Title: Making body work sequences visible: an ethnographic study of acute orthopaedic hospital wards

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Abstract: Within health and social care, academic attention is increasingly paid to understanding the nature and centrality of body work. Relatively little is known about how and where body work specifically fits into the wider work relations that produce it in healthcare settings. We draw on ethnographic observations of staff practice in three National Health Service acute hospital wards in the United Kingdom to make visible the micro-processes of patient care sequences including both body work and the work contextualising and supporting it. Our data, produced in 2015, show body work interactions in acute care to be critically embedded within a context of initiating, preparing, moving, and restoring and proceeding. Shades of privacy and objectification of the body are present throughout these sequences. Whilst accomplishing tasks away from the physical body, staff members must also maintain physical and cognitive work focussed on producing body work. Thus, patient care is necessarily complex, requiring much staff time and energy to deliver it. We argue that by making visible the micro-processes that hospital patient care depends on, including both body work and the work sequences supporting it, the complex physical and cognitive workload required to deliver care can be better recognised.

Introduction

This paper examines acute hospital care practices to make visible work sequences intertwined with body work. We draw on observational data generated in acute orthopaedic wards during the PERFECTED Programme, a study about hip fracture and cognitive impairment. Observations in these spaces where older bodies are physically and, in many cases, cognitively vulnerable provided a vehicle through which to explore how body work sequences and micro-processes were enacted. We draw on our data to examine and map the micro-processes supporting body work in acute care. Sequences of work included initiating, preparing, moving, and restoring and proceeding work. To enable policy to fit to practice, there is a need for more intricate understandings of the work underlying the delivery of care (Hansen and Grosen 2019). Through making visible the sequences in which body work takes place we can better understand the nature of the work underlying face-to-face patient care. This work is necessarily complex, requiring physical and cognitive staff resource to deliver. Therefore, a nuanced understanding of the micro-processes underlying day-to-day care, often overlooked in policy arenas, enables better recognition of resource need and staff workloads. Body work micro-processes are legitimate to examine since they bring to the fore the skills and multifaceted work processes undertaken by frontline staff, which shape working practices and patient experience. We draw on notions of objectivity and privacy in care as we make visible the micro-processes of body work sequences.

Body work is defined as “work that focuses directly on the bodies of others, who thereby become the object of the worker’s labour” and described as being “practised on both an

object and a subject and … involves both a knowledge of the materiality of the body and an awareness of the personhood that is present in that body" (Twigg et al 2011[a], pg173-4; Twigg et al 2011[b], pg2). Theorising body work in this way has been instrumental in directing focus towards how the body is experienced from within working relations (Wolkowitz 2002) and how societal expectations are reflected in the nature of embodied work (Wolkowitz 2006). This focus has enabled power dynamics involved in body work to be identified and examined (Twigg et al 2011b), including marked gender and racial inequalities in the labour force (Cohen and Wolkowitz 2018; Twigg 2004). This brings to the fore the way in which complexities in the materiality of body work are ignored politically, for example with responsibility for suboptimal care conferred onto care workers as opposed to acknowledging policy issues such as a lack of resources (Cohen and Wolkowitz 2018).

Body work is work conducted on a body by another embodied actor (Gale 2011). Such work can be emotive (Gimlin 2007), labour intensive, and difficult to standardise due to the unpredictable and often unexplicated nature of bodies' manifestations, activities and involvement in experiences, interactions and discourses (Cohen 2011). Where a person works on others' bodies, their work may lead to those bodies being treated only as types of objects ("objectification") or recognised as being linked to ("incorporated") personal experiences through which to engage with people as more than bodies (Gross 2012). For example, pharmacists have been found to look at bodies with a "pharmacy gaze", which combines a public health lens with a risk lens (Jamie 2014). Objectification of patients' bodies contrasts with notions of person-centred care where attending to the subject is foregrounded (Brooker 2004). However, people can fluctuate between objectifying the body and seeing the subjective person (Gross 2012). Attending to the body as subject and object requires staff to be attuned to how each person experiences their own body and illness (Slatman and Widdershoven 2015). Within this dynamic, co-operative recipient-practitioner relationships can also enable body work to be experienced as positive and perhaps thereby good care (England and Dyck 2011; Mol 2008). Body work sits within a complex socio-practice context, where staff have to encounter the body as an object whilst also engaging with it co-operatively as a subject.

Hospital wards provide distinct settings for body work. Here nurses and other hospital staff take on important roles in navigating the physical and social complexities of dealing with bodies and their care and treatment (Lawler 1991). This work conforms to notions of public and private bodily actions and care. Often the nature of such work constitutes managing the aspects of bodily care that are deemed unpalatable, needing to be private, hidden and avoided to prevent uncomfortable encounters (Lawton 1998). Staff working closest to unpalatable bodily actions are often those less qualified and with low power (Twigg et al 2011 [b]) reflecting divisions of labour in body work (England and Dyck 2011).

Acute hospital staff face shifting situations requiring them to co-ordinate different mind-sets, knowledge, goals and skills. Potential conflicts for staff can include maintaining patient safety, keeping up with work, and eliciting patient and family approval (Ebright et al 2003). In acute care, work is complex with nurses juggling both direct and indirect care with non-patient activities (Swiger et al 2016). Nurses often think about patient care processes beyond physical

involvement with their patient (Potter et al 2005). This sequencing of staff thoughts and actions preceding, during and following body work is important to examine, as a way to bring in to focus key micro-actions that shape working practices. Focus on body work as part of a sequence has enabled previous studies to illuminate co-ordination between team members' actions, positioning of workers' own bodies, the order of activities, and the social organisation of the work sequence (Moreira 2004; Hindmarsh and Pilnick 2007).

Observational research examining body work has been scarce due to the intimacy of interactions and the lower status of staff members usually associated with it (Twigg et al 2011[b]). Institutional ethnography offers an approach for examining the complexities in enacting and delivering body work and associated actions in the acute hospital ward; the setting in which nurses and other healthcare staff operate. This method of inquiry is concerned with making visible everyday 'ordinary' work actions, which are less frequently given explicit attention as work practices (Smith 2003; 2005). It can produce descriptions of what is relevant in practice, 'mapping' actions undertaken, and so critically clarifying the processes and forces in operation (Devault 2006). Institutional ethnography provides a means to uncover how those working within frontline institutions deal with the pressures they are required to manage to deliver institutional requirements, devised and set out by others and so, in presenting and managing social relations (Smith 2005). We used this approach to examine micro-processes as a way to understand how body work sequences are enacted in acute hospital wards, thereby illuminating the complex work necessary to underpin frontline hospital care.

Methods

The study and its context

The analysis reported here draws on an ethnographic observational study, part of a wider programme of research aiming to improve acute orthopaedic hospital care for older patients with a hip fracture and cognitive impairment; the PERFECTED Programme. The ethnographic study aimed to understand the day-to-day work of staff on acute orthopaedic wards. The analysis set out here examined the everyday work of ward staff as a means to access their experiences when negotiating organisation-led requirements (Campbell 1998) specifically relating to work sequences involving body work.

Observations focussed on staff practices in the shared spaces of the ward excluding behind-curtain care of patients. The study was reviewed and approved by the National Research Ethics Service Committee East Midlands-Leicester (reference: 14/EM/1020).

Study settings

Ethnographic observations were undertaken in acute orthopaedic wards in three National Health Service (NHS) hospitals. Hospital selection was purposive; located in different regions of England (see Table 1).

Table 1: Characteristics of study wards

Ward	Number of beds in ward	Region in England	Staff participants (Total n=423)
A	36	East Anglia	166
B	28	Midlands	121
C	28	Yorkshire	136

Participants and the consenting process

We recruited staff working on the study wards as participants. These included both ward-based NHS staff: nurses, healthcare assistants (HCAs), physiotherapists, occupational therapists, and doctors who provided orthopaedic hospital care and non-ward-based staff: speech and language therapists, ortho-geriatricians, geriatricians, orthopaedic surgeons, porters, anaesthetists and social workers. To recruit staff research nurses provided staff members with study information sheets and once 75 percent of the ward staff had consented the ward became a 'research ward'. We continued to recruit any staff encountered on the wards. Patients and visitors were informed about the study via posters and information leaflets placed prominently on the ward. Our focus on staff actions meant patients and visitors were not consented and no personal information was documented about them in the observation notes. In all, 423 participants consented to participate, eight declined. No observation notes were written regarding staff members who had declined to take part. No participant is named in this article.

Data collection

Observations (204 hours) took place during 48 sessions (generally of 4 hours duration) between Sept-Dec 2015. Observations took place on all seven days of the week and covered all 24 hours over four weeks at each hospital site. Observers were five health research associates and three lay researchers who had had experience of being carers for people with dementia through an acute hospital stay. Lay co-researchers had an experiential lens from which to view the activities on the ward, enhancing the variety of actions noted in the recorded dataset. Lay co-researchers received training and were always accompanied by a research associate whilst observing, with a debriefing discussion taking place after each observation. The observers took a 'marginal' role (Hammersley and Atkinson 1995) as overt and non-participant observers. *Ad-hoc* ethnographic brief interviews with staff in the hospital wards helped researchers to make sense of their observations. Detailed field notes were written in full view of participants whilst observing. These were typed and anonymised as soon as possible after each observation.

Analysis

An abductive approach (a creative inferential process involving repeatedly moving back and forth between observations and theoretical concepts) was used to analyse these data (Tavory and Timmermans 2014). The typed notes were read by six members of the research team (NL, AV, TB, SH, JC, FP) who discussed initial physical themes (things and actions clearly evident in the wards such as, paperwork, clothing, telephones and sleep) and theoretical themes (such

as ‘disjunctures’ (forthcoming)) until consensus was reached. Observation notes were then uploaded to NVivo11 and coded by two researchers (AV and TB) to the agreed 21 physical themes. These data were then interrogated and coded to theoretical themes. Despite not observing behind curtain care, our data included aspects of front of curtain body work and partial information of behind curtain body work such as how it was managed, conversations and timings. Researchers had noticed that many staff interactions with patients on the ward linked with actions preceding and following them. Therefore, for the analysis presented here, ten of the physical themes (alarms, communication, equipment, meals, medications, patient movement, physical environment, sleep, time, and toileting) were re-examined by researcher (TB) in relation to body work and actions preceding and following interactions. Emergent themes were discussed and refined with the wider research team enabling the identification of a general sequence related to body work in acute orthopaedic wards.

Findings

Body work sequences in the acute ward

Data revealed complex interconnected sequences of body work. The body work interface (staff physically or socially in contact with the patient’s body as a subject and/or an object) relied on a wider system of essential work undertaken separate to the body, but which underpinned interactions with it. As Figure 1 shows, sequences generally started with an initiation of body work, then staff members preparing for body work, moving to body work, before completing by conducting restoring and proceeding work. Sequences involved staff or patients themselves moving the body and discussing body work and actions to ensure safety throughout. A sequence was manifested to some extent for each distinct instance of body work.

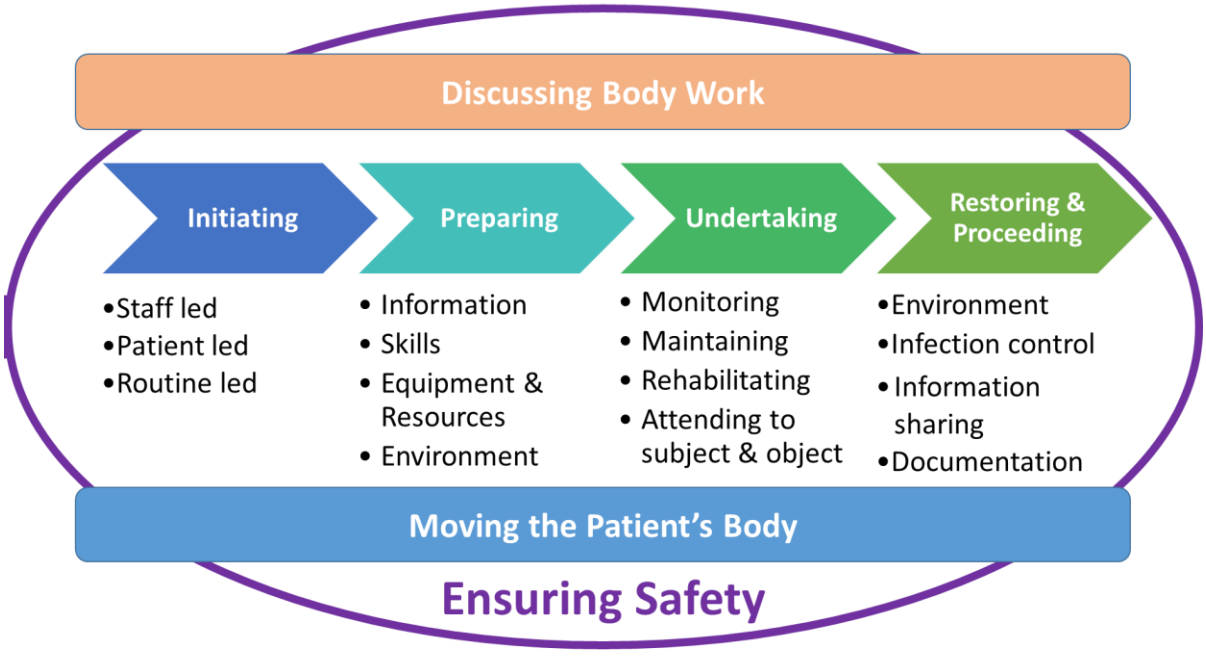

Figure 1: Model of Body Work Sequences with Patients in the Acute Ward

Initiating body work

Body work actions were often initiated by staff, less frequently by patients. Staff initiated body work by noticing a patient they perceived as in need of intervention and reacting to it or having the task included within their role or responsibilities.

> *HCA 1 and 2 are both going around together with the Kylie* [bed protection sheet] *trolley and laundry skip bin. They were toileting patients. HCA2 says "If I had a penny for every time I do all 40 patients, I'd be rich". HCA1 says "Start with patient1B and go round" … They both go behind patient1B's curtains.* (Researcher 3, Ward A, Evening)

Here the HCAs were required to be responsible for toileting all patients, so were navigating this requirement by moving from one patient to the next and initiating a body work interaction. This excerpt reflects the objectification of patients' bodies, where staff members viewed bodies as objects of focus for a specific task to be moved on from when completed. Even though curtains were in use, privacy was diminished due to the prominence of specific equipment and staff-staff conversation enabling observers to be aware of the type of body work action being undertaken.

Patients initiated body work in three ways: by using the alarm system, calling out or asking for help, or through situational factors, such as pointing out a risk or other obvious need for intervention. This example illustrates a typical situational factor:

> *Nurse calls to HCA for assistance in moving Green(4)* [patient in green bay, bed 4] *who is falling out of bed* (Researcher 1, Ward A, Night)

Often when patients initiated body work, it was in connection with their physical bodily needs such as toileting or to be made comfortable. Patients initiating such activities provided key examples of the work required of patients to let staff know of their needs. This also illustrates the way(s) in which patients could have some power in shaping the order and content of work for staff on the ward.

The routine of the acute ward initiated many body work actions. The routine was driven by set time-linked actions in the 24-hour day. For example, this included mealtimes, medication rounds, staff shift patterns, and ward rounds conducted by doctors and consultants. These time-linked actions led to tasks such as washing, dressing and toileting also being routinised, to fit in with the other set actions. Due to the high needs of patients on the acute wards, staff would regularly undertake "patient observations" of bodily functioning (including monitoring patients' temperature, breathing, blood pressure), along with regular turning of patients to prevent pressure ulcers.

> *I am told that usually obs* [patient observations] *are taken at 6am; 10am; 2pm; 6pm and 10pm unless the patient is on different obs. For example, patients quite a few days post-op may be on twelve hourly obs* (Researcher 2, Ward B, Morning)

Usual care meant staff had to concurrently navigate different patient routines for each individual, as well as wider, more generic, ward routines. Routine-led actions often demonstrated a marked prioritisation of the objective biomedical body over the subjective

body. Staff worked to deliver the care or actions deemed necessary at the time, whereas patients had limited control over the type or timing of bodily care they would receive. For body work to occur, some form of initiation of the action needed to happen.

Preparing for body work

Preparation work took place before body work occurred, either before or after initiating it. Staff often needed to access relevant information before they could act. This included information about the body as an object (such as, blood test results, urine output level, current mobility level), but also as subject (such as, likes, dislikes, possibility of resistance-to-care). Oral and documentary information were key drivers of staff actions. This excerpt describes a significant document informing frontline staff:

> *Nursing Handover notes: This is the key piece of paper that nurses, HCAs, O.Ts and Physios carry around folded up and in their pockets and I see it being regularly taken out and referred to … It contains information on medical conditions, care needed, … discharge situation* (Researcher 2, Ward A, Afternoon)

Handover notes were used throughout shifts to orientate staff to each patient's circumstances before a body work interaction; they supplemented the face-to-face handovers in which discussions of patients also passed on key information between staff. These mechanisms of arming staff with necessary information about patients worked to enable staff to approach body work interactions in an appropriate way, addressing the body as an object and/or subject as deemed necessary.

Staff members with the right skills were needed to be available to complete body work actions:

> *Bed6 asks the pharmacist for help. The pharmacist explains that he cannot help and will go and get a nurse ... The pharmacist tells a HCA that the patient needs help … "I'm a pharmacist but he is asking for someone"* (Researcher 2, Ward A, Evening)

Here, the pharmacist passes the patient's expressed need on to the HCA showing that even though staff may be available, clear divisions of labour were present and linked to different bodily responsibilities. For example, nurses and HCA's, and not pharmacists, were linked to toileting actions.

Considerable work was required to ensure everything necessary for the body work was in place prior to starting interactions. Although required equipment was usually available nearby on the ward, each item needed for the specific body work instance was collected by staff and repositioned close to the patient whilst preparing.

> *The Senior Nurse and HCA2 are getting ready to go into the patient in the side room … They wheel the Trolley* [full of supplies such as sheets, incontinence pads, Kylies] *to the side room to make things easier for them. The Senior Nurse says, "I think I'll get a big bowl of water"* (Researcher 3, Ward A, Evening)

Here a senior nurse was preparing to engage in washing a patient with an HCA, work that was often undertaken by more junior staff members. This was an unscheduled wash due to an

episode of diarrhoea so may explain their involvement. During preparation for the body work interaction the nurse's focus was on the body as a physical object and the equipment needed to wash it and leave it clean. This objectification of the body when away from the body and preparing for body work was common to many staff roles. Use of side rooms, as in this example, offered more privacy for patients whilst also providing opportunities for staff to control microbial infections and/or offer a space for patients who were perceived as disrupting the harmony in a bay.

Staff also either prepared the environment ready for the body work task or moved the person bodily to the setting where body work would take place. Often in the bays in the acute wards, preparing the environment was in the form of moving tables out of the way and/or drawing the curtains around the patient's bed. Curtains created some privacy for body work however this was only privacy in visual terms, since observers and those in adjoining bays could still hear body work being undertaken.

> *From another bay I can hear a loud conversation between a patient and a staff member from behind a curtain … "Let me look at your bum, it looks alright, those are nice slippers."* (Researcher 2, Ward A, Evening)

Of note, during this body work interaction the staff member was both objectifying and de-objectifying the body by engaging the subjective body in conversation first about their 'bum' and then their 'slippers'. In addition to sounds escaping, curtains did not always fully conceal the patient.

> *Bed4 is behind a curtain but I can see the patient's leg hanging off the bed.* (Researcher 2, Ward C, Night)

The privacy created by curtains only imposed restrictions on staff in particular roles from entering. For example, HCAs and nurses would move in and out of the curtains either to assist with body work or to communicate with the staff members within the 'private' area. Occasionally staff in other roles would violate the privacy of the curtain, as this excerpt shows:

> *A Porter arrives on the bay, he pokes his head in curtains of patient2 "ultrasound" the staff member in the curtains says "okay". The Porter locates the patient's notes and speaks on a walkie-talkie "yeah, just a few minutes delay while they get the patient into bed"* (Researcher 3, Ward A)

Here the porter (staff member with the right skills for the job) was ready for the next body work task, moving the patient to a new setting, but was having to wait for the patient to be ready. Moving bodies to a setting where body work could take place was both a form of preparation for the main care interaction and of body work. Breaching the closed curtains and relaying the delay to a colleague indicates the organisational drive for efficient working. It also demonstrates the fragility of privacy in the ward space, where people with more power than the patient can override the measures in place should they wish. One ward had a sign on curtains to maximise and further enforce the privacy of the curtained-off area.

…curtains are closed with a big red sign – "care in progress please do not enter". (Researcher 1, Ward C)

While this sign may have increased privacy by reducing interruptions behind the curtain, conversely it also publicly and explicitly drew attention to the private body work going on behind the curtain. Usually the boundary of the curtain was respected by those in staff roles not needing to go behind them and also visitors to the ward. Therefore, curtains generally played a key role in allowing staff members to create a (semi)private environment for body work in communal bays. This was not an issue observed with side rooms. Preparing for body work was always apparent in some capacity before body work happened.

Undertaking body work

Body work interactions required ward staff to attend to both the subjective and objective body. However, often the body as a physical object was the main focus driving much of the enacted work. Such body work involved monitoring, maintaining or rehabilitating the body.

Monitoring the body as an object was given prime importance for and by staff in medical observations. Monitoring work included a variety of tests of physical function assessments, such as measuring bodily inputs, outputs and temperature, and checking skin integrity, blood pressure and blood sugar levels.

HCA2 is checking blood sugars with the machine, she is currently at patient 6B … HCA2 says "I'll be ever so quick [name]" "Can I pinch one of these fingers?" (Researcher 3, Ward A, Evening)

While focussed on gathering information from the physical body to enable monitoring, staff often also attended to the subjective body to make the encounter palatable to the patient. However, interaction with the person was not optional for some encounters, such as pricking fingers to obtain blood samples.

Body work to maintain the body was enacted in providing food or medicine, toileting activities, or keeping the body clean and hygienic. These specific actions were directed at physically preserving and sustaining the body in a healthy and comfortable state.

From behind the curtain I hear a patient scream … There are two HCAs in there changing her [incontinence] *pad and getting her ready for the night. ..They give the patient reassurance "You're doing ever so well." and orientation "it's 10 o'clock now."* (Researcher 2, Ward A, Evening)

Of note, activities such as checking catheter outputs and taking blood sugar samples and indeed most medication administration took place in front of curtains, whereas injections, toileting, and washing took place behind curtains. The last of these excerpts shows that attending to the body as an object during body work tasks facilitated the subject to be attended to, or engaged, as well. This dual focus from staff was very often the case. Key examples of involvement were seen when staff offered a choice involving their interpersonal engagement to the patient via verbal or non-verbal communication, or through touch.

Physical body work tasks provided prime opportunities for staff members to attend to the subject, since they were in close proximity to them. However, the role of the subjective body in the body work encounter was variable over time, place, occasions and activities. For example, sometimes staff carried out care-tasks when the subject was asleep:

> *Patients are then repositioned at 12 and 4 and their incontinence pads checked. The HCA explains that repositioning is done by a pillow being placed under the one side of a patient's bottom and then being moved to the other side when repositioned. They try to do this as much as possible without waking the patient.* (Researcher 2, Ward A, Evening)

Here, staff routinely undertook maintenance work throughout the night to prevent a breakdown in skin integrity and potential pressure ulcers. This, sometimes covert, work was focussed primarily on maintaining the physical body, indicating the priority of safety and accountability factors on the ward over those of potential patient choice. The possibility of disturbing sleep was deemed a risk worth taking for these types of body work, in this case preventative treatment. However, covert care, without waking patients, could be viewed as benefitting the objective and subjective body in terms of sleep quality. Patients had little or no power over what would be done to their body while they were sleeping, reflecting a low status in the ward dynamic. Patients' agency in body work encounters was sometimes manifest:

> Handover excerpt: *Patient is refusing to do anything with the physios, even stand. "There is no reasoning with her." The patient has* [mental] *capacity … If there is no improvement by Monday they will "checklist" her (do a continuing care assessment).* (Researcher 2, Ward A, Morning)

Here a patient was exerting their power, since the patient's views were counter to the staff view staff appear to discount this agency to refuse assistance and re-interpret it as non-compliance. Staff raise the issue of mental capacity in relation to the patient, indicating one of the legal frameworks within which they have to work. For example, if a patient has mental capacity to consent to treatment or not, staff legally have to respect their right to make an unwise decision (Mental Capacity Act 2005) although they may not agree with it. This 'non-compliance' could be viewed as patient resistance to the power status of staff. It shows body work as being inhibited or facilitated by patient compliance and in some cases legal frameworks. In other instances, staff members requested patients' input by offering them choices:

> *I hear HCA2 in the Y Bay with a patient "we're going to put you on your side to take the pressure off your bottom. Which side would you like?"* (Researcher 3, Ward A, Evening)

At times, body work provided opportunities for staff to allow patients some agency over the interaction. This recognition of the subjective body was one way in which staff could enable personhood. However, the choice here was over which side rather than whether the care

took place or not, which seemingly was not a real choice. Sometimes, organisational circumstances worked against such choices being offered to patients:

> *The patient has not been got out of bed because they have been short staffed, but they* [the patient] *have been turned a lot* (Researcher 3, Ward A, Evening)

Organisational constraints had led to the body work being of a different nature than would usually have been the case. The subjective patient body had little control over this situation. Movement of the body as an object had occurred, which was the priority for staff given the circumstances.

Rehabilitating work was pervasive. Physiotherapists often led this work, but other staff members such as nurses and HCAs also facilitated it.

> *She* [staff nurse] *gives the patient her walking frame and instructs the patient to push down on the bed in order to stand up she advises her "this will tip if you push down on this"* (Researcher 2, Ward B, Morning)

Patients often undertook body work in collaboration with staff, particularly within rehabilitation activities. Here staff placed the onus on the patient to put effort into their own rehabilitation, requiring the physical and subjective body itself to carry out the work. This was a way of transferring some power to the patient and/or for staff to exert their power over the patient's own actions through some element of supervision.

Similarly, one frequent feature of body work that could also be seen as a transference of power over their own body work was staff setting the patient up with the task and leaving them to undertake it alone, for a period before staff would return.

> *An alarm goes off-RBay. The Student Nurse goes in with an apron and some gloves on. She comes out to get a "bottle" takes a bed pan in, draws the curtains and asks patient2R to "ring when you're done" The Student Nurse then washes her hands.* (Researcher 3, Ward A, Night)

Here the patient's bodily need was ascertainable by all present, even with the use of curtains. Instances of patients independently conducting their own body work following initial staff support were common. Body work interactions therefore varied in the amount of interaction with the subject and object depending on the task, the patient's ability, staff resource, time of day and many other diverse factors. Staff's monitoring, maintaining and rehabilitating work required them to meet organisational requirements and public expectations of attending to the objective and the subjective body, often simultaneously. A monitored, maintained and rehabilitated body was the ultimate goal of hospital care, with patient experience an indication of the quality of these actions.

Restoring and proceeding: returning to an inactive body work state and completing follow-on actions

After undertaking body work, staff worked to restore the previous state of a body, which may have been less active and to proceed with any follow-on actions. Restoring work was seen to focus on putting the environment back together, returning the body to its pre-body work

setting, putting away equipment, and/or infection control tasks. A new post-body work inactive state was created, where the patient could now be left alone for a period of time before initiating the next instance of body work. This process effectively removed the evidence that body work had occurred.

> *The curtain is pulled back from bed4 and nurse1 takes a full bed pan away* (Researcher 2, Ward B, Afternoon)

After (semi)private body work interactions were complete the body was considered acceptable for viewing again in the public area of the ward, so curtains were pulled back. It was acceptable to transport containers of bodily fluid through the public area, paradoxically signifying the body work task undertaken whilst also removing the evidence of it. Other restoring tasks included tidying actions:

> *HCA2 comes out of the Y Bay, she has turned the light off. She writes in some notes and puts the diabetic thing back in its box* (Researcher 3, Ward A, Night)

Returning the night environment to be darkened and equipment to its usual place were key restoring tasks.

Staff always returned the patient to a place of safety, for example their bed or chair. This body work was part of the interaction itself, but also the restoring work to position the body in a place they could be safely left post-body work.

> *HCA1 and Nurse1 assist patient2R to walk around the bed with a frame and get into the chair beside it. I hear "you're going into here" "hold onto this then" "take a few more steps" "few more steps 'name'" "in this seat"* (Researcher 3, Ward B)

This excerpt also demonstrates the expected contribution, via taking instructions, movement and/or rehabilitation work required, of the worked-on body itself within body work interactions.

Infection control was an integral part of restoring work, where staff often worked with objects and materials emerging from or linked to body work. Staff removed personal protective equipment, ensured the safe disposal of bodily fluids and/or contaminated equipment and washed their hands:

> *HCA2 comes out with a full bed pan and goes to the sluice … HCA2 washes her hands in the Bay and talks to Nurse2* (Researcher 3, Ward A, Night)

Staff were often observed restoring themselves to a clean state representing that of pre-body work. Restoration work was conducted publicly, showing all present that body work had taken place through the evidence being tidied away.

Once staff had completed restoring work they engaged in proceeding work. Proceeding work focussed on follow-on actions stemming from the body work task such as documenting what had been done, information-sharing with colleagues or sending samples off for testing. Staff particularly focussed on information sharing, which occurred in the form of writing notes, formal handovers, and informally updating key staff members.

> *I see a nurse entering data on the computer … she's updating the notes for all the blue and yellow patients in readiness for the 7pm hand-over of staff* (Researcher 1, Ward A, Afternoon)

Information was collated and prepared both to demonstrate body work actions that have taken place and to enable the staff following this shift, and beyond, to be able to equip themselves with necessary knowledge to conduct future body work appropriately (preparation work). Documentation was a key activity, since the organisation required evidence of actions undertaken.

> *Senior nurse … sits at the nurses' station, puts the swabs in envelopes, and writes in notes.* (Researcher 3, Ward C, Night)

Senior nurses mostly undertook indirect body work actions such as sending away samples in contrast to HCAs, whose labour was focussed largely on direct body work. Tasks such as sending samples off worked to move care forward, so that staff could find out information to further inform their care/treatment decisions in the following hours/days.

The working relations requiring staff to create the tidy post-body work body with all evidence of body work removed indicated that work on the body itself was viewed as something to be hidden once completed. However, conversely, proceeding work involved staff conducting follow-up actions demonstrating that body work had been undertaken, usually to enable knowledge to be gained or passed on to inform future body work. Therefore, physical traces of work conducted on the body were hidden with the body itself being 'cleaned' and made to fade into the background, whilst at the same time other types of work, such as record keeping and test results, ensured that a trace of the body work remained. Organisational requirements and legal frameworks that audit staff actions via documentary evidence may drive the heavy focus on documenting work, at least in part. However, the status of different types of work is apparent.

Discussion

We observed the everyday work of acute hospital orthopaedic ward staff as a way to access staff practices when negotiating organisation-led requirements in and around the encounter of body work. Our analysis has enabled the mapping of essential sequences surrounding and underpinning direct patient care in settings where broken bones, lack of mobility, and the need for physiotherapy makes them particularly body focussed. Undertaking body work requires initiating, preparing, and restoring/proceeding work, conditioned both by the nature of the bodily engagements needed and also organisational requirements. This process involves staff moving and discussing the body, and ensuring safety in their practices throughout. By attending to the micro-processes on which such hospital care depends, we have shown that body work was linked to multiple tasks not directly connected to the body itself but to the conditions of that work, both physical and organisational. Essential tasks supporting body work (such as assembling equipment, information and suitably skilled staff) are largely accomplished separately in time and place from the physical body. However, while carrying out such body-separated yet body-related working tasks, staff members' physical and cognitive focus nonetheless remains on producing body work (Potter et al 2005).

Identifying and understanding the sequences of essential work that underpin and support body work is important if we are to elicit a recognition from policy makers of the workload, including staff time and energy, required to deliver patient care.

In our data, objectification not only occurred during body work, but also prior to it and beyond it when staff were away from actual bodies. Ward staff worked within the constraints of organisational routines and procedures, which influence how body work was structured on the ward (Aveling et al 2016; Kerr 2013). Lack of resources, limited time, high workload and prioritising efficiency can lead staff to focus on tasks rather than relating with individuals (Cohen and Wolkowitz 2018; Armstrong et al 2009; Foner 1995). Relational experiences of staff and those they care for become lost in the drive for productivity and profit (Diamond 1992). In the acute ward context, the whole sequence of initiation, preparation, monitoring, maintaining, rehabilitating, restoring and proceeding work produced bodies as predominantly biomedical objects. Essential tasks, which underpin this biomedically-objectifying work perpetuate this view through staff continually monitoring, discussing and documenting bodily actions and indicators.

Although the aforementioned organisational factors were drivers of some objectification of the body in our data, other instances appeared to enable staff members to focus on key body work actions. For example, when staff considered the physical needs of the body or how to move it and when they provided care to patients who were asleep. Since staff-patient interactions were embedded into the work sequence, this allowed a focus on the body as an object at other times. Objectification of the body could have a function in frontline care; enabling staff to assess and conduct needed aspects of body work as they process the body. Staff delivering patient care may need to objectify the body to a certain extent to gain the perspective needed to conduct their work satisfactorily. Variation in the level of objectification seemed partly linked to the nature of each action undertaken. For example, when assembling necessary equipment staff seemed to focus mainly on what the objective body needed, whereas administering medications that followed a strictly documented process and engaged with the subjective body therefore required less objectification. In other body work encounters staff attended to the subject as well as the physical body. De-objectifying aspects of interactions such as offering choices and commenting on clothes, such as slippers, worked to engage the patient in the action and also allowed staff to attend to patients' personhood. Attending to the subjective and objective body are necessary aspects of patient care (Slatman and Widdershoven 2015; Gross 2012). As others have indicated (Wolkowitz 2002; Foner 1995), this dual focus from staff may demonstrate inherent tendencies for objectification in body work. In our data, when staff were away from the physical body objectification gained greater prominence.

Organisational systems mean that producing body work, can only cover one set of priorities in a plethora of practice requirements amongst everyday work. For body work encounters to occur, staff had to attend to essential actions, preceding and following the body work interaction. These were essential for the work to be accomplished and judged as fundamental in staff-patient and staff-staff interactions, but also in the context of organisational requirements of staff practices. An inherent tension is that while staff are attending to these

duties designated as essential, they are moved away from the physical body itself. This tension challenges the current narratives defining person-centred care as optimal, especially in dementia care (Brooker 2004). Our findings exposed other contradictions inherent in the provision of care. For example, "turns" to prevent pressure ulcers could disturb patients' sleep or constitute care without the patient's knowledge or re-confirmed consent. Here staff are navigating organisational demands of their roles, conducting body work to prevent potentially serious biomedical consequences on the physical body, but which in the moment may negatively affect subjective patient experience by disturbing sleep.

Our data problematised the notion of a clear boundary between public and private body work in the acute ward setting. Privacy of body work in this environment, even behind-curtain care, was often only semi-private with conversations and bodily noises still audible, allowing researchers (as well as others) to ascertain intimate and revealing insights. Other compromises of privacy included leaking smells, staff members transgressing the physical privacy boundaries and staff publicly preparing or restoring equipment clearly needed for 'messy' bodily tasks. Basins containing body fluids, although often covered, were unavoidably transported through the 'public' areas of the wards to sluice rooms, contradictorily undermining notions of privacy while in the very process of hiding away evidence of body work. Side rooms offered more privacy; closed doors reduced opportunities to observe, hear, or smell. Body work to be hidden was often physically and socially intimate in nature, exposing bodies and uncomfortable or messy bodily aspects; not deemed appropriate for public consumption (Lawton 1998; Lawler 1991). This was reflected in the regulated conditions of our research ethical permissions not to observe behind curtain care. Management of the unpalatable aspects of body work involving bodily outputs were difficult to keep private in the ward environment, particularly at bedsides in communal bay settings. Thus, ward environments and the practices undertaken in these contexts work to illuminate the public and private nature of body work. Publicly visible body work, such as medication administration (of tablets), mobilising or assisted eating, was judged to be commonly and socially acceptable, and conspicuously non-revealing of bodies.

Our study involved several researchers from differing backgrounds and a large number of observations across multiple days and times. However, we only examined practice in three acute orthopaedic hospital wards in England. Nevertheless, staff actions across the three wards had similar relations to the micro work sequences surrounding body work interactions. As the focus of our observations was usual routine care and not behind curtain care our findings offer specific and partial in-depth knowledge about body work processes, which nonetheless provide critical instances of what can constitute publicly performed 'usual care' and of 'routine pressures'. These establish the demands that staff must manage. The staff members we observed may not have been acting in the same ways they did when not observed, but the similarities recorded over time and across spaces and locations suggest otherwise.

Conclusions

Examining the micro-processes of patient care in acute hospital ward settings enabled us to make visible body work sequences. Body work relies on and is embedded within a context of

initiating, preparing, moving, and restoring and proceeding work. Differing levels of privacy and objectification of the body are present throughout these sequences. Whilst accomplishing tasks away from the physical body, staff members must also maintain physical and cognitive work focussed on producing body work. By making visible the micro-processes that acute hospital patient care depends on, including both body work and the work sequences supporting it, the complex physical and cognitive workload required to deliver care can be acknowledged. Recognition of the many intertwined actions necessary in the convoluted processes of patient care can usefully inform policy makers of the resources required in these settings. To improve the care interface, we need to engage with all underlying systems as vehicles for enacting change.

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