


# Patient Centeredness from a Perspective of History of the Present: A Genealogical Analysis

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## Abstract

The overall aim of this study, performed in Sweden, was to problematize the contemporary national and transnational discourse on patient centeredness, which during recent decades has become a given, having become established as a dogma in conversations, writing, and thinking about patients and health care. We did that by showing that ideas such as patient centeredness can be seen differently from the way they are depicted in contemporary discourses about health care. In the presented analysis, we drew on Foucault's concepts of governmentality, 'history of the present' and genealogy. This means that we reflected on contemporary conceptions of how phenomena, such as the care seeker, have been constructed within other discourses about health care. Empirically, we used different health policy documents—government reports from three different historical periods. The analysis showed that contemporary narratives about centeredness are neither more, nor less, care seeker-centered than the narratives of yesteryear. Rather, the phenomenon of the care seeker is given different frames and meanings within the framework of different economic and historical discourses about health care. Our analysis raised questions about the contemporary construction of patient centeredness. In a world with such huge economic differences between nations, as well as between citizens within most nations, the contemporary discourse may be limited as it does not problematize structural issues in the same way as previous discourses had done. Perhaps what is needed today are national and international patient-centered or person-centered discourses which also discuss policies and practices that are population- and social group-centered. In the final discussion of the analysis, we identified a new patient-centered discourse, which views the patient as a resource among other resources. The most important limitation of this type of study is that it is only about discourses and policy issues and not about daily practical activities.

## Keywords

genealogy, government reports, history of the present, patient centeredness, person centeredness, shared decision making, Sweden

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## Introduction

The purpose of this study, performed in Sweden, was to discuss and problematize the discourses on patient centeredness which form the basis for contemporary national, international, and transnational reforms in the field of health care. For some decades, a discursive movement has been underway with the stated aim to change the position and power of care seekers in the health care system (EPF, 2016; Swedish Code of Statutes, 2014: p. 821; WHO, 2016). This study was conducted to explore the implications of the discursive movement. According to the discourse, both the effort to improve patients' quality of life and the endeavor to reduce society's costs are important driving forces in this development (Castro et al., 2016; EPF, 2016; Hewitt-Taylor, 2015; Schofield et al., 2012; Siouta, 2016; Siouta et al., 2019;

Slater, 2006; WHO, 2016). The goal is that the patient should be active and involved in all aspects of his or her own care (Ekman et al., 2011; Hewitt-Taylor, 2015; Siouta, 2016; Siouta et al., 2019). This endeavor, in terms of patient centering, has influenced national guidelines and policy in various countries and organizations including the US, the UK, Australia, New Zealand, Norway, and Sweden, as well as the EU and World Health Organization (WHO) (Broom et al., 2019; Hewitt-Taylor, 2015; Kitson et al., 2013). Furthermore,

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similar discussions about ‘centeredness’ are held also in other areas of society; for instance in education, pupil or student centering is in focus (Olsson et al., 2018). Therefore, this can be seen as an expression of a profound political change in how we should perceive health care, education, and society, and how we as individuals should be and become. This discussion is included, not only in the contemporary discourse on health care and education but also in the discourse on society as a whole. We hope that, by identifying and describing the change, our study will contribute to deepening a critical understanding of what is going on in the health care system (and across society), regarding patient (and student, etc) centeredness.

The meaning of the concept of patient centeredness is not entirely clear. Pluut (2016) identified three different discourses on patient centeredness: (1) Caring for patients; the patient is constructed as a whole and vulnerable person who needs help. The main roles of the health professionals are to care, lessen suffering, and take responsibility for decision making. The information given to the patient is given to promote patient compliance; (2) Empowering patients; the patient is constructed as an autonomous decision maker and the role of the health professionals is to advise and coach the patient in decision making and facilitate this process for the patient. Information to the patient is given to make the patient’s choice possible; and (3) Being responsive; the health professionals have to be responsive to the context, the patient’s values, needs, and varying preferences, as there is no best way to carry out the encounter with the patient. The health professionals have to tailor the information, sometimes for compliance and sometimes for choice, and sometimes they have to withhold the information. The decisions are made by the professionals and/or the patient depending on the context and on who the patient is. Pluut’s discourse analysis (2016) has been useful in the discussion of the study carried out here.

*We* analyzed patient centering differently from the way it is usually studied in today’s research. In this study, we were not interested in issues such as what patient centeredness means for the recovery process or what is required from the patients, relatives, and staff. Nor have we focused on issues such as implementation, goals, organization, resources, and results. The findings from these kinds of research include that patient-centered care models are cost-effective and that they improve patients’ experience and clinical outcomes (Broom et al., 2019; Ekman et al., 2011; Kitson et al., 2013; Siouta, 2016; Siouta et al., 2019). Our main theoretical perspective was Foucault’s concept of governmentality (1994a). This means that we were interested in the politics of patient centering, that is, in how patient centering functions as a key concept in the contemporary policy on health care and health care delivery. We were interested in the kind of staff and care seekers we are expected to be and become, and in who we need to be, to be included in the contemporary discourse and vision of patient centering. Furthermore, we were interested

in how these constructions operated as governmental rationality in a contemporary context as well as in historical health care contexts (Foucault, 1994a; Olsson et al., 2018; Popkewitz, 2008; Rodin, 2015). Our methodological approach was genealogy and the history of the present. This means that this study aimed to deepen, not the understanding of past time (history), but the understanding of the present time. We used three historical discourses and constructions of the subject “care seeker” to render problematic our assumptions about the contemporary discourse (Foucault, 1994b; Popkewitz, 2008).

There is some research of relevance for our study. Pluut (2016) identified three different discourses on patient centeredness. Fage-Butle (2011) analyzed the value of patient information and communication from a discursive point of view. Rodin (2015) investigated how the discourses on humanization and economic efficiency are shaping professionals’ mentality in such a way that humanization is being destabilized. Marlin et al. (2013) studied how power acts on subjectification and behavior in professional contexts. Van Rensburg et al.’s (2016) governmentality study examined how power is (re)produced, channeled, and negotiated between health professionals and patients. However, there are no studies of patient centeredness from our perspective, namely, the perspective of history of the present, or genealogy.

## Theory

The genealogical approach in this study meant that we compared contemporary discourses with two different historical discourses. Drawing on Foucault (1990), we can state that discourse is about what is said, and what can be said and thought about certain phenomena, in this case, phenomena such as health care, health care professionals, and health care seekers in different historical and social contexts. Thus, discourses govern how a topic can be meaningfully talked and reasoned about. Discourses also influence how ideas, in this case, the idea of patient centeredness, are put into practice and regulate and govern the conduct of subjects such as health care professionals and health care seekers. Therefore, we were interested in the governmental rationalities that permeate the discourses. We used Foucault’s concept of governmentality to think about conditions that make the present possible—in this case, discursive formation of the contemporary health care system, health care professionals, and care seekers concerning patient-centered care (Foucault, 1994a; Petersson et al., 2014; Rodin, 2015). This kind of analysis has the advantage that it does not require a prior definition of concepts such as health professionals, patients, patient centeredness, or shared decision making (Petersson et al., 2014; Popkewitz, 2008). Instead, it enabled us to study how these concepts and other floating signifiers acquire meaning within particular regimes of discourse and practice. Studies on governmentality pay particular attention to the relationships

between governance, knowledge, power, and political reasoning concerning questions such as how to govern those who are expected to govern themselves, and how much to govern (Pettersson et al., 2014; Popkewitz, 2008). The analytical potential of the concept shows itself in its ability to bring together studies of governance of entities such as the society, the health care system, the clinic, the staff, and the patient.

## Methodology

The methodological approach of our analysis was based on Foucault's concepts of genealogy and history of the present (Foucault, 1994b). We used three historical discourses and constructions of the subject "care seeker" to render problematic our assumptions about the contemporary discourse (Foucault, 1994b; Popkewitz, 2008). The concepts provided a way to deepen the understanding of how discourses, ideas, and practices develop, change, and come to be seen as truthful and powerful in different historical contexts. We used the perspective to reflect contemporary conceptions, in this case, the conception of patient centering, against how similar phenomena have been constructed at different times or within other discourses about health care. The purpose of this approach is to shake up conceptions that are, to a greater or lesser extent, taken for granted at the present. We did this by showing that ideas such as patient centeredness can be seen differently from the way they are seen in contemporary discourses. Not that one discourse, and, hence, construction, of the care seeker is better than any other, but reflecting today's ideas against the background of other possible discourses could contribute to expanding the freedom of thought in conversations around contemporary questions of health care. As our interest was genealogy or history of the present, we examined how different phenomena were constructed in texts rather than what actually happens in the field of health care as practical activities (Foucault, 1990). Ethical approval was not obtained because the empirical sources for this article are authoritative health care texts that are all publicly available.

The study was conducted in a Swedish context. The Swedish Health and Medical Care Act stipulates that health care professions have an obligation to involve the care seeker in his or her care to enable shared decision making (Swedish Code of Statutes, 2014, p. 821). Despite the Swedish context, we believe that the conclusions of the analysis will be relevant internationally as well because the problematized contemporary discourse is transnational. Thus, we have undertaken a case study that has bearing in most national contexts (Bryman, 2008).

We started our analysis by looking at contemporary documents about patient centering, followed by documents from two different historical periods, the 1950s/1960s and the 1970s/1980s. The empirical sources for this article were 12 official health documents, government reports following

investigations, in Swedish known as *Statens offentliga utredningar* (SOU) (see Appendix 1, Empirical sources). In Sweden, important political decisions, for example decisions regarding legislation and change in socially important activities such as health care and education, can only be taken following an official investigation. The investigation is carried out by a committee consisting of representatives of political parties, relevant authorities, interest groups, and various experts. The report of the inquiry is then sent for a referral to various social organizations. Finally, the government presents a proposal for a decision by parliament.

We searched the reports in [regina.kb.se/SOU/](http://regina.kb.se/SOU/) where all government reports from 1922 to 1999 are digitalized, and in <https://www.regeringen.se/rattsliga-dokument/statens-offentliga-utredningar/> where all reports from 2000 are digitalized. Therefore, all government reports can be read online. We selected all relevant SOU reports from three periods because they have been of crucial importance in the development and (re)construction of the welfare state and health care system in Sweden. During the 1950s and the 1960s in Sweden, the economy expanded, which meant that large financial resources could be invested in health care. During the late 1970s and early 1980s, the economic conditions of the welfare state, and therefore also of the health care system, started to deteriorate dramatically. Then, during the 1990s, a new discourse emerged in the documents. The Swedish welfare model was undergoing change, with huge effects on the health care system. Parts of the health care system were being privatized to promote competition among different health care providers. Care seekers were given the freedom to choose between different caregivers and different forms of treatment. Therefore, the documents were central in shaping the discourses about health and health care. Furthermore, we also included a contemporary discourse that did not emerge in government reports, namely, the discourse on person centeredness. This discourse is considered to be a counterdiscourse to the patient-centered discourse (Broom et al., 2019; Ekman et al., 2011; Miles, 2017; Starfield, 2011). The care seeker of the patient-centered discourse is, according to Ottosson (1999) and Pluut (2016), placed within a biopsychosocial perspective where health and illness are seen as embedded in people's overall life situation. The care seeker of the person-centered discourse is placed within a phenomenological and hermeneutical perspective with a focus on the care seeker's narrative about his or her own life-world (Broom et al., 2019).

The genealogical analysis of the empirical material and the presentation of the findings were guided by Dean's questions (2013): (1) What problems are constructed in the documents?; (2) What solutions are constructed?; and (3) How are the included and excluded subjects, patients, and staff constructed? For this paper, we refer to recipients of care as "care seekers." When we use the terms "patient," "person," or "individual," we refer to the textual data, that is, to how the concepts are used in the documents.

## Results

### Problematization of Available Resources

The presentation of the results begins with an analysis of the problems that were constructed and addressed within the three abovementioned periods. According to the contemporary discourse (patient-centered as well as person-centered), we are currently facing a global crisis of increasing costs in the health care sector (SOU, 2016). This problem is especially severe in Sweden, according to the Swedish government report titled “Effective care”:

*The rate of increase in costs in the Swedish healthcare system is faster than in many other countries. Sweden currently has healthcare costs that are clearly above the average in the OECD. (SOU 2016: 2, p. 118)*

Moreover, large cost increases are expected “for the foreseeable future,” mainly because the proportion of elderly people in the population is increasing and consequently there are increased costs for the treatment of various lifelong chronic diseases (SOU 2016: 2, p. 118). Furthermore, technical and medical developments in health care are considered to be cost-driven (SOU 2013: 2).

Another problem is the lack of staff (SOU 2016: 2). According to the narrative, all kinds of different resources, economic, and personnel, which historically built up the Swedish health care system, will be limited in the future (SOU 2017: 47; SOU 2013: 2).

However, the problematization of resources is by no means new. Even in the government reports from the 1970s and 1980s, the future was constructed and problematized as threatening in economic terms. According to various government reports, the health care costs had become too high during the first few post-World War II decades (SOU 1979: 78; SOU 1981: 2; SOU 1984: 39). The documents from the 1970s and 1980s also stressed that there was a risk of costs further increasing because of cost-driven medical–technical development and because the proportion of the elderly in the population was expected to grow.

Another problem, also during this period, was the lack of medical staff (SOU 1979: 78). The increase in costs was considered particularly problematic because the resources were expected to decrease due to “declining economic growth in the country” (SOU 1979: 78, p. 18).

Against this background, the requirements on priorities in the health care sector and on efficiency in the broad sense will be tightened. (SOU 1979: 26, p. 48)

The economic problems were in part due to individuals’ unhealthy lifestyle practices. Therefore, it was argued that preventive measures would be a “better method of dealing with the growing needs and resource problems” than would demanding a continued expansion of the health care system

(SOU 1984: 39, p. 99). Preventive measures would lead to a reduction in the financial burden on the health care system and better utilization of resources, especially as one of the health care problems was considered to be the lack of personnel (SOU 1984: 39, p. 99; SOU 1977: 66).

*It cannot be ruled out that the development we outlined with better-informed patients will lead to staff and other resources being better utilized than before. (SOU 1977: 66, pp. 93–94)*

The threatening future that was constructed during the 1970s and 1980s was set against a picture of an expansive economy in the previous period, of the 1950s and 1960s. Whereas the question in the 1960s had been how the growing economic resources should be distributed, the question in the 1970s and 1980s was how reduced resources should be prioritized while needs were increasing (SOU 1979: 26).

In the discourse that emerged during the 1950s and 1960s, the economy was problematized in a completely different way than in either contemporary discourse or the discourse of the 1970s/1980s. Instead of constructing the future as a threat in terms of economy, the discourse was shaped by hope in economic terms—hope that the strong expansion of the social economy in the post-World War II period and, therefore, of health and medical care, would continue into the foreseeable future. There were still problems to be solved as there were still large population groups that were poor and lived under “extremely difficult conditions” (SOU 1958: 15). Against the backdrop of these neglected needs, as well as the desire to utilize continued medical advances, demands for a high rate of expansion continued.

*[. . .] one must accept that the total healthcare cost share in gross domestic product will continue to rise even more. (SOU 1963: 21, p. 68)*

Despite the fact that health care had already been expanded, there were still major problems, since the potential demand for care, from mainly poorer groups, was much greater than the supply. In view of the expected economic growth, it was therefore argued that “there are strong reasons for allowing the expansion to continue” (SOU 1958: 15, p. 134).

*Although one completely disregards the individual’s happiness opportunities and needs and sees the matter from narrow socioeconomic considerations, healthcare costs thus largely represent a profitable investment. (SOU 1958: 15, p. 145)*

Health care was simply seen as a profitable investment for the whole of society even if this view considered only the economic aspects. Also in this period, the staff question was problematized in a way that resembled the two other periods. The lack of staff, doctors as well as nurses, was considered the most difficult problem during the time (SOU 1948: 14; SOU 1963: 15).



### **The Problematization of the Existing Hierarchical System within the Health Care System**

Another issue that is problematized in contemporary discourse is the existing power relationships in the health care system, in particular the position of the patients. It is of great importance to equip the patient with both power and knowledge, which requires a change in the power relations in the health care system.

*A better balance of power between the patient and the health care professions also creates better conditions for engaging the patient in their own treatment. (SOU 2013: 2, p. 66)*

A changed balance of power between the staff and the patients is therefore considered to be a prerequisite for the patient to be “able to make active choices” between both different caregivers and different forms of treatment (SOU 2016: 2, p. 65).

However, the problematization of the hierarchical system is not new. Even in the government reports from the 1970s and 1980s, the internal structure of the health care system was problematized, in particular the relationships between different staff groups. It was claimed that these relationships must be given “special attention,” especially as deficiencies in the relationship between staff groups were ‘reflected in the relationships between staff and patients’ (SOU 1977: 66, p. 29). The authoritarian and hierarchical structure created problems of cooperation and communication between different staff groups and between the staff and patients. Thus, it limited patients’ co-influence in their own care situation, which was considered problematic in view of the democratization in the rest of society (SOU 1977: 66).

In the discourse that took shape during the 1950s to the 1960s, the patient’s position in the hierarchical health care system was not problematized in the same way as in the two discourses above. Rather, the power issues that were constructed and problematized in this discourse concerned the hierarchical system in the whole of society where large population groups were poor and lived under “extremely difficult conditions” (SOU 1958: 15). And since the demand for care, mainly from the poorer groups, was much greater than the supply, there was strong reason to focus on these groups (SOU 1958: 15).

### **Solutions Constructed in the Discourses**

In the contemporary narrative of a threatened future, patient centering as well as person centering is seen as a solution to the problems and as a hope for the future. The government report on patient power claims that patient centering has proven to be cost-effective and improve patients’ experiences of care (SOU 2013: 2).

*Patient-centered care models have been shown to be cost-effective as well as to improve the patient experience and clinical outcomes. (SOU 2013: 2, p. 48)*

Patient-centered as well as person-centered care will shorten care times, reduce sick leave, reduce medical complications, and improve the quality of life and self-confidence of patients (SOU 2013: 2). The hope and aim are that changes in the power relations within the health care system will result in more efficient use of the financial and personnel resources in the health care system because there is ‘every reason to build systems in the health and medical care that effectively utilize all existing resources’ in both health care practice and preventive activities (SOU 2013: 2, p. 80). Against this background, the patient, in the patient-centered discourse, is assigned a central position, role, and responsibility in the care team.

*[. . .] which means that tasks and responsibilities relating to the individual’s care naturally are “delegated” to the patient according to his or her competence and ability. (SOU 2016: 2, p. 142)*

The patient thus becomes a part of the team’s delegation order in the same way as the members of the caring staff are part of this order, that is, as a resource among other resources. To make delegation possible, the patients have to be equipped with both power and knowledge, which requires the power relations in the health care system to be changed.

*Strengthening the patient’s opportunities and rights to relevant and useful knowledge is a means of strengthening the patient’s power. (SOU 2013: 2, p. 66)*

Strengthened power and “in-depth knowledge” are considered a prerequisite for the patient to be “able to make active choices” (SOU 2016: 2, p. 65).

However, the construction of the care seeker with a focus on individuality as a solution and hope for the future is not something new. Also in the discourse from the 1960s and 1970s, this kind of construction of the care seeker appeared, in this case referred to as “individual-centered care.”

*The individual-centered care [. . .] contains a broad register of supportive and treating measures that the individual himself could perform if he had the necessary power, will, or knowledge and aim to help to “recover his independence as soon as possible”. (SOU 1979: 26, p. 57)*

Therefore, it was considered important to “activate the care seeker” (SOU 1977: 66, p. 67). To make this possible, the patient had to receive information and knowledge about the whole caring process in a form that was “strongly individualized to the individual patient” and that required changes in the power relations in the health care system (SOU 1979: 26, p. 50).

Another solution and hope for the future was to strengthen the so-called “group care model” that could contribute to changing the current role distribution between different staff groups, and between staff and patients (SOU 1977: 66, p. 68). According to this model, care seekers and caregivers were divided into groups and the care within each group of care seekers was managed by one and the same staff group.

*The benefits of group care are considered to be, among other things, that it provides better care for the patients—better contacts and, therefore, safety—and greater job satisfaction for the staff—better communication—and thus strengthens the democratic spirit. (SOU 1977: 66, p. 68)*

Group care was therefore considered to be able to solve a number of the problems constructed in the text. Through fewer and better contacts, continuity for the care seeker was hoped to be improved while the work satisfaction for the staff was expected to increase.

However, group care differed from team care which was constructed in patient-centered discourses, in that, in group care, the care seeker was not constructed as a team member, co-participant, and part of the delegation order in the way this is being done in contemporary discourse.

The solutions and hopes for the future that were constructed and that dominated the discourse of the 1950s and 1960s did not construct health care in terms of the care seeker’s individuality. The hope for the future that was constructed in the discourse was the expected progress of medical science and developments in the health care system (SOU 1963: 21). This hope was constructed already in the late 1940s (SOU 1948: 14; SOU 1948: 24). In a government report from 1948, it was argued that the ‘full use of the results of medical science’ would lead to a significant improvement in the health of the population (SOU 1948: 14, p. 17). In the discourse that took shape during the 1940s to the 1960s, the doctor’s medical practice was in focus (SOU 1948: 14; SOU 1963: 21). Also in this discourse, the activities in the health care departments were designed as teamwork, which, however, included only nurses, sub nurses, and health care assistants, but not the physician (SOU 1964: 45). However, since the personnel situation, that is, the shortage of doctors and nurses, was constructed as problematic, it was argued that existing resources must be better utilized by investing significantly more in open care and “recurrent general health surveys” for the entire population (SOU 1958: 15, p. 59).

Another area of importance for both the individual and the society’s economy was, according to the discourse, health-informing activities, those oriented toward the environment as well as those focused on personal care.

*Often, the organized health information, which is directed at different groups within society, has the dual purpose of influencing the individual’s habits and way of life in both his own [interests] and the interests of society. (SOU 1958: 15, p. 59)*

Therefore, the discourse that emerged during the first few post-war decades can be regarded as a system-centered and population-oriented discourse.

## The Construction of the Subject—the Care Seeker

The purpose of the following section is to deepen the analysis of what qualities, abilities, responsibilities, roles, and positions are attributed to the care seeker within the different discourses.

### The Construction of the Care Seeker in the Patient-Centered Discourse

In the patient-centered discourse, the care seeker is constructed as a so far “relatively untapped resource,” as a resource among all other resources and as a hope for the future (SOU 2013: 2, p. 80). The patient is also constructed as a “unique person” with his or her own will and preferences, rather than as a carrier of disease (SOU 2016: 2, p. 11).

*Some key themes are to see the patient as a unique person rather than as a carrier of a disease, [and to recognize] that the patient has their own will and their own preferences and that the patient wants to be involved in decisions about their own care. (SOU 2016: 2, p. 14)*

The patient is furthermore constructed as a “self-determining” and “decision-making” subject and as a “co-creator” of his or her own care (SOU 2013: 2, p. 78). These characteristics or abilities are present in the great majority of the population; and therefore, most of the population is included in the constructed patient-centered discourse (SOU 2013: 2). However, there are some groups that are constructed as excluded, namely, those who are “unable to make decisions,” who cannot or do not want to be active decision makers, such as elderly patients or patients in a very serious condition (SOU 2013: 2, p. 14). Also, some more problematic patients are potential decision makers, but refuse to be an active, learning, and participating resource, in spite of the fact that most of them have the resources and capacity to fulfill the expectations constructed in the discourse (SOU 2013: 2).

The patient as a resource among other resources is expected to contribute to solving both his and her own health problems and, in doing so, the expected financial problems of the health care system. The patient who emerges in the discourse on patient centering is therefore constructed not only as an object with health problems but also as one of the solutions of him or herself as a problem. Thus, the construction of the future establishes the care seeker as a key actor in promoting her or his health as well as promoting the sustainability of the health care system.

## The Construction of the Care Seeker in the Person-Centered Discourse

In the person-centered discourse, the care seeker is likewise constructed as a hope for the future in terms of his or her qualities and abilities, by being active, participating, and responsible in an economically threatening context of “already overburdened health care systems throughout the world” (Ekman et al., 2011, p. 248).

However, according to Ekman et al. (2011) and the Gothenburg Center of Person-Centered Care (GPCC, 2018), the term “patient” tends to objectify the care seeker and put the disease in central focus, while the word “person” is assumed to support, or contribute to supporting, the care seeker’s sense of being not a “part person,” but a “whole person” (Ekman et al., 2011).

*In our view, the word “patient” tends to objectify and reduce the person to a mere recipient of medical services, or to “one who is acted on.” Person-centered care highlights the importance of knowing the person behind the patient—as a human being with reason, will, feelings and needs—in order to engage the person as an active partner in his/her care and treatment. (Ekman et al., 2011, p. 249)*

Thus, in the context of the person-centered narrative, the *patient* is constructed as “one who is acted on,” objectified, and reduced to being a recipient of medical services, without will, feelings, and needs. In contrast to the construction of the care seeker as a passive patient, the care seeker as a *person* is constructed as an active person with a will, feelings, and needs. The care seeker in the person-centered discourse is also equipped with dispositions and characteristics, such as being unique and self-determining, and learning and participating in shared decision making, and at the same time is vulnerable (Ekman et al., 2011). However, in both discourses, patient and person, the care seeker is constructed as an active partner equipped with dispositions and characteristics such as being unique and self-determining, and learning and participating in shared decision making. Thus, the construction of the *patient* in the patient-centered discourse and the construction of the *person* in the person-centered discourse seem to be more or less the same. However, the construction of, or the meaning given to, the concept *patient* in the person-centered discourse is not the same as the construction of and meaning that is given to the *patient* in the patient-centered discourse. Thus, the limited construction of the concept of the patient in the person-centered discourse appears to be a rhetorical means to argue for the concept of person.

In the person-centered narrative, the person is constructed as a whole and unique subject through the use of phenomenological, hermeneutic, and interpretive images (Broom et al., 2019; Ekman et al., 2014).

*The staff should, as listeners, have a phenomenological approach and interpretive approach, i.e. be responsive and try*

*to understand what this person wants to tell. (Ekman et al., 2014, p. 8)*

Using the phenomenological image, the person-centered discourse stresses the person’s narrative as it can “capture the person’s suffering in an everyday context” (Ekman et al., 2011, p. 249). The patient is also constructed as a narrator who can tell freely; and the nurse is constructed as a listener who listens responsively and with understanding to the narrator’s life story or life-world and whole life situation (Ekman et al., 2014). Thus, the person is constructed as someone to listen to and understand, and not as part of the team’s delegation, and as a resource among other resources.

## The Construction of the Care Seeker in the Individual-Centered Discourse

Also, within this, individual-centered, discourse, the care seeker was constructed as a hope for the future and as an active, conscious, and critically thinking individual equipped with the ability to receive information and learn (SOU 1977: 66).

*One should have [as a] starting point that the patient is an active and critical thinking person, [who] strives to make the best of their situation. Therefore, demands should also be made on the patient’s own activity and measures taken to increase his consciousness and stimulate him to request information. (SOU 1977: 66, p. 10)*

The patient was also constructed as a whole individual in terms of physical, mental, and social needs that interact with each other and that must be met by assessing the individual patient’s entire situation and not just by making a symptom-oriented medical assessment (SOU 1977: 66, p. 39). The care seeker was further constructed as an individual with the capacity to make decisions when given the ‘opportunity to make decisions in different choice situations’ in his or her own care (SOU 1977: 66, p. 39). One way of enabling decision making was through dialogue between the staff and the care seeker, a dialogue that was expected to strengthen the care seeker’s initiative capacity and his or her opportunity to be ‘able to participate in designing action alternatives’ (SOU 1977: 66, p. 39).

Simultaneously, as the individual was constructed as a solution, in terms of being participatory, conscious, informed, and independent, the discourse emphasized that ill health and illness have a connection to economic, social, and professional conditions (SOU 1981: 2). This means that those seeking health care, as individuals, are not just “a kind;” they are different kinds of people with large individual variations.

*The opportunities to receive care must not be affected by such conditions as nationality, gender, age, education, ability to pay, cultural differences, ability to take initiative, the nature of the disease, and the duration of the disease. (SOU 1979: 78, p. 22)*



Against the background of the differences between different population groups constructed in the discourse, several risk groups appeared. The health risk groups included people who made use of available health care facilities to a lesser extent compared to others, for example, unemployed persons, individuals with low education, and immigrants. According to the discourse, the greatest effects on both health and economics would be achieved through special initiatives on these risk groups (SOU 1984: 39).

### *The Construction of the Care Seeker in the System—and Population-Centered Discourse*

Within this discourse, the care seeker was not at all discussed, problematized, or constructed in terms of individuality in the same way as in the three other discourses. In the documents, the patient, that is, the care seeker, was just a patient and a passive recipient of care. Compared to the three other discourses, the care seeker as an individual was more or less invisible. When problematized, this was done first of all in terms of different population groups as, according to the discourse, large population groups lived under difficult conditions (SOU 1958: 15). An exception, in a way, was the discussion of health information.

*Often, the organized health information, which is directed at different groups within society, has the dual purpose of influencing the individual's habits and way of life in both his own [interests] and the interests of society. (SOU 1958: 15, p. 59)*

Thus, health information, which aimed to influence the individual's way of life, was problematized, framed, and adapted to individuals belonging to different socioeconomic groups.

## **Discussion**

In the contemporary discourses, there is the assumption that concepts and practices of patient and person centering are steps forward and that they will better meet the interests of the care seeker, compared to previous discourses and practices. The genealogical analysis in this study problematizes this assumption by showing that the phenomenon of the care seeker is given different meanings by different historical discourses. The analysis has further shown that, from a governmentality perspective, all the discourses analyzed have one thing in common: All the discourses construct their solutions, and the dispositions, positions, and roles of the care seeker, within the context of different notions of future economic opportunities or threats. According to the contemporary discourses (patient-centered as well as person-centered), we are facing a global crisis of increasing costs in the health care sector, a crisis that additionally seems to apply especially to Sweden. Thus, the future has been constructed as a threat.

The discourse of the 1970s also constructed the future in threatening terms, as the resources for health care were then expected to decrease. Thus, the discursive construction of this threatening future operated as a governmental technology with the power to promote the idea that the solutions that were constructed by the discourse were the obvious solutions. From a governmental point of view, the future was thus inscribed in the present and operated as a spatial concept, rather than a temporal concept. As a governmental technology, the future was already here. In the discourse of the 1950s and 1960s, the future operated similarly. However, instead of a threat, the discourse of the 1950s and 1960s constructed the future as hope because the economy was expected to expand. Thus, in all the discourses analyzed, the construction of the future operates as a spatial governmental technology with the aim of making and promoting solutions (and thus giving hope for the future) that are presented as the obvious solutions. This kind of inscription of the future in the present operates as a governing principle in most areas of society, including education, health promotion, and business marketing (Olsson et al., 2014; Popkewitz et al., 2006). In the discourses where the future is constructed in more threatening terms, the gaze, and, consequently, the problematization and the hope for the future, are shifted away from the traditional resource toward the individual care seeker in terms of individual, patient, or person centering. Consequently, in these discourses, there is a need for the construction of an active care seeker who is able to contribute to his or her health care so that health care staff are allowed to focus on what is considered their main tasks. This was obvious in particular in a contemporary patient-centered discourse which is similar to the discourse that Pluut (2016) identified as the empowering patient's discourse. This discourse constructed the patient as an autonomous decision maker and viewed the role of health professionals as one of advising and coaching the patient in decision making and facilitating this process. However, in the construction of the patient in the contemporary patient-centered discourse, something new appeared in our study compared to Pluut's categories. According to this discourse, the resources that the system has traditionally rested on are deemed exhausted. And in the search for, and construction of, a new resource, the gaze turns to what is considered a hitherto rich and untapped resource, namely, the care seeker him- or herself. The care seeker as hope is constructed as a resource and a co-creator of his or her own care and is assigned a role and position in the caregiving team's delegation order, as a resource among other resources. Thus, the construction of the patient in the government reports can be considered as a new patient-centered discourse with the patient as a resource among others.

The construction of the care seeker as a resource and team member does not appear in the person-centered discourse, where the care seeker as hope is, rather, constructed as a narrator—someone to listen to and understand. And in the population and system-centered discourse post-World War II, the gaze and problematization did not focus the individual care seeker in the same way as in the other discourses. He or she was constructed



as an object for care, primarily in collective terms and categories such as the general public, the population, and different socio-economic groups. When the hope for the future was economic expansion and the development of medical science, no space for an active care seeker was constructed.

In contemporary care practice, as well as in research on patient and person centering, it is assumed that these constructions of centering, from the perspective of the care seeker, are to be regarded as a step forward. From a genealogical perspective, this is not self-evident as the different ways of positioning and assigning the care seeker's disposition and abilities can be seen as a reflection of the problems that are constructed and focused in the discourses of different times. From the perspective of the care seeker, it is not self-evident that categorizations in collective terms, such as groups of poor people living under extremely difficult conditions, imply less centering than seen with the contemporary patient and person-centered constructions and focuses. Also from the perspective of the care seeker, it is not obvious that it is a step forward to be constructed as a resource in health care, and as a co-creator, narrator, or participant in the nursing team's delegation order. It is not self-evident that it is a positive development to be constructed as a member of a team, a resource among other resources, and, therefore, as a solution of the patient as a problem, compared to merely being constructed as an active, participating, and learning individual with problems. Thus, the genealogical analysis has shown that the contemporary narrative about patient centeredness is neither more, nor less, "care seeker"-centered than the narrative of yesteryear. Rather, the phenomenon of care seeker is given different meanings within the framework of contemporary discourse, while the care centeredness constructed in previous discourses was given meaning in other historical contexts.

In a world with such huge, and increasing, economic differences between nations, as well as between citizens within most nations—a world in which we are facing a global scenario of increasing health care costs—the contemporary discourse may be limited as these discourses do not problematize structural issues in the same way as previous discourses had done. Perhaps what is needed is a national and international patient-centered discourse, to discuss policies and practices that also are population- and social group-centered. The most important limitation of this type of study is that it is only about discourses and policy issues and not about daily practical activities.

## Appendix I

### Empirical Sources

SOU 2017: 47. Nästa steg på vägen mot en mer jämlik hälsa. (The next step on the road to a more equal health) [in Swedish]. Stockholm, Sweden: Socialdepartementet.  
 SOU 2016: 2. Effektiv vård. (Effective care) [in Swedish]. Stockholm, Sweden: Socialdepartementet.

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SOU 1948: 14. Den öppna läkarvården i riket. (The open medical care in the kingdom) [in Swedish]. Stockholm, Sweden: Inrikesdepartementet.

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