

---

## ARTICLES IN ENGLISH

*Lika Rodin*

### **"GOVERNMENTALITY" IN THE CLINICAL CONTEXT: THE PARADOXES OF HUMANIZATION OF HEALTHCARE IN SWEDEN**

The humanization of healthcare provision is a vibrant topic in academic and public discussions. Sweden has pioneered innovative educational policies seeking to forge commitment among a new generation of doctors to a "patient-centred" approach. In accordance with Michel Foucault's theoretical elaborations, this study takes the discourse of humanization to be a feature of politico-economic regulation or governing, and measures the adherence of doctors to this humanization project. Conducted in western and southern Sweden among practitioners in public primary and specialized care, the survey confirmed the importance of patient-centeredness at the level of doctors' rhetoric, self-reflection and in self-reported clinical practice. Additionally, another discourse shaping the collective professional "mentality" – the discourse of economic efficiency – emerged from the collected data, potentially destabilizing the effects of humanization.

*Key words:* governmentality, discourse, Foucault, humanization of health care, psychodermatology, patient-centred approach

The issue of healthcare humanization has been at the center of academic and public attention in the last decades. A discussion arose based on a critique of the

---

Lika Rodin – PhD, lecturer at the University of Skövde, Sweden. Email: lika.rodin@his.se

objectification, disciplining and re-socialization of patients to fit the subjugated positioning they typically experience in their relationships with modern medical institutions (Foucault 2003; Goffman 1991; Mishler 1984). It triggered a wide movement within the political and professional establishments aimed at installing ethical norms in the professional culture and policies and strengthening the focus of attention on the patient's personality, life situation, and illness-related needs. Today, variations of a "client-centered approach" are increasingly integrated in medical professional education and practices around the globe (Pelzang 2010). These are grounded in the biopsychosocial model of ill health, an idea that views doctor-patient encounters as democratic and collaborative interactions between two individuals, accepts a consumer-oriented ethos, and promotes therapeutic aspirations and technologies (Mead, Bower 2010). The patient-centred mode can be seen as enhancing the established principles of bioethics (e.g. Ells et al. 2011), furthering wide discourse about transformations of medical professionalism (e.g. Klingberg-Allvin et al. 2005) and eventually contributing to the process of humanization of health care organization and provision. This survey study considers client-centeredness as an element of "governmental rationality" (Gordon 1991) and attempts to measure the extent to which medical practitioners in Sweden internalize this humanization discourse. Dermatology is assumed to be the primary domain of the analysis due to special importance of psychosocial aspects in skin illnesses (Tosti et al. 2005; Williamson et al. 2001).

This paper proceeds to give an outline of the divergent rationalities currently shaping healthcare in Sweden. Further, the concept of governmentality is offered to provide a theoretical framework for a discussion on the complex discursive field of national healthcare provision. The empirical section of the paper explains what methodology was used and displays the survey results, followed by a discussion of the research results that puts the study's findings into the wider social-political and economic context of contemporary Swedish society.

### **Healthcare in Sweden and the move towards humanization**

Healthcare in Sweden represents a remarkable attempt to merge time and economic efficiency, scientific knowledge, social fairness, safety and patient-centeredness (Socialsturelsen 2009a). The imperative of the humanization of healthcare provision is especially emphasized, as for example, in the Swedish Health and Medical Services Act. Enlarging contemporary principles of bioethics it declares: "respect for patient autonomy and integrity;" "good contacts between patient and healthcare professionals;" and the primacy of the "patient's need for continuity and safety of healthcare" (Svensk författningssamling 1982). The National Indicators for Good Care provide a definition of the patient-centred approach as sensitivity to the patient's "social context" and "specific needs, requirements, expectations and values" (Socialsturelsen 2009b: 21). Enhanced involvement of the patient in treatment choices, continuity in follow-up measures

and providing sufficient information are thought to improve the individual's agency and ability to manage oneself in daily situations. Communication and doctor-patient dialogue in which the patient's understandings and experiences play a valuable role are seen to be prerequisites for improvement in the care recipient's health condition and wellbeing. These indicators correspond with the definition of the "patient-centred" approach in the international academic literature as being driven by

an understanding of the patient as a unique human being and refers to a style of doctor-patient encounter characterized by responsiveness to patient needs and preferences, using the patient's knowledge to guide actively the interaction and information giving, and shared decision making (Rogers et al. 2005:226).

Professional training cultivates a variety of positive tendencies such as future doctors' empathy; recognition of patients' rights and the importance of ethical concerns in relations to patients and their relatives; a "holistic view of the patient from a scientific and humanistic approach;" and reflection on one's own need for knowledge and skills (Svenska Läkaresällskapet 2013). Similarly, in nursing, a "holistic" view of treatment, respect, and support of patients is inscribed into the professional code (Swedish Society of Nursing 2011).

Alongside humanization concerns, the idea that "there is no clear correlation between high costs and the best results" (Socialsturelsen 2009a: 22) fashions the approach to healthcare provision in Sweden. In this context, economic and managerial training is increasingly requested to occupy a significant place in medical professional education (Sveriges Läkarförbund 2006), creating the conditions for economic efficiency even in the face of reductions in public spending on welfare. The contemporary situation within the healthcare system is typically characterized by sharpened specialization and technical leveling (Socialsturelsen 2009a), lean-model orientation, and "managerialism" expanded with the introduction of "telemedicine"/"telecare" and related technological innovations, such as distant diagnostics and medical advising (Peterson 2011, 2012).

### **Theoretical framework**

The concept of governmentality of the French philosopher Michel Foucault provides the theoretical framework for this research. It is rooted in Foucault's idea of government as "a form of activity aimed to shape, guide or affect the conduct of some person or persons" (Gordon 1991:2). Governmentality studies examine the "art of government" (Foucault 1991: 89) in regards to the contemporary mode of domination and control grounded in inspirations for wide population management by means of scientifically fashioned and justified surveillance and preventive policies (Foucault 1997, 2003, 2007). At the micro-level of sociality, governing is maintained at the intersection of power command and self-steering (Foucault

1997). As explained by Maurizio Lazzarato, "[c]apital wants a situation where command resides within the subject him- or herself, and within the communicative process" (1996: 135). Consequently, governmentality scholars capitalize on "mentalities of government" as "thought made practical and technical" (Dean 2010: 27). Mitchell Dean (2010: 24–25) put forward an approach that opens up to a plurality of elements shaping collective "forms of thought" or mentality "involved in practices of government." Quite similarly to the Althusserian notion of ideology/interpellation (Althusser 2008), governmentality in one of Dean's definitions signifies a subscription of an individual – as social subject constituted in particular relations of power – to the related symbolic-material order that remains mainly unreflected (Dean 2010).

For Foucault (1990), the formation of governing is associated with the rise of a new power form – biopower – that has championed previously dominant power regimes of sovereignty and discipline. Biopower is concerned with a population's state of living and manifests itself as a "pastoral power" explained by a metaphor of a "shepherd watching over the sheep" (Foucault 1997: 67; see also Rose 2001). It valorizes on cultivation of the population – its health, economic and psychosocial wellbeing – by means of "techniques, technologies, experts, and apparatuses for the care and administration of the life of each and of all, from town planning to health services" (Rose 2007: 54). While focus of Foucault's related discussion is predominantly on management of population as biosocial bodies, Michael Hardt and Antonio Negri (2000) capitalize on biopower's concern with affective aspects of individual lives – creativity, sociality and "becoming" – as valuable assets to be reached by the agents of power and incorporated into the process of production. Contemporary patient-centered health-care practices then present not only examples of "affective labor" – activities that demand the investment of the worker's psychosocial capabilities into working tasks (Hardt 1999) – but need to be seen as increasingly involved in biopolitical production through the enhancement of patients' affective resources. This approach rests on the "recruitment" of medical practitioners as agents of governing and on the cultivation of related professional mentalities.

Pastoral power manifests itself in the welfare state with its particular attention to non-coercive forms of security regimes (Gordon 1991; Rose 2001). The Swedish model of the welfare state and governing technologies it has developed have attracted special attention in studies on biopower and governmentality (see Rose 2001; Larsson et al. 2012). Contemporary biopower in Sweden is seen to be a historical legacy of a social engineering movement emerging from the early 1900s (Larsson et al. 2012). At that point, the wellness of society's members was closely associated with general geopolitical strength:

Population fitness was liable to threats from within and without, and national governments had the obligation to guard against these threats and to take measures to enhance that fitness through policies formulated by, and enhanced through, the apparatus of the state (Rose 2007: 63).

Culminating in shocking experiments of "pastoral eugenics" (e.g. compulsory sterilization), the idea of social engineering lost its legitimacy in the second part of the 20<sup>th</sup> century. Strong ethical guidelines were installed into medical practices to ensure moral accountability in medical authorities. During the last few decades, however, a trend has emerged towards the gradual withdrawal of the state from the task of maintaining population wellness, and the number of private agents active in healthcare provision has increased. In this context, the state's function is found to be transforming into facilitation and cultivation of the "will to health" (Rose 2001: 6). Bioethics has turned into an innovative tool of management and control. Driven by the request for a "productive" and "enabling sociality" (in terms of Hardt, Negri 2000), the contemporary "relational" pastoral power is especially concerned with the emotional dynamics of clinical encounters. It shapes doctor-patient interactions into "bi-directional," "non-directive," and "affective" exchange (Rose 2001: 10).

This research places the project of healthcare humanization in the context of other biopolitical technologies that capitalize on sociality as a resource to be (re)produced and managed in clinical settings. It assumes that, in the case of healthcare provision, the current "style of governing" (Larsson et al. 2012) forms a specific mode of collective thinking that doctors may acquire in the course of socialization in the professional culture.

### **Methodology**

The research utilized a survey design to address prevalence of specific discourses among medical practitioners. A tradition of measuring discursive patterns is well established in social research (e.g. propaganda studies). Moreover, there is a continuing discussion of the issue of strict correspondence between research epistemology and method (see Bryman 1984; Weaver, Olson 2005). This survey was conducted during autumn 2013-spring 2014 in western and southern Sweden and involved medical practitioners affiliated with middle- and large-size public institutions of primary and specialized care. An initial strategy of total sampling turned out to be mediated by "gate keepers." A questionnaire comprising 24 questions that tested the relationship between doctors' embeddedness in the professional culture, which is broadly defined as a material-symbolic field constituted by a multiplicity of discourses/ideologies "adopted as moral preferences or principles of life" (Johanson cit. in Therborn 1982: 6), and their approaches to non-clinical aspects of dermatological sicknesses. The embeddedness was measured by the length of practitioners' professional experience and the level of their specialization. Sensitivity to the variety of patients' illness-related psychosocial issues was taken as a major index of actualization of a patient-focused doctrine.

The questionnaire collected background information on the participants (gender, years in practice, level of working tasks, experience with dermatological

cases, and specialized training) as well as data on the estimated demographical characteristics of their patient population and general acknowledgement of non-medical issues accompanying chronic skin illnesses. A suggested list of possible individual and social issues associated with dermatological disorders (non-clinical aspects) was composed on the basis of academic studies on "alopecia" (hair loss). The questionnaire further addressed three scales: sensitivity to non-clinical aspects of dermatological illnesses (2 items); attitudes towards non-clinical aspects of dermatological illnesses (2 items); and praxis of dealing with non-clinical aspects of dermatological illnesses (7 items). Most questions offered single- or multiple-choice answers; in some cases, there was the possibility to add specifying details. After evaluation of the study design and instruments by the Ethics Committee, the questionnaires were distributed via regular mail to doctors at major primary care institutions and specialized dermatological clinics in the region.

The obtained data was processed with the help of the SPSS-21 statistical program, using descriptive and Chi-test statistics. Semi-open questions and respondents' spontaneous reactions were analyzed by identifying categories of meanings or themes and their frequency.

The study volume was shaped by factors limiting access to the field and by the overall low response rate (approximately 15%). However, the data obtained still reveals significant regularities in the respondents' replies.

## Results

The survey involved 116 doctors (57% women and 43% men) affiliated with state-sponsored institutions of primary and specialized healthcare (82% and 18% respectively). In distinction to those working in primary care, participants representing skin clinics had usually worked in the profession for 10 years or more (76% and 58% respectively); this corresponds with the average medical experience for doctors in Sweden (Lönestatistik 2014). Psychologically-oriented training in management of dermatological cases was rather unusual (or some even unknown) among respondents: 9 out of 10 reported not having any training in the psychological aspects of skin disorders, which was especially pronounced for doctors affiliated at primary care (99%) in comparison to specialized clinics (71%). Furthermore, approximately a quarter of those who attended some psychological courses reported rather low benefit from those. 68% of respondents were unaware if there are any official instructions or recommendations addressing the management of psychosocial difficulties associated with dermatological disorders.

As many as 92% of the respondents reported meeting dermatological patients every week with a wide variety of skin problems. As the data demonstrated, practitioners at specialized clinics come across a larger number of issues and more intensively, especially in regards to complex or/and severe skin conditions such as autoimmune or hormonal disorders and skin cancer. Overall,

as can be expected, doctors' encounters with skin disorders increase with time in practice. 76% of the respondents indicated that the age of the patient population is rather heterogeneous: people of different ages are represented in relatively equal proportions. A quarter of the respondents reported overrepresentation of women among their patients with dermatological disorders. Further, the distribution of regularities along three earlier specified scales are presented in Table 1 and discussed below.

#### **Sensitivity to non-clinical aspects of dermatological illnesses**

80% of the respondents identified three or more individual and social issues associated with long-term dermatological conditions. As the data further demonstrate, overall receptiveness to non-clinical aspects of dermatological disorders tended to increase with professional experience. Doctors affiliated to skin clinics more often detected an impact of the diseases on patients' selves and relationships with others, especially when it came to patients' workplace relationships and participation in leisure activities.

As many as 40.5% of the participants, more often dermatologists in specialized clinics, exhibited a high degree of awareness and sensitivity to the issue of social-psychological effects of skin diseases. They reported collecting information from various sources, including academic literature, information provided by patient organizations, discussions with colleagues, courses, media, and their own imagination. Practitioners at primary care institutions frequently relied on imagination and on personal experience, though this tendency appeared to decrease in time.

#### **Attitudes towards non-clinical aspects of dermatological illnesses**

Almost all respondents (99%) agreed with the statement that long-term dermatological problems affect patients' social and personal lives; 46%, more frequently doctors at dermatological clinics, indicated a strong level of agreement with the statement. Furthermore, 88.5% of the respondents agreed that non-medical aspects should be more widely considered by the healthcare system.

#### **Praxis of addressing non-clinical aspects of dermatological illnesses**

Almost 82% of the respondents, more often doctors at skin clinics and practitioners with longer work experience, reported taking some actions to address the psychosocial effects of dermatological sicknesses, such as discussion with a patient, referral to a counselor, and referral to a patient organization or a self-help/support group. More than half of the doctors reported using various ways to attend to non-clinical issues. At the same time, as followed from the analysis of an open-ended question, one fifth of the primary-care practitioners did not take any action for a number of reasons, including insufficient knowledge

of possible actions; no request from the patient; and recognition of the impossibility of accounting for concerns about the psychological effects in the framework of clinical examination and treatment. In a limited number of cases, sending the patient up the ladder of professional specialization (to a dermatologist) was defined as the best way of dealing with the illness itself and related psychosocial troubles.

70% of the respondents, more likely doctors at specialized institutions, reflected on the non-clinical effects of dermatological ailments. 42% of the participants, who were usually practitioners affiliated to skin clinics and were more likely to have more than 10 years working experience, were involved in discussions with colleagues about the psychosocial impact of dermatological disorders. At the same time, 70% of the respondents indicated a need to enhance their knowledge in psychodermatology; 78% stated that they needed more information on how to address those psychosocial problems, more likely specialists at dermatological clinics. Finally, 31% of the doctors involved in the study, predominantly specialists at skin clinics and more often female practitioners, expressed a desire to see changes in the current approach.

A number of spontaneous suggestions emerged about potential changes. Among the concerns of doctors at primary care clinics was the availability of resources in terms of time and staff. Thus it was suggested to have a nurse at primary care units that could offer patients extra time with advice or support. In a somewhat similar manner, doctors affiliated at dermatological clinics pointed to the shortage of resources, especially in regards to time. One of skin doctors commented on the issue of time limits and possible changes to this: "*More time for each patient. Clinical visit as a standard 20 min, but some patients are booked for 15, 10 and 5 minutes visit.*" Some dermatologists indicated a need for additional training in psychological management via short-term courses (e.g. on the technique of "motivational conversation"). The importance of general clinical efficiency manifested in the wish for improvement of diagnostic procedures and treatment. As was stated, timely and quality treatment allows for the improvement of the patient's physical health followed by the stabilization of his/her psychosocial wellness.

Another important issue raised by the respondents was the efficiency of internal communication within the health care system, which can be measured by the time it took for a patient to be referred from primary care to a dermatological clinic and by the duration of the follow-up regime. The management of patients on the basis of the severity of their conditions was one of the central tasks for primary care doctors, with complicated cases to be sent to dermatological clinics and less threatening disorders to be assisted at the primary care facility. The problem of internal communication was relevant for the context of specialized clinics as well, in this case with psychiatric-psychological units. It was further suggested to develop a model of teamwork among the counselor, nurse, and dermatologist involved in each case.



## Discussion

The survey measured doctors' self-reported compliance with the discourse of healthcare humanization, in relations to their embeddness into the professional culture. It assumed that psychosocial wellness is increasingly recognized as an important factor of general health and fitness, essential to ensuring the productivity of individuals and the population at large (Foucault 1997; Hardt, Negri 2000). In this sense, wellbeing becomes an object of biopower to be addressed in clinical settings. Medical professionals appear as middle-range agents of governing; the related collective patterns of thought have been cultivated to maintain the related regime in micro-level interactions.

All doctors involved in the study demonstrated recognition of the psychosocial impacts of dermatological disorders, and a vast majority agreed on the necessity to account for non-clinical elements of the disease in medical practice. This is consistent with the humanitarian imperative shaping general professional training (Svenska Läkaresällskapet 2013). As one respondent indicated in the section of open question: *"If one works from a patient-centered approach, the psychological and social consequences of a sickness are necessarily included into treatment. The whole Specialist Registrar-stage focuses on this."* As more and more professional knowledge and experience is acquired, doctors in different levels of the healthcare system increasingly report taking some action to address non-clinical issues, including situations characterized by the absence of the disciplining power of formal guidelines. In accordance with the doctrine of client-centeredness, they value therapeutic techniques (such as "motivational talk") as practical tools for enhancing patients' self-resources. In general, an inquiring-supporting conversation with a patient – a form of enabling sociality – appeared as a typical format used by the doctors, irrespective of their knowledge of psychology and psychodermatology more specifically. To a lesser extent, the practitioners benefited from other agencies (e.g. self-help/patient groups) trying to deal with the psychosocial issues themselves or in cooperation with other narrow specialists within the healthcare system. A majority of the participants demonstrated self-reflectivity and a desire for further education in psychosocial management in dermatology, in line with the normative goals for medical training. The listed regularities signal the prevalence of the humanitarian, patient-centered perspective in doctors' self-reported attitudes and clinical practices.

The technical level of specialization appeared as a significant factor shaping doctors' self-acknowledged sensitivity to the psychosocial dimensions of dermatological disorders, as well as related behavioral descriptions. Dermatologists may feel more engaged with skin disorders in general and their effects on peoples' life due to professional specialization. They are responsible for assisting patients with more complex and severe or dangerous conditions. Moreover, patients happen to spend a long time on a waiting list for a skin clinic that frequently coincides with progression of the illness and a corresponding increase

in its psychosocial side effects. Dermatologists reported that they tend to discuss the non-clinical impacts of skin disorders with colleagues, reflect upon those, and undertake a wider variety of actions aimed at supporting patients and enhancing their coping capabilities. They also more actively searched for knowledge on appropriate measures of a non-clinical nature for patients with dermatological problems. One third of the study participants were not satisfied with the current approaches they have been implementing and desired a change in their work with patients, which was less true with doctors in primary care. This pattern may be problematic with increasing demand to reduce the flow of patients to dermatological clinics and the promotion of primary care and alternative healthcare agents in the treatment of illnesses that were previously assigned to specialized medical institutes (e.g. Region Skåne 2013).

Simultaneously, the principle of efficiency emerged in open-ended participant responses. It emphasizes the relevance of specialization level for optimal treatment of patients (Pettersson 2012). Categorization based on an assessment of the severity of the patient's condition was found to be an important element of decision-making at the primary level of healthcare. Spending on healthcare dramatically decreased in Sweden during 1980s-1993s from 9.2% to 7.5% of GDP (Diderichsen 1999: 146) with following gradual recovery up to 9.1% of GDP in 2004 (Falkenhall, Zackrisson 2007: 7). The experience of financial scarcity motivated particular attention to the issue of healthcare economic efficiency that nowadays constitutes a leading theme in public debates and policy measures (Pettersson 2012). Sharpened leveling of the healthcare system and narrowed specialization alongside the increased tendency of primary care to send more severe cases directly up the ladder of technical specialization, did not appear to be a guarantee for "good" care (meaning also humanized care in Swedish context) due to structural obstacles. The publicly recognized problem of shortage in narrowly specialized practitioners and restricted access to specialized medical services (Socialsturelsen 2014) has not yet been solved, with medical trade union battling to maintain the status of the professional group (Sveriges Television 2009; Olsson 2014). The Swedish National Board commented on the issue:

Research on the health care professions indicates that the more individual groups of professionals specialize, the higher status they get – in relation to those working directly with the patients. The risk of this development is that the specialization will contribute to development away from its main mission – which is to solve the patient's problems (Socialsturelsen 2009a: 23).

With the variety of possible explanations, the task to accommodate within 5–15 minutes at a dermatological clinic a discussion on personal aspects of the disease, among diagnostic procedures, choice of a treatment and communication of treatment regime becomes a challenge. Paradoxically, due to organizational and structural aspects, more disturbed individuals may end up

with less support. The situation calls for additional attention to a discrepancy between humanization aspirations, demand for economic efficiency, and a politically-shaped division of labor within the healthcare system.

\*\*\*

Attempts to accommodate these diverse discourses, such as the humanization or client-oriented approach and economic efficiency, can be detected in the respondents' accounts. This ambition reflects the existing rationalities and organizational-ideological frame of healthcare in general, that is developed to maintain the welfarist biopolitical governing. The complexity of value claims sporadically pushes professionals into situations of ethical dilemmas and "moral distress" (Källemark et al. 2004), shaping professional commitments and the psychological welfare of the physicians. At other times, humanitarian discourse can be used by authorities and other governing agents to justify economic measures, such as the reduction of expensive hospital placing and the "de-institutionalization" of healthcare provision (Pettersson 2012). Dean (2010) suggested that governmentality frequently remains unrecognized by the involved individuals. An important challenge then would be to enhance critically oriented aspects of professional education which would, in turn, allow doctors to perceive the complexity of power relationships shaping clinical practices, while addressing the paradoxes of humanization of healthcare in Sweden.

This study does not escape the typical limitations of quantitative research (see, Bryman 2008: 171–172). A follow-up qualitative inquiry might be needed to scrutinize clinical practices in relation to the discourse of client-centeredness, as well as to examine doctors' agency and creativity in the implementation of humanization aspirations.

### Acknowledgements

The study was financially supported by the Skaraborg Institute for Research and Development (Skövde, Sweden).

### References

- Althusser L. (2008) *On Ideology*, London: Verso.
- Bryman A. (1984) The Debate about Quantitative and Qualitative Research: A Question of Method or Epistemology? *The British Journal of Sociology*, 35 (1): 75–92
- Bryman A. (2008) *Samhällsvetenskapliga Metoder*. B. Nilsson (tr.), Stockholm: Liber.
- Dean M. (2010) *Governmentality: Power and Rule in Modern Society*, Los Angeles: Sage.
- Ells C, Hunt M., Chambers-Evans J (2011) Relational Autonomy as an Essential Component of Patient-Centered Care. *International Journal of Feminist Approaches to Bioethics*, 4 (2): 79–101.

- Falkenhall B., Zackrisson M. (2007) *Sjukvårdssektorns Tillväxtpöjligheter En Studie av Erfarenheter från Kanada och USA*. Available at: <https://clck.ru/9adAM> (accessed 20.12.2014).
- Foucault M. (1997) *Ethics: Subjectivity and Truth. The Essential Works of Michel Foucault, 1954–1984*. P. Rabinov (ed.), R. Hurley et al. (tr.). Vol. 1, New York: The New Press.
- Foucault M. (2003) *The Birth of the Clinic. An Archaeology of Medical Perception*. A-M. Sheridan (tr.), London: Routledge.
- Foucault M. (2007) *Security, territory, population: lectures at the Collège de France, 1977–1978*. M. Senellart, F. Ewald, A. Fontana (eds.), G. Burchell (tr.), New York: Palgrave Macmillan.
- Foucault M. (2003) *Society Must be Defended: Lectures at the college De France, 1975–76*. M. Bertani, A. Fontana (eds.), D. Macey (tr.), New York: Picador.
- Foucault M (1991) Governmentality. C. Burchell, C. Cordon, B. Miller (eds.). *The Foucault Effect. Studies in Governmentality with Two Lectures by and Interview with Michel Foucault*, Chicago: The University of Chicago Press: 87–104.
- Foucault M. (1990) *The History of Sexuality. Vol. 1. The will to knowledge*. R. Hurley (tr.), London: Penguin Books.
- Gordon C. (1991) Governmental Rationality: An Introduction. C. Burchell, C. Cordon, B. Miller (eds.). *The Foucault Effect. Studies in Governmentality with Two Lectures by and Interview with Michel Foucault*, Chicago: The University of Chicago Press: 1–50.
- Goffman I. (1991) *Asylums: Essays in the Social Situation of Mental Patients and Other Inmates*, London: Penguin Books.
- Hardt M. (1999) Affective Labor. *Boundary*, 2(26): 89–100.
- Hardt M., Negri A. (2000) *Empire*, Cambridge, MA: Harvard University Press.
- Klingberg-Allvin M., Van Tamb V., Thu Ngab N., Ransjo-Arvidsona A-B., Johansson A. (2005) Ethics of Justice and Ethics of Care. Values and Attitudes Among Midwifery Students on Adolescent Sexuality and Abortion in Vietnam and Their Implications for Midwifery Education: A survey by Questionnaire and Interview. *International Journal of Nursing Studies*, 44(2007): 37–46.
- Källemarck S., Höglunda A-T., Hansson M-G., Wester Holmb P., Arnetza B. (2004) Living With Conflicts: Ethical Dilemmas and Moral Distress in the Health Care System. *Social Science & Medicine*, 58: 1075–1084.
- Lazzarato M. (1996) Immaterial Labor. P. Virno, M. Hardt (eds.), P. Colilli, E. Emory (tr.), *Radical Thought in Italy: A Potential Politics*, Minneapolis: University of Minnesota Press: 133–147.
- Larsson B., Letell M., Thörn H. (eds.) (2012) *Transformation of the Swedish Welfare State: From Social engineering to Governance?* New York: Palgrave Macmillan.
- Lönestatistik (n.d.) *Läkare Loner*. Available at: <https://clck.ru/9adAV> (accessed 24.11.2014).

- Mead N., Bower P. (2000) Patient-Centredness: A Conceptual Framework and Review of the Empirical Literature. *Social Science & Medicine*, 51(7): 1087–1110.
- Mishler E. (1984) *The Discourse of Medicine: Dialectics of Medical Interviews*, Norwood, New Jersey: Ablex Publishing Corporation.
- Olsson M. (2014) Tusentals Kommer Inte in på Läkarprogrammet. Men Trots Läkarbrist Finns Inga Planer På Fler Utbildningsplatser. *Göteborgs Posten*. Available at: <https://clck.ru/9adAZ> (accessed 15.11.2014).
- Petersson J. (2011) Medicine at a Distance in Sweden: Spatiotemporal Matters in Accomplishing Working Telemedicine. *Science Studies*, 24(2): 43–63.
- Petersson J. (2012) From Medicine by Wire to Governing Wireless: Changing Geographies of Healthcare. B. Larsson, M. Letell, H. Thörn (eds.). *Transformation of the Swedish Welfare State: From Social Engineering to Governance?* New York: Palgrave Macmillan: 153–167.
- Pelzang R. (2010) Time to Learn: Understanding Patient-Centred Care. *British Journal of Nursing*, 19(14): 912–917.
- Rogers A., Kennedy A., Nelson E., Robinson A. (2005) Uncovering the Limits of Patient-centeredness: Implementing a Self-management Trail for Chronic Illness. *Qualitative Health Research*, 125(2): 224–239.
- Rose N. (2001) The Politics of Life Itself. *Theory Culture Society*, 18(1): 1–30.
- Rose N. (2007) *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the 21 Century*, New Jersey: Princeton University Press.
- Region Skåne (2013) *Vårdval Avseende Hud och Hudvård. Beslutsförslag av Hälso-och Sjukvårdsnämnden*. Available at: <https://clck.ru/9adAd> (accessed 15.11.2014).
- Socialsturelsen (2014) *Fortsatt Brist på Läkare och Specialistsjuksköterskor*. Available at: <https://clck.ru/9adAf> (accessed 17.11.2014).
- Socialsturelsen (2009a) *Hälso- och Sjukvårdsrapport 2009*. Available at: <https://clck.ru/9bNAZ> (accessed 24.11.2014).
- Socialsturelsen (2009b) *Nationella Indikatorer för God Vård*. Available at: <https://clck.ru/9adAj> (accessed 26.11.2014).
- Svenska Läkaresällskapet (2013) *Nationella Mål för Etikutbildningen i Läkarprogramme*. Available at: <https://clck.ru/9adAo> (accessed 19.11.2014).
- Svensk författningssamling (1982) *Hälso- och Sjukvårds lag 1982:763*. Available at: <https://clck.ru/9adAq> (accessed 19.11.2014).
- Sveriges Läkarförbund (2006) *Förslag till Författningsändringar Med Anledning av en Ny Utbildnings- och Examenstruktur för den Högre Utbildningen*. Available at: <https://clck.ru/9adAm> (accessed 01.12.2014).

Sveriges Television (2009) *Läkarförbundet Bromsade Utbildning*. Available at: <https://clck.ru/9adAs> (accessed 27.11.2014).

Swedish Society of Nursing (2011) *The Foundation of Nursing Care Values*. Available at: <https://clck.ru/9bNAb> (accessed 09.09.2014).

Therborn G. (1982) *The Power and the Power of Ideology*, London: Verso.

Tosti A., Bellavista S., Longo S., Pazzaglia M. (2005) Tendency to Underestimate the Severity of Androgenetic Alopecia. *British Journal of Dermatology*, 152(6): 1362–1363.

Weaver K., Olson J. (2006). Understanding Paradigms Used for Nursing Research. *Journal of Advanced Nursing*, 53(4): 459–469.

Williamson D., Gonzalez M., Finlay A. (2001) The Effect of Hair Loss on *Quality of Life*. *Journal of the European Academy of Dermatology and Venerology*, 15: 137–139.