These two values are clearly articulated by the nurses and in written descriptions of the programme and, furthermore, they are clearly embedded in the various sociomaterial practices of prevention. The value of effectiveness is enacted through different technologies, such as scanners, scales, and software, all of which enable the measuring, registering, and monitoring of specific parameters. The value of autonomy is practised through different pedagogical strategies, such as Motivational Interviewing, and psychological theories and models such as the Wheel of Change and the Balance-diagram, through which the pa-

tient's individual choices and motivations are enacted.

The two values imply different understandings of preventive capacity and responsibility. Within a value of effectiveness, which builds on the biomedical knowledge form and evaluation criteria, preventive capacity becomes an issue of patients' rational reasoning – of understanding the correlation between lifestyle and its impact on the disease and the possibility of acting upon this knowledge. Preventive responsibility is thus placed with the professional and her ability to communicate this knowledge to the patient in an understandable way and to apply methods in the correct manner, which point at the specific capacities that are required of her. Within the value of autonomy, preventive capacity rather becomes a matter of patients' choices between options and evaluating pros and cons according to individually defined values (which may or may not include biomedical criteria). Here, the preventive responsibility is thus placed with the patient and becomes a matter of his will to live according to the healthy recommendations or to live according to other values and understandings of health and 'life quality'.

Although these two values are articulated regarding the preventive work, they are not the only values that are practised in the preventive work. In the preventive encounters between nurses and patients, other practices take place, which are difficult to categorise under the values of autonomy and effectiveness. In Chapter 6, we come across examples where we might ask whether patient autonomy is ensured or manipulated. In Chapter 7, we come across examples where the value of effectiveness is compromised by the patients' reformulation of the programme and the nurses' acceptance of this. What we see, however, is not only the failure to live up to these values; rather, I would argue that we see that prevention is practised according to other values. We see that nurses be-

come engaged in patients' preventive developments because the GGG programme implies more conversations and regard issues that enables a more intimate relationship with the patients. We see that nurses use their knowledge about the individual patient to suggest practical ways to translate healthy advice into everyday routines and situations at home and if these suggestions fail, then the adaption of the advice into something more realistic. If smoking is what keeps the patient from falling asleep while working as a truck driver, then smoking cessation might not be the healthiest advice and other preventive activities might then be more suitable. If total smoking cessation is not possible, then a reduction of cigarettes is still a good thing, although it is not as effective as total smoking cessation. If the patient is not able to walk according to the recommendations, he is praised for his other efforts. This modification of the preventive intervention is one that fits poorly with the value of effectiveness, which evaluates according to set criteria. We also see that the preventive consultations are used for other purposes such as to maintain contact with needy patients, who would normally have been discharged to ensure that 'somebody' looks after the patient. And we see how nurses also exercise finger-wagging because they "want what is best" for the patient. How can we understand these practices, which do not align with the values of effectiveness or autonomy?

In Annemarie Mol's book *The Logic of Care: Health and the Problem of Patient Choice* (2008), she argues that such practices may be thought of as a logic of care. In the book, she critically discusses the predominant ideal of 'choice' within healthcare, both formulated in healthcare politics and among healthcare practitioners. Her overall argument is that the celebration of choice in healthcare happens at the expense of other values, such as 'care'. Based on the observations of the healthcare practices at a Dutch diabetes clinic, she illus-

trates the collaborative and continuous effort to attune knowledge and technologies to the patients' diseased bodies and everyday lives and argues that the ideal of choice is inadequate to understand this practice. The task that Mol engages in is to make explicit the logic of the practices she observes and thus to "make words for, and out of, practices" (Mol 2008: 8). The term "logic" refers to the rationality that is implicitly embedded in practices and elucidates what is appropriate to do in specific sites and situations. Her description of the logic of choice resembles what I have described as the value of autonomy. Similarly, the value of effectiveness may be compared to what Nielsen and Grøn (inspired by Mol) define as a 'logic of change' which they use in their analysis of the Chronic Disease Self-Management Program (Nielsen & Grøn 2012). In their analysis, Nielsen and Grøn critically point to the standardized trajectories of change that the programme entails. In a similar way, the GGG programme also sets up, perhaps not set trajectories of change, but certainly change categories to evaluate the programme's effects by.

The logic of care comes across in Mol's descriptions of different practices and points to the compromises, adaptability, continuous effort, "tinkering", and situational balancing of various values and outcomes in clinical practices as characteristics of care. I have also made similar observations in my material, which point to practices that do not correspond to the values of autonomy or effectiveness, although these values come across very strongly in the nurses' articulations and the various materializations within the clinical encounter. Mol's characterization of a care logic provides other criteria for evaluating the preventive work. Mol describes the logic of care as 'fluid', as it does not set up set criteria such as the logic of change, but rather is characterized as "a sticky combination of adaptability and perseverance" (Mol 2008: 79). Because the majority of today's illnesses are chronic, care does not have health as its final goal, but

rather ‘a good life’. This ‘good life’ is not static, but continues to change, and care should therefore be praised for its adaptability and ability to compromise, instead of striving for values such as effectiveness according to set criteria, as she states. In another place, Mol also argues that instead of *proving* the effects of healthcare practices, healthcare research should instead focus on *improving* healthcare, by developing methods that do not merely evaluate healthcare according to pre-set standards of *effectiveness* but strive to investigate the various *effects* that healthcare interventions have (Mol 2006: 405).

However, the logic of care is not without its own problems; she writes: “That there are no fixed variables in the logic of care generates the possibility of fluid adaption, but it also implies that there is nothing fixed to hold on to” (Mol 2008: 92), and this issue is specifically part of the frustrations that the nurses in my study articulate in Chapter 8. Although care practices form part of the preventive work, the values of autonomy and effectiveness primarily form the conditions for evaluating the preventive work. This means that the unpredictability, compromising, and adaptability that occur in the preventive encounters and in the individual preventive courses are not perceived as a value or criteria for evaluating the preventive work, but rather are perceived as frustrating failures – to draw on the image of the cleansing function of the filtering organs, some aspects of the preventive work are cleansed and re-circulated, while others are discharged as waste.

Bringing in ‘care’ as another filter may provide other criteria for evaluating prevention. However, it is unclear in Mol’s account what ‘care’ more precisely implies. One could argue that ‘care’ is just as insufficient and problematic as the values of autonomy/choice and effectiveness, and, one could also critically question, whether autonomy and effectiveness are un-caring values. At least it requires a deeper knowl-

edge about 'care' and its history and theoretical grounding within the nursing tradition to engage deeper in this debate. What I would instead argue at a more general level is, that we should not rely on any values uncritically, but be observant of alternative ways of perceiving, ordering and evaluating and adding these alternative filtering organs.

THE THESIS' CONTRIBUTIONS

Contributions to the Field of Prevention and Health Promotion

The field of prevention and health promotion is approached both practically and theoretically by a range of disciplines such as public health, nursing, health pedagogy, anthropology, and sociology with each being involved in different debates, practices, and theorizing towards different objectives. Within this field I formulate two contributions. The first is to point to the analytical approach of ANT, which generates empirical findings that expand the existing conceptualisation and understanding of prevention as a social and psychological phenomenon. It draws attention to prevention's practical, material, and mundane distribution into everyday arrangements. The other contribution is aimed at unsettling what has become a somewhat settled critique within the field of prevention and health promotion, represented by governmentality-inspired studies.

Adding Actors and Expanding the Vocabulary

In the introduction, I showed how the patient-centred approach was formulated as an ethical and more effective alternative to a professional-centred approach, and which formulated a break with the traditional biomedical understanding and associated rationalist approach to healthy behaviour change. The patient-centred approach builds on the patient's individual values, understandings, and circumstances in its treatment and care, and it acknowledges that the biomedical explanation between lifestyle and disease is not

the only motivation for the way a person lives his life. Within prevention and health promotion work, which strives towards improving the individual's lifestyle, the issue of motivation is pointed to as being central for lifestyle changes, where Motivational Interviewing, within the Danish healthcare system, has become a widely used method for this. The psychological theory on behaviour change, which forms the backdrop of this approach, especially points to personal motivation as a key factor for successful behaviour change. Personal behaviour is here understood as an 'internal' matter (the patient's own opinion and wishes) rather than an 'external' matter (surrounding societal, cultural, or other individuals' opinions and wishes). Focus is thus placed on the individual and a psychological approach (and to a certain degree a social approach) in order to understand preventive and health promoting work.

The analytical approach of generalized symmetry that ANT formulates expands this focus and adds other actors – or actants – to the analysis. In Chapter 6, I demonstrated that motivation understood as an inner capacity is combined with an external motivation that sets lifestyle changes in motion in relationships between humans and non-humans and which extends beyond the individual's mind-set. This approach implies a different understanding of responsibility. Where inner motivation is very much an understanding that places responsibility with(in) the individual patient as a choice to make, the practicing of prevention in a distributed network also places the preventive responsibility in homely spaces, things, technologies, and social relations that in various ways come to support or challenge the preventive work. By foregrounding the value of the individual, the patient-centred approach thus centres the responsibility on the patient and neglects the work and importance of a range of actors (human and nonhuman), including mundane homely practices, technologies, and social relations that include

health professionals. ANT does not offer a causal explanation to the question of why patients change their behaviour or not. Its general explorative approach to empirically investigate how actor-networks are temporarily achieved, as well as its expansive approach in terms of what to include in its analysis, teaches us that there is no general explanation, but rather that temporary success is a cumulative effect of heterogeneous relations. Ultimately, this means that the unpredictability of the preventive work is not necessarily a failure that has to do with a certain preventive programme or approach, but a general ontological premise that requires continual building, adaptability, and rearrangement. In terms of the building of patients' preventive capacities and responsibilities, we see how this not only regards intellectual reasoning, but is distributed in sociomaterial relations where mundane technologies play a role in translating motivation into practice.

This unpredictability in terms of what triggers the (temporary) preventive behaviour is exactly what the nurses articulate and get frustrated with in their work. Different explanations are given to understand this unpredictability; sometimes individual conditions are pointed out as explanations for failed preventive behaviour. Conventional sociological wisdom would talk about this complexity, and hence, unpredictability, in terms of "structural conditions" (i.e. culture, society, economy, environment, and education). However, instead of explaining and placing responsibility on and capacity within the individual actor or explaining or placing responsibility at 'structural' conditions, the ANT analysis traces the network of heterogeneous actors and actants that are involved in successful or failed preventive efforts. The purpose is not to give up by pointing to all the relations that a network order requires (and at the same time may comprise fragile points where the network breaks) and that it therefore is impossible to act. Instead, it

emphasises the continual work, effort, and tinkering that is required to keep up a network order that is constantly challenged by other network orders. As such, it gives a theoretical vocabulary for a practice that the nurses are already engaged in: Observing the mundane practices of patients' lives, their circumstances, social relations, bodily values, and the practical possibilities to relate the preventive work to in order to build and distribute prevention to patients' home life.

By describing how GGG is practised, I have attempted, as Mol describes, "to make words for and out of practices" (Mol 2005:8). This means that by studying the ways that principles, programmes, and ideals are practised, we might observe realities that are enacted differently than discursive logics and rationales. By articulating the different values within the preventive work, I have attempted to elucidate the different opportunities and limitations that each puts on the evaluation of prevention. It is not an attempt to identify the best way to practise prevention, to point to values that should guide the preventive efforts, but to point to other, already existing, values that may challenge the predominant problematisation of prevention as an issue of either effect or autonomy. Approaching prevention as a matter of care may be an opportunity to see other values in the preventive work. The call for care, however, takes us into another theoretical field, namely, that of nursing, where the concept of care not only is one of the fundamental concepts for the discipline, but also one of the most debated. This debate lies outside the scope of this thesis; however, a modest ambition is that the theoretical approach and conceptualisation that frames this thesis may contribute to the existing debate about care within nursing theory.

Unsettling a Settled Critique:

The Problematic Relationship between the Public and Private

Here, I discuss my findings in relation to common critiques in the field of health promotion and prevention, especially studies inspired by Foucault's concept of governmentality and the further development of this by various proponents. In the introduction chapter, I argued that GGG's patient-centred approach could be understood as an example of a modern neoliberal governmental technology, which governs through the mobilization of individuals' self-governing by shaping their self-understanding and conduct according to general public health political objectives and bio-medical categorization and knowledge. Foucault's understanding of power has drawn attention to the fact that modern governing does not operate from a powerful centre, but rather works in various relations which enable a "governing at a distance" (Rose and Miller 1992). Studies drawing on the concept of governmentality have critically explored how contemporary health promotion and prevention transgresses the public/private boundary by shaping the values of collectivities and individuals to fit better with public health objectives, and these studies have convincingly argued that health promoting and preventive strategies that define themselves as being 'patient-centred' and 'empowering' continue to exercise bio-medically defined understandings and values of health, albeit in more subtle ways. Although these critiques are not as high-pitched as in the early take-up of Foucault, where studies of medicine and healthcare were interpreted in more or less subtle strategies for social control (Armstrong 1983, 1995, Atkinson 1995, Turner 1997), it may, however, be argued that the critical emphasis remains in that these studies take a keen interest in demonstrating how public, global, and biomedical health objectives are installed into private, local, or lay lives at the expense of alternative understandings of

health and definitions of a “good life” (Pii & Villadsen 2013)³⁴. In my analysis in Chapter 6, I have also shown how patients’ lives and actions are translated (by nurses, patients, and various technologies) in relation to the different prevention knowledge forms that include biomedical knowledge, psychological knowledge, and also a more practical home-oriented knowledge. As such the chapter demonstrates and adds to the governmentality-inspired analyses of how public health goals reach into patients’ private lives and exercise power ‘at a distance’.

However, different counter-critiques may be voiced to these claims. One sceptical approach, often stated by anthropologists (for example, Lupton 1997), regards the empirical material that many governmentality critiques are based on, namely, discourse analysis (which aligns with Foucault’s method of historical and documentary analysis), which may regard discursive logics at a programmatic level but neglects to investigate how these discursive logics unfold in other practices. In my work, I have engaged in such an exploration and have shown that dominant discursive logics are practised in encounters between nurses and patients, but also that other practices take place. This was the focus in Chapter 7, where I drew attention to the ways that patients not only subject to the understandings and knowledge forms promoted by GGG, but also challenged the programme’s values and purpose. These observations engender another critical insight that shows how such modern governmental technologies as GGG also provide opportunities for patients to reformulate, resist,

34 A similar critique is formulated by Jensen 2010, who states that although many critical studies of healthcare refer to a Foucauldian understanding of power, they still continue to portray power as repressive, although this was exactly what Foucault wanted to avoid when he stated that, power is exercised only over free subjects who are faced with a field of possibilities which may offer several ways of acting (Jensen 2010: 123).

and redistribute tasks and responsibilities, which eschews an interpretation that views the powers of the professional health system as invasive and unidirectional. This points to the fact that (preventive) governing is not only *productive* – in that it produces certain subjectivities and truths by which we are governed and govern ourselves – but also has a *responsive* ³⁵side, in that its services (knowledge and interventions) are actively sought by patients to cure their diseases, relieve their pain, receive comfort and to learn how to handle their illness, and that patients in this quest also actively reformulate and translate preventive offers to suit their hopes and aspirations.

This perspective also forms another counter-critique against what seems to be an underlying presumption of the critical governmentality studies, namely, an understanding of an isolated subject with an inherent identity. With an ANT approach that understands actors as effects of the relations they enter, it is rather proposed that “the subject is not corrupted by the interference of ‘techniques of the self’. Instead, these techniques *grant* a self, capacity and intentions” (Gomart 2002: 520). What this approach enables us to see is that patients actively engage in the preventive programmes such as GGG because they wish to learn from and engage in relationships with the clinical staff, knowledge, and resources that may enable them to manage their condition.

Theoretical Contribution to ANT: The Vascular System as Analytical Form

In this thesis, I have evoked the form, object, and properties of the vascular system in different ways and with different purposes in my analyses. As described in Chapter 3, the vascular system as an analytical heuristic was not developed with the particular intention of

35 This distinction between a productive and responsive side to health care was suggested by my colleague Marius Gudmand-Høyer.

dissolving a hierarchical relationship between the theoretical and the empirical as proposed by some voices in the recent debate about the relationship between the two. Instead, the vascular system turned out to be both part of the theoretical resources I was drawing on and part of the empirical object I was studying and thus became an opportunity to explore this curious overlapping relationship of the conceptual and empirical.

Firstly, the vascular form has made it possible for me to hold together two different analytical approaches found within ANT. It is a form that enables both a network and fluid understanding of ontology. I have evoked it in my analyses to illustrate how prevention is practised in different ways where it sometimes takes the form of a network that holds together a range of different actors in a framed order – understood as the structure of the arterial wall. At other times, prevention takes a fluid form, in which it crosses boundaries in transformative exchanges. One of the strengths of the vascular system is its ontological complexity. It is comprised of set structures, semi-perforated limits, fluid substances, and filtering organs. This complexity enables a range of analytical possibilities for approaching prevention's multiple ontologies while still understanding how they are held together and are related. Prevention is both structured along set criteria and escapes this structure in fluid forms, depending on its different locations in the vascular system. In the organization of prevention within the vascular specialty and the health professionals, prevention is built according to structured logics and pathways that strategically connect to the stakes and concerns within the specialty. In the encounters between nurses and patients, prevention is built upon the established structures, but also transgresses these when distributed into the particular lives of the individual patients. Prevention in these locations thus has a semi-perforated structure that allows for transgression without resulting in network collapses.

The vascular system also points to the circularity of prevention's distribution. We understand that an organizational and professional practice of establishing prevention within the vascular specialty precedes the preventive encounter between nurses and patients and also that the experiences of these encounters also flow back into the continual organizational and professional building of prevention. The figure thus illustrates that prevention's movement is not only an outwards distribution from the healthcare system to the patient, but that it also has a backwards movement, affecting healthcare organization and professionals in different ways.

The filtering organs in the vascular system have been used as an image for the major values and related conditions that the preventive work is being evaluated in relation to. The values of effectiveness and autonomy work as filtering mechanisms that re-circulate some aspects of the preventive work, such as its measurable results or the political/ethical agenda of patient choice or autonomy, while filtering and discharging other practices and potential values of preventive work such as the inherent mundane, adaptive, and tinkering care practices.

Another strength of the vascular system as an analytical form is that it both relates to already established imageries within the theoretical framework and is a central object within the field of study. This makes it a common reference, which both the theory and the empirical field of study may contribute to. The theory's network-ontology (as explicated earlier) contributes to the practical field of study by expanding the analytical approach and understanding of prevention as a network, including both human and non-human actors. The theory's fluid ontology implies a multiple understanding of ontology and points to an object always being part of different coexisting networks and illustrates how an object moves and flows between different net-

works, transgressing network structures without necessarily implying a network collapse. The practical field of study may also contribute to theory with its specific knowledge about the vascular system in terms of its functions, complications, and the various vascular interventions and thereby develop the theoretical conceptualisations. However, I have not fully exhausted the analytical possibility of the vascular system. For instance, I think that there is an interesting issue of flow velocity that could point to different intensities in the preventive movement.

Overall, the vascular system has provided me with a range of productive imageries and worked as a creative heuristic in my research process. It has provided new imageries and engaged the people I have presented it to and has provoked heated discussions regarding how far to take it, its status as metaphor, analogy, or analytics, and its confusing mix of the empirical and conceptual. These discussions point at one of the figure's major strengths: It is an imagery that many different actors can connected to – in the same way that metaphors in general are part of our everyday language. Despite this productiveness and collaboration that the vascular system implies, there are also some limitations or risks in its use. Like any other theory or conceptualisation, the vascular system as an analytical figure may overshadow the empirical findings of the research so that these are arranged to fit the analytical figure at the cost of the empirical findings, concepts, and local understandings. I have therefore also tried to limit the use of the vascular system in the introductory and summarizing sections of each chapter and have used it as an organizing map by inserting images of the vascular system in-between the chapters.

I end the thesis by pointing out, that the purpose of my work is not to settle on set criteria, critiques, concepts, or analytical figures to understand, illustrate, argue or evaluate patient-centred prevention.

Instead, I propose for engaging in the possibilities that the empirical material, the theoretical resources, and their various intertwinements provide in order to stay agile in our approach to complex objects and relations. These objects continue to change and develop and implies therefore a continual development of our understandings and conceptualisations - whether these regard an empirical field such as health promotion and prevention or a theoretical field such as ANT.

References

- Akrich, M. 1992: "The De-Scriptio[n] of Technical Objects". In: W. Bijker & J. Law (eds.) *Shaping Technology/Building Society: Studies in Sociotechnical Change*. Boston. The MIT Press: 205-24.
- Anderson, J.M 1996: Empowering Patients: Issues and Strategies. *Social Science and Medicine*, 43 (5): 697-705
- Armstrong, D. (1983) *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century*, Cambridge: Cambridge University Press.
- Armstrong, D. (1994) 'Bodies of knowledge/knowledge of bodies: Foucault and the problem of human anatomy', in G. Scambler (ed) *Sociological Theory and Medical Sociology*, London: Tavistock.
- Australian Commission on Safety and Quality in Health Care 2011
- Bensing, J. 2000: Bridging the gap. The separate worlds of evidence-based medicine and patient-centered medicine *Patient Education and Counseling* 39: 17-25
- Berg, Marc 1997: *Rationalizing Medical Work: Decision-Support Techniques and Medical Practices*. Cambridge, Mass: The MIT Press
- Bismuth, J., Kofoed, S.C., Sillesen, H. 2001 (May): Lipidsænkende behandling af patienter med aterosklerotisk sygdom i underekstremiteterne. *Ugeskrift for læger*.
- Bowker, G.C. & Star, S.L. 2000: "The ICD as Information Structure" *Sorting Things Out. Classifications and its Consequences*. Cambridge, Mass.: The MIT Press
- Broberg, H. 2000 (March 16): Karkirurg leder efter nye opgaver. *Dagens Medicin*.
- Brunsted, B. 2001 (February 22): Karterapi er mere end en operation. *Dagens Medicin*

- Braddock et al. 2012: The Patient-Centered Medical Home: An Ethical Analysis of Principles and Practice *Journal of General Internal Medicine* 28(1):141–6
- Byrne, P. & Long, B. 1976: *Doctors Talking to Patients*. London: HMSO
- Callon, M. 1986a: “Some Elements in a sociology of translation: Demystification of the scallops and fishermen of St. Brieuc Bay” In: J. Law (ed.): *Power, action and belief – a new sociology of knowledge?* London: Routledge and Kegan Paul: 196-232
- Callon, M. 1986b: “The Sociology of an Actor’s Network: the Case of the Electric Vehicle”. In: M. Callon, J. Law & A. Rip (eds.): *Mapping the Dynamics of Science and Technology*. TOWN: Houdmills: 19-34
- Callon, M. 1998: “An Essay on Framing and Overflowing: Economic Externalities Revisited by Sociology”. In M. Callon (Ed.) *The Laws of the Markets*. Oxford and Keele, Blackwell and the Sociological Review: 244-269.
- Callon, M. 1999: “Actor-Network Theory: the Market Test” in J. Law and J. Hassard (eds.) *Actor Network and After*. Oxford: Blackwell Publishing: 181-195.
- Clark, J. & Lang, N. 1992: Nursing’s next advance: An internal classification for nursing practice. *International Nursing Review* 39(4): 109-111
- Conrad, P. 1992: Medicalization and Social Control *Annual Review of Sociology* 18: 209-232
- Coveney, J. 1998: The government and ethics of health promotion: the importance of Michel Foucault. *Health Education Research. Theory & Practice* 13 (3): 459-468
- Cruikshank, B. 1999: *The Will to Empower. Democratic Citizens and Other Subjects*. Ithaca: Cornell

- Cussins, A. 1992: Content, Embodiment and Objectivity: The Theory of Cognitive Trails. *Mind* 101 (404): 651-688
- Cussins, C. 1996: Ontological Choreography: Agency through Objectification in Infertility Clinics. *Social Studies of Science* 26 (3): 575-610
- Czarniawska, B. & Hernes, T. 2005: *Actor-network theory and organizing*. Malmö: Liber and Copenhagen Business School Press
- Dansk Sygeplejeselskab & Dansk Sygeplejeråd 2012: *Dokumentation af sygepleje – en status rapport*. Dansk sygeplejeråd.
- Dahlager, L. 2005: *I samtalens rum. En magtanalyse med afsæt i den livsstilsrelaterede forebyggelsessamtale*. Ph.d.-afhandling. Det Sundhedsvidenskabelige Fakultet, Københavns Universitet.
- Dalum, P., Sonne, T. & Davidsen, M. 2000: *At tale om Forandring – en bog om sundhedsadfærd og motiverende samtaleteknik*. Tobaksskaderådet
- Dean, M. 1999: *Governmentality. Power and Rule in Modern Society*. London: Sage
- de Laet, M. & Mol, A. 2000: The Zimbabwean Bush Pump. *Social Studies of Science* 30:225-63
- Finn, M. & Sarangi, S. 2008: Quality of life as mode of governance: NGO talk of HIV 'positive' health in India. *Social Science and Medicine* 66(7): 1568-1578
- Engel, G. 1977: "The need for a new medical model: A challenge for biomedicine". *Science* 196:129–136
- Foucault, M. 1997: "The Birth of Biopolitics" in Rabinow, P. (ed.) *Ethics. Subjectivity and Truth* London: Penguin Books
- Fredslund, H. 2001: *Når "vilde" problemer tæmmes – en filosofisk-hermeneutisk fortolkning af en forebyggelsessamtale på en afdeling på Bispebjerg Hospital*. Ph.d.-afhandling. Institut for Folkesundhedsvidenskab. Københavns Universitet.

- Gad, C. & Jensen, C. 2010. On the Consequences of Post-ANT. *Science, Technology & Human Values* 35:55-80.
- Geertz, C. 2000 [1973]: *The Interpretation of Cultures*. New York, NY: Basic Books
- Gomart 2004: 520). Towards generous constraint: freedom and coercion in a French addiction treatment *Sociology of Health & Illness* 24 (5):517-549
- Greismas, J.A. [1966]1983: *Structural Semantics: An Attempt at a Method*. Lincoln, Nebraska: University of Nebraska Press.
- Greco, M. 2009: Thinking beyond Polemics. Approaching the Health Society through Foucault. *ÖZS* 34 (2):13–27
- Hansen, B.G. 2011: Adapting in the Knowledge Economy: Lateral Strategies for Scientists and Those who Study Them. PhD thesis. Copenhagen: Copenhagen Business School.
- Henare, A., Holbraad, M., Wastell, S. 2007: *Thinking through Things: theorising artefacts Ethnographically*. Oxon and New York: Routledge
- Hudon, C., Fortin, M, Haggerty, J., Loignon, C., Lambert, M., Poitras, M. 2012: Patient-centered care in chronic disease management: A thematic analysis of the literature in family medicine *Patient Education and Counseling* 88: 170–176
- Jensen, C. 2010: *Ontologies for Developing Things. Making Health Care Futures Through Technology*. Rotterdam: Sense Publishers
- Jensen, C. 2014(forthcoming) The Conceptual and the Empirical in Continuous Variation. *Science, Technology and Human Values*: 1-25
- Kjær, P. & Petersen, A. (eds.) *Ledelse gennem patienten – nye styringsformer i sundhedsvæsenet*. København: Handelshøjskolens Forlag
- Knudsen, J. & Olsen, G. 2012: Patient-centreret praksis på danske sygehuse vil styrke kvaliteten. *Ugeskrift for Læger* 174 (45):2791-2795

Lacey, N. & Backer, E. 2008 Evidence-based and Patient-centered Care: Results From an STFM Group Project *Health Services Research* 40, (6): 417-22

Lakoff, G. & Johnson, M. 1980: *Metaphors We Live By*. Chicago: University of Chicago Press

Langer, J.W. 2001 (November 22): Sund levevis istedet for operation. *Dagens Medicin*.

Latour, B. 1986: "The powers of association". In J. Law (ed.) *Power, Action, Belief – a new sociology of knowledge?* London: Routledge & Kegan Paul: 264-280

Latour, B. 1987: *Science in Action: How to follow scientists and engineers through society*. Cambridge, MA: Harvard University Press.

Latour, B. 1988: *The Pasteurization of France*. Cambridge, Mass: Harvard University Press

Latour, B. 1991: "Technology is society made durable". In J. Law (ed) *A Sociology of Monsters. Essays on Power, Technology and Domination*. London: Routledge: 103-132

Latour, B. 1996: *Aramis, or the Love of Technology*. Cambridge, Mass: Harvard University Press

Latour, B. 1999a: "On recalling ANT". In J. Law & J. Hassard (eds.) *Actor Network Theory and after*. Oxford: Blackwell Publishing: 15-25

Latour, B. 1999b: *Pandora's Hope: Essays on the Reality of Science Studies*. Boston: President and Fellows of Harvard College

Latour, B. 2005: *Reassembling the Social: An Introduction to Actor-Network Theory*. Oxford: Oxford University Press

Latour, B. & Woolgar, S. [1979] 1986: *Laboratory Life: The Construction of Scientific Facts*. Princeton, NJ: Princeton University Press

- Law, J. 1986: "On the Methods of Long Distance Control: Vessels, Navigation and the Portuguese Route to India". In J. Law (ed.) *Power, Action, Belief – a new sociology of knowledge?* London: Routledge & Kegan Paul: 234-263
- Law, J. 1988. "The Anatomy of a Socio-Technical Struggle: The Design of the TSR 2." In: Elliott, B. (ed.) *Technology and Social Process*. Edinburgh: Edinburgh University Press.
- Law, J. 1994: *Organizing Modernity*. Oxford: Blackwell Publishers
- Law, J. 2004: *After Method. Mess in Social Science Research*. London: Routledge
- Law, J. 2009: "Actor Network Theory and Material Semiotics". In: B. Turner (ed.) *The New Blackwell Companion to Social Theory*. TOWN: Wiley-Blackwell Publishing Ltd.
- Law, J. & Hassard, J. (eds.) 1999: *Actor Network and After*. Oxford: Blackwell Publishing
- Law, J. 1999: "After ANT: complexity, naming and topology" In: Law, J. & Hassard, J. (eds.) 1999: *Actor Network and After*. Oxford: Blackwell Publishing: 1-14
- Law, J. & Singleton, V. 2005: Object Lessons. *Organization* 12 (3):331-355
- Lee, N. & Brown, S.D. 1994: Otherness and the Actor Network: The Undiscovered Continent. *American Behavioral Scientist* 36: 772-90
- Levack, W., Dean, S., Siegert, R. McPherson, K. 2011: Navigating patient-centered goal setting in inpatient stroke rehabilitation: How clinicians control the process to meet perceived professional responsibilities. *Patient Education and Counseling* 85: 206–213
- Larsen, L.T. 2011: "The birth of lifestyle politics: The political management of lifestyle diseases in the United States and Denmark" in Bröckling, Krasmann & Lemke (eds.) *Governmentality: Current Issues and Future Challenges*. London Routledge

- Lupton, D. (1997) 'Foucault and the Medicalisation Critique', in: A. Petersen & R. Bunton (eds.) *Foucault, Health and Medicine*, New York: Routledge
- Malinowski, B. 1922 *Argonauts of the Western Pacific*. London: Routledge & Kegan Paul
- Mabeck, C.E., Kallerup, H. & Maunsbach, M. 1999: Den motiverende samtale. Dansk selskab for almen medicin
- McDonald, D.A. 1974: *Blood Flow in Arteries*. (2nd edition). Southhampton: Edward Arnold
- Mathar, T. & Jansen, Y. 2010: *Health Promotion and Prevention Programmes in Practice. How Patients' health Practices are Rationalised, Reconceptualised and Reorganised*. Bielefeld: transcript
- Maurer, B. 2005: Mutual Life, Limited: Islamic banking, Alternative Currencies, LateralReason. Princeton, NJ: Princeton University Press
- Mead, N. & Bower, P. 2000: Patient-centredness: a conceptual framework and review of the empirical literature. *Social Science & Medicine* 51 (2000) 1087-1110
- Miller, W. and Rollnick, S. 1991: *Motivational Interviewing: Preparing People to Change Addictive Behaviour*. New York: Guilford Press
- Mol, A. & Law, J. 1994: Regions, Networks, and Fluids: Anaemia and Social Topology. *Social Studies of Science* 24 (4):641-790.
- Mol, A. 1999: "Ontological Politics. A word and some questions". In: J. Law and J. Hassard (eds.) *Actor Network and After*. Oxford: Blackwell Publishing: 74-89
- Mol, A. 2002: *The Body Multiple*. Durham: Duke University Press
- Mol, A. 2006: Proving or Improving: On Health Care Research as a Form of Self-Reflection *Qualitative Health Research* 16 (3): 405-414
- Mol, A. 2008: *The Logic of Care: Health and the Problem of Patient Choice*. Abingdon, Oxon: Routledge

- Nielsen, A. 2010: *Travelling Technologies and Transformations in Health Care*. PhD thesis. Copenhagen: Copenhagen Business School
- Nielsen, A. & Grøn, L. 2012: Standardising the Lay: Logics of Change in Programs of Disease Self-management. *Culture Unbound* 4
- Parsons, T. 1951: "The Professions and Social Structures" in Parsons, T. *Essays in Sociological Theory*. New York: The Free Press
- Pedersen, F.S. 2003 (June 6): Forandring: Succes når sygeplejersker selv ordinerer medicin. *Berlingske*
- Percy, W. (1958): "Metaphor as Mistake" *The Sewanee Review* 66 (1):79-99
- Pii, K. 2010: "Den forebyggende indsats" in Kjær, P. & Petersen, A. (eds.) *Ledelse gennem patienten – nye styringsformer i sundhedsvæsenet*. København: Handelshøjskolens Forlag
- Pii, K. 2012: "Sygeplejerskers arbejde med patient-centreret forebyggelse" in Järvinen, M. & Mik-Meyer, N. (eds.): *At skabe en professional: Autonomi og ansvar i velfærdsstaten*.
- Pii, K. & Villadsen, K. 2013: Protect the Patient from Whom? When Patients Resist Governmentality and seek more Expert Guidance *Social Theory and Health* 11: 19–39
- Pols, J. 2012: *Care at a Distance: On the Closeness of Technology*. Amsterdam: Amsterdam University Press
- Pols, J. & Moser, I. 2009: Cold technologies versus warm care? On affective and social relations with and through care technologies *European Journal of Disability Research* 3: 159-178
- Prochaska, J.O., Norcross, J.C., DiClemente, C.C. (1994) *Changing for Good*, New York: Avon Books
- Ratner, H. 2012: *Promises of Reflexivity. Managing and Researching Inclusive Schools*. PhD thesis. Copenhagen: Copenhagen Business School

- Riles 2000 *The Network Inside Out*. Michigan: University of Michigan Press.
- Ritzaus Bureau 2000 (September 20): Patienter med åreforkalkning er svært underbehandlet. *Ritzaus Bureau*
- Rose, N. 1999: *The Powers of Freedom*. Cambridge: Cambridge University Press
- Rose, N. & Miller, P. 1992: Political Power Beyond the state: Problematics of Government. *British Journal of Sociology* 43 (2): 173-205.
- Savigny, E., Schatzki, T. & Knorr-Cetina, K. 2000: *The Practice Turn in Contemporary Theory*. London: Routledge
- Singleton, D.V. 2005: The promise of public health: Vulnerable policy and lazy citizens. *Environment and Planning D Society and Space* 23 (5): 771-786.
- Sillesen, H., Madelung, S., Eldrup, N. & Roed, M. (2007): "Organising a Nurse-driven PAD Rehabilitation Clinic Within the Vascular Surgical Department: What is Required and are Treatment Goals Reached? – A Prospective Study" *European Society for Vascular Surgery* 33:26-32
- Star, S.L. 1991: "Power, Technologies and the Phenomenology of Conventions: On Being Allergic to Onions". In: J. Law (ed.) *A sociology of Monsters. Essays on Power, Technology and Domination*. London: Routledge: pp
- Sørensen, E. *STS goes to school: Spatial Imageries of technologies, knowledge and presence*. PhD Thesis. Faculty of Social Science, Copenhagen University.
- Serres, M. 1974: *La Traduction, Hermes III*. Paris, Les Editions de Minuit.
- Stengers, I. (2011): "Comparison as a Matter of Concern", *Common Knowledge* 17 (1): 48-64

- Stewart, M., Brown, J., Weston, W. 1995: *Patient-centred Medicine. Transforming the Clinical Method*. Thousand Oaks, CA: Sage Publications.
- Strathern, M. 1999: *Property, Substance and Effect*. London/New Brunswick: Athlone Press
- Turner, B.S. (1997) 'Foreword: From governmentality to risk, some reflections on Foucault's contribution to medical sociology, in: The Politics of Life Itself', *Theory Culture & Society*
- Tucker, C., Marsiske, M., Rice, K. , Nielson, J. & Herman, K. 2011: Patient-Centered Culturally
- Sensitive Health Care: Model Testing and Refinement. *Health Psychology* 30 (3): 342–350
- Valgård, S. 2003: *Folkesundhed som politik. Danmark og Sverige fra 1930 til i dag*. Gylling: Narayana Press
- Verran, H. 2001: *Science and an African Logic*. Chicago and London: Chicago University Press
- Vikkelsø [Svenningsen], S. 2003: *Electronic patient records and medical practice: Reorganization of roles, responsibilities, and risks*. PhD thesis. Copenhagen: Copenhagen Business School
- Vikkelsø, S. 2007: Description as Intervention: Engagement and Resistance in Actor-Network Analyses. *Science as Culture* 16 (3): 297-309
- Villadsen, K. & Pii, K. 2012: Forebyggelse på tværs af det offentlige og private: Når patienter trodser myndiggørelse og efterspørger mere professionel involvering. *Tidsskrift for forskning i sygdom og samfund* 17: 119-142
- Wilson, P.M., Kendall, S., Brooks, F. 2007: The Expert Patient Programme: a paradox of patient empowerment and medical dominance. *Health and Social Care in the Community* 15 (5): 426–438
- Wilson P.M. 2001: A policy analysis of the Expert Patient in the

United Kingdomself-care as an expression of pastoral power?
Health and Social Care in the Community, 9 (3): 134–142

Wyatt, S. & Balmer, B. 2007: Home on the Range: What and Where is the Middle in Science and Technology Studies. *Science, Technology and Human Values* 32 (6):619-627

Zola, I. 1983: *Socio-Medical Inquiries: Recollections, Reflections and Reconsiderations* Philadelphia: Temple University Press

English Summary

RESPONSIBILITY FLOWS IN PATIENT-CENTRED PREVENTION

The patient-centred approach is expanding in the Danish health-care system. This approach strives to organize treatment and care so that it takes departure in the individual patient's personal values, wishes and motivations. The intention behind the approach is to offer more effective and more ethical treatment and care. The patient-centred approach assigns to a great extent the responsibility for individuals' state of health and improvement to the individual patient. But what challenges does the approach pose for the professionals who work with it? In this thesis, I seek to explore the organizational and managerial problematics that the patient-centred approach implies in a case from the vascular specialty in the Danish healthcare system. The research question that I explore in the thesis is: How is preventive capacity and responsibility built and distributed in patient-centred prevention practices?

The thesis builds on ethnographic fieldwork focusing on how a specific prevention programme, GGG, within the vascular specialty in Danish health care is being practiced among health professionals and patients. The programme is aimed at patients suffering from painful leg cramps, called *claudicatio intermittens*, which is a symptom of atherosclerosis. The GGG programme consists of preventive medicine as well as lifestyle oriented conversations led by a specially trained nurse. The conversations rests on the method Motivational Interviewing (Miller & Rollnick 1992) as well as behavior change theory and models such as the Wheel of Change (Prochaska et al 1994), which are well-established in the preventive and health

promoting work in the Danish healthcare system. GGG is defined as a patient-centred prevention programme, which takes departure in the individual patient's personal opinions, wishes and motivation for lifestyle changes.

The thesis draws on concepts and discussions within the tradition of Science, Technology and Society (STS) studies and in particular Actor-Network Theory (ANT), which views 'the social' as ongoing and distributed construction processes that consist of heterogeneous sociomaterial relations. Through the thesis, the vascular system is evoked as an analytical figure and heuristic, which map out the various preventive practices that are presented in the thesis.

Chapter 2 (Actor-Network Theory: An Approach for Studying Strategies and Multiplicity) presents the analytical frame of the thesis. I combine both classical ANT and critical developments of ANT, which are identified respectively as 'strategy-oriented' and 'multiplicity-oriented' ANT. Combining the two approaches allows me to map relations that create strong preventive actor-networks as well as follow prevention's multiplicity as it is enacted in practice. I unfold the metaphorical resources of the vascular system, blood and flow, which are found in the ANT literature and which I develop further through my analytical chapters by introducing vascular properties and functions that expand the analytical imagery further.

Chapter 3 (Research Practice: Empirical, Theoretical and Methodological Intertwinements) presents the research process behind the thesis. Besides describing the practicalities of the project's onset and methodological approach, I point to some of the crucial decisions I made regarding the framing of the project including the occasion that led me to evoke the vascular system as an analytical heuristic.

Chapter 4 (Building Preventive Pathways into the Vascular Specialty: The Development of GGG), deals with the building of prevention as a professional task within vascular surgery and the development of the GGG programme at Gentofte Hospital. I show how prevention is translated into a vascular concern by linking it to existing interests and problems of surgeons and nurses within the vascular specialty. The chapter describes the strategic work in mobilising prevention as a vascular task and points out the new roles and responsibilities that GGG imply for the professionals in the field. In vascular terms, I focus on the heart that generates the preventive flow and the arteries that form the passages for prevention within the vascular specialty.

Chapter 5 (Complications in the Preventive Pathways: Adjusting GGG and the Preventive Flow) follows the further development and translation of GGG as it is implemented at Rigshospitalet. I describe two challenges that obstruct the preventive flow and diverts from the initial strategic mobilization of prevention within the vascular field. One regards the surgeons' neglect of referring patients to the preventive programme. The other regards a decrease in preventive enthusiasm among the nurses who work with prevention. These challenges are managed with different organizational interventions that ensure the preventive flow by creating a bypass around the occluding doctors and by creating new preventive tasks that ensures a richer vascularization of the preventive work.

In Chapter 6 (Distributing Prevention to the Patient's Home: Strategies for Lifestyle Changes in the GGG Consultation), I focus on the preventive encounters between nurses and patients. I explore how patients' preventive capacities and responsibilities are built and distributed from the clinical space to patients' home spaces by different motivational practices. I show that the distribution

depends on an openness in the preventive conversation where patients provide information about their life situation and personal motivation for lifestyle changes, which enables the nurses to create passages for the preventive capacity and responsibility to flow into the patients' everyday lives, practicalities, and concerns. The chapter draws on the image of capillaries - the complex network in which the metabolic process takes place. The blood flow that is delivered to the capillaries through the arterial passages carries nutrients and oxygen, which are perfused into the cells of the tissue in the metabolic process.

The focus in Chapter 7 (Overflows in the Preventive Encounter: Patients' Re-distribution of Preventive Responsibility and Redefinition of GGG) also focuses on the GGG consultations between nurses and patients. I show how the openness, which the patient-centred preventive consultation depends on, also forms openings for the patients to return issues, demands, and expectations, which 'overflows' GGG's scope and formulates new types of professional responsibilities for the nurses. Although the nurses attempt to frame these overflows, the issues and demands put forward by the patients still continue to concern the nurses. This, I propose, resembles another part of the metabolic process in the capillaries, namely, the exchange of waste products and deoxygenated blood, which are returned via the veins.

In Chapter 8 (Prevention's Backflow: Professional Responsibility in Patient-centred Prevention Work), I focus on nurses' reflections on the preventive work, what I propose as the backflow of the preventive work. I describe the experiences and challenges that nurses express about the preventive work and how they try to deal with these. The preventive work is experienced as a demanding practice that requires that the nurse 'use herself' as a central tool in the

preventive work, which at times blurs the boundary between her professional and personal responsibility. Furthermore, nurses also express the challenge that lies in the conflicting values in the patient-centred approach; namely, the value of ensuring patient autonomy and at the same time providing effective preventive outcomes.

Chapter 9 (Concluding Discussion: Prevention's Circulation and Filtering Organs) summarizes the findings across the empirical chapters and relates this to the thesis' research question regarding the building and distribution of preventive capacity and responsibility among health professionals and patients across the clinical/home boundary. I point out that the distribution of prevention happens in a circular process between the health professionals and patients across clinical and home spaces. After this summary, the chapter discusses the values of autonomy and effectiveness which patient-centred prevention is articulated and evaluated according to. I draw on the image of the filtering organs that connects to the vascular system and which cleanses the blood as it circulates. I describe prevention's ideals as such filtering organs, which cleanses patient-centred prevention in specific ways by redistributing some qualities of the preventive work while discharging others. In the discussion, I argue that the ideals of autonomy and effectiveness are inadequate to discuss and evaluate prevention according to the way that it is being practised. I thus propose that other ideals, or filters, may be formulated in order to provide other understandings and criteria for evaluation of the preventive work.

Furthermore, I specify the thesis' contributions to two fields of audiences, the 'practice-oriented' field of prevention and health promotion, where ANT's analytical approach and the empirical findings expands the common social and psychological understandings and problematisation of prevention within this field. The other field

that the thesis contributes to is STS and especially ANT, where I point to the productiveness of combining the two approaches within the tradition and I furthermore discuss my use of the vascular system as an analytical imagery and relate this to the debate within STS regarding the relationship between the conceptual and empirical.

Dansk resume

ANSVARSTRØMNINGER I PATIENT-CENTRET FOREBYGGELSE

Den patient-centrede tilgang vinder stadig mere frem i det danske sundhedsvæsen. Denne tilgang lægger vægt på, at behandling sker med udgangspunkt i den individuelle patients værdier, motivation og ønsker. Intentionen bag tilgangen handler både om at tilbyde mere effektiv og mere etisk behandling og pleje. Den patient-centrede tilgang udpeger i udpræget grad patienten som ansvarshaver for sin sundhedstilstand og forbedring. Men hvilke udfordringer stiller patient-centret forebyggelse for de sundhedsprofessionelle, der arbejder med det? I afhandlingen søger jeg at belyse de ledelsesmæssige og organisatoriske problematikker og udfordringer, der opstår i og omkring patient-centreret arbejde. Afhandlingen omhandler patient-centreret forebyggelse indenfor det karkirurgiske speciale i Danmark. Forskningsspørgsmålet, som afhandlingen søger at belyse lyder: Hvordan opbygges og distribueres forebyggende kapacitet og ansvar i patient-centrede forebyggelsespraksisser?

Undersøgelsen bygger på en etnografisk undersøgelse af, hvordan et specifikt forebyggelsesprogram, kaldet GGG, indenfor karkirurgien i det danske sundhedsvæsen praktiseres af sundhedsprofessionelle og patienter. Forebyggelsesprogrammet er rettet mod patienter, der lider af smertefulde benkræmper ved gang, kaldet claudicatio intermittens, eller 'vindueskiggersyndrom', som er et symptom på generel åreforkalkning. Forebyggelsesprogrammet består af forebyggende medicinering såvel som individuelle livs-tilsorienterede forebyggelsessamtaler med en specialuddannet sygeplejerske. Samtalerne bygger på metoden Den motivende sam-

tale (Miller & Rollnick 1991) samt adfærdspsykologiske teorier og modeller som Forandringshjulet (Prochaska et al. 1994), der er udbredte metoder og værktøjer i det forebyggende og sundhedsfremmende arbejde i det danske sundhedssystem. GGG defineres som et patient-centreret forebyggelsesprogram, der tager udgangspunkt i den enkelte patients personlige holdninger, ønsker og motivation for livsstilsændringer.

I afhandlingen trækker jeg på begreber og diskussioner indenfor Science, Technology and Society (STS) traditionen og i særlig grad aktør-netværks teori (ANT), som betragter 'det sociale' som igangværende og distribuerede konstruktionsprocesser, der består af heterogene sociomaterielle relationer. Igennem afhandlingen anvendes blodkarsystemet som analytisk figur og redskab, og som kortlægger de forskellige forebyggende praksisser, som præsenteres i afhandlingen.

Kapitel 2 (Aktør-netværksteori: En tilgang til at studere strategier og multiplicitet) præsenterer afhandlingens teoretiske ramme. Jeg kombinerer både klassisk ANT og kritiske udviklinger af ANT, som henholdsvis identificeres som 'strategi-orienteret' og 'multiplicitets-orienteret' ANT. Ved at kombinere de to tilgange er det muligt dels at kortlægge relationer, der skaber et stærkt forebyggende aktør-netværk og dels at følge forebyggelsens multiplicitet, som den udspiller sig i praksis. I dette kapitel udfolder jeg de metaforiske ressourcer vedrørende blodkarsystemet, blod og andre begreber der tager udgangspunkt i 'flydende' former, der findes i ANT-litteraturen, og som jeg udvikler i løbet af afhandlingens kapitler ved at bidrage med yderligere egenskaber og funktioner ved blodkarsystemet for dermed at udvide det eksisterende analytiske repetoire.

Kapitel 3 (Forskningspraksis: Empiriske, teoretiske og metodolo-

giske sammenblandinger) omhandler afhandlingens bagvedliggende forskningsproces. Udover at beskrive projektets opstart, motivation og metodiske design, peger jeg på nogle af de beslutninger, som jeg traf vedrørende afhandlingens ramme. Blandt andet beskriver jeg den episode, som førte til udviklingen af blodkarsystemet som analytisk figur og redskab.

Kapitel 4 (Opbygningen af forebyggende veje ind i det karkirurgiske speciale: Udviklingen af GGG) beskæftiger sig med opbygningen af forebyggelse som arbejdsområde indenfor karkirurgien og udviklingen af GGG på Gentofte hospital. Ved at trække på strategiorienteret ANT viser jeg, hvordan forebyggelse bliver oversat til et karkirurgisk anliggende ved at relatere det til eksisterende bekymringer og interesser blandt specialets læger og sygeplejersker. Kapitlet beskriver det strategiske arbejde, der indgår i at mobilisere forebyggelse som en karkirurgiske opgave, og peger på de nye roller og ansvarsområder, som GGG indebærer for specialet professionelle. Der trækkes på analogier til hjertet, som frembringer den forebyggende strømning samt de hovedarterier, der skaber vejene for forebyggelse ind i det karkirurgiske speciale.

Kapitel 5 (Komplikationer i det forebyggende arbejde: Tilpasningen af GGG og den forebyggende strømning) følger den videre udvikling af GGG, idet programmet implementeres på Rigshospitalet. Jeg beskriver to udfordringer, der hindrer den forebyggende strømning, og som udfordrer mobiliseringsstrategien for indførelsen af forebyggelse. Den første udfordring vedrører lægernes mangelfulde henvisning af patienter til GGG. Den anden udfordring vedrører sygeplejerskernes aftagende entusiasme omkring det forebyggende arbejde. Disse udfordringer håndteres ved forskellige organisatoriske tiltag, som genopretter den forebyggende strømning: Dels indsættes der en 'bypass' omkring de obstruerende læger, og

dels iværksættes nye forebyggelsesopgaver, der udgør flere veje for den forebyggende strømning i det karkirurgiske speciale.

Kapitel 6 (Distribuering af forebyggelse til patientens hjem: Strategier for livsstilsændringer i GGG konsultationen) fokuserer på de forebyggende møder mellem sygeplejersker og patienter. I dette kapitel undersøger jeg, hvordan patienters forebyggende kapacitet og ansvar opbygges og distribueres fra det kliniske rum til patienters hjemlige rum via forskellige motiverende praksisser. Jeg viser, hvordan distributionen beror på en åbenhed i den forebyggende konsultation, hvor patienten bidrager med information omkring sin livssituation og personlige motivation for livsstilsændringer. Denne åbenhed muliggør, at sygeplejersken kan skabe passager for den forebyggende indsats i patientens hverdagsliv. Kapitlet trækker på billedet af kapillærerne, et komplekst semiperforeret netværk, hvor næringsstoffer i blodstrømmen overføres til vævet.

Kapitel 7 (Overløb i det forebyggende møde: Patienters re-distribution af forebyggende ansvar og redefinering af GGG) har fortsat fokus på GGG konsultationerne mellem sygeplejersker og patienter. Her viser jeg, hvordan den åbenhed, som de forebyggende konsultationer beror på, også danner åbninger for, at patienten kan fremsætte krav og forventninger, der 'overløber' GGGs formål, og som ansvarliggør sygeplejerskerne på nye måder. Selv om sygeplejerskerne forsøger at dæmme op for disse overløb, er der stadig nogle af de fremsatte forventninger og krav, der påvirker dem. Dette beskrives som den anden proces i den metaboliske udveksling, hvor affaldsstoffer optages af blodstrømningen og bringes videre til kroppens filtrerende organer via tilbageløbet i venesystemet.

Kapitel 8 (Forebyggelsens tilbageløb: Professionelt ansvar i patient-centreret forebyggelsesarbejde) fokuserer på sygeplejerskernes re-

fleksioner over det forebyggende arbejde, hvilket jeg beskriver som forebyggelsens 'tilbageløb'. Jeg beskriver de erfaringer og udfordringer, som sygeplejerskerne udtrykker omkring det forebyggende arbejde. Det forebyggende arbejde opleves som krævende og medfører, at sygeplejersken 'bruger sig selv' som et central redskab, hvilket betyder, at grænsen mellem det professionelle og personlige ansvar udviskes. Yderligere udtrykker sygeplejerskerne også, at det patient-centrerede forebyggende arbejde er en udfordring, fordi det opstiller modsatrettede værdier: Dels baserer den patient-centrerede tilgang sig på en ambition om at sikre patientens autonomi men samtidigt er der en stærk optagethed af at påvise konkrete resultater og konstatere forebyggelsesarbejdets effekt.

Kapitel 9 (Afsluttende Konklusion: Forebyggelsens Cirkulation og Filtrerende Organer) opsummerer afhandlingens kapitler og forholder disse til forskningsspørgsmålet. Overordnet påpeger jeg, at distribueringen af forebyggende kapacitet og ansvar sker i en cirkulær proces mellem klinikkens professionelle og patienterne på tværs af kliniske og hjemlige rum. Herefter diskuterer jeg de værdier, som artikuleres omkring patient-centreret forebyggelse, autonomi og effektivitet, som forebyggelsesarbejdet evalueres i henhold til. Jeg trækker på billedet af blodkarsystemets filtrerende organer, som renser blodet i dets cirkulation. Jeg beskriver forebyggelsens værdier som sådanne filtre, der renser det forebyggende arbejde på særlige måder ved at redistribuere nogle egenskaber og skille sig af med andre. I diskussionen argumenterer jeg for, at værdierne omkring autonomi og effektivitet er utilstrækkelige i evalueringen af det forebyggende arbejde, som det praktiseres og argumenterer for, at der kan fremsættes andre værdier eller filtre, som forebyggelsesarbejdet med fordel kan forstås og vurderes i forhold til.

I kapitlet anskueliggør jeg, hvordan afhandlingen bidrager dels til

det praktiske felt omkring forebyggelse og sundhedsfremme og dels det teoretiske felt omkring STS og særligt ANT. I forhold til det praktiske felt bidrager afhandlingen med sine analyser både til udfordring og udvidelse af de dominerende sociale og psykologiske forklaringer og kritikker, der ellers præger feltet. I forhold til det teoretiske felt omkring STS/ANT bidrager afhandlingen ved at demonstrere det produktive i at kombinere de to analytiske tilgange indenfor ANT-traditionen (henholdsvis den strategi-orienterede og multiplicitet-orienterede tilgang). Herudover diskuterer jeg brugen af blodkarsystemet som analytisk figur og værktøj gennem afhandlingen og relaterer dette til aktuelle debatter omkring forholdet mellem det empiriske og teoretiske.

Afhandlingen afsluttes med overvejelser omkring vigtigheden af ikke at forlade sig på etablerede kriterier, kritikker, begreber eller analytiske figurer i forståelsen og evalueringen af det patient-centrede forebyggende arbejde. I stedet opfordres der til en nysgerrig undersøgelse af de muligheder som både det empiriske, teoretiske og deres særlige relationer indebærer.

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