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Appealing to the 'experience' of the patient in the care of the dying

Abstract The care of dying patients in hospital is characterized by the co-presence of four different frames: practical, medical, lay and psychological. Within the psychological frame, the staff define the patient as an experiencing subject, exposed to the staff members' knowledge and involvement.

The psychological frame is used in two different circumstances. First, it is used by the staff members when the patient deviates from an expected identity within some other frame. The deviation creates a threat to the working conditions and moral order at the ward. The threat is managed through a shift into the psychological frame. Second, the psychological frame is used spontaneously in the accounts of their work given by staff members to the sociological field researcher. The image of care associated with the field researcher is characterized by a special awareness of the psychological issues. Thus the field researcher is inevitably a part of the functioning of the new kind of surveillance working through the psychological frame.

Introduction

The aim of this paper is to situate field research in some new elements of the social reality of a hospital. These new elements stem from the widening scope of the medical gaze beyond the mere body of the patient to his subjective experience. The results presented here stem from ethnographic field work, on the issues of death and dying in hospital, carried out in Autumn 1986–Summer 1987 in a university hospital in Southern Finland.

Active data collection occupied approximately six months. During that time, I worked full time at three different wards of the hospital. My role as a sociological researcher was openly revealed both to the staff and the patients. Three methods of data recording were used: field notes, tape-recording of staff meetings, and tape-recording of interviews with the staff members. The bulk of data is in the form of field notes. The tape-recorded

interviews are not used in this article; much of the field notes, however, records informal talk between the researcher and the staff members.

Four frames of death in the modern hospital

The social reality of death in modern hospital is characterised by a diversity of meanings. To put it in Goffman's (see Goffman 1974, esp. 10–11) terms, four different frames can be identified in the care of the dying. Each frame opens a particular perspective on death; the meaning of death is different in each.

The first of these perspectives refers to the *practical frame of death*. From this point of view, death and dying mean the set of pracitices enforced when somebody is dying on the ward. These practices include intensive nursing care before death, then cleaning and clothing the corpse, announcing the news to the family of the deceased, writing the death certificate, contacting the pathologist, etc. All the different professional groups have their own tasks.

Another frame is the *medical*. Here death and dying mean biological processes in the patient's body, which cannot be reversed by therapeutic action. Within this frame, the central activity is to define the patient's situation in biomedical terms, and to decide on the course of therapeutic action.

The third frame to be considered here is the *lay frame*. It is a layman's affective perspective on death and dying. In other words, here the meaning of death is the same to the hospital staff as it is to people not working in hospital: an upsetting and existential crisis, and a call to human communion. Death is accompanied by strong feelings.

In the fourth perspective, within the *psychological frame*, the issue is the experience of the patient, the family and the staff itself, constituted within the lay frame. But the involvement is dramatically different. The feelings and experience shaped in the lay frame are now treated in a detached manner. They are interpreted and managed in terms of psychological concepts, such as awareness of death, repression of feelings, denial of death, acting out one's anger and the like. In this case, death means emotional and cognitive processes which can be identified, controlled and managed.

As Strong (1979, 1987) has argued, an essential feature in any framing of a situation is that a frame offers certain identities to the participants sharing the encounter. Within different frames the participants have different rights and duties. This is also the case with all the frames concerned here. The identities of different parties are summarised in Table 1.

Framing a situation is always an interactional issue, a result of negotiation (cf. Dingwall *et al* 1983:45; Tannen and Wallat 1987). The rules

Table 1 *Frames and Identities*

Frame	The staff members' identity	The patients' identity
Practical	*Acting subject* taking care of necessary daily tasks in the ward	*Object* of daily practical tasks; limited subjectivity in collaborating in the tasks with the staff
Medical	*Knowing and acting subject* knowing the medical situation of the patient and accomplishing the medical intervention	*Object* of medical knowledge responding to the medical involvement
Lay	*Feeling and experiencing subject* in the face of a fellow man's death.	*Feeling and experiencing subject* in the face of his or her own death in relation to fellow men
Psychological	*Knowing and acting subject* knowing the emotional reactions of the patients, the family and the staff itself, and capable of managing them	*Feeling and experiencing subject* exposed to psychological knowledge and involvement

that constitute the frame may be given as an external and compelling structure, as Gonos (1987) has emphasized; but how and when a frame is used is at least partly up to the interactants.

The process of interaction leading to the application of a certain frame and the exclusion of others can be studied sociologically.

My main target here is the use of the psychological frame in the care of dying people. It is of special interest, because it clearly reflects the development of medical discourse during the last few decades. As Arney and Bergen (1984) and Armstrong (1983) have shown, the management of patients in modern medicine is not restricted to their bodies, but also covers their subjective experience and social relations. Interest in these is especially vivid in the care of dying people (see also Armstrong 1987). Beginning in the sixties, an increasing psychologically and social psychologically oriented literature has appeared about dying and the care of dying people (see e.g. Glaser and Strauss 1965, Kubler-Ross 1969, Brim 1970, Weissman 1972, Kastenbaum and Aisenberg 1976, Feifel 1977, Charmaz 1980, Ariès 1982, Gilmore and Gilmore 1988).[1]

Everyday talk within the psychological frame in hospital is characterized by the use of concepts relatively close to those used in the literature on death and dying. Stages of dying, denial of death, the different parties'

awareness of the coming death, and criticism of the social and emotional isolation of the patient are the stock in trade of both the literature and everyday talk within the psychological frame.[2] In this paper I will analyse the conditions under which staff members draw upon this wider definition of a patient, and what is done by this. As the analysis will later show, drawing upon the experience of the patient has interesting connections with the politics of field research.

The argument will proceed in four stages. First, the use of the psychological frame in problem solving is analysed. The second theme is its application in the staff members' accounts of care presented to the field researcher. The third stage is scrutinising the identities of the researcher within the psychological frame. Finally, as a conclusion, the implications of the use of the psychological frame for power relations in sociological field work are considered.

The psychological frame and identity problems in other frames

After a detailed study of ethnographic field data about the ordinary flow of activities and staff members' talk related to their work in the three different hospital wards, I have been able to identify two major uses of the psychological frame in relation to the care of dying people. The first is related to the solving of identity disturbances perceived in other frames. It is illustrated in the following discussion:

Tape recording made at the nurses' regular meeting at the turn of the shift of a leukemia ward. The discussion is about Mrs. A. She has recently had problems with a nurse.
1. *Nurse A*: In room 31, bed number two, Mrs A., a 40 year old lady, with myelodysplastic syndrome. [A few sentences describing the symptoms and the medication of the patient] We had some problems with this lady in the evening. She came to say, at about eight pm, that she was going home. She wouldn't stay here any more nights with the nurse who was here last night, because this nurse didn't want to give her a heparin block. [A heparin block is used when an intravenous infusion is interrupted, to prevent clotting of the cannula. This releases the patient temporarily from the infusion line so she/he can walk freely around: author's note.] I said that I'm not authorised to let her go home, instead I could suggest to the nurse on duty that she give her the heparin block, but it is not something I can promise because it is the nurse on duty who makes the decision. And that the nurse on duty has generally been right, because if we followed the rules strictly, we would release the patients only in the morning for the shower. And this lady then phoned Kaj Wallgren [the junior physician at the ward], and Kaj said that the heparin block has to be put on between the infusions of antibiotics. And

then I asked Merja [the nurse in question] what the situation was, and she told me that on Sunday evening Eija [another nurse, called here nurse B] had said to this lady that when she had been going to take the heparin block to her, she was probably on the phone. And she had suggested that the lady should ring the bell when the infusion was over, so we could administer the heparin block then.

2. *Nurse B*: And not even the antibiotics had been infused by then.

3. *Nurse A*: Yes, and then around the time of the evening report she came to say that now she would like to have the block. It was almost ten pm then. So both Kaija [a nurse from the evening shift] and Merja said it is so late now, the next medication will come at twelve, it doesn't make sense to administer it now.

4. *Nurses Aide*: Sorry to interrupt, but I told Kaija at about eight that she wanted to have the heparin block now, but Kaija said that it would be given to her if we had time. But then she didn't have time for that.

5. *Ward Sister*: That's certainly right. If you are in a hurry, the heparin block is secondary. If you are doing something else. This is what we have decided.

6. *Nurse A*: That's right. And they [the nurses] had many problems with Teuvo [another patient] at the same time, so they were certainly busy. And, well, probably there is something, now she – this lady – gives vent to all her anxiety. She was really trembling, she was so annoyed last night. And, well, Iiris [the nurse with whom Mrs. A had the quarrel] had tried to discuss this that night, and she said that this lady became very difficult. You can't get into eye-contact with her at all, and she really is trembling.

7. *Ward Sister*: Yes, we have had a lot of difficulty with her. Leila [one of the physicians] has treated her for a long time. One morning she refused to be taken for the blood test. And then at the ward round, she denied it. This meant that she twisted the issue. Really, it must be anxiety which makes her behave like that.

After a while the ward sister continues:

8. (. . .) I asked today if she would soon be sent home. But that will not happen very soon.

9. *Nurse A*: She still has some fever.

10. *Ward Sister*: In other words, she certainly is . . . as she is a single parent, I can't remember how old her child is.

11. *Nurse B*: No, she has a husband.

12. *Ward Sister*: No, she is divorced.

13. *Nurse B*: But the husband was here during the weekend.

14. *Ward Sister*: Well, I don't know, but perhaps they are divorced.

15. *Nurse's Aide*: This man comes to see her with the child.

16. *Ward Sister*: Well, I was just thinking, that as she is so young, and if she has this disease now, she certainly knows that if this takes a bad turn, she will not be able to pull through. So I think there is a problem because

of that. You know, she has often wanted to go home, to take care of things there.

17. *Nurse A*: She said that she has been in many places, but this is the worst and we are disgusting.

18. *Ward Sister*: It's a very hard accusation from her.

19. *Nurse A*: Yes.

20. *Ward Sister*: Usually they don't react that strongly. But perhaps she has the right to act the way she wants.

A few minutes later nurse B adds:

21. And if we now adopt a different policy . . . certainly she has troubles, but if we give in now, then the others would demand the same, where would that lead?

22. *Nurse A*: Yes, I think it is wrong if we yield in this case when the others have to be connected to their infusion lines all the time.

23. *Nurse B*: They would also want to be released, but they haven't got the courage to make demands. But the point with her is not the infusion lines, it is something else.

24. *Nurse A*: Sure, it's something else.

25. *Ward Sister*: [Speaks first about the lack of nursing staff which is the reason why there is not enough time to carry out each patient's wishes.] And I believe that the physicians will admit that this can't be done, if the result is that some antibiotics will then be skipped. It would be absolutely wrong.

26. *Nurse A*: It'll be interesting to see what she says at the ward rounds.

27. *Ward Sister*: Yes, it will. Well, she doesn't always express these feelings at the ward rounds.

(NK 610–614)

After a routine account of the patient's condition within the medical frame, the nurses move on to discuss a perceived problem. The patient will not cooperate with the staff. At the beginning of the extract, the situation is described as a very practical one, a question of being released from the infusion. In connection with this practical issue, the patient, however, deviates from the expected identity of a patient along the practical frame. She is reported not to have conformed to this identity as an object of practical tasks. The deviation from this presupposed identity in the practical frame is so dramatic, that the rule of irrelevance – our ability to ignore things that do not fit to the framing (see Strong 1987) – has not sufficed to maintain the order. Mrs. A has *broken the frame* (Goffman 1974:374).

Now the staff members draw upon the psychological frame. The psychological issues are anticipated in utterance 6 by Nurse A, and they are stated explicitly by the Ward Sister in utterance 7: Really, it must be anxiety which makes her behave like that. The psychological frame is used here as a *vocabulary of motive* (Mills, as cited by Silverman 1987:240), as a

device of appropriate motives to be used in the interpretation of other people's conduct. With the help of the psychological vocabulary of motive, the patient's demands are interpreted as something that must not be taken at its face value, but as representations of underlying feelings. As the two nurses summarise it in utterances 23 and 24, 'it is something else'.[3]

Death as a social-psychological issue is introduced into the discussion quite late, in utterances 10–16. The patient's anxiety is explained by her anticipatory knowledge of being separated from her family through death. The context of this interpretation reveals that *the dying patient as an experiencing subject is needed here for organisational purposes*. The constitution of the experiencing patient seems to be motivated by the need to maintain working order and predictable conditions in the ward. Nurse B asks in utterance 21: 'If we give in now, then the others would demand the same, where would that lead?' But as the point is 'something else' (namely, the anxiety of the dying patient), then there is no reason to let working conditions be damaged by giving in.

The constitution of the patient as an experiencing subject is also related here to the struggle of authority between nursing staff and physicians. As the last three utterances show, the nurses feel that the physicians might be on Mrs. A's side: but if the point is put in psychological terms ('something else') or medical terms ('skipping antibiotics'), then the physicians probably wouldn't support her in the conflict.

In terms of the frame analysis, the point here is that the disturbances in the identity of the patient in one frame, namely the practical frame, are solved by shifting to the application of the psychological frame. A patient's deviation from the identity presupposed by the practical frame threatens the daily working order and authority relations on the ward. Through the shift of the frame, the scene is completedly reorganized. The patient's deviation is legitimated (Berger and Luckmann 1966:110 ff.) because psychological considerations have shown that 'it is something else'. Now, the ward sister can say (in utterance 20) that 'she has the right to act the way she wants'. The patient's deviation is not a threat any more.

The practical frame is by no means the only one from which a shift to the psychological frame can be made in order to sort out difficulties. In fact, shifts are also made from all the other frames. Identity distortions in any of them cause a threat to the working conditions and/or the moral order of the ward; this threat can be managed through a shift into the psychological frame. Within the medical frame, the identity distortions may result from the patient being unwilling to be treated according to the canons of medical logic, or even from the patient not responding to the treatment when it is supposed to be effective. There are shifts from the lay frame to the psychological frame when the patient withdraws from communication with the staff, or expresses an unexpected (in terms of common sense) type or amount of emotion.[4] Identity disturbances can also be solved through shifts into other frames: e.g. the patient's senseless talk and accusations

towards the staff (deviation from the expected identity within the lay frame) can be dealt with by strong medication and by interpreting the patient's behaviour as a result of brain damage caused by the illness (shift into the medical frame).

But the psychological frame has a special position here in the fabric of shifts from frame to frame. It is the problem-solving frame, which resolves the identity disturbances faced in other frames. Shifts are never made from the psychological frame to other frames in order to solve problems. The psychological frame is specially devoted to this – not for problems originally faced in psychological terms, but ones faced in practical, medical and lay terms.

Thus, the people working in hospital are not 'cultural dopes' (Garfinkel 1967) in their relation to the new broadened medical discourse. The concept of the experiencing patient is not determining the action of the staff, but it is used by them for their purposes in the specific institutional context in which they work.

Telling the researcher about the psychological aspects of hospital work

The main function of the psychological frame seems to be to resolve the patients' identity disturbances faced within other frames. I have searched for a case where the use of the psychological frame would emerge in its own right – that is, without preceding or anticipated identity distortions in other frames. I have found only two types of case.

One of these is the counselling sessions which were occasionally held at one of the three wards I studied. The other type of deviant case is that of talking to the researcher. Both deviant cases have much in common. Here, however, I will concentrate on the latter.

As a participating observer, I had numerous talks with the hospital staff. The staff members knew that I was doing sociological research about the care of dying patients. Besides my occasional participation in the use of the psychological frame for dealing with the identity disturbances, there was another way in which it was used. It was specific for discussions between the staff and myself. This is reflected in the next extract from my field notes. The scene is the office of the ward, with several staff members coming and going. I have a chat with Dr A, a female junior physician. Mr B, the patient we speak about, is a man about 70, who died a few days after this conversation.

> I ask A how Mr B is now. The physician says that his condition has become somewhat worse. And she continues by telling me the following: Mostly he has been sleeping, every now and then he is awake for a little while. When awake, he is conscious and is able to speak a little. There has been discussion about stopping the medication. Now a diuretic is

being infused intravenously, and that's all, in addition to the pain medication. The infusion could be stopped – the kidneys are not working any more – this, however, has not been done.
His family members have often been here: wife and children are there now. The son arrived yesterday from Germany. I have had a discussion with him today. The family has adjusted to the situation well. They have asked, however, that the situation should not be prolonged more than necessary. But the diuretic infusion does not in fact prolong the situation; the family members understood that.
The patient himself is aware of the fact that his liver is damaged. He can certainly infer the severity of his condition from this. When I talked with him, I asked whether he had anything to ask, and he had nothing. I think he is so tired that he does not have the strength to concentrate on anything else but the situation at hand. The same was said by the family members: Mr B doesn't speak with them about his illness either.
I ask the physician (. . .)

(KPK 1331–1333)

In this rather long passage of the physician's spontaneous talk to the sociologist we can identify a passage in the beginning where the medical frame is used. In the third paragraph, there is a shift into the psychological frame. Within this frame, there is a long account of the patient's and the family's reactions and their contact with the physician.

Now, the physician's willingness to give a detailed account of the psychological aspects of the case seems not to be functional in relation to any perceived disturbances in the patient's (or the family's) identity. The case is in medical control, in the way that active treatment (except for the diuretic) has been stopped, and the death of the patient is expected in medical terms. There are no references to practical problems, or any indications of lack of communication between the patient, family and staff.

Dr A's use of the psychological frame can be explained in relation to myself, the hearer, as a researcher. As Goffman (1984:503; see also 1981:16–17) has emphasised, through much of our talk we prove grounds for approval, sympathy and exoneration. Cuff (1980:35) similarly says that any account displays its teller in moral terms.

Dr A here presents herself as a professional aware of the psychological aspects of the care of dying people. She has considered the patient and his family as experiencing subjects and made her inferences about their emotional and cognitive reactions in relation to the coming death. Her awareness of the psychological issues is presented as evidence for the moral adequacy of her professional conduct. Knowledge has a strong moral aspect here, so to speak. Knowing about the psychological side is not a question of mere cognition but is also a moral issue.[5] Thus, the reason for Dr. A's moving into the psychological frame is not an identity disturbance in some other frame.

Giving an account is not only related to the teller: it is related to the audience, too. 'How one speaks or writes about things depends on who is spoken or written to' (Gubrium and Buckholdt 1982:4; see also Gubrium *et al.* 1982). The way Dr. A here described the patient and her own action with the patient reveals the images that she supposed that I have, as a researcher, about the realities described. The terms in which she chose to display her moral adequacy tell as much about her expectations of the audience as about herself.

The image related to the audience, to the researcher, in this example reflects his presumed special awareness of and interest in the psychological aspects of care. In addition to the medical aspects of the situation, the audience is supposed to be especially interested in the physician's relationship with the patient's family members, her awareness of the family members' adjustment to the coming death, the family members' participation in the medical decision making, her talking about death with the patient and her understanding the patient's emotional and cognitive reactions in relation to his coming death.

The case above reflects neatly a general feature of the relationship between different frames in the wards studied. The general feature can be schematized as follows. The four original frames of taking care of the dying are here once again encompassed by a new frame, which is *the research itself*. To put it in Goffman's terms, there has occurred an instance of *keying* (Goffman 1974:43–44). Everything happening in the care of the dying is now transposed into another activity, the research. The whole scene is once again rearticulated.

Because of the overall reframing by 'research', the dynamics between the four original frames has changed. In the accounts given to the researcher about care, the psychological frame is given a central position. It does not now serve primarily as a problem solver for the other frames, but is used in its own right. The lay frame also gets a more central position. But the practical and medical frames, on the other hand, which were so central in the staff members' ordinary talk related to their work, are now somewhat peripheral.

The keying of the four original frames into 'research' has its impact on their dynamics. Further evidence for this is the case of the emergency ward. At the emergency ward, the psychological frame was very rarely used in ordinary talk between the staff members. The reason for this was, I think, the specific temporal structure of the ward. The patients usually spent only one or two days there before being placed in other wards. An overall solution to all possible identity disturbances was always very near: the patient would be sent away in a day or two. Psychological considerations were not needed. There were several patients admitted each day because of attempted suicide. But even they did not inspire any psychological talk.[6]

While talking with the researcher, however, the staff members of the

emergency ward *did* use the psychological frame with the same intensity as the staff members of the other wards. They were especially keen on telling stories about the experiences of former patients and family members, and about their own feelings while working with them. The need for presentation in moral terms was also there in the emergency ward, as was the image of specific psychological awareness related to the researcher. That is why the psychologised talk did make sense in the midst of a non-psychological environment.

Identities of the researcher

Let us go back to the starting point of this paper. Encounters between people are always framed, and the framing endows the participants with specific identities. Now, as I encountered the staff members as a researcher, and the encounter took place in the 'research' frame, what kind of identities was I supplied with? Although sociological research is not usually a part of the everyday life in hospital, a number of quite stable, recurring identities of a field researcher within the social reality of hospital can be found from my field data.

There is one specific identity related to the research process. In it, the researcher is doing his own work. This identity has a technical and an intellectual side. The technical side entails the right and obligation to follow and record all kinds of events. The intellectual side refers to the thinking: the researcher is supposed to discover something. Another identity of the researcher was connected to ethical questions. I was expected to be a specialist in ethical thinking concerning the problem of the prolongation of life.

The research frame and the four frames of taking care of dying people are laminated onto each other. Similarly, the rest of the identities of the researcher have their connections to the four original frames. Those identities of the researcher which are connected to the practical, medical and lay frames are logical counterparts of the respective identities of the staff members. The researcher is a spectator, who asks questions and is told about medical and practical issues. Concerning the lay frame, the researcher is a fellow man who can be curious or feel distress about the suffering and the destinies of the patients and their families. What is of a special interest here, is the identity of the researcher in relation to the psychological frame.

This identity can be summarised in three points. The researcher was *specially aware* of the psychological aspects of the care, he was *a critic* of psychologically wrong ways of acting, and he was a *potential resource* in managing the psychological issues.

The researcher's identity as being specially aware of the psychological aspects of care is reflected by the case referred to above. There Dr A offers

me an identity as a specialist interested in these issues. The special awareness is not limited to the reactions of patients and their families; it covers the staff as well. As a researcher, I was supposed to be interested in the way that the staff truly feel and experience death and dying. The following example illustrates this. The scene is the office of an ordinary medical ward, where I have been observing for about 10 days before the discussion.

> I am leaning on a desk in the office. Nurse A is doing some paper work.
> She asks me: How long did you stay at Ward 17?
> *AP*: Three months.
> *Nurse A*: Do you intend to stay here as long?
> *AP*: Yes, about the same time.
> I continue by saying that you do not learn to see and understand things
> so quickly. She says: Yes, certainly you have to stay a long time in order
> to establish such a relationship with the staff members that they will tell
> you what they really think about things.
>
> (KPK 769)

The issue is, as Nurse A puts it, what the staff members really think. It is covered up somehow, and it is the task of the researcher to uncover it. The staff members' task, according to the psychological frame, is to make the patients confess their innermost experiences (cf. Foucault's (1979:58–70) discussion about the importance of confession in our society). Similarly, it is the researcher's task to make the staff members confess *their* experiences.[7]

The researcher's identity as a critic is also implied in Dr A's account of the psychological aspects of the care of Mr B presented above. The critic's identity was offered to me quite explicitly in many small dialogues during the working days in the wards. The next extract is from field notes at the leukemia ward. A nurse and I are in the room of a patient with several life-threatening conditions.

> The patient says to me that he would like to sit up. I repeat this to the
> nurse and ask her whether it is possible. She says yes, and continues that
> when one is busy with the infusions and all the other things to be
> managed, you actually haven't the time to hear what the patient has to
> say.
>
> (KPK 399)

The nurse shifts into the psychological frame by making 'listening to the patient' the topic of the discussion. By using the discursive tactic called by Cuff (1980:49; cf. Silverman 1987:243) 'taking the responsibility of unit problems' she defends her position against potential charges from the researcher-critic.

The researcher's identity as a potential resource person in managing psychological issues in the ward did not have as explicit a relationship to

the research as the two other identities. As a manager of psychological issues I was working *qua* staff member as well as *qua* researcher. Nevertheless, beginning from the first preliminary contacts with the administrative personnel of the hospital, I was offered an identity of 'counsellor' for the patients. And during the fieldwork I was repeatedly asked by the staff members to talk to patients who were supposed to have emotional problems. I at once realized that this role could be utilised as a legitimating device for my presence in the wards. Sometimes staff members also identified me as a 'therapist' or 'a supportive person' in relation to themselves.

The identities of the researcher were naturally shaped by an ongoing negotiation between me and the staff members. My general impression was that of a consensus. How I presented myself was accepted by the staff, and what the staff offered me as an identity was usually accepted by me.[8] Through studying quantitatively the fieldnotes about my discussions with the staff members one can gain more insight into the construction of the researcher's identity. In most of the discussions I recorded, one can identify which party was offering a certain identity to the researcher (e.g., in the last example referred to above, it is the nurse, not I, who endows me with the role of a psychological critic). Table 2 offers a simple count of the frequencies with which different parties introduced different identities to the researcher.

Although the reliability of such counts is certainly quite low,[9] they can nevertheless be used as subsidiary evidence (cf. Silverman 1985:138–155). These figures show that staff members offered to the researcher identities located in the psychological frame relatively much more often than he did himself. This is also the case with the identity located within the lay frame. The opposite is true when it comes to the medical identity. Rather, I had to

Table 2 *Frequencies with which staff members, or the researcher himself, introduced the identities of the researcher in different frames*

Frame of the identity	Introducer of the identity		
	Staff member	Researcher	Total
Medical	24	51	75
Practical	52	32	84
Lay	43	3	46
Psychological	145	30	175
Research			
–as work	28	5	33
–as ethical thinking	17	6	23
Others	15	3	18
Total	324	130	454

show an active concern with medical questions; the staff members did not spontaneously regard me as interested in them.

Summarising the qualitative and the quantitative results: I was incorporated into the psychological frame in several ways. As a sociological field worker I was, indeed, an incarnation of the new socially and psychologically conscious medical discourse. I was the one who knew about those things, and the one who criticised. The knowledge and the criticism, however, were in the field before me: I could only adopt the identities which were there waiting for me, the social researcher. But could it have been any other way? Or should it be?

Power, psychology, and field research

In *Asylums* Goffman (1961:83–84) discussed the interpretative scheme offered by a total institution. An essential part was a theory of human nature, an elementary psychology used by the staff to rationalise the activities of the total institution, and to maintain social distance from inmates and a stereotyped view of them. Use of psychology and the practice of power were thus closely connected.

While criticising the new psychologically-conscious medical discourse as a new form of professional surveillance, Arney and Bergen (1984) adopt the theme treated by Goffman in his early writings. But there is also an interesting difference. The psychological theories of the total institution blocked communication between the staff and the inmates, and justified the existence of two different social and cultural worlds. The power had a silencing effect. This is not the case with the new medicine analysed by Arney and Bergen. It incites the patient, physician and nurse to speak to each other about their experience. Medicine takes on the task of helping people to become what they 'really' are. But the 'true nature' of people is, in the last analysis, a construction of medicine itself.

In his discussion about *Panopticon* and the modern forms of surveillance Foucault has emphasized that power is no longer substantially identified with particular individuals or particular social positions. 'Power becomes a machinery controlled by no-one' (Foucault 1978:13; see also Foucault 1977). According to Arney and Bergen (*ibid.* 167), this also holds true in modern medicine. Medical power is no longer located in the hands and eyes of the physician, but 'in large and pervasive structures that exert their force on physicians and patients alike'. The use of the psychological frame in the care of dying people points to new pervasive structures of power.

In the total institutions studied by Goffman it did make sense, for a researcher, to take the side of the inmate, or the underdog, against oppression by the institution and its staff. But how it is in a modern hospital, where the patients, staff members and researcher are all constituted by the same (psychological) discourse? As an incarnation of the

psychological frame I, the field researcher, was quite obviously a part of the functioning of the new kind of power. If the Foucauldian thesis of the omnipresence of power in modern society holds true, then there is no way out of qualitative sociology being a part of the functioning of power and surveillance. Resignation to that, however, is not necessarily the final word from sociology in relation to medical practice.

The question of *articulation*, treated at length in the recent work of Silverman (1985 and 1987), is the point where sociology has something positive to say in relation to medical practice. The crucial point lies in the *relationship* between different discourses, or frames. The meaning of discourses, of frames, and the workings of power mediated through them, cannot be understood if they are taken separately. It is in the relationship between discourses, 'where effects of power are constituted and challenged' (Silverman 1987:135). Instead of arguing for or against the use of social-psychological models in medicine, sociology should explicate the way those models are used, the circumstances that they are applied in, and the intended and unintended consequences of their use. These are social issues, permeated by power relations.

I hope this paper has shown that the psychological frame can be related to the other frames in different ways in different institutional and situational contexts. Recognizing this, and following the research policy recommended by Silverman, inevitably entails some distancing from the identity endowed to the researcher during the field work. Perhaps to be incorporated in the psychological frame was the best way of doing the fieldwork and relating to the people there. But the ways of relating to the people studied should change in pace with the results of the analysis of the field data once collected. The concern about the articulation of different frames should be reported back to the people studied; in my case to those working in the wards which were studied and also to others working in terminal care. I hope my results will encourage them to study the links between the worlds represented by different frames and to create a dialogue between them.

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Notes

1 In Finland the appearance of such literature has been specially rapid in the eighties – ten or fifteen years later than in the English-speaking world. During last three years there has been one widely read book a year – which is a rather impressive achievement in such a small country. Death and dying have also become a very popular topic in the updating training of hospital staff.

2 This does not mean that the psychological frame would not have existed before the appearance of such literature. It may be the case that people in all ages and all societies have had some kind of folk-psychologies for dealing with specific human reactions and problems. The use of a psychological frame may be a part of the human condition. But the specific shape that the psychological frame takes in modern medicine is certainly historically and socially conditioned. This specific shape is reflected by the modern literature on death and dying.

3 We are witnessing here a discursive practice of domination (see Silverman and Torode 1980:3–19; Silverman 1987:137–138): a practice that constitutes one speech as the reality behind the appearances of other speeches.

4 The ways of using the lay frame and their relation to the psychological frame are central issues that are not dealt with here. It must be remembered that the lay frame does not represent an 'authentic' reaction to death any more than any other frame. The lay frame has its situationally and institutionally conditioned uses, as do the others.

5 A parallel instance of moralisation of knowledge was the physicians' way of using the medical frame at ward rounds in the leukemia ward. Talk about medical facts, especially those related to the near future, with the patient was a mutual display of the parties' morality in the battle against leukemia.

6 I have recorded two exceptions: in one case the husband of a suicidal patient had talked on the phone to a nurse in a very strange way, which made the nurses assume that the reason for the patient's attempted suicide was difficulties in the marriage. In another case the patient was a psychiatric nurse himself; the reason for his attempted suicide was assumed to be hardships at work. There was a consultant from the psychiatric outpatient clinic who had discussions with suicidal patients. These discussions were referred to as a purely practical matter by the staff members. To use the terminology of Basil Bernstein (see Atkinson 1985:27), here we can see an instance of boundary maintenance between the frames. The boundary maintenance is a practice available for the hospital staff for the management of some situations.

7 I am grateful to David Armstrong for drawing my attention to this parallelism.

8 Usually it was the staff members who introduced the psychological (and the lay) frame in their encounters with me; but sometimes it was I who did it. In my field

notes, three conflicts in framing these encounters arose. In all the deviant cases I was trying to introduce the psychological or the lay frame but it was implicitly rejected by the staff members. They kept the encounter within the practical or medical frame. A common feature in all these cases was the temporal or spatial proximity of a dying patient or the death of a patient. This is another example of 'boundary maintenance' between the frames. The practice of boundary maintenance is not, however, always applied when the actual death is near. Sometimes the staff members were also keen on introducing the psychological frame to me in the very proximity of death.

9 I assume that my recording of references to the practical frame has been most unsatisfactory. Passing remarks made on practical issues were certainly much more numerous than presented here. But the references to the other frames have been recorded more meticulously.

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