

### Abstract

This paper presents and discusses the implications of labelling for patients who are a part of diagnostic group. Nurses not only allocate patient groups to a 'bed space' according to their illness, but they also allocate the individual by their past history, as well as by that patient's previous level of surveillance, giving the act of labelling not only a structuring effect on patient care and diagnosis, but also a historicity. These beliefs are unthinkingly applied to both cohort and individual patient. The outcomes of such a practice led to group distinctions bestowed upon individuals regardless of whether such classification and organisation fit the patient or not. The effect of labelling left patients cared for the same way regardless of individual differences and left nurses relying on indirect mechanisms of control to look after these patients.

**Key Words** adolescent patient, anorexia nervosa, cystic fibrosis, diagnosis, labelling

## The Effect of Labelling Practices in an Adolescent Facility

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### Introduction

The overall aim of this paper is to demonstrate how 'labelling' practices impact on adolescent patient care. Grouping patients together in relation to their diagnosis is viewed as allowing clinicians to tailor patient care and set outcomes for recovery. Attached to the patients' diagnosis is the level of surveillance determined necessary to maintain patient safety and provide the required standard of care. Hutton[1] undertook a study designed to understand the spatial dynamic of how space is used on an adolescent ward. Using findings from this study this paper shows how labelling practices impact on both nurses and patients on this ward.

When studying a purpose-built adolescent facility, it became evident that some adolescent patients are set up differently than others. What then became apparent was that various patient groups were treated differently to others, and that a process of 'labelling' was taking place. Due to the nature of admissions at the time the study took place, this paper will pay particular attention to the diagnosis of Anorexia Nervosa (AN) and also Cystic Fibrosis (CF), and discuss how because of activities such as labelling, both adolescent patients and the nurses caring for them, are caught in socially constructed reductionist behaviours that then impact on the individual patient. To demonstrate the effect of labelling this paper will present data highlighting how processes such as patient allocation, planned care, labels and descriptors are ascribed to adolescent patients, have an impact on the behaviours of both patients and nurses.

This particular analysis explores how labelling of patient groups by means of diagnosis can affect nursing values, and how care is then measured and dispensed to the patient. Acts of diagnosis are not only acts of labelling, but

are ways of making the 'abnormal' visible and available for the legitimisation of expertise. Such acts are infiltrated with power such that, for instance, in nursing care, patients are labelled as 'good' or 'bad'. [2] These value judgements are consequentially added to the diagnosis and other factors. This process allows nurses to allocate patient behaviour to 'safe' or 'unsafe' categories and they then tend to allocate their time and care according to this division.

### Theoretical framework: labelling theory

In this section of the paper we outline contemporary analyses of classification and sorting, by using the work of Foucault and others. To theorise and discuss labelling practices and their implications for nursing practice we will first discuss Becker's theory of labelling, followed by Goffman's work on the total institution and lastly we will discuss Foucault's post-modern perspective of labelling. Firstly though, we will compare Becker, Goffman, and Foucault, moving from normative theories of labelling to post-modern perspectives. Both Becker [3] and Goffman [4] used interactionist perspectives to explore the effects of labelling on deviant or 'abnormal' populations. In Goffman's case, he explored the impact of 'spoiled identity' and 'stigma' as well as foreshadowing Foucault's analysis of incarceration in his study of total institutions.

Roach Anleu asserts that for 'labelling theorists the focus must be on the social audience, which determines whether certain activities are defined as deviation'. [5 p58] Becker [3] demonstrated the affects of labelling through devising a typology of deviance to cross-classify behaviours and describe responses that these behaviours may evoke. Even though Becker's perception of deviance relied on the structural organisation with its tendency to develop rules, he also recognised that an individual may belong to many groups, and a rule in one group may be directly opposed to that of another. Therefore this tacit rule-breaking does *not* mean that the individual is then 'deviant' because they broke the rule. Becker [3] states it is when the behaviour of the person is successfully labelled as deviant that the behaviour is then deemed as deviant! Becker used his work to understand the origins of deviant behaviour; his work in the most part was set around groups, such as homosexuals, or drug addicts. [3] Even though this work was significant at the time Becker does not explain the social situation or context used which then contributes to the labelling behaviour.

Goffman wrote about the labelling of mentally ill patients for his work on the *total institutions*. Goffman [4] identified how micro-relations of power operate to make visible those who

are labelled. When Goffman discusses labelling processes in the asylum, his work on the *total institution* suggest the process of admission to hospital alter the private and public identity of the patient. Once this process is complete, it is the individual's role as a mentally ill patient that then tarnishes their identity. Coupled with complete indoctrination of inmates, through imposed routines, attire, diet, and cohabitation condition, these individuals are then positioned without rights, and stripped of their previous identity. The patient's role, the attributed label and set of circumstances is impacted further by organisational contingencies. These values state how the patient should behave which are then adopted by staff and enforced. [4,5] Focusing on how the mentally ill patient is positioned through their set of circumstances, however, provides no insight as to how the processes affect the labeller or labellee. To understand the affects of labelling on the entire set of relationships we turn to Foucault's work on the prison and the clinic. [6,7]

Foucault, like Goffman, discussed mechanisms of power within hospitals. The hospital, like the mental institution, has become a place bristled with unspoken obligations and moral limitations for those who frequent its buildings. As a consequence, patients are considered to be part of society until they enter the hospital's four walls, where they may then be reduced to 'an illness', and become socialised into the hospital's environment. [6] Interactions between the actions of labelling, the location and grids of power/knowledge-operating horizontally and vertically- make visible the objects (that is, those who are labelled). Labels and labelling are used to accomplish a sorting of humans through social interactions. Importantly, it needs to be acknowledged that these mechanisms operate not by the orders of one powerful person, but are a culmination of a series of decisions, responses and actions that have taken place over a period of time. These structures and discourses combine to form a source of disciplinary power and knowledge which in turn impacts on patient care. [6,7]

Foucault's work is important to this paper, because on the surface, the impact of decisions and structures in organisations may be small. However, disciplines such as nursing and medicine learn to use these decisions to limit and control practices or movements of individuals, thus limiting the way the body or the person can challenge and resist the labelling and labels applied in these environments. The operations of clinical power made overt through the use of metaphors such as the panopticon show how the clinic itself is a place which holds 'expert knowledge'. In this setting and any setting of control, power is used to place individuals, isolate

or combine them through grids of visibility. In essence, the person is regulated according to where they are placed in space.[7] This new mechanism, that is the clinic or hospital, defined how individuals held power over others and was used to influence individuals to act in a resolute manner. In essence, discipline produces 'subjected' and 'practised' bodies which in turn produce and become docile bodies.[6,8] The practice of labelling people under surveillance led to clinicians increasing their knowledge from this surveillance, thus reinforcing their power and expertise in health care.

The labelling of people under surveillance cements clinical power but it also leaves room for the individual to gain knowledge and enables them to resist the labelling and how they are positioned. Foucault states that power is in operation everywhere and affects everyone- the labeller and the labellee.[6] Furthermore, Foucault's theory allows a researcher to examine the production process and ideological constructs of space against how these are lived out; giving insight into how both the labeller and the labellee are positioned.

This paper is not concerned with the cause of behaviour or what the person is labelled as, it is more concerned with the consequences of the behaviour in this setting that have been *produced* from the labelling. While interactionist approaches to labelling point to the social nature of labelling and its impact on those viewed as 'different', authors such as Foucault has taken the analysis of such socially-developed constructions one step further. In particular what Foucault highlights in his analysis of such acts is that those who are labelled are capable of resisting such actions, implying that power is in operation at all levels and locations. Moreover, those actively labelling do not always understand the implications of their actions on the labellee; therefore in this paper we highlight how labelling impacts on both patients and nurses in an adolescent ward.

## Results

### *Labelling through diagnosis*

Diagnosis as a label operates on many different levels, for the two groups of patients providing the examples in this paper. The medical nature of the patients' illness was seen to impact on the beliefs and actions of the nurses and therefore how they should treat the patient.

The main consideration, eating disorder patients. Their behaviour can at times jeopardize their own safety, I feel that, that if we can have a closer observation in that critical time that it benefits the patients. We are able to give them better care (Caitlin).

The psychiatric nature of AN as an illness creates a percep-

tion for nursing staff that this cohort needed a greater level of surveillance than those long-term patients, who have what could be considered a merely physical illness. Nurse *Caitlin* attributes patient behaviour to the diagnosis of the eating disorder patient (AN), stating that all of these patients require close observation, and with this type of observation patients will benefit through better nursing care.

If it's a patient that is who is here for observation say, umm I tend to say, "We should just pull the curtains back 'cause we need to keep an eye on you. I know that you need personal time as well, but ... we've got to keep an eye on you (Lydia).

But if it's a patient say with CF, and, sometimes they do, they just need their personal space, so I think yeah that's fine, you know, keep the curtains around, umm they'll venture out when they are well and happy (Rebecca).

In this second case the patient diagnosed with CF is permitted privacy, which is said to be due to the understanding that this is what these patients need. Here the diagnosis signals that the patient does not need to be stringently observed and they are allowed to have their privacy as part of their treatment. For the patient that needs closer observation, such as a patient diagnosed with AN, while their need for privacy is also acknowledged, it is instantly negated by the nurse's need to observe closely: and that this act, the nurse needing to observe the patient, takes precedence. However this need to observe the patient comes at a cost to both the nurse and the patient.

You want to provide a safe environment to nurse the sick, but when you have got mentally ill patients, umm that need the supervision, it's very hard to draw the line between, I'll supervise you 'this much', but I'll let you get away and do 'this much' (Lydia).

The focus on supervision for the nurse creates a subtext; the patient is doing something wrong and making observation necessary. The nurse (Lydia) is in a dilemma; attempting to nurse these patients in a respectful manner through acknowledging their need for privacy, however being unsure as to how she can provide this to them in the current circumstances. In this setting, the need for control offered in the form of observation exemplifies good nursing care.

I knock for all of them [adolescent patients] and say I'm coming in ... can I come in. whatever ... but for the anorexics I knock on the door and I say you've got three seconds and I'm coming in One, two, three, and I open the door ... (De'Anne).

De'Anne does not appear to share the same internal conflict as Lydia when nursing these patients. De'Anne labels such patients as *Anorexics* stripping them of any other identity

other than anorexic. She uses her nursing position to act in an authoritarian manner where the patient has no privacy or rights. De'Anne's strategy is control; she takes on a regulating role that dehumanises the patients and herself. Unbeknown to nursing staff like De'Anne, they are caught up in apparatus such as the *medical gaze* constructing the body in medico-scientific terms and objectifying the patients they are caring for. De'Anne's actions also reveal how nurses rely on elements of regulation and control to perform their nursing; allowing surveillance to become permanent in its effect.[7]

De'Anne's and Lydia's behaviours are examples of how they undertake surveillance in different ways. The methods they use evoke different feelings and they position themselves differently, however they are focused on the same outcome, the control and regulation of the patient. The AN patient body is regulated and controlled in this environment, and this form of control of the patient due to their label has become acceptable behaviour for nurses on this ward.

Both patients diagnosed with AN and CF are adolescents with an illness; however one illness is afforded privacy, the other is not. The rationale for this is founded on the belief that the patient diagnosed with AN requires closer observation. Here the label given to the patient is explicit in its intent: these patients need to be seen to be safe. The other type of patient group, the patient with CF, is by comparison considered safe and trustworthy. They are able to venture out of their room when they are 'well and happy'; the patient labelled as AN is neither afforded that luxury, nor opportunity.

The labelling affect is two-sided; patients also begin to respond to their surveillance.

[curtains] nurses always open them up, they think oh yeah an anorexic patient always doing something in her room... (Sonja; patient).

Sonja is aware that she is labelled as being unsafe. This awareness enables her to recognise that when she closes the curtain around her bed space there is a high likelihood that they will be reopened again.

Surveillance has an impact on the behaviour of the patient, who will still close the curtain to gain some privacy knowing that this privacy will be short-lived. Sonja was aware of why she was being observed, and that it was directly linked to her diagnosis; nonetheless, she did what she could to be private, and to this end the closing of the curtain as her main tool. Continuous surveillance such as this has an homogenising effect, that is internalised power, so in the end, patients govern themselves depending on structures, discourses, and histories surrounding them.[6]

## Allocation

As well as observation the effects of labelling are apparent spatially in patient care through the mechanism of patient allocation. For example, patients were located on the ward due to their diagnosis; patients diagnosed with AN are allocated rooms close to the nurses station where they can be easily observed, whereas long term chronically ill patients, such as those with CF are allocated rooms away from high traffic areas.

Patients newly diagnosed with an eating disorder (AN) are allocated into two-bedded rooms, next to the nursing station when they are first admitted and unknown to the ward. Once their condition has been stabilised these patients are then allocated to the four-bedded bay closest to the nursing station (Observation 36).

As well as implications for allocation, patients are expected to adhere to structured routines whereby staff 'know where they should be' at any given time. Patients admitted with an initial diagnosis of AN are expected to adhere to a Five-step Level Program (Ward AN Guidelines). Patients are governed through this structure where written routines and codes of behaviour are expected to be followed.

To encourage positive role modelling and the normalisation of eating, nursing staff will remain in the dining room to encourage normal eating patterns and to supervise the meal (Ward AN Guidelines).

General ward guidelines are also used to govern these patients, further serving to assist nurses in objectifying those with AN.

The ward CF booklet contains similar information to the general ward information sheet. It also contains a few patient specific features for this diagnostic grouping, such as lung function tests and goals for each admission (Ward CF Guidelines). The opening line of the brochure says: '*As an adolescent with Cystic Fibrosis you have a lot of experience and knowledge about CF and hospital*' (Ward CF guidelines). Interestingly patients diagnosed with AN are also a group that have a great deal of experience and knowledge in the hospital however, the 5-step program that is issued to them does not acknowledge that they may have been in the ward before; nor does it acknowledge that they may have prior experience of hospital. The introductory paragraph states;

The program consists of a "Level system" which is loosely based on behaviour modification philosophy (...) The 5 Levels are clearly defined, documented and communicated to the patient and family. All patients are admitted at Level 1 or 2. Progression through the Levels will be based on a combination of weight gain, improvement in eating habits, general compliance

with the program, improvement in psychological behaviours. Cooperation with the defined Levels optimises the achievements of a successful outcome (Ward AN Guidelines).

In fact when nurses did talk about the experience patients with AN, it was once again with negative connotations.

Eating disorder girls, I mean, quite often might go for syringes and things like that to tamper with tubes and things ... (Sue).

Nurses are left to interpret and thereby control patients through allocation and written guidelines. Codes such as written guidelines are then used to guide and interpret care. In this way guidelines are similar to diagnosis, in that they are used to control and classify patients as groups and not as individuals.[2,6,7] The form of knowledge and action that can occur in the ward is made operational and institutional through the combined power of labelling, guidelines and allocation.[6,7] So, through allocation, nurses are not just controlling patients and their space use, they are also announcing ways in which the ward operates. Moreover, Foucault<sup>7</sup> argues that rules and discipline organise individuals in space and require a specific enclosure in space[7] such as the adolescent ward.

Objectification of the human body through guidelines, routines and allocating the patient in specific ways serves as a form of normalisation indicating how the patient should behave.[8] Nurses felt concerned that they needed to supervise patients with AN thereby allocating them to bedrooms close to the nurses' station

Both groups of patients groups of patients with a diagnosis of either CF, or AN, are well known to the nurses on the ward. Both AN, and CF, are chronic conditions that require re-admissions to hospital. However, those with AN are not talked about as though they are chronically ill, instead they are labelled as 'psychiatric patients' with all that label adds to their first diagnosis.

I think especially the chronically ill kids, more thinking of your cystic fibrosis the families aren't going to be there all the time. Umm, especially at the time that they are starting to learn about their illness and things like that that you actually become... not like a mother to them but more of a, more than just being a nurse to them, 'cause they see you so much... so you become important to them. ... the chronic illness kids actually go to you with more personal things... (Rebecca).

Nurses say there are patients that can be left alone and others that cannot. Patients who have a diagnosis of CF do not need to be seen, thus they are given the 'safe' tag, and in addition to privacy they are afforded the privilege of entering nursing

spaces even though they are patients.

I used to hang out and just sit out at the nurse's station with them, like, especially like on night shifts and stuff. We used to stay up really late (Alice; patient).

CF is a genetic disorder, leading to an excessive production of mucous, affecting many organs, including the lungs leading to multiple chest infections, and frequent hospital admissions. Even if these patients are well they still require to be admitted to hospital for a fortnight twice a year (referred to as a 'tune-up'). The assumptions attached to this diagnosis are linked to the notion that they are accustomed to hospitalisations during the course of their lives due to the recurrent nature of their disease. Due to the regular admissions of these patients, they are seen as familiar and trustworthy, therefore they are admitted into nursing spaces and are not deemed to be 'unsafe', so therefore warrant less observation. Patients who suffer from CF are given much more leeway as to which ward areas they enter compared to acute patients, or patients with AN.

Nurses have established long-term relationships with these patients, and make no reference to keeping medical patients safe. Nurses recognise, and give importance to these patients needing and getting time on their own — highlighting the difference in how these two cohorts are positioned. Patients with a diagnosis of AN are seen as culpable for their illness, they are not seen as 'victims of circumstance', but victims of their behaviour. Such a view encourages a less sympathetic position towards this group. These operations of power become self-fulfilling, perpetuating the ward ideology that these patients need strict enforcement of guidelines, and place allocation within the ward.

### *Patients "behaving badly"*

The range of practices that constitute and consequently condemn the individual to the status of the 'label' attributed to them, also enables the patient to behave in ways that confirm their treatment. Patients diagnosed with AN pushed the boundaries of their program by flaunting rules and avoiding surveillance in any way that they could.

Alex walks directly to the patient's bedside. Danielle is lying in bed. She is face down and has the covers over her. The bed is crumpled and the covers look weighty (like she has 3 or 4 blankets covering her).

Alex has Danielle's feed in her hand. (A gavage bag with a line is attached to a naso-gastric tube and is used to give enteral feeds through a naso-gastric tube). Alex walks around to the left side of Danielle's bed, and places the equipment in her hand on the bedside locker. Danielle has not moved. Alex pulls back the covers and looks for Danielle's nasogastric

tube so that she can connect the feed. She cannot find the tube. She asks the patient to move ...

“Danielle can you move?” says Alex.

Danielle moves her right shoulder off of the bed. Alex retrieves the naso-gastric tube. Alex lifts the fluid bag and places it on the IV pole next to the patient’s bed. She then connects the naso-gastric tube to the feed, and begins to gavage the feed.

Alex taps her feet as the feed goes in. Hands on hips, face and eyes looking upwards towards the ceiling. Danielle lays supine on the bed, face down. When the procedure is finished Alex packs up her equipment and leaves the room (Observation 11).

The behaviour of Danielle in avoiding the nurse’s gaze, and in not cooperating in her own care, led to a cementing of the punitive strategies that nurses employed. Danielle lies on her stomach and ensures that it is hard for the nurse to get to the naso-gastric tube. During the feed she does not speak, look up, or get up from her stomach. All of these acts are acts of resistance. This example shows that patients will react and respond to how they were nursed on the ward. Through pushing against the parameters of protocols, and rules and guidelines for care, patients with AN respond to the processes of labelling and to the label given to them. They are aware that nursing staff do not trust them, so they tend to act as if they have nothing to lose.

In addition, nurses claim that the patients with a diagnosis such as AN had a certain amount of knowledge about the hospital and their own illness. It appeared that nurses felt that patients would use this knowledge to jeopardise their own care and safety.

... we have found on occasions that patients go to the medical records and read their own files and you know, things that are kept behind the desk like scissors or anything along those lines then they have got easy access (Caitlin).

Patients on this ward have a tendency, especially the eating disorder patients, can’t go anywhere near the syringes are, or ... they like to have pockets full of them. They use them to aspirate their tubes ... or they finally, they figure it out they go to the umm treatment areas when we are not looking and get them from there (Helen).

Nurses feel that patients may use their knowledge of how the hospital works to undermine their safety while they are in hospital. This knowledge, coupled with perceptions of their illness, makes nurses claim that safety is their prime motivator in caring for these patients, and that surveillance is a necessary tool to ensure safe patient care. By labelling the patient with AN as ‘unsafe’ and treating them accordingly, nursing staff are unknowingly creating a situation for

themselves where surveillance and guidelines become major elements of caring for the patient with a diagnosis of AN.

In addition, as the patient is not always cooperative with nurses these actions put them more at odds with nursing staff. This tension and the need for surveillance affects how nurses nurse the patient. Such an operation reinforces and regulates actions of nursing staff, as well as acting as a form of justification.

In the ward environment, social evaluations were not overtly linked to any of the traits or variables that people were considered to possess because of their label. Rather, evaluations were more likely to come from a complex web of socially constructed influences showing how access to spaces, and placement in certain locations were not neutral in their effects.[7] How patients are cared for was set through practices of observation and objectification which enabled nurses to supervise and discipline their patients<sup>8</sup>. In this instance, past experience influences the label placed on the patient when they enter the hospital setting. This labelling or grouping of patients carried over from one admission to the next, so that each group of patients were in the main, categorised as one group, not as individual patients – either patients with AN or CF.[2,11]

## Discussion

By observing patients through the ‘filter of the diagnosis’, separate behavioural expectations were placed on each patient cohort, thus obscuring and de-individualising the patient.

Rosenberg asserts that

The use of ideal–typical disease pictures creates experience as well as conceptualising and recording it. The power of specific disease entities rests not in their ... abstract quality, but in their ability to acquire social texture and circumstantiality, to structure and legitimate practice patterns, to shape institutional decisions, and to determine the treatment of particular patients.[12 p250]

In this study of the organisation of care on an adolescent unit, more than the medical nature of patients’ illnesses impacts on the beliefs and actions of the nurse and influences and shapes how they treat the patient. Moreover, lack of knowledge about the nature of AN as an illness, creates a perceived notion of the need for greater level of surveillance. Nurses believed a greater level of surveillance and control would maintain safety of this group. These ideas were attached to the diagnosis and patients with this condition. Those patients with a diagnosis of AN were seen as always already

non-compliant to the rules of the unit and their treatment, whereas patients with a long-term medical illness, such as CF, were viewed as 'good', and rewarded accordingly.

May[2] says that patients tend to be classified and classed as groups and not as individuals, but Rosenberg[12] highlights how such groupings are used in the *ordering* of individuals. Such was the case for individual patients in this study. Young people were reacted to as though they were as 'one' with their diagnosis. If they had a diagnosis of AN, they needed to undertake much more work to show their willingness to comply with treatment if they were to escape such assumptions. However, patients with chronic illnesses such as CF, due to the very nature of their illness, were considered safe, and because of this were granted private time behind curtains by the nursing staff.

Situations were made difficult when nurses focussed on non-disease entities to classify and govern care to patients. When patients with a diagnosis of AN were nursed in a way that focused on their safety, nurses forgot the physical and emotional situation of these patients—to the detriment of their total care. The system of *visibility*[6] increased the possibility of non-compliance over and above the significance of all other symptoms or patient requirements. King and de Sales[13] claim that nurses focus on the control of actions of patients when their behaviour is not understandable to them. Furthermore, Muscari states that the "the development and maintenance of a therapeutic alliance [with patients with AN] is arduous and requires continuous effort".[14 p131] In this work, Lydia recognised this effort, whereas De'Anne did not. Nursing literature which condones a tumultuous relationship between patients and nurses does not focus on whether these patients will have effective health outcomes from their prescribed treatment. Ramjam looked at the establishment of the therapeutic relationship between nurses and patients with eating disorders. She found that there was a "tremendous need for education".[15 p501] for nurses who looked after EATING DISORDERS patients, and also suggests that the institutionalisation of adolescents with anorexia nervosa is a problem in and of itself.

Both of these above conditions seem to apply to the relations between nurses on this unit and patients who are diagnosed with AN. What is not clear from such statements is that the conditions speak only of outcomes (emotional, social and so on) for patients. It is our contention that these situations have consequences for nurses' understandings about themselves in such a setting. As labelling theories suggest attribution of value-laden characteristics occurs when patients fall outside of categories that are accepted generally as the norm.[15]

While Brown[16] emphasises an *interactionist* perspective, Foucault[7] presents a more nuanced and complex account for nurses **and** patients. These analyses propose that visibilities and power are used to locate, control and affirm a point of view once a category becomes overlaid with more than its disease characteristics. These activities affect the nurses and patients in such a setting having circumstantiality as to what counts as appropriate behaviour for both sets of actors. Moreover, it can be shown that the way in which the ward is organised and its spaces used is directly traceable to how a condition is socially textured.[12]

Hugman[17] states that it is quite a common phenomenon for patients to be treated differently by nursing staff if they feel that the patient is responsible for their own illness. He also claims that the most *indirect* forms of control in the caring professions are the most effective. Differentiation of patients is one of the mechanisms of control that has become ingrained in the daily practice of the nursing staff.[17] Latimer[9] asserts that classification practices, using the nursing gaze and enforcement of boundaries use and reinforce social systems of the wider society within the microcosm of the ward. The organisation of ward spaces, and access to valued locations and 'privacy' that is provided on the adolescent ward of this study are undertaken through the operation of a set of treatment technologies and protocols. These reductionist guidelines when applied to a ward and its inhabitants fit such technologies imperfectly as the patients' and nurses' needs are more 'holistic, multidimensional, and contingent'. [12 p252] It is clear that where value judgements are added to these seemingly objective technologies, conflict between staff and patients is an unintended consequence, as well as the stigmatising of people who must live with such a label. Where a patient is considered more deserving because the condition is not 'their' fault, time, space and opportunity are 'bent' to humanise any such technology, through, for example, admission into nursing areas.

## Conclusion

This paper has shown how the act of labelling impacts on both the patient and nurses. Apparatuses such as labelling and space allocation can transform a therapeutic relationship to one where the concept of 'safety' augments and overlays the naming of a disease entity. Levels of surveillance and potentials for visibility are caught up in the socially-derived value judgements used by nurses and account for how a ward is organised. The paradox of using *singular* labels and *reductionist* care regimens when a patient's care requires *holistic, multidimensional* and *contingent* practices led to

the nurses being in a quandary as to how best to deal with organisational stringencies. In such a situation they resort to following and enforcing rules and regulations that in the end suit no-one—even those with a positive valuation.

Using a social constructionist approach to diagnosis, while affording a view of the contingent and socially derived nature of diagnosis and labelling, does not show how a ward as a space is cut through by such activities, and then used to legitimise the actions of health professionals and patients. A spatial analysis shows that patients can elude the specifications set by labelling and treatment regimes. It also shows how ineffectual labelling technologies are for controlling. When labels and their regimes rub up against the individual patient and nurse, they disclose how the treatment spaces constructed for visibility hide just as much as they make visible. Labels for disease entities have a long history of organising medical and nursing work, however, they also hide the individual experience of the illness under their taxonomies.

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