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Nurses' Experience of Caring amidst Developments in Welfare Technology in Elderly Care

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In Norway, the dominant policy understanding of welfare technology sees its development in elderly care as exclusively positive and effective, benefitting both the individual and society at large. However, nurses tend to be viewed as an obstacle to broader use of welfare technology in primary care. This article looks at how nurses experience caring amidst developments in welfare technology in elderly care. The study draws on a psychosocial approach (Olesen, 2020) that enables interpretation of nurses' expressions of their experiences with caring and welfare technology on the individual level and in the historical, societal and sociocultural context the nurses are situated within. The article illustrates how welfare technology must not be understood one-dimensionally as tools providing specific outcomes and demonstrates how the nurses' experience of caring amidst developments in welfare technology may be understood as layers of contradictory notions about care, welfare technology and the nursing role.

Keywords: elderly care, welfare technology, care, nurses, psychosocial approach.

Introduction

In recent decades, the narrative of welfare technology in the field of elderly care has changed from seeing it as a promising development to considering it as a premise for public older adult care and a condition for ensuring the very continuation of the welfare state (Alvsåker & Ågotnes, 2022; Haukelien, 2021; Norwegian Ministry of Health and Care Services, 2006, 2011). Today, the political discourse about elderly care is dominated by economic rationality and a scenario in which a threatening elderly wave will flood a willing and responsible, but overloaded state (Haukelien, 2021). Neoliberal ideals such as the autonomous individual, living at home as long as possible, and care considered as a service bought and sold, are part of the current market-oriented care policy (Official

Norwegian Report, 2011). Welfare technology has been presented as a solution to solving the challenges caused by the increasing number of elderly people and the shortage of health care personnel. The dominant policy understanding of welfare technology sees its development as an exclusively positive, effective practice that benefits both the individual and society at large (Alvsåker & Ågotnes, 2022). Welfare technology is seen as enabling the elderly to be as autonomous and independent of the state as possible to reduce demand and costs (Haukelien, 2021). However, the implementation of welfare technology is not proceeding as smoothly as expected. Female-dominated work and professional communities, such as the nursing field, are often described as being stuck in habits and traditions and welfare technology is often presented as a modern corrective for these groups (Haukelien, 2020). Nurses are also constructed as an obstacle to the wider use of welfare technology in primary care (Corneliussen & Dyb, 2021). Research has shown that elderly care staff have a positive view of welfare technological solutions despite their scepticism, but that health care workers do take issue with the understanding of welfare technology as an objective tool that creates measurable, planned changes and general, rational and practical solutions (Haukelien, 2020). The implementation of welfare technology produces invisible extra work, unintended consequences, and considerable unpredictability in established professional practice (Haukelien, 2020). It has been questioned whether the use of welfare technology reduces costs (Thygesen, 2019) and whether female care workers are coerced to accept rationalities that undermine their professional and ethical understanding of "proper care work" (Sundsbø et al., 2023). Against this background, the following research question will be answered in this article: How do nurses experience caring amidst developments in welfare technology in elderly care?

For this study I conducted interviews with ten nurses, nine female and one male aged 28 to 59. They worked in nursing homes and in digital and face-to-face home care. This study was conducted as part of the research project Caring Futures: Developing Care Ethics for Technology-Mediated Care Practices (QUALITECH).[1] The study was approved by the Norwegian Centre for Research Data. The participants were provided with a written and verbal description of the study and signed a written consent form to

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participate in the interviews. The participants' names, and certain aspects of what they said, have been changed to protect their anonymity. In the interviews the nurses were invited to talk about their life history, what it meant to them to be a nurse and experiences that were important to them.

A Psychosocial Approach

To study how nurses experience caring amidst developments in welfare technology in elderly care, a psychosocial approach (Olesen, 2020) was chosen as the theoretical perspective in this study. A psychosocial approach provides a life history interpretative framework for the professional's identity, socialized subjectivity, and experience, which are specifically related to the historical, societal and sociocultural context of the professional (Dybbroe, 2012; Finholt-Pedersen, 2022; Liveng, 2012; Nielsen, 1999; Olesen, 2017; Ramvi, 2015).

The analysis of the interviews revealed that the psychosocial notion of experience evolved into a meaningful interpretative concept of the nurses' experience of caring. This is because the concept of experience involves the formation of a socialisation process through which individual subjectivity is shaped and developed (Olesen, 2007, 2012), revealing possible layers of meanings for interpreting the nurses' different experiences amidst developments in welfare technology in elderly care.

Experience thus refers to the subject-object dialectic, in which consciousness is understood as being produced and presupposed in social practice and as contextualising the potentials of experience through conscious and active practice in everyday life (Olesen, 1997, 2020). This means that experience is seen as an active process that is always embedded in a specific life trajectory that has given rise to previous experiences. This process is decisive for subject's perceived practical opportunities and thereby his / her life strategy. Experience is then understood as a relatively independent inner mental structure that exists in dialectic interaction with collective cultural knowledge and ideas and is produced and exists on the sociocultural level (Olesen, 1997, 2020). On this basis, experience can be summarised as the product of individual learning through the process of being-in-the-world experiences (Olesen, 2002, 2007).

The theoretical basis for this is the psychoanalytic interpretation of cultural phenomena, which sees psychological dynamics, defenses, defense mechanisms and

unconscious motivations as intertwined with social relations (Nielsen, 1999). In a psychosocial interpretative framework, this is understood as an inner psychological modality of the culture (Nielsen, 1999). Social relationships and psychological perspectives are understood as both consciously and unconsciously mediated. Unconscious dynamics are then seen as active forces throughout life and can be linked to the concrete experiential life history context in which particular competencies are acquired (Olesen, 2017). It is this inclusion of both the socialisation of the individual experience and the objectivation of collective cultural experience in the form of knowledge (Olesen, 2007) that has unfolded possible interpretative layers of meaning of the nurses' experiences amidst welfare technology developments in elderly care.

Analysis

An interpretation group was involved in the analysis. The members were Ellen Ramvi, Wendy Hollway and Henning Salling Olesen, who all have experience of in-depth hermeneutic interpretations. The group had four online interpretation meetings. For each group meeting, I prepared one segment of the interviews. We interpreted four segments, but only three of them will be presented in this article, as the fourth one was similar to two of the cases.

In the interpretation group we conducted in-depth hermeneutic interpretations of the segments I prepared for the meetings. These interpretations were guided by the conceptual framework of psychoanalysis and knowledge of the societal, historical and cultural contexts of elderly care and the nursing profession in Norwegian society. In these interpretations, we were not concerned about reducing the manifest meaning of the interviews to a latent meaning, but rather about investigating what could be interpreted as layers of meaning in the explicit interview texts (Gripsrud et al., 2018; Olesen, 2020).

In the initial stage of the analysis, we looked at spots in the texts that "irritate" (Prokop, 1996, p. 22). Bjerrum Nielsen (1999, p. 5) explores this "where something "does not fit" or seems to be missing, where the text becomes contradictory or maybe too coherent, where the rhetoric is experienced as ambiguous, touching, or untrustworthy". The following analysis is structured around two experiences I had during the interviews. The first experience was an unexpected but overwhelming feeling of being cared for and

secure during nine of the interviews. The second experience was a painful feeling of being unworthy that I had during one interview.

My subjectivity as a researcher is important in relation to the creation of meaning that was produced in the interviews and what can be interpreted as layers of meaning in the interview texts (Fog, 2005). To illuminate this, I would like to highlight three domains of experience to contextualize my background in relation to care, the nursing role and elderly care. Working as a care assistant as a young adult in nursing homes during my studies in theology and psychology stands out as a defining experience in my life. I still carry with me the memories of the different patients, dependent and vulnerable in their own ways, whom I met during those years. Reflecting with my mother, who is a nurse, about caring for different patients, care work and care for children and elderly people also stands out as a significant experience in my approach to this study. Lastly, being a mother of two children has expanded my understanding of care and what it means to relate to and know another person and how difficult it is at times to articulate the complexities of caring. My subjectivity as a researcher has also been an important instrument in the in-depth interpretations of these interviews and can be described as an ongoing co-produced relational dialogue of unconsciousness in the process of knowing (Hollway, 2016). This means that the silent and more subdued interactions I sensed in the interview situations, which can easily evade everyday logic (Dybbroe, 2020), were integrated into the process of knowing (Hollway, 2016).

In the following, the findings of this study will be presented. One of the main impressions of this material as a whole was that it was difficult to thematize the nurses' care experiences. For this reason, the data analysis will be presented in two parts. Firstly, the general and overall findings of the data will be presented. Secondly, as it was difficult to thematize the nurses' experience of caring, I will present three cases to describe the complexities involved in their experiences of caring amidst developments of welfare technology in elderly care. Then I will discuss what can be interpreted as layers of meaning in the data. Lastly, I conclude by describing how a psychosocial interpretative framework, and the associated notion of experience, suggests interpretations of how nurses experience caring amidst developments in welfare technology.

Overall Findings

In our analysis of the interviews, two conspicuous observations throughout the data caught our attention. At times, the nurses talked about themselves and elderly care according to the political and societal ideals of elderly care and the use of welfare technology. They referred to the increasing numbers of elderly people in the years to come: "The wave of elderly people just keeps on coming" (Daisy). They talked about the lack of "hands" to take care of them: "We're not getting too many new pairs of hands for the work" (Julia). They also stated that they are instructed to use welfare technology: "There's a lot of focus in this municipality on using technology where it can be used*"* (Anna). Welfare technology, such as electronic medicine dispensers and global positioning systems (GPS), was described as increasing patients' autonomy and independence. The nurses also referred to the ideal of rehabilitation of older people: "Most people want to live at home as long as possible, so in that regard technology is very good, it makes it possible for people to stay at home a bit longer than otherwise, and makes it safe, and not everybody likes us coming four times a day [laughing], so they can be a bit more independent" (Sophia). The nurses also referred to the familiar dichotomy of "the classic warm hands, the cold technology" (Camilla). Often when they talked about care work, they used regulatory language "We must only do what is described in the instructions … very strict" (Emma).

The nurses' references to the above-mentioned policy ideals for elderly care were general and appeared to be detached from their everyday experiences of caring. When they talked about their experiences of caring, they mentioned patients, often multimorbid, who need extensive care to manage such basic needs as personal hygiene and nutrition and have to be looked after day and night. These patients will never be rehabilitated to the extent that they can care for themselves; on the contrary, they will deteriorate and die. Despite the policy ideal of increasing use of welfare technology, the nurses, except for one, did not refer to experiences with welfare technology when they talked about their day-to-day care, except when I asked about it. The welfare technologies they talked about did not match the care needs of most of their patients. Only some patients were said to benefit from GPS, as many were incapable of leaving the house or nursing home, or too cognitively impaired to use a medicine dispenser. The nurses spend time evaluating which patients may benefit from a medicine dispenser and monitoring

whether they take their medications, as they only know whether medicine is taken out of the dispenser, and not whether it has been taken. One nurse said that she searches for empty packs in the bin to determine whether patients have taken their medications.

The other observation we made was that the nurses seemed to lack language to describe the complexities involved in their caring. Their examples from their care work revealed a different picture of elderly care from the policy ideals. The nurses described a finely tuned relationship with the individual patient. They explained that they care for different patients in different ways, based on the individual patient's emotional and medical needs and life situation. The complexities involved in their caring could not be reflected by specific procedures or in a linear manner.

There were two themes in the data that appeared to embrace what we perceived as expressions of the complexities of the nurses' caring. The nurses often talked about lack of time as a threat to care for their patients in accordance with their professional understanding of what it means to be a nurse. Time constraints in various situations were related to care for the patients' emotional and social needs and their life situation, which are not covered by the strict instructions for the patient. The nurses spent considerable time finding a balance between their different patients' needs and divided their time between them to meet these needs.

> *"*There are also days when the patients are not like in a critical situation, but situations where you feel you were too quick and she was lonely today, I should have stayed a little longer at her place or he enjoyed having a visitor today but I didn't have time, I could only give the medications and then run off, you know, and you take it home with you, it's all about your conscience." (Anna)

Another topic that evolved in analyzing the interviews was the nurses' talk about using their nursing gaze in their care. In the health policy discourse, nurses are often referred to as hands, but this metaphor seems to obscure the qualifications of the nurses' caring. When the nurses discussed their competencies in care work, they did not refer to themselves as hands. Instead, they talked about their clinical gaze, their nursing gaze, their professional knowledge and experience, their nuanced evaluation of the individual patient's condition and cooperation with the patient's relatives.

The nurses' care descriptions appeared obvious to us; we implicitly understood and sensed them through the examples they provided, but it appeared to be difficult for the nurses to articulate their caring in a care discourse. To best describe the complexities of their care experiences amidst developments in welfare technology in elderly care, I will in the following present three cases, the cases of Emma, Sarah, and Camilla. The cases of Emma and Sarah illustrate what we perceived as a lack of discourse to fully describe the complexities and nuances involved in their caring for particular patients, where welfare technology did not appear to be a central aspect of their care experiences. Camilla differed from Emma and Sarah, as she exemplified a different care understanding, in which welfare technology constituted a defining part of her experience of providing care.

Knowing the Individual Patient

Emma has been a nurse for several years and has experience from hospitals and home care. Now she is one of the two nurses responsible for digital home care. She described home nursing in terms of its strict instructions with little flexibility to use her discretion to care for the individual patient "We are only allowed to do what is stated in the instructions". Consequently, if she had not been offered the opportunity to work in the digital home care office, she would have left the nursing profession.

The aim of digital home care is to remotely monitor patients such as those suffering from chronic obstructive pulmonary disease, diabetes, or cancer, to prevent unnecessary fluctuations and readmissions. The patients take the necessary measurements at home and send the results to the nurse in the digital home office. Emma described how interpreting readings by patients on the computer is about so much more than checking that they are within the acceptable limits: "It's more complicated than that, you have to do some searching". She explained that to understand whether patients are deteriorating, she needs to know the individual patient. With some patients she prefers to visit them at home, to see how they move, to see their face and to get an impression of who they are. Only by knowing them as individuals can she interpret their measurements and the development of their disease from the digital home office. The fact that she is allowed to use her professional discretion in the care of each patient is why she appreciates this position so much.

Listening to Emma's descriptions of care for particular patients, I did not understand exactly what competencies were involved in her care and I asked her more about this. She explained that understanding the individual patient's needs is part of the nurse's gaze, which involves her professional knowledge and experience and knowing and relating to each patient.

> "You have to use your nursing gaze and see what's going on … yes [laughs] yes, that's the way it is, it's just, well, it's your education".

To me, her sharing of her experience revealed nuances in the nurse's gaze that were not captured in her articulations about her professional knowledge and experience, and I continued to ask her about what was involved in the nursing gaze. In that context she talked about a patient who was to receive digital home care to monitor his chronic obstructive pulmonary disease but had not yet received the equipment and started the measurements. In the process of arranging this for the patient, Emma spoke to him on the phone and during this call she got the impression that he was about to drink himself to death. She had never met him and did not know anything about him except for the pulmonary disease. I asked how she sensed that he was about to drink himself to death, and she said there was something in his voice and what he said. It was Easter 2020 and Norwegian society was locked down due to the COVID-19 pandemic. The digital home office was closed during Easter. She talked to her superior about the condition of the patient, and even though Emma was off duty, they agreed that she should continue to phone him during Easter until they could provide a more appropriate solution after the holiday period. Emma learned that he had abused alcohol for years and refused rehabilitation. Several facilities turned him down, but finally Emma managed to find him a place.

Through this experience Emma explained what it means to use the "nurse's gaze" in caring for a patient. I was touched by Emma's sensitivity to this man and her sense of responsibility to hold on to him during the Easter holidays. Her way of talking about him suggested to me that through their phone calls she could sense this patient's despair and was able to contain him and keep him going through the critical days of the Easter holidays. Although she could not use her "gaze", as they spoke on the phone, she was

able to apply her medical knowledge, sensitivity, and ability to embrace the man's emotional state in this care experience.

This experience demonstrates that when Emma can speak about specific relational experiences with patients, she is able to describe the complexities of care for which she has no discourse. We can see that Emma not only used her professional knowledge, but also her subjectivity and discretion in caring for the man in this particular example. The case of Emma demonstrates how, despite her job in digital home care, relating to individual patients is the foundation of her ability to care. The digital care technology she uses involves tools to meet specific medical needs, while her caring is best described as based on her relating to individual patients.

Seeing the Person Behind the Diagnosis

Sarah has worked as a nurse in different fields of rehabilitation and in elderly care all her professional life and is planning to retire in a few years. For Sarah, nursing is all about "seeing the person behind the façade". She talked about seeing the person in front of you in order to look behind their diagnosis and life situation. When reading the interview with Sarah, both the interpretation group and I were emotionally moved by her description of her care. Sarah revealed one of her first experiences in nursing, when she and a colleague invited a patient who had not been outside her institution for about 20 years to go shopping on the patient's birthday. Sarah said that she would never forget the joy on this woman's face that day and she became emotional and wiped away a tear as she talked about the experience. Sarah continued to discuss recent experiences that were similarly about seeing the whole person, not just the patient's symptoms and diagnosis. One of these experiences involved two women, an old mother, and her adult daughter, who were in a difficult situation. These women were under Sarah's area of responsibility. She managed to help the daughter receive a diagnosis, which entitled her to a monthly state benefit and a small flat. Then Sarah talked about one of the patients she cares for now who suffers from dementia. This woman is in a wheelchair and has lost her ability to communicate verbally, but Sarah explained that she knows the kind of music this woman used to appreciate, saying: "Then you see her whole body lights up" when Sarah puts this music on.

Sarah talked about a radio programme on the increasing numbers of patients suffering from dementia in our society and the associated financial burden. In this context, Sarah referred to welfare technology and emphasised that there are many exciting technologies to use in elderly care. She then described the care needs of patients suffering from dementia based on her experience and explained that dementia is a demanding situation. Due to their loss of cognitive abilities, these patients "need interpersonal contact in their lives". Sarah said that she was afraid that the increased use of welfare technology will reduce the interpersonal contact that these patients need most.

In Sarah's ward they tried the medicine dispenser *Pilly*, but due to these patients' limited cognitive abilities, it was far too complicated for them to handle. She referred to discussions about the organisation of the dementia ward, and she seemed to blame herself for being concerned with the individual patients' situations and care needs, while being unable to focus on the larger picture of working with dementia patients.

Again, we see how difficult it was for Sarah to generalise using a discourse of care, and how she referred to examples of relating to particular patients to explore what care in nursing meant to her. Sarah does not oppose the use of welfare technology in her caring for dementia patients, but she is critical of its use when it does not match the needs of the patients or deprives them of the interpersonal contact they need in their lives.

Helping with Medical Needs

At the time of the interview, Camilla had been a nurse for six years and was working in home nursing. Describing her first year as a nurse, Camilla said that she felt "suffocated at the beginning … there was so much to do", but that new organisational models had made it easier to be a nurse.

During the interview with Camilla, I had a strong feeling of being completely worthless and in the interpretation group we reflected on different ways of understanding this reaction. One possible interpretation of this reaction was discussed in relation to Camilla's understanding of care. Camilla articulated a different understanding of elderly care from that of the other nurses. In talking about her nursing, Camilla focused on practicalities and organisational aspects of home care. Early in the interview Camilla described herself as a technological optimist and said that every nurse should be. Camilla has used welfare technology since she started as a nurse, and she is satisfied with it. The

welfare technologies used in her unit include GPS and medicine dispensers, but many patients receive traditional home care. Camilla sees the use of welfare technology as a solution for society's ability to care for the increasing numbers of elderly people. She explained how digital medicine dispensers can promote freedom as patients do not have to wait for the nurse to deliver the medicines: "Being able to leave the house and for many people not having to wait is a relief". However, one of her concerns was how the clinical gaze can be digitalized; she found this to be a challenge.

Camilla explained that welfare technologies are expensive, and she placed them within a cost-benefit rationality. Municipalities need to save money to use them. A patient will receive a dispenser if it reduces costs. However, if a nurse must visit the patient for other needs, the patient will not be given the dispenser. In relation to this, I asked Camilla about times when she felt that her professional viewpoint suggested a different assessment than cost-benefit rationality. She replied that she thought everybody experiences this at times and explained that she had become so accustomed to working within this rationality that she finds it difficult to separate her professional viewpoint from the cost-benefit rationality. In relation to this rationality, she talked about prioritising patient-related instructions as a trade-off between different patients to reach the budget. However, she did disagree strongly with the cost-benefit rationality when patients who are obviously incapable of living at home are refused a place in a nursing home and described this as unethical. She explained that she had spoken up in such cases, and that the logic of trade-offs between patients to balance the budget was a difficult position to be in.

Camilla expressed herself in dichotomies when discussing her understanding of the nursing role and use of welfare technology. She simplified what it meant to be a professional "We are not your friend; we are professionals who will help you medically" when she spoke about the nursing role. Camilla questioned the traditional nursing role of being at the patient's bedside and caring for both their medical and emotional needs. She also referred to the well-known dichotomy of warm hands and cold technology, and reversed this by pointing to research that has emphasised that patients living at home are happy with fewer visits if they feel taken care of in other ways.

Camilla differs from the other nurses in this study. She describes herself as a technological optimist and discusses the nursing role in terms of a dichotomy between the use of welfare technology and the traditional nursing role where the nurse was meant

to care for patients' emotional, social and medical needs. She idealizes the use of welfare technology, such as medicine dispensers being tools that create predetermined outcomes for patients such as greater freedom. However, when economic concerns conflict with her professional discretion, for example when patients who need to be in nursing homes are refused a place, she does oppose the economic rationality in organizing elderly care.

Discussion: Holistic Care, Medical Needs and Welfare Technology

Emma, Sarah, and Camilla have different experiences of providing elderly care amidst developments in welfare technology. Emma and Sarah expressed themselves within the policy ideals of developments in welfare technology, but when they described their day-to-day care for the elderly, a form of complex care was revealed. It was difficult for them to describe the nuances and complexities of their care work in general terms. Such general talk about their care work was avoided by speaking about specific relational experiences with patients. They relate to and care for their patients' medical and emotional needs as well as their life situations. They find ways to provide care within structures of strict instructions and time constraints. They seem to integrate the use of welfare technology as tools when appropriate. In the following I refer to their care provision as holistic care.

Camilla differs from Emma and Sarah. Camilla described herself as a technological optimist and positioned herself in relation to the historical nursing role of being at the patient's bedside. She argued that the historical nursing role is intrusive and paternalistic. Her understanding of care is structured around a dichotomisation between nurses performing medical tasks and being distant and nurses caring for patients' emotional needs by being present for them. The interpretation group suggested that this dichotomisation could be interpreted as a split between the patient's emotional and medical care needs, rationalised as the ideal for patient autonomy and independence.

A common feature of the interviews was that we did not fully understand the nurses' general talk about welfare technology as the solution to the increasing numbers of elderly and the shortage of nurses in the years to come. It was not clear to us how the welfare technologies to which these nurses referred, such as GPS, medicine dispensers and digital home care, could solve challenges related to the increasing number of elderly people with extensive care needs and their death. Furthermore, despite their general talk about welfare technology, these nurses experienced caring in welfare technology

developments in different ways. Emma and Sarah used welfare technology when appropriate as tools in their holistic care, whereas Camilla viewed welfare technology as the new approach to elderly care.

The life history perspective, which focuses on the experiencing subject, opens up an understanding of this general talk that can be seen as a boundary zone between socially codified knowledge and individual sensory experiences. Thomas Leithauser's (1976) expression "the general vagueness of communication of everyday life" is useful in exploring the relationship between welfare technology as socially codified knowledge and the differences between the nurses' experiences of caring amidst developments in welfare technology.

Kirsten Weber explores the "general vagueness of communication" as concerning substance and social reference and is recognised as such when someone that does not belong to the specific community searches for a general cultural meaning in what is said, but cannot find it (Weber, 2020)). This "communication takes place in a field defined around the "lowest common denominator" of observation, between the substance that the communication is explicitly about and the subjectivity and experience of the people involved" (Weber, 2020, p. 33). When people within a specific community react in individually different manners, and the differences are not articulated, it is difficult to perceive otherness (Weber, 2020). The "general vagueness of communication" takes place and functions as the glue that keeps everyday life together, by hiding differences and enabling the process of "getting on" (Weber, 2020). Instead of articulating discrepancies, "some emotional complementary compensation takes over, so that recognition or silencing and denial in various and changing combinations sustain one another" (Weber, 2020, p. 34). This communication through symbols does not produce consensus, but functions well in communication, even if based on prejudice or articulated in cliches (Weber, 2020). Weber (2020) explains this as the psychoanalytic dimension of the understanding of subjective learning. When faced with contradictions, people will relate to external stimuli and their internal resources in different ways (Weber, 2020). From this perspective, Leithauser's term "general vagueness of communication" can describe what appears to be the shared symbols that are at hand for the nurses to organise their self-images and experiences in their nursing work (Weber, 2020). The nurses' talk about welfare technology may not only be understood as objects and acting. It may also

be seen as triggering emotions and the subjectivity and experience of those involved (Weber, 2020).

The historical and societal conditions of the nursing role and care can suggest "the general vagueness of communication" as one interpretative framework for Emma's and Sarah's general talk about welfare technology and their holistic care. The nurse is situated in a particular historically conditioned form of female gender construction (Vike, 2013). Modern nursing represents a specific form of processing the pre-reformation and modern constructions of the feminine (Vike, 2013) and can be understood in the ambivalence between women's subordination and independence (Adriansen, 2015). The nursing profession is founded on a relational ontology that sees individuals as dependent on and responsible for each other (Martinsen, 2012). The nurse is responsible for acquiring the knowledge necessary to understand the patient's needs, regardless of whether these are physical or existential needs (Delmar, 2013). The nurse must assess each situation individually and care built on relationships involves task-oriented work (Fjørtoft et al., 2021). In complex social and societal situatedness, care-based nursing has been legitimized as an alternative to the natural science paradigm, which is the foundation for medicine and instrumental organisational governance and politics (Vike, 2013). Gendered holistic care, which has been rendered elusive by the dominant political discourse and organizational governance, can, in comparison to formal academic knowledge, be seen as a subordinated form of knowing. At this new historical point in time, when welfare technology enters the scene, there is a new clash between these two forms of knowing. Within this societal and historical situatedness, the nurses' general talk about welfare technology and their struggle to articulate a holistic care discourse may be understood as the product of their individual learning through the process of their being-in-the world experience (Olesen, 2002). In a contradictory way, nurses' learning process may be seen as the acquisition of symbolic knowledge, their holistic care as a subordinate form of knowing. Unable to articulate their holistic care through a care discourse, they express themselves in terms of the discourses at hand, such as their general talk about welfare technology. The societal silencing of holistic care and the nurses' limited ability to articulate their holistic care provision, due to its symbolic nature, can in turn be understood as a dimension of oppression (Weber, 2020). Nurses and holistic care can then

be seen as existing in a societal sphere of suppression, positioning these nurses in a double bind of suppression (Weber, 2020).

The interpretation of Camilla's general talk about welfare technology as the "general vagueness of communication" opens up another layer of meaning. In Camilla's case, welfare technology may be seen not only as an object solving the problem of the shortage of nurses, but also as a tool providing specific outcomes for patients. Welfare technology may also be seen as a symbol, an object triggering emotion, in Camilla's experience of caring. Camilla's understanding of care and the use of welfare technology are structured around the dichotomisation between nurses performing medical tasks and being distant, and nurses being present and caring for the patients' emotional needs and life situation. In this dichotomy welfare technology becomes a tool for the nurse to withdraw from relating to patients and caring for their emotional needs. The use of welfare technology may then be interpreted as a form of defense against the complexities involved in relating to patients' emotional needs and life situations. In turn, Camilla's defence against the complexities of holistic care may be seen as partly based on different societal forces and her life history experiences, manifesting itself as idealization of the use of welfare technology in elderly care. In this interpretative framework, Camilla's general talk about welfare technology may be interpreted as a defense against relating to patients' non-medical needs. In this case, welfare technology such as medicine dispensers can be seen as a tool to help the nurse to avoid relating to such needs.

Conclusion

In this article I have illustrated how a psychosocial approach and its theorising of experience contributes to answering this article's research question: How do nurses experience caring amidst developments in welfare technology in elderly care? The focus on the experiencing subject enables an understanding of the nurses' general talk about welfare technology as a boundary zone between socially codified knowledge and individual sensory experiences. This critical perspective particularly illustrates how welfare technologies must not be understood one-dimensionally as tools providing specific outcomes. The social and societal situatedness of the nursing profession gave rise to several contradictory notions among the nurses about welfare technology and its function in care for older people. Emma and Sarah, despite their trust in welfare

technology, continue to work within a holistic care rationality where medicine dispensers, GPS or digital nursing are seen as helpful or unhelpful tools, and are integrated or not, depending on whether they are considered useful. In Camilla's case I showed that her split between patients' medical and emotional needs is used to rationalise her confidence in welfare technology as a means to give elderly people autonomy and independence. Welfare technology in this perspective may be seen as a tool to help the nurse to avoid caring for patients' emotional needs and life situation.

At this new historical point in time, when welfare technology enters the scene, leading to a new clash between the formal academic form of knowing and nurses' unarticulated holistic caring, formal academic knowledge may dominate the already subordinated holistic care knowledge. The use of welfare technology and the normalisation of not relating to patients places nurses and nursing in a societal contradiction: the nursing profession is supposed to care but welfare technology might be used as a tool to withdraw from relating to patients. Nurses' acceptance of the welfare technology narrative may in turn change the relational foundation for the nursing profession and what it means to care.

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