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Professional Subjectivity in the Swedish Healthcare Context: The Ambiguous Rehabilitation Coordinator

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Abstract

The study examines a new professional function, the rehabilitation coordinator, in Sweden's healthcare system. The rehabilitation coordinator acts as an inter-organizational facilitator in the return-to-work process. Using a Foucauldian perspective, the rehabilitation coordinator as a subject could be considered both as an objectified function shaped by governmental regulation and as a process by which the individual chooses how to perform the role. The rehabilitation coordinator must navigate between legislative regulations and adhere to their own professional ethics, resulting in varying forms of subjectivity. Metaphors used by rehabilitation coordinators provide insights into how individuals perceive their ethical responsibilities and how they approach interactions with patients and healthcare professionals. The paper underscores the ambiguity of the role and sheds light on how diverse considerations inherent in professional roles but also within the subject molds professional subjectivity in the Swedish healthcare system.

Keywords

Governmentality, insurance medicine, professional ethics, professional subjectivity, rehabilitation coordinator, return-to-work, subjectivation

This paper focuses on how a new healthcare professional function—*rehabilitation coordinator (ReCo)*—is enacted as a role by an active subject. The paper thus brings to the fore the differentiation between function and role—a function being the instrumentalized performance while a role entails how a person-as-subject chooses to perform this function. Given that there is not one single way a subject molds a role, there will be different forms of subjectivity within a given context, different forms of professional subjectivity. In this paper, subjectivity points to the individual's ethical self-formation in relation to themselves, and what the individual takes to be the truth (Foucault, 2005, 2019). Using the Foucauldian interpretation of subjectivity is meaningful in a care professional context, since what is performed in the role is, alongside the results from years of explicit professional education and training, also disclosed in what seems to be an ethical way of treating the patient as an individual human being. The central research question is how the ReCo enacts professional subjectivity in relation to the governing framework of the function.

The article answers to the call for studies exploring the subjects of governing and the process of subject formation (Brady, 2011, 2014; Li, 2007; Newton, 1998) and, within this, a call for a second generation of governmentality studies (Hansen Löfstrand & Jacobsson, 2022) on how different governing attempts are received by the subjects themselves. Hansen Löfstrand and Jacobsson (2022, p. 1) declare "the scholarship on governmentality has so far produced an enormously useful body of literature on the 'how' aspect of governing" but has not taken into consideration human subjectivities' willingness to change and how these attempts to shape the conduct has been acknowledged by the individuals, the subjects. Hence, the article adds to the literature on the transformation of subjectivities in professional work. An empirical perspective of how subjectivities appear in professional settings allows an exploration of the dynamics how rational rules and regulations created to govern human subjectivity in diverse contexts enact, targeting the interplay between professionals and patient/client under conditioned forms of governing and rationality. On the matter, Lindwall (2022) in exploring the tension between encouraging client autonomy and institutional constraints, underscores the complex nature of social work interactions, where subtle power dynamics play a crucial role in shaping both client and social worker subjectivities. Jacobsson (2022) focuses on how organizational narratives shape caseworker subjectivities profoundly, impacting professional identities, client relationships, and job satisfaction. By examining the multifaceted interplay between institutional stories and individual experiences, the nuanced process of caseworker subjectivity formation is highlighted, revealing a malleable yet personally influenced construct. In another study, Näslund and Thedvall (2022) focus on models used in social work practice, and the effect on social workers as they use the models to transform their clients. The authors conclude that models function as technologies of governmentality transforming the subjectivities of those subjected to them, but mainly shaped those whose subjectivity already was in line with the model. This needs to be considered while studying subject malleability, acknowledging the apprehension that concepts and models are supposed to be employed in a taken-for-granted, exceedingly mechanical manner, as highlighted by Sunnerfjell

(2022). Collectively, these studies reveal the intricate interplay of institutional influences and personal experiences in shaping subjectivity while cautioning against the mechanical application of concepts and models in practice.

The article is outlined as follows. Initially, after a brief overview of the ReCo context, an introduction of governmentality as a concept follows. Then a summary of the Swedish sick leave bureaucracy is presented. Next, the theoretical context of subjectivation is outlined; thereafter, the empirical design and findings are presented and finally analytically discussed in the last section.

The ReCo context

Healthcare professionals dealing with the matter of sick leave on a daily basis are expected to avoid unnecessary or unjustified economic reimbursement from the welfare system to the patient, fulfilling the strategic imperative stated by the government which, in a Swedish context, means that everyone who can work should do so. In this respect, the ReCo function has been constructed at the point in the healthcare system where governmental-induced procedures are to be carried out in day-to-day healthcare practice. The paper focuses on this newly constructed professional function organized within the Swedish publicly funded healthcare system. Since 2020, the function has been legally enforced (Socialdepartementet, 2019) by the Swedish government to cut back on national sick leave rates. To reduce sick leave absence, the ReCo is intended to act as an inter-organizational facilitator between the patient (as an employee), the employer/manager, national authorities—foremost *Försäkringskassan* [the Swedish Social Insurance Agency (SSIA)]—and medical professionals within their own organization. Applying a Foucauldian perspective, the ReCo function can be perceived as an example of a governmentality tool, an objectified subject designated to operate in a professional role at this point of intersection between governmental regulation and the individual who is expected to return to working life. To do this, the ReCo is expected to manage, guide, coach, steer, push, help, and facilitate the individual to conduct his/her behavior in the right way. These balancing strategies exemplify the contradiction in governmentality—to suppress and strengthen—where individuals, by freely governing themselves, are expected to re-create society's power relations (Hörnqvist, 2012).

Governmentality

When *governmentality* was introduced by Foucault, it was as a term to describe the conduct of conduct (Bevir, 2011; Dean, 2010; Foucault, 1991; Hörnqvist, 2012). It was a way of describing how the state governs the population but also how the individual governs him/herself in individualized technologies of the self. Foucault's point was that even if the governing rationality of the liberal state reflects the freedom of the individual, governmentality works through freedom where individuals have learned to choose to govern themselves in a certain direction (Alamaa & Altermark, 2022). Today's handling of the sick leave process could be

seen as governmentalization. The individual—both the ReCo and the patient—are supposed to act in the best interest of society, according to their choices.

Rose and Miller (2010) emphasize that governmentality becomes an expression of all the procedures that embody ways of thinking regarding governing society and its population from a distance that has developed in recent centuries. Knowledge of the composition of the population, of economics, of psychology, etc., provides a kind of "intellectual machinery" (Rose & Miller, 2010, p. 280) for the state, and in this way, society can be analyzed, and knowledge made rationally understandable. In a governmentalized society centralized governance is carried out via decentralization so that individuals govern themselves in accordance with what is expected of them in relation to prevailing knowledge. The ReCo as a tax-funded functionary in the sick leave and rehabilitation process within the Swedish social security system could be understood in this Foucauldian perspective. A society where governmentality is at the center, Foucault states, is closely linked to the maintenance of security. In this context, it relates to the social security system in Sweden, where the rationality behind the sick leave policy is to lower the expenditure to protect the state finances. The individualized technologies of the self are expected to contribute to the aim of securing the prosperity of the state. Bluntly said, if on sick leave get back to work as soon as possible.

The Swedish sick leave bureaucracy

Normally, sick leave can be decided by the employee perceiving him- or herself to be unfit for work until day seven of a sick leave period. From day eight onwards, a medical certificate must be issued by a physician. In case of sickness absence, sickness pay is paid by the employer for the first 14 days. From day 15 onwards, the sickness absence must be notified to the authorities, i.e., the SSIA, by the employer. To receive sickness benefits from day 15 onwards, the individual must file an application with the SSIA. A designated SSIA clerk will assess the medical certificate issued by the physician and decide whether and to what extent incapacity for work and, thus, sickness benefits can be approved. If the employee is assessed to be incapacitated for work, sickness benefit from SSIA is paid to the corresponding degree to which the incapacity has been judged: 25%, 50%, 75%, or 100%.

In Sweden, the healthcare professional's assessment, and diagnosis of a person's illness, as stated in a medical certificate, is seen only as a recommendation for sick leave. The final decision is made by the SSIA official, who abides by strict enforcement of the regulations which were introduced on July 1, 2008 (Socialdepartementet [Health and Human Services Department], 2008). The regulations are operationalized in the so-called rehab(ilitation) chain (Socialdepartementet, 2010). The rehab chain is a bureaucratic tool, a categorizing timeline. This categorization is broadened the longer a sick leave lasts. The time limits concretely represent the following: 1) during the first 90 days of sick leave, the right to sickness benefit is assessed in relation to the individual's regular work; 2) between 90 and 180 days the right to sickness benefit is assessed to existing work assignments at the employer, and; 3) at a 180-

day time limit the right to sickness benefit is assessed as to whether the patient is employable in any part of the entire labor market in which such work is normally occurring. In sum, although certain assessment reliefs have now been introduced, bureaucratically set time limits have been given priority over medical assessments in the sick leave process. It is the SSIA official, not the medical professional, who has the final word about whether the patient is able to work or whether s/he is qualified for a certain percentage of sick leave benefits or not at all.

This operationalization could appear to be a straightforward, simple way of dealing with who is eligible for sickness benefits and who is not, and it works well in shorter or obvious cases of sick leave, absence due to influenza, a common cold, a broken leg, and the like. Problems arise when it comes to mental ill-health, pain syndromes, and other often long-lasting diagnoses that do not easily make themselves visible and objectifiable and are, therefore, hard to precisely assess and describe. Consequently, when medical knowledge on how to best rehabilitate a person and the timeframe of the rehabilitation chain collide, the SSIA official, with its bureaucratic (rather than medical) knowledge, has veto power over medical professionals.

The SSIA officials' approach to assessing a patient´s right to sick leave benefits since the rehab chain was introduced in 2008 has been thoroughly studied (see, e.g., Eriksson et al., 2014; Jacobsson, 2022; Jacobsson & Hollertz, 2021; Sohlberg et al., 2018). In Sweden, this alteration is undertaken under the caption of *insurance medicine,* a concept that has surfaced as a buzzword in governing strategic documents during the last couple of years as the right way to think and act. In a Foucauldian perspective power and knowledge cannot be strictly separated (Foucault, 1982). Insurance medicine deals with how functional status (of body and mind), diagnostics, treatment, rehabilitation, and the prevention of illness and injury affect and are affected by how different insurance policies are designed. This also points out which knowledge has the power to guide actions in day-to-day business (AFA Försäkring, 2022). The newly constructed ReCo function is assumed to be working under the headline of insurance medicine.

The question of sick leave is thus transformed from a medical professional question into a biopolitical matter. What is still underexplored is how this affects the healthcare professional´s context. Governing documents assume that the logic of healthcare professionals with their intuitive centering of the individual, and biopolitical logic in the form of overall legal governance, can easily be brought together under a single function. The ReCo, as a healthcare professional engaged in this assignment, often alongside his or her own care profession, is thus supposed to combine two fields of knowledge with their respective contextual organizational power incentives: healthcare professional ethics dealing with the individual (the patient), and biopolitics dealing with the collective (the population). This creates a balancing act between professional ethics and biopolitical considerations.

Theoretical framing and method

Subjectivation

In the Foucauldian context, subjectivation refers to the ethics of self and is a central concept in governmentality as it applies the concept of governmentality as a set of strategic practices defining the relations of self to self, and of self to others "within the strategic field of power relations in their mobility, transformability, and reversibility" (Foucault, 2005, p. 252). In this regard, governmentality refers to individuals´ relation to themselves and others in the implementation of individual strategies based on ethics (Bonnafous-Boucher, 2009). Subjectivity is thus produced in a sense "as that which is constituted and transformed through the relation it has to its own truth" (Foucault, 2019, p. 32). In this article, the focus is on the concept of professional subjectivity, which contributes to the insight into how a professional role manages the governing framework of a function.

Within the Foucauldian theory of subjectivity, it is useful to notice a distinction. Foucault (2005, p. 333) refers to different ways through which subjectivation takes shape: on the one hand, in the sense that the subject chooses to follow an ethical standpoint that refers to the law, morality, a holy scripture, etc.; in other words, a submission to a truth that is pronounced by someone other than the individual. The individual chooses to follow this as the right thing to do. On the other hand, the subject is ready to act in resistance, criticism, and the like, with the intention of shaping the self, based on his/her own ethics. Even if the concept of subjectivation does not have a sharply defined meaning between these two perspectives (McGushin, 2007) it provides a deeper understanding of possible subjectivity when we compose ourselves as active, ethical subjects (Milchman & Rosenberg, 2007, 2009). The concept provides a theoretical tool for understanding forms of professional subjectivities, which also includes the intrinsic malleability of the individual self when handling governing regulations.

Empirical research design

In this qualitative study, the material is gathered through semi-structured interviews with ReCos directly engaged with patients at local, publicly funded, basic healthcare centers (BHCC) in Sweden. BHCCs are local healthcare facilities where all services are provided which do not need specialized healthcare at a hospital. Hence, at BHCCs, work in addition to ReCos, e.g., general practitioners (GPs), physiotherapists, occupational therapists, and psychotherapists. Sick leave is typically handled at BHCC where the GP issues a sick leave, which is directed to the SSIA for assessment—and approval or non-approval—as described above. The individual is responsible for the employer gaining access to the medical certificate. As mentioned in the introductory part, the staff involved with the patient are supposed to engage with the workplace to minimize the number of days on sick leave. The ReCo is supposed to handle this duty.

Interviews covered a list of topics on how daily practice is carried out and with what rationalities, focusing on ReCo's descriptions of their relationships with patients and others, such as GPs, employers, and SSIA officers. Grey literature in the form of regional and national steering documents, as well as legal documents concerning the developments and implementation of the ReCo function, have been used to investigate the base of knowledge that foregrounds this function.

A total of 19 semi-structured interviews (n=19) were conducted with ReCos from two Swedish healthcare regions. Three participants were interviewed on two occasions, partly within the framework of a pilot project that preceded the study, and partly during a follow-up interview. About one year passed between these occasions. The interviews that were part of the pilot project were conducted in the fall of 2018. The remaining interviews were conducted from fall 2019 until spring 2021. All participants were women who, at the time of the interviews, were between 29 and 64 years of age, with an average age of 45.7 years. They had held the ReCo assignment between two months and ten years. Interviews were conducted at the ReCos' workplaces and lasted between 45 and 90 minutes.

Table 1

Participant Demographics

Gender	Profession without brackets: Working both as ReCo and in actual profession (Profession in brackets): Working only as ReCo	Experience working as ReCo
Female n=19	Occupational therapist	2 yrs
	(Medical administrator)	2 mos
	Physiotherapist	1 yr
	Psychotherapist	3 yrs
	(Occupational therapist)	5 yrs
	(Behavioural scientist)	4 yrs
	Physiotherapist	2 yrs
	(Physiotherapist)	2 yrs
	Physiotherapist	1 yr
	Psychotherapist	4 yrs
	Occupational therapist	1 yr
	(Medical administrator)	1 yr
	Occupational therapist	3 yrs
	Occupational therapist	2,5 yrs
	Psychotherapist	1 yr
	Occupational therapist	4 yrs
	(Behavioural scientist)	4 yrs
	(Administrator)	10 yrs
	Physiotherapist	5 yrs

As Table 1 shows, the interviewees had different professional backgrounds. All but five people were healthcare professionals focusing on rehabilitative treatment, i.e., occupational therapists, physiotherapists, or psychotherapists. Others had backgrounds in either behavioral science or administration. At the time of the interviews, seven served solely in the function of ReCo, and the remaining persons divided their working hours between their regular profession and the ReCo function, which varied in the time available to each position. The interviewees who stated that they had shared duties explained that although there was a specific time in terms of percentage scheduled for the assignment, the time allocated to each often depended on the health center's number of listed people, and it was difficult to allocate the exact time in percentage spent on each assignment. Time set aside for the various work tasks tended to overlap, largely depending on the difficulty of establishing contact with external persons.

Processing of the material

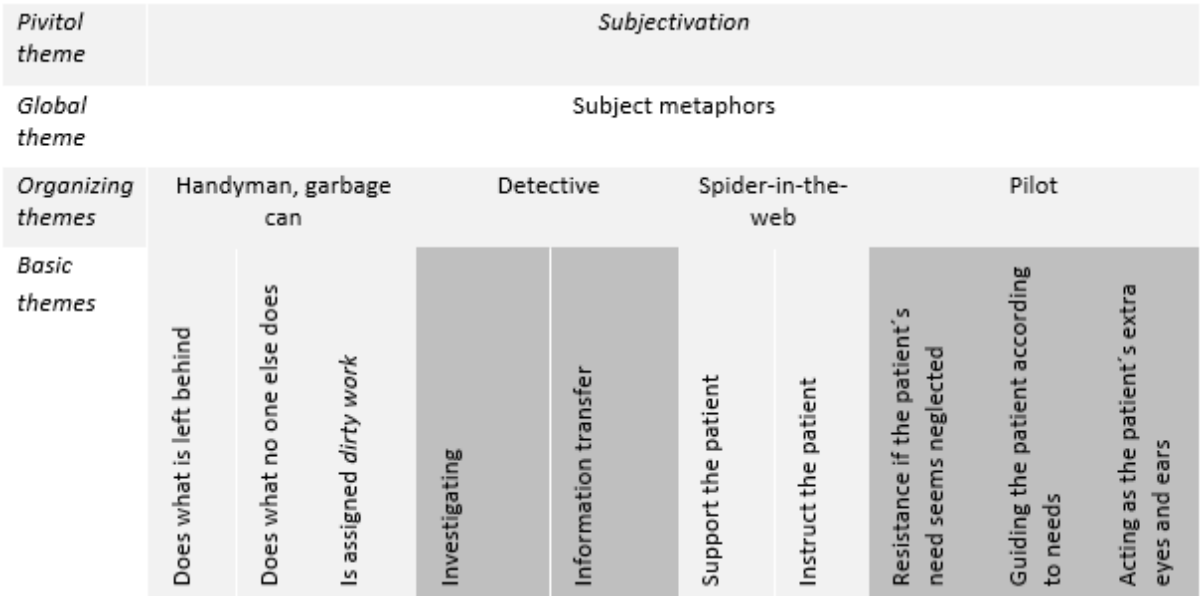
All interviews were recorded, and files were transferred to NVivo (NVivo), designed for preparatory structuring and processing of qualitative empirical material prior to analysis. The interview material was transcribed manually in NVivo with some adjustments to spoken language when required to increase understanding. After the audio files were transcribed, the actual structuring and analysis of the material began.

The processing of the qualitative material has been carried out based on thematic analysis (Attride-Stirling, 2001; Braun & Clarke, 2006), where the material was systematized in thematic networks as a way of organizing this step-by-step. Using Braun and Clarke's (2006) terminology, this processing has been carried out as a theoretical thematic analysis since it is based on a previously established theoretical anchoring. In accordance with Braun and Clarke (2006), who emphasize that analysis is not something that occurs only at the end, the material has been processed from the start of the study. During work, repeated readings and listening of interview material and field notes took place with an abductive approach to material and theory (Kvale & Brinkman, 2014). An abductive approach uses existing knowledge and frames of reference to find theoretical patterns and structures and thus make the empirical material comprehensible through a theoretical pre-understanding. The interpretation of the empirical material can be deepened by returning to theory/material through what can be compared to a hermeneutic spiral. Alvesson and Sköldberg (2008, p. 61) describe the abduction process as an oscillation between (empirically loaded) theory and (theory loaded) empirically collected material. Thus, although the processing of notes and voice memos took place from the start, the explicit coding was based on Attride-Stirling's (2006, p. 391) three stages of processing based on basic, organizing, and global themes. Attride-Stirling (2001, p. 386) describes the thematic analysis in the form of web-like illustrations like Braun and Clarke's (2006) thematic network maps.

The first stage consists of the material being broken down and coded after a coding framework has been established. In the application of a coding framework, an overall level—pivotal theme—has been added which represents subjectivation (see Figure 1).

Figure 1

Thematic Network for Overall Theme of Subjectivation



With an abductive approach, the empirical material has been processed, and basic themes, organizing themes, and finally, global themes (Attride-Stirling, 2001) have been analyzed. In the work identifying themes, we have been guided by Ryan and Bernard's (2003) rhetorical question, "How do you know a theme when you see one?" The answer is: "You know you have found a theme when you can answer the question; What is this expression an example of?" (Ryan & Bernard, 2003, p. 87). In this case, the theoretical literature has abductively guided the questions to the material; in other words, new questions have been asked of the various empirical materials during new readings/listening, together with a return to theoretical readings.

Empirical findings

A common theme in the interviews is the lack of clarity as to how to perform the function and the will to—in this role—act in the best interest of the patient. Even if the strategic purpose of the ReCo described in legal paragraphs, governing documents, etc., is abstractly clear, what they are expected to carry out in daily practice turns out to be highly unclear; both for the ReCo and for healthcare management in general. The ReCo, as an individual, is tasked with managing state expectations at the population level while simultaneously coping with his or her own professional ethics at the individual level.

A need for clarification

A person starting out as a ReCo must figure out how to organize their work. Clarification is required regarding oneself and others. It is difficult to make clear to others what is unclear to oneself. A contributing factor appears to be that neither the person recruiting nor the person being recruited knows what is actually expected of the position. A further complicating factor is added if the ReCo is also expected to work at several healthcare units where everyone has their own ingrained norms and assumptions about how sick leave and the rehabilitation process should be carried out. The norms—which are largely unspoken and unclear—can be based on different ways of understanding the role of medical care combined with what should or could be done in regard to sick leave in order to execute work compatible with government-driven insurance medicine. In the interviews, ReCos talk about difficulties identifying the group norms that lie beneath the surface and play a role in how the internal group behaves toward the ReCo and in establishing their own desired work routines.

For the individual who accepts the position, a challenging time begins that is described as more or less frustrating. To create clarity both for oneself and others, it is therefore required that each ReCo decides how to sort things out. This is interpreted within each individual ReCo´s prerequisites and underlying experiences, and most of all through their professional affiliation. Even if the definition of what constitutes a *profession* is somewhat vague, it is often made clear that the theoretical, scientific part of a profession has gained a highly important role. Academic education based on separate scientific subjects is fundamental (see e. g., Abbott, 1988; Brante et al., 2015; Christoffersen, 2017; Franzén & Tzimoula, 2021; Liljegren et al., 2018; Molander & Terum, 2008) which also applies to healthcare professions. When ReCos, who also practice a healthcare profession, describe in the interviews what they do, their profession is often taken as a starting point. This is nothing remarkable in and of itself. It is simply reasonable that a person who belongs to a profession interprets the assignment accordingly. Professional education provides a sense of belonging and legitimization, where a certain way of thinking and acting has been practiced or programmed into an understanding of the right way of doing and thinking professionally.

It is, therefore, more or less expected that for healthcare professionals, the professional knowledge will form the basis for the ReCo assignment. When the ReCo is expected to find their feet in their new role, their healthcare profession will provide direction on how to perceive what to do within the framework of the assignment. This means that interpretations of how the task should be carried out vary, based on the knowledge that lies in the foreground of the respective profession or what each person thinks of as professionally right to do both scientifically and ethically. One way of clarifying this is, therefore, the complexity of the professional context's delineation supported by professional ethics. Each profession cares about its distinctiveness, which is shown through the respective professional associations, where the importance of promoting one's own professional knowledge as an ethical subject is distinguished from neighboring professions in a horizontal demarcation.

Metaphors—disclosure of subjectivity

Which discourse is used—and perceived as possible to use—creates the subject that acts professionally. Since the ReCo function is described in terms of acting on an overall level, statements of the ReCo´s own metaphors can illustrate what is done within the scope of the role. The chosen metaphor offers a clue to what shapes professional *subjectivity*. In addition to the official taken-for-granted metaphor, where the ReCo is pictured as a *spider-in-the-web*, which is used in official communication discourse about the function, the interviewees imagined themselves as a *detective, lifeline, life pilot, garbage can, the patient's extra eyes and ears, Mrs. Fixit, valve, bridge, etc*. If *spider-in-the-web* is a prevalent metaphor for a preconceived notion of what is being done, and used by some of the ReCos, other metaphors can be seen as a clarification of how ReCos make the task comprehensible to themselves.

Spider-in-the-web

A ReCo who pictured herself as a *spider-in-the-web* described her thoughts on how to inform colleagues at the BHCC on how to deal with patients. The ReCo introduced supporting documents to internal medical staff in order for them to act in what was perceived to be a good way of dealing with patients calling to make appointments:

> I have made a sort of support document for nurses, about how they can think... there are many [patients] who call when they are in an acute crisis... maybe a close relative has died or is ill or something... but it's not you who are calling that are sick, it's a normal life event—a crisis—but you can't normally get a sick leave for that, because it's normal…There are many people who make an appointment to see a doctor and [the patient] then thinks that they will be on sick leave, no, it is not a case of illness! Talk to your employer, [...] it may be time to take out family days, perhaps take compensation days or vacation...but not sick leave because you are not sick in that sense, you feel bad but that is normal... (ReCo 14)

The ReCo in the citation is an example of a ReCo who felt it was her duty to teach the staff the presupposed ethically right way to think and behave, providing a net for catching the patient and keeping them from falling into sick leave, and teaching patients calling to get an appointment appropriate ways of thinking and acting.

A detective

The interpretation of what a *detective*, *life pilot,* or acting as the *patient's extra eyes and ears* means differs in detail, but the overall meaning can be intuited. How the assignment is metaphorically described can offer a clue to what the ReCo regards as ethical guidance; to follow the rules or to follow one's own beliefs. Being a *detective* offers a patient-centered image with a productive power's need for knowledge at the center. *Productive power* refers to a system where the aim of power relations is to do good but is nevertheless within the social scope of what is expected in society. In relation to the balancing scales of professional ethics

and biopolitical considerations, the scales of the latter weigh more heavily with the ReCo detective. Here ethics is formed by what is pronounced by someone else—regulations are to be adhered to—and the ReCo chooses to follow through an inner conviction that following the regulations is the right thing to do. In order to be able to guide, help, support—or in other words to control through knowledge—the ReCo forms a power relationship with the patient. How the ReCo relates to knowledge acquisition from the patient becomes fundamental. Ultimately, being able to support, collaborate, and coordinate requires an acquisition of knowledge that can be used in the next step. The question is how and with what purpose.

The ReCo, who takes on the role of detective, becomes a Sherlock Holmes who, in an attempt to gain knowledge of the patient, lifts all the rocks to find out what is hidden beneath. With this approach, the goal is to get the patient to open up and talk about what is not visible to the eye, about merits and shortcomings, about possibilities and obstacles, and about what cannot be seen in a blood test or X-ray. The knowledge gained can then be passed on by the ReCo as an acting expert —with the patient's consent—to others who meet the patient in the care unit.

> The only thing the doctor then needs to do is to then connect it with my journal notes from our conversation and put this together with what the doctor observes in the room, what objective findings the doctor can find that support—or does not support—what the patient describes and that we have found out in our conversation… (ReCo 6)

Acting as a *detective* is about uncovering the hidden to help those who are perceived to be in need, the patient—or healthcare professionals—to get the patient back to work.

A *life pilot* or a *pair of extra eyes and ears*

Acting as a *life pilot* and being *a pair of extra eyes and ears* for the patient conveys an image of the patient at the center—but in a different way. Here, the coordinator acts within professional ethics in another way. In this case, it is the patient as an individual and their own ability which is in focus. Even if the patient is in need of help, the patient is seen as the expert in his/her life. Someone who acts as a *pilot* gives an active image of assisting the patient through life by helping prepare the way when the patient must deal with life with all the ups and downs it entails, especially in connection with being on sick leave. Like a pilot who assists a ship in navigating through difficult passages, the ReCo *life pilot* helps the patient get through the difficulties of life and eventually let go when the patient is able to manage on their own again. Above all, it is important to let the *piloting* take its time without the process being disturbed by the rehab chain's time limits interrupting and complicating the process. Even the *extra eyes and ears* offers an image of someone standing by the patient's side ready to help if needed but with great confidence that the patient is autonomous and has abilities. The ReCo as an *extra pair of eyes and ears* can, for example, assist the patient in meetings with authorities and employers but also during doctor's visits. Acting as a *life pilot*, or *extra eyes*

and ears means placing the ReCo role within care ethics. Not surprisingly, the strongest questioning of the function's presupposed obligation is expressed when ReCos see themselves in these metaphors.

Mrs Fix-it or garbage can

The *detective* and other metaphors illustrate how subjectivities are formed, as do ReCo as a *garbage can* and as *Mrs Fix-it*. The difference is intuitively large between these two. The ReCo, who refers to their role as a *garbage can,* expresses a different image than the one who articulates herself as *Mrs. Fix-it*. The *garbage can* provide an image of one who takes on whatever falls outside the actual tasks, the one who does what no one else does, from a place at the bottom of the hierarchy without any real boundaries; receiving whatever goes into the *garbage can*. Although the metaphor must be considered a pejorative one, in this case, uttered by the *garbage can* herself, which can thus be interpreted as detracting from the nature of the assignment, the negative connotation of the *garbage can* concept can be balanced out by the fact that it is beneficial to the patient (and the organization). Even a real *garbage can* has a function, albeit not in appreciative terms, but still a function.

Taking on the role of *Mrs. Fix-it* conveys a completely different picture of internal relations. Being a *Mrs. Fix-it* offers an image of knowing many things and being an active problem solver for everyone. A positive scenario emerges. The person who sees herself as such also expresses a willingness to do what no one else does, but with the precondition that this is not done by anyone else within the scope of a medical profession. The role has simply been shaped to be an all-in-one function intended to solve problems—outside the medical sphere. Problems of a major and minor nature are taken care of so long as they do not interfere with the mandate of the care professions. An observer on the side summed up the role that the ReCo in question repeated in the interview: "Everything that no one else can do—it will end up with you... everything that you cannot manage in care and treatment—that was the role you were given." The role of the ReCo becomes clear because everything that is done has a clear reference point outside of explicit care.

A *valve* or a *bridge*

The more pragmatic metaphors describe a clear picture of a bridging or supporting role, or a valve between different parties, intended to calm down and explain the situation.

> Almost always when there is a rejection [of the application of sick leave benefit] that concerns our patients, I look at it, explain, and I call the SSIA case manager—usually I get an answer—I talk about it... but they [the patients] are upset, they are pissed off, they are angry at the case manager, at me, at the doctor, and think why hasn't he written what he should...this is where I clarify the regulations and that the doctor only writes exactly what he *can* write...it becomes a bit like you sit like a valve between everyone... (ReCo 18)

Anyone who describes themselves as a *bridge* gives the impression that they form a link between parties who otherwise would not reach each other. This may apply to the patient who does not dare open the letter from SSIA or answer the phone when they think the SSIA case manager is calling. The gap that arises between the individual and the authority is bridged by the ReCos, who perceive their role as landing in between. This can also apply to the patient who meets many different doctors at health centers with many so-called relay doctors, in which case the ReCo can describe herself as a bridge between the patient and the new GP. The doctors change, but the ReCo remains and can transfer knowledge that helps both parties.

Discussion

Using metaphors is one way to shed light on how subjectivity is not fixed within a function, but as put forward by Hansen Löfstrand and Jacobsson (2022) subjectivity transformation is conditioned by dialectic dynamics between governmental rationalities and the subject's agency. Different professional ethical standpoints provide examples of how subjectivities within a certain professional setting are not static, and also that the "subject's *agency* is at the very same time—at any point in time—conditioned" (Hansen Löfstrand & Jacobsson, 2022, p. 169). The ReCo who is not adhering to the presupposed rationalities is aware of this, but nevertheless struggles to follow what they think of as ethically sound related to their profession. When the concept of insurance medicine is widely introduced, the organizational narrative (Jacobsson, 2022) within the healthcare sector is put under pressure to change due to steering from authorities of what should be seen as correct knowledge and a self-evidently right way of acting. The use of metaphors is one way to shed light on diverse ways of how subjects relate to this.

On the one hand, the instrumentalized function of being a ReCo could be seen as the objectified subject through the exercise of power/knowledge, a tool to enforce the taken-for-granted knowledge conditioned by governmental rationalities to execute effective return to work—any work—for people on sick leave. On the other hand, the role in which the ReCo act as an active subject with agency to determine what to do can be seen as subjectivation. With a Foucauldian understanding of subjectivity, the ReCo enunciated ethical acting as a "subject objectifying himself within a true discourse" (Foucault, 2005, p. 333), in the sense that the subject chooses to follow a discourse that refers to the law or/and morality. An example of this is the case where the ReCo instructs colleagues about the proper way to act towards patients calling for a doctor´s appointment. The recurring theme was that regulations must be followed and the ReCo had to take on the role as a guardian of the law, disciplined by regulations and acting as an expert according to these regulations, constituting a subjectivity according to what one should do in order to be a responsible citizen. Or, the "subjectivation of true discourse takes place in a practice that the individual exercises on himself" (Foucault, 2005, p. 333), as in the case where the ReCo expressed being guided by professional ethics which is displayed in resistance or critique of the system and in efforts to encourage and help

the patient contest the system in case sick leave was not approved by the SSIA official in spite of the assessment of the medical professionals. Frustration and resistance were expressed in these cases.

In the overall guiding documents (legal framework e.g., the rehab chain, governance documents, etc.) concerning the ReCo function, conduct within the realm of what strengthens governmentalized society is taken for granted. This taken-for-granted-ness is an illusion of a non-problematic balancing act between different ethical standpoints; where the ReCo is figured as a fixed, essential subject. As if the biopolitical framed ethical righteousness of the cause—to get the individual to return to work following the rehab chain timeframes—is beyond questioning. The rehab chain is the presupposed model to adhere to, but as Näslund and Thedvall (2022) and Sunnerfjell (2022) highlight, models as technologies of governmentality are not simply followed in a mechanical way. The ReCos, whose subjectivity was concurrent with the model, found it helpful, while those whose subjectivity was not found it hindering and a nuisance. A not-so-unproblematic balancing act evolves in daily practice when the legal framework leads to a normative, disciplined standpoint or a more normalizing one. Both the normative and normalizing standpoints are different examples of how ethical perspectives differ and, therefore, how different subjectivities emerge. However, both are meant to help the patient in the best possible way.

If *normalizing* is about asking questions to *gain* knowledge—to direct indirectly in the next step—*norming* is about *providing* knowledge for the purpose of helping/directing; to help the patient walk the line of right behavior. The normative approach has informative expressions in the foreground and is based on what should be—in other words, a fostering, disciplining approach. The ReCo provides knowledge to the individual (patient) to see his/her responsibility, need for change, and what he/she must do. The information is expressed as a normative statement but still appeals to the individual's empowerment to what could be considered the right behavior.

Within the dynamic interplay of conditioned rationalities and the agency of the self, the ReCo, implemented as a new professional function ends up being ambiguous. The function is carried out within the subjects´ various professions enhancing professional ethics either guided by the ethics of following regulations or articulating critique and resistance to act in the best interest of the patient.

Even if this paper concerns ReCos specifically, this could be applied to other professions dealing with how an "objective" professional function is enacted as a role by an active subject. Within a professional organization, there will always be different forms of subjectivity and different ways in which individuals form their ethical selves in relation to themselves through what is thought to be the truth (Foucault, 2005, 2019). This phenomenon needs to be discussed and taken seriously.

Conclusion

In this paper, we have investigated the newly constructed ReCo function and role. The balancing strategies of the ambiguous ReCo exemplify the contradiction in the governmentality society strategic imperatives—to suppress and strengthen—where individuals, through self-governance, are expected to re-create society's power relations (Hörnqvist, 2012). Depending on how the individual relates to themselves, the transforming of subjectivities is molded. Using metaphors is one way to shed light on how subjectivity is not static within what a function should do due to the fact that the subjects´ own subjectivity differs, which also holds true for the constitution of professional subjectivity. This needs to be taken into consideration and discussed beyond the taken-for-granted assumptions that subjectivity is fixed and unified when implementing new professional functions.

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