Twenty years of management of care in Chile: what we know, what we do not know, what is yet to come. An analysis of arguments

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ABSTRACT
For over 20 years, the notion of ‘management of care’ has been foregrounded as key in the jurisdiction of the nursing profession, with the aim of detaching itself from the wider medical umbrella. A number of voices have advocated such centrality. These include juridical, academic and occupational perspectives. Critical stances, although peripheral, have also been voiced. These have been received, at best, with a ‘polite silence’ in mainstream circles.

By looking at the arguments surrounding the ‘management of care’ circulated in these two decades, this article reports the various forms of discursive practice that participate in the political process of autonomy building. Particularly, we focus on the validity of the arguments as well as the cohesion across arguments within the knowledge system. In doing so, we evaluate its main premises and foundations, the reach of the conceptualisation and its disjointed, differing and incomplete bases. Similarly, we used an inferential technique for the reconstruction of omitted and unexpressed assertions.

The article introduces an approach of the humanities that is seldom seen in healthcare. It also proposes a research agenda in regard to management of care for the upcoming decades.

INTRODUCTION
Different spheres of the professional language of nursing in Chile have changed as its occupational area changes. Discourses are now imbued with ideas such as management, leadership and strategy, which reflect in one way or another State reforms that began in the 1980s. Changes in language convey changes in ideas.

A central concept in this transformation is ‘care management’ (gestión del cuidado), which becomes one of the most significant landmarks in the development of contemporary nursing in Chile. While care has been considered to be insufficient in representing the nursing jurisdiction, care management has implanted a sense of emancipation from the medical profession. From a legislative perspective, a reasonable level of autonomy can be identified, which in turn circumscribes a field of professional responsibility. This implies that failures in this field can be at least in part attributed to the nursing system. Likewise, the idea of care management has been used as a bastion of differentiation from other caring professions, even if this is still a widely debated issue.

At an organisational level, it has also become a constituent element of the restructuring of complex tertiary health institutions. Irrespective of their names, care management divisions have replaced former nursing coordinating units, although with very similar functions and responsibilities. The main change, at least from the nurses’ standpoint, concerns the line of authority, which eventually refers to the quest of not being attached to medical units. Owing to this connotation, its influence has had a supranational reach. For example, a network of care management created by the author of the present paper at the Pan-American Health Organisation, and handed over to other authors based in Chile.

By using the juncture of curricular changes in nursing schools, the idea of care management worked its way through academic discourses. An example of this is a move from administration courses to care management courses—under different names—that now are even found at the postgraduate level (eg, https://goo.gl/2dLEsM). However, although it is relatively easy to identify intuitively the spheres in which it operates, care management is highly imprecise. In sum, it seems axiomatic that care management ‘is what nurses do’. Or at least, nurses in Chile. Given this conceptual imprecision, its meaning—often implicit—has led to serious problems of explanation, and therefore, of credibility of what the nursing profession really stands for in its prerogatives. What are its premises? In what conditions does the concept operate? What variations are there in different settings? And more importantly, how does it translate into practices?

This article reports the results of a study analysing the discourses produced over the 20 years that have past since care management was made official as the core of nursing practice in Chile. These discourses have circulated through different channels and by different voices, some of them advocating it, but some others criticising it. Even though the defence of care management as the core professional role has been much publicised, critical voices within nursing have been received with some scepticism. The focus of this study was the analysis of arguments surrounding the notion of care management and the consistency across arguments within the system of representations in nursing. Arguments sit on a prominent position in human knowledge; primarily, arguments organise what is known in logically related propositions, they solve differences in opinions and mediate the transmission of knowledge. Since incomplete arguments are common in this area, an inferential technique of argument analysis was necessary to identify implicit and unexpressed premises.
Through an increased awareness of language and its social implications, the care management project seeks to make and influence political decisions. The hypothesis, however, suggests that care management is an undertheorised notion and that, although often used in the trade arena, it only enjoys a very marginal position in the nursing theoretical system.

The contribution of this article is thus twofold. On the one hand, it pieces disparate information about care management, as understood from the nursing stance. And on the other hand, it makes the case of the linguistic features that participate in the organisation of a social movement and the strengthening of a profession’s power base.

**METHODOLOGY**

This study was concerned with the validity of arguments as well as the consistency across arguments. To that end, a pragma-dialectical approach was used.16 17 This type of analysis consists of extracting the arguments and looking at their premises, reasons and conclusions. This is aimed at identifying the type of reasoning, the standpoint of the arguer and, if required, the validity of the argument. Nevertheless, when people express their ideas they do not always build technically complete arguments, which is often the case in nursing documents. In this case, the technique aims to trace the available fragments, situate them within a reasoning scheme and place them in their sociohistorical context and through this process infer its algorithms, stances and assumptions.

The method consists of a critical assessment in four stages20: 1. Confrontation stage (or search for differences); 2. Opening stage (or identification of starting points of the parties); 3. Argumentation stage (or how reasons are expressed, put or received); 4. Concluding stage (or evaluation of the result of the discussion).

It is important to consider that this type of analysis is useful in evaluating arguments, not isolated sentences. Let us take as an example the following:

Rain is more common in winter.

This is a sentence, not an argument. Therefore, it cannot be assessed through this analysis, unlike the following passage:

Rain is more common in winter because cold air cannot hold a lot of humidity. That is why in warm seasons the air is more humid but it rains less.

This is technically an argument because it includes a claim (that, in this case, is a causal relation) that leads to a conclusion that arises from the reasoning (regardless of whether the conclusion is right or not). There is a premise (rain is more common in winter), we are given a reason (cold air cannot hold a lot of water) and there is a conclusion (during warm seasons the air is more humid but it rains less).

In performing this four-stage analysis, additional tasks are also undertaken, such as identifying arguments, evaluating the validity of the arguments, identifying premises and assumptions, reconstructing implicit or unexpressed premises and aggregating families of arguments.

**The corpus**

The corpus included a series of documents that were organised into four different categories in ways that different registers were covered, that is, ranging from those aimed at wider audiences to those aimed at a jury (table 1). The documents included doctoral dissertations, (mainstream) journal articles, books and book chapters and other documents (laws, public releases, conferences, etc). In this last category, documents relating the jurisprudence were included, as many of the academic documents referred to them.

Given the length of the documents, particularly dissertations and books, the corpus was limited by using a criterion of soundness. That is, discarding the documents that addressed the notion of care management but only in a tangential fashion. Even so, the search covered the past 20 years, as this is the period in which care management has reached the public sphere.

**RESULTS**

The main findings of the study were organised into five different argumentative lines. These included traits of care management, the emphasis on ownership, the critical voices about its centrality in nursing, its position in the disciplinary knowledge and the definitional stress of the arguments.

**One care management and three traits: autonomy, ownership and responsibility**

In examining the literature, part of the publications that address care management at length are doctoral dissertations. In this section, the main arguments of three dissertations will be presented, in which the process of making nurses’ roles explicit is introduced in academic arguments. As the arguments were extracted from the documents, three traits surfaced from the analysis—autonomy, ownership and responsibility.

I can recall the words of my teacher, ‘you guys will graduate under a new law, you’ll be autonomous as nurses’. This law defines the professional practice of a nurse, because before this definition the nurse was referred to as a medical collaborator.21

This excerpt reflects Núñez’s reflection on her own work as a nurse historian, stressing the discourses of nurses’ autonomy towards the late 1990s. It is mentioned that the legislation that modified the Healthcare Act in 1997 introduced a definition of nursing practice. Although not explicitly, she means a modification of the definition, because she adds that before that nursing

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**Table 1 Organisation of the corpus**

<table>
<thead>
<tr>
<th>Category</th>
<th>Documents</th>
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<tbody>
<tr>
<td>Doctoral dissertations</td>
<td>Ferreira22, Núñez21, Galdames9</td>
</tr>
<tr>
<td>Journal articles</td>
<td>Milos16, Milos et al10, Milos et al13, Milos and Larrain17, Milos and Larrain18, Ayala9, Torres et al4, Ayala et al19</td>
</tr>
<tr>
<td>Books and book chapters</td>
<td>Ayala et al17, Hernández and Caballero43, Torres7, Ayala44, Alarcón36</td>
</tr>
<tr>
<td>Other documents</td>
<td>Healthcare Act73, Chilean Nurses Association, Ministry of Health of Chile60, National Audit Office’s Ruling34, Ayala et al44, National Audit Office’s Ruling33, National Audit Office’s Ruling35</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
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was understood as a service of collaboration to doctors. In this fragment, the author gathers different discourses from that period, in which the term collaboration has a negative connotation. Other discourses in which nurses were spoken of as ‘doctors’ helpers’ were being replaced by the idea of ‘doctors’ allies’. But despite this change, this circumscribes that which nursing is not.

Then, the reflection on the legal changes in 1997 goes:

 [...] the state of Chile defines the social role of the nurse as care management, the performance of actions that arise from medical diagnosis and treatment, and the duty to safeguard the best possible administration of resources for the patient. Defining the social role implied that nurses now have a social responsibility and autonomy in the care of people in healthcare settings.21

Here, the emphasis is also on definitional aspects, with the State as an organising sociopolitical entity. By mentioning the State, the passage highlights the expectation that this claim will not be contested by other parties (ie, other professional associations), as it comes to the intermediate conclusion that nurses now have a social responsibility associated with their social role (although it is not clear whether this responsibility existed before or not). As a grand conclusion, the argument claims that the changes in the jurisprudence lead to the autonomy of the nurses in the care of the individuals in healthcare.

In another doctoral dissertation, although addressing the nursing profession in Uruguay, Ferreira22 uses as a referential frame the Healthcare Act of Chile. The dissertation sustains that legal changes are important for the context of renewal of nursing. It reads, for example, that:

Among the positive consequences of introducing nurses in the law 19.937 on health administration, we can underline that the organisation of nursing services is safeguarded, according to the definition of the Healthcare Act, as it enables the evolution and development of the care management’s content. In the context of the healthcare reform, full autonomy for the profession is promoted and guaranteed, which also indicates that care management is the role that pertains to nursing.

On the one hand, Ferreira asserts that this legislation protects nurses because it captures the current transformation of nursing practice. On the other hand, he deduces that these changes imply for nursing practice both full autonomy and professional ownership.

By analysing them together, it becomes clear that these conclusions sit in the sphere of inference, and are thus very revealing of the intra nursing frames of analysis. While there is no obvious legal basis for claims of autonomy or ownership, this deduction may respond to the language with which the law project was socialised among nurses in the 1990s. The terms ‘autonomy’ and ‘ownership’ may have been much more enticing than the idea of a ‘manager nurse’, because many nurses felt strongly about providing direct care to their patients23 given the growing abundance of forms, processes and other office tasks that the reformers required from them.24,25 This corresponds to a sociohistorical context of a State that embraced neoliberal policies for the healthcare sector. Considering the strong opposition of the Chilean Medical Association, which set the tone for an overt political dispute, nurses were a key group in the reform process.

Given the dearth of national literature, Ferreira mostly-as the starting point.

Although drawing on a nursing standpoint—partly scientific and partly occupational—the work of Galdames is of great historical value. It brings to the fore a process that often remains untold, in which nurses participated as an interest group in the making of the law. Interest groups represent and protect a stance during a negotiation, which can be affected by the decisions being made. Financed initially by Pan American Health Organization (PAHO) in 1994, the process had a limited timespan and, seemingly, without the conditions for mass participation of nurses across the country. However, the members of the project, called ‘Legal Bases of Chilean Nursing’, saw in this law a ‘way of normalising legally the nursing role and thus of strengthening the profession socially’ (p. 51) and that the negotiations for a common legislation aimed to ‘gain legal backing as an autonomous profession through the Healthcare Act’ (p. 52). Despite internal differences—the author tells—about its noticeably commercial connotation, the term ‘management’ (of care) was eventually introduced in the project in 1996 with the intention of defining an ‘area that is exclusive of the nurse’. That is, ‘the content of the nursing practice, which includes providing nursing care and the effective administration of human and material resources’ (p. 57). A number of other publications have followed on from this premise of autonomy.9,25-31

A third doctoral dissertation8 gives us useful information in this regard. In her reconstruction of the origins of the legislation on care management, Galdames states:

 [...] the 2004 Public Regulation of Healthcare Services offered the chance for legitimisation of the nursing profession in the structure of health institutions, and the Administrative Regulation No. 19 legitimised the nurse as the responsible for care management.

In a single sentence the notion of legitimisation is used twice when referring to the regulation that followed from the Healthcare Act. This word choice is not random. The author is aware that these reforms of the healthcare system became an exceptional opportunity, as her analysis suggests, and in fact comes to a similar conclusion: the nurse’s responsibility and exclusivity in the care management area:

Arising from the legislation and from the science of nursing, care management is an act that is exclusive to the nurse, which is based on the caring science. (p. 69)

[...] in practice, the understanding of the care management as nurses’ social role is different from the epistemic and ontological foundations that lie in the legal definition of care management (p. 69)

The reader, however, will notice the leaning behind these passages. By taking them together and in light of the context of vindication in which they are written, it is easier to understand their stance. Whichever epistemic basis may have inspired the law project, depicted in Galdames’ narrative as a rather occupational issue, the authorities clarified afterwards that the term ‘care’ in the law was generic in nature. Therefore, its juridical usage does not fully coincide with the one of the nursing profession. It is also important to recall that even the most influential theory bodies in nursing26 refer to care as a human act, that in health settings is undertaken by different disciplines. For example, Watson27 states: ‘By assessing caring empirically, nursing and other health sciences may uncover more of a caring science view about its basic, relational/ontological assumptions’ (p. 5). The arguments in question are thus formally valid, but the admissibility of their conclusions is affected by the premise used as the starting point.

Original research
All in all, this analysis uncovers three traits associated with the notion of care management: autonomy, ownership and responsibility. Of these three, only responsibility arises naturally from valid premises. There is no certainty so far that responsibility may also imply autonomy or ownership, although the arguments being analysed tend to equate the three elements within a single semantic field. Noteworthy is that responsibility means that negligent performance can be attributed to a specific group.

Taken together, we may notice some important information: all these documents were written from the standpoint of the nursing profession, which is the main stakeholder in the quest for legitimacy, autonomy and ownership. Indeed, care management as a nursing field is being addressed by three academics who are affiliated to the nursing discipline (and even studied the same doctoral programme). This does not render the arguments invalid; but influences the choice of premises. At the same time, it makes it difficult for these discourses to circulate in outlets other than nursing journals, given their politically charged charges. Both occupational and academic, the care management discourse reinforces a sense of upward mobility of practising nurses in the clinic and of academic nurses in the broader system of disciplines. Similarly, this same leaning seems to prevent authors from considering opposing arguments, in which case the discussion could be much more nuanced.

**Proper actions are correct actions: beyond the prerogatives**

Having explored some basic traits of care management, it is necessary to discuss one of them in detail, as it is an iterative idea across the different documents of the corpus. That is the claim of care management as an area owned by nursing.

Possibly, the work by Milos et al\(^1\) is the one that has had more visibility in the conceptualisation of care management from a regulatory perspective. The central claim is that care management is defined as an area that is exclusive to nursing practice, which according to Galdames\(^9\) was the actual goal of the committee in charge of the law project. In this regard, Milos et al\(^32\) state:

\[
[...] we can notice that the legislature has entrusted care management exclusively to nurses, a responsibility that has not been assigned legally to any other profession, which becomes an area that is owned exclusively by nursing. (p. 18)
\]

It should come as no surprise, as explained, that this development responds to vindication logics. For this same reason, the argument draws on the Estoppel legal doctrine (translated into Spanish as ‘actos propios’ theory; the word *propio* meaning both ‘own’ and ‘correct’) to suggest that care management is a ‘property’ of the nursing profession, as conceived during the inception of the law project. This is an unexpressed premise, which is best understood owing to the dissertation by Galdames.\(^9\) By using the notion of *actos propios*, she sustains that:

\[
[of all the responsibilities assigned by law] only care management would be exclusive in nature. (p. 57)
\]

However, the text of the 1997 Act was ambiguous regarding nurses, virtually overlooking the idea of occupational exclusivity, which opened up room for a shared jurisdiction. It is necessary to keep in mind that an important aspect of law-making is that changes can indeed occur during the debates, as they did, which may alter the initial aim of the law project. It is therefore likely that the legislation is intentionally vague in this respect, considering that other professions have similar functions, for example, nurses and midwives’ run the wards and manage flows of work.

Quite possibly, this was a response to demands of other interest groups. The nursing trade has expressed a number of times their discontent with this generic view of care management, because it prevents this function from becoming exclusive. To this discontent, the National Audit Office has counterargued the same number of times refusing the request. In a 2010 verdict, which clarified a previous verdict, it is argued, ‘care management, as stated earlier, encompasses an area that is larger than nurses’ activities’\(^33\); other verdicts read accordingly.\(^34\)\(^35\) Regarding this argument, Alarcón\(^36\) underlines that these dispositions are definitive in nature:

This analysis, which arises from the administrative jurisprudence, is in accordance with one of the pillars of the interpretive function of the National Audit Office; that is, dependence on previous rulings, which is aimed at having coherence and consistency across its own decisions.

Although controversial in the trade arena, this interpretation is decisive if we consider that it is for the National Audit Office to determine the meaning and application of administrative laws, which are not limited to a particular case but applicable to eventual similar cases.

In order to understand better the discrepancy between the prerogatives and the application of the law, first it is necessary to comprehend the concept of *actos propios*. The notion of *actos propios* (Estoppel) originated in the Roman Doctrine and means ‘correct actions’ (in several languages, *proper/propre* means ‘correct’, ‘appropriate’, ‘as it should’). Also in Spanish, to act properly (*en propiedad*) is to act as expected, and this is the sense in which the law used the term care management; rather than regarding it as a ‘property’ of a group.\(^36\) Unfortunately, this is no trivial omission in the statement by Milos et al., for it invalidates the central claim of an article that, in fact, intends to explain the interpretation of care management as understood in the law. This is not to disregard nurses’ initial intention here, but rather is to explain why, although carefully constructed, the owned actions argument has not been considered as plausible by the authorities that can interpret administrative laws (ie, the Agency Executive).

Noticeably, Milos and Larraín\(^37\) no longer use the term ‘property’ or ‘own’, but still advocate for an exclusive occupational area:

\[
[...] in charge of care management are exclusive to nurses. (p. 9, emphasis added)
\]

Also noticeable is that the terminology in recent publications by the same authors tends to change. For example, Milos and Larraín\(^38\) state:

Universally, the nurse is—sociologically or juridically—the holder of care management. (p. 144)

It is not absolutely clear whether such change reflects the clarification above—nor is it what being a holder of something ‘sociologically’ may mean. However, in using the term ‘holder’ the authors seem to imply that nurses are ‘in charge’ of care management and therefore function as ‘trustees’. Likewise, the term ‘propios’ seems to be used in a less strict fashion, as an equivalent for ‘that concern to’. While speaking of research, the article reads:

\[
Nurses must [sic] promote research that allows them, on the one hand, to identify and describe safety problems that are propios to nursing, and on the other hand, to develop and evaluate the solutions
\]
that be applicable to the healthcare settings. (pp. 150–51, emphasis added).

There are also more ambiguous usages of the term, such as this:

Generally, the nurse-patient relationship creates an ethical-juridical bond that leads to a main obligation, which is to provide judiciously the services that are propios to the nurse. (p. 148, emphasis added)

In any case, this reformulation may capture the limitations of using the Estoppel frame, but also reflect the evolution of the care management concept since its inception. It is important to notice that the concern of this argument is the claim of a property—also from an intraprofessional vindicative perspective—considering how problematic it would be to establish a clean-cut division of labour in healthcare.

In considering the fallacy beneath the Estoppel approach, the argumentation technique would benefit from some reformulation with a view to—if necessary at all—an exclusive occupational jurisdiction. And in that case, it would also be important to make transparent that its main function is to avoid potential intrusion from other professions, instead of only using it politically in the name of better care for the patient. This is, of course, an aspect that would also require some empirical testing regarding the nature of care management in practice and the skill mix that it implies.

There is a sense, however, in which nurses would greatly benefit from altering the ownership structure in health. For ownership is as the very basis of neoliberal reforms in which nurses now take part, which would ultimately facilitate their full participation in the market.

Care and care management in the constellation of concepts: critical voices

Even though the debates about care management in Chile are dominated by a handful of publications, these permeate nursing discourses. More importantly, the texts are clearly organised as a political discourse, depicting an implicit dispute for legitimacy. However, there are also critical stances that circulate at a lesser pace, which we can label as ‘critical voices’. Among the reasons for this lesser pace is their non-conformity with the available definitions. Once a definition has been socialised and fixed in the imaginary, actors eventually forget the components that are not in the definition, until critical voices emerge.

This section looks at the main areas in which these minority voices have foregrounded arguments. Minority voices are important here, for they have questioned the core assumptions beneath the care management project. This is not to say these have undermined nurses’ social movement; although risking being labelled as potential political adversaries, they generally seek to turn shallow narratives of vindication into a sound academic discourse. These critical stances are organised into two subsections, one relating how care management is integrated into existing nursing conceptualisations, and the other relating care management in healthcare organisations.

How care management is integrated into existing nursing conceptualisations

An important part of this analysis concerns the constellation of nursing concepts and the position of care management in it. One of the main problems in conceptualising care management is to find a ‘one size fits all’ definition. In this case, one that encompasses all levels and contexts in which nurses work that at the same time may be compatible with pre-existing disciplinary knowledge.

This problem is apparent in, for example, Milos et al referring to care management as ‘the core of the nursing discipline’ and ‘the abstract knowledge of the profession’ (p. 21). On the same page, the authors suggest that care management collects the theoretical knowledge that belongs to nursing and translates it into a specific activity. This is a rather striking assertion, for the one claim on which there seems to be large agreement in the literature is that care constitutes the core concept of the nursing discipline.

From an argumentative point of view, the problem is evident. If care management is the ‘application of a professional reasoning’ and at the same time is ‘the abstract knowledge’ of nursing, the statement becomes a circular argument, as explained in the following:

Care management is the application of a professional reasoning, while the reasoning is based on knowledge; but care management is that knowledge, which results in that care management is the application of care management.

This conflict arises from a definition that is based on a concept, which in turn is defined by the first concept, a circularity that undermines consistency across definitions. Of course, one possible interpretation would be that the abstract knowledge is applied to reasoning itself, as if solving a theoretical problem. But in that case, care management would be but a mere intellectualism, without any relevance to actual professional practice. This would also revoke another popular definition of care management as ‘the put into practice of professional and instrumental skills’. Abstract knowledge is exactly that, an abstraction.

In a detailed account, Hernández and Caballero add to the explanation of this conceptual discrepancy. By drawing on publications that use elements of induction, disciplinary conceptualisations and position statements by international nursing entities, the authors conclude that there is no sufficient justification to give care management such a central status in the nursing knowledge. In the current knowledge system, care management seems more compatible with one particular aspect of the discipline, namely nursing management and nursing governance. What is more, care management is limited to a model of nursing practice that is specific to the Chilean case.

The argument by Hernández and Caballero sheds light into three key ideas about the compatibility of the concept with the nursing discipline: (a) care management is not the core concept of nursing; (b) care management is not the science of nursing; (c) care management corresponds to nursing management.

Back to the argument by Milos et al, then, it reads:

Care, though the essence of nurses’ work, in practice can be delivered by a nursing technician, by another professional or by a nursing auxiliary. Care management, by contrast, is the unique contribution of the profession to society. This represents the abstract knowledge of the profession as well as its capacity to solve problems at discretion. (p. 19)

This assertion needs a closer analysis. If care management is not really the abstract knowledge, as Hernández and Caballero explain, then this definitional aspect would need to be revised because of the need to specify the contribution of nursing to society, and because of the gapping arguments about a contribution that is specific to nursing.

But even more important for the present article is that the care management concept could be integrated more easily into the nursing conceptual scaffolding if one distinguishes care from...
care management. This is, in any case, a difference that the cited authors seem to agree on.

Likewise, Ayala proposes different levels on which care management operates in practice as an occupational area, which are also compatible with the conceptual analysis above. It is explained:

It is noticeable, too, […] that this definition embeds a distinction between care and care management, which is a reconceptualisation of former nursing roles known as ‘direct care’ and ‘administration’… (therefore) I infer that care management is not the abstract knowledge of nursing. (p. 140)

In a recent publication, Milos and Larrain go even further, claiming that care management has two components, an ‘abstract part’ (management) and a ‘concrete part’ (care) (see p. 148). This reconceptualisation solves certain issues in its previous formulation, but we are given an explanation that is difficult to follow. But what is more, when applying the concept to the area of risks and dangers, the explanation insists that care ‘is mostly related to doing things’ (p. 149). By this token, however, the explanation reverses the most accepted conceptual relation in the nursing discipline.

This reverse relation assigns care a task-like status, guided by the abstraction that is management. However, it is important to keep in mind that this issue has been widely debated among nursing theorists. Care is a human trait that, as a moral ideal, operates as a motivation for action; there are even aspects of care (ie, active listening, teaching and so on) that can be more directly linked to certain therapeutic interventions. Otherwise stated, certain actions can communicate care, as this has long been considered to be a symbolic dimension of interpersonal relationships. But care is not an action per se, nor can it be reduced to a set of tasks.

Without aiming at classifying this as an error, this reverse relation would need more theorisation to be convincing enough as to enter current debates, and at the same time, expand the explanation about care management. Nevertheless, this work by Milos and Larrain might also be regarded as a critical stance towards the domination of the nursing discipline in the nursing value system, although this aspect would need some clarification on the part of the authors.

As relevant as they are for theoretical consistency, these precisions have repercussions for nurses’ interpretation of their work and area of competence. Although it is remarkable that the critical stances have not received sufficient attention in the debate, neither to accept them nor to refute them. This may well reflect the high level of ambiguity of ideas relating care management, which can also result from a larger problem of knowledge-building techniques.

Care management in healthcare organisations
A second group of critical voices focuses on care management from an organisational perspective. How can care management be integrated into the healthcare reform? In an article published in 2009, Milos et al used a frame of functionalist sociology (ie, occupational situs) to establish a nursing hierarchy and distribute tasks within it in the context of care management. The argument looks promising, but turns out to be confusing. It takes as a starting point a shortage of nurses, which in light of growing care needs, results in a series of consequences, including ‘a distortion of the nursing model’ (p. 18); that is to say, a process of inadequate delegation of tasks to people supposedly lacking the necessary training. So far, the reasoning is clear. To remedy the situation, the authors suggest a focus on three elements (although not sufficiently differentiated): (i) improving staff performance; (ii) optimising the use of nurses and (iii) increasing productivity. And in so doing, they propose the configuration of a nursing situs (which on p. 20 they consider as ‘a reality’), among other things. Leaving aside the normative tone for a while, it is not entirely clear how such situs—as imagined by the authors—would solve the shortage of nurses, as in four paragraphs (pp. 20–21) we are given a meagre description of its operation.

Put simply, the notion of situs, and by extension that of occupational situs, is an ordination scheme of socially related groups. On the basis of social differences, it creates ‘categories of work’ and orders them in a status hierarchy. However, as the adjective suggests, this same hierarchical order is the downside of the model as a representation of a society composed by interrelated, dynamic classes. Also by extension, in the work area it neglects the empirical application, the exchangeability of roles, the influence of organisational contexts and the agency of professionals as individuals in building status.

In response to such deficit, there appeared in 2015 a 13-page paper explaining the rise and fall of the notion of situs in sociology, and postulates its implausibility in light of the current system of academic credentials, particularly because of the difficulty of manipulating a situs at the observer’s will. At the centre of this explanation lie the empirical problems of the situs approach, for which reason the sociology of the professions discarded it towards the 1970s. The article reads on p. 137:

It is well founded to think that the notion of occupational situs, apart from its empirical limitations, is eventually abandoned by sociological discussions insofar as other paradigms dismissed post-war functionalism, as society and work become increasingly complex, and as the (American) social model is criticised on different fronts.

However, the intention of Milos et al is noble. With a view to circumscribe care management as an independent occupational area, the authors intend to develop a ‘nursing situs’ as a field detached from medicine, with the professional nurse sitting at the top of the structure. But as one understands this implicit premise in looking at the sociohistorical context, it follows that the argument pertains more to the political arena than it does to the technical arena. Thus, it is persuasive in nature.

In the same response by Ayala, part of this issue is fleshed out. There is a legitimate quest for recognition and autonomy. However, the organisation of work is based on social hierarchies (ie, men/women, experienced/beginners, professionals/assistants and so on), and on an unavoidable hierarchy of activities:

using it [the notion of situs] in the analysis of applied nursing may misleadingly suggest a complete detachment from the dominant profession in health, because regardless of the socially constructed hierarchies there is also a stratification—thus subordination—of tasks. (p. 138)

It is also discussed that the idea of a situs in care management—as proposed—leads to the consolidation of hierarchies in health and divide work between intellectual tasks and manual tasks. This, because contemporary organisational models tend to optimise work by combining both dimensions:

[…] in contemporary organisations very few positions are designed solely to think and direct—typically high-ranking posts—and also few—if at all—solely to do things without any general understanding of the principles and functions that govern their tasks.
In summary, the dissociation between care and care management can be useful for analytical purposes and considering them as two different constructs is organisationally helpful, as previous subsections suggest. On the one hand, care management can be used as a driving force in the development of nursing management. But, on the other hand, it is also useful in that it considers organisational models that optimise the talents that are available to the patient, as stated in the legal mandate. Furthermore, conceptual precision may be important in social movements, for language changes images and perceptions of the arguers. Minority voices seem to uphold important premises for nurses’ rhetoric that have not been heard so far.

Care management: a position in the knowledge system

In 2014, the first textbook on care management in Chile started life. Titled ‘Management of Care in Nursing’, the foreword was written by a representative of the Chilean Association of Nursing Education. Its contents came to fill a very significant gap in educational plans. Given her expertise in the area, Professor L Galdames (Andrés Bello University) was requested to write a book review, so that the text could be critically assessed and introduced to the readership through an academic medium. She kindly accepted. When the review was sent to a mainstream journal, the answer was that it would not be possible to publish it because, first of all, book reviews were not in the scope of the journal, and second of all, the journal did not have a book reviews section. True, there was not any established tradition of publishing book reviews. And, seemingly, not even an intention to create it or to adapt it to the existing sections.

What this anecdote illustrates, away from any animosity against the editorial board, is the lack of affinity of the notion of care management with the system of knowledge in nursing. It is somewhat comparable with the concept of ‘nursing governance’ more broadly, but this also sits on a marginal position and has been seldom used in this context. Often times, teachers of nursing care (say, clinical problems, procedures and standardised care plans) are the largest group of faculty nurses, in comparison to teachers of care management. The latter subject is sometimes added without much planning to the last years of the curriculum, given the imminent healthcare reform. And considering its applied nature, it is also common that the teaching resorts to formal ties with healthcare managers, trade representatives and public health professors. They have first-hand knowledge of organisational processes and of the way care management translates into practices, values and approaches. Seen from this perspective, care management, although commonplace in professional narratives, seems disconnected from clinically dominated foundational contents.

Alongside this disconnection, care management continues to be an area with scant problematisation and, even scant, theorisation. Sitting on a marginal position in study programmes, an given the disarticulation of the teaching and the apparent lack of substance, it is no surprise that even after 20 years it is still a side topic in the system of knowledge. A search on Ciencia y Enfermeria from 2002 onwards (the period available online) shows that among the nearly 400 articles published, only 6 address some aspect of care management in their central claim. While articles about care management in Chile are also published abroad, these are not very many either.

What can we extract from this marginality? Recent discussions illuminate these matters. As nowadays it is widely accepted that the ethos of nursing is the care of those who go through health and illness experiences, the conversion of occupational roles to the administration of health systems involves intraprofessional and interdisciplinary frictions. The function of theory is to offer representations of practice, and in an ideological sense, to control it. By controlling practice, it controls its methods, foundations and approaches as well as its future directions. In an ideal world, this would look like a coherent whole in which a learnt group decides and prescribes what is best for practice—and intends to neutralise other influences—whereas practice ‘must’ submit itself to those intellectual devices. But idealism, by definition, leaves out the practical issues of reality; for example, the dynamics of the occupational field that mediate the expansion of some roles and the termination of others, which in a longitudinal analysis accounts for transformations across time. For this same reason, theoretical representations may easily become obsolete: changes occur more rapidly in the practical arena.

Considering discipline and profession as two functionally differentiated systems can be useful in understanding a conceptual problem that is much more complex than a mere theory/practice break-up:

In our judgement, such schism is best understood as a differentiation between two different systems: nursing discipline and nursing profession – the one looking for recognition as scientific knowledge and the other circumscribing an occupational niche. Each of these systems constructs itself in reference to its own functioning and generates its own dynamics.

We have to entertain the possibility that from its marginal position care management, as a differentiated system, may be producing its own devices to operate and make sense of the operations. Inductive logics are distinctive of these processes (a conceptual model emerging from the functioning of the system), rather than deductive logics (the adjustment of practice in accordance with theoretical considerations). An example of this is the accounts that seek to combine well-known conceptual models with the organising responsibilities of the new occupational roles:

If care management is understood as the practice of adjusting the value chain to care services, then this understanding brings more general nursing conceptualisations of previous definitions to a practical level. [...] If care management is regarded as either a set of coordinating skills or an ability to promote self-care, by contrasting the two definitions available it still seems necessary to precise operationally what care management requires in practice, in the area of nursing governance. (pp. 140–41)

An even more eloquent example is that of Torres et al. By means of an interactive model in which different actors directly involved in care management provide their views during structured rounds of consultation (Delphi Method), the authors gather a set of (self)representations about what seems to be some consensus. Part of these representations includes professional functions, processes, dimensions, among other things, as well as the patterns that define an appropriate practice. With this, they outline canons of ‘normal’ practice for a relatively established occupational field, and what is more, in gathering results and indicators, they identify competences and roles. The following passage may serve as an example for the validity of the argument:

These aspects contribute to defining the boundaries of care management, the professionals that are involved and the situations in which they do care management. They may also serve to identify what care management is and what it is not. (p. 68)
Such differentiation, however, does not mean that care management is becoming a separate profession. But this might occur in the future. The more its technical and conceptual devices develop and consolidate, the more the system understands itself independently as a different disciplinary entity, and the more formalised and institutionalised as an occupational field. This, until the new entity ends up completely differentiated and emancipated from the original entity by means of a suitable sociopolitical apparatus.

So far, this tension sits in an uncomfortable position in the nursing system. On the one hand, academic discourses uphold steadily that care is the core concept of nursing as an autonomous discipline, and on the other hand, the instances of political vindication formalise care management as the trait of practice, but without attaining occupational exclusivity. These two doctrines grow contradictory; the one brackets the evolution of healthcare work, and the other grows with its back towards nursing theory. This is not to say that these two doctrines cancel each other out; it rather shows that mass mobilisation through language can, too, be heterogeneous. As discussed above, nurses' defence of care management serves the interests of at least two subgroups at a time.

It is very likely that, more than ever, the selective function of academic media will operate. This is what Latour, in the context of science studies, calls 'centres of calculation'.

Nonetheless, the stability of a system can never be guaranteed. It follows, then, that its configuration is susceptible of change, depending on the interaction between the intervening forces and the dynamics of care management as an occupational area.

Care management: the problem of the definitions

The starting point of the care management project can be traced back, as Galdames tells, to the 1990s definitions. Definitions are certainly important, although problematic. What seems necessary to highlight, however, is that definitions can be politically motivated. In this section, three definitional problems of care management are discussed.

The first problem of definitions is that they are often normative—a few decide the meaning that others have to adopt. Definitions, therefore, cannot always be value-free. It follows that a definition will not be necessarily adopted in full, but only the fragments that may best fit the existing value frame of the audience, or those that may seem more intelligible to them.

Similarly, the use of a legal definition of care management will fix context-specific meanings. But while not being open-ended, it may not capture what care management means 20 years later. Additionaly, irrespective of the discussion, it is necessary to look at the type of definition being used (ie, legal, operational, disciplinary) and identify the underlying values. Here are the most widely circulated definitions of care management that emphasise different traits of care management:

- [it is the practice of personal, professional and instrumental skills in organising, coordinating and integrating care in the different service levels, in ways that ensure the continuity and effectiveness of care.]

- [it is the application of professional reasoning in planning, organising and controlling care services that are direct, timely, safe, holistic, continuous and customised, in a healthcare context.]

- [is a professional and institutional ability to deliver people the services they need to gain increasing levels of individual and family welfare while going through health and illness experiences, be it substituting, compensating or strengthening people's abilities.]

- [is to align the value chain to provide top quality care and to manage the resources rationally to cover people's needs in the best possible way.]

These four definitions have in common an applied nature of care management, highlighting a certain consensus as an occupational area. Noticeably, institutional definitions emphasise mental verbs (ie, organise, coordinate, plan, adjust, control, etc), while more conceptual definitions emphasise action verbs (ie, deliver, substitute, etc), with the former group likely inducing a sense of hierarchical differentiation and the latter an intention of integrating knowledge and practice. Although these definitions are not arguments per se, it seemed useful to include them here so as to identify the politically charged images they circulate.

A second problem is the difficulty, mentioned earlier in this paper, of formulating a one-size-fits-all definition. To date, available descriptions and working documents are mostly linked to hospital reform, addressing the role of the hospital in a system that is organised by levels. Similarly, the cited definitions (except one) imply that the practice of nursing always involves patient care and that care management is always management of care. Let us consider the case of nurses sitting on high-ranking administrative positions, those who are in charge of human resources, or consumables or supplies for medical services in a broader sense. These roles often require generic qualifications, where individual trajectories are more relevant than the types of professional title. But equally, a nurse is likely to perform functions like these with a nursing lens, and therefore be more prone to decisions that support direct patient care or be more sensitive to the necessities of nurses in the wards. In this case, certain definitions will be more appropriate than others in covering this type of practice, which may or may not be considered to be care management.

Furthermore, the definition by Ayala et al.

 introduces an important element of responsibility. If care management is an individual service that happens in a vacuum, disjoined from its organisational context, then eventual institutional failures will be unimportant. Although these failures may affect health outcomes, it is the nurse who is to blame for any defective care. Obviously, this is an error of thinking. So this definition moves the topic forward by arguing that it is also an institutional ability.

A third problem, and this is a very evident one, is the insistence that we do need definitions (also an implicit assumption in the study by Ayala), at the expense of other instrumentally useful devices. Definitions seek clarification. But in this case, such emphasis is rather about supporting a sociopolitical discourse than about building some scaffolding with which to operationalise care management in the clinic. Distinctively, discourses have focused more on defining who is in and who is out (‘us vs them’). As discussed, fixed definitions tend to make us forget everything else that is not in the definition. It would thus be necessary to build typologies, contexts, conditions, approaches, tools, standards, and why not, terminologies that reflect better the identity of care managers. But in the main, it would be necessary to intertwine nurses’ sociopolitical interests with the best interests of their patients.
DISCUSSION

The analysis in this article brings into discussion political implications of nurses’ social movements on three levels: the level of the methodology, the level of theory and the level of future research.

The level of the methodology

It is necessary to discuss the analytical technique used here. One essential trait of argumentation is that there is always some form of appeal to other parties’ reasonableness to convince them that the message is right. This implies that there is another party, for whom the argument will be of interest. The question is, then, who are these arguments for? What is their purpose?

As discussed, discourses of care management circulate primarily—if not exclusively—in nursing outlets. Mainstream ideas are formulated from a trade logic, seeking to circumscribe an occupational area in which only nurses be legitimate. Given the readership of such outlets, mostly other nurses, it becomes evident that it is them the main audience of the arguments. It would thus be plausible to think the arguments aim at persuasion. Changes in roles and responsibilities induced by the State reform have meant reconsidering the fundamental roles of nurses in organisations, although this was not shared by all the nurses. As a way of homogenising representations of nursing practice across the country, these discourses operate as an ideological device. On the one side are the speakers (the authors), and on the other side the addressees (the readers, including other authors). An interesting passage in Milos reflects this prescriptive (and prescriptive) logic of definitions:

[…] one has to keep in mind that this law will only achieve its aim if nurses perform the components of this legal definition. (p. 14)

But the counterpart in an argument is not always in a position to speak back, because that also needs an argumentative ability. The lack of answers may thus be due to either a technical limitation or an absolute consensus. Considering that the critical voices come from other academics, the latter is far from being the reason. In this case, the internalisation of dominant discourses may arise, at least partly, from an ad verecundiam fallacy (the authority, or the training, of the speaker is used as an evidence for the reliability of the conclusion); for example, by following the magister dixit formula (A states B; and A is an authority on the topic; therefore B is true; which is to say B is true because A says so). It could also be the case that some discourses surrounding care management, although technically invalid, fallacious or vague, may be ‘intersubjectively valid’. That is, they may have some communicational or symbolic validity within a community, regardless of how logical their structure is; particularly so when the community is emotionally involved. Therefore, it would be necessary to separate them from academic arguments, which by definition appeal to the reasonableness of the arguers.

Nevertheless, persuasion is not the only effect here. These discourses may well aim at dissuading groups whose demands are not favourable for the nursing stance. Among these groups are the medical association and the midwifery association, which are as well emotionally involved in the reformation of professional jurisdictions. By using iterative ideas such as responsibility, autonomy and property, detractors might eventually desist from their proceedings.

Persuasion and dissuasion together reveal something even more important. Though the arguments may be academically sound, discourses refer to care management as a technical entity and as a social movement. As such, it represents the conviction of a group that is convinced of something: the need of a redistribution of power. This is why argumentative analysis is useful as a method here.

The level of theory

Clearly, theorising is not only formulating explanatory theories. Theorising is a cumulative process that ranges from constructing concepts, testing claims, establishing relations, formulating models, trialling them and assembling them in broader explanations. The research in which this article is based is a step towards evaluating arguments, this being a key piece of the conceptual scaffolding of a discipline. Care management has received much attention over the past two decades, a timespan in which several conceptualisations have been proposed with more or less success.

Irrespective of its current empirical validity, it is important that this aspect of nursing care will develop and, ideally, enter existing disciplinary theory frames. In doing so, it would be crucial to use elements of inductivism (bottom-up) by drawing on the perspectives of care managers. Here, an evaluative attitude (x seems to be y) would be more effective than a prescriptive attitude (x must be y). Some evidence points to that direction, which seems promising for the future of theorisation. Possibly, the most suitable area is nursing governance, as proposed by Hernández and Caballero, or the area of clinical management, as proposed by Torres, or both. Considering that theorisation depends largely on concepts and interrelations between them, and that on them other concepts and interrelations will also depend, this theorising may open up room for more argumentative lines that together can have an incremental effect. Like methods, knowledge tends to improve over time. Overall, concepts need to look beyond a purely political dispute for recognition.

The level of future research

To date, the core matter in care management has been the definitions. Furthermore, the dominant views support nursing vindications. Although it has to be admitted that the present analysis arises from an externalist perspective, it is understandable that nursing authors’ stances may not be equidistant. With a view to developing new perspectives, it would be useful to explore the theoretical gaps that this study reports and address the critical stances: what are their premises? what implications may these stances have? what definitions capture the dynamics of care management more realistically?

This highlights the need to refine the concepts, and to test them empirically. If a definition is correct (ie, care management is an area that is exclusive to nurses), then it should be consistent with the actual practice (eg, by verifying whether care is not managed by professionals other than nurses). It is unclear the extent to which the claim of exclusivity is useful beyond the vindication narrative. But let us consider that vindications may also consider parallel groups, which in turn can make for a better organisation of services. Arguments foregrounded by other groups may pave the way for a more comprehensive discussion, and possibly, for a conjoint strategy.

Lastly, it also highlights important loose ends regarding the articulation of concepts with the organisational and methodological aspects of care services. Constructive in this respect are other publications. This is an area that tends to develop its own representations, which grows at a steadier pace than the theoretical definitions, but this will benefit from an integrative approach within a broader frame that transcends political claims.
CONCLUSIONS
This article has presented a compilation of the main arguments surrounding the notion of care management in Chile, covering the 20 years since it was made official. At the same time, the article has introduced an analytical technique that is new in health research: the pragma-dialectical approach.

Contextualised by a social movement in a neoliberal-reformed system, this analysis identified the main claims of the arguments and assessed the validity of their premises and conclusions. These arguments are partly academic and partly occupational, and this is an important difference. The main findings show certain traits that are defined as inherent of care management, although not all of them arise naturally from valid arguments. Previously, this aspect has been reported by critical views within nursing, especially in regard to its linkage with the nursing discipline. When analysed together, the available arguments leave us with very intriguing questions: what do we actually know about care management? And of it, what is actually valid as knowledge? How do we move beyond a quest for legitimacy?

The overemphasis on definitions depicts a modest advance in the theorising of other aspects, and a poor—even contradictory—articulation across arguments, and ultimately a marginal position in the constellation of concepts. On the one hand, this has import for the interpretation of what actually constitutes care management in nursing practice and its representations. And on the other hand, nursing theory needs to be rethought in regard to this particular aspect of practice.

It is praiseworthy that during these 20 years there have been efforts for moving forward this aspect of the nursing profession, especially if this model is to be adopted in other countries. But these attempts have solved some problems and raised others. One of the problems is, precisely, that the emphasis on political rationality neglects the dynamics, tools and devices that care management requires in the field. And by the same token, it risks circulating notions that may not exist in the occupational arena, be it exclusive or interprofessional.

Aligned with a slight change of focus towards certain canons and parameters of ‘normal’ practice in care management, this article was aimed at offering a contribution that proposes a research agenda for the decades to come.

Contributors I am the sole contributor to this manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement All primary sources used in this research are publicly available.

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NOTES
1. In Chile, midwifery and nursing are two different professions, which often raises jurisdictional conflicts.

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