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'Busyness' and the preclusion of quality palliative district nursing care

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Abstract

Ethical care is beginning to be recognised as care that accounts for the views of those at the receiving end of care. However, in the context of palliative and supportive district nursing care, the patients' and their carers' views are seldom heard. This qualitative research study explores these views. Data were collected through semi-structured interviews with 26 patients with palliative and supportive care needs receiving district nursing care, and 13 of their carers. Participants were recruited via community nurses and hospices between September 2010 and October 2011. Post-structural discourse analysis is used to examine how discourses operate on a moral level. One discourse, 'busyness', is argued to preclude a moral form of nursing care. The discourse of friendship is presented to contrast this. Discussion explores Gallagher's 'slow ethics' and challenges the currently accepted ways of measuring to improve quality of care concluding that quality cannot be measured.

Keywords

Butler, district nursing, palliative and supportive care, post-structural morality, quality of care, slow ethics, bricolage

Introduction

Palliative and supportive care is becoming an increasing field of concern[1] and district nurses[i] are key to providing such care to patients and their carers.[2] Research on the quality of palliative and supportive district nursing care has incorporated a wide range of viewpoints such as: professional's,[3] funder(s)',[4] healthcare manager's,[5] district nurse's[6] and carer's.[7] In broader healthcare ethics, Gallagher[8] highlights that there is an ethical imperative and increasing need for professionals to 'listen to and learn from the experiences of those at the receiving end of our care' (p. 30). However, in the field of palliative and supportive district nursing care, patients' views are seldom heard. Therefore, a research project to consider the ethical implications of the development of quality in palliative and supportive district nursing care is timely.

Before a presentation of patients' and carers' views can occur, it is important to recognise that any rendering of these views does not occur outside of broader sociopolitical frames under which these views are formed. This necessitates a brief overview of contemporary healthcare policy. The UK National Health

[i]District nurses are registered nurses who work in the community providing a wide range of care in homes and clinics.

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Service has developed in line with neo-liberal ideologies where market forces and choice play key roles in developing quality.[9] Neo-liberalism reforms patients and carers as 'consumers' who exercise choice to drive quality of care.[9] However, this is questionable when there is little evidence that patients access information to inform choices,[10] and several areas of healthcare (such as district nursing) remain allocated broadly on the basis of geographical location and chance, not informed choice. Therefore, the functioning of the underpinning ideology also needs to be questioned alongside the representation of patients' views to explore how sociopolitical ideologies affect the quality and morality of care that is/can be received/perceived by patients and carers. Such critiques, while being relevant to district nursing have broader implications for healthcare as a whole, and these are the primary focus of this article.

Philosophical underpinnings

Research into quality of care generally has two dominant philosophical approaches. Positivist research that tends to view quality of care as measurable and definable via external and validated tools,[11] and constructivist approaches that assume that quality is a construction by any of the involved parties, which can be described qualitatively but not precisely measured.[6–7] However, both these approaches fail to understand what frames these measures and constructions of quality by failing to account for how the individual(s) involved are themselves constructed, and therefore what is constructible.

This article adopts a post-structuralist approach to address the notion of quality by considering 'individuals' as dialectically constructed and constructing subjects. Instead of considering people as separate autonomous individuals, one can conceptualise individuals as 'subjects' who are not truly self-sustaining and individual in their identity; they instead are subjected to frames of thinking (discourses) and are unable to act without a primary subjection to these discourses. This results in less of individuality and instead a 'subjectivity', which cannot properly be considered to be 'possessed' by subjects.[ii] Butler[12] conceives this form of subjectivity as 'performative': a requirement to perform and re-perform extant discourses to become viable and then repetitively perform these discourses to remain a viable subject. Therefore, one constructs discourses (by performing them) but is also constructed by these performances. However, the necessity to repeat produces an ability to resist and (re)form[iii] one's subjectivity through novel and even erroneous performances. Hence, a dialectic process of (re)formation constantly occurs and is occurring where subjects both gain and sustain their identity by being subjected to and (re)performing discourses.

These ideas are combined with a Deleuzian term 'becoming-other',[13] a phrase used to describe the continual and constant (re)forming of subjectivity. Within such a framework, it is argued that morality is allowing subjectivities to expand and resist becoming-totalised by any discourses, instead becoming-other, while remaining viable acting subjects. However, Deleuze argues for a constant movement and changing to resist ever being fully subjected to discourse, something that within a palliative care scenario seems to risk beginning a (re)formation that may not be able to be completed, that is, risking one becoming-none-identity and unviable. Instead, an ethical act is argued to be one where subjects perform discourses in relation to others, which tend to produce the possibility for becoming-other, whatever the other may be. It is a tendency towards, rather than a definite production of, moral/immoral actions that is being argued as moral here. This is because, as Stacey[14] demonstrates in her discussion on the dynamics of a psychoanalysis group, one cannot know if one's language while trying to emancipate and allow this becoming-other actually results in a foreclosure. Therefore, one cannot mandate any moral act as always producing a becoming-other in

[ii]Hence, when speaking of patients and carers subjectivities, an apostrophe is not used. Instead in this article an * is used.

[iii]Within this article for the sake of brevity and in keeping with academic practice when discussing Butlerian concepts, forming and reforming will be expressed by the use of brackets around the 're' thus: (re)form. This expresses the inability for individuals to account for and/or trace the initial and continual formation of their subjectivity.

others. Instead, morality is about creating the possibilities for a tendency towards becoming-other. Discourses that can be empirically suggested as tending to preclude and/or curtail becoming-other can therefore be suggested to be 'immoral' or 'unethical' and can become the focus of critique to reduce their presence as discourses that structure subjectivities, while the converse is argued for discourses that tend to produce becoming-other. Therefore, a post-structuralist philosophy guides analysis away from either quantifiable factors or aggregating the lived experience of individuals and instead incorporates a questioning of what broader discourses construct quality of care, and the subjects who are constructed by it.

The first half of this article aims to analyse the empirical data guided by the above post-structuralist philosophy. The second half of this article examines how a post-structuralist analysis of quality care can produce a productive reading of Gallagher's[15] slow ethics. For Gallagher,[15] slow ethics goes against the 'trend towards speed and time-saving initiatives' (p. 711) and instead takes inspiration from the slow art movement to 'focus instead on the quality of the interactions and what contributes to the flourishing of patient, families and practitioners' (p. 712). While a 'fast ethics' may have valid areas of concern such as protecting vulnerable people, Gallagher[8] calls for a development for slow ethics within healthcare to restructure the way we think in a more reflective way rather than just reacting to the latest moral panic. It is hoped that a reading of this slow ethics through a post-structural analysis of the quality of palliative and supportive district nursing care will develop an understanding of how 'slow ethics' may be progressed towards even under current political ideologies.

Empirical background

Patients were recruited in five community healthcare trusts via district nurses and other specialist community nurses (i.e. palliative care nurses and heart failure nurses), and via research nurses and hospice staff in five hospices. Inclusion criteria were as follows: above 18 years, able to consent, able to participate in an in-depth interview, (and for patients only) receiving or requiring palliative or supportive care and 'active' on a district nursing case load. Exclusion criteria for patients were as follows: current contact with the authors in a professional or social capacity and resident of a nursing or residential home; for carers, exclusion criteria were as follows: professional care staff of the patient and if the patient declined to be interviewed. A total of 26 patients and 13 carers were recruited (see Table 1 for sample characteristics). Three cases contained second interviews. This study was approved by Northwest 8 NHS research ethics committee (reference 10/H1013/3).

Combining grounded theory's coding and discourse analysis techniques

A post-structuralist 'bricolage'[16] approach was adopted to combine the most productive tools for the analytical tasks at hand, namely, grounded theory's coding tools[17] for interview protocol development, and discourse analysis[18] for analysing data alongside post-structuralist theories.

Grounded theory methods were not used for a substantive analysis because they aim to build up a theory or framework from within the social world. Data analysis becomes implicated alongside that which it is analysing and therefore cannot be read alongside alternative post-structuralist theories. Equally, discourse analysis techniques were not used for interview protocol development because they lack the tools and methods to iteratively develop data collection[19] limiting the breadth and depth of the data.

Interview protocol development

This qualitative study used semi-structured interviews that were audio-recorded and professionally transcribed. The initial protocol was developed by reviewing literature and discussion with a research

Table 1. Demographics of sample.

Patient characteristics (n = 26)	Carer characteristics (n = 13)
Diagnosis	Age
Malignant = 18	Mean = 68
Non-malignant = 6	Range = 58–79
Co-morbidity = 1	Gender
Undisclosed = 1	Female = 7
Age	Male = 6
Mean = 70	Ethnicity
Range = 48–98	White = 12
Gender	Non-White = 1
Males = 11	Opposite-sex partnership
Females = 7	Yes = 12
Ethnicity	Undisclosed = 1
White = 24	
Non-White = 2	
Opposite-sex partnership	
Yes = 25	
Undisclosed =1	

advisory group resulting in the following topics: relationship with district nurses, timekeeping, care at home and continuity.

Patients and carers were interviewed (using the same protocol but with appropriate rephrasing of questions), and grounded theory's coding tools[17] were used to iteratively develop the protocol alongside data collection. In order for the grounded theory tools to be congruent with a post-structuralist philosophy, coding of transcripts happened as independently as possible with no aim of building a coding scheme or theory. The number of codes ranged from 70 to 426 with a mean of 178 broadly in keeping with the duration of the interviews (a mean of 36 min ranging from 12 to 109 min). Coding structures were regularly compared across interview transcripts for new themes to add to subsequent protocols. For example, several patients and carers discussed their previous experiences of district nurses, and therefore, this topic was added. In addition, the following themes were also added: previous knowledge of district nurses, discussions with other patients/carers about district nurses, use of touch, what do you do for your district nurse(s) and information sheets.

Discourse analysis

Discourse analysis involved reading passages of text, examining what discourses were circulating and how these discourses functioned within an understanding of post-structural theories on morality, that is, did a particular discourse about district nursing produce or preclude a becoming-other of patients* and carers* subjectivities. Analysis therefore did not aim to ground itself in the social world, but instead questioned how the constructions of quality district nursing care in turn constructed the constructors delimiting what quality of care could be.

Research validity and reliability

While a need is recognised for research to be logical and honest, post-structuralist researchers often fail to recognise the necessity of terms such as 'rigour' and 'validity' in producing the researcher as viable, and therefore, such terms cannot go ignored. Post-structuralist research does not claim to produce a truth in

reference to external tools. Instead, multiplications of *subjectivities* must occur,[20] and the limits must be rendered for research to be considered 'valid'. Therefore, in addition to the limits of the research question discussed in the introduction, the sample characteristics also imposed limits. In particular, the sample was predominantly White and comprised patients in same-sex long-term partnerships, with a cancer diagnosis and above 60 years. Further research could investigate how views and the effects of discourses alter in accordance with a variety of demographic factors.

Reliability, in the sense of being able to reproduce the same results, is not something post-structuralist research aims for, as it is recognised that there will always be, indeed should be, multiple possible readings of texts. Therefore, this article demonstrates validity and reliability in a post-structuralist frame by giving an account of the limitations of the research, and demonstrating how it multiplies rather than restricts subjectivities.

Selection of themes

Many themes on district nursing arose in the interviews such as knowledge, the effect on the home, timekeeping, and the genesis of care. However, the word 'busy' and its conjugations were noted to be present in 17 out of 31 participants' interviews (more than any other theme). This alone was insufficient to make it the subject of an entire article, but it was enough to examine how it affected and interacted with other themes. Codes and interviews where the phrase 'busy' occurred were reviewed for the effects of busyness. These were then gathered into a sub-theme and a memo was written. The writing of this memo made it apparent that 'busyness' had the potential to widely affect district nursing care. The effects of busyness were then read in line with the post-structuralist moral theory to examine how busyness discursively operated. In addition, the discourse of 'friendship' is presented as a morally functioning discourse to contrast the immorality of busyness. It was chosen because it was also frequently occurring in the data and helps balance the representation of district nursing. To do so otherwise may risk implicitly suggesting district nursing is entirely immorally structured, which is not the aim of the authors.

It should be noted that the rendering of the interviews occurs in tandem with the theoretical frameworks that produced these readings. To render the interviews away from any theoretical frameworks or extant texts would risk (implicitly) suggesting that they can 'speak for themselves' in some way. This is not congruent with post-structuralist philosophies that assert that it is placing limits on the possibilities of texts through their interaction with other texts that makes them intelligible and thus analysable.[21] Therefore, interplays of data, theory and analysis occur throughout rendering the findings.

Findings

Busyness: circulating and forming subjectivities

Some patients and carers (referred to as P and C, respectively) reported that nurses claimed to 'be busy':

> P18: There's no way they can commit themselves to any length of time … I've said, jokingly, oh, you're running a bit behind today! 'we've been very busy, we've had an emergency or we've had this happen'.

However, such reports were rare; instead, patients and carers formed their understanding of district nurses' actions using discourses of busyness, which were not expressed by district nurses but performatively (re)formed district nurses* subjectivities, thus busyness was performed:

> P5: I know they do a good job and they're busy … I always say, 'You know, do you want a drink or something?' … I think it's only once when Samantha had a drink off me.

Suggesting that nurses are 'busy' is not new in academic[22] and non-academic literature.[23] However, what has not been explored is how 'busyness' shapes and limits patients* and carers* subjectivities and their thinking about quality of care. Declining a drink could have multiple readings, but instead, it is read as a 'busy' district nurse. Refusing a cup of tea and reading it as secondary to 'busyness' appears relatively banal and non-consequential to patient care. However, busyness also affects the way patients conceptualised and accessed psychosocial care, intravenous medications and even physical care:

Interviewer: Do you think it would be useful for them to just come and visit you? From your point of view, not from theirs.
P16: It would be a confidence builder, yeah. But that's all ... it would take too much time ... so I wouldn't expect that to happen ... but I didn't expect them to stay long, 'cos I expected them to be busy. So I never questioned, you know, why have they rushed off.

Busyness also prevents patients from re-imagining or asking for more care. Intravenous medication administration was cited as something that two patients (P14 and P26) would find beneficial from district nurses. However, P14/C14 rejected it as possible because of 'busyness':

Interviewer: ... in the future ... do you think their role might change from just doing the line? Do you think they might start doing other things?
C14: I think they could do ... I think it's [administering IV medications] something they could offer, whether they'd be able to offer it I think is a different thing cause you just see that they're so busy now.

Busyness even made current physical care unviable:

P19: Some occasions my wife's been here when they've said it, 'Oh, well, we've not been told to do it [leg dressings], we're busy, we've got a lot of jobs on, would it be possible to do it tomorrow? We'll tell someone to do it tomorrow'.

Despite redressing P19's legs being within the district nurses' remit, and it being an effective way of achieving pain relief for P19, busyness rendered it unviable. It appears that almost any nursing action can be made unviable by busyness, and busyness comes to be one of the ways in which patients* and carers* subjectivities become unquestioningly restricted.

Docile-patient/immoral-nurse

When participants were asked what they thought district nurses could do for them in the future (despite all but one patient being open about their increasing morbidity and eventual mortality), very few had any clear idea of what their district nursing care would become. P25 and C25 demonstrated the clearest conceptualisation of palliative and supportive district nursing care:

Interviewer: Do you feel that the district nurses could do anything more for you if you became more unwell at home?
P25: Well, I suppose they would do, yes, definitely.
Interviewer: What sort of things do you think they might do?
P25: Well, I don't know ... it just depends what it is that I have. I don't know, I suppose they'd look after me.
C25: I mean nobody's ever told you that.
P25: No.
C25: So you don't know what to expect for when you get ...
P25: Like bedfast or anything like that, I know.

P25 realises to some extent what death will entail, but this is coupled with only a vague, 'I suppose they'd look after me'. Many other patients had no notion of what their district nursing care could become if their illness and needs changed. Instead, they appeared to enter into a realm of fantasy where district nurses could become anything, do anything and were faultless:

> Interviewer: Are there any things you think they're unable to help with then?
> C17: There's nothing really ...
> P17: I'm sure if we needed help they would help us ... If we need them they come, if we want anything ...

While this may appear at first to be moral, the idea that district nursing can become anything and do anything without fault would render district nursing unintelligible; subjectivities must be limited to bring subjects into being.[12] Therefore, district nursing must have limits and cannot 'do and be anything'. How then is this limitless district nurse produced and maintained if it is unviable?

If as Butler's theories suggest subjects are dialectically (re)formed,[12] then being a patient or a carer in relation to a 'busy' district nurse affects patients* and carers* subjectivities. It appears that patients and carers become reformed as docile in relation to 'busyness', curtailing their objections and desires because nurses are 'busy'. However, 'quality care' prevails because the docile subjective positions are unable to change or reform district nursing care. The district nurse then becomes reformed as being without limit because the patient/carer-docile-subject never attempts to find or place limits on the district nurses* subjectivity. This limitless district nurse against a highly limited patient/carer subjectivity precludes any ability to develop care in new directions, yet produces unbounded praise for district nurses where they are (re)formed as 'doing anything'. A pseudo-quality emerges, pseudo because it cannot be considered 'quality' within the theoretical framework but is claimed to be quality by patients and carers. While such pseudo-quality is not always as stark and clear in all the cases presented in this study, 'busyness' being enacted by nurses affects the subjectivity of the patient and carer and their ability to challenge their care. If patients are unable to reform their current subjectivity by the fact of their subjected docility via the discourse of busyness, then the very basis of the patient–carer–nurse triad and the care that occurs within it becomes immoral.

Moral district nursing care: becoming-friend, becoming-other

Merely deconstructing care in this way and declaring it immoral do not account for what moral care may look like, as theorised moral care should produce subjectivities that can become-other. Therefore, the discourse of friendship is briefly presented as a discourse that tends to function morally. Several participants described the nurse as a friend:

> P1: When I did start to need them the Sister came out ... they observed my wife doing a drain and they were quite happy to leave her to it ... they came back a few more times to observe ... and we became ... I wouldn't say we're good friends because we've not known each other that long, but I feel as though they are a friend that I can talk to if and when I ever need to ... possibly one day I will need their professional expertise a lot more than I do now and if we have a good working relationship now when it comes to the time where I will need them I feel I know I can trust them to do whatever's necessary ... without upsetting me or the wife.

Where district nurses began with a physical care task, they were not considered friends, but slowly they became friends. While the discourse of friendship can restrict in much the same way as any other discourse can, in the above case, P1 envisaged nurses helping him in the future. This was facilitated by the friendship with his district nurses. Therefore, friendship can be seen as a moral discourse because it tends to open up new possibilities and new actions for the patients, such as psychosocial needs. However, the district nurses

are not fully (re)formed by friendship nor need they become fully one thing or another.[24] Instead, the post-structural analysis of the empirical data suggests some district nurses exceed their subjectivity but do not escape it, becoming-friend but remaining nurse:

> Interviewer: What would you say the district nurse has become to you then? Do they remain fully district nurses, or does the relationship change at all?
>
> P24: No, they remain district nurses, but kind of friends ... not friends like friends that you go out with but ... you feel like you can kind of tell them things and, if you're not feeling so good ... you feel you can say to them, 'Oh look is this something normal? I don't feel too good' and if they don't know they'll ... maybe speak to the doctor ... you've built up that kind of personal relationship.

Exceeding subjectivity in this way allows space for friendships to open up. Actions are allowed to flow from this novel subjective site, which may not have occurred from within the initially performed physical discourses of district nursing. Therefore, district nurses becoming-friends can be considered moral in that it allows patients to engage in care that is valued but may be unviable within extant discourses of district nursing.

Discussion

The aim of this discussion is not to expand on what 'slow ethics' may look like, but instead consider how a post-structuralist critique of 'busyness' may be read beside Gallagher's slow ethics to move towards slowness.[15] In order to address this, it is necessary to review some of the critique of neo-liberalism that is currently driving healthcare so that an academic reformation can be attempted.

Will competition increase busyness?

Social acceleration, where technology decreases the time taken to perform essential tasks (such as eating and washing) and increases the amount of time available for economically productive tasks (such as the mobile phone creating an always available worker), has been suggested as a factor that contributes to the production of busyness in everyday life.[25] It is suggested that this feeling of social acceleration occurs through capitalism's desire to produce new and more efficient means of producing more for less, in turn shaping subjectivities in relation to efficiency.[26] Competition is key in producing social acceleration by placing providers in competition, potentially making one provider economically unviable, something undesirable in a capitalist framework.[27] Such social acceleration and the subsequent busyness that is produced have been documented in multiple areas such as domestic life,[28] work life[29] and political activism[27] but not in healthcare.

While opposing concepts like 'wastefulness', 'inefficiency' and 'slowness' appear undesirable qualities, they remain subjective and require further analysis. For example, efficiency in district nursing becomes contested when tasks such as lighting fires and cleaning are done,[30] yet remain uncontested when dressing leg ulcers. By this logic, efficiency pertains to the tasks that only a district nurse can carry out, meaning it is inefficient for district nurses to become friends. While it is clear that not all nurses abide by the restrictions placed on their practice,[30] efficiency in modern day society is so pervasive and considered desirable[31] that to be considered inefficient risks one's identity within capitalist frameworks. Therefore, 'efficiency' begins to preclude 'slow' actions that may not have measurable short-term consequences but remain beneficial.[27] In this study, befriending was not a viable action in its own right, and instead only became viable when tied to physical tasks. There were also no examples of district nurses conducting similarly 'slow' tasks such as aromatherapy or massage despite there being evidence that they are valued by and beneficial to patients and carers.[32] This suggests that broader sociopolitical ideology shapes what are viable district nursing actions and what quality care can be.

Can choice drive quality?

For individuals who experience poor care, being able to choose an alternative provider may produce better quality care for that individual. Currently, within district nursing in the United Kingdom, unlike other areas of healthcare, patients and carers have no choice over which district nursing service they receive. Could choice therefore be the solution to producing quality, or could it further serve to restrict patients* and carers* subjectivities? Key to answering this question is how choice is instigated. Choice is not only used to produce quality for the individual but also within an entire service.[33] Putting aside arguments about whether patients and carers can exercise choice, discussion instead focuses on how choice acts to produce or preclude moral actions.

If choice is to function in a market to produce quality, information must be produced that allows choices to be made to produce measures of quality for palliative and supportive district nursing services.[11] Examining these various tools' internal logic, there is little to object to in what they regard to be quality care such as pain control and preventing social isolation. However, in an effort to account more fully for time and money, a desire arises for measuring quality in standardised ways to compare services:

> Every sector of the healthcare system, efforts are underway to improve quality of care provided, increase cost-effectiveness ... best practice and enhance public accountability ... To evaluate the effectiveness of interventions by home care agencies at these potential turning points, it would be helpful to have standardized performance measures to document changes in client characteristics that can be compared between agencies.[34] (pp. 665–667)

This produces a market economy rather than merely providing guidance for professionals. In addition, 'choice' produces measurements, which may begin to reform patients* and carers* subjectivities in line with the discourses expressed in such tools, by virtue of district nursing actions being economically unviable if they are unmeasurable. The question therefore becomes, in what ways does choice, through the production of measures, come to (re)form patients* and carers* subjectivities, and can this (re)formation be considered moral?

Choice within neo-liberal healthcare markets, while liberating the individual from poor care, systematically aims to increase efficiency. This increasing efficiency has the effect of producing a social acceleration, bringing with it busyness such as described by the patients and carers in this study. Therefore, choice appears not to produce quality for a whole system (though it may for the individual) but instead produces systems of measurement that force the immoral restricting of patients* and carers* subjectivities. Measuring of quality in this way becomes paradoxical, where measurement itself fixes and defines care and in turn fixes and defines the patients and carers who are subjected by these extant discourses. Busyness then ensues through the desire to increase the measures and achieve 'quality'. However, care has become immoral by restricting or precluding non-measured care; quality must become something that cannot be and is not measured because measurement immediately begins to erode the quality that it measures. Therefore, quality becomes a rejection of measuring, choice and any other way of attempting to direct practice so that it can be measured. This is not to say that guidelines such as those for pain should not be used to guide clinical treatment; indeed, that is the very thing that they should be used for. However, 'best practice' should not as suggested be used to define quality of care[3] as it will begin to restrict subjectivities preventing novel, moral actions precluding quality of care.

The reduction of busyness

What is the solution to reduce busyness within healthcare, slow nursing practice and increase quality of care? Busyness will undoubtedly remain since eliminating it is implausible. However, if 'measuring' and 'choosing' as ideologies are removed, then busyness may cease to be a structuring condition of district nursing, and its subjugating power to permeate and preclude the moral reformation of patients* and carers*

subjectivities is reduced. In this way, nurses may be allowed to 'slow down' and cease producing patients as measured and efficient subjects.

Producing research on best practice may therefore continue, but it should not be considered commensurate with quality care. This is something that current UK policy goes some way to remedying by promising to end relentless measuring[35] but fails to realise that choice produces measurements, and measurements preclude quality care.

Conclusion: towards slow ethics?

The empirical evidence rendered in line with a post-structuralist reading of morality in this article develops Gallagher's[15] questioning of initiatives such as *The Productive Ward.* Gallagher recognises that such initiatives have laudable aims in freeing up time to care but also recognises that they may be improved if aspects of 'slow ethics' are incorporated. This article suggests that such improvement could be directed towards reducing or eliminating the measuring that is espoused in initiatives such as *The Productive Ward*.[36] Therefore, the post-structuralist rendering of quality rejects similar initiatives in district nursing, which aim to develop quality indicators to measure and improve the quality of district nursing.[11] It is the authors' suggestion that there is no clear dividing line between 'quality care' and 'ethical care', and that by adopting a post-structuralist approach, it is possible to unite these concepts and analyse empirical data to suggest ways in which quality can be improved without recourse to measurement. This analysis suggests quality, ethical, moral and slow (call it what you will) care should be produced by liberating those involved in care to allow a (re)formation of subjectivities with discourses that themselves allow (re)formations to occur. By removing the need and desire for measuring, busyness would be reduced and slowness increased, in turn reducing the subjugation that patients and carers experience. Therefore, quality care becomes a slowing down, liberated, day-to-day moral endeavour characterised by the ability for subjectivities to be (re)formed by discourses such as friendship, which produce a tendency towards becoming-other, rather than being characterised by efficiency, speeding up and measuring, which tend towards subjugation via busyness producing subjectivities that are less/unable to (re)form.

Conflict of interest

The authors declare that there is no conflict of interest.

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