

NEGOTIATING ACCESS:

Practices of Inclusion and Exclusion in the
Performance of 'Real' Emergency Medicine

By

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Degree of Ph.D.

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Abstract

This ethnography examines how Accident and Emergency (A&E) operates as both threshold and gatekeeper. The study draws upon field work undertaken in the accident and emergency department of a major UK teaching hospital. Focussing on patients' and staffs' everyday practices and interactions, the study shows how, and in what moments, medical, administrative and cultural classifications are drawn upon to legitimate and contest different interests. The exploration of categorisation and classification practices is important, not only for a better understanding of A&E as a site in which access to important life chances are negotiated, but also for understanding more about the relations between medicine and socio-cultural classification, and the consequences for those enrolled in their re-making.

A&E is shown to be an important sociological site in which forms of knowledge, moral values and relations of power are produced. The thesis situates itself between a body of sociological research that focuses on medical practices as socially constructed, and that pays attention to how medicine re-produces socio-cultural classification, and a set of literatures that account for medicine as particular forms of knowledge. Building on an emergent tradition of research that extends and moves beyond this division, the thesis adopts a particular view of medical knowledge practice that is performative, existent in and through social relations, not only the social relations that occur between people and between people and materials, but also the relations that occur with other modes of ordering such as those produced through clinical governance guidelines.

The thesis shows how staff continually perform 'real' emergency medicine. 'Real' emergency medicine is shown to be produced in a number of different ways. It is often accounted for as purely clinical, and as a knowledge practice that relies upon a specific form of medical perception and clinical practice. However, in their accounts of those persons presenting at A&E who fall beyond the boundaries of the purely clinical, members help to accomplish what the 'real' is not. In other moments 'real' emergency medicine includes the organisation and rationing of resources through medical staffs' managing of clinical expertise. Finally, during processes of patient assessments 'real' emergency medicine can be accomplished through patient's own performance of good citizenship as they negotiate their access to health services. Thus, in developing 'accessing' as its central trope, the study shows how A&E as a critical site, is one in which medicine emerges as deeply implicated in mundane practices of social inclusion and exclusion.

STATEMENTS OF DECLARATION

This work has not previously been accepted in substance for any degree and is not concurrently submitted in candidature for any degree.

Signed *AE Diller*

Date *28-09-07*

This thesis is being submitted in partial fulfillment of the requirements for the degree of PhD

Signed *AE Diller*

Date *28-09-07*

This thesis is the result of my own independent work/investigation, except where otherwise stated. Other sources are acknowledged by explicit references.

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Chapter 1

Constructing the Site

Prelude

‘Each year, patients make over 15 million visits to Accident & Emergency (A&E) departments in the UK, and about 15% are admitted. A&E departments feel the pressure of the recent national yearly increase in rates of emergency hospital admissions. The increased workload and recruitment difficulties, particularly for junior doctors, place considerable strain on the A&E departments’ ability to maintain good quality of care. Older people are relatively frequent users of A&E departments, particularly the oldest old. Perhaps 20% of those over 85 years of age attend an A&E each year. About half of these attendances follow trauma (a fall or other accident), most of the remainder with illness. There is no convincing evidence that older people use A&E inappropriately, although social isolation is associated with an increased risk of attendance. The proportion of attendances, which could be classified as primary health care in type, is lower among older patients.’ (The British Geriatrics Society: 2001).

This thesis presents an ethnography of ‘Accident and Emergency’ (A&E) with a focus on the assessment, care and treatment of older people. A&E's significance as a political and symbolic space pertains to its ‘place’ in society. On the one hand, it is a site of ‘social’ or welfarist medicine, developed from the voluntary casualty hospitals of the 19th and early 20th centuries. As such it has a history of treating a city’s poor and working class sick and injured: a health service that is ‘open’ to all. On the other hand it is ‘a curious specialty’ because, unlike most medical specialties that originated from increasing sub-specialization, A&E evolved from the need to provide immediate and broad coverage of acute disease and injury across all body systems (Guly 2005).

A&E emerges in my study as a messy space, where people from all walks of life can cross paths and where no one kind or severity of medical condition is encountered. Significantly, the people who come in and out of A&E still include those more vulnerable members of the community: the poor, the homeless, those addicted to drugs or alcohol, prostitutes, self-harmers, the mentally ill, people suffering domestic violence, the frail elderly. On a Friday or Saturday night, the number and variety of people seeking help increases, arriving at the hospital doors on foot, in cabs, in cars, and by ambulance or sometimes police cars. Some people can be very drunk, stoned

or threatening. The needs of those who attend A&E are, as a consequence, also enormously diverse: with RTA's (Road Traffic Accidents) and other extreme cases being rushed through to the resuscitation rooms, passed those in the waiting areas. Indeed, I came to realise in my study that for many waiting is what A&E mainly consists of.

A&E thus can appear, at times, as a space for containing the mad, the bad and the sad. But, in a National Health Service under increasing strain, A&E is being reconstituted as a threshold, a site of access to medicine and treatment. In this view A&E is a place where people are 'sorted out', but not necessarily in terms of treatment and care for illness or injury. Rather, what seemed to me to be extraordinary energy, time and effort goes into people being ordered into categories of 'need' according to complex medical, administrative and socio-cultural systems of classification.

Thus while A&E staff have historically had problems with their status as belonging to a proper, that is well-defined, clinical specialty, in its alignment with trauma medicine and the constitution of emergency medicine as a specialty in its own right, accident and emergency seems to have been gradually increasing its professional status. This thesis shows that this status, that of 'real' emergency medicine as a specialty in its own right, is the precarious accomplishment of the minute and complex day to day work of people interacting in A&E. Critically, what the study shows is that what gets abandoned in this work of accomplishing 'real' emergency medicine, is the notion of the hospital as a community service that can provide shelter and care to the poor, or where treatment and welfare provision can be offered to those who have limited possibilities to seek help. Indeed, the particular A&E department under study, as part of a hospital striving to be a 'centre(s) for excellence' (Vetter 1995), emerges as a space for the performance of expert clinical work that seems to involve excluding traditional notions of social medicine and marginalising any expression of community responsibility. On the contrary anyone except the visibly critically ill or injured is taught that they should 'sort' themselves out.

Introduction to the Thesis

This chapter introduces the thesis through establishing A&E as a ‘critical case’. In addition to providing a brief overview of the thesis’ main content, some context for the research is offered through a biography of the research questions. These are followed by an account of the study’s analytical framework. This study explores the complex categorical work involved in medical practice and decision making in an Accident and Emergency (A&E) department and asks: what specifically does this work accomplish? The organisation of medical work is analysed as a means with which practitioners within A&E align themselves to, and reproduce particular classification systems or modes of ordering that enable them to achieve and perform identity. The contribution offered by this work is in showing the complex negotiations that occur between those working in A&E and the attending patients and how these negotiations produce ‘real’ emergency medicine.

A&E is shown to be an important sociological site in which forms of knowledge, moral values and relations of power are produced and reproduced. The thesis situates itself between a body of sociological research that focuses on medical knowledge practices as social processes, paying attention to how medicine re-produces socio-cultural classification and a set of literatures that account for medicine as particular knowledge forms. Building on a tradition of research that moves beyond this division the thesis adopts a particular view of medical knowledge practice that is performative, existing in and through social relations; these social relations not only occur between people and between people and materials, but also between other modes of ordering, such as those produced through forms of governance or technologies of managing health care provision.

Although a description of this study as first and foremost an ethnographic study of an A&E department may be efficient and concise, it does not fully explain the scope of this work. Firstly, the research site is more than the physical place of A&E, and includes medicine, morality and governance that are (re)produced through a place such as A&E. That is not to suggest that the characteristics of A&E as a place are not also highly significant. The specificity of the research setting is crucial in as much as

it is only through close and detailed observation of language, talk and text that moments of significance in social action are elicited (this is discussed in more detail in Chapter Three). However it is what emerges from the accumulation and comparison of these significant moments that is important, as these are often drawn from and produce forms of knowledge that reflect a wider socio-cultural landscape.

This study therefore analyses A&E as a critical case; a site of potential crisis, where access to life chances are accessed or denied through the ordering work carried out by medical staff. This thesis does not seek merely to provide a detailed description of older people in A&E, but rather attempts to create an analytical account of A&E as such a critical case, a local specific site where it is possible to observe, in aspects of talk, language and text the creation and manifestation of specific cultural practices and values such as those embedded in the current conception of 'good citizenship' (see Chapter Eight).

Specifically A&E can be understood as standing at a threshold between providing emergency care and as a gatekeeper over the distribution of 'acute care medicine' as a highly valued resource. A&E offers a space of negotiation, a threshold between two domains, the outside domain of subjective illness, represented by those individuals who define themselves as in need of emergency care, and the inside world of medical expertise, represented as medical staff acting upon objective knowledge of disease. Access to this domain of expertise has become increasingly protected with the fears of mounting demand for limited resources; a fear compounded by the narrowing frame within which the task of emergency medical services is understood. A&E is therefore problematic as a space in which medicine can be performed as purely clinical.

A&E is also a site in which the access and flow of patients must be managed, not only the attempted access of potential patients to the expertise of emergency medicine, but also the access of emergency patients to hospital wards. This task creates a space of potential conflict between the valued work of A&E (that of highly pressurised expert medical intervention with fast, measurable results), and the needs and demands of those who attempt to pass through this threshold. A&E is therefore a site of particular interest for sociological attention. As Douglas (1966) points out, it is in the margins, the spaces between categories where society's energy lies; it is these in-between

spaces that problematise the usually taken for granted categories and boundary lines that order and make up our worlds. Specifically, it is through the contested space of A&E that categories and social orders can be made and remade.

This thesis thus examines how A&E operates as both threshold and gatekeeper. As a result A&E emerges as social space where socio-cultural classification is produced and reproduced and where interests are accounted for and contested; it is a 'critical case' through which the generation of cultural material can be observed. The exploration of these categories and classification systems is important, not only for a better understanding of A&E as a site in which access to important life chances are negotiated, but also for understanding more about the relation between medicine and socio-cultural classification, and the consequences for all those enrolled in these categorical processes.

The research takes a specific interest in the assessment and treatment of older patients in A&E in order to elicit accounts of patients who have traditionally been constructed as problematic to medicine. Significantly, older patients with complex health and social needs are often problematic to the work of doing medicine, offering less opportunity to showcase the possibilities offered by 'pure' medical intervention. This problematic status of older patients to health care systems has been shown to have intensified because of the fiscally and organisationally driven concerns with efficient health care delivery, faster throughput and measurable output (Latimer 1999, 2000).

Emergency services have historically been a focal point for the problematisation of older people. The establishment of the emergency service following the Second World War saw patient numbers in hospitals being an issue for concern, especially in relation to older and chronically sick patients who were first identified as patients more likely to block scarce hospital beds (Evers 1993). Furthermore the creation of geriatric medicine was spurred by the problematisation of long-stay care, of which the elderly and chronically sick were the majority. The specialism was therefore in part born out of professional interests regarding the concern of the quality of life of older patients but also encompassed concerns about the costs to society of ever increasing numbers of chronically sick aged people in publicly paid for hospitals (Sidell 1995).

In the current context contemporary policy is directed at, on the one hand, the rationalisation of A&E to the treatment of acutely ill patients, in order to achieve maximum throughput and efficiency, and, on the other, the development of a more health promoting primary care system that also manages the health and social care needs of the chronically sick and disabled (DOH 2004): for example, in the document 'Achieving improved access to services through better hospital care for older people' this dual function is described as follows:

'If the NHS and social care services get it right for older people, then this helps tackle the 'problems' of the acute sector i.e. by avoiding unnecessary admissions and by achieving the shortest appropriate lengths of stay, this reduces pressure on A&E and on acute beds, and thereby helps to tackle waits, cancelled operations, waiting times etc.'(DOH 2004).

Chew-Graham et al (2004) suggest there has been a growing recognition that if the right alternative services were in place, then inappropriate referrals to A&E could be reduced. Their study suggests that due to this recognition A&E departments are less likely to undertake processes of 'victim blaming'. This current research pays particular attention to the construction of appropriateness in A&E and in particular how this works to mediate processes of negotiation for access to services, specifically through the accounts made by patients themselves.

This study suggests that a difficulty arises when some groups presenting at A&E with acute symptoms also have more complex health and social care needs which do not easily fit into the forms of regulation or categories currently organising emergency medicine and acute hospital care. This is particularly true of older people: it is the high attendance of older patients (categorised as those over sixty five) at A&E that form a significant part of the yearly increase in rates of emergency hospital admissions that has been flagged as a major factor placing strain on acute medical services, resulting in limited resources (The British Geriatrics Society: 2001). Two thirds of acute in-patient days are taken by people over sixty five years of age and the admission rates for this group are three times higher than those between the ages of sixteen and sixty four. The length of stay of patients presenting at A&E is also a concern, with those in this higher age bracket experiencing stays that are significantly longer than younger patients (DOH: 2004; Welsh Assembly Government: 2003).

It is therefore evident that although these policies of rationing emergency medicine are based on the parallel availability of primary health care services, patients with complex health and social needs, such as the elderly, also experience acute medical symptoms and thus continue to access health care/social support through presentation at hospital emergency departments. Some of the consequences of this positioning of older people in the organisation of emergency health services are becoming increasingly newsworthy. The reports on the findings from the Healthcare Commission investigating the care of older people in hospitals carried out this year (2007) have suggested that older patients are being denied their dignity, with stories that tell of people's basic needs not being met by hospital staff, such as help not being given to those patients unable to feed themselves or use the toilet facilities (BBC, 2007). It is the discontinuity between which patient categories are being organisationally constituted as appropriate to emergency medicine, and those individuals who arrive at A&E, particularly the elderly, that marks A&E as a space of contestation: a threshold space through which negotiation must occur either to help or hinder patients' subsequent trajectory through emergency health services.

To develop further the problematic status of older people within health care services more generally, Latimer (1999) identifies two difficulties older people have in gaining entry into positive staff constituted categories. Firstly, developing Jeffreys (1979) observation, she suggests that patients can provide materials with which to construct staff identities. Patients who can be assessed, diagnosed and successfully treated provide useful materials for demonstrating good medical practice. Older patients' needs are often complex: they are difficult to diagnose quickly, often with no clearly visible outcome or recovery and most significantly their recovery is often one that cannot be identifiable as a consequence of a given treatment. In other words older people are not easily 'transformed' into a medical disposal that is a solvable problem (Berg 1992).

This problem is partly exaggerated by the difficulty in ascribing older people to a patient category. Often older people have both chronic health problems coupled with serious acute symptoms; these troubles may be exacerbated by older people suffering difficult social circumstances. This complexity poses challenges for medical professionals to construct older people into a medically successful disposal and it also

creates problems when ascribing older people to an organisationally constituted patient category.

Secondly, Latimer (2000) argues that the incorporation of social factors influencing ill health in ageing have become so inherent in the understanding of older patients that illness and disease in old age are ceasing to be seen by medical professionals as matters that are of medical concern at all:

‘Discourses that ‘socialise’ illness risk being enrolled in a policy context in ways which permit recategorising illness and suffering in older people as social problems, and which thus marginalize the place of disease in an ageing life.’ (Latimer 2000: 385)

This infiltration of the social into the medical problems of older people means that older people’s troubles are categorised as social rather than medical and subsequently hospital care is denied to them. By obtaining inclusion into a positive medical category shelter is provided for the older person to ‘keep at bay their effacement as merely a ‘social problem’ (Latimer 2000: 383).

This problematic status of older patients in health care services is particularly significant when viewed in relation to the heightened rationalisation of A&E, an emergency service providing acute medical care for trauma patients. It is therefore the bringing together of A&E as a medical space that is in-between, a threshold in which the movement of patients is managed, and older people as patients in-between, with multiple health care needs compounded by poor social circumstances, that establishes the observation of older people within an A&E service as a critical case. It is through this critical case that it is possible to observe the local, specific aspects of medical knowledge practice, health service organisation, delivery and use in a way that makes visible the wider cultural values, and forms of knowledge and power that mediate them.

The emphasis on A&E as gatekeeper and as threshold allows the issue of access to come into view as a central theme. Forms of classification or modes of ordering are brought into play around the problem of access. All moments where staff and patients are in negotiation over interests, where accounts are made to justify or legitimate place, actions or decisions are understood as moments of accessing. The particular

modes of ordering that are vital to the arguments of this thesis were elicited through focussing on these moments of accessing, taking an ethnographic approach that pays attention to the work undertaken by the members of the research site to make actions and decisions accountable. This approach, discussed in Chapter Three, also brings to light how these accounts were aligned to, and constitutive of, significant forms of classification. Furthermore, taking a critical approach the thesis shows how the production and reproduction of these orders also (re)accomplishes specific relations of power.

Conceptually this thesis locates the research, the research setting and the research participants in a wider socio-cultural context. The coming together of forms of knowledge that inform and are informed by health service organisational practices is traced; in particular medicine and management as domains of thought are examined in order to appreciate the complexity of their relations to one another in the current context of health service delivery and use. The advancement of medical ideas is important to show how medicine influences and is influenced by ways of thinking beyond the boundaries of the clinic. An understanding of medical knowledge as culturally and historically constituted is important for the purposes of this research in order to appreciate better the forms of medical practice that occur in A&E and to make sense of the interrelations of medicine as a set of ideas within wider socio-cultural contexts. These interrelations both frame and are created in the social relations of staff, patients, relatives, managers and material objects in A&E.

Medical staff within A&E are shown to undertake the continual task of producing 'real' emergency medicine as 'purely clinical' and as only responding to 'true' emergency cases. However, this construction is continually undermined as particular patients impede the production of 'real' emergency medicine. Its openness and accessibility as an emergency medical service is complicated by those individuals who believe themselves to be in need but who are constructed by staff as 'not medical' cases. In addition as well as a treatment centre, A&E as gatekeeper to the distribution of resources further exaggerates the problem of producing 'real' emergency medicine. In producing what is 'real', emergency medicine and non-emergency medicine are continually being re-made collecting and re-constituting

those aspects deemed integral to the work of emergency medicine while those aspects that are deemed ‘pollutants’ are held apart.

Much work has already been done that shows the significance of socio-cultural classification for medical work and decision-making. Specifically for this research, revisiting and bringing together the following literature in Chapter Two provides important analytical tools through which the situated practices of those undertaking medical work in A&E can be observed: the significance of the institutional, administrative and managerial organisation of medical work; the performative nature of medical knowledge and practice; the perception and judgement of patients’ moral and social worth; and the usefulness of patients to staffs’ identity work.

Previous studies are significant for this research in understanding the complex relations of categorical work undertaken by medical staff, particularly in emergency settings, and as such provide some building blocks through which to better observe and illustrate the ways in which medical work is accounted for in multiple ways and for a variety of purposes. Some important conceptual work about the understanding of medical knowledge practice is also developed in this chapter. Importantly, through identifying medicine as performance, its boundaries are reconfigured and become more permeable so that it can not only spread beyond the physical and professional limits of medicine and medical practice but it is also understood as a form of knowledge that is able to shift and alter its shape in order to incorporate other ideas that may be useful to its performance.

The substantive and conceptual interest of the thesis has now been established with brief reference having been made to the literary and methodological tradition in which the research is situated (these are discussed in detail in Chapters Two and Three). The remaining chapters are summarised below in order to provide an overview of the thesis’ main arguments that have been generated from the research materials gathered in the field and interpreted through an analytical framework that is described in the latter part of this chapter.

Chapter Four develops the importance and significance of access both methodologically and substantively for this research. It illustrates through extracts

from fieldnotes how the researcher moved from moments of becoming a partial member to becoming 'matter out of place' (Douglas 1966). This ambiguity occurred at moments of accessing, where the researcher sought to gain entry to observations, spaces or social networks, and it was the replication of this experience in the experiences of patients and members of the public in their own moments of accessing that is central to the appreciation of A&E as a site of contention.

Moments of accessing are developed in Chapter Five which provides a detailed account of the practices and processes of assessment that occur in and through the various spaces and sectors of the emergency department. This chapter works to construct and explore the place of the threshold where the work of 'managing' is most intensely felt. The chapter pays particular attention to forms of regulation and practices of self-checking that mediate the actions and decisions undertaken by staff and bring to the fore issues of rationing and managing resources. The work of managing patients is also shown to be organised upon a particular division of labour whereby those staff working at the threshold bear more responsibility for sorting and prioritising in order to protect the work of 'real' emergency medicine.

The consequences for those working at the threshold is the central focus of Chapter Six, where an analysis of the ways and means with which medical staff cope with competing calls upon them to respond to patients as full persons in need of care, and to the needs to manage and prioritise those patients in order to ration limited resources. The particular conditions of working at the threshold, some of which are described in Chapter Five, are developed in order to show the difficulties staff experience in creating and maintaining moral proximity to their patients. The chapter suggests that in some contexts staff efface patients as full persons through strategies of distancing in order to meet the demands placed upon them to manage patients as well as treat them.

Chapter Seven re-examines the importance of typifications, and the ways in which staff construct patients as types prior to their assessment of the patient as a full subject, for the ordering and categorising of patients in A&E. Moral judgements about social worth as an available means with which to order patients is the focus of attention in this chapter. Social worth in this A&E department is shown to pertain to

specific understandings of service use and good citizenship. Alongside the developments in medical ideas and the interrelations these have with wider socio-cultural frameworks discussed through the previous literatures in Chapter Two and analysed through materials from the field in Chapter Eight, the establishment of a particular moral order, based around ideas of citizenship, is traced for the purposes of this chapter.

This moral order is viewed with specific reference to how these ideas provide frameworks through which the work of organising health care services, as well as the work of accessing and obtaining these services, can be achieved. Through utilizing ideas of governance, the continual construction of 'citizenship' is discussed. It is how these discourses are produced and reproduced in and through the social relations of A&E that are explored. The practices of ordering patients according to these notions are shown to be carried out through processes of negotiation that patients participate in, either through being enrolled in and reproducing these modes of ordering, or in their attempts to produce other accounts that make up the world in a different way. These practices of accounting are shown to have very different and important consequences for emergency patient careers.

Chapter Eight, drawing on the conceptual considerations outlined in Chapter Two, explores the relations between clinical governance and medicine in the actions and accounts of medical staff. The chapter illustrates how medical professionals are able to account for their work in a number of different ways that are aligned to classification systems of both medicine and management. Significantly this chapter shows how these two ways of performing 'real' emergency medicine have merged together in some of the accounts made by medical staff. However, what this means for the everyday practices of ordering and organising medical work is shown to be more complex and is explored in relation to the multitude of purposes for which staff provide accounts, in particular aspects of identity and membership work are taken into consideration as part of the process of accomplishing 'real' emergency medicine.

All these classification systems are explored for how they are achieved. As well as moral judgements and typifications, the thesis explores the mediation of organisational, administrative and managerial ordering principles with a particular

focus on clinical guidelines and regulation. These are explored for their effects upon the actions and decisions made by staff, but are also explored for how they assist in the specific production of medical knowledge practices and notions of moral or social worth within A&E.

None of these ways of organising and accounting for the work of A&E medicine is presented in this thesis as being separate and distinct from one another. Rather these accounts provide different facets of the social organisation of A&E. What the thesis shows is the importance of situation and context in the deployment of modes of ordering. Importantly the thesis shows how staff within A&E are able to use and deploy multiple modes of ordering in order to achieve the successful performance of 'real' emergency medicine and furthermore how, at moments, patients themselves become enrolled in this performance.

Biography of the Research Questions

It is useful for the understanding of the content and focus of this thesis to briefly explore the process through which the research came into being, to provide some further context for thinking about A&E as a site of interest. As with much other qualitative research, my interest in the substantive area sprang from a combination of personal and intellectual curiosity. Throughout my undergraduate studies I had become increasingly fascinated by medical sociology, perhaps spurred from a more general attraction to medicine that had been with me since school. Many aspects of medicine, as social and cultural practice, were interesting to me, particularly the study of such practices through an analysis of categorical work undertaken by medical staff. The development of this academic attention was accompanied at the same time by the experiences of my family in the care and treatment of my chronically and acutely sick grandmother. Watching as my grandmother moved continually in out and through various health and social care systems brought to light how her sickness and the sickness of many older people had become increasingly placeless. I therefore began to think generally about older people and specifically about the available categories through which the place of older people in medicine could be accomplished.

It is difficult in hindsight to establish what came first in the development of this research endeavour; an academic awareness or a personal response to social phenomena. Coming across Latimer's (1999, 2000) work on older people in an acute medical unit is a significant part of the telling of this story. The way in which categorisation work was shown to have real and significant consequences for vulnerable older people, as well as providing a re-telling of the significance of categorical work for the accomplishment of medical staffs' identity work, brought together my personal concern and intellectual interest.

This does not however explain why it was that I selected Accident and Emergency (A&E) as the setting in which to explore these issues. This decision was founded upon the particular ways in which older people had already been framed, in both academic and policy literature, as problematic to medicine, which was the subject of my masters dissertation. The separation of acute and chronic, and social and medical, as organisationally constituted categories of assessment, with the important consequences these categories have for the care and treatment of patients, seemed particularly relevant to the work of A&E. This was mirrored in the increasing rationalisation of emergency medicine towards the treatment of acute trauma patients. It seemed to me highly appropriate to study the impact of medicine as cultural practice, situated within complex social relations, in a setting where the work of accomplishing medicine is highly pressured and resources are more intensely rationed than in other health care settings (Vassy 2001 see Chapter Two, p.37).

This research explores these interests through focusing upon the following set of questions:

- What are the available categories through which medical staff order and organise their work?
- How and why do staff engage in ordering work?
- What is accomplished through the categorical work undertaken by staff?

- How and why do patients and relatives perform in processes of assessment?
- What are the categories and classifications through which patients and relatives act?
- What systems of classification are the available categories aligned to?
- How do these systems of classification create and re-create relations of power?
- Who benefits and who is disadvantaged as a result of the ordering work that is accomplished?

Analytical Framework

The previous sections have provided an overview of the thesis' main content and arguments with a specific focus placed on the complexity of the research site as a critical case. This critical case has been set alongside the researcher's own personal and intellectual interest in undertaking the research and the subsequent development of the research questions. With this in mind, it is necessary to determine how and why categorical work is integral to the understanding of A&E as a 'critical case': a space in which modes of ordering are produced and reproduced with important consequences for medical staff and patients who both embody and participate in their continual construction.

In order to develop this argument, it is important to think about what we mean by categories, classification and ordering. It must be made clear that such an analytical focus on categories and classification does not sustain a search for the underlying social order of emergency medicine: it is orderings, situated and embodied in social relations that are the primary interest of this research. It must also be acknowledged that within these social orderings, materials of all kinds can be implicated, including talk, bodies, texts and machines (Law 1994). This is exemplified in the subsequent chapters.

To comprehend the extent to which classifying and ordering are integral tools through which the social world of A&E is made, we must first establish the socially and culturally contingent nature of categories and classes of things. This is the first step in understanding the role such an analytical framework can play in understanding the meanings and interpretations that are formed by and through the everyday social relations of A&E.

The Construction of Categories

In order to think about categorical work within A&E as accomplishing ‘modes of ordering’ (Law 1994)¹ it is important to make clear the form and nature of categories as they are represented in the research. Categories do not exist as entities in themselves separate from and acting upon the social world; they are accomplished through the work undertaken in social relations.

As an illustration of this, it may be useful to look first at the work of structural anthropologists such as Edmund Leach (1964) and his essay on animal categories and verbal abuse which contested the commonly held belief that orders of things were simply given in nature. Leach puts forward a theory that places categories and classification systems firmly in the social domain. He suggests that since a child cannot distinguish between things as a grown adult does, the child must go through a process of learning these distinctions through the acquisition of names so that it is in fact language that structures our world rather than the other way around:

‘I postulate that the physical and social environment of a young child is perceived as a continuum. It does not contain any intrinsically separate ‘things.’ The child, in due course, is taught to impose upon this environment a kind of discriminating grid which services to distinguish the world as being composed of a large number of separate things, each labelled with a name. This world is a representation of our language categories, not vice versa.’ (Leach 1964: 34).

A further example can be derived from the work of Durkheim & Mauss (1963) who describe the way in which we understand and practice the ‘classification function’ as a relatively recent phenomenon. To classify, the way we understand it today, is to arrange things, animals, people into groups that are distinct from each other and

¹ Modes of ordering is an important concept that is developed in more detail on p.22 of this chapter.

clearly separated by definite lines of demarcation. This in itself is a historical development. This form of classification, that holds all things together while at the same time clearly separating them and depositing them into strict, defined groups, is based on a science of taxonomy. This systematic, tree like structure places a single classification that refers to all objects at the top and below are categories that refer to the subgroups making up the whole classification. A good example of this structure is the family tree, charts that show family relations.

The roots of taxonomy are found in the work of Swedish medic Carl Linnaeus in his classification of living things, the *Systema Naturae*. His work involved the grouping of species according to shared physical characteristics and, more importantly, by doing this he created a new scientific classification that has since dominated modern western thinking about the world and all things in it. In particular the hierarchical grouping of all organisms, from the larger Kingdom to the specific species, has had strong influence on conceptual frameworks of what it means to classify (Koerner 2001).

This particularly modern conception of classification does not allow for huge void like spaces between classes of things whilst at the same time it encapsulates a model that has fixed and definite outlines. This, however, was not always the case. Aristotle was the first known to have proclaimed the existence of specific differences between forms, particularly in his theory of universals. He sought to separate the naming of those things that can be shared by many (universals) indicating the sort of thing it is such as man, and those things of substance which are particular such as the sun (Russell 2005). Those before him and indeed others of his time had far less sense of this distinction.

Foucault (1966) at the very outset of 'The Order of Things' uses as an example a passage from Borges that quotes a certain Chinese encyclopaedia in which animals are divided into seemingly strange categories, including: 'belonging to the Emperor' and 'frenzied'. This example seeks to 'disturb and threaten with collapse our age-old distinction between the Same and the Other' (Foucault 1966: Xvi). Through such an example we immediately question another system of thought, but more importantly in

doing so we are forced to experience the limitations of our own system of thought, in the impossibility of thinking in this different way.

Durkheim & Mauss (1963) were among the first to suggest that to find answers to such complex questions about the way we order and classify our world, we must look outside the limitations of nature and the perceptions that occur in singular minds and we must look instead to society itself, the social and cultural elements of life. Their work on 'primitive' classification makes clear that it is not simply in the past that we find blurred, confused understandings: there are examples of weakened distinctions even in contemporary society. In literature, mythology, and religion there are fundamental confusions of images and ideas: stories, myths, tales and beliefs that see the substantiation of persons, souls and bodies. In religion in particular we witness the spiritualization of material objects. These are clear examples of ideas that could not arise if things were represented by determined concepts of classified, separated forms.

Re-incarnation, the idea that the form an individual takes in *this* life is merely the caterpillar to the butterfly - the butterfly they will become in the next - reflects this blurring of the distinctions between different forms of life. These blurred distinctions between sign and thing, name and person, work to fuse people, animals and inanimate objects 'in relations of the most perfect identity to each other' (Durkheim & Mauss 1963: 7). In other words, it is the signification of a thing, person or object to the beliefs and values of the society that work to uphold its place within it.

This is illustrated in the work of Levi-Strauss (1966) where he represents the 'native' thinker who claims that all sacred things must have their place. What Levi-Strauss illustrates is that in fact the reverse is true: objects are sacred *as a result* of being in their place, for if they were taken out of their place even in thought, the entire universe would be destroyed: 'Sacred objects therefore contribute to the maintenance of order in the universe by occupying the place allocated to them' (p.10), thus indicating the powerful nature of ordering work and what accomplishments are made possible. They make up the world.

Durkheim and Mauss provided the foundations from which sociology began to identify and investigate further the social basis of all forms of knowledge. Important questions have since been posed regarding the social construction of reality: how far should the belief in the construction of reality be followed and what can be known about the kinds of reality that are construable? For Durkheim and Mauss, although they drew many comparisons between the way in which we understand our world and the forms of classification of so-called primitive societies, they saw limits to these similarities, claiming that primitive classification was more weighted and therefore distorted by social concerns than that of modern scientific thought.

However, as Bowker and Star (2002) argue, the principles of ordering so ingrained in the consciousness of modern western scientific thought, centre on ideals that are significantly flawed: the first of these is that each category must be mutually exclusive, 'into which any object addressed by the system will neatly and uniquely fit' (Bowker & Star 2002: 10); the second of which is that a system of classification must have total coverage of the world it describes. As many of the previous accounts have shown, these ideals are particularly problematic and are certainly not objective reflections of the natural world.

Furthermore studies and research that have since descended from these earlier anthropological works of Durkheim & Mauss and Levi-Strauss seem to support the contrary viewpoint:

'Even in the laboratory, the researcher has options open to him. There are options for following this line of inquiry rather than that, of referring to these other works or omitting them. He must choose for the sake of structuring his own contribution. It is fitted into a conversation between scholars and so is pared down here and blown up there. The categories of valuable and useless areas of work are identified, ranked and bounded, elements assigned to the classes and sub-classes, rules made to hold the framework of knowledge steady. The alleged gap between what we know about the construction of everyday knowledge and the construction of scientific knowledge is not as big as is supposed.' (Douglas 1973: 12).

This way of thinking about categories and classification, in contrast, is embedded within a wider conceptual framework that views all forms of reality as existing in and produced through social relations. However, understanding how we are able to comprehend the world around us through our social context is a problem that has been left to artists, novelists and poets rather than to social scientists; instead, sociologists

have splintered into narrow fields of expertise thus ‘bounding the reality they wish to investigate’ (Douglas 1973: 10).

What the earlier anthropological accounts sought to show were the ways in which things, materials and people exist through the identification and perception of others; a well established argument within the interactionist tradition. However, they were also extremely important in beginning to show how and why categorical work is undertaken and its integral role in the organising of social relations. Where these arguments were limited, particularly in the earliest work of Durkheim and Mauss’ ‘Primitive Classification’, was in their structuralist sensibility. There is a lack of recognition that definitions, perceptions or meanings of things are unstable and changeable. This instability exists not only through history and across cultures but also within cultures, societies, institutions, situations and even within moments: they are ‘drawn from the consequences of the situation’ (Bowker & Star 2002: 290).

Social categories must therefore be understood in relation to their dependence upon the judgement of social groups; the example of religious beliefs is again a good illustration of the changing definition of objects according to particular groups of people. This does not only hold true for simple definitions of things or people but also for social behaviour: as Goffman makes clear in his work on behaviour in public places, psychiatrists bring attention to behaviour in their patients that are deemed to be ‘inappropriate in the situation’ (Goffman 1963: 3). However, as Goffman points out:

‘An act can, of course, be proper or improper only according to the judgement of a specific social group, and even within the smallest and warmest of groups there is likely to be some dissensus and doubt.’ (Goffman 1963: 5).

What is important about what Goffman is arguing here is that whether an act is deemed to be appropriate or not must often be worked at, it is not simply given. It must be recognised, acknowledged by others in the groups and furthermore this recognition must be shared and performed by the members of the group; in other words it must be accomplished.

Accomplishing the Social, Categories and Classification in Action

These earlier anthropological accounts challenged the modernist paradigm by providing the means through which interpretation and meaning became important explanations for how the world is ordered: time and culture, for all societies, were the contingencies upon which these meanings and interpretations were fixed. However, it was this fixedness that caught these accounts in a modernist trap: meanings and interpretations within society were deemed to be stable, making it possible to reveal a social order that acted upon individuals. In contrast this current research is interested in social orderings, the work² that is done to make up and perform the social. Rather than attempting to reveal the makings of an ordered world, this approach takes as its starting point the understanding that the social world is complex and messy. The illusions of order, that are themselves fleeting, are understood to be the product of a lot of work;

‘work that may occasionally be more or less successfully hidden behind an appearance of ordered simplicity. This is not however to suggest that orderings cannot have significant effects, it is rather to enable a more intricate understanding of the complexity of the social world, whereby truths can be made and unmade, and understanding the conditions in which these makings are possible.’ (Law 1994: 5).

This research therefore builds on the premise that order is something which members of any organization, or in any setting, must work at to produce (Bittner 1973). It also works on the basis that orders have a temporal clause; orderliness is not binding and shared for all time. These considerations have therefore led to an emphasis on ‘the importance of negotiation, the process of give-and-take, of diplomacy, of bargaining-which characterizes organizational life’ (Strauss et al 1963: 148).

It is in the intricacies of the everyday way people organise, order and classify their worlds through speech, actions and materials, that understandings of a social space and institution can be found: through this work A&E, as particular orders, can be accomplished and re-accomplished. Therefore by making these processes of classification within A&E problematic we make visible the ‘ordinarily invisible’ (Bowker & Star 2002: 3) entities that can also help to reveal relations of power - something I return to in more detail later in Chapter Three.

² Work in this context refers to the practices that individuals and social groups perform in order to make knowledge claims stable.

Categories and classification are essential components through which it is possible to organise social life, as has been shown. Within all areas of social life there is order, or more accurately, order must be accomplished, an accomplishment involving an immense amount of work. The work of accomplishing social order can serve particular purposes (examples of which are offered in subsequent chapters), so that it is not the case, as Law shows, that viewing social life as accomplished orderings, is to discount power relations, or to attempt to suggest that 'anything goes'. There is merely an appreciation that it is through the work of individuals that order is accomplished and that this order is not an order at all but one of many sorts of ordering possibilities.

The significance of these orderings are also not reduced as a result of such a premise; orderings are significant in understanding how and why social life is organised the way it is. Furthermore, orderings may and can become patterned, recurring within social relations and hence become 'modes of ordering' (Law 1994). Modes of ordering are 'recurring patterns embodied within, witnessed by, generated in and reproduced as part of the ordering of human and non-human relations' (p.83) and as is shown in subsequent chapters, it is possible to distinguish these orderings in social groups, networks and relations. As Law shows through his research, categorical work can become enrolled in and can enrol members in particular modes of ordering:

'it is possible to impute several modes of ordering to the talk and the actions of managers. And I'm saying that people are written into them in varying degree...I'm saying that agents are effects which are generated by such modes of ordering' (p.75)

Up until now the discussion has remained quite abstract in focussing on the need for social groups to perform categorical work; there is a need for such work to be done for the accomplishment of social organisation or social orders. However, the participation of individuals in categorical work, or more significantly in the production and reproduction of particular modes of ordering, are essential means through which people are able to perform identity work and often are a means through which membership can be accomplished (Latimer 2004). In this sense, ordering modes are used for sense-making, but are also tools that may usefully do certain jobs for certain purposes.

In Latimer's (2004) paper on multi-disciplinary work in a British hospital trust, she reveals how consultants are able to (re)accomplish hierarchy and dominance through aligning cultural materials with social processes. The focus of the paper is on establishing the place of materials in the ordering of social relations, as objects that provide tools for constituting, as well as expressing social relations. What is of significance for the purpose of this research in what Latimer is showing is the way in which a specifically medical mode of ordering that can be discerned in talk and materials provides the means through which to (re)accomplish medicine as a dominant authoritative voice; it is a means through which to perform identity, to achieve membership and specifically in the example of multi-disciplinary work in a hospital, to aid the re-establishment of medical power.

The classifications from which to comprehend relations between people and between people and things, as modes of ordering, can sometimes seem unquestionable; they are understood to be *naturally* so. It is within these taken for granted meanings that relations of power, existent in hierarchical systems of classification, are both produced and manifest themselves. Illusions of order hide the processes through which they were generated and as such can be understood by members as facts, truths that become reproduced in the actions and interactions of those members who interpret them to be 'true'. This has important ramifications for how researchers go about accessing these modes of ordering, a point I return to in greater detail when discussing the purposes of undertaking ethnographic research and in particular participant observation (see Chapter Three).

The Significance of Categories

Classifying and ordering works are not simple, logical reflections of the *best* way to organise people and things; rather they are a reflection of complex rules and values that exist in and are created through social relations (in fact they 'embody moral and aesthetic choices that in turn craft people's identities, aspirations and dignity' (Bowker and Star 2002: 4)). In studying these modes of ordering sustained through categorical work it is possible to distinguish particular recurring discursive practices that help to order social relations and, on occasions, modes of ordering become more matters of fact, thereby (re)accomplishing dominance as a means of organising

people, objects and things. As a consequence these modes of ordering serve to subvert or exclude other potential ways of ordering. Therefore, the work of categorising should not be ignored as simply arbitrary notions of common sense or logic but rather they should be identified as political actions that deserve attention and in some cases justification.

So far the discussion has been mainly focussed upon what systems of classification and ordering work can reveal to us about how social relations are accomplished. However, as well as actively doing the work of categorising in our daily lives we are also victims of our encounters with classification systems often in extreme and negative ways. Those systems that exist within bureaucratic organisations can work to constrain individuals and can even be ‘a direct tool mediating human suffering’ (Bowker and Star 2002: 26). The difficulty arises when individual lives and circumstances conflict with the categories affixed to them by these systems of classification.

As has been previously discussed, while systems of classification are commonplace in our everyday lives, as modes of ordering they remain invisible. However, what is important to acknowledge - and indeed analyse - are those systems of classification that exist in large bureaucratic organisations, or that exist in systems of government that have become standardised and are therefore conscious, visible forms of classification and as such can create objects of contention. These standards are just as important when recognised as further modes of ordering, identified and analysed in precisely the same way as those more implicit, everyday orderings. Although standards are overt systems of classification, the meanings attributed to such standards are often just as complex.

Through this discussion, we can begin to see the usefulness of understanding categories and classification within a setting such as A&E, as a means through which to make visible the production and accomplishment of orders which uphold specific interpretations of values, morals and ideals. This ordering work is also useful for individual members to perform identity work and achieve membership. Furthermore, through the building of particular modes of ordering, these can become forms of knowledge or ideas understood by members as matters of fact, placing objects, people

and materials in hierarchical relations to one another, while subverting the political nature of the processes that accomplish such orders.

In understanding the social world of A&E and the categories that exist within it we begin to understand the extent to which medical staff and patients produce and become enrolled in particular modes of ordering, creating and recreating victors and victims in ways that have ‘enjoining deep consequences for those touched by them’ (Bowker & Star 2002: 290).

The significance of A&E as a critical case has been explored in this chapter through providing detail of its complex position as threshold and gatekeeper, particularly in the current context of health service provision. Furthermore, the analytical approach developed in this chapter is important for underpinning the way in which the research materials have been considered and for the advancement of the thesis’ argument. In view of this approach and the research questions posed, the next chapter seeks to explore some of the literatures that have provided important insights into the categories and classification systems available to medical staff in the organising of their work and the assessing of patients.

Chapter 2

Medicine and Its Relations

‘Medicine is a social science and politics is nothing more than medicine on a larger scale.’ (Rudolf Virchow 1821-1902).

Introduction

It has been suggested in the previous chapter that as a critical case, A&E may be a site in which the (re)production of socio-cultural classification occurs. This chapter builds on that contention and seeks to clarify the complex relationship between wider socio-cultural orderings and the practices of emergency medicine carried out in A&E. In order to do this the chapter provides an analysis of literatures that account for the production of medicine and importantly how this production is accomplished through the complex relations that occur between medicine and other modes of ordering. The literatures presented in this chapter have therefore been selected for their contribution to the consideration of how medicine is produced and, in particular, how this production is accomplished through its relations with other classification systems.

Through the drawing together of multiple accounts of medical knowledge practice this chapter explores the particular categories and systems of classification that inform and produce medical knowledge practice. These accounts have been drawn from within medicine itself and from within the history and philosophy of medical science, medical sociology and medical anthropology. The literatures gathered and analysed are treated as research materials through which particular accounts of the medical domain can be explored and critiqued in order to situate the research within its own conceptual framework for understanding medical knowledge practices.

The analysis illustrates some important divisions between those who treat medical perception and the clinic as ‘pure’¹ domains, as distinct and separate from the politics of organisation, and those who choose to account for medicine as social processes without paying attention to knowledge production or its consequences. Accounts that

¹ The term ‘pure’ used in this chapter refers to Douglas’ (1966) notion of purity that reflects something that is whole, complete and self contained, that has definite hard boundaries that separates it from other forms.

move beyond this division are particularly useful for the purposes of this thesis' interest in the relations between medicine as productive of epistemology and the consequential politics of organisation these epistemologies produce. This thesis suggests that it is not logical or useful to view either separately, particularly as these relations have important implications for patients.

The purpose of this analysis is in part to show how disciplines involved in the study of medicine are as much enrolled in the work of producing the medical domain as medicine itself and what is produced through these accounts can also take on similar forms. The social sciences, much like medicine, are performative; they produce reality (Law and Urry 2004). More importantly the chapter examines the relations that medical knowledge practices have with other systems of ordering such as managerial concerns, notions of moral worth, and systems of health care organisation and the consequences of these relations for patients. The chapter builds upon accounts that are deemed helpful to this understanding but also makes clear where, why and in what way this thesis departs from some of the realities that have previously been made.

It must be acknowledged that the ordering of ideas will always involve a certain degree of pragmatism, particularly in making decisions about how to group and organise literatures to produce a coherent story. For the purposes of this chapter and for setting up the conceptual understanding of the production of medical knowledge practices employed in this thesis, the separations and distinctions have been made for argument's sake while being mindful of the complexities and nuances of the literatures discussed as well as their relations to one another.

Medicine as Socially Constructed

This section illustrates how medicine reproduces socio-cultural classification. Specifically the section deals with the notion of deviance through an exploration of the ways staff categorise patients on the basis of their perceived adherence to wider socio-cultural rules of behaviour and moral values. This notion is developed to offer a more nuanced interpretation that helps us to understand the importance of organisation and institutional structures as well as patient typification and moral

judgements in the categorising of patients. The role in which staff's perceived job function plays in the categorization process is discussed in detail providing insight into the ways in which staff's own professional interests are implicated in the organisation of medical work. While drawing on the concepts of categorization and ordering the section illustrates that patient categories are fluid and ambiguous rather than fixed and stable. The purpose of this section is therefore to illustrate the significance of these studies for this thesis' understanding of categorisation work while indicating moving beyond this tradition of work that does not account for the relationship between socio-cultural ordering and the production of patient's bodies as diseased.

Socio-Cultural Classification

Within medical sociology, particularly within the interactionist tradition, research has attempted to illustrate how medicine is socially constructed. In particular these studies are interested in how medicine helps to reproduce socio-cultural classification. As is discussed, such research is useful in accounting for the multitude of complex socio-cultural orderings through which medicine is practiced; however, where this study departs somewhat from this tradition is in its concentration on the bridging of knowledge and practice. Thus this study pays particular attention to socio-cultural orderings, including the production of medical knowledge as one of these ordering systems: it thus treats the production of diseases and bodies themselves in relation to, rather than as distinct from, socio-cultural classification which expands the researcher's field of vision.

For example, Jeffrey (1979) reveals how specific social rules determine the legitimacy of patients' attendance within casualty departments. Members of staff are shown to produce socially constituted patient categories that interact with scientifically determined medical diagnoses. It is those patients who break the rules who are labelled negatively: these include those who are responsible for their particular illness or responsible for a slow or difficult recovery such as 'drunks' or 'overdoses'; those who are not restricted in their activities by their illness and could therefore be considered 'trivial'; or those patients who are uncooperative with staff and are subsequently interpreted as patients who do not want to help themselves. These types

of patients are also referred to as 'normal rubbish', everyday, routine cases or types of patients who attend casualty regularly. Using Parsons' (1951) well formulated linkage between illness and deviance, Jeffrey describes how these patients breach the expectations attached to the sick role and therefore are subject to punishment in the form of staff attitudes towards them that consequently affects the care and treatment that is given. The relationship between the sick and the deviant is reinforced (a more nuanced interpretation of deviance is forwarded later in this chapter).

On the contrary, patients ascribed to a good category are those who are considered medically interesting, who provide unusual cases, those that allow medical staff to practice skills for passing professional examinations or to practice in their chosen speciality or that simply allow them to demonstrate their competency and maturity. Here we begin to understand how the ordering of patients becomes entwined with wider socio-cultural relations as medical decisions regarding assessments and treatments are made on the basis of the patient's entry into staff constituted categories of either 'good interesting' or 'normal rubbish' (again these categories are deconstructed later in this chapter). Furthermore these are determined through moral judgements and the organisationally constituted career interests of staff.

Thus Jeffrey's account helps to challenge the notion that medical knowledge practice can exist outside of the institutions and cultural orderings in which it is practiced, particularly showing aspects of moral and professional organisational value in the categorising of patients. However, this is accomplished through the bracketing off of orders that relate specifically to medicine's production of diseases and bodies themselves that are merely shown to be acted upon on social grounds. The work of producing 'scientifically determined medical diagnosis' remains unresolved.

Roth and Douglas' (1983) study built on the earlier work of Jeffrey in showing two key social elements through which staff ordered and categorised patients. These were firstly how 'deserving' or 'undeserving' patients were- depending on the social worth attributed to them- and, secondly, how 'legitimate' or 'non-legitimate' the patients' claims to emergency services were- these were framed according to whether or not their demands matched the concept which personnel have of their own work. As Roth and Douglas argue,

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‘All work groups and organized occupations strive to maintain control over their own work conditions. They develop notions about what tasks are appropriate under what circumstances and strive to keep work demands within the bounds of these definitions. If they serve a clientele or public, they develop notions of who among them are most and least deserving of service.’ (1983: 71).

They further support Jeffrey’s claims that staff make judgements based upon perceptions regarding a patient’s moral fitness and these judgements are made in conjunction to the perceived appropriateness of the patient’s visit to the emergency room.

As Roth and Douglas suggest concepts of social worth are a reflection of those common in the wider society. As they make clear there is no evidence that professional medical training achieves universal moral neutrality, a point supported by Becker et al (1961). Particularly labelled as ‘undeserving’ are those on welfare who are referred to as ‘sponging off taxpayers’ and this label is further compounded if patients themselves are taken to represent the effects of an immoral life where aspects of drink or drugs, or illegitimate children have contributed to their welfare position. Roth and Douglas thus build on Jeffrey’s claim that medicine reproduces socio-cultural classification through describing some of the moral values attributed to particular patients that formulate the decisions made by medical professionals.

The complex, self-perpetuating dynamic between the definition of ‘devalued’ or ‘favoured’ categories and the attributes of the patient distinguishes Roth and Douglas’ contribution. Drunks, for example, are defined as drunks when they arrive at the emergency room due to particular aspects of the patient’s career such as being poorly dressed, from a bad neighbourhood, or being without accompanying friends or family etc.;

‘Once the drunk label was accepted by the emergency room staff, a more careful examination was not likely to be made unless some particularly arresting new information appeared (for example, the patient had convulsions, a relative appeared to tell them that he had diabetes, an examination of his wallet showed him to be a solid citizen), and the more subtle pathologies were not likely to be discovered. Thus, it is just as true to say that the label of “drunk” is accepted by hospital personnel because of the way the patient is treated as it is to say that the patient is treated in a certain way because he is drunk.’ (p.80).

Furthermore they suggest that the very definition of these pathological states depends in part on how the patient is categorized in moral terms by the screening and

treatment of personnel. For example, a defined 'trouble-maker' who began to thrash about and behave in a strange manner resulted in the police being called and threats of arrest being made. However, the same actions from a 'non-trouble maker' resulted in attempts being made to reach a medical explanation for the behaviour. However, what is lacking from these studies- and what this work aims to consider- are details of these pathological states and their medical explanations; how these states and explanations are produced in the discourses and practical enactments of staff are not the focus of their analysis.

Having acknowledged this shortcoming in the work of Roth and Douglas, their writing does provide illuminating insights into categorization based upon staff's perceived work role and the demands that are deemed appropriate to medical staff's position. When demands fall outside this boundary the claim for emergency services is understood by staff to be illegitimate: doctor's in training, for example, like to see those patients who will enable them to gain different experiences to those gained in other areas of specialisation.

Another important insight gleaned from Roth and Douglas is the common complaint from staff that emergency services were 'abused' by the public. It was suggested that the emergency room was often used by the public just because it gives quicker or immediately accessible service at any hour of the day or night. Medical residents in their study complained particularly about all the people presenting long-standing or chronic diseases which, although displaying serious symptoms, were not seen to 'belong in the emergency department' (p.84). Consolidating some of the importance of clinical experience in the categorising of patients into labels of legitimate or illegitimate, Roth and Douglas show how particular types of cases were more likely to be deemed illegitimate including stomach pains, delusions, muscle spasms, depression. Psychiatric cases in general were perceived to be illegitimate as these were usually not useful for residents to practice their diagnostic and treatment skills and were therefore an unwelcome intrusion- these typifications have particular resonance within an accident and emergency study which pays particular attention to the assessment and categorization of older patients.

Other studies which illustrate this important relationship between medical staff's identity work and the categorization of patients can be found in the ethnographic works on medical students. Studies such as Becker et al (1961) and Atkinson (1997) have been integral to the understanding of how medical students categorise patients on the basis of their usefulness to their needs and interests. For example in Becker et al's study, patients viewed negatively by staff were often labelled a 'crock': a patient 'with multiple complaints but no discernible physical pathology' (Becker 1993: 3). Such attributes were labelled negatively because such patients provide no materials with which to gain clinical experience or achieve 'medical miracles'. While these studies are valuable in understanding elements of medicine that are deemed in some way social, some of the complexities of knowledge practices are lacking in their disregard of the ways in which multiple complaints or 'discernible physical pathology' are themselves performed. Although this analysis helps to show how culturally produced values within the medical profession help to order patients as legitimate or illegitimate, in looking for the ways medicine is socially constructed the possibilities for ordering patients through the production of medicine 'itself' are lost: for example the way in which chronic and acute illness is produced and performed through the very organisation of medical work and, importantly, what the consequences of these performances are for those patients whose bodies are produced as being chronically or acutely ill.

A further contribution made by this tradition of work to the approach taken within this study is the branding of patients as 'types' as Jeffrey (1979) and Roth and Douglas (1983) have shown. Hughes (1980) extends the processes of categorization that lie behind the accounts of the patient's condition offered by casualty department staff through focussing on those staff members that do the categorical work before the patient reaches the doctor: these include reception staff, triage nurses and, in particular, 'ambulance men' or paramedics as we would now call them. Hughes describes these judgements as typifications because as his analysis shows 'ambulance men' (or paramedics) would act on 'rule of thumb'. They would make general conceptions based on the type of case they perceived the patient to be. It was therefore generalized knowledge understood within the dimensions of a particular case.

Such typified pictures of patients are built up in the course of the ambulance journey and these typifications are shown to affect the patient's initial handling in the casualty department of the hospital. Typifications tend to have a processional and interactional character: as shown in Hughes' account they tend to emerge and become elaborated, revised, or rejected both over time and through the interactions of various casualty staff members who account for the patient's condition:

'In the Accident and Emergency setting there is an extended process of theorising about patients' conditions involving many layers of typifications with both commonsense and medical elements, and the transition from typifications to other forms of definition of patients is far from clear-cut.' (Hughes 1980: 116).

Hughes therefore attends to the interactions and transference of judgements and typifications -and their long term influences in the patient's progression through the department- from 'ambulance men' to nursing staff which often provide the starting point for such theorising about a patient.

In cases where 'crewmen' would form a negative response to patients, these tended to be due to social factors such as their appearance, manner or the circumstances surrounding their particular condition. When these negative responses occurred, Hughes showed there to be little attention paid to obtaining more details about the case. The significant contribution that Hughes' work makes to this study is not only the importance of paying attention to those judgements and decisions made by members of staff prior to a doctor's assessment, and the influences these have on the future progression of patients, but also in showing the interactional processes of building, shifting, revising, or rejecting categorisations and typifications of patients that occur in the communications between different members of casualty staff over time:

'The patterns of social interaction and talk that surround the 'emergency' case rarely amount to any cumulative progression towards the collection of a set of unambiguous facts. More usually there is a process in which a number of persons encounter an ill or injured patient having heard only a brief account of his condition, expand that information on the basis of their own investigations, and then compress the details into a short description when the patient is passed on to someone else' (p.130).

Hughes' account tells us a lot about the routines and practices of medical decision making as based upon the building up of experiences of cases. What Hughes does not then go on to explore is how these typifications are produced and performed in the diagnoses made by paramedics. This then begs the question, whether the accounts of

medical professionals are themselves social? There is no doubt that sometimes they are but, what is of interest here, is that they are at other times *performed* as purely medical. Thus while this study draws on Hughes it would argue that his work may have been enhanced by a consideration of the accomplishment of those purely medical cases.

This study also argues that while an awareness of categorisation is essential, a more nuanced approach than that accomplished in the previous accounts is required. This is now be considered through the work of Dingwall and Murray (1983) who demonstrate that the assigning of patients to positive or negative is more ambiguous and unstable than some of the previous accounts suggest. Categories can shift and change and often patients may move from one to another. Dingwall and Murray (1983) criticise Jeffrey's dichotomous categories, 'good interesting', and 'normal rubbish' suggesting it was a too simplistic analysis of all the social and organisational elements involved in assigning patient categories. Although Jeffrey himself explained that these categories exist not in opposition but rather as two poles on a continuum, there are, as Dingwall & Murray point out, both blurring and contradictions within this that make it difficult for these patient categories to remain distinct.

Dingwall and Murray (1983) illustrated this through their study of the treatment of children in Accident and Emergency (A&E) departments. In this work they begin with what they consider to be the contradiction that although children do break the rules outlined by Jeffrey that govern entry to legitimacy, they are not punished. They are not assigned to a negative patient category because of their membership in the social category of childhood. On the contrary the opposite occurs, often seeing the acceleration of children to examination and treatment in order to avoid disruption to the department. From this initial point of departure Dingwall and Murray expand on the work of Jeffrey by showing more of the intricacies of the social and organisational factors that influence medical staff's attitudes and behaviours towards patients.

For Dingwall and Murray the placement of these patients in categories of either good or bad is far more ambiguous, so that 'even 'bad' patients could become 'good'. Their example of a tramp who is later found to have TB and therefore good 'clinical

material' indicates how patient categories are in fact transitory and unfixed and can be constituted and reconstituted by medical staff:

'These categories interact so that deviants can become valued for their clinical interest. Moreover, this categorisation provides for systematic variations in the way staff frame their encounters with patients.' (Dingwall and Murray 1983:141).

While members of staff often complain about patients who present with what they determine to be trivial troubles to each other this is not always reflected in their actions towards them. Only those patients who persistently attend with 'trivial' complaints are sanctioned (Dingwall & Murray 1983). Thus while this study adopts traditional categorisation work, it is cognisant of how these categories are fluid rather than fixed and stable.

Dingwall and Murray's research is also valuable in that it provides sociological understanding of the organisationally constituted patient categories that occur in medical settings: not only are patients consigned to categories as a result of their clinical material for doctors' examination -although the clinical materials themselves remain outside of this analysis- many patients are consigned to categories before they even reach the A&E department. This refers to the many filtering processes that exist before patients see a doctor which involve patients being placed into a category and thus an order of priority. These processes are based on doctors working 'under the rule of clinical priority' (Dingwall and Murray 1983: 142); in other words they want a steady flow of interesting cases and enough time to properly act and demonstrate their skills with each one. The staff involved in the filtering processes, however deal with unpredictable variety of patients. In this way it is the categorisation processes themselves that bridge the gap between doctors and the filtering staff. The filtering staff provide the grounds upon which to hold back some patients and accelerate others, while the doctors revise the clinical status of the patients upon examination thus making the action taken previously automatically defensible.

This work is particularly valuable in that it develops Jeffrey's study by using his ideas and moving them away from a notion of deviance, identifying categorisation as grounded in the social organisation of the department, its scheduling and the maintenance of order. In taking into account organisational and institutional orderings as well as the moral typifications of patients, Dingwall and Murray extend

the field of sociological attention. However, where this valuable extension differs from the approach undertaken within this study is it remains closed as to how these orderings inform and are informed by the performance of particular types of bodies and diseases as well as persons. Significantly what remains absent is how the performance of doctors' clinical focus is itself implicated in the forms of organisational and institutional factors which Dingwall and Murray describe. Thus this study agrees with Dingwall and Murray that deviance is not always the only means with which to understand medical staff's construction of negative patient categories.

A further development away from a reliance upon deviance as an explanation for staff's categorisation of patients is provided by Strong (1980). Building on the role-relationships of doctors and patients established in his work on paediatric clinics (1979), Strong suggests that the idea that particular types of 'difficult' patients such as alcoholics are labelled 'difficult' as a result of stereotyping or ignorance on the part of medical staff misses many of the rational grounds upon which medical staff perceive these patients to be problematic. Alcoholics 'in no way satisfied the basic assumptions on which their ordinary relationship with patients was premised' (p.42). For example, medical intervention could do little to provide knowledge of, or indeed cure the problem- furthermore the patients themselves did not define drinking as a problem to be solved. Treating alcoholics is therefore 'dirty-work' due to this disjuncture in role-relationships.

Consequently this study sees role-expectation as a particularly useful analysis for understanding the interactive processes through which medical professionals negatively categorise patients. Perhaps through further attention being paid to the production of 'real' medicine, the knowledge practices that, in their performance, work to set the limits of these role expectations would help better understand the establishment of what counts as 'dirty-work'. How is it that such expectations are produced and maintained? Such an understanding is essential to the practices of performing what is or is not a medical problem. As some of the accounts offered later in this chapter shows, the understanding of what is medical and what can be cured are not fixed but actively produced.

Categorisation and Patient Outcomes

While the accounts so far have focused upon the practices of medical professionals in the categorising of patients, there has been limited focus placed upon the consequences of this categorical work for patients themselves, and this is a key aspect of this study. Vassy (2001) in her study of micro-rationing in a French emergency department suggests that previous research has paid insufficient attention to the practical consequences of categorisation for patient care outcomes. The previous research shows that negative categorisation of patients can lead to delays in assessment or treatment or denial of access to care. Vassy suggests that these are two basic forms of health care rationing and in doing so makes the link between practices of categorisation and the rationing of health services. Vassy suggests that emergency departments are an interesting place to observe health rationing in action. One of the more obvious forms of micro-rationing is that of 're-directing' patients to other care settings, which effectively means they are turned away from the emergency service. This, Vassy claims, could be a form of 'rationing by deflection' (p.620) protecting resources by offloading the 'problem' to other carers.

Building on the work of Hughes (1980) and others, Vassy shows how much of this rationing work is undertaken by clerks or reception staff who, through on-the-job experience, use clinical categories to typify attending potential patients. Although patients are generally seen in the order they arrive, clerks are expected to make nurses aware of more urgent cases, putting them at the top of the pile and, therefore having a gatekeeper role and a responsibility to prioritise certain patients. This work resonates with Charles-Jones et al's (2003) more recent study on the redistribution of primary care in which reception staff and triage nurses act as gatekeepers to primary medicine that is re-distributed according to the 'old hierarchies of knowledge and expertise' (p.87). This work is highly significant and relevant to this study in demonstrating not only the significant role played by these gatekeepers in the distribution of health care but also how the distribution of medical work helps to re-accomplish relations of power.

Vassy's study showed how clerks would use the duration of time patients claimed to have suffered with the problem they presented as a useful criteria with which to assess

patients' legitimacy to the emergency service. If the problem had been suffered for more than a few days most staff would consider this patient not to be a legitimate emergency case. The doctors interviewed in Vassy's study considered that only fifteen to twenty percent of attendees were 'real emergencies' or 'really urgent cases'. Whether or not these cases were denied or 're-directed' for care was dependent upon whether the particular doctor was 'broad' (those who believe that every person or most people attending should be examined as a practice responsible to provide care and to protect against the risk of medical mistakes), or 'firm' (those who re-direct patients whose problems are more long term, suggesting they will be able to wait for care from a more appropriate service).

What is especially relevant in Vassy's study are her offerings of some of the doctor's accounts as to why this rationing work was carried out. One argument referred to what was best for patients in the long run:

'to get disadvantaged patients into the habit of coming to the ED (emergency department) is not good for them; they would be better off looking for a doctor in a health care setting who can provide both initial treatment and continuing care. What is at stake is to educate the patients as to how they should use the health care system' (2001: 623).

In a similar vein to the studies described previously Vassy shows how criteria for distinguishing between legitimate and illegitimate attendees were not solely clinical. Organisational criteria also played a role in decisions regarding patient re-direction, these included: the number of people waiting; which specialists were on-call or available at particular times of the day or night; the extent of the co-operation between the outpatient clinics and the emergency department.

Moral judgements are also revisited in Vassy's study with two particularly significant accounts: firstly, that those patients who make explicit their use of the emergency department as a more convenient care provider than other health care settings, are likely to be re-directed elsewhere; secondly, those patients who fail to follow instructions regarding return visits to the hospital, who attend frequently with trivial complaints 'break an unwritten rule about the proper demands they can make' (p.625). In such cases, the patients themselves, in their accounts of their reasons for attendance, can negotiate themselves into either 'better' or 'worse' staff constituted patient categories.

The significance of Vassy's study for this research is in showing how patients' accounts of how and why they were using health services were a means with which staff categorised them on the basis of moral worth. Although Vassy focuses her attention on the consequences of these 'micro-rationing' processes for patients, these are framed according to what she terms 'health care outcomes'. The consequences for patients are therefore situated from within medicine rather than within the patients' own world; in other words the ways in which patients are made up through the performances of medical knowledge practices and the consequences these have for patients' experiences of these knowledge practices are not explored.

Patient's Participation in Categorical Work

The issues of patient's participation in processes of categorical work are important for this thesis' understanding of the production and maintenance of emergency medicine. In previous explanations of patients' participation the focus has been placed on the relationship between patient compliance and staff's categorisation of them as good or bad. Lorber (1975) for example, in a study of surgical patients in a general hospital in the US, provides an account of the extent to which those patients who did not subscribe to 'good patient' norms of behaviour described as trust, co-operation, 'uncomplainingness and 'undemandingness', were more likely to be categorised as 'problem patients'. Building on the work of Friedson (1970), Lorber suggests that the 'rationalization, standardization, and depersonalization' of hospitals 'are felt to be worth the price when the results achieved clearly benefit the patient' (p.213). Therefore rules and routines for patient behaviour are enforced on this basis, so that autonomy is reduced in order to encourage acceptance of routine treatment.

Goffman's (1968) understanding of the treatment of patients as 'non-persons', whereby the ideal situation for staff would be for the social self to go home while the damaged physical container is left for repair, is influential in the understanding of patient compliance. Lorber suggests that part of the hospital patient role, as well as the traditional components of the sick role, are the obligations to submit to hospital routine without protest. Troublesome patients were found to be somewhat neglected by staff whereas they would do more for the compliant patient. Similarly Glaser and

Strauss (1965) illustrated how patients who caused emotional scenes or were particularly questioning of staff would be scolded, reprimanded, and then avoided.

These studies provide an important but limited account of patient's involvement in staff constituted patient categories. The means with which patients may succeed in achieving positive staff constituted categories may be through more complex means than mere compliance and adherence to institutional rules and practices.² This research shows how patients who are able to provide convincing accounts that accomplish themselves as fitting the perceived categories of 'good' or 'deserving' patient may not necessarily have to lose face or comply unwittingly with staff demands.

The tradition of work discussed in this section has been integral to the understanding of medical practice as enrolled in and reproducing of socio-cultural classification. This has provided an important challenge to the construction of medicine as a knowledge practice that acts upon objectively revealed diseases or lesions in the body. Where this perspective is limited is in sectioning off the practices that produce diseases and diagnosis or medicine 'itself' from the field of study. This sectioning off reduces medicine's relations to the influence of socio-cultural orderings on medical decision making rather than exploring how such ordering systems relate to the performance of medicine 'itself'.

The benefit of this tradition of work is in challenging the perception of medicine as being distinct from the social and cultural frameworks within which it is practiced, showing that values relating to morality, status and class are not left at the door of the emergency unit. However, what are missing from their accounts are the complex relations between the moral, social and administrative orderings of patients as 'worthy' or 'unworthy', 'legitimate' or 'non-legitimate', 'good interesting' or 'normal rubbish' and the productions of patients' bodies as diseased, healthy, or traumatised.

² Goffman's work on the depersonalising affect of institutions provides a more complex and insightful offering of the relations between institutional practice and patient conformity than can be given justice here. However, these remain focussed to notions of conformity and the reduction of patients as full persons (something discussed in detail in Chapter Six). This research suggests that there may be further means with which patients may negotiate their place into more positive staff constituted patient categories.

To appreciate the contribution that these studies have made to the sociology of medicine, it is important to better understand some of the ideas being challenged by these studies. The following section therefore explores some of the ideas of medical science, or biomedicine and begins to think about how these ideas are performed and what might be accomplished through such a performance.

Medicine as Biomedical Science

This section provides some discussion of accounts that produce medicine as particular types of epistemology and focuses specifically on both the construction of ‘medical science’ or ‘biomedicine’ and critiques of such constructions. The purpose of the presentation of these accounts is to explore how medicine has been performed as a particular form of knowledge practice that is able to reveal diseases and legions in the body: in a sense these accounts attempt to construct what medicine *is*. Through analysis of these accounts as well as the critiques that attempt to conceptually shift these descriptions to an exploration of what medicine *does*, it is possible to see how such a performance is accomplished: what sorts of bodies, diseases and patients are produced as a result and what the consequences of such a performance might be for patients.

The accounts of scientific medicine have been drawn mainly from the ideas created and developed by physicians in Europe, particularly in France during the eighteenth and nineteenth century. This was a period that according to Porter (1997) saw the sedimentation of ‘scientific medicine’ that came to characterize the medicine of the West. Embroiled in this change was the notion that all that was needed to be known about disease and illness could be found in some form in the body. Porter suggests it is this particular development of medicine that can be identified today as a large contributing factor in our cultural landscape:

‘The west has evolved a culture preoccupied with the self, with the individual and his or her identity, and this quest has come to be equated with (or reduced to) the individual body and the embodied personality, expressed through body language’. (Porter 1997: 7).

It could also be suggested that medicine is *both* enrolled in and (re)produced through the cultural landscape of its time; a suggestion in part illustrated in the studies

discussed in the previous section. What is important to remember is that medicine, contrary to some of the accounts offered here, has never existed outside of the institutions and cultures in which it is practiced and produced. The relations between medical knowledge practices and cultural orderings cannot be viewed simplistically as causalities, rather they are in continual dialogue and it is through this dialogue that it is possible for particular orderings to become dominant.

A more detailed attention to these accounts, offered here, also brings to light how medicine has never existed as a coherent body of knowledge with one clear epistemological foundation; rather medicine is shown to have coexisting systems of knowledge that shape the practice of medicine in different ways. What this thesis attempts to show however is the contradiction between the heterogeneity of medical knowledge practice and the performance of medicine by clinicians, in aspects of their identity and membership work, as constant, stable and a 'true' reading of the body.

A significant figure in the production of medicine as science was Claude Bernard, whose aspiration was to produce a medicine that sought to hold true to its laboratory foundations. Bernard's is a classic account of what many commentators within the social sciences have termed biological reductionism (for example see the work of Cunningham and Andrews 1997). For Bernard, medicine is scientific and, like all science, can only be discovered by experimental means; as such one should adopt the same reasoning whether studying living beings or inorganic bodies. Although Bernard acknowledges that living beings have differing complexities and difficulties of investigation that make these principles much harder to apply to medical science than to physics, for example, it was his premise that,

'The more complex the science, the more essential it is, in fact, to establish a good experimental standard, so as to secure comparable facts, free from sources of error. Nothing, I believe, is to-day so important to the progress of medicine'. (Bernard 1856/1957: 3).

Such an account produces medical knowledge as a scientific epistemology based upon ontology of objective reality that can be revealed through the practices of physicians. Patients within this construction of medicine become mere distractions to that which can be revealed through experimental means in the laboratory.

Accounts and critiques of medicine as scientific from philosophers of medical science offer a detailed analysis of these scientifically performed frameworks for understanding disease. Their analysis shows how, as an epistemology, the medicine that is produced in the works of physicians such as Bernard are in fact quite different to the epistemology of science in important ways. These contributions are helpful, not only for understanding some of the cultural orderings that interact with the production of medicine 'itself', as ideas that both derive from and give birth to the socio-cultural orderings that were discussed in the previous section, but also for showing some of the important distinctions that can be made between the accounts of various physicians of 'medical science' and the different realities they make.

Through such critiques we are better able to pay attention to these constructions, not to understand what medicine is, but to understand how medicine performs itself as 'scientific'. The importance of this understanding for this thesis is to gain a better appreciation of the relations medicine has to forms of managing, the typifications of patients, moral judgements and institutional pressures such as those described in the previous section. If medicine 'itself' is performance, then it is possible to understand it through these complex interrelating systems of ordering.

Canguilhem, a significant French philosopher of science of the twentieth century, wrote about the particular construction within medical science of normality and pathology. His significance for the purpose of this debate is his provision of both a thorough explanation of and challenge to the reduction of medicine and biology to a physical science that he suggested was established through the constructions of disease developed during the eighteenth and nineteenth century. Canguilhem (1966/1989) sought to reopen and critique the thesis 'to which pathological phenomena are identical to corresponding normal phenomena save for quantitative variations' (p.35).

The link between the normal and the pathological is an important story to tell in the making of medicine as science. Bernard in particular suggested that in order for medicine to become scientific it must be founded on physiology, on the normal:

'Since science can be established only by the comparative method, knowledge of pathological or abnormal conditions cannot be gained without previous knowledge of

normal states, just as the therapeutic action of abnormal agents, or medicines, on the organism cannot be scientifically understood without first studying the physiological action of the normal agents which maintain the phenomena of life'. (Bernard 1856/1957: 2).

Bernard's ideas worked to sediment the separation between physiology, allowing the maintenance of the normal state of living, and pathological: showing us disease and the causes of diseases, thus replicating the binary position of the normal and the pathological.

'Knowledge of causes of the phenomena of life in the normal state, i.e., physiology, will teach us to maintain normal conditions of life and to conserve health. Knowledge of diseases and of their determining causes, i.e. pathology, will lead us, on the one hand, to prevent the development of morbid conditions, and, on the other, to fight their results with medical agents, i.e., to cure the diseases.' (Bernard 1865/1957: 1-2).

For Canguilhem, the connection between the normal and the pathological encapsulates two distinct and yet supporting representations of disease. In the first representation, developed through the work of Pasteur in his germ theory of disease, it is possible to see the object of disease, the germ, albeit through the means of a microscope. What is significant about this representation is that to see an entity is already to foresee an action as the entity is localized in the body (as Canguilhem notes, in order to act it is necessary to localize). The action comes in the form of restoring the diseased organ to its normal state through various technical means, thus viewing nothing good to come from nature (Canguilhem 1966/1991). The second representation sees disease as being a generalised reaction to bring about a cure; the organism develops a disease to get well. This representation works in direct contrast to the previous representation as it views nature as working through equilibrium outside, within and throughout the human body. Therapy must therefore first tolerate and even reinforce these spontaneous, therapeutic reactions from the body.

What exists in *both* these representations is that 'to govern disease means to become acquainted with its relations with the normal state, which the living man – loving life – wants to regain' (Canguilhem 1966/1991: 41). Canguilhem's criticism of these representations of disease within medical 'science' suggests that medicine as an epistemology encompasses far more than the mechanical modelling of organisms. Furthermore he suggests that through ideologically prioritizing the physiological, it supports the positive contention that the normal can be known and laid down as law,

prior to the pathological, thus becoming obsessed, not with human nature, but with normality its representation.

Following Canguilhem, Foucault provided further insight into the production of biomedical perception. Through understanding the domain, the limits and boundaries of medical knowledge as shifting and emerging over time, Foucault further developed the notion of medicine as a culturally specific form of rationality as opposed to an objective science. Significantly Foucault shed light on the emergence of the pathological body. Foucault's analysis mainly focussed on the work of Bichat, a French anatomist and physiologist writing mainly during the latter part of the eighteenth century. Bichat's main contribution to medical science was his work on anatomy and experimental surgery but most significantly it was his identification of the importance of tissues as distinct entities and his argument that diseases attack tissues rather than whole organs: thus his fundamental contribution was to show that the differences between the normal and the pathological lay on a continuum: 'Disease was not distinct from health as black from white; rather illnesses occur when normal functions went awry: they were shades of grey' (Porter 1997:313).

Foucault maintained that Bichat's work created a visualization of the surface of the body and thus a new foundation through which medical knowledge could be performed. In place of symptoms or organs, tissues assumed primacy and were regarded as pathological sites.

'Even as the guillotine was dispensing its political medicine, this outlook made death the essence of medical inquiry. In Bichat's view, life ('the sum of all the functions by which death is resisted') became somehow contingent, evanescent and, in the end, a loser. No longer was dying, as the Hippocratics taught, a natural terminus; like the Terror, indeed like the Grim Reaper, death ruled the world.' (Porter 1997: 307).

Bichat's work therefore established death as the surface upon which to visualize disease. Our lives, under this understanding, are punctuated with multiple miniature deaths. This not only shifted understandings within medical thought and practice but also fundamentally changed the relationship between life, death and disease:

'It is not because he falls ill that man dies; fundamentally, it is because he may die that man may fall ill. And beneath the chronological life/disease/death relation, another, earlier, deeper figure is traced: that which links life and death, and so frees, besides, the signs of disease.' (Foucault 1973: 155).

Thus disease itself is territorialized upon the question of death. It is at this moment that medicine as a particular way of seeing began to spread beyond the realms of medicine itself as it was able to talk about life and its relation to death in new ways, thus helping to produce itself as knowledge that could offer more than the practices of treating disease.

Osborne (1998) makes the point that within this particular construction of medical perception, disease is produced on the basis of what can be observed within the body; it does not have an existence of its own. This is quite contrary to Bernard's experimental medicine where disease is best revealed abstracted from the patient's body and viewed in the laboratory. He explains that it is often noted that the 'case' history used in modern medicine is based upon the Hippocratic writings; however this is somewhat misleading. In Hippocratic writings case history is a method with which to discover how the disease has interacted with the patient, how it has affected them, an understanding of illness that characterised the Antiquity period of which Hippocrates was the founding father (Porter 1997). Osborne suggests that the modern use of case history is quite different: the case somehow *is* the disease. Disease in this sense has not essence but rather becomes events, thus creating a body of knowledge that is numerical in its approach, dealing with regularities in disease. This is useful in thinking about how particular kinds of diseases can be produced with specific techniques from which to discover them. This specific performance of medicine is relevant in understanding how a performance of disease as a culmination of events relates to forms of managing and regulating medical practice (a point developed in detail in Chapter 8).

Medical perception, through the critical analysis of medicine as science from the philosophers such as Canguilhem and Foucault, shifts and becomes understood as being ideological in its epistemology. This understanding shows its persuasive strength as knowledge practice, not just for understanding disease and illness but also for human life, death, health and well being. Osborne (1998) explains that this is not to devalue it or suggest that it may be false. It is ideological in that it represents more than the sum of the institutional realities of medicine and thus there is the capacity for medical norms to stray beyond themselves and infiltrate other forms of knowledge.

Understanding medicine as an ideology is useful in understanding how medicine is able to reassert its dominance, particularly as it is becoming increasingly contested. As Greco (2004) suggests such a concept offers a more complex analysis of medical knowledge than the distinctions between science and false science or orthodoxy and heresy. This is because,

‘it enables us to preserve a crucial acknowledgment of the specificity of science in general, and of medical science in particular. On the other hand, it also allows us to challenge the sharp contrast between science and non-science by setting the contrast within a diachronic perspective.’ (p.687).

Medical ideology makes claims about reality that reach further than the norms of science would allow. Furthermore medicine as an ideology applies those explanations within general controversies associated with political, legal, moral or simply practical dilemmas: ‘scientific ideology derives its impetus from an unconscious need for direct access to the totality of being’ (Canguilhem cited in Greco 2004: 688). The understanding of medicine as ideological is revisited later in this chapter to further explore how the ideas produced through performances of medicine as biomedicine have become embedded in wider discourses of social and cultural relations. Before moving on to this discussion, it is necessary to reiterate that it is the production and performance of biomedicine that is of interest to this research. This is in contrast to some interpretations of biomedicine that suggest an understanding of what medicine is rather than what it produces. It is also important to make clear that these productions of medicine as forms of biomedicine are attended to in order to elicit some of the discursive, rhetorical and material means with which medical ‘facts’ are made. This can be seen as part of clinicians’ engagement in a process of ‘heterogeneous engineering’ (Law 1987)

Medicine as a Pure Domain

Osborne’s (1998) interpretations provide some useful observations regarding how these ‘modern’ (established during the development of ‘scientific medicine’) ways of looking and seeing construct an understanding of illness and disease and, in particular, what these understandings might mean for medicine’s wider appropriation. However, in his analysis he often shifts from talking about the production of modern medicine as embedded in the practices of looking and seeing, to offering explanations for what

modern medicine actually *is*. In this shift however Osborne is in danger of falling into a trap of producing an abstracted description of medicine, one that exists outside its production in social relations. There are moments when Osborne moves to the position of making his own coherent and stable medical reality through suggesting what is at the heart of what medicine is:

‘Perhaps one might even say that such a gaze is generically ideological in that it entails a combination of different rationalisms and their synthesis into a norm that is more than the sum of the norms of such rationalisms but which has a conjectural yet ideographic logic of its own; for the practising doctor, a necessary ideological effect to be sure. Such an individualizing gaze is at the heart of what medicine is, yet also sets the limits to medicine as a form of rationality.’ (Osborne 1998: 263-264).

Accounts of medicine as ideological are much more useful in understanding how it is possible for different kinds of medicine to be produced across time and space than accounts of medicine as science allow; however Osborne’s particular treatment of medical perception as abstracted from social relations- implying that it can be known and talked about outside of the practices that work to produce it- is at risk of producing another account of medicine as a pure domain.

Interestingly it is not only the abstraction of medical ideas from their enacted performances that can fall under the danger of re-producing medicine and the clinic as a pure domain. Writers who focus on the distinct and separate ways of knowing and practicing within medicine by medical professionals with detailed description of sites and institutional settings as being distinctively and uniquely medical, can also help to produce similar accounts of medicine as pure, unpolluted domains that exist outside the politics of its organisation and its production through its relation to other cultural orderings.

Atkinson’s (1995) account for example, although particularly insightful in suggesting that medical knowledge is grounded in material as well as cultural resources, draws attention to how medicine is produced and reproduced through socially and culturally distinct practices. Atkinson shows how it is through the ceremonial practices of medical work, such as a ward round, that recreate the consecrated space of the clinical encounter:

‘The clinical gaze is focused on the patient, whose presence is the literal embodiment of medical rationality. The dramaturgical enactment of the teaching round is a daily

reconstruction of modern medicine. Through it, the clinical gaze is reproduced and warranted' (p.61).

The organisational complexity of the hospital is also shown to disperse the clinical gaze so that it is not focussed solely on the patient's body at the bedside; the body is fragmented and made through the work of a number of social actors and technologies of inspection (laboratories, x-ray, ultrasound etc) in many different spaces where data relating to the body 'may be read and interpreted in *absentia*' (p.62). All of these work to produce representations of the body that subsequently become the object of the gaze.

Medical textbooks and other guides that include illustrations of anatomical features through photographic or diagrammatic representation are also instrumental to the reproduction of medical knowledge. Reference to such examples through the course of medical work draws the practitioner's attention to what could be described as an 'ideal type' (Atkinson 1995: 69), as they seek to simplify and reduce the ambiguities and complexities of what is being seen through offering a representation of the right sort of features for that particular pathology.

Although the complex organisation of the hospital is shown to disperse the clinical gaze, this complexity is represented upon medical grounds; it is a reflection of the technological and epistemological nature of medicine in practice that reconstitutes its gaze across time and space. In Atkinson's account it is the culturally and materially unique medical domain that is being produced or 'the consecrated space of the clinical encounter'. This account is replicated in much of the work undertaken by medical professionals in the performance and production of medicine. Medical knowledge and practice reproduces itself as unique, as existing apart from all other forms of knowing and acting in the world.

Particularly important in this research is the absence of patients, other than their inclusion as the object of medicine, thus reproducing an understanding that medicine can be best understood apart from patients, such as the description of laboratory medicine described by Bernard (1865/1957). Atkinson's account is therefore useful in showing how medicine performs itself through the ceremonial practices of medical work and particularly through paying attention to the materiality of medical

knowledge practices. However, further attention needs to be paid to the organisational politics of medical knowledge production and further still to the consequences of such practices for the patients who experience them.

Medicine as Ideology

Returning to the concept of medicine as ideology, this section helps make sense of some of the complex ordering systems bound up in the production of medicine as 'biomedicine'. The discussion of these ordering systems further illustrates the dialogue, discussed earlier in the chapter, that occurs between all forms of knowledge production whether moral, social, scientific or ideological and how these relations help medicine perform itself in various ways. Law (2004) and Mol (1998) suggest that those aspects of knowledge production that are able to successfully map on to one another are most likely to become naturalised ways of thinking or knowing (Law 1994), so that the cost of undermining such claims becomes too 'expensive'. This discussion is therefore important in showing how it is through the relations between knowledges, the adoption and adaptation of ideas in the performance of medicine, that has helped it maintain its position of power. In other words it is the skilled practices of alignments made between forms of knowledge, texts, people and materials, that are often disconnected and disordered, that makes the performance of medicine as being ordered and stable possible.

In moving from an account of medicine as science to medicine as ideology, it is possible to talk about how the production of medical perception can occur outside the boundaries of the clinic. Some of the scientific accounts referred to earlier, now reconfigured as ideological, take on quite different connotations. The significance of Brousaiss work, as Hacking (1990) describes, is that such physiological medicine is preoccupied with determining how 'excitation can deviate from the normal state and constitute an abnormal or diseased state' (Brousaiss cited in Hacking 1990: 82). Thus the meanings attributed to the word 'normal', according to Hacking, evolved in a medical context. When pathology became the study of unhealthy organs rather than sick people, it became defined as deviant from the normal, as all variation was characterized in terms of variation from the 'normal' state.

According to Hacking it is this understanding of normal that, partly as a result of Comte's enthusiasm for Broussais' work, entered the sphere of the social. 'Normal' in this context became more than the ordinary healthy state, it became the purified state that we should endeavour to achieve: 'in short progress and the normal state became inextricably linked' (Hacking 1990: 168). The term 'normal' holds a hidden power, not just of ambiguity between fact and value that had previously lived within 'normal', but also of the contention between normal as average and normal as perfection to which we may evolve.

It is the power that productions of the normal and the pathological have held outside the realms of medical institutions that is of significance here:

'Such is another medical ideology: something which may be unremarkable in narrowly medical terms, but which has powers, so to speak, beyond itself, as a principle of transferability.' (Osborne 1998: 270).

The notion produced in Bernard's account provided earlier, of the need to map out normality in order to pre-empt and control the abnormal, has reached far beyond the realms of medicine. This has allowed for and encouraged a mapping out of pathological states that represent not just disease, but criminal behaviour, mental health or even unemployment which can then be compared to constructed characteristics of normality. As a result, these pathological understandings derived from the ideological premises produced within medicine have become powerful tools for attempting to understand, not only ill health and disease but also social problems such as crime and poverty (Foucault 1973; Conrad 1979; Rose 1999, 2005).

For the power of expertise, the normal is an immeasurably useful concept for what Foucault termed 'the disciplines' such as psychology, pedagogy, social work etc:

'For the marks that once indicated status, privilege and affiliation were increasingly replaced – or at least supplemented – by a whole range of degrees of normality indicating membership of homogeneous social body but also playing a part in classification, hierarchization and the distribution of rank' (Foucault cited in Osborne 1998: 270).

Osborne (1998) argues that at the heart of all these disciplines lies the original corrective human science, medicine. These disciplines might not use the normal in the exact medical notion, but they borrow it in the context of different 'regional rationalisms'. A particularly useful re-framing of medicalization that Osborne puts forward here is to suggest that, instead of understanding medicalization as a

conspiracy that tells a story of medical authority holding dominance over other areas, what should be considered is that it is an ideology that has principles of functioning that can be shifted and used in other fields of knowledge. This thesis would suggest that medicine's principles of functioning are multiple, as the accounts here have already indicated. However, the notion that these can be shifted and used in other fields is particularly useful. Even more useful for the purposes of this thesis is that those medical ideologies may also be just as capable of taking on other forms of knowledge or ways of seeing that can be used to help perform its functioning principles.

Conrad (1979) points out, medical ideology as a form of social control, can occur without the active participation of the medical profession. His analysis is useful in understanding the permeable nature of medical ideas not only in issues of wider social concern, such as deviant behaviour, the focus of Conrad's work, but its incorporation of ideas that suit its purpose:

'An irony of the medical use of behaviour modification is that behaviourism explicitly denies the medical model (that behaviour is a symptom of illness) and adopts an environmental, albeit still individual, solution to the problem. This has not, however, hindered its adoption by medical professionals, perhaps because physicians frequently have been only able to treat 'symptoms' rather than causes, anyway.'
(Conrad 1979: 4).

The boundaries of medicine according to Conrad are becoming increasingly elastic and expansive. However, this is not viewed simplistically as being merely the consequences of a powerful professional group, rather it relies on an adoption and adaptation of dominant ideas within wider society; this thesis would argue that the adoption and adaptation of ideas occurs within the production of medicine as well as outside it. An example offered by Conrad is the definition during the nineteenth century of masturbation as an illness in order to control what was at the time deemed socially and morally unacceptable behaviour.

Building on the notion that medicine as ideology is able to adopt and adapt to other forms of knowledge, Osborne (1993) suggests that certain neo-liberal ideals are infiltrating the medical domain through the development of clinical governance. This argument is based on the contention that the relationship between medicine and the state must not only be viewed in relation to the state's adoption of particular forms of

rationality that are ideologically medical. However, government is not only significant for securing or curtailing the protection, status and power of the medical profession, but also, according to Osborne, has in recent years attempted to shape the very foundations of medicine itself.

Although, there is current criticism of the neo-liberal corrosion of medical autonomy, there needs to be more recognition of the historical links that exist between liberalism and the professions. Using Foucault's notion of liberalism as being a permanent critique of governmental reason (a form of government always critical of itself), Osborne (1993) suggests that medicine and liberalism are closely aligned within the idea of 'liberal profession'.

The liberal profession is always suspicious of its own authority, must establish responsibility both within itself and to its constituency without seeking to govern either professionals or their clients in a straightforward, directive way. For medicine this represents specific concerns within its own ideology.

"Perhaps this is because, given the generic 'incapacity of the patient, it is within medicine that the legitimacy of the authority relation will be particularly problematic, not least because relations between doctor and patient are no doubt intrinsically difficult to contractualize." (Osborne 1993: 346).

Prior to the modern establishment of medicine in the 19th century, healers competed in an open market of expertise in order to attract students to their particular medical endeavour (Porter 1997), so that truth became something that could be owned and sold. Now, however the clinical ideal is organized around an unfolding truth to which both doctor and student are servants. In this sense it is truth itself which governs the medical profession. It is therefore the profession itself that provides the guarantee of medical competence, as it is the profession itself embodies this clinical truth.

However, when analysing this issue with regard to the profession's responsibility to the patients, it is how this truth is to be regulated that is of concern. This has traditionally occurred at a distance. Rather than there being control over medical acts, control is framed in terms of 'regulating the competence of the subject of medical

truth' (Osborne 1993: 349). It is therefore the task of the profession to provide the establishment of conditions for assessing the competence of practitioners.

Osborne makes the argument that those acts with which to delimit the expertise of the profession, such as ethical codes of practice or the introduction of a medical register, were not simply a means of securing status patterns for sectors of the profession and to enclose medical knowledge. They were in fact liberal manoeuvres. They attempt to govern medicine at a distance, even whilst this entailed the maintenance of the social status of clinicians as a key determinant of competence itself.

Through Osborne's argument, the strong link between liberalism and medicine is made clear; the very nature of medicine becomes entwined with those of liberal values and concerns. Within Britain in the nineteenth century there was a definite contractual, hence liberal nature of clinical medicine. Physicians would gain knowledge and status through providing their expertise freely in hospitals in response to the available wealth in private practice. 'This is reciprocity of a liberal order in so far as it entails self-governing, and no doubt self-perpetuating "economic" exchange' (Osborne 1993: 350).

To return to an earlier discussion, it is not only liberal ideology and the notion of the liberal profession that was inherently linked up with medicine itself, but also medical reason began, during the mid-nineteenth century, to be called upon not just for clinical questions but for much larger issues of society through bio-political technologies of public health, sanitary provision, geographical topographies of disease, and so forth. 'No doubt the very idea of society, as an organic whole subject to laws and variables derives from this moment of installation of the medico-administrative complex in the mid-nineteenth century.' (Osborne 1993: 351)

However, this coming together of medicine and governing for the most part seemed to work one way, in the taking up of medical rationality in the political understanding of society. There was, during this time and for some time to come, a limiting, liberal notion of governing applied to medicine and the medical profession. Even when welfarism took hold, and the National Health Service became a reality, there remained a liberal sensibility when it came to the government of medicine.

“In short, welfare like liberalism placed a certain value upon the powers of clinical truth, itself to act as the regulator of government; if medical knowledge were left to itself the requirements of government would decline. Even the continued existence of a private sector through the period of the NHS perhaps could be said to have acted as a kind of guarantee for this rule of clinical truth. If truth could maintain a market for itself then this would guarantee the strictly neutral and economic deployment of truth within the socialized context of the NHS itself.” (Osborne 1993: 352-353)

In recent years this separation may not be useful. Simply to understand the power of the state as being restricted to the organisation and administration of medical provision is to underestimate the influence that recent regulation has had. Although we have already seen in previous governments the role of the state in laying the foundations for the infiltration of managerial, market led practices within the health service, these have often been met with conflict from the medical profession on the basis that they have worked against the pre-eminence of clinical truth as a means for making clinical decisions. However more recent regulation, in the form of clinical governance, has attempted to enrol the medical profession and to impart particular ways of thinking, not only to the medical profession but to attempt to make them part of medicine itself, thus having real influence over actual instances of medical assessment, treatment and diagnosis (this argument is discussed further in Chapter Eight).

What some of the descriptions of medicine discussed in this section miss- particularly in the accounts of medicine as pure- is the extent to which constructions of medicine as science exist among other possible constructions that have, at particular moments, taken precedence in the actions and interactions of those who enact them in performing medicine. As Foucault makes clear it is medical discourse that constructs the object of which it describes. Significantly for Foucault the ways of seeing described as ‘modern medicine’ only exists in the social relations of the clinic, the ways of seeing that are brought into being through their emergence into language:

‘it is nothing more than a syntactical reorganization of disease in which the limits of the visible and invisible follow a new pattern; the abyss beneath illness, which was the illness itself, has emerged into the light of language.’ (Foucault 1973: 195).

In spending time analysing the work of specific physicians of ‘medical science’ and in identifying the different kinds of medical science they make, the very notion of knowledge as solid and stable rather than productive and performative is challenged.

The accounts that construct medicine as a science are helpful in order to attend to the intricacies through which medicine can be produced, so that medicine is not understood as a coherent whole (Berg and Mol 1998). For the purposes of this research medicine is not understood as a fixed, stable knowledge form that can be theorised outside the practices that produce it; instead it is embedded in the social and material relations of the clinic. However, an analysis of the production of medicine as science is useful in focussing attention on how and why medicine is at times performed as simply revealing what *is*, as objectively diagnosing and treating disease in the body. Hence, as the previous accounts of medical science have shown, medical knowledge is heterogeneous; there are multiple conceptions of disease that are able to co-exist, not just through the accounts of clinicians but in the materiality of clinical work. These multiple accounts, as the next section attends to, sit alongside other forms of knowledge that are (re)produced in medical work.

Medicine as Performance

In the previous section the descriptions of medicine as ideological were useful in establishing how medical knowledge practice is able to be flexible so that knowledge, in this context, is not based upon objective facts as suggested in Bernard's (1865/1957) account, but rather as practices that produce particular objects and subsequent effects. This section analyses an emergent tradition of work that moves beyond the divisions between a tradition that focuses on the social elements of medical decision making, resulting in the failure to provide analysis of how and why medicine produces itself in particular ways, and a tradition of work that accounts for medicine as epistemology that can be abstracted from the practices that work to produce it.³

³ Understanding medicine as ideological has provided the starting point for thinking in a more complex way about the relations between medical knowledge practice and the forms of socio-cultural orderings described in the first section of this chapter.

The Patient as Subject

Armstrong (1983) is particularly important in challenging the idea that the production of medical knowledge can be understood as mere biological reductionism; an epistemology that is only interested in the body without taking account of the 'whole person'. In his study of British medical knowledge in the twentieth century Armstrong suggests that the social and the subjective 'whole person' have increasingly entered into the realm of the medical knowledge practices:

'The new body is not a disciplined object constituted by a medical gaze which traverses it, but a body fabricated by a gaze which surrounds it: the new body is one held in constant juxtaposition to other bodies, a body constituted by its social relationships and relative mental functioning, a body, of necessity, of a subject rather than an object.' (Armstrong 1983: 102).

A particular account of this shift is in the changing nature of the doctor-patient interaction. Armstrong analyses what he describes as a new discourse that engenders a fabrication of the patient as a subject. However, the frameworks of this introduction of the patient as subject were based upon the problem of the patients in creating limitations for doctors to successfully treat the patient as object. This builds on a particular conception of medicine as science whereby patients are reduced to pollutants that complicate the route to observing what exists in the body. These subjects were therefore constructed in particular ways. Firstly, the patients as a problem were constituted as 'defaulters'- this later was reconstituted as 'compliance'- suggesting that patients as subjects could not be assumed to act upon medical advice. This eventually shifted to the problem of communication, recognising that little of what doctors tell patients can be understood or remembered so that the patient as a full person was constructed as in need of enlightenment and reassurance. Armstrong suggests that this focus of medical attention on specific aspects of the patient's personality reflected an inclusion within medical practice of more predominant psycho-social considerations, thus resulting in a medicine in which 'the whole patient must be studied and treated as well as his infected tissues...every patient is anxious and disturbed' (Armstrong 1983: 107).

What Armstrong argues is that an individual identity of the patient was created through this discourse so that medicine- as previously with the body- worked to

construct the 'idiosyncratic patients' as effect and object of knowledge. It became a way of ordering bodies among other bodies which, in doing so, constituted them:

'A discourse on default constituted the patient as a potential defaulter; a discourse on communication rendered meanings between doctor and patient problematic; a discourse on personality established the centrality of patient subjectivity to the medical enterprise; and so on.' (1983: 110).

The whole person therefore actually becomes fabricated on these smaller discourses. Armstrong's account is helpful in showing how the specifics of medical discourse work to construct its objects so that patients, as subjects as well as objects, can be made and remade with significant consequences.

Good (1994) suggests that in order to understand further how medicine constructs its objects it is necessary to bring together critical studies of practice and the analysis of embodied experience. Furthermore he argues that whatever grounding medicine has in the materialism of the natural sciences, as a form of activity it joins the material to the moral domain. Here Good brings together medicine as epistemology and medicine as social as inseparable from one another as they are bound up in embodied experiences. Through the study of medical students, Good shows how the reproduction of medicine involves more than merely taking on new knowledge but rather it is 'a process of coming to inhabit a new world' (p.70).

The world of medicine gets built up as a distinctive world of experience, a lifeworld with a distinctive reality system. Good describes first the learned practices of seeing, in which the body becomes newly constituted as a medical body, such as the bodies made up in the accounts of the physicians of 'medical science' discussed earlier in the chapter; this is separate and distinct from the bodies with which we interact in our everyday lives. Accompanying this shift in perception- extending Foucault and other earlier analysis- are complex and distinct emotional responses that emerge from understanding the body as a site of medical knowledge. Furthermore in learning and accomplishing new (medical) forms of writing and speaking, students are enrolled in and reproduce the world of medicine as a distinctive lifeworld, so that the clinician's approach to diseases, patients and illnesses are approached with these distinctive forms in mind. As Good comments, 'writing authorizes the medical student as it constructs the patient' (p.77). Good's work is significant as it provides details of how

knowledge is produced through its enactments in the clinic, in practices of writing and speaking, that help to enrol the performers in the production and reproduction of medicine.

In building on the complexities of medicine as it is produced and performed, Silverman (1987) criticises the stark distinction made between the discourse of medicine and the discourse of the lifeworld and suggests that this approach ignores the place of medical discourse in modern societies and the ways in which it has entered our own accounts of ourselves; an argument that has resonance both to the accounts of medicine as ideology and the perspective taken within this study. He also argues that these accounts often prioritise the voice of the lifeworld as somehow being more authentic, without recognising that the assumptions of the values through which such voices emerge are in many cases in line with progressive practices of the caring profession.

Silverman is thus correctly concerned with the calls being placed on the medical profession to open its narrow frame and move away from the biomedical model (whatever this refers to)⁴ towards a social perspective where all elements of personal, emotional and environmental life are considered:

‘Such a social perspective seems to offer a totally unrestricted form of surveillance in which the medical gaze can roam freely. It also is naïve to assume that a discourse of the social is necessarily liberating.’ (p. 198).

Arney and Bergen (1983) build on the concerns outlined by Silverman by suggesting that by the mid-twentieth century socio-emotional elements of patient care had become technical concerns central to medical discourse that was expanding to become something more than strictly medical:

‘Mechanistic relationships in the body lost their prominence to relationships mediated by information flows in a broader ecology. The domain of the doctor expanded. The socio-moral definition of life was joined with the bio-physical definition of life to form a single medical discourse on life that was something greater than the traditional, strictly confined medical discourse.’ (p. 12).

The significance of this for medical practice and doctor-patient relations, as Silverman describes, is that it incites patients to talk and through their accounts patients are

⁴ As the analysis offered here alludes to, the ‘biomedical’ model encompasses quite complex and at times multiple and contradicting accounts of medicine.

enrolled in and thus aid the production of this expanding medical discourse. This is not to suggest that this expanding medicine locates the patient's view as always central, rather there is still a tension that exists between reading the patient as object and reading the patient as subject. Furthermore, from the point of view of sociological analysis, Silverman suggests that we must keep in mind the difficulties for commentators to stand outside the contemporary discourses contained within these debates; we are, in part, enrolled in its construction, as this chapter has begun to show. He argues, therefore, that we must go beyond genealogical analysis and attention to text to undertake analysis of medical work in practice in order to study the relation between voices and their production of discursive forms.

Silverman is important for the purposes of this discussion in three ways: firstly, in recognising that there are many constructions of medicine, not only those produced by the medical profession themselves but also, significantly, they are produced from within patients' talk; the second element of Silverman's work which holds relevance for this study is his challenging of the idea that medical knowledge practice produces one coherent form of knowledge that can be described and analysed- in particular he challenges the notion that medicine only speaks of patients as objects; thirdly in challenging the separation made between the talk of 'medical science' and the talk of the 'lifeworld', Silverman helps to show how these discourses are only ever produced in dialogue with each other, for example in the interactions between doctors and patients so that medical and social discourses are available to both.

Medicine and Its Practical Enactments

One study that does pay attention to the production of discursive forms in the production of medical knowledge is Berg's (1992) study, working within the field of the sociology of science. In his 'laboratory study', he makes visible the processes by which physicians transform a patient's problem into a solvable problem. Berg makes clear that for a problem to become solvable the doctor must be able to propose a disposal, and this disposal is the result of the reduction of all possible forms of action that could be taken into one. For Berg, there are many processes by which medical professionals, just like scientists, are able to achieve a specific result. Patient histories, for example, previously thought to be simply uncovered by the physician,

are on the contrary reconstructed in the process of making a problem 'solvable'. The type of question a doctor asks, the way they are asked, and the interpretation of the answers, are all ways in which the doctor, while obtaining a patient's history, steer the conversation in order to 'correspond to the transformation she has in mind' (Berg 1992: 156).

Just as scientists undertake one type of experiment over another in order to prove a given hypothesis, for Berg doctors similarly select certain examination procedures and omit others,

'thus pre-structuring the 'pathological' reality she will want to counteract. Furthermore, the way the examination is performed equally shapes the outcome. When the physician does not expect crackles or wheezes, she will listen to the lungs more hastily and hear less; when she does expect added lung sounds she will auscultate more thoroughly and, accordingly, hear more.' (Berg 1992: 158).

Berg outlines how both patient histories and examination data can be given more or less validity depending on their usefulness in determining the desired transformation. As in the work of Jeffrey (1979) and Dingwall and Murray (1983) described previously in this chapter, the character of a patient may be brought into question by medical staff which serves to downgrade the data derived from patient histories: examples of medical staff's downgrading of patient's data within Berg's study include the adding of phrases to the patient's notes such as 'according to the patient' or simply adding quotation marks to their comments. Moral questioning of a patient's character- this occurs within the work of Berg though not Jeffrey or Dingwall and Murray- occurs only as part of the overarching process of transformation that staff, through continual negotiation of the available data, are trying to achieve: if the data is useful, the patient can be described as 'intelligent' or 'rarely visits the physician' (Berg 1992). Similarly the validity of the examination can also be questioned or given emphasis by up or downgrading the quality of the performer or the worth of the examination technique. These observations indicate how the basis of medicine in practice- gaining patient histories and performing examination procedures- are shaped and moulded by individual medical professionals in a way that, as Berg points out, two very different 'transformations' can be achieved with regards to the same patient.

Berg's work thus develops sociological understanding of medical decision making in providing a fuller explanation of the complexity of the many clinical, social, organisational and material elements that influence any single disposal. What Berg argues is that there is no hierarchy through which one element is deemed more significant than any other; however, an important element of Berg's work is the process by which medical professionals actively perform processes of discursive negotiation in order to achieve a 'solvable problem':

'The physician does not passively solve a puzzle with pre-set pieces: in articulating elements to the transformation, they are actively moulded and reconstructed. Furthermore, it has been demonstrated how these elements intermix with other prevailing cross-cutting systems of relevance in medical practice, such as time, organisation, image of the patient and financial considerations...There is no such thing as a secluded self-explanatory domain in medical action.' (Berg 1992: 168).

The concept, for example, of a solvable problem inherently contains within it a disposal. Therefore it is the pragmatic actions of medics that work to perform processes of 'transforming' that produce this seemingly natural disposal. Berg does not, however, suggest that there are no boundaries for medical professionals at work, rather he views the routine as the medical professional's paradigm (Kuhn 1962). The routines of medical professionals thus provide a frame of reference by which actions can be compared with others and are therefore verified by the 'safety of the norm' (Berg 1992: 170); if routines are broken, justification for this stray from the 'proper' course of action must be given. It is this routine that provides the structure in which medical action can take place.

The significance of Berg for this thesis is the way in which he details how medicine performs itself as pure, objective and scientific through the practices of producing 'solvable problems' and, more importantly, the problem identified is simply one among many. Berg's study thus shows the possibilities available in shifting attention towards how medicine is produced, how a diagnosis is accomplished through negotiating the multiplicity and at times contradictory forms of knowledge available, or how bodies are labelled as being one type of pathological reality over another. This can help further elicit how medicine, through its relations to other forms of knowledge such as those socio-cultural classifications described in the first section of this chapter, is able to produce a solvable problem.

This shift of attention towards the practices of medical professionals and how medical work is accomplished is furthered by Mol (1998; 2002) in her ethnographic work on Atherosclerosis which focuses specifically on the heterogeneity of medical practice and is particularly interested in the production of medical knowledge through practical enactments. She suggests that medical perception or medical ontology is multiple, that it is not a coherent whole. Her contention is that there are no single objects, bodies or diseases, to which medicine attends or even produces. If single objects exist at all, they only exist as virtual entities that are the result of multiple performances of disease which successfully map on to one another to form one single disease entity. Furthermore, the production of a virtual entity involves a great deal of work and is particularly difficult to achieve. In other words, medical practice performs bodies and diseases locally; thus medicine's ontology is multiple.

The significance of this perspective is firstly that it helps to overcome the difficulties for anthropology, sociology and history and philosophy of medicine- some of which have been discussed here- in either believing that the body and diseases do coincide with what medical textbooks say about them, or resisting and separating out the body and disease itself. Mol's solution to this problem provides a way to attend to the body and its diseases 'themselves' as the multiplicity of objects that are practically performed. She goes on to argue that,

'If it is true that it performs many bodies and many diseases, medical practice can no longer be defended through its foundation in the body and disease. But neither can it be attacked any longer as practice that reduces human beings to fragments while forgetting about the patients as a whole. There is no whole that can be reduced: the variety of objects locally performed do not add up to form a single picture. They go this way, that way, the other. To act in one way does not simply differ from another possible act. Instead it may even be at odds with it. The question therefore is not "what is a human being?" or "What is life?" The question is "What to do?" How do medical practices perform and change our bodies, diseases, lives and how to balance between the various alternatives?' (1998:163).

Mol's work pays attention to the material as well as the discursive practices that help to perform objects such as diseases and bodies. This helps to move beyond some of the divisions put forward in this discussion. It also suggests that if there are multiple objects available to be performed, why and what are the consequences of performing objects as single entities, particularly when this involves a considerable amount of work? Furthermore, when single accounts are not produced and multiple objects are allowed to coexist, how are decisions made regarding how to move forward?

What must also be acknowledged here is the heterogeneous forms of other knowledges that impinge on the production of these multiple and sometimes contradictory objects. Different and coexisting forms of nursing knowledge can also produce quite contradictory nursing practices that will both restrict and contribute to the production of different forms of medical knowledge. These may include a professional, decision-making and evidenced-based nursing practice for example, or on the contrary, a patient-centred, holistic and individualised one (May et al 2006; Latimer 2003). The (re)production of these available knowledges in the social and material practices of nurses' work can help accomplish, but can also restrict and impinge upon, the medical productions of bodies and disease.

In beginning from an understanding of medicine as performed and produced, Latimer's (1997) work on older people in an acute medical unit is important for showing how the production of medicine as specific forms of knowledge are deeply implicated in the practices of organising and ordering medical work. Latimer identifies how older people do not provide good materials for demonstrating good medical practice. Their needs are complex; they are difficult to diagnose quickly with often no clearly visible outcome or recovery that can be identifiable as a consequence of a given treatment. In other words older people are not easily 'transformed' into a solvable problem to use Berg's terms. This problem is partly enhanced by the difficulty in ascribing older people to a patient category. Often older people have both chronic health problems coupled with serious acute symptoms, troubles which are confounded by older people suffering difficult social circumstances. This complexity makes it difficult for medical professionals to construct older people into a medically successful disposal and it also creates problems when ascribing older people to a patient category: they generally do not provide good clinical materials thus resulting in their placement within a negative patient category.

Latimer's work in part builds on the studies described earlier in the categorising of patients according to staff's professional interests. However, unlike some of these studies, Latimer also shows how it is through the ordering work undertaken by staff in dividing up patients as medical or social, chronic or acute, that helps to perform

medicine 'itself' as distinct from the pollutants such as the social factors that influence ill health.

The notion of medicine as performative helps researchers to ask what these performances accomplish which is something that a recent study by White (2002) is especially useful in showing. White demonstrates how professionals order clusters of symptoms and troubles into a recognisable case. The work of paediatrics, psychologists and psychiatrists perform and reproduce aspects of occupational and service identities and they accomplish particular classifications of cases. In exploring the moral work that is undertaken during these processes of classification, White builds on the work of those studies described at the beginning of this chapter; however in paying attention to the performance and production of the 'case' White moves beyond the studies that chose to section off the production of diagnoses.

Where White builds and departs from previous research is in her accounting for patients in context rather than practitioners describing their work to researchers and then being watched by the researcher who judges whether this telling does or does not marry with the observed interactions. What White reveals in her work is that the telling of medical cases 'induct novices and affirm, transmit and legitimate medical knowledge, but more mundanely they get diagnosis done' (p.416). This focus is important for this thesis, in not only recognising and paying attention to how knowledge is produced and what kind of performance is being accomplished but also in its consideration of the consequences of these accomplishments.

White illustrates how a patient's problem is shifted to being understood as psychosocial rather than medical through the complex rhetorical work undertaken in the telling of the case. This argument is made through her study of multi disciplinary work in the care of children. Within this work the child as patient is identified as having a medical problem existing independently of parenting; however when the problem is seen to be exacerbated by parenting, the case shifts towards a psychosocial approach. This is accomplished through the accompanying narratives about parents or carers from those telling the case: the case now becomes 'not just medical';

'Narratives about these cases have the flavour of detective sorties with anomalous physical findings, such as failure to gain weight, set alongside characterisations of carers. Cases may begin 'medical' and evolve gradually to a 'not just medical' or

psychosocial formulation through formal and informal case-talk between professionals.’ (White 2002: 418).

White is therefore suggesting that action to undertake further investigation often relies substantially on moral judgement and these judgements are acted upon on the basis of the skills and techniques of persuasion: rhetorical and practical work to bring off a ‘not just medical’ reading of a case through the strategies of argumentation. One example that White refers to is the combination of ‘journal science’ (Atkinson 1995) and the adjudication on good enough parenting in order to produce a powerful case so that scientific, objective facts are entwined with moral reasoning and good story telling.

What White adds to this tradition of work is that routine medical knowledge practice in the hospital and clinics rely on this case-telling competency so that normative judgements about parents are a routine feature of the work. The re-definition of the case to become ‘not just medical’ allows for the moral categories of ‘bad parents’ or ‘bad patients’ (patients by proxy) to be attributed to parents. Patients’ intellectual limitations are common in paediatric accounts, but if they are ‘help-seeking’ and ‘help-accepting’ they may avoid the category of ‘bad patients’; while they are still ‘bad parents’ they may still occupy the category ‘good patients’ who are grateful and can be helped. However, White suggests that,

‘once parents breach the ‘category-bound’ expectations (of themselves as parents and as users of expert help) to accept or follow advice, or do not ‘see the need to change’, they become potentially classifiable as both bad parents and bad patients.’ (p.429).

Further to the acceptance of help from parents, a reference to gratitude is also important. White elicits the wide variety of orderings through which medical professionals are able to categorise and classify patients in their work. In judgements about the quality of parental love, clinicians routinely invoke their feelings about the family and these feelings are evoked through the processes of story telling in making a case. These feelings are constructed around the perceptions of how parents *should* be both when with their children and when talking about them;

‘In clinical practice, judgements about ‘appropriate affect’ form part of a repertoire of rationalities upon which clinicians draw in making sense of cases. Despite their qualitative nature they are indispensable warrants for certainty in case formulation’ (p.431).

White's analysis is valuable to the arguments within this thesis as it shows how medical cases are built. Interestingly it is through the performance of medical knowledge practice that both medical and 'not just medical' cases are performed. The process of performing cases in White's study shows how the importance of aspects of story telling and rhetoric are bound up with the discourses of medicine as 'science' in making these persuasive accounts. This may help us begin to think about answering the questions posed by Mol's (2002) position: if multiple realities exist how are decisions made about which reality to act upon? Perhaps it is through the skills of persuasion and argumentation that single realities are accomplished. Her focus on the participation of patients in this knowledge production, in particular their performance of gratitude, is useful for this research where the accounts made by patients are understood to be important in the production of medical knowledge practice.

In thinking about how an approach that attempts to discover how medical knowledge practice is *performed* in an emergency service, the research undertaken by Dodier and Camus (1998) in study of a French emergency service is particularly useful. Although this study could be described as a further account that attempts to look for how medicine is social, it has specific substantive and conceptual relevance for this thesis in that it is research that has helped develop some analytical tools through which to understand the production and performance of emergency medical knowledge practice.

A&E is described as a space in which contradicting forces of a public service open to all coexist with the need of the service to specialise in fields at the cutting edge of medicine and biomedical research:

'An emergency service must be able to bypass the usual formalities for gaining access to medical attention: the need to make an appointment, deadlines for treatment, the relevant administrative formalities, opening hours. However, at the same time, the emergency service, as a specialised service, must also answer to another concept of emergency: a restricted range of conditions or symptoms generating more or less serious life-threatening situation.' (Dodier and Camus 1998: 413).

Although Dodier and Camus' study supports previous research that shows the way in which patients are dealt with is dependent on the way in which they are categorised in situ by staff and that these categories are based on more than clinical criteria, they also suggest that Roth and Douglas (1983) and Jeffrey (1979) congeal these categories

and make categorisation dichotomous- a criticism shared by Dingwall and Murray (1983). To support this they argue that patients are categorised through the constant establishing of orders of precedence between patients, via a series of small operations, in the framework of the management of a flow of demands distributed between the different actors in the department. They are therefore interested in and provide analysis of patients' 'mobilising worth' which refers to the extent of the mobilisation of staff on the basis of a particular patient in establishing his or her place in the order of precedence. They suggest there is a need to add further complexity, in particular to recognise that staff reactions take on different dimensions in different situations and contexts, the effects of which may be contradictory: the same person is likely to switch between different forms of commitment from one situation to another. This research builds on this complexity in providing an analysis of the multiple knowledge productions that occur within A&E, how these are performed and how the different forms of knowledges that are produced relate to one another in the everyday practices of A&E work.

A patient's 'mobilising worth' depends on their closeness to the core of real emergencies. Dodier and Camus contend that the definition of 'real emergencies' can effect quantity of resources mobilised, the number of persons attributed to the care of the patient and their professional capacity, the type and expense of various equipment and whether or not the patient will disrupt current work lines. The concept of 'real' emergency is especially helpful for this research where knowledge production is understood as a process that can help achieve a number of different accomplishments such as patient disposal, legitimating decision-making, performing identity work, and re-establishing the dominance of particular forms of knowledge over others. The construction of the 'real' emergency case in this context offers much more to the analysis of the production and performance of medical knowledge practice. Mobilising worth will also depend on the patients' social demands. The perception that these patients may be manipulating the emergency service to access services through simulation or exaggeration of medical problems can often stem from categorising a patient in this way:

As in many other medical contexts, the medical decision is at the same time a decision concerning allocation of rights that influences how doctors deal with individual's complaints.' (p.424).

Social problems therefore can ‘demobilise’ patients’ progression to the accessing of emergency services. However, these patients can be remobilised by some members of staff who respond positively to social demands that are rejected by others. Building on earlier research Dodier and Camus also show the importance of intellectual interest for staff in the establishment of a patient’s ‘mobilising worth’. These interests aid medical professionals in their taking on of medically challenging cases. However, there must also be the hope of clarification in such cases in order to show ability and competency and, as such, this excludes rather poorly differentiated conditions such as alterations in the general state of elderly people. As well as reflecting the individual member of staffs’ need to learn and to perform competency, Dodier and Camus also suggest that these categories of interesting and uninteresting are in part a reflection of the growing role of medical research in the activity of hospital doctors.

Dodier and Camus’ study has particular substantive and conceptual resonance for this research. They pay attention to the complexity of ordering work and suggest that staff may respond to multiple calls through which to organise their work in quite different and opposing ways. Furthermore, aspects of moral worth are linked to institutionally and culturally produced notions of service use, something that has important ramifications for understanding the production of ‘real’ emergency medicine in A&E. The notion of a ‘real’ emergency put forward in this study is particularly interesting for this thesis’ analysis where the construction of a ‘real’ emergency is understood as part of a wider performance of ‘real’ emergency medicine.

Summary and Discussion

The purpose of this chapter in drawing on the literatures presented here, particularly from medical science and the history and philosophy of medicine, is to show the complexity of the relations through which medicine performs itself. What this analysis shows is that medical knowledge practice can be produced and performed differently and that the accounts of those choosing to study and critique it are as much a part of their production as medical professionals themselves. Additionally this chapter has sought to show how medicine is not a coherent whole that can be easily described; how medical knowledge practice as a system for ordering and organising

ill people remains seemingly coherent, stable and dominant has emerged as a significant part of the thesis' focus.

The specific literatures drawn upon in this discussion are important to show the multitude of ways in which medicine can be constructed. In particular the chapter has shown the divisions that are embedded in both medicine and modernity between those who produce medicine as separate from the politics of organisation, either through producing it as distinct and unique cultural practice or through constructing a medical knowledge that exists outside its practical enactment, and those who seek to show how medicine is a product of social and cultural classification. The reason for treating these literatures as research materials is in part due to the approach taken in this thesis that has formulated its conceptual framework through the continual oscillation between different bodies of literatures and the materials gathered from the field. It is also an attempt to remove the separation between the accounts described in this chapter and the accounts of those produced inside medical settings, as these are all considered to be available discourses through which medicine is able to perform itself.

For this research, the production and performance of 'real' emergency medicine forms an integral part of the ordering work carried out within A&E. These performances produce patients as multiple objects and subjects and also help to reproduce socio-cultural classification. This is not to suggest that A&E medicine as a practice is fragmented into many parts, rather it is to acknowledge that a great deal of work is undertaken within A&E to perform medicine as a stable and coherent whole in the face of coexisting and at times opposing ontologies (Mol 2002). What some of the literatures have begun to show and what this thesis builds upon is that it is through medicine's relations with other modes of ordering, such as forms of managing or notions of moral worth, that help medicine perform itself in particular ways that (re)accomplishes its position of power.

Significantly the literatures discussed here pay little attention to the effects of knowledge production on patients. Some of the literatures discuss the consequences of ordering work carried out by medical staff, particularly in the accounts of those who suggest that processes of ordering and categorising are practices of rationing or

micro-rationing (Vassy 2001; Griffiths 2001); however these attend to the medical production of patient categories and do not attend specifically to the effects of these productions from inside the patient's own world.

Some exceptions to this are Latimer's work on older people which illustrates how older patients undertake practices of effacement in order to comply with the performance of medicine as separate from the pollutants of social or personal circumstances. Mol (2002) also theorizes about what she terms medicine's 'ontological politics: a politics that has to do with the way in which problems are framed, bodies are shaped, and lives are pushed and pulled into one shape or another' (p.viii). Thus Mol seeks to shift our attention away from judging medicine as an epistemology (how effective it is in accurately describing reality) in order to pay attention to what medicine does, what are the realities it produces and what are the effects of such realities for patients?

Silverman (1987) also makes the important link between knowledge production and its consequences for patients' experiences of these productions. Particularly he pays close attention to the disciplining practices bound up in the discourses that produce medical knowledge practice. Specifically he shows how it is through the performance of medicine as social knowledge that particular clinical decisions are accomplished and legitimated. Thus Silverman not only illustrates how knowledge production and the politics of organising patients in particular ways cannot be separated but also how the relation between these have important effects for patients' treatment.

The significance of understanding biomedicine as ideological and medical knowledge practice as being actively performed is especially useful for developing the arguments of this thesis. Biomedicine as ideology is a means with which to understand medicine's wider appropriation in society, such as the pathological explanations of crime and deviance for example. Medical knowledge practice understood as active performance also explains medicine's ability to adopt and adapt to other forms of knowledge outside its own, so that medicine's relations to forms of governance, practices of managing, and wider socio-cultural and moral orderings are understood to be in dialogue rather than in causal relations to one another. This prevents the risk of ignoring the significance that medicine, as ideas, has had on wider social relations and

the influence wider social relations have on medical decisions. However, it also attends to the ways in which medicine 'itself' is being continually re-made and as such is able to take on knowledges, such as the psycho-social 'whole person', and claim them for its own. The interest in medicine adopted in this thesis is much the same as Hacking's interest in memory

'I am not looking for the trite wisdom that there are different kinds of memory. I wonder why there is one creature 'memory' of which there are so many different kinds.' (Hacking 1995: 3).

It is therefore how emergency medicine is accomplished, through the work of medical staff and patients in A&E, as a coherent and stable organising system, that is of interest to this research. The challenge of the research process is therefore to elicit the ways in which medicine is produced and accounted for by social actors in A&E. How such accounts and productions can be elicited, as well as the meanings attributed to such accounts, is the subject of the next chapter.

Chapter 3

Entering the Field

‘The culture of a people is an ensemble of texts, themselves ensembles, which the anthropologist strains to read over the shoulders of those to whom they properly belong. There are enormous difficulties in such an enterprise, methodological pitfalls to make a Freudian quake, and some moral perplexities as well....But to regard such forms as ‘saying something of something’ and saying it to somebody, is at least to open up the possibility of an analysis which attends to their substance rather than to reductive formulas professing to account for them’. (Clifford Geertz 1973: 452-453).

Introduction

The previous chapters have established the significance of A&E as a culturally symbolic site through which it is possible to elicit the coming together of complex ordering systems and forms of knowledge production. This chapter provides an account of participant observation as the method through which this thesis has sought to elicit such modes of ordering. The chapter justifies how and why participant observation is the best means for exploring the research interests outlined in Chapter One, through focussing on its attributes as a method that closely attends to the meanings and interpretations of those members of the research site. Situated within an ethnographic tradition, it is the meanings of the everyday, the mundane ‘matters of fact’ that are of interest to this research. It is through an understanding of these meanings that systems of ordering (such as those described in Chapter One and Chapter Two) can be elicited. As this chapter shows, these meanings are best reached through participant observation.

The second section of this chapter provides a detailed account of the fieldwork process, including some of the difficulties and challenges that were faced in accessing the site and its members. These difficulties are accounted for not only to show the boundaries that limit the possibilities of participant observation, but also to illustrate how such difficulties can become ethnographically significant. Understood as part of the fieldwork process, the latter part of this second section is devoted to the analytical process. A detailed description of how the materials generated in the field have been treated throughout the research process is established, in particular how the materials

were recorded and collated for analytical purposes. Finally, the importance of ethnographic writing in the construction rather than the representation of the research site is considered.

Eliciting Orders of Significance

Participant observation has been traditionally understood as a method through which to access the meanings and interpretations of those members of the researcher's site of study: 'participant observation enables the research worker to secure his data within mediums, symbols and experiential worlds which have meanings to his respondents' (Vidich 1955: 354). It is therefore a way of understanding social phenomena from the point of view of the research participants (Dewal and Dewalt 2002). Such a method allows the researcher to 'get inside' the research participant's world, to attempt to know what every member knows, to participate in order to understand the interpretations of those with whom you become a member (or at least a partial member). It is thus a method that can help the researcher begin to show how meaning is attributed in the organisation of people, work and materials into classes and categories.

In order to elicit the ordering systems described in the previous chapters, it is essential to become a part of your participants' ways of seeing, thus to participate in their everyday activities. This is the fundamental premise of participant observation in producing ethnography. It is through being a member of a social group that it is possible to understand how it is that orders of significance are accomplished in everyday practices and experiences (O'Connell-Davidson and Layder 1994). Participant observation therefore builds on the ways in which people make sense of their worlds in everyday life, suggesting that these are the best ways through which to access meanings (Hammersley and Atkinson 1983). This chapter shows how systems of classification become taken for granted, as 'matters of fact', and that these can only be made visible by 'getting inside' and becoming part of the everyday routines and practices of those in A&E through participant observation.

What is of interest to this research is what Douglas (1999) refers to as 'backgrounding', information that is pushed out of sight; it is therefore essential that the researcher find a means with which to become a part of the social world being researched in order to bring such information into view. This information may take many forms of backgrounding: It may, for example, simply be regarded as self-evident knowledge that needs no logical explanation for its legitimacy,

'However, its stability is an illusion, for a large part of discourse is dedicated to creating, revising, and obliquely affirming this implicit background, without ever directing explicit attention upon it. When the background of assumption upholds what is verbally explicit, meanings come across loud and clear. Through these implicit channels of meaning, human society itself is achieved, clarity, and speed of clue-reading ensured. In the elusive exchange between explicit and implicit meanings a perceived-to-be-regular universe establishes itself precariously, shifts, topples, and sets itself up again.' (Douglas 1999: 3).

It is therefore through the work of participation that it is possible to identify how and why some information comes to be discounted. As has already been mentioned, the work of making particular information or orderings intelligible works, at the same time, to destroy other orderings or competing information. The undertaking of participant observation attempts to first recognise the work of making intelligible the work of ordering that filters particular ways of seeing and, furthermore to at least momentarily turn off these filters so that other information or other possibilities for ordering can be seen.

Classification work permeates almost every part of our lives and yet it is often so ingrained, unconscious and part of what Garfinkel refers to as the 'socially standardised' (1967: 36), that its significance often remains in the dark. To bring these into light, emphasis must be placed on the 'familiar scenes of everyday activities, treated by members as the 'natural facts of life' (Garfinkel 1967: 35). As an ethnographer, the social world and all that exists within it cannot be taken for granted.

What is essential in carrying out participant observation is that it allows attention to be placed on context and process. Context is significant for understanding when and how it is possible to accomplish particular modes of ordering (Law 1994: see Chapter One) and when and how it is not. The concentration of participant observation on

social processes is also paramount, as it is in the process- the move from meaning to action- that categorical work is carried out (Silverman 2006).

The importance of ethnography, and in particular participant observation, is that it is a 'process of critical engagement with our own being-in-the-world, beyond the taking for granted of that which already exists.' (Van Loon 2001: p.274). Thus we, as social beings, experiencing what other members are experiencing, are best equipped to identify ordering work. As Raymond Williams (1981) describes, it is experience that mediates between being and consciousness, and therefore between those things that exist and those things that make sense. It is therefore through experience that researchers are able to reach the meanings and interpretations that help to order social relations.

In Savage's (2003) comment on the importance of what she terms 'participative observation' she makes the point that researchers must reach their knowledge and understanding through participation as well as observation, rather than dismiss these as mere interference that should be rejected as stuff that gets in the way of what is really at stake. For Savage, this refers to an embodied approach to the undertaking of research building on the 'capacity of the embodied self to understand those regarded as other through physical involvement in their world.' (Savage 2003: 55).

This research is thus interested in power as relational and productive, existent in and created through the ordering of social relations. Power in this sense is all pervasive, it exists in and is produced through the minuscule, mundane practices of the everyday and in some senses can best be identified through personal experience. Participant observation is particularly useful for explicating such practices, for identifying how and when power, dominance and hierarchies appear and are felt, not only through the observations of the members of the site, but also through the researcher's being in and experiencing the site themselves as partial members. As Latimer has noted, the researcher as a social being immersed in social spaces acts as the most effective register of culture and social ordering (Latimer 2007).

This particularly critical approach to ethnography is an attempt, to use Foucault's (1973/1991) terms, to analyse thought (thought meaning ways of thinking or ways of

knowing) as public and social practice. In other words, through participant observation, the ordering of social relations that both create and constrain ways of thinking can be elicited. What is particularly important in this formulation is that ‘conversation, between individuals or cultures is only possible within contexts shaped and constrained by historical, cultural and political relations and the only partially discursive social practices that constitute them.’ (Rabinow 1986: 238). It is the social relations that are of importance here, how *individuals* act is significant for what this tells us about what actions are possible within a particular time and space, and furthermore what this tells us about the wider socio-cultural processes of ordering.

For Foucault, developing the work of Canguilhem, for something to be deemed true, it must fulfil some complex conditions that identify it as being ‘within the true’ (Foucault cited in Rabinow 1986: 238). In other words for new propositions, ideas or practices to become accepted, they must develop from within ways of knowing that are already understood to be true. From this approach, ‘what matters is the way discourses engender and construct particular subjectivities, which in turn are acted through and thereby upon, particular discourses’. (Morley cited in Van Loon 2001: 276).

Ethnography, viewed as a text in the broadest sense, produces many different representations of events that occur over time and in a variety of situations. What the process of re-writing such representations allows the researcher to do is to lay these representations alongside each other. What this research looked for through the undertaking of this process is- taking an ethnomethodological approach- how actors are able to construct their actions as accountable, as that which is ‘observable’ and ‘reportable’, ‘available to members as situated practices of looking-and-telling.’ (Garfinkel 1967:1). It is through a detailed observation of these moments that modes of ordering come in to view. It allows the researcher to view and experience how orders are accomplished in making accountable the everyday actions and interactions of those within their research site.

When observing, experiencing and analyzing these moments when accounts are made, the participant observer is able to view the particular materials that make up these accounts and these materials will ‘depend heavily for sense upon their serial

placement, upon their relevance to the auditor's projects, or upon the developing course of the organizational occasions of their use' (Garfinkel 1967: 3). Much can therefore be understood through such a view upon these accounts about how subjects carry out and accomplish identity work and membership through the situated deployment and shifts in alignment to particular modes of ordering. Garfinkel's notion of making accounts is also useful for eliciting what Fernandez (1986) suggests is part of our fundamental mission in human life:

'it is the mission of our argumentative powers, I argue, to preserve our place and our gratifying performances and hence the world in which these things are lodged and to persuade others to recognize that place, that performance, and that world.' (p.viii).

Latimer gives an example of how a doctor assessing a patient can at one moment assess a patient as object and in another as subject, two opposing modes of ordering that uphold very different sets of interests: 'Knowing when to shift between the two worlds that these two bodies bring into play is all a part of 'doing' good doctor'. (Latimer 2004: 6) It is therefore through close attention to the reflexive accounts of members that allows processes of ordering to come into view. Furthermore, the accomplishment of power can be seen not only in the deployment of one particularly dominant mode of ordering, but also through shifts in deployment of different, even opposing ordering modes.

This approach to materials gathered through participant observation attempts to analyse representations. This analysis is conducted not for how they reveal social structures that determine the lives of others, neither in the hope to show the multiplicity and complexity of possibilities for social action, presenting a world where anything goes; rather it seeks to show multiple, available discourses, or modes of ordering as well as what can be achieved by the deployment and accomplishment of these orderings at particular moments and in particular contexts how and in what way do they, if only for a moment, order the world? (Law 1994). Furthermore, the question must be asserted what is the purpose and what are the benefits of ordering the world in this way and who benefits from such ordering?

This particular way of writing ethnography therefore attempts to show the work that is being done, to reveal what is hidden behind illusions of order and organisation; it attempts, through a process of reading, writing and re-writing, to build up

interpretations, through the collating of representations across time and space that show ‘the dynamism that underpins the apparent stability of social life.’ (Latimer 2007: 7). It is therefore an approach that recognises the dominance of particular modes of ordering, by showing the means with which this particular illusion of stability is held in place.

The creation of text through ethnographic research is made up of multiple forms of representation drawn from a range of registers (Silverman 2006). These registers include materials from the research setting such as medical notes, reference books, and patient records. However, they also include materials or texts made up by the researcher, such as field notes, records of transcripts from conversations, medical assessments, thoughts and feelings from the research setting. These can then be re-read and re-written alongside each other providing crosschecks. This is not to suggest that this approach provides a more truthful account of the setting, rather it provides a method for considering how ‘reality’ is made up, of multiple voices and multiple positions (Law 2004). This particular approach to ethnographic work therefore seeks to make multiple voices and interpretations heard, paying attention to both members and the researcher’s own ways of seeing and understanding the site.

This is particularly important in moving away from the pseudo-scientific objectivism of traditional anthropology that denied the deeply political aspects of personal experience. In undertaking ethnographic work in this way, it allows the participant observer to see, not the present given identity of the other, but rather the ‘temporal and symbolic constructions that engage in determining and establishing relationships (between selves and others)’ (Van Loon 2001: 278). The fixed representatives of the other- or indeed of selves- are existent in discursive practices, but it is the work of the participant observer to view these as accomplished representations that exist among many more representations, revealing their permeable and unstable character. This is in part an ethical move, following the work of post-colonialist writers such as Edward Said (1978) who viewed the constructed authority of identification of the ‘Other’ employed by the traditional ethnographers as a means with which to delineate ‘his’ or ‘her’ subjects. It is also, however, a means with which the researcher can better understand how such illusions of fixedness are achieved and sustained.

This approach to ethnographic work therefore rejects the ideal that many aspire to, of representing the social world in the writing of ethnographic work. There has been an assumption that the ability to do this is merely a matter of correspondence between the subjects and events themselves and the process of writing (Hammersley and Atkinson 1983). However, this notion is misguided; the ethnographer can never be his or her subjects, in the same way the writing of an event can never be the same as the event itself. Although interactionist ethnographers agree that representation is never possible, it is for many of them the ideal to which to aspire. This, as Denzin (1999) makes clear, is to limit the creative and theoretically informed encounters with the ways in which people actually make sense of the world in which they live. To recognise this 'différance' (Derrida 1978) is to provide the means with which the researcher remains aware of the politics of everyday life. To aspire to facticity inherently quashes the local, situated work of producing factual knowledge:

'If ethnography is the writing of difference, and thereby takes place as a problematization of the representational, then the situatedness of the ethnographer becomes affirmed as, rather than a limitation to, the formation of 'understanding'. This understanding is nothing but an active acknowledgement of and participation in the construction of 'sense' in everyday life settings. Lived experience is simply irreducible to the sociological categories that we may invoke to impose on them a 'structure of sense' that lies beyond the experience itself.' (Val Loon 2001: 281).

Embracing this approach, a focus on writing as integral to the practice of participant observation begins to make obvious sense. In understanding ethnographic writing as a constructed truth, it is not only a means with which we attempt to reveal previously subverted or subordinated voices, but also in making the participant observer more attune to all truth claims, it focuses the attention on the processes through which something is believed to be true: the how rather than the what. It thus engages the researcher in critical thinking that identifies all forms of knowledge as mediated by claims of rhetoric and power:

'Hermeneutic philosophy in its varying styles, from Wilhelm Dilthey and Paul Ricoeur to Heidegger, reminds us that the simplest cultural accounts are intentional creations, that interpreters constantly construct themselves through the others they study'. (Clifford 1986: 10).

The point here is that the process of creating a text from fieldwork is an essential part of how we come to understand our research site. Text, produced through the compilation and transformation of observations, is materialised and to some extent becomes substantive and mobile and therefore can become detached from the

processes used to create it. This allows us to read the text as a story, a discourse itself. It is then in the further reading and re-reading which occurs in between our reading of other textualities that we begin to make up our site. The other readings include the purposeful reading of books or articles that have been revisited or newly found, or they may include those readings derived from watching a play, or talking with friends and colleagues,

‘rereadings may be moved in ways that we are not even aware of. For me, this is one of the most interesting aspects of rereading and rewriting, it is evidence of the ways in which we are continuously emerging ‘intertextual’ space, which includes “our selves”. It is in these ways that we are rewriting to ‘make up’ and illuminate our site.’ (Latimer 2007: 5).

Doing Fieldwork and Analysing Texts

Qualitative research can take on a multitude of forms and can be used for a variety of purposes all of which, if the research is sound, have a strong theoretical foundation. In order to reveal the practices and processes of ordering that occur in A&E, it is not enough to simply ask for the accounts of the participants, although this is an important part. Participant observation is paramount in order to gain an insight into the everyday, mundane practices of your research participants, as has already been shown. Constructions of these practices in the conversations and interviews carried out with participants offer a partial reality of A&E derived from the perspective of the participant. These are useful in themselves in providing accounts (to return to Garfinkel’s idea for a moment) of members actions and interactions and can become more useful when set alongside observations of the actions themselves, as well as their relations to the actions of others and their relations to objects and materials in the site. It is important not to exclude inanimate objects as part of the formation of social relations, something that has been well established through the anthropological tradition. These objects can be treated as textual because they are read by members as more than functional: material objects and practices have a symbolic and an expressive dimension, they are interpreted by social beings as conveying meaning (Geertz 1973).

The job of ‘getting inside’ as a participant observer is somewhat of a difficult and precarious process, as I discuss in detail in Chapter Four. However, in what follows I

attempt to outline the ways and means in which I attempted to gain some insights into my research questions through the activity of participant observation. To begin with, observation was mainly carried out by shadowing members of staff in their daily activities. The decision to begin in this way was so that all elements of clinical work around the care and treatment of attending patients, with specific focus on older patients, could be identified and explored. One of the significant revelations of a preliminary visit to the unit was the discovery that the distinctions made between the various sections of A&E seemed more significant than its overall organisation. This was at least apparent in the descriptions provided by Dr Prichard, a senior consultant who guided the tour. This particular understanding of A&E was also mirrored in its spatial organisation, something explored in Chapter Five.

As the organisation of A&E was distinctly separated into areas of expertise directed towards specific patient needs, it was decided that it would be sensible for observation to be spread across these different sections, so that these areas could be experienced and compared to one another as well as attempting to gain some insight into the organisation of these as part of A&E as a whole. The separation of these areas for the organisation of A&E work and the production of emergency medicine emerged as highly significant through the course of the research process and became an integral part of understanding moments of access negotiation (issues explored in more detail in Chapters Four and Five).

The period of observation was carried out over six months and ran from winter through to the summer. The dates and the full schedule of the observation was initially going to be arranged with the clinical director and nurse manager of the department creating a full and detailed timetable, one that could be presented to the ethics committee prior to commencing the research. However, this was not how the project evolved in practice. After my first meeting with the nurse manager I got an idea of the general shift patterns of nurses and doctors in the department and decided that the observation periods should aim to match these patterns.

During most of the fieldwork process I would attend the department three times a week and this would usually include either a Saturday or a Sunday. The shift patterns for nurses altered slightly depending on the area of the department they were working.

The early shift ran from seven o'clock in the morning until four o'clock in the afternoon and the late shift would begin at three in the afternoon and end at midnight- the hour crossover accounted for the handover of patients. The night shift for doctors would run from nine o'clock at night until seven o'clock in the morning. The nurses' night shifts were similar although I did observe on a couple of night shifts where nurses were working from seven in the evening until seven in the morning. I did not observe night shifts routinely every week, I would schedule observation of night shifts once a month and made sure that these included at least one Friday and one Saturday night over the course of the fieldwork.

The decision to undertake fieldwork in this way was firstly to attempt to gain a more thorough view of the rhythms of A&E from the perspectives of the staff so that I would experience (although only partially and differently) the same temporal organisation of A&E. There were times when this was not possible or was decided against for various reasons. For example, if I wanted to spend time with one particular participant, often they would decide on the best time in which this observation would take place.

Conducting observation as a novice- as was certainly the case for this research- can often be an ambiguous and unruly activity. One common difficulty occurs in knowing what objects, actions and interactions, or conversations might be significant. Here lies the importance of fieldnotes. For all researchers, even the most sophisticated of ethnographers, one cannot make immediate decisions about what is or is not significant in the setting:

'First of all, he has to find out that certain activities, which at first sight might appear incoherent and not correlated, have meaning. He then has to find out what is constant and relevant in these activities, and what accidental and inessential, that is, to find out the laws and rules of all the transactions. Again, the Ethnographer has to construct the picture of the big institution, very much as the physicist constructs his theory from the experimental data, which always have been within reach of everybody, but which needed a consistent interpretation..' (Malinowski 1922: 84).

Although Malinowski's account is somewhat scientific in its endeavour to seek out rules and laws, the notion of consistent interpretation, of thorough and diligent field notes from which significant observations will emerge, is important. Unlike Malinowski, this research it is not in an attempt to justifiably re-present the research

site, but rather to acquire as many representations from as many different members across a variety of situations, so that the constructed ethnographic text is multi-authored, as well as to show how these voices are mediated by relations of power.

As a novice to the practice of participant observation I wrote as much and as often as was possible, attempting to record as much of the details of events, activities and language. I developed a practice for writing my field notes that responded to my experiences in the setting. Writing field notes in the setting was not possible for a number of reasons. On the first day of fieldwork I attempted to write notes amongst my participants in the field, but this had immediate ramifications. The visibility of the notebook and my note taking clearly made many of the participants feel uncomfortable. At first I tried to rectify this by showing them the notebook, I suggested that they could write in it themselves if they wished, but this did not help matters; it seemed that the notebook produced a mixture of responses from disinterest to suspicion. I would observe for a period, ordinarily no longer than an hour, and then I would seek out a private area (usually the staff toilets) with my notebook and sit and write my field notes. If I had observed particular conversations or assessments that involved a lot of dialogue I would make brief notes in the setting as reminders and then seek out a private space immediately to write up the interaction in full. Similarly, I found that it was essential to write up field notes almost immediately following a period of observation.

As with much ethnographic research, the first few days of the research were, or at least seemed to be, most bountiful for the production of fieldnotes. Everything was new and different; my field notes were full of detailed descriptions of every space, object and interaction. Following the first few days, these started to feel familiar and within a few weeks became a part of my everyday experiences of being in A&E. That is not to say that observations became less interesting. Those moments of interest, when members made their actions 'accountable' to some extent became more plentiful once I became more a part of the site.

As the initial focus of the research was on the place of older people in A&E it was decided that specific attention should be placed upon older patients who arrive at A&E, their needs and treatment. However, I wanted to view as many assessments of

patients as possible, in order to form an understanding of the ways in which staff categorise and distinguish all patients, believing that this would provide a greater understanding of the place of older people among the ordering practices of medical staff more generally.

It was planned that criteria for the selection of patient participants, those whom I would talk to, was to be developed with staff in the field. This was for the main part a response to ethical concerns about making judgements regarding which patients were more or less able to participate on the grounds of their state of health, both mentally and physically. It was also deemed appropriate that staff would have knowledge or at least some appreciation of whom might fit the most common range of presenting conditions, or which patients have complex health and social care needs. The decisions made by staff about which patients would be *relevant* to the study and which would not become interesting and useful accounts in themselves in gaining a better understanding of some of the systems of classification through which medical staff sought to organise patients.

Once in the field it became evident that establishing these criteria with staff was not particularly productive. Before entering the field it was envisaged that I would spend my time closely aligned to particular members of staff which would facilitate this development of criteria for establishing patient participants, however this proved not to be the case. I would always ask staff's permission, regardless of their surprise or confusion at these requests, before approaching patients. However, in terms of discussing their relative appropriateness for the study, there was less engagement at this level.

In part this shift meant that the experiences of patient participants were more difficult to reach, as staff were less enthused about orchestrating relations between me and their patients. This meant that my attention was drawn towards the ways in which staff ordered the work they did, how they assessed patients and organised the work of A&E, and how they accounted for this assessing and organising work. What came into view from these observations revealed a great deal, not only about the care and treatment of older patients, but of all patients. However, what were withdrawn from view to some extent were the accounts of patients themselves, the accounts of their

experiences of this ordering work. What I did access, with regard to patients, was doctors and nurses' representations of patients, in a variety of forms, through narratives of assessments, during nurses handovers, or in notes, descriptions and labels. Mostly these occurred without the patient being present, and therefore 'involve the virtual patient – people's accounts of them, verbal and in writing, or representations of their parts, such as blood test results, or x-ray films and scans' (Latimer 2007: 9).

The research had initially planned to include more formal qualitative interviews that would form an equal focus of the research. A significant part of what I was interested in was the ways in which staff account for the work that they do: I wanted to understand the process of assessment work from their perspective. However, I became aware that negotiating more formal interviews with staff was more difficult than I first imagined. Attempting to find time and an appropriate space with which to carry out interviews was a challenge. However, more of a challenge was negotiating with staff for them to agree to being interviewed. I tried a number of strategies. Prior to the research process I had planned to discuss with my gatekeepers the details of how to carry out interviews with staff. My main gatekeeper, who I liaised with throughout the course of the research, was Dr Prichard who was the clinical director of the department. On the first few visits I would remind Dr Prichard of this concern and he agreed that this was important, stating that he would get together a group of nurses and doctors who it would be interesting for me to speak to. However, these plans never seemed to come to fruition. As with many other elements of the fieldwork, I realised that I would need to be much more proactive in seeking out staff to interview.

The first strategy was to suggest doing an interview with staff at moments of interest in the setting. For example, following an assessment, a member of staff would often discuss with me the decisions they had made regarding the patient. This seemed to me to be an appropriate point at which to ask them if they would be happy to talk to me further about these issues in an interview. The problems I experienced in attempting this was that, even if staff agreed to this, which did happen often, it was difficult to make definite plans as to when and where this would take place. Also what tended to occur in the setting was that staff would become immediately more

conscious and would often stop their discussion with me, as if it was not needed now if I was to interview them at a later date.

The absence of more formal interview material was not altogether negative either; what occurred during my periods of observation was that the informal conversations that I had with staff were fruitful in explicating these issues. Staffs' accounts in the setting, following patient assessments, or interactions with other members of staff, provided material for revealing the construction and re-construction of particular ways of ordering A&E work.

This was not to suggest that I had no formal interactions with medical staff. However, these occurred much more pragmatically, in the setting, taking advantage of opportunities as they arose. For example, on one particular fieldwork day, I had arrived with a view to continue my observations in the unit and had, by chance, met with my gatekeeper, Dr Prichard, who asked me how the research was going. I responded by explaining the difficulties I was having in arranging interviews and he told me to come back the next day, when there was a training day for junior level doctors, a great opportunity to seek out half an hour with a few of them to talk about the research. When I returned the next day I was invited to join a group of eight doctors to talk to them as a group. These impromptu interactions occurred sporadically throughout the research and formed part of the fieldwork process and were particularly helpful in understanding more about the site. The unconventional (unconventional for qualitative research) ways in which they came about helped me develop an awareness of the central issue of 'accessing' that is discussed in detail in the next chapter.

To discuss analysis is a difficult task for those undertaking ethnographic research. There is no one point, or period of analysis that occurs, it is a continual process, one that 'begins in the pre-fieldwork phase, in the formulation and clarification of research problems, and continues through to the process of writing reports, articles, and books' (Hammersley and Atkinson 1983: 205). One of the advantages of undertaking in-depth, ethnographic research is that it allowed me to shift focus according to evolving experiences and interpretations of the research site, which was important to the development of this research. This process of experience and

interpretation, as for all social beings, happened continually throughout the time of the research. Interpretations, reflexions and constructions of the site were not held in suspension until such time as I was able to remove myself from the site and reflect upon the objects of observation I had gathered, but rather formed part of a continual writing and re-writing of the text.

It was important for this research to be responsive to interpretations of the research site: in recognising the importance of making explicit our interpretations, rather than taking on a 'naturalistic commitment to 'tell it like it is' (Hammersley and Atkinson 1983: 206), we are better able to develop processes of analysis that facilitate a close relationship between analysis and research practice. This enabled me to respond to the development of theoretical understandings of the research site (Silverman 2006), while at the same time providing the opportunity to explore these understandings across many contexts and situations, and for a variety of research subjects.

For this research it is important to recognise that the research materials were generated through the fieldwork and analytical process: fieldwork is not a process of gathering data. As Coffey and Atkinson (1996) suggest, analysis should not be considered the means with which the researcher reports on what was found, rather we construct a version of our research site. The interpretations gathered through periods of observation were brought together and assembled into a text (Silverman 2006). Text is used here to imply that the product of this ethnographic material is understood to be a creation, something that is made up of interpretations. I formed a text through the compilation of all materials generated through the fieldwork. These included: fieldnotes, notes and transcripts of interviews carried out in the setting and written reflections of fieldwork experiences. These created a chronological story of events and experiences that helped me begin the process of analysis. It was through the creation of this completed story, that now has a discourse of its own, that the process of re-reading could begin.

This story was kept and re-read numerous times across the course of the analytical process. Many approaches to the analysis of qualitative research materials work through a process of coding. This involves the segmenting of the research material into sizable chunks and assigning labels to these chunks according to a particular

concept that has either emerged through the processes of generating and reading the material, or that have been pre-determined according to the interests of the study (Coffey and Atkinson 1996). This was not quite the approach that I took for the organising and analysing of my research materials. 'All researchers need to be able to organize, manage, and retrieve the most meaningful bits of our data' (Coffey and Atkinson 1996: 26), and this was certainly true in my own case, however I attempted to do this through a process of splitting up my completed fieldwork story into further smaller stories that captured events, conversations, interactions and member's accounts. As far as possible, these were created through attending to the naturally occurring beginnings and endings that shaped these stories or events in the setting.

Once I had generated these smaller stories they could then be read with specific attention being paid to instances where talk performed or produced social acts (Austin 1962), recognising that words produce social realities and enrol those who speak them into the consequences of the realities produced (Potter 2004). I then placed these smaller stories alongside one another and alongside other possible accounts of the research site, including those produced within the academic literature, to begin to make sense of what these interpretations may mean in order to rewrite the site and produce an ethnographic text.

Throughout this chapter's discussion, the importance of textual practice in the production of ethnographies is noted as being of particular significance, it is therefore necessary to reflect on some of the peculiarities of my own writing practices in the production of this ethnography. I have paid particular attention to the specifics of language, dialogue and interaction in order to represent the accounts and interpretations of the participants themselves, as well as my own interpretations of these accounts. As the research questions formulated in Chapter One make clear, this thesis aims to understand how members of the site organise and order the world of A&E and it is premised that this is achieved through various forms of accounting that is carried out in the setting. In the process of rewriting the site, it is therefore essential that participants' own accounts remain central to the process of analysis. Through entering into a commitment to introduce multiple perspectives and voices in my analysis and representation, a more collaborative text is generated that is 'constructed

by the sociologist, the reader and the social actors represented in the setting' (Atkinson 1990: 82).

As with many ethnographic texts, my construction of the research site is accomplished through techniques of writing that help to convey the meanings generated through the research material. As 'every perspective requires a metaphor to organize it' (Fernandez 1986: 29), I have developed my main arguments through the utilisation of three central tropes that function as metaphors through which meaning is conveyed. 'Moments of accessing', 'the performance of 'real' emergency medicine' and 'sorting out' at the threshold, are used in this sense as rhetorical tools through which I attempt to more effectively describe a complex set of relations in which multiple meanings intersect.

The analytical framework developed in Chapter One and the conceptual tradition in which I situate myself (discussed in Chapter Two) have evolved through the process of writing and rewriting the site. It was through the reading and re-reading of the research materials, alongside different bodies of literature, which have together aided the development of my conceptual and analytical approach to the research site. The literatures that have helped me understand the ways in which social and cultural orderings are produced within the research setting were those that best fit with my own experiences of being a partial member of the site. It is therefore in the reading across and between the research site, generated research materials and academic texts that have produced both the analytical framework and the completed textual construction that is this ethnography.

It is through the process of reading and rewriting these texts that I have been able to make explicit the taken for granted ordering work that both myself as the researcher and the members of my site are enrolled in. Significantly I have attempted to interpret these texts as both 'intertextual' and 'contestable' because they involve multiple forms of representation and because other interpretations are always possible; they are always partial truths (Rabinow 1986). Intertextual analysis specifically allowed me to view and understand how texts 'selectively draw upon' orders of discourse (the everyday practices of how we configure text, such as story telling and genres for example) that are available to those producing and interpreting text in particular social

circumstances. In this way, it has been possible through the analysis to link the small, local creation and construction of social relations to their wider socio-cultural frames.

‘Intertextual analysis draws attention to the dependence of texts upon society and history in the form of the resources made available within the order of discourse (genres, discourses, etc.).’ (Fairclough 1992: 195).

For this ethnography the process of analysis was not one in which I attempted to seek out the facts, to re-present the site as it truly is (as all forms of representation are interpretation), but rather to show how members achieve and maintain claims that are thought, or believed, to be true. This is not to suggest that interpretation and analysis of this kind cannot employ forms of rigour. If the position is held that it is through interpretation that the world is being continually reconstituted, processes of reflexivity and reflection can be employed as a means with which to scrutinize the researcher’s own knowledge practices, as well as those of the subjects of study, in order to problematise what is assumed or taken for granted. This ensures that the research does not ‘take sides’, but rather views these practices as a way of more fully understanding how members of the study divide up and order the world (Latimer 2007). In this sense critical ethnography can also be valid, but is valid ‘on its own terms, rather than in accordance with the narrow constraints of positivism.’ (Wainwright 1997).

This ethnography brings the broader critique of social relations to bear on the organising of analytical themes, so that the analysis was not derived exclusively from the generated research materials, but rather from an oscillation between those and the social critique. It was not possible to empathise with members of the study completely, as I cannot ever be a full member. It is also the case that in moments I have set my own interpretations of the subjects of the study’s accounts, which they use to organise and construct their world, among my own forms of knowledge practices. What is important is to recognise when this happens and to make explicit how these interpretations are made (Jones 1985).

The usefulness of applying the works of ethnomethodologists who seek to describe (or make up) the social world, which have traditionally been viewed in opposition to the work of sociologists more theoretically driven, for my own analysis of ethnographic material is in their skill of showing the strange in the familiar. Their

ability, through detailed, close inspection of the way members make accounts, is to show how the appearance of what is ordinary or taken for granted simply 'how things are' is instead the consequence of interactional accomplishments (Hammersley & Atkinson 1983). However, in this analysis I attempt to show how these accomplishments are worked at through the deployment of particular modes of ordering that construct and re-construct relations of power. It is here that there is some departure from the ethnomethodological tradition, while recognising that the study of members' accounts is important in understanding how members accomplish ordering work.

Reflections on Reflexivity

It is important to recognise that we, as sociologists, remain inside and caught up in ordering work too: significant modes of ordering can be imputed in our talk and in our text and these cannot be escaped. It is also important to recognise that in the processes of producing our texts not only do we interpret-as recognised by most if not all qualitative researchers- but further that our interpretations become representations of a particular social world. This process is merely another form of social ordering. As Law (1994) makes clear in his sanctioning of modest pragmatism in the undertaking of research, research is hard. The successful illusion of simple order, even if only temporary, as often presented in ethnographies where the power of the authorial narrator presents a world organised and ordered, is the product of a great deal of work:

'The ethnographer is a little like Hermes: a messenger who, given methodologies for uncovering the masked, the latent, the unconscious, may even obtain his message through stealth. He presents languages, cultures, and societies in all their opacity, their foreignness, their meaninglessness; then like the magician, the hermeneut, Hermes himself, he clarifies the opaque, renders the foreign familiar, and gives meaning to the meaningless. He decodes the message. He interprets.' (Crapanzano 1986: 51).

Prior to the cultural turn, anthropologists presented their finished work, as a text, as representations of reality, born out of intense and detailed description of a research site that has been objectively observed over a long period of time. This has changed and there has been an acknowledgement that these texts are in fact re-representations, constructions born out of the researcher's interpretations of their participation in a particular setting. This shift in understanding creates many important ramifications

for the writing and reading of ethnography and, further, for the practice of participant observation.

It is the role of the ethnographer to make the everyday foreign, or to put it another way, to show the work that is being done in order for the everyday to seem mundane. However, paradoxically, sense must then be made of this foreignness. The skill of the ethnographer is therefore in the presentation of the foreign and the interpretation that makes it familiar. These skills are accomplished in the writing, it is rhetorical; furthermore it must be, in order to persuade the reader of the strength of the description on offer. What was previously the case, in the traditional narratives of anthropological texts presenting the dominant authorial voice, was that the processes of interpretation and construction were subverted through these rhetorical devices so that the author's skill of interpretation disappear and become simply an invisible voice of authority (Crapanzano 1986).

This research attempts, where possible, to make explicit these processes of interpretation and construction. This is not to present the thoughts, feelings and experiences of the researcher over and above those members of their site of study; this would merely be a new way of prioritising the author's voice. Reflexivity is, within this approach, a means with which to recognise the ways of seeing and interpretations that we bring to the setting and how these are bound up in the social relations of our site. Thus reflexivity becomes not just an ethical issue of making explicit the previously subverted constructions that go in to the production of an ethnographic text, it is also an important analytical process, through which more can be understood about the site and subjects of the research.

The undermining of the ethnographic authorial voice is not something that need be deemed a crisis for the work of social researchers. It is merely a recognition that ethnographic writing is 'itself an inter-subjective and spatially and temporally contingent enterprise' (Van Loon 2001: 279). That is not to suggest that these texts do not have meaning, that they cannot create understandings of a site, it is rather to make clear that these meanings are not fixed. The texts we produce are read, re-read, interpreted and re-interpreted, mediated through the readings of other texts and other ways of knowing.

Importantly, the process of writing ethnography does much more than communicate about particular people and places, it simultaneously creates forms of relationship through the partial participation of the researcher. 'It carried the traces of one community into another, and thus stands to dislocate the traditions of both opening the possibilities for new forms of relationships'. (Gergen and Gergen 2003: 12). The changing nature of the relationship between researcher and research subjects has been well theorised and practically performed, in works of participatory research.

The current research attempts to address the balance of power relations through making explicit the intertextual nature of the research process, so that it is not only the mediated relations of research subjects that work to make up the ethnographic text, but also those of the researcher as part of this site. It is also important to attempt to write an ethnographic text that reveals multiple voices and interpretations, through close attention to language and interaction. Furthermore, it is recognised that the researcher is only ever a partial member of the research site and therefore cannot fully represent the meanings and interpretations of subjects. Interpretations of the researcher must always be understood as partial; 'I'm not sure I can tell the truth...I can only tell what I know'. (Price cited in Clifford 1986: 8).

This chapter has explained how and why participant observation has been employed as the method for this study. The processes through which the research materials were gathered in the field and the subsequent treatment of these materials in the writing of ethnography have been paid particular attention, specifically the acknowledgment of the subjective interpretations of the researcher in constructing the site. Some of the challenges that were met in attempting to get inside the social world of A&E were touched upon in the description of the fieldwork experience, however these deserve further attention. The next chapter therefore explores in detail the moments and events in which difficulties in gaining access were experienced and illustrates how these are of ethnographic importance to the practices of ordering in A&E work.

Chapter 4

Lost in the Field

As I began hanging about Cornerville, I found that I needed an explanation for myself and for my study. As long as I was with Doc and vouched for by him, no one asked me who I was or what I was doing. When I circulated in other groups or even among the Nortons without him, it was obvious that they were curious about me. I began with a rather elaborate explanation. I was studying the social history of Cornerville – but I had a new angle. Instead of working from the past up to the present, I was seeking to get a thorough knowledge of present conditions and then work from present to past. I was quite pleased with this explanation at the time, but nobody else seemed to care for it. I gave the explanation on only two occasions, and each time, when I had finished, there was an awkward silence. No one, myself included, knew what to say' (William Foote Whyte 1943/1993: 300)

Introduction

This chapter develops the importance of 'moments of accessing'. In building upon the previous chapters, the difficulties of accessing I experienced, as the researcher, mirroring those of potential A&E patients, are shown to be key moments in which emergency medicine is performed. The chapter details the process of doing participant observation from the beginning stages of accessing A&E, through to the experiences of being in the research site and pays particular attention to those situations in which accounts to legitimate one's place, purpose or actions had to be made. Visiting these moments of accessing reveals a great deal about Accident and Emergency (A&E) as an organisation, social space, and site for the accomplishment of emergency medicine.

I have chosen some extracts from my fieldnotes that exemplify the problems I experienced in 'getting inside'. What these encounters reveal are a messy, complex, and confusing A&E that had I not been positioned between being a partial member of the site and an outsider, would have perhaps seemed more ordered, structured and comprehensible. What the chapter illustrates is the ethnographic significance of seeing and experiencing this complexity which was integral to the development of my understandings and interpretations of A&E.



Accessing the Site

Once the research site, A&E, had been determined, there was the daunting task of obtaining access to an A&E department. Fortunately I live within reach of a large teaching hospital that has an accompanying Emergency Unit serving a large geographical area. After some discussion with my supervisors, I decided that by immersing myself in this one large A&E department for a considerable period of time, I would generate enough rich material that would enable me to explore my research questions. It was not the aim of the research to assess the organisation of one A&E department in relation to another. However, it must be recognised that the extent to which I am able to construct A&E as a cultural domain, is limited to the peculiarities of one specific A&E department and of my own experiences and interpretations of that department.

The first port of call in obtaining access was to establish who the key gatekeepers were and set up meetings with them to explain the research and attempt to gain their support. This involved two meetings, the first was with the nurse manager of the department (who unfortunately retired before the fieldwork began) and the second was with the clinical director of A&E who I liaised with for the duration of the study. These meetings were also sought as a means with which to decipher, with those working within the setting, the most effective strategy for undertaking fieldwork. It was important to gain an insight into the physical organisation of the setting to answer some practical questions: where should I undertake interviews with staff? How should I approach patients? All of which needed to be clearly outlined prior to commencing research. This was not essential for the ethnographic nature of my research, where the process by which these were negotiated have formed valuable research materials, but it was essential for presentation of the research to the ethics committee. However, the knowledge these key gatekeepers had of the setting proved invaluable in understanding the organisational processes of A&E.

Following the initial meeting with the clinical director which involved an informal discussion, the aim of which was to establish that he was, in principle, in support of

the research, there was a second meeting after I had begun working on my application for official ethical approval. An initial research protocol that formed the first stages of my application to the ethics committee was sent to the director prior to the meeting taking place. During this meeting we discussed the protocol and agreed on some alterations following his advice. There was some difficulty in balancing the extent to which the support and help of the director was needed (and appreciated) with maintaining the qualitative integrity of the research. At times we seemed to be talking at cross purposes, something that became quite a familiar experience throughout the research process.

Official Ethical Reviews

Traditionally one would expect to find a brief mention of ethical review procedures in a thesis' methods chapter. For this research the process of ethical review was an important moment of accessing in which aspects of 'real' emergency medicine were performed. It was through the experience of formal ethical review that the difficulty of getting inside began to reveal how emergency medicine is produced and reproduced through categorical work. Significantly this categorical work is not only undertaken by A&E medical staff in the ordering of patients but also involves those with a role to play in the maintenance of medical research in ethics committees. This became evident in their ordering and categorising of me as a researcher, and my research.

In the process of gaining entry I was prepared for and expectant of an official process through which I would need to justify the ethics of my research. I hoped that these procedures would form the first part of my journey to become a legitimate member of the site, that passing this review would open up the site and its members to me. As is explored later in the chapter, this proved not to be the case. The official procedure for obtaining ethical approval for the research was much more detached from the research site and from the networks in which I wanted to become a part than I had envisaged. Gaining access in this formal sense, as I came to realise, had little bearing on gaining entry as a partial member to the site itself.

The ethics review procedure was a much lengthier process than I had at first expected. Not surprisingly, as with a lot of research investigating the social world, much of the fieldwork process was reactionary as opposed to pre-emptive. When dealing with bureaucratic processes, such as ethical review committees, this is especially the case. The first step was to apply for an approval of the study from the Research and Development Office (R&D) of the relevant NHS Trust in which the hospital is based. The R&D office is set up to assess what extra time, resources and finances will be involved in carrying out the proposed research, as well as providing an initial assessment of the study's ethics and validity at a local level. This formal process of checking the resource implications of the research mirrored many of the auditing procedures and guidelines for medical work that were experienced in the setting (Chapter Five illustrates).

The first difficulty that arose in this procedure was the trust's concerns over anonymity and data protection. Although the research proposal stated that all research materials would be anonymised, this had to be reiterated in numerous correspondences with the R&D's data protection officer. This difficulty arose as the research materials that were to be generated were deemed to be more at risk of being identifiable than those generated in clinical trials or a statistical analysis where individuals could be reduced to numbers. The ethical standards of the research were thus being judged against research standards that make absent the subjective voices of individual research participants, which on the contrary make up the central focus of this research.

Interestingly, the trust requires that every application for a research project be from an employee of the trust and therefore an honorary contract from the NHS trust must be obtained before final approval can be given. This is performed in order to protect against forms of litigation that may stem from the research. The concerns over accountability and guarding against the risks of litigation were experienced on numerous occasions during the fieldwork, perhaps in part generated by the practices of auditing and self-checking that mediate clinical work (further details of these practices are provided in Chapter Five).

The process of obtaining status as a staff member gave me hope; I thought that perhaps becoming a member of staff would make building relationships with patients and other members of staff within A&E easier. This hope was proved to be misplaced as the examples provided later in the chapter illustrate. Also, this seemingly simple requirement was one of the most difficult to achieve as it involved relying on incredibly busy individuals to act on your behalf, individuals for whom a small scale individual social research project is low down on their list of priorities. The difficulty of gaining the interest or attention of A&E medical staff was routinely experienced once in the field. The practices and purposes of an in-depth exploratory study such as this one provided little materials with which staff could perform their identity as physicians or reproduce the purposes or successes of 'real' emergency medicine. However becoming an honorary member of staff felt as if I had moved a step closer to becoming part of the social networks of A&E.

After a negotiation period that spanned over six months the research proposal was accepted by the R&D office. However four issues were highlighted as needing clarification or explanation, these were: the timing of the proposed interviews, it was advised that these should be shortened; the need to provide full interview schedules; the need to tailor the information sheets and informed consent forms to the particular participants of the study. Much of this was useful advice and the points were rectified and sent back to the R&D office. However, the request for full interview schedules was more difficult. I had provided topic guides around which the conversations with participants would be focussed, a decision made on the basis of the particularly qualitative nature of the research. However, this did not meet the R&D requirements. As a compromise, I offered more detailed topic guides, with possible questions listed as prompts. Following the receipt of these changes final approval was given from the R&D office for the research to be carried out, subject to the local research and ethics committee's decision.

The next stage in the application procedure was to complete the COREC (Central Office for Research Ethics Committees) application form. Initially I had assumed that as the proposed research was to be undertaken in one site that the application need only be made directly to that one local research ethics committee (LREC). However, following recent governmental changes regarding research practice all research must

go through the national application first. I was informed by administrators at COREC that by using this nationally standardised form, all applications to undertake research in the NHS undergo the same uniform process. This form is therefore the same for all applicants, whether the study involves a clinical trial, multi-site studies or a single site non-clinical study such as my own. A large number of questions on these forms were not relevant to the research and were focussed upon issues relating to clinical trials. The supporting documents required were therefore of much more importance in establishing the ethical validity of the research, these included: the research protocol sent out to all members of the ethics review panel along with the research participants information sheets and consent forms and interview schedules; a summary, synopsis or diagram of the research protocol in 'non-technical' language. These documents were much more significant in providing an account of the proposed research.

From experiencing a variety of set-backs throughout earlier stages of the procedure, as well as observing those experienced by some fellow doctoral researchers, I decided that the documents should present the proposed research with little reference to theoretical underpinnings, or sociological analysis. This, although strange from a sociological perspective where ethical validity of ones methods is inextricably linked to ones epistemological perspective, seemed to better meet the requirements of the ethics review panel. In a similar way to the concerns of the data protection officer from the hospital's R&D office, the research was continually being shifted and re-shaped according to an instrumental understanding of research that is best able to provide evidence.

I received a standard letter within five days confirming receipt of the application and informing me that the formal review of the research will commence within the next sixty days. Confirmation was received and the meeting was scheduled for approximately one month after the application had been submitted. This scheduled date was almost a year after the process for obtaining ethical approval had begun. With the possibility that the panel could reject the research proposal or that so much would need to be changed that the increasingly tight timeframe for the research would be further affected, I was incredibly anxious about the meeting.

The panel meeting, quite contrary to all other stages of the application procedure went remarkably smoothly. The decision to be descriptive rather than analytical in describing the methods to be deployed was proved wise. The panel consisted of a mixture of professionals, experts and lay members of the public. The questions posed were mainly to seek clarification regarding the practical details of how the particular methods would be carried out rather than being a response to any substantial ethical concerns.

In describing the process of obtaining ethical approval in a clear and logical manner, it is difficult to show quite how disorganised and frustrating experiencing the process was. One significant barrier was the amount of time taken up finding out what the procedure for access and ethical approval actually entailed. The system for ethical approval was undergoing a great deal of change during the period of my application and it was not until I began the work of building an application that I discovered that much of the work I had conducted was no longer relevant or in some cases needed to be sent to different individuals or organisations. What further exacerbated this problem was that these procedures continued to change over the course of the application process.

This was not only a difficulty for researchers; it was also extremely confusing for the individuals in charge of administrating ethical reviews. Personnel in each different organisation or sometimes within a specific department in the same organisation would provide differing information regarding the application process. As with many bureaucratic systems, the separate departments and organisations responsible for each part of the process often had little or no knowledge of the work being conducted by those responsible for the other parts of the same process, thus making it extremely difficult for researchers attempting to navigate themselves from start to finish.

Obtaining ethical approval marked the beginning of a journey that would in some ways come to characterise the fieldwork process. I felt like I was being positioned at the boundary, observing from the outside the interactions happening inside the site, never quite a full member. Furthermore, in moments where I was able to get inside, this was accomplished through the re-framing of my research upon more acceptable

grounds. The difficulties I experienced throughout the process of ethical review in attempting to explain the research process, was mirrored in the access negotiations that occurred in the site. Hoping that this more formal procedure for obtaining access would help the informal interactions with those members of the site proved an optimistic and somewhat naïve view. Gaining access through an ethical review procedure has little meaning for gaining access to a research site and legitimacy for your presence as a researcher remains precarious and something that must be continually worked out with those members of the site.

Ethics Committees and Ethical Research

From the beginning of my research journey I had been extremely conscious of the ethical implications of my research. Like all research that involves human subjects, there were a number of ethical considerations that needed consideration. I therefore expected to undertake an application for ethical approval from an independent panel when proposing to do research in a public health setting, not least a highly pressured environment such as A&E. It was also expected that such a process would be necessary for researching a vulnerable group such as older people within such a setting.

When I thought about the ethical issues that were most significant in carrying out my research two elements were of immediate concern: firstly the increased vulnerability of patient participants, as many participants may have suffered a very recent trauma, be in pain or discomfort, or perhaps be confused or shaken up, there was the possibility that the presence of a researcher may heighten these feelings of vulnerability; secondly, within a setting such as A&E, patients may have automatic trust in those who they deem to be part of their clinical care.

It was important that the well being of *all* patients, particularly patient participants remained a research priority. Simply by being there and being part of the institution of the hospital there is a duty and automatic responsibility towards patients in not jeopardising their trust. I felt an ethical responsibility to ensure that there was an understanding of my role within the setting by those participating in the study, both patients and staff members, particularly when talking to older patients. Even after

clearly defining the purposes of the project and what participation in it would entail, older patient would at times assume that I was in some way connected to the hospital. Some older patients called me nurse, and others would confuse my research as having something to do with their clinical care. It was therefore difficult, particularly for those more confused patients, to decipher whether they had understood what I had told them. The issue of informed consent in this context is therefore not altogether straight-forward. Many of the participants could have consented on the grounds of their own different interpretation of my purposes in talking to them.

My role as a non clinical researcher in an A&E department was extremely difficult to manage which was in part due to the ethical problem of intruding on such a highly pressured health service. The ethical imperative to appreciate that the priority of staff should always be to the care and treatment of patients formed the basis for carrying out fieldwork observations. This concern was reiterated in many ways and in many forms throughout the research and although I never felt that I was in danger of crossing any ethical boundaries, it did add to the difficulties I felt in managing my role and identity as a researcher and in accessing observations.

What is significant about these ethical responsibilities to participants is that they cannot be easily resolved through institutional ethics review procedures such as the one I experienced. What I found in the practical undertaking of the fieldwork was that there were many more complex ethical questions that arose that required immediate ethical choices to be made that could not have been planned for prior to carrying out the research.

The recent formulation of a UK wide standardised system of ethical review procedures for all clinical research (all research that has any affinity to the NHS) referred to previously has derived in part from the recent shift towards evidence-based medicine. Evidence-based medicine seeks to change the content and structure of medicine to involve a close relationship between medicine and scientific evidence, making the clinician even more competent and less likely to become 'clouded' by experience or theorizing (Pope 2003). It is also interesting that there has been an increase in clinical trials as a result of evidence-based thinking which also may be part of this recent development towards a more standardised ethical review system.

Although research involving the NHS is not made up exclusively of clinical trials, the system has been formulated on the basis of ethical considerations of a more clinical nature.

The argument put forward in favour of standardisation is that by establishing standards that all applications must follow, every member of an ethics committee and every applicant are provided with accessible and simple information to inform them how to evaluate the necessary benefits, harms, costs and risks of a particular research proposal. There is a sense through this procedure that a simple cost/benefit analysis can be made possible from which to assess the ethical validity of research. Furthermore, it is argued that these standards establish a transparency of practice because they provide order, an understanding of what ethical practices are expected and they facilitate coordination between diverse projects. This argument is well established in support of standardisation in general (Drummond et al 1993).

The standardised application forms used in this process are a good example of how a material transparency is achieved through means of record keeping. One could question whether this is more an issue of accountability, rather than an issue of good ethics. Strathern's (1995) work on audit cultures holds some sway here. In understanding the ethical review procedure as audit, the adherence and compliance to standardised practices of research proposals and research ethics have disciplining effects. Researchers and their research are pre-emptively shaped according to the concerns of accountability and evidence-making. Strathern's argument regarding the disciplining effects of audit cultures are discussed further in the chapter that follows, where aspects of medical work are shown to be mediated by practices of self-checking that arguably discipline those who come into contact with them through the social adjustment such practices encourage.

Where the standardized view is problematic is in recognising that guidelines and procedures that produce standards to be met may not necessarily 'the correct' standards. In undertaking a cost/benefit analysis for example, what is understood to be costly and what is understood to be beneficial is value laden: ethical complexities cannot be reduced to a formula that will resolve the issues produced by all research proposals. The shift of balance to favour either the costs of the proposed research or

the benefits can also never be the result of evidence alone. It is interesting that within the ethics application itself, what is expected to be given as the purpose or justification for the research is focused almost solely on filling up 'scientific knowledge gaps', with little importance placed on theoretical justification for research, justification that would make explicit the values specific to the project being proposed. This fixing of value to specific outcomes works to undermine any recognition that decisions are made on the basis of values: they are political and should therefore be made explicit in order for judgements to be made about research ethics. This was certainly reflected in the review panel that I experienced, whereby the ethical content of my research was judged on routines and procedures to be followed rather than on the research's intellectual, theoretical or ethical integrity.

Further problems may occur if the guidelines become so bureaucratic that they lose any real meaning; if they simply become instrumental, a means to an end as it were. A good example that has been used to describe this problem within evidence-based medicine is that procedures and guidelines become like a 'cookbook' and that practitioners merely follow the recipes, causing what has been dubbed as the 'McDonaldization' of medicine, where every patient problem would be addressed generically, as one more instance of the same (Timmermans & Berg 2003). The relations between medicine and managing, particularly aspects of clinical guidelines born out of an 'evidence-based' ideal are important to this thesis' argument about the performance of 'real' emergency medicine. Specifically the thesis shows how some aspects of biomedical discourse are shown to sit well alongside some features of medical management, with important effects. However, the extent to which this meeting of discursive forms constrains or regulates medical professionals at work is shown to remain complex. (These issues are discussed in detail in Chapter Seven). The purpose of considering these relations here is that, in a similar way to the increased technologies of managing mediating emergency medicine within A&E (see Chapters Five and Eight), it is through the ethical review procedures that research of medical settings is being managed in a similar way.

This process could be highly problematic when assessing ethical standards of research because each case may not be judged on the ethical issues specific to the research proposed but rather on a list of bureaucratic standards to be met. By using functions

such as standard phrases for example, that can simply be inserted into a research protocol or patient informed consent form, a degree of focus on the complexities of ethical considerations may be lost. To return to the particular ethical considerations I discussed earlier, it is clear that they cannot be easily resolved through this system, even with the most meticulous of planning. The reactions of research participants to situations that may arise within a setting such as an Accident and Emergency department are extremely difficult to predict and often following detailed procedural standards for ethical conduct is impossible and in some cases ethically inappropriate.

Ethical conduct in many instances comes down to the researcher's pragmatism when adapting to a situation where official procedures are not possible in a way that still upholds the ethical foundations of research practice. The weighing up of costs versus benefits does not allow for a discussion and understanding of the subjectivities of both participants and researchers in undertaking research and the important ethical connotations of these. Whose costs and whose benefits are being balanced? What is important when thinking about the ethical conduct of research is the culture of research practice, the way research is carried out, the relations built between researcher and participants. These are difficult to alter through the guidance of formal procedures.

This is not to suggest that being made to think about the ethical content of your research and being reviewed on this basis is at all detrimental; on the contrary it is something that should be encouraged. What is being suggested is that if the process that attempts to undertake this assessment becomes too bureaucratic, it will simply become an administrative task. This could undermine the importance of ethical evaluation of a kind that is not temporally stagnant but ongoing and that occurs in the complex world of social relations.

It has become clear that the ethical review procedure has had particular ethnographic effects. Viewing the process of formal ethical review as audit, it can be understood as a means with which the research was continually being re-framed and re-constituted. Although there are concessions and deviations in the procedure made for non-clinical research undertaken in a clinical setting, these existed as digressions before the research had to be brought back to judgements founded upon a particular form of

medicine, one that is managed and audited. As a result, any discussions about the research during this procedure were undertaken within a context where the principles and guidelines of research were founded upon the ideals of evidence-making and accountability.

Accessing, Positioning and Emotional Labour

Once official ethical approval had been confirmed I felt excited about the prospect of finally beginning my fieldwork, until the realisation of what this actually meant became clearer. Access, when undertaking ethnographic research is an ongoing negotiation and one that I would become extremely familiar with during my fieldwork. One recurring difficulty that I encountered was the reframing of my research by the participants. This involved all participants in various ways, but was most problematic when in the context of gaining access to observations. Quite often medical staff, particularly doctors and consultants would reframe my research on the basis of its methods, or its purpose. This was perhaps in part due to a lack in my ability to clearly describe the research, but was also due to the descriptions that were offered not sitting well with the 'normal expectations' of worthwhile research. To use Atkinson's (1997) description of similar experiences in the field, they seemed 'woolly' and 'subjective' (p.34). The extract below describes my frustrations during meetings with my main gatekeeper, Dr Prichard.

'Generalisability and statistical significance'

I sat and waited for Dr Prichard to come. I was slightly nervous about meeting him again, as he had always been quite stern during previous meetings and seemed rather confused by my proposed research. He often asked questions about generalisability and statistical significance. During our first meeting I felt a need and had attempted to respond to these questions by providing an explanation, as best I could, of the principles of qualitative research, in particular the questions that I sought to answer and why they were best answered by these particular methods. I realised quickly from his expression that he was not impressed. I began to realise as I spent more time with Dr Prichard, that when he fired these questions he was much happier when I did not respond. This became apparent after our first meeting when, exasperated at our inability to find common ground, I found myself out of answers. Instead of there being an uncomfortable silence or awkwardness, Dr Prichard responded himself to his questions by explaining ways in which I could carry out my research that would rectify these oversights, as he saw them.

It was as I discovered much less problematic for the practical purposes of continuing access to my research site, to allow Dr Prichard to formulate his own interpretation of the research than it was to base our discussions on my, far less 'scientific' explanations. What these difficult meetings and many similar interactions that occurred during the fieldwork process revealed, was a particularly medical way of seeing and understanding research and the research process. The sorts of knowledges accepted as evidence and those that were rejected, or to use Canguilhem's (1966/1991) terms, what is 'in the realm of the true' and what is not, were made visible during these conversations. Although medical practitioners may call upon subjective accounts in everyday interactions, often occurring in the form of 'typifications' used to accomplish the work of organising patients (see Chapter Seven), these accounts are viewed entirely separately from those that inform research evidence that merely objectively show 'what is'.

These sorts of difficulties were confounded by the continual, local access negotiations I encountered at the start of each visit to the A&E department. This difficulty in the describing of my research was felt and experienced routinely. Often when I arrived at A&E at the beginning of each fieldwork session I would not be known and I therefore needed to find the member of staff in charge and negotiate their agreement for my presence. This negotiation involved what became the dreaded pitch, the offering of an explanation for me and my research which, as experienced by Foote Whyte (1943) in his study of Cornerville, began as a lengthy and detailed offering which over the course of the study became a short, succinct explanation that was more often than not developed by the participants themselves. These included explanations such as 'she's looking at the socials' or 'she's writing about how old people get a bum deal'. These explanations as well as forming interesting research material, took on a life of their own. The way I became known by different members of staff was often determined by such explanations. They could determine what information, or which patients' staff deemed to be of interest to my study. In addition these explanations would position me in particular ways. It became dreaded as it was at times met by either disinterest (a common reaction from the nurses) or suspicion (a common reaction from the doctors).

The interpretations of my study were not only formulated by medical professionals but by all participants in one form or another. Patient participants would also re-frame my research in particular ways. These re-framings often caused some difficult ethical dilemmas. For example, patient participants might redefine me as a clinical researcher, a nurse carrying out research. Although always providing as clear an explanation as possible of my role and identity and the research, in particular that I had no affiliation to the hospital and that their participation had in no way any repercussions for their care and treatment, these explanations were often understood and interpreted in a variety of unintended ways by the participants.

The need to continually renegotiate my position was in part due to the particular organisation of the department, something that I became acutely aware of as a result of routinely giving my pitch. Although the department was separated into distinct areas that, according to Dr Pritchard, reflected the specific needs of patients, staff would rotate between these areas frequently and in some cases this could happen from one shift to the next. This meant that I would continually work with different members of staff and, more importantly, the continual movement of staff between the various areas of A&E was experienced by the staff themselves. This revealed not just something about the difficulty I had in gaining entry into social networks, it also revealed something about the social organisation of the space, specifically, that perhaps people were too mobile so that such relations were absent and there was nothing to gain entry to.

The following extract describes my attempt to enlist the help of a senior registrar during one of his shifts at the unit. It not only exemplifies the process of transformation that occurred in the description and interpretation of my study, but also offers a good illustration of the awkward self presentation work involved in attempting to build social relations in the field.

'Huge numbers'

I then spotted a doctor who I had not been formally introduced to but I had seen around the unit on numerous occasions. I went over to him, introduced myself and asked him if it would be okay to shadow him for the day. I was trying hard, against my nature, to be pushy as I was getting concerned about observing particular

interactions that I felt were lacking in the research. He responded by saying *well, err... I'm the only senior doctor on today so, what is it that you're doing exactly?* I explained that I was exploring the experiences of older patients who attend the unit. This shortened version was a response to the disinterest I had received from the nurses; the only thing the nurses needed to know was what the research would mean for them doing their job. It was also from the awkwardness of the suspicion that I received from some of the doctors. He then went on to suggest looking at the patients notes, *I don't know if you'd be allowed to do this, that's something you may have to ask Dr Prichard, but if you asked at reception they could give you the records of all patients over 65 or whatever who have attended and then you could look at their notes. You'd get huge numbers of data that way.* I said I wasn't sure if I had clearance to look at patients' notes but that I would look into it.¹

I was in actual fact well aware that I did not have approval to look at patients' notes. 'Huge numbers', as he put it were also not a great deal of use to my study. After plucking up the courage to ask the registrar for his help, I had not prepared myself for the possibility of him declining. I had not quite built up my confidence to the point of pushing him on this issue. Had I been more adept, I may have tried a number of tactics in order to persuade him to allow me to observe his work such as flattery, name dropping or pulling rank all of which I had successfully, albeit accidentally accomplished in other situations. Unfortunately I had not developed these skills in such a way that I could call on them in moments of necessity. During the conversation the consultant had informed me of the best possible methods with which to obtain research data. This type of advice occurred frequently, so that in the midst of the conversations, staff would inform me of how best to carry out the study. On one occasion, a consultant spent half an hour describing how to produce the best cross check of all patients over sixty five, drawing graphs and tables as illustrations.

I do not mean to suggest that these gestures of advice were not genuine attempts to help. However, they were also doing other work. The constant affirmation of clinical, quantitative or scientific method as the best means of obtaining useful information regarding medical work was present in these accounts. In other similar interactions with medical staff, the practitioner would refer to key knowledge areas that are of integral importance to the study that those with clinical experience would be aware of. They would impart this knowledge to me, so that it would correctly inform the research, thereby accomplishing a combination of clinical practice and

¹ Throughout the thesis the recorded speech of members of the research site is represented by the use of Italics and ... represents a pause or break in the conversation

clinical research as a dominant way of knowing about older people in an emergency unit.

These accounts accomplished identity work through particular modes of ordering: firstly, that the particular clinician was competent and up to date with the latest research evidence that would inform any elements of clinical work, aligning themselves to an evidence-based medicine discourse such as the kind being performed through the ethical review procedures; secondly, that clinical experience alongside such knowledge cannot be beaten in the understanding of any form of medical practice thus aligning themselves to a biomedical discourse and re-accomplishing the dominance of the clinic. It is my problematic status during these particular 'moments of accessing' that provide the means with which medical staff are able to perform this boundary work. In showing me the acceptable forms of research that happen inside medicine, my position outside, along with those patients and forms of research deemed to be in some way not 'real', is re-affirmed while at the same time re-constituting what makes up the inside, the 'real' work of emergency medicine.

Fitting In

One fundamental difficulty I found during the fieldwork was the seemingly impossible task of fitting in. The process of 'hanging about' (Becker et al 1961) A&E was at times somewhat of an emotional labour in which I was forever attempting to negotiate my role and place, something that I never fully accomplished. As Jarzabkowski (2001) makes clear the issue of emotional labour in ethnographic research can be viewed from two perspectives 'the participants' expectations of me and my own expectations of myself' (p.136). This was very much the case for my own experiences of fieldwork. I needed to manage my emotions in order to conform to the expectations of my participants and even more limiting was my own need to 'fit in'. The following extract describes a particular attempt that I made to observe a young doctor working in 'Trolley bay' that indicates the type of emotional labour that I experienced during the fieldwork process.

Abandoned in the field

They (Dr Prichard and Mrs Brown) had decided that the best thing would be for me to observe one of the doctors who was due to be based in Trolley Bay but he wasn't arriving until 4pm so asked if I was okay to wait. To which I said yes of course. I was really pleased, as it seemed that they had played a more proactive part in helping me gain access to further areas of the unit. I got the impression that Dr Prichard especially, felt a little embarrassed about how disorganised my time at the unit had been so far, with introductions and placements being left up to me. After waiting, the doctor that Mrs Brown and Dr Prichard had decided I should follow arrives. Mrs Brown introduces us and explains what my research is about briefly and asks him if it would be okay if I observed him working. The doctor is quite young and very quiet, he only responds with gestures, nods, shrugs of the shoulders. He half smiled and nodded, which Mrs Brown took to mean, yes. She goes back to the office and leaves us. The doctor then, not looking at me and without saying anything, walks out of the room at pace, in the direction of the staff toilets and locker room. Unsure of where he was going and whether I should follow him, feeling the future embarrassment of following him to the toilet, I assumed that he must be coming back and waited there for him to return. Unfortunately my assumption was wrong and he didn't come back. I felt really awkward and for what seemed like an endless amount of time I stood motionless in the same spot trying to work out what had just happened and what I should do. In the end I decided I should head to Trolley bay anyway, where I hoped he may be so that I could approach him and attempt to re-establish what it was that I wanted to do, but he was nowhere to be seen. I therefore introduced myself to the nurses and told them what I was doing and asked if they would mind me hanging around.

This example, aside from being an amusing anecdote from the field, is one of many where attempting to access observations involved a particular degree of self presentation that has wider implications for selfhood, identity and emotionality. In undertaking ethnographic fieldwork we do identity work, in the roles we take on, in the expectations we have and fulfil, and in the relationships we establish; these are all formed through processes of self presentation and identity construction. Where these are not maintained, or where roles and expectations are not met, as in all areas of social life, feelings of failure, embarrassment and general awkwardness ensues, as illustrated in the extract above. Moments when relations in the field are well negotiated, when expectations are fully met, are emotional as well as practical and intellectual accomplishments (Coffey 1999).

On some occasions I managed to achieve blending in. For example, in some fleeting moments I was mistaken for a member of staff by patients or other staff members due to my identification badge, or through positioning myself in staff designated areas. However, in many more situations other than adhering to the obstacle of my physical

presence, people moved passed me, and talked around me as if I were not there at all. As Geertz (1973) describes, you become a 'nonperson, invisible' (p.412). As time in the field progressed I would attempt more and more to build relationships or to assert my presence but I would often remain in the background. I was never able to become part of a network of social relations whereby I had a role, a purpose or a sense of belonging. The following extract is one of my early entries into my research diary in which I first described these feelings.

Feeling useless

While I sat there, numerous members of staff would come in and out, looking at rota tables that were placed on the wall just inside the main door, or to speak to one of the administrative staff, or the nurse manager, who's office was situated in one of the offices that surrounded the centre square where I sat. Many would look at me with curiosity, wondering who I was and what I was doing. I would come to realise very quickly that one way to stand out in an environment such as A&E is to be motionless, not doing anything or talking to anyone, being without purpose. This was something that not only marked me as an outsider, but was also incredibly difficult to manage personally. Although I did, of course have a purpose, a very real purpose it was not one that fit easily into the processes of the unit and as such there were moments when I would feel useless, in the way of others' more meaningful, purposeful activities.

Part of the difficulty that I felt in attempting to fit in was that every action and interaction for staff must be purposeful. Even in moments where staff were chatting, gossiping or joking with one another, there seemed purpose to it; there was always an air of efficiency maintained in all activity, something that 'hanging about' clearly lacked. Even in offering explanations of my study, the qualities of openness and exploration that inevitably came through seemed so distant from the qualities that were valued in A&E.

Aside from the difficulty of not finding a role or purpose within the organisation, this problem began to grow into a more general question about A&E; whether there was anything to become a part of. The feelings I experienced of not belonging, of being outside a social network may have been as a result of there being nothing to get inside. As I discovered, the use of technologies of communication such as the triage boxes, or electronic patient record systems, something described by Engesmo and Tjora (2006), have in some cases come to replace face-to-face interaction where

practices of 'taking others into account' exist. What I began to reflect upon as these observations came to light, was that perhaps the difficulties I was experiencing in trying to 'fit in' were a reflection of this change. There were less face-to-face interactions about patient assessments between different members of staff, thus social networks and groups were lacking with which to get inside; the organisation and cohesion of the department was not so much established through networks of face-to-face interaction but rather through organisational and communicative technologies (See Chapter Five), which were much more difficult to permeate.

Roles in the Field

One way in which most researchers in the field deal with the problem of fitting in is to take on roles that help to perform particular functions or provide purpose. Perhaps most commonly the role of the ethnographic researcher has been described through the varying degrees to which s/he participates or observes in the setting. For this research, the researcher is always a participant, believing that as a social being, presence in a social setting will always involve participation: a researcher is never a complete observer. My presence, even if quiet would always contribute to the social context in which I was situated in some way or another. The flexibility of the balance between being a part of the social situation and also observing that situation was at times a response to the particular individual or group that I was involved with, and indeed what action or interaction they were involved with. For example, I participated much more freely amongst a group of nurses talking informally whereas I would remain much quieter amongst a consultant's assessment of a possible surgical patient. It was therefore appropriate to negotiate this balance within the field.

This balance or flexibility does not fully explore the particular roles that I found to be of most use while in the fieldwork setting. One role that was frequently useful while observing in the field, particularly when observing Dr Prichard, was that of the student. This role was prescribed to me by many members of staff, more commonly by the older doctors and consultants, but sometimes by the nurses as well. Aside from my age and gender that cannot be ignored as playing a part in the way I was positioned, this was often a role that enabled staff and me to feel more comfortable. As the following extract describes, Dr Prichard was particularly comfortable in

positioning himself as the teacher and me as a student. This was significant as the roles enabled us both to manage our identities in order to avoid social awkwardness; we were both clear about what was expected and were able to meet the respective expectations of us, as the following extract exemplifies.

Playing student

Following the previous meetings between myself and Dr Prichard I have very much fallen in to the role of student. We both seemed more comfortable in these roles. I found myself following his instructions and writing things down he was saying. Sometimes he would even repeat something slowly to give me enough time to get it exactly right. I would at times forget that the purpose of my presence there was to carry out research, for my own thesis. I would watch closely as he explained the results of x-rays to me and i would write information down as he reeled off statistics to me, not as observations but as if they were facts that I would be tested on at a later date.

Fieldwork, Research Framing and Older Patients

During my time in the field I began to realise that many of the themes that were emerging were not only relevant to older patients. It was never my intention to only observe older patients through A&E; I wanted to gain a full and rich experience of the department including its social, administrative and medical organisation and this did not mean limiting the assessments that were observed according to age. The aim was to pay particular attention to older patients who attended in order to identify any particular forms or categories for assessment for this traditionally problematic group (as made clear in Chapter One). However, by describing my research in the setting as being particularly interested in older people this began to limit what staff perceived to be of interest to me. Assessments that could have been observed were deemed to be outside the remit of the research project. Discussions generated with staff that were in response to my research would generally centre on particular stories of older people. This was of course not all negative and provided me with valuable research materials relating to the way in which older people were ordered. Of particular concern were the boundaries placed on my observations as a result of staff interpretations of older patients with complex health needs and what these boundaries revealed about how these sorts of patients were 'typified' (see Chapter Seven).

My difficult status, derived from staff's interpretation of the patients of interest to the study, produce a heightened awareness of the experiences of those patients who were placed into negative staff constituted patient categories. The categorical work undertaken by staff during my own moments of accessing were ethnographically significant in building on the accounts of previous studies (described in Chapter Two), particularly through emphasising what can be accomplished by this categorising work. As this thesis shows, it is not merely patients who are ordered into good or bad, legitimate or illegitimate, but research practices and researchers can also be ordered the same way, particularly if this helps in the performance of 'real' emergency medicine.

Summary & Discussion

The way in which I experienced difficulties 'getting inside' was a reflection of the same practices and procedures through which the organisation of A&E attempted to protect the *real* work of emergency medicine. As is explored in more detail in the following chapter, the socio-spatial organisation of A&E reflects and aids the reproduction of a separation between those patients and assessments of patients deemed more trivial in their problems and the needs of those requiring more expert medical treatment. This separation was felt in my own experiences of attempting to observe cases and assessments in all areas of the unit. In undertaking observations without the aid of an informant as a guide, I often experienced barriers to accessing areas where the reproduction of expert medical care was carried out, such as the HDU (high dependency unit) and the resuscitation rooms. It was the experience of this barrier in my own research that brought to light this implicit distinction. There was never a point at which I was told that I could not observe in these areas, but it was made clear to me that the sorts of patients I was interested in, 'the socials' (see Chapter Seven for a more detailed exploration of patients ordered on the basis of 'types') would not be in those areas. Therefore it was through the interpretation of the research I was doing and more importantly the interpretation of the patients of interest to my research that kept me at the boundary, in a similar way to those patients, outside the 'real' work of emergency medicine.

The ethical review procedure was not, as I thought it may have been, a means with which to gain access in any meaningful sense to social groups or networks of A&E from which to establish a role as a member (other than of course my official admittance to the site), it was also not a process through which my actions in the field were moulded on ethical considerations. Rather ethical decisions were made in the moment as immediate responses based upon broader foundations of respect and protection for the well being of others, something that is difficult to control through the kind of standardised procedure that was experienced. However, what these procedures did reveal to me were the values through which official committees deemed research to be legitimate. In my experience of the ethical review, valid research, at least valid social research, had to be presented as abstract from their theoretical context or political values as analytical and theoretical underpinnings are not seen to be relevant to the ethical validity of social research in a clinical setting.

Furthermore, the formal ethical review procedure marked the beginning of my continual negotiation between my own research and its relations with 'real' medicine. The attempts to re-frame the research onto medical scientific grounds that occurred through these negotiations in the setting created unique spaces in which I was able to gain partial entry into the worlds of those medical staff who accounted for my research in such a way. However, in the formal review procedure this re-framing created limitations in my ability to present the ethical foundations of my research. However, what I also want to press is the alignment between medicine and managing emergent in the ethical review procedure that is particularly significant as an example of the disciplining effect of the audit culture (Strathern 2000).

What this chapter draws attention to is the way in which my place within A&E was one of ambiguity. I was in a state of continual negotiation and had to perform a great deal of self presentation work in order to accomplish access to observations. However, this ambiguous place meant that I experienced, not only staffs' ordered sense of A&E where the logical practices of providing emergency medicine are taken for granted, but also the confusion and disorder experienced by many patients and members of the public in attempting to navigate and access medical care and treatment. The work that I had to do, in order to secure myself a place in A&E drew my attention to the similar work that was required from patients, as well as the means

with which staff responded and assessed such work. This interplay between my own experiences and others in the site was an integral part of bringing into view the identity work undertaken, not only by patients in attempting to gain access, but also by staff in their responses to these attempts.

Throughout the research I moved between two positions: the moments I got inside as a partial member, when staff would adopt me and take me inside their world; to the other moments when I remained outside, limited to the areas where my sorts of patients would reside, existing as a 'nonperson' attempting to be noticed. The moments when I got inside I was particularly interested, not only in what staff would show me in their worlds and how they accounted for their work, but also in how I had accomplished getting inside.

This unique positioning as matter 'out of place' (Douglas 1966) directed my attention to the broader issues of how social relations in A&E were managed by staff and patients, particularly through self management and identity work. The focus upon older patients therefore shifted to a broader interest in how staff and patients managed gaining and controlling access to medical treatment and care. Furthermore, this space of liminality (Turner 1974) in which I existed as a potential member, neither patient nor staff member, also brought to light how technologies were integral to the maintenance of networks in which members took others into account.

As I never gained a definite role or place within A&E, these moments of getting inside were temporary and remained precarious: they would always need to be worked out. It was never routine or part of the course for staff to allow me to observe their work, or discuss it with me. Why particular members of staff would decide to show me their work or account for their assessments was therefore important. On some occasions, staff would adopt me to evidence a point they had made in previous conversations we had shared. As the previous analysis shows, often when staff adopted me they were undertaking identity or membership work. Whether these were undertaken for the purposes of re-establishing medicine as a dominant mode of ordering, or undertaking identity work through performing competency in medical practice, it was through my particularly ambiguous role that this work was brought to light. The wider socio-spatial organisation of A&E had a significant part to play in

my ambiguous positioning, as well as the positioning of staff and patients, something Chapter Five explores in greater detail.

Chapter 5

The Socio-Spatial Organisation of A&E

‘Place is the effect of similitude, a non-representation that is mobilized through the placing of things in complex relations to one another and the agency/power effects that are performed by those arrangements.’ (Kevin Hetherington 1997: 187).

Introduction

In this chapter I offer a rich description of how space is organised and its significance for the ordering of social relations in A&E. The chapter identifies how spaces reflect and produce relations of hierarchy that help accomplish the performance of A&E as a site of emergency medicine. What this description shows is how the constituted divisions between spaces provide the conditions for a continually occurring interaction between available medical, administrative and managerial categories through which staff organise their work.

From the moment an assessment form is generated for a new patient, the patient is continually constituted and re-constituted through a complex interplay that exists between these available categories. Those areas closest to the periphery of the unit, are ‘front stage’ and are occupied mainly by nursing staff. Front stage areas involve the work of assessing, sorting and prioritising patients as well as managing them as a group making claims to emergency medical resources. These areas work as ‘thresholds’, where access to the spaces more centrally based ‘back stage’ is negotiated.

The spaces that exist towards the centre of the department are ‘back stage’ areas and these are more commonly occupied by doctors as well as nurses and patients. In these spaces technical and medical expertise are more on show and the managerial and administrative technologies that are most explicit front stage become less visible. Nurses in these central spaces tend to remain in one area with specific patients to manage. For nurses in these areas time is spent organising and recording the status of patients, including bed management, facilitating patient discharges or the transference

of patients to hospital wards. Doctors are not fixed in the same way; they are always moving across and between areas. As a result of nurses' management work, doctors¹ are able to remain back stage, in the clinically defined areas of work, treating those pre-assessed, ordered and prioritised patients. Interestingly, the work undertaken back stage is also constituted by medical staff as being the 'front-line' of emergency medicine. This is where the heroics of treating those with life threatening emergencies occurs, away from the everyday, mundane practices of those 'back stage', who sort and manage those non 'true' emergencies cases. The definition of front-stage and back-stage is therefore contingent upon the particular social and spatial position through which A&E is experienced.

Through providing a detailed description of A&E as spaces, it is possible to gain insight into divisions and categories available to staff in organising and accounting for their work of assessing and prioritising patients. In addition to exploring the department's overall divisions of space, providing insight into the ways in which different expertise and types of patients are divided up and grouped together, the chapter pays attention to the work undertaken at the 'threshold', where the contestation and negotiation for access to the inside expertise of emergency medicine is most intensely governed.

The Place

The emergency unit is part of a large, city based teaching hospital. The university hospital was born out of a tradition that advocated a combination of education, training, research and medical practice on one site. In 1962 the building of the hospital complex, bringing together medical and dental hospitals with university education, training and research began. The history of research based at the hospital began with the Tenovus Institute for Cancer Research in 1968. A professor, teacher and practitioner at the hospital wrote a key text regarding effectiveness and efficiency in the health service which, according to the hospital's website, gave birth to 'the concept of evidence-based medicine'.

¹ Doctors are enrolled in different ways in the discourse of management however this rarely occurs through the practices of managing patients at the threshold.

The Accident and Emergency department is one of the biggest in the U.K and covers a large area of the city's emergency needs. As an integral part of the teaching hospital, the department is involved in various research projects and is a significant part of the hospital's teaching and training programmes. The unit therefore identifies itself as a site of 'first class emergency medicine' and it is this definition that is often called upon in the organisation of the unit.

Entering into the hospital complex, the visitor is faced with a myriad of car parks, buildings and interconnecting pathways. The hospital complex is quite a confusing place for visitors. There are attempts to make it more comprehensible through the use of signposts with names, arrows and instructions, all directing the visitor to the appropriate place. The number of different buildings with varying purposes that exist in the complex becomes immediately apparent. For example, the medical students' social club is situated along side the Outpatients section of the hospital that is located in front of the Tenovus Centre for Cancer research, re-affirming the bringing together of science and research with medical practice, education and training.

For the visitor, the Emergency unit is accessed through the main entrance which is clearly signposted from every entrance into the complex. For staff however, there are many alternative routes and entrances into the unit from inside the hospital. Outside, at the front of the unit there is a car park where ambulances are often parked. This is also the point where patients are dropped off or picked up by relatives or taxis. There are sometimes patients, relatives or staff members outside on their mobile phones, having a cigarette or simply getting some air. Paramedics will also congregate in the car park after bringing a patient in or when they are awaiting a call.

The entrance to the Unit consists of double automatic doors with a foyer before two more automatic doors that open straight onto the waiting area. The waiting area consists of lines of chairs that face inwards towards the unit itself. The chairs are formed by a metal base that connects them to one another and also to the floor with foam for the cushioning of the seating covered with plastic. Some chairs are ripped, exposing the foam underneath and at busy times there are often chairs stained with blood or vomit.

The atmosphere in the waiting room changes from day to day and at different times during the day or night. Mid morning is generally quiet, the waiting area is mostly taken up with older patients who have slipped or fallen while on their mid morning walk. The cleaners also tend to do their duties between eight and nine in the morning to ensure that the floors and the chairs are clean and there is little rubbish. However, on the weekends this can change quite dramatically, Sunday morning for example is mostly full of younger patients, quite often men, who have suffered alcohol related injuries the night before and have woken up in pain.

From five in the afternoon onwards the waiting area tends to fill a little more as people finish work. Children who have been ill and not improved through the day and older patients are brought in by relatives at this time. Then, later into the evening the numbers tend to increase further however those who arrive in the early hours of the morning are likely to be taken straight to trolley bay or the assessment unit as these tend to arrive by ambulance on GP (General Practitioner) referral. Those with chronic illnesses, symptoms tend to become more acute during the night, and more accidents can occur. This is especially true for older patients who tend to suffer more ill health and accidents during the night.

Through the afternoon and evening the waiting area becomes a louder, more uncomfortable place, with more patients waiting to be seen. It can get littered and messy as the cleaners become less frequent. This noisy atmosphere becomes heightened through the night, particularly on a Friday or Saturday night when the effects of alcohol play a large part. On these nights, especially when they are coupled with a sports event like a football or rugby match, it is not just the numbers of people that create the noise levels but the varying levels of inebriation of the patients and their friends and relatives. It is not unusual to see bodies stretched across the chairs with bloody noses or head wounds where a patient has passed out while waiting to be seen, or patients brought in for fighting accompanied by a couple of police officers who will sit between the two offenders in order to ensure no further damage can be done.

For many, on these nights A&E is a scary place to be. One Sunday morning when I was talking to some nurses, a young girl called to ask how long the wait might be.

She had been in the night before after falling over (possibly breaking her ankle) but had not stayed because, as she told the nurse, she did not feel safe. It is not just patients who can feel unsafe. All around the waiting area there are posters explaining the unit's no tolerance policy on violence or abuse towards the staff. If for any reason a member of staff feels threatened they are within their rights to refuse to give treatment. Although I never witnessed patients being turned away on these grounds, I did witness patients being verbally abusive towards staff.

The shifts that occur over time have significant ramifications for the way in which medical staff working within the department identify, assess and prioritise patients. There may be a general change in the triage process, whereby establishing a patients' priority of need is influenced by the overall context in which the individual patient becomes part of 'the patients'. This is most severely felt by those working in the front stage areas, where 'the patients' as a group have a significant presence and where there is a greater responsibility to manage them as a group. The rhythms of A&E not only involve patient attendance, there are also the temporal structures within the unit itself, particularly the running of staff timetables that needs co-ordination². These temporal structures form part of what Melia (1979) refers to as the 'turbulence' of the hospital ward. These turbulences are characterised by issues of time, the conflicting calls to often juxtaposed duties of providing care, distributing resources and undertaking administrative work.

For Melia (1979) these 'turbulences' are managed by nursing staff in order to limit their effects on the patients being cared for. Sbaih (2002) argues that it is nurses' role in managing the tensions of A&E work that allows for the accomplishment of emergency care. These tensions refer to the expectation of patients with low priority of need to wait while those with more immediate needs are treated. In the case of A&E it is arguably the patients themselves who cause the turbulences, as attempts at accessing become more forceful due to the practices of prioritising (the triage system)

² Although recognising the importance of temporality to the social ordering of A&E, the focus of this thesis does allow for a thorough analysis of these relations here. In particular the shifting of other ordering systems through the mediations of social time would offer an interesting dimension to the arguments of this thesis but constraints and focus do not allow for this. Therefore for a more detailed insight into issues of time and temporality in hospitals see Zerubavel (1979).

and assessing patients. It is this 'turbulence' that must be managed and this managing is mainly undertaken by nursing staff but aided by reception staff and health officers.

Front stage, Back stage and the Division of Labour

To the left of the waiting area is reception. This is where any visitor to the department must register themselves. The reception desks are separated from the waiting area by a wall. There are two large openings like windows along the wall that see through to the person on the reception desk, these have sliding plastic shutters that reach across the windows that can be closed completely. At the reception desk an initial assessment form is generated. The forms include simple pieces of information such as the patient's name and date of birth, along with their complaint. For the more common complaints, they are coded by the reception staff. For example an injury to the left ankle would be entered LA injury. This is significant, as although reception staff are not necessarily viewed as an integral part of the process of organising and ordering patients according to priority of need as Hughes (1980) illustrates (see Chapter Two), they do offer the first step in the process of building typifications regarding the patient that may have important ramifications for the patient's career through the department.

The patient's initial assessment form or file provides the means through which he/she is made visible to medical staff. Without it, the patient and their problem, from the point of view of the medical staff, does not exist. The medical categories available to staff to categorise, and subsequently assess, examine and treat patients are shaped by the materiality of the patient's file. The medical categories assigned by the staff to patients following an assessment, must fit the administratively constructed questions, codes and spaces that exist on the assessment form.

The generation of these forms mean that the patient is then automatically logged on to the interconnecting computer system 'Jonah'. Jonah provides a checking system for every A&E patient at all stages of the assessment process. Individual members of staff who have encountered a particular patient at a specific stage in the assessment process must log onto the system to record the assessment or treatment that has been

carried out, thus automatically recording the time that the activity took place. Subsequently, the length of time that passes between various stages of the assessment is also documented. For example, the time it takes for a patient to be assessed by a doctor, following a triage assessment, can be called upon by any member of staff in the department through 'Jonah'. This information can also be called upon for purposes outside of the day to day routines of those in the department, to ascertain the working practices of the unit as a whole. Through this system the progress of patient's passing through the A&E system can be monitored at all times. As Nurse Morris explains:

'System that would change our lives'

It's called Jonah. It's fairly new, it's there to increase efficiency across the department. It was first introduced in Greenfields which was one of the worst Emergency Units in Britain and now it is one the best so we bought it here.

How it works is you book patients in following their assessment and then update the system with say, SBD (seen by doctor) or R (referral) or whatever. It's the target that no patient should be waiting following assessment for more than 4hours, the patient on the computer then becomes 'in breach' of the target. The systems aim's to ensure that everyone is made responsible for working efficiently 'cause with this, everyone is accountable 'cause it knows at all times who's responsible for each patient in the department.

Before it was brought in it was made out like it would be this miraculous system that would change our lives. It hasn't but we are beginning to see a slight improvement from it.

This computer system is a means through which the work of medical staff is continually mediated by administrative accounting practices. The particular effects of the checking purposes of Jonah are significant. They create, in individual members of staff, the responsibility for their part in successfully keeping to the trust and government guidelines for patient waiting times and for processing patients through the unit as quickly and efficiently as possible. Not only must medical work be mediated by administrative materials, but the choices made and actions carried out by medical staff must be recorded, and in the process of recording them, there is an automatic recourse to the financial and temporal pressures upon each member of staff.

Interestingly the basis upon which Greenfields was deemed the best or the worst A&E department is automatically determined by the guidelines put forward by Jonah. The criteria upon which the department will be judged are both produced and tested by a

technology such as the Jonah computer system. As May (2006) makes clear, 'the promotion of specific systems of practice are formally revealed to be 'effective', even though effectiveness is itself never politically clear cut' (p.518). In this case, through a reliance upon Jonah, effectiveness refers to meeting government guidelines regarding patient waiting times and the movement of patients through the department.

These practices of recording are actually a means of self-checking for medical staff, checking the waiting time for their patient, checking the disposal rates for their patients, checking the number and cost of examinations and treatments given to their patients, as well as checking all these variables for other members of staff. This self-checking actually works to do more than simply audit and record, as Strathern (2000) makes clear:

'Some governments (and the UK is an example) have discovered that if they make explicit the practices whereby people check themselves, they can ostensibly withdraw to the position of simply checking the resultant indicators of performance. Their intervention has already taken place: the social adjustment which corporations, public bodies and individual persons have already made to those self-checking practices now re-described as evidence of their accountability to the state.' (Strathern 2000: 4).

In other words the very presence of these auditing technologies mediates the behaviour of those who work with them. As Nurse Morris describes, the Jonah system was installed as an integral part of the department's organisation as a reaction to other trusts who had used the system and reported positive results in helping to keep to government targets. It is not therefore a government requirement for such systems to be used by emergency departments; however the result of such a system is to regulate the behaviour of those who come into contact with them. As Rose states,

'Rendering something auditable shapes the process that is to be audited: setting objectives, proliferating standardized forms, generating new systems of record-keeping and accountability.' (Rose 1999: 154).

The significance of material objects such as the computer system Jonah, or more traditionally the patient record (in the case of A&E the patient record is represented by the initial assessment form) has long been identified as significant, not only to the assisting of medical professionals in the ordering of patients, but actually becomes a 'constitutive element of current medical work' (Berg 1996). Berg argues that different medical records mediate medical work in different ways, thus illustrating the effects such materials have in relations between medical staff, and patients and

patients' subsequent trajectory. In A&E, a patient's trajectory is firstly shaped through the initial assessment form, that orders patients on the basis of administratively organised categories that represent the patient's attending problem, and secondly, through Jonah which shapes the relations between staff and patients on the basis of government guidelines.

The production and development of the patient record in A&E is undertaken by many members of A&E staff prior to it reaching a doctor: clerical staff at reception, paramedics and triage nurses. The production of the initial assessment form, that is added to and developed by these staff members to form the patient record, is also the result of mediating technologies such as the computer system 'Jonah' used for patient tracking. These processes are all means with which the patient is 'inscribed' (Latour 1986; Rose 1989b) and these inscriptions are subsequently read by the doctor. Such inscriptions are built upon, added to and changed over time and in A&E these inscriptions are developed through numerous members of staff who build upon the production of the patient in important ways. When doctors 'collect patients'³, they actually collect the two dimensional material inscriptions of patients produced through the patient record, not the 'three dimensional subject' (Mort et al 2003: 273). The three dimensional subject may subsequently be attended to, depending upon the inscriptions of the patient that have been previously made and now read.

Once registered at the reception, the patient will then be asked to wait in the waiting area to be called. At quieter times the patient may be told to take a ticket from the dispenser in the waiting area, the ticket has a number which is then called when the triage nurse on duty is ready to see the patient. This happens in the order of when patients arrive, unless reception staff deem a patient to be particularly serious. The waiting time to see a triage nurse is normally fairly short, under half an hour, unless the unit is extremely busy and then it may take longer. When called to the triage nurse, the patient's number is either called through a Tannoy system controlled in assessment room one or the triage nurse will go out to the waiting area and call the patient by name.

³ This is a term used frequently by doctors on duty to refer to the process of collecting a patient's assessment form from one of the triage boxes, whether the patient is then called from the waiting area and assessed depends upon a number of other factors.

Assessment room one is directly in front of the waiting area with a door marked Nurses assessment room one, this is mostly where patients are called to be triaged. Inside on the right wall, close to the door where the patients enter, there is a computer with a chair in front of it where the triage nurse would sit to assess the patient. The computer is set up for Jonah so that once the nurse has triaged a patient he/she can enter the information on the system. This computer is the one most commonly used by many medical staff to log their work onto Jonah and to check the progress of particular patients.

Above the computer in the far corner of the wall close to the ceiling is a monitor showing the waiting area, this forms an important part of being able to manage 'the patients' as a group. On the same wall and directly next to the door is another chair where the patient sits, opposite the nurse. On the left wall, slightly behind the patient is another chair that is used for the relative, friend, or neighbour who has come in with the patient. Further along the left wall above the sink is a locked medicine cabinet generally used to offer patients pain relief. There is also a door on the back wall (it is at the back from the perspective of a patient being assessed, for many staff members this door is at the front) that opens on to a corridor leading to other areas of the Emergency unit. This area is restricted and allows only staff members' access. On the desk on the back wall is another computer that is most commonly used by doctors to view x-ray results on screen or to obtain more detailed patient notes.

Above the desks along both the right and back walls are shelves with various guides, pamphlets, index books, and box files for the purposes of either recording information, such as the ordering of clinical materials or health and safety procedures, or obtaining information from clinical dictionaries, drugs index books and other medical reference sources. Atkinson (1995) suggests these medical materials play an important role in helping to reproduce medical knowledge, such as the identification of the 'ideal type' of a particularly pathology being investigated (see Chapter Two, p. 49). However, what is missed in Atkinson's account and what is very much apparent in A&E is that the materials that make up the department are not purely medical. Those administrative materials that record, audit and administrate are equally as significant in helping to define the situation. Assessment room one is almost

exclusively used for triaging patients but it is also where nurses and doctors who are working in 'Minors' or Minor Injuries, (of which assessment room one is the centre) and often other areas of the unit, may congregate to discuss a patient, read an x-ray on the computer, enter work or track a patient on 'Jonah', or just to chat and gossip.

Assessment room one is the focal point of the A&E department's task of managing patients. It is the most commonly used area to record and track the progress of patients through the department. The monitor allowing for the constant surveillance of patients waiting to be seen affirms it as a space that most directly separates the outside public (those in the waiting area yet to be triaged) from the patients and staff within the department. It is for this reason that I have described assessment room one and other periphery areas as a threshold space because they are the spaces through which patients attempt to pass in order to become legitimate patients and full members of A&E.

It is the threshold areas that work to constitute A&E as a space of potential and actual crisis. Passing, to use Garfinkel's (1967) notion refers to the achievement of living and conducting oneself as normal while consistently having 'to provide for the possibility of detection and ruin carried on within socially structured conditions' (p.137). What this means for those patients at the threshold of A&E is that the difficulties posed to them occur precisely because of their attempts to comply with the legitimate order of the appropriate A&E patient.

In order for patients to pass they must understand the possible meanings for 'real' A&E patients in order to undertake the work of complying with such orders. It is the work of the medical staff within the department to provide a given definition of the social situation (Goffman 1959) that is A&E. This is achieved through the presentation and performances carried out front stage to an audience who, in this case, are the patients. This presentation takes place, not just in order to maintain the definition of the situation, but also to protect those back stage areas, where preparation for this presentation occurs and where the work of 'real' emergency medicine is carried out 'on the front-line'.

Assessment room one is the foremost front stage region that exists outside of the waiting area. It is the area where patients are initially addressed, assessed and sorted into categories of priority. It is the region where potential A&E patients first come into contact with medical staff working in the department⁴. It is also where patients would seek further information, help or guidance about their condition. It is therefore the one place that waiting potential patients could attempt to access medical staff without prior invitation. It is where staff perform in order to define A&E as a situation where 'real' emergency medicine is carried out so that the audience is able to understand and respond appropriately to this given definition.

Subsequently this front stage performance is essential to maintain and uphold the work that is carried out further within the department. This performance work is carried out by the nursing staff who manage the potential patients that present themselves so that only those who fit the given definition of A&E and who respond appropriately to this particular definition of the situation, are able to move backstage. To switch perspective for a moment, it is also possible to identify the work of sorting and prioritising patients as work that is undertaken back stage, away from the heroics of front line emergency medicine that deals in life and death situations. Thus, the nurses at the threshold, from this perspective, undertake the necessary work of managing the demands made by A&E patients, yet to be established as legitimate demands, backstage in order for the important front stage work to continue.

The initial assessment form generated at reception, or by the paramedic during the ambulance journey, depending upon how the patient was brought to A&E, is either automatically faxed into assessment room one from reception, or is delivered personally by the paramedical staff. These are collected by the triage nurse and the patient is then called. The triage assessment consists firstly of general questions regarding the patient's general health; any medication the patient may be on or any allergies they may have. The nurse will then go on to ask about their specific complaint that has caused them to attend A&E. This is then followed by an examination of the patient's injury or illness. The results of these questions or

⁴ It must be acknowledged that the contact with staff that A&E patients have had prior to their assessment by a triage nurse are important in the process of categorising them into orders of priority and can have real implications for their subsequent trajectory through the department.

examinations are recorded on the patient's assessment form and they are then given a triage category between one and five (these will be described in detail in chapter Seven).

The application of triage categories is carried out by nursing staff who work at this threshold area. This work sifts out those who do not fit the given definition of 'true A&E patients' as stated in the leaflets left on the waiting area chairs entitled 'Information for patients and relatives waiting to be seen' (the content of these leaflets are analysed in Chapter Seven, p176), allowing the doctors back stage to continue carrying out 'true' clinical work. This also means that the most explicit ordering and managing work remains front stage at the threshold areas, or back stage away from the life and death work carried out on the front line. As Allen (1997) makes clear in her work on the nursing medicine boundary: 'not only did the nurses on the ward have to be competent clinicians, but they also had to have the skills to manage the turbulence of the work environment' (p.506). This is certainly the case in A&E where the turbulent working environment is contributed to by the dangers posed by patients themselves; patients form part of this turbulence because they must be assessed on the basis of their legitimacy as 'true' emergencies.

Once their category of priority has been established, the patient is then told to go back to the waiting area and wait to be called by a doctor. The assessment forms, with the information from the triage assessment added, is then placed by the triage nurse in one of the five triage boxes which are each marked with a colour coded triage category. These boxes are attached to the wall on the corridor directly outside the back door to assessment room one. They are then collected by the doctors on duty in order of triage category, so that the higher priority categories are always seen first. This is another means through which the organisation of the department works to keep the nursing staff front stage, to undertake the work of rationing through the ordering, rewarding and disciplining (see chapter Seven) of patients. Meanwhile the doctors are able to remain back stage, only visiting front stage periodically to 'collect patients' previously vetted and coded by the nurses at the threshold.

Not all A&E patients must pass through this threshold space, where the work of sorting and prioritising patients is done. Some patients, such as those who arrive by

an ambulance on a blue light, are already categorised as in need of emergency treatment. These patients do not arrive at the waiting area but are driven up to the back door of the emergency department by paramedics. The back door is situated near the resuscitation rooms and high dependency unit. These prefigured patients are not only signified as being 'real' emergencies by the blue light of the ambulance on their arrival, they would also have been 'called in' by the paramedics to warn A&E staff prior to their arrival so that they would be on hand to meet them at the door.

The corridor to the left of assessment room one, facing the waiting area is where further assessment rooms are situated. All these rooms, like assessment room one, have front doors that open on to the corridor which runs from the waiting area and back doors on to the corridor where the triage boxes are and where access to other areas of the emergency unit can be found. These rooms are mostly used by doctors to assess triaged patients, although when the department is busy they can sometimes be used for further triaging. Unlike assessment room one, these rooms only exist as treatment and assessment rooms, they have medical equipment but there are no computers or files for administrative work.

Although parallel spatially to assessment room one, these rooms are not front stage in the same way. The lack of computers and administrative apparatus implies a more medical than managerial space. There is also generally only the medical practitioner, the patient being assessed and possibly the patient's friend or relative in the other assessment rooms at any one time which suggests that it is more medical than managerial work that is being carried out. They are separated from the waiting area, slightly further away physically but also patients cannot access these rooms unless requested to by a doctor, they are not a focal point of reference for those waiting to be seen, as is the case for assessment room one.

These parallel corridors separated by assessment rooms are a good example of the ways in which the spaces of A&E are organised. On the one hand there is a separation of distinct areas of care and expertise, while on the other there are corridors and linking spaces that enables a fluidity of movement that connects these distinct areas. The function of this connectedness and fluidity is not open to all people, but rather it is only offered to those with the knowledge of the space. The knowledge of

how the space is organised is not the only barrier to this freedom of movement, there are also areas that are off limits to patients and patients' friends and relatives, the corridor through the back door of assessment room one for example. This connectedness is also not advantages for all members of staff either. Nurses work their shifts in set areas with responsibility to treat and manage specific patients so that, although they have detailed knowledge of the entire space of A&E, they remain in one area with responsibility for the organisation and care of patients in these areas.

The relative transience and permanence of medical and nursing staff has been referred to previously (Hughes 1988, Allen 1997) making reference to the shorter periods of time in which medical staff remained on one ward in comparison to nursing staff who were more likely to stay in a position for more substantial lengths of time. What is significant about this for A&E, is that nurses tended to work in A&E on a long term basis, albeit moving between the various areas of A&E, as opposed to doctors, particularly junior level doctors, who would be placed in A&E for relatively short periods of time before moving on. The significance of this has already been established (Hughes 1988), but deserves more explicit attention here. Nurses were much more knowledgeable regarding local protocols and aspects of practice for how things should be done, something that in many cases the doctors were highly aware of. One junior doctor told me during an early visit to the unit that *'if you want to know something, ask one of the nurses, they run the show'*. This spreads to areas of clinical practice, whereby nurses had more experience of commonly administered drug dosages for example, so that doctors would ask their advice on these issues as well as requesting practical guidance on what forms to fill etc. The following example shows how nurses would exert their experience in cases where they believed it was needed.

'Nurses run the show'

Shortly after this, a man was brought in on a minor injuries trolley into trolley bay by the two doctors. The man was clearly in immense pain and very distressed – he was wailing and writhing on the trolley. The nurses rushed to help the two doctors to get the man onto his side; unfortunately there was no room in any of the cubicles for him. Many of the nurses were commenting that he should be in resus' and not in there, but for the time being they had to help with in the short term. They decided he needed oxygen immediately and some fluids and drugs so they removed another patient from her trolley who was waiting to be sent up to the ward and put her in the corridor until

the porters arrived. They all lifted the patient, who was still very distressed and had begun to vomit violently, onto the trolley bed which allowed them to give him what he needed before moving him to resus'. While they were treating him the nurses were asking the doctor if they could give him diazepam and they seemed to think that he needed it. The doctor had said no, explaining that he didn't need it, but after the nurses asked again and pressed him further he agreed.

This example was particularly significant as the doctor who was treating the man, as I discovered following the event, was new to the hospital and the nurses had discussed him on a number of occasions, describing their need to manage him.

The spatial placement of nurses within A&E also has a part to play in the organisation of relations between different medical staff and the patients. Nurses are responsible for particular patients and doctors tend to be more mobile, nurses in A&E are fixed in their particular area. This different spatial organisation of work creates different perspectives and priorities of work between nurses and doctors. Allen (1997) describes how nurses' concerns were focussed to the particular patients in their area, whereas doctors were concerned with the whole unit and new admissions. Nurses were also,

'ever-conscious of the constraints of external organisational timetables; considerable nursing effort went into co-ordinating patient care activities and ensuring that treatments were carried out to schedule. Moreover, it was nurses who were faced with the distress of patients and/or relatives' (Allen 1997:509).

I would also add that it was nurses in A&E who would take on the work of managing patients, responding to the pressures of immediate and contestable claims to resources. In Allen's study of hospital wards it was nurses' proximity to the patients that gave them a key role in protecting them from organisational turbulence, in A&E the proximity to patients where the legitimacy of patients is continually questioned, exacerbates their role to manage turbulence but with slightly different connotations. It is the dangers and threats posed by the patients themselves that create a space of turbulence in hindering staffs' performance of 'real' emergency medicine.

The role of nurses, protecting the work of those backstage did not only involve sorting legitimate from illegitimate patients, but also involved the managing of priority of need for legitimate patients in order to manage the workload of doctors. Sympathetic to the strains placed upon medical staff, nurses would use various strategies to

manage these strains on their behalf. These involved: saving up tasks rather than calling a doctor every time they were needed, anticipating patients' needs so that doctors could be asked to prescribe in advance, or simply write up a script for a drug to be distributed as required, allowing the nurses to act without calling the doctor. This management work is also significant as it is the nurses who first exert a medical gaze in making judgements about what is medically relevant, and what has clinical priority (Allen 1997).⁵

The experience of the space of A&E re-asserts the significance of moments of access. For an outsider the space is very different to the experiences of staff members. Paradoxically, although one area is almost always connected to another in some way, for patients there is a feeling of being kept or trapped in one space and there is no sense or understanding of the linkages that exist. This is most apparent in the waiting area. Here a patient can see the movement of other patients, doctors, nurses in and out of various rooms and down corridors away from the waiting area, however in order to gain access to the assessment and treatment they need, they must remain where they are until they are called and have passed through the threshold.

The entire unit is organised in a circular fashion. The corridor alongside the assessment rooms, on the left side of the waiting area leads to x-ray and there are male and female toilets for public use on the left opposite the assessment rooms. There are blue markings that look like footprints along the floor of the corridor that mark the way to x-ray for those patients who have been sent there from an assessment room by a nurse or a doctor. Turning right through x-ray, you arrive at H.D.U (High dependency unit) and H.D.U is directly connected to the Resuscitation rooms which are also situated at the end of the corridor that separates Trolley bay, the Assessment Unit and Trauma from the staff rooms and the Trauma clinic waiting area. Parallel to the trauma clinic waiting area is the corridor from which to access the assessment rooms. These corridors that circle around the unit form a spiral effect that links all the different areas together from the outside in.

⁵ Clearly there is much more to say about the division of labour between nursing and medicine and the consequences for health care provision. However for the purposes of this thesis, a focus on the division of labour is relevant for how it aids the successful production of 'real' emergency medicine. (For a detailed account of the gendered division between nursing and medicine see Davies 1995; Walby et al 1994; Witz 1992 or for a discussion about status and power in relation to the division of labour see Eaton and Webb 1972; Weitz 1981)

This circular organisation seems to work to create an outer and inner circle that reflects the distinction between front stage and back stage. The outer circle would include the waiting area and reception, x-ray and the assessment rooms which are more front stage areas. The inner circle includes Trolley bay, the Assessment unit, H.D.U and resuscitation which are back stage areas. These two circles seem to represent an access barrier. Those patients deemed to be the more 'trivial' cases, such as minor injuries for example, would in the most part never access the 'inner circle' or back stage areas where the work of medical expertise is more on show; where there is visual evidence of medical expertise. In the inner circle you may see I.Vs, monitoring machines, oxygen, patients in beds, trolleys, white boards with patient details. This is also a result of the work carried out by nursing staff front stage. The sifting and ordering of patients in order to limit the burden of managing and administering for those back stage.

The interconnections that seem to work in a contradictory way (both to allow for easy flow of patients/materials/drugs/information between the different areas while at the same time creating a marked distinction between 'trivial' cases and managerial work and 'serious' cases and the work of medicine), also creates the possibility for the promotion of those who are shown to be, through test results and doctors examination, in need of further medical expertise and can proceed to the spaces where these are offered back stage.

The experience of these spaces helps to generate 'moments of accessing' for patients where patients routinely experience the need to account for the claims they make to assessments, diagnoses and treatments. These calls to patients to account for their attendance is to a great extent accomplished, not only by the organisational work that medical staff undertake and their relations to objects and materials that mediate them, but also, through the constituted spaces of A&E'. Prior (1988) argues that the architecture of hospitals is,

'inextricably bound up with the forms of medical theorizing and medical practice which were operant at the hour of their construction and, what is more, all subsequent modifications to hospital design can be seen as a product of alterations in medical discourse.' (p.110).

Thus, this thesis illustrates how spaces, along with social action and interaction, work to help perform A&E as a place of 'real' emergency medicine. Through this performance, these spaces also restrict those patients who do not fit this definition, who are kept at the threshold, unable to pass and become a legitimate A&E patient.

There is a separate distinct area that is not like any of the others and does not fit into either the inner or outer circle. This area is Paediatrics or 'Peads' as it is called by staff. It is located along a corridor to the right of assessment room one and can be accessed from the same corridor that leads to the trauma clinic waiting area. The paediatric area deals with nearly all types of problems that children may attend A&E for, apart from those very serious cases that go straight to the resuscitation rooms, which also has a distinct paediatric section within it. The feel of the paediatric areas are quite different. There are lots of colours everywhere with murals on the walls, posters of Disney films and mobiles hanging over bed cubicles. They are also more enclosed compared to the rest of the unit. This is in stark contrast from the waiting area that is very bleak and open to world outside the department. As a result, the waiting area feels less safe, calm or secure than the confines of the more enclosed areas such as the children's assessment area or the areas of more extensive expertise such as H.D.U.

There is a correspondence between where you are physically in the emergency unit and the extent to which either medical knowledge and expertise or management and rationing are on show. Trauma, for example is not as front stage as minor injuries or x-ray, however it is not quite as far backstage as say, the assessment unit, and certainly not the resuscitation rooms. In Trauma there are objects identifiable as specifically medical tools: beds and trolleys to offer patients who need to lie down, crutches that are made easily accessible, along the right hand side wall there are cabinets with draws containing dressings, slings, and other materials used for broken bones, burns and sometimes damaged eyes. These materials represent the work that is done in this area. Although they may not be technologically advanced, they are specifically used for 'Trauma' patients. This is distinct from the triaging work carried out in assessment room one. Although there are medical devices used to take a patient's temperature or blood pressure for example, these do not exclusively represent the work of emergency medicine. Furthermore, alongside these clinical

tools are technologies for managing such as fax machines, computers and various forms of paper work.

There is a waiting area directly linked to Trauma for those returning patients who have come in to have their wounds checked or redressed or to have a cast put on or taken off. In this waiting area, there is still a sense of being close to the periphery, front stage areas of the unit. Trauma itself is an open space with only roughly separated areas for examination and treatment with curtains that are nearly always left open. There is also a wide opening onto the main waiting room and the corridors surrounding it.

The trauma unit was an interesting space, particularly during 'clinic'. Clinic referred to specific time periods when the trauma area was used for returning patients to attend for a variety of reasons, such as having stitches taken out, removing a cast, or checking a burn. During these times, the patients were automatically legitimated members of A&E as returning patients, and would therefore not need to pass through the threshold space. However, as was explained to me by a senior consultant, these patients were viewed entirely separately to the role of A&E, understanding the priority of the unit to always be to the treatment of those patients attending for the first time, those 'true' emergencies. The place of trauma spatially makes sense under this definition, close to the periphery but also quite separate from the activities of the rest of the unit.

The Assessment unit, which is further inside the unit, has a hospital ward feel about it. The space is larger and organised quite differently. There are definite cubicles for each patient with curtains often drawn or half drawn and there is a large nurses' station. The nurses' station is situated in the middle of the cubicles and has a large white board with a grid that corresponds to each cubicle. Behind the nurses' station is the Sister's office where drugs and other materials can be found. As well as being the place that nurses situate themselves most frequently, it is also a place where the doctors, especially student or junior doctors would spend their time, writing up their notes, discussing a patient or just chatting to one another. The nurses' station is where the nurses handover to each other following the end of a shift. The Assessment

unit is one of the few areas in the unit where patients may remain over night or even a couple of days while they are waiting to be discharged or taken up to a hospital ward.

The assessment unit is more separate from the rest of the unit; there is a sense in which you are far away from the outside world and also far away from those patients waiting in the waiting area, in Trauma or being assessed in the Minor Injuries Unit. The Assessment unit is more of a backstage area. Patients who have been referred by their GP are often moved directly into the assessment unit and those that are moved into it from any other area have generally already been established as legitimate A&E patients. There is therefore less performance work needed in this area, the definition of the situation has been previously established.

Trolley bay is very similar to the Assessment unit in its spatial layout. However, it seems to be more open to the ebb and flow of the rest of the unit and is therefore more transient in nature. There is, similarly to the Assessment unit, a hospital ward feel to it, with the nurses' station constituting the central base for the organisation of the area along with separate cubicles for the patients. However, there is more interference from outside the area than in the Assessment unit. Patients are often wheeled in and out on trolleys, especially at busy times when the overflow of other areas is unable to cope with the demand. There is still a sense of being enclosed from the world outside the hospital, while at the same time there are more visual and audible reminders that there are other patients, staff members and other areas outside and these can and do have influence over the organisation of Trolley bay.

The work carried out by nurses at the nurses' station in both the Assessment unit and Trolley bay is significant as this is where the organising work is carried out. It is the nursing staff who are responsible for transferring patients to hospital wards or to facilitate the discharging of a patient. In order to do this, they must liaise with those administrative staff such as bed management for example, as well as other medical staff within the department such as physio-therapists, medical and surgical doctors and sometimes they must liaise with professionals outside the department such as social services.

Although these tasks are medical interventions, they also involve administrative tasks. There must always be an up-to-date record of the beds in the area; who is awaiting a bed, who is due to be discharged, who has secured a bed in a hospital ward and is waiting to be transferred. These movements must be recorded and the information must be readily available. Significantly, these activities re-affirm the task of managing the demand for scarce resources.

Although I did not spend as much time in H.D.U, a reflection of my being constituted as 'out of place' (as discussed in chapter Four), the general layout of the area was quite different. There were, again separated cubicles, this time the curtains were almost always open, for constant observation of the patients. Located next to the resuscitation room, the need for medical technology and medical expertise is heightened. This area is also restricted, whereby only staff and family members of the patients are allowed access, and there is a real sense of distance from the rest of the unit. The atmosphere is more sterile, all the walls are very bare, it is quieter, the desks are clear and the staff talk in whispers. This is quite different to the assessment unit or trolley bay where the nurses stations' are full of clutter and people chatting, nurses talking to patients, often loudly to make sure they can hear what's being said, and staff and patients moving around, in and out of the unit. H.D.U was the most back-stage of all areas, there was little work of performing A&E as a space of emergency medicine, as this was more easily achieved through the materials of the space.

Summary and Discussion

Through an analysis of the social, spatial, and temporal organisation of A&E, it is possible to identify how social relations are mediated by material objects and surrounding spaces, as well as by social and temporal dimensions. The patterned passing of time that works to re-configure how decisions are made regarding patient assessments is a good illustration of this complexity and the means with which the physical space aids the performance of those working front stage in creating and constructing a definition of A&E as a particular social situation is another.

The division of labour between those nurses working front stage, and doctors back stage is important for the concerns and priorities of different types of medical staff. More importantly it also reveals a great deal about the way in which A&E work is organised and understood. This chapter has shown the interplay between medical and administrative work in the organisation of patient care. This interplay is most keenly felt for nursing staff who work front stage, particularly at the threshold areas. The threshold areas are liminal (Turner 1974) spaces; they are the places through which patients are able to pass from a member of the public outsider, to a legitimate A&E patient. The dangers that exist in all liminal spaces are characterised in A&E as the turbulences of managing patients making claims to A&E resources.

The front stage areas work not only as an arena to perform the definition of A&E as a space for acute, emergency medicine, in order for patients to comprehend the situation and act accordingly, but also as a space that works to protect the areas backstage. Their tasks are to sift and sort patients at this initial stage so that doctors, who generally remain backstage, can perform their role of doing 'real' emergency medicine with those patients who best fit the definition of A&E, a site of emergency medicine. This managing work continues for legitimate patients, in collating and ordering them so that doctors' time is spent most efficiently on those patients deemed most medically important according to this performance.

As has been shown, the need to manage resources manifests itself in a variety of administrative tasks that must be undertaken alongside the work of performing medicine; auditing devices such as 'Jonah', organising beds a resource through bed management and the continuous processes of ordering patients' into categories of priority through the triage system. These processes are not formal mechanisms of control, but instead are activities through which staff self-check and thereby regulate the work they do according to the implicit meanings that such practices convey. They bring to the fore staff's need, not only to treat patients according to their medical need but, also, to treat patients according to the needs of the institution to ration resources.

Others have argued that due to this type of, increasingly bureaucratic, organisation in which medical practitioners in hospitals must work, there is a certain loss of clinical autonomy as a result of the inherent conflict between professional and bureaucratic

power (Armstrong & Green 1993). However, what is absent from this debate is the extent to which it is possible to separate decisions based upon clinical autonomy, and decisions resulting from administrative concern - the complexity of the relationship between medicine and forms of clinical governance is something that deserves further attention (see chapter Eight).

What must also be explored is the effect that these concerns have on how staff are able to make decisions that are ethically and morally responsive to their patients. How far do these concerns act as barriers to responding to concerns that may exist in opposition to those of managing patients as claimants of emergency medical resources? It is this question that is explored in the following chapter.

Chapter 6

Effacement Work at the Threshold

‘Effacing the face consists in casting the objects of action in a position from which they cannot challenge the actor in their capacity as a course of moral demands; that is, in evicting them from the class of beings that may potentially confront the actor as a ‘face’. From the explicit exemption of the declared enemy from moral protection, through the classifying of selected groups among the resources of action which can be evaluated solely in terms of their technical, instrumental value, all the way to the removal of the stranger from routine human encounter in which his face might become visible and glare as a moral demand. In each case the limiting impact of moral responsibility for the Other is suspended and rendered ineffective.’ (Zygmunt Bauman 1991: 145).

Introduction

The previous chapter has shown the continual interplay between the available administrative, managerial and medical categories through which staff assess, order and treat patients. Furthermore, the interplay between managing and treating patients has been shown to be most intensely felt for those staff working at the threshold. This chapter seeks to explore some of the possible repercussions for those working at the threshold, whose work is mediated by the concerns of A&E as an institution in which patients must be managed as well as treated. It is the contention of this chapter that this tension, under particular conditions, can create a space of demoralisation; where it is increasingly difficult for staff to respond to patients as full persons.

For Bauman (1990), morality is the automatic, natural responsibility for the other that occurs as a result of proximity to the other. Proximity refers to the responsibility derived from the other, responsibility is also directly a response to the other; one cannot be conceived without the other. It pre-empts any intellectual, rational thoughts or decisions that are made regarding the other, ‘it is the essential primary and fundamental structure of subjectivity. Ethics does not follow subjectivity: it is subjectivity that is ethical.’ (p.18). For Bauman it is not the agencies of social organisation that are needed to tame the natural moral inadequacies of human beings, rather it is precisely modern society that creates the means through which to limit proximity, creating a world where action is possible without being underlined by ‘the innate human capacity of moral regulation’ (Bauman 1990: 29). Using this notion of

proximity within A&E, it must be understood to exist before any professional or managerial interest. What is important to make clear at the outset of this discussion is that proximity, as it is being utilised here, is understood to be something that must be accomplished, shaped and managed and therefore an institution where a lack of this proximity is experienced must equally be achieved through the particular ordering of social relations that occur within it.

The loss of proximity that Bauman refers to has been suggested to be in part due to the specific conditions of modern living. Simmel (1903/1971) describes these limits of proximity or separation of our moral responsibilities from the mundane, everyday existence as the need we have in modern urban communities to detach ourselves from others in order to protect ourselves from the dangers and difficulties of living among strangers. This dissociation is the only means through which people are able to live next to each other, but not together. However this has also been coupled with a shift of societal value toward rational thinking, the logic of reason; a new way of thinking that negates the need for morality as a means through which to act (Fevre 2000). The dominance of rationality as a means through which to order and categorise patients in A&E is something discussed in more detail later in the chapter.

These limits to proximity do not necessarily refer to a mere physical distance between people, although this is often part of the means through which moral responsibility can be appeased. For example, as discussed in Chapter Five, people in the waiting area of A&E are separated from the staff working on the 'real' front line of emergency medicine in the resus' rooms and in H.D.U. However, there are also forms of social organisation such as the mediating technologies of managing, auditing and rationing described in Chapter Five, that even with the occurrence of face to face contact, limit the proximity of the other in specific ways, restricting moral responsibility. These technologies therefore not only render the other 'faceless' allowing the self to be free from moral responsibility for the other, but they also allow the self to 'draw security from anticipated moral responsibility of others' (Bauman 1990: 30), in the form of institutions, social agencies and organisations.

Through the use of extracts taken my fieldnotes, I show how staff are able to create distances that limit the possibility for moral proximity. However, the illustrations are

further elicited through an analysis of the circumstances in which proximity can be re-established. Reflections upon my own marginal status as a researcher (as described in Chapter Four) are also explored alongside fieldwork extracts in order to show how these experiences brought staff's effacement work into view and subsequently allowed them to become ethnographically significant. What should be clear in this analysis is that this is not an attempt to brand medical staff immoral in their actions and accounts. Rather I am suggesting that patients and patients' relatives may be effaced as full moral subjects as a means by which staff are better able to respond to the calls of organising and ordering at the threshold. It is therefore the particular modes of ordering that staff are enrolled in that create a space in which calls to morality become increasingly difficult to meet.

As the previous chapter has shown, for staff working in an A&E department there is a duty to assess claims made by patients and relatives to various medical resources such as assessments, treatments and examinations. This duty is produced in and understood through the practices and discourses of auditing, labelling, and most significantly through processes of self-checking that mediate the actions and decisions of staff, such as the targets-driven computer system 'Jonah'. This responsibility forms part of a greater obligation of all medical staff to ration resources according to a priority of need derived from a constructed notion of 'real' emergency medicine.

The consequences of such rationing may include the delaying of a patient's assessment, or perhaps even re-directing them to another service. These obligations are most significantly felt for those working at the threshold, where negotiations for resources are most keenly experienced by both staff and patients. Medical and managerial tasks are often not easily separable and are therefore not always understood by staff to be distinct activities of responsibility meaning that the calls to manage are enrolled in the everyday production of emergency medicine (an argument developed in Chapter Eight). However, it is the consequences of these calls that this chapter explores.

The administrative practices of ordering patients into distinct categories based upon pre-defined classifications is one of the earliest ways in which the processes of A&E organisation work to create the means through which the proximity of patients to staff

is limited. The initial assessment form described in the previous chapter is one way in which patients are identified through specific, limited sets of criteria. The processes of ordering patients are continually mediated by managerial technologies such as screening and auditing that reinforce the need for staff to manage and ration as well as to assess, examine and treat patients. Contradictions then arise at these sites of negotiation, where the problem of caring and treating ill people is juxtaposed with the responsibility to manage and protect limited resources. The mediated processes of bureaucratisation¹ through which staff relate to patients are based around values of rationality: logical thoughts of calculation and accounting (Weber 1968). It is this rational process of managing patient care that provides the means through which decisions to act can be made that limit response to moral proximity.

Patients are therefore placed in a problematic position for staff; reduced from full moral subjects that evoke responsibility, they can become a collection of parts or attributes that can be labelled, ordered and quantified. It is on the basis of these set parts that action (in the form of assessments, examinations and treatments) is taken, thus working to demote the legitimacy of action taken as a consequence of moral responsibility. In this context staff are guided not by 'selfishness and immoral cruelty, only moral indifference. The Other does not become an enemy; he only loses his ethically commanding humanity.' (Bauman 1990: 28-29).

Staff working at the threshold, a space of conflicting concerns, attempt to efface the other, ensuring that they remain 'faceless', not a total moral subject. This effacement may be subjected towards either the patients and/or relatives seeking resources, or the organisation itself may provide the specific negative conditions under which work within A&E must be carried out, allowing the patient as the other to remain faceless. By doing this effacement work, staff are able to displace their moral responsibilities that are often contradicted by the organisational principles in which they work.

Narrating Responsibility Disposal

¹ Bureaucratisation and managerialism can be viewed as stark opposites with quite importantly distinct connotations. However, in the context of A&E work, bureaucratisation refers to particular standardised processes of auditing, recording and labelling patients assessment that are part of the routine practices of managing patients.

For those working at the threshold, modes of ordering produced through managerial technologies that mediate many aspects of medical work have very real effects for the constituting of patient categories and the subsequent forms of action taken in assessing, examining and treating patients. However, these actions and the processes through which they are decided upon are not questioned, explained or legitimated by or for those within the institution. Only in moments where the social world outside permeates the institution, where patients exist as full moral subjects who evoke moral responsibility, is it necessary for staff to explore or legitimate actions that are taken that may involve the reduction of patients to those claiming resources. The following example is a conversation between two nurses where there is a clear use of narrative in order to legitimate this process of reduction. The narration is undertaken not to verify the actions to one another, but rather to provide a description of the contextual basis of such actions to an outsider, who does not share in their understanding and experience of working at the threshold.

'Doing this job will drive you mad'

On this occasion there was a nurse I had not met yet in charge of minor injuries. Nurse Harbury. I introduce myself to her and again described briefly my research interests. She was not unfriendly, but clearly quite disinterested. After getting quite despondent with patients congregating in complaint at the door to assessment room 1, where she was based, she growls at a fellow member of staff, an older nurse called Sister Smith.

They have a chat about *'what this job does to you after a while'*, She claims, *'doing this job will drive you mad, you end up hating the patients'* She looks at me, the conversation seems very much for my benefit. Sister Smith responds by saying *'you're too young to be feeling like that...you should be smiling sweetly at the patients still'*

To which nurse Harbury answers *'it would take a lot to make me smile at the patients....no, I do like the little old ladies, I'll smile at them.'*

This particular conversation became ethnographically significant, in part, due to my own experience of feeling outside, peripheral and, in this case, an inconvenient intrusion into staff's daily routines and activities. It is this intrusion that creates the necessity for these nurses to discuss their otherwise 'normalised' behaviours.

The door to assessment room one is a significant threshold area that keeps separate the patients awaiting access to the unit. The door is the only point of visible access

for patients in the waiting area and is the place where information from medical staff is sought by patients and potential patients. It is a threshold where constant negotiations between staff and patients can be observed. It is a place where staff invite patients in, allowing them the first point of access to desired services through the process of triaging. However, it is also a place where staff attempt to keep patients at bay, in the waiting area away from the important work of 'real' emergency medicine.

I felt the significance of this door myself when I arrived at the emergency unit to observe some of the nurses working a night shift in the minor injuries area of the department. The following extract is taken from my fieldnotes and describes the concerns I had about accessing minor injuries through the door to assessment room one.

The door to assessment room one

When arriving at the Emergency unit, already feeling a little unsure about my return, I was unable to get to minor injuries from my normal route as there had been an incident in one of the corridors. There were a few male nurses stood around some sort of spillage on the floor and a couple of patients. I was unable to decipher what was happening but it was clear that the staff wanted me out of the way. One of male nurse, who was a large man with an Australian accent, asked me who I was and where I was going quite abruptly. I told him who I was and showed him my I.D badge to verify my statement. He responded by telling me that *'you'll have to go in from the waiting room side.'* I nodded and went on my way. As I turned around and began walking in the other direction I became even more nervous about the sudden prospect of having to knock at the door of assessment room one. Once I reached the door I gave it an assertive, but not insistent (at least that was my intention) knock. This was, as expected, ignored. I decided it would be best to wait rather than knock again. I waited for a while and then, having no will to knock again, I returned to my usual route where the earlier incident had been dealt with and the corridor cleared.

From my experiences of observing in assessment room one, it was clear that this door was often the space in which conflict between staff and patients was played out. My experiences of these conflicts, often the consequence of patients entering the room without invitation, added to my own hesitance when faced with the dilemma of knocking at the door and posturing whether to wait for a response or to continue on without invitation. The door thus became a physical symbol of the distinction made between the patients as a group, whom the staff can 'end up hating' and the legitimate 'true' emergency patients and staff. For the staff working at these threshold areas, the patients are conceived as a group to be managed, a group in opposition. As Bauman

(1990) notes, as soon as the other is cognized, they become an object causing a fundamental break in proximity to the other.

In the context of this specific threshold area at the door to assessment room one, the patients as the other are established as a group, reducing each individual patient to a mere part of this opposing group. The purposes of the administrative and managerial technologies that permeate all areas of work carried out by staff are to monitor the progress of each patient until the moment of their disposal. This threshold area is therefore a significant space in which the patients as a group can be effaced as numbers that need to be disposed of, so that the object of the staffs' tasks, to clear the waiting area, can be achieved.

The continual persistence of patients congregating and knocking at the door is therefore extremely frustrating for staff, as it makes their task of dealing with patients as numbers that form an opposing group more difficult. The marked distinction of staff and patients is made problematic by the presence of the researcher; an outsider who is not privy to the processes of effacement that occur within the institution. Outside the institution, neither as a member of staff or a patient to be effaced, there exists a face that is visible as a moral demand (Bauman 1991) and here embodied by the researcher. It is this problem that is addressed by Nurse Harbury's conversation with Sister Smith. It works in a similar way to that of the protagonist narrating his/her actions in a novel or film. It allows Nurse Harbury to account for her actions of growling with frustration about the patients with the added benefit of being able to contextualise and legitimate her motives. In film and literature, this provides the reader/audience with a better understanding of the subjective meaning attributed to the character's actions in a way that can sometimes provide legitimacy for the actions, or at least evoke feelings of empathy in the reader.

As outlined above, Nurse Harbury explains that 'Doing this job will drive you mad'. In other words, it is not that these actions are the result of her individual personality or morality, but rather a result of doing the job: she is simply acting according to the conditions under which she must work. She is following the rules governed by the social organisation that maintains rationality as a means through which to uphold efficiency, or at least the performance of efficiency, which may help the production of

A&E as an organisation that prioritises ‘real’ emergencies. It is these processes that work to efface the other (the patients) as merely those who claim services, not the moral inadequacy of the individual member of staff. Similarly, Sister Smith’s response regarding her age (Sister is considerably older than Nurse Harbury), in a sense reinforces this view as she is suggesting that the longer you are subjected to these ways of thinking and acting, the more likely you are to ‘go mad’ or end up ‘hating the patients’ or both.

The Patient as Claimant

The initial step with which patients are reduced, rendered less than full moral subjects, is through the reduction of proximity. For this to occur, proximity must be replaced with social distance which can only occur through a physical or spiritual separation of the other so that ‘responsibility is silenced once proximity is eroded; it may eventually be replaced with resentment once the fellow human subject is transformed into an Other’ (Bauman 1989: 184).

This separation of the other is accomplished through the technical achievement of modern rational society. In the case of A&E, it is the mediation of such rational activity in the everyday practices of A&E staff that allows for the separation of the patients as other. The proximity of human interaction is replaced with social distance through the continual mediation of these relations with technologies of accountability and efficiency which make difficult relations that respond to patients as full persons. As the previous chapter describes, these technologies create important relations in A&E work between medical staff and patients. If different patient records mediate medical work in different ways (Berg 1996 see Chapter Five p.123), then the consequences of technologies that frame the patients’ assessments around orders of managerial and clinical concern must be taken seriously.

These processes of transforming the patient into the other form the necessary basis through which the effacement of the patient as self can occur; the reduction of the patient as a moral subject to a mere collection of parts or attributes that cannot be ascribed moral subjectivity (Bauman 1991). The shifting of patienthood on the basis

of inscriptions that constitute patients in particular ways (Mort et al 2003, discussed in Chapter Five) are a significant means by which patients are transformed into the other. The permeation of managerial rationalisation into the work undertaken by those at the threshold, particularly through the production of the patient record, constitutes the demotion of the patient from a full moral subject to a 'faceless' entity characterised by specific attributes that centre around their claim for services.

'I'll open the door when I'm ready to and not before'

Following some difficulty with a mentally ill patient who had refused to leave the A&E department, there was a young woman with a cut on her ankle waiting to be seen by a doctor who the nurses believed to be a self harmer. She has been waiting a considerable amount of time and had repeatedly knocked on the door to the assessment room, which added to the annoyance of the staff who had been ignoring her knocking.

After the fourth or fifth time, Sister Smith opens the door and said *Look I'm with a patient at the moment. I will open the door when I'm ready to and not before.*

The young woman was clearly frustrated and responded by saying that she had been told to knock on the door by the reception staff. An hour later she left.

This is a good example of the conflict that can occur around the door to assessment room one. It is a stark visible representation of the separation that is in continual formation to ensure that social distance exists between the staff and the patients, creating the patient as the other. The sheer frustration of both the patient concerned, who had been waiting for hours in what was a relatively quiet waiting area, and from Sister herself who had been interrupted many times by patients at the door further exacerbates the conflict.

It became clear from other conversations between members of staff earlier that day, that although this particular young woman had been triaged and been placed in category 4 (which refers to minor injuries commonly experienced as cuts, breaks etc.), due to the nurses' suspicions that she had cut herself, along with her frequent knocks at the door to the assessment room, she may have been left to wait longer than would have ordinarily been the case for a category four patient. The girl had presented and accounted for her case, that she had been told to knock by the reception staff and that she had been waiting a particularly long time, but eventually after receiving no concessions from the nursing staff, she decided to leave.

The rationalisation of A&E as a service to treat strictly acute medical cases, those 'real' emergency cases, exacerbates the consequences of these technologies that mediate A&E work that constitute patients as a group to be managed and disposed of. The problem that this girl attends with is therefore seen as a mere attribute that effaces her, not only as part of the patients as a group in opposition, but worse than that, she becomes a 'bad' patient. She is seen to be responsible for her own injury and is also forthright in attempting to obtain the services she needs. Both these attributes are used as a further means through which she can be effaced as merely a 'problem' patient. The processes of effacement brought about through the social organisation of the institution not only allow for the effacement of the patients as a group, but also provides the means through which specific attributes can become tools enabling staff to further efface patients.

Patients become dissembled into traits and it is these traits that are used to order and classify them to achieve the best possible resulting disposal. In the case of the self-harmer, it was her own perceived responsibility for her ailment that defined her, and she therefore became faceless; she was unable to be ascribed moral subjectivity. To act upon such specific elements or traits allow the staff to avoid moments that may induce morally significant effects.

The means with which traits can become rational tools to enable the effacement of patients at the threshold is further discussed in the next chapter. These traits however are re-configured as typifications (Schutz 1970), the means through which staff are able to order patients as particular types. As the analysis shows, these types are often based on particular moral orders that help construct the 'true' A&E patient. However these orders are rarely made as responses to patients' calls as full persons; rather these moral orderings provide the means through which such traits and types can be produced. The actions and interactions accounted for by staff through these forms of moral ordering, whereby patients and or their relatives are judged to be 'good' or 'bad', work to further distance staff from patients as full persons. As noted previously, as soon as the other is cognized, proximity is diminished (Bauman 1990).

In this particular case the space around the door to assessment room one had become an area of staff defence against patients. Although Sister had become disgruntled,

particularly with the young woman to whom she directed her frustration, she was also responding to the many other patients who had knocked at the door and interrupted her work throughout the day. In this way patients become a homogenised other, where proximity to a unique moral subject is effaced so that all that is left is the other that is merely an instrumental part of the practices and processes of A&E work. Clearly, as the previous extract shows, it is knowledge of these continuous negotiations, and the context in which they are played out that allows for a more comprehensive understanding of the actions of the nursing staff. For patients faced with these actions without this understanding of context and their objectification as a generalized other, their waiting can sometimes come to feel hopeless, as was the case for this young woman.

Technologies of Distance

One of the problems faced by staff in their disposal of moral responsibility is dealing with situations that question the moral underpinnings of actions that are taken; where mistakes have been made and suggestions of a lack of proper care arise. This problem can be appeased through actions and explanations that form a distance between the actions carried out by staff and the negative consequences of such actions.

The value placed on rational thoughts and actions as a means through which to make decisions and to act in social life has undermined thoughts and actions based upon moral considerations to the point where they are considered irrational, private and not to be relied upon in the organisation of social life and institutions. This shift in emphasis has seen what Bauman refers to as the privatization of morality (Bauman 1991). This privatization of the moral allows for a social world where institutions such as A&E have staff whose actions become 'adiaphoric', indifferent; their actions cannot be judged as good or evil, as these were not the grounds upon which decisions to act in particular ways were taken (Bauman 1991). Rather, they may only be judged on the rational, technical grounds that provided the means to decide things and act accordingly.

The devaluing of moral criteria as a basis upon which to make choices has bolstered the need for social institutions and organisations to increase the distance at which human action is able to bring effects. The understanding of human beings as inherently morally flawed and needing the regulation and control of social organisations, coupled with the growing emphasis on valuing rationality as a means through which to act, has created institutions which are not governed by the moral guidance of individuals who have a responsibility towards others. Rather, they are to be governed by the organisational guidelines such as the technologies of managing within A&E mediating the ways in which patients are to be ordered, assessed and disposed of. These guidelines are not subject to the limitations of a moral drive; they provide the distance between the actions of individual members of staff and the moral implications of these actions. Bauman (1989: 194) states:

‘as long as one cannot unambiguously relate what one saw to such innocent and minuscule acts of one’s own as pushing button or switching a pointer, a moral conflict is unlikely to appear, or likely to appear in a muted form.’

These rational, technical means of organising are useful in sustaining a sense of morality while breaks in proximity work to reduce human beings into others, thus relegating patients from a self who is able to evoke moral responsibility to render them faceless. These rational, logical decisions that can be taken as a result of the mediated systems of recording and accounting that exist in A&E, provide the means through which staff are able to distance their own actions and decisions from the moral implications of responsibility. In other words, ‘social organisation is a machine that keeps moral responsibility afloat; it belongs to no one in particular and leaves the actor, as a moral subject, speechless and defenceless when faced with the twin powers of the task and the procedural rules.’ (Bauman 1991: 145).

The following conversation between nurses refers to a situation in which a man collapsed in the waiting area and is found fitting on the floor by two doctors:

Post-crisis discussions

When things had calmed down a couple of other nurses were back working in the assessment unit and Claire and Stuart told them what had happened:

Stuart: You missed all the fun. A guy collapsed in the waiting room and was found fitting on the waiting room floor by a couple of doctors who bought him in here,

because that's obviously the best place for him (sarcastically). On a minors trolley! We couldn't even give him oxygen or anything.

Claire: I'm not even gonna start or I'll get myself in a whole lot of trouble. Who's that Chinese doctor? (Referring to the doctor who had treated the man)

Stuart tells her his name

Claire: He's a real idiot!

As well as this crisis providing an opportunity for Claire and Stuart to impart an exiting story to some other members of staff, in their telling of it, they are also able to distance themselves from both the problems that caused the man to collapse in the waiting area, as well as how the problem was dealt with. In showing dissent regarding the way the doctors dealt with the problem, and specifically the doctor who treated the man, there is a sense in which they, as nurses are more unified; they have a common enemy in both the hospital as an institution and other groups of staff such as the doctors.

In establishing themselves as a group that exists outside of the situation they had encountered, even though they had significant roles to play, these two members of staff are able to deflect the moral responsibility towards the patient: they do not constitute themselves as part of the particular organisational process that caused the situation to occur. The procedural processes of assessment, care and treatment mediated by administrative practices and tasks, create the conditions under which it is possible to differ moral responsibility away from each individual person, and towards the social organisation itself as the guardian of morality that ensures individual action is regulated.

Following this conversation, there is another incident in which a staff discussion works to distance them from a situation they deem to be problematic.

Carry-on-caring

Closely after this conversation, a man, probably in his eighties, who seemed to be in a great deal of pain was brought in by two paramedics and a young man, presumably the man's son. According to one of the paramedics talking to nurse Claire, he had only just come out of hospital a day or two before for a chest infection. He hasn't been for a pee in over 24 hours he informed Nurse Claire. He then said *'I know it*

might seem a bit 'carryonish' but shouldn't patients be made to pee before being discharged from hospital.'

Nurse Claire: *Well I'll tell ya, I'm Australian and I've never seen anything like this place.'*

Although this man had been discharged from the hospital only a day or two earlier, the conversation attempts to distinguish their own work practices from the hospital's actions or 'this place'. In other words it cannot be the problem of staff members, as individual members of staff can only act according to the rules and regulations as set out by the institution. The paramedic whose work is carried out mainly outside the confines of the institution cannot understand why this man was not made to go to the toilet before he was discharged from hospital. By claiming that this may be seen to be 'carryonish', he is suggesting that the hospital's focus may result in an undervaluing of practices that are viewed to be simple or old fashioned. The paramedic is suggesting that it is these very practices that if carried out could have prevented this man from returning back to the hospital just days after he had been discharged. This distancing is achieved therefore by both a physical distancing of his work and that undertaken within the hospital, but also the distancing of time, of a different ethos of the past. The paramedic is able to suggest that the means with which care is organised today, is problematic. Again, this does not place any individual as being morally negligible.

Nurse Claire, being in the more difficult position of working within the hospital, distinguishing herself from 'this place' on the basis of her being Australian, suggesting that she is unfamiliar with the practices of care that happen in this hospital and that she is continually shocked by what she sees. The moral responsibility for this man is therefore not an automatic response of proximity but rather is constituted as being neglected by the organisation. Again, this conversation works to unite the staff and defer responsibility through the expectations of moral safeguarding to be undertaken by A&E as an institution. Although the problems that they discuss and are frustrated with often include the actions of other members of staff, they are often not discussed in a way that recognises this. On the contrary, it is the place, the organisation that is made problematic.

Re-creating Proximity

The previous examples have shown how technologies that mediate and help constitute medical knowledge practices can create a space where staff become distanced from patients as full moral subjects. However, there are moments when this distancing is challenged and the moral subject of the patient becomes visible once more as a face that evokes moral responsibility; in other words where proximity is restored. As the example of the two nurses discussing their work in the extract entitled 'doing this job will drive you mad' at the beginning of this chapter illustrates, there are occasions when staff legitimate the distancing work that they carry out. The legitimating on this occasion was due to the noticeable presence of the researcher, an outsider. There are therefore scenarios where the moral does become visible and challenges the social organisation of distance.

The following example of Sister Brown assessing Mrs Jackson provides a situation in which, through the prolonged and sustained narrative of the patient, Mrs Jackson, Sister Brown is increasingly unable to perform the distancing work that has been described previously.

'I'm sorry Ms Jackson'

The first patient I observed was a sixty six year old woman, Mrs Jackson, who came in for a twisted ankle and foot. She explained that she had done it while getting out of her son's car at the cinema the night before.

There are no obvious signs of swelling or bruising but the woman appears to be in a lot of pain.

Mrs Jackson: *Honestly, I've been crawling around the house on my bum... I can't put any weight on it at all*

Sister Brown: *Well, just to warn you. If your foot isn't broken you'll have to put weight on it and walk on it properly otherwise it won't heal.*

Later, following an ex-ray of the patient's foot....

Sister Brown: *It's not broken so you'll need to take regular pain relief. The best is to take a combination of paracetamol and anti-inflammatory which you can take together three times a day. For the first couple of days elevate it, put an ice pack on it but make sure its wrapped in something don't put it straight on the skin and make sure its for no longer than 10 minutes in any hour. After a couple of days start trying to walk around on it.*

Mrs Jackson: *What about driving?*

Sister: *I wouldn't drive because with the pain you're having you won't have full control of the car*

Mrs Jackson: (beginning to look upset) *My husband's in a care home you see and I drive to visit him a couple of times a day.*

Sister: *What about your son who brought you in today, does he drive, could he not take you?*

Mrs Jackson: (getting more upset) *He's going back to London later today, he was just visiting*

Sister: (A little more sympathetic) *Ah, oh dear. It makes life difficult doesn't it?*

Mrs Jackson: (Begins to cry) *How will I get to see him?*

Sister Brown comforts Mrs Jackson by putting her arm around her, Mrs Jackson immediately seems better from Sister Brown's kindness.

Mrs Jackson: *I'll just have to get taxis I suppose*

Sister: *Well after a couple of days the pain should have eased a lot, you could try driving then.*

In this example Sister Brown initially remains distant to Mrs Jackson, seeming quite dismissive of her explanations of pain and 'crawling around on her bum' and even pre-warns her of the course of action she may have to take if her ankle proves not to be broken. However, through Mrs Jackson's sadness about the difficulties she will have in seeing her husband, Sister Brown begins to soften. The introduction of emotion into the interaction between Sister and patient, along with the patients' own accounting for her circumstances as well as her resolve to make the best of things 'I'll just have to get taxis I suppose' begins to chip away at the technologies that create distance and provides a space through which proximity may be restored. Furthermore, the case of Mrs Jackson challenges the distancing technologies that surround the work of A&E through her own narrative that places her outside 'the patients' as a group and provides the means through which she regains her personhood.

Significantly, challenges to distancing work through the attempts to introduce the patient as person does not always end in the reconstitution of personhood. As has been seen in earlier examples, those more persistent patients who attempt to make visible their needs as full persons can be classified as 'problem' patients. They are not successful in creating a space of proximity, rather their persistence is used as a tool through which staff are able to carry out further effacement work through the typification of the patient that may, on the contrary, lead to practices of disciplining (see Chapter Seven).

The following example describes the last moments of the crisis described in the earlier extract 'Post-Crisis Discussions'.

The irony of reassurance

When eventually the nurses began to take him towards resus' the man managed to speak and asked if he was safe to which Nurse Claire replied *yes, we're going to look after you don't worry*. He then asked *am I going to die* to which she replied *No you're not going to die, not while I'm here*. Nurse Stuart then said *'you're definitely not going to die here*. Nurse Claire: *Far too much paper work for us*.

Interestingly this example shows how when proximity is re-established in the work of staff who become able to respond to a moral call from a patient as a full person, they are able to re-configure the forms of ordering that have worked previously to distance them from patients as a means with which to offer reassurance, calm and care to a frightened man. The ordering work carried out by staff in processes of assessment that are mediated by practices of self-checking against targets and guidelines and the categorising and labelling of patients according to standardised practices, as has already been shown, create a space in which staff are less able to respond to patients as full persons. In this example the calls to staff to act and make decisions according to managerial orders are removed. The need to make an automatic response is essential so that proximity can be re-established and the patient can no longer be cognized. Through joking about the amount of paper work that would be generated for A&E staff if this man were to die, Nurse Claire is able to reduce the calls to manage, making it possible for her to morally respond to this particular patient as a full person.

Summary and Discussion

Bauman's contention that is built upon in this chapter is not that human beings need social organisations and institutions in order to curtail their selfish natural urges but rather it is these organisations/institutions that create the contexts in which responses to proximity are made more difficult and therefore create a potentially demoralised social space. This is significant as it is not the premise of this work that A&E staff are morally lacking or that they are incapable of responding to patients' worth as full patients, rather it is the specific conditions of A&E work and the calls to A&E staff

that creates the circumstances whereby it is increasingly difficult for staff to respond to patients' subjectivity.²

It is also the contention of this chapter that this space of demoralisation is actively accomplished through the work of those within the setting, through the specific orderings of social relations that occur within A&E. The organisation of A&E as an institution is therefore not abstracted from its continuous construction in the actions and interactions of those social actors within it. It is the meanings created in and through the technologies that mediate the actions of A&E staff described in this chapter and in Chapter Five, and more importantly in the relations between these technologies and A&E staff that creates a space in which moral proximity is reduced.

Effacement work provides A&E staff with a tool that enables them to respond to the calls made on them to manage patients and these calls exist in and through the social relations that occur between patients, A&E staff and technologies of managing (see Chapter Five). Effacement work therefore both responds to and further creates a space of demoralisation. The examples taken from the field and explored in this chapter show how staff, in their relations with each other and with patients, are able to efface the moral subjectivity of patients. This is shown to be achieved through a variety of different strategies. The understanding of patients as a group claiming resources needing to be managed is one important way in which patients' personhood is reduced. This is accomplished through the separation of 'the patients' at the threshold from the spaces where 'real' emergency medicine is carried out, so that the individualising needs of patients can be effaced.

² It is necessary to briefly outline the current debate within nursing regarding aspects of patient care. It is argued that the professionalisation of nursing has devalued aspects of care in the mandate of nursing practice and should thus be re-affirmed (Kirby and Slevin 1992; Watson 1989). However, these arguments have been criticised for producing a particular notion of 'care' that focuses on the formulation of an instrumental ideology of care that can be thread through nurses' education and training as well as their work practices (Barker, Reynolds & Ward 1995). It has also been suggested that the importance attributed to notions of emotion work that are somewhat idealistic and naively formulated upon ideas of nursing practices of the past, create further demoralised nurses whose work experiences cannot match the idealised construction of nursing created through notions of 'care' (Allen 2004; Allen 1997b and Dingwall and Allen 2001). The argument put forward here exists outside of this debate. This work does not seek to address a debate regarding whether caring or emotion work is de-valued. Rather, it suggests that the specific organisation of social relations produced in A&E create a potential space in which it is increasingly difficult for staff to respond to patients as full moral persons.

When individual patients attempt to make their claims distinct, as in the case of the self-harmer, staff respond to a particular negatively constituted attribute of individual patients based upon more dominant calls to ration and manage³, thus rendering them dissembled so that the patient still remains faceless and is responded to not as a full person, but merely as a representation of this negative trait. A further means with which staff are able to cope with and (re)produce a space where moral proximity is reduced is through the distancing of their moral responsibility through the shifting of responsibility towards the institution as a rational regulator of individual staff action.

It must be recognised that staff are unable to respond to calls of moral responsibility due to the pressures of opposing calls for rational decision-making founded on the basis of a need to manage and ration limited resources. Where moments of effacement are not possible and where moral proximity is restored, such as those examples described above, staff are able to respond to moral calls and displace those pressures. The effacement of patients as full moral persons, through the constitution of patients as claimants or through displacing moral responsibility to the institution as the moral care taker, therefore exists as the means with which staff are able to act under pressures and calls that do not allow for patients to be seen as full persons, as faces evoking proximity.

This chapter has touched upon what it has described as 'negative traits', staff constituted attributes of patients that are used as tools through which to efface their needs as full persons. The next chapter explores these labels in more detail through an analysis of them as typifications built up through A&E staff's experiences and assessments of patients and their categorisation according to a specific performance of 'real' emergency medicine.

³ Calls to managerial orderings may become more or less dominant depending upon the specifics of the situational context. The argument here suggests that at the threshold, calls to ration and manage are more intensely felt, making it more difficult for staff to respond to moral calls for patient proximity.

Chapter 7

Figuring Patients and Knowledge-ability

‘What the sociologist calls ‘system,’ ‘role,’ ‘status,’ ‘role expectations,’ ‘situation,’ and ‘institutionalization,’ is experienced by the individual actor on the social scene in entirely different terms. To him all the factors denoted by these concepts are elements of a network of typifications - typifications of human individuals, of their course-of-action patterns, of their motives and goals, or of the socio-cultural products which originated in their actions. These types were formed in the main by others, his predecessors or contemporaries, as appropriate tools for coming to terms with things and men, accepted as such by the group into which he was born. But there are also self-typifications: man typifies to a certain extent his own situation within the social world and the various relations he has to his fellow men and cultural objects.’ (Alfred Schutz 1970: 119).

Introduction

This chapter explores the ways in which the performance of ‘real’ emergency medicine is accomplished through the assessing of patients as types. Patients typified as ‘socials’, ‘a-copias’ or ‘crap’, to name a few, are shown to help staff in their production of A&E as a space in which the treatment of ‘true’ emergency cases is carried out. Attending to such typifications is integral to understanding the particular production of medicine being performed. Such labels also have important consequences for patients. Specifically, this chapter illustrates how forms of disciplining occur, whereby patients are encouraged to perform more appropriately to the given definition of the situation (Goffman 1959).

In Schutz’ (1970) work on typifications, objects become comprehensible through a generalized knowledge of the type of object it is, or the typical style in which it manifests itself. This extends not just to the physical world but to all areas of socio-cultural life and understanding. This chapter explores the ways in which staff working in A&E, through their daily activities of assessment, figure patients according to particular types. Following this exploration the chapter identifies the possible consequences of these typifications for the care and treatment of patients, and identifies the role patients and patients’ relatives may play in their own placement into staff constituted patient categories, or how they might contribute to their definition of

a particular type of patient. As the chapter illustrates, it is this interaction that forms a substantial part of the process of negotiating access to assessment, care and treatment.

Finally, this chapter offers the possibility of a new type of moral ordering that provides categorical frameworks from which staff are able to figure patients. This ordering focuses attention on the participation of patients and patients' relatives as part of the figuring process. As Strauss et al (1963) have shown, patients play an important role in the processes of negotiation that occur in hospitals as negotiating lay citizens bargaining for privileges. This chapter shows how patients may achieve or fail in accessing privileges of assessment, care and treatment in A&E.

Typifications and 'Real' Emergencies

During the fieldwork, staff tended to show less overt hostility towards older patients attending A&E in comparison to younger patients, particularly older teenagers and those in their early twenties. Younger patients were often discussed by staff, following assessments or in general conversation, on the basis of an identified problematic attitude to their own health, to the health of others and most commonly to health services. Notions of younger patients lacking in responsibility, placing an emphasis on their individual health needs and showing a lack of respect for health services were particularly strong themes in staff's descriptions. This construction of the younger patient was most commonly produced at the threshold, where patients exist as a group to be managed. Young people can, in these areas and at particular times, become synonymous with the alcohol and drug related type of attendees, and are often attributed with the accompanying violent behaviour.

In many instances older patients were discussed quite differently, particularly when being directly contrasted with younger patients. Descriptions of older patients neglecting their own health needs in favour of taking responsibility for limiting their use of hospital services and thus showing respect for emergency health services were common. Notions of older patients not wanting to 'make a fuss' or 'having faith in their GP' are examples of this particular construction of the older patient. Following a conversation with another member of staff, one triage nurse joked that she would never smile at the patients but then corrected herself saying *'I'll smile at the little old*

ladies'. The following extract is an example of the way in which staff working at the threshold construct this age distinction with younger people being typified as inappropriate attendees.

The younger patient

After discussing my research with Nurse Morris, where I tell her that I'm interested in older patients because they often have quite complicated problems that involve acute medical problems which can be further affected by their social circumstances, she responds by telling me that in her experience older people use the correct service for their problems; they are more likely than younger people to call out their GP before attending A&E, *Whereas younger patients want to be seen now so they come to A&E. I think it's coz older people still have faith in their GP*, she explains.

Following this conversation Nurse Morris calls the first patient to assessment room one. A young man in his early twenties knocks and opens the door. He has a shaved head and is wearing a sweat shirt with a hood, and baggy jeans. Nurse Morris asks the patient to take a seat.

Nurse Morris: *So what's the problem then?*

Patient: *I've had really bad pain in my stomach all last night. I took some pain killers but they didn't work.*

Nurse Morris: *Have you been to see your GP?*

Patient: *My GP's in Park Green and I live in Sand Grove*

Nurse Morris: *So have you moved?*

Patient: *Yeah*

Nurse Morris: *Well, you need to register with a new local GP then.*

Nurse Morris then examines the patient. She takes his blood pressure, takes some blood and checks his temperature.

Following the examination the patient is told to go back to the waiting area for the doctor to call him. Nurse Morris turns to me and explains,

'he should go in triage category 5, make him wait for hours, but he'll just sit there all day so its easier to get a doctor to see him and send him home'.

There is a great deal more to say regarding this assessment, specifically about why Nurse Morris did not choose to discipline the patient by labelling him triage category five. Issues of disciplining are explored later in the chapter when details of the triage categories and processes of assessment are analysed in more detail. This extract is useful at this stage to identify how the positive construction of older patients was taken up and used in particular contexts to justify the widespread contention that younger patients do not perform the correct A&E patient behaviour. This was particularly the case for staff working at the threshold dealing with the stressful task of managing patients as a group. In this situation, the job of managing older patients was often easier than managing those younger, often more forceful patients.

However, this was not the only view of older patients held by staff. In many cases there remained a perceived problem for A&E as a service focused on the care of those acute medical cases, to deal with the complexity of the difficulties that face older people. This problem remains identifiable in staff accounts.

Although many of the older people who attend A&E are in need of emergency medical care, they often have long term, chronic medical and social needs accompanying them. The following extracts from fieldnotes show that within the cultural domain of emergency medical care, particular types of older patients remain problematic. What is interesting to explore is why some older patients remain relegated to being simply another 'social' (Latimer 1997), while others are able to achieve placement into more positive staff constituted patient categories.

As discussed in Chapter Two, past studies of casualty departments, emergency rooms and other hospital services for acute medicine (Jeffrey 1979, Latimer 1999, Dingwall & Murray 1983, Becker et al 1961, see Chapter Two) have produced some interesting analysis of the labels used by staff to categorise particular patients as problematic; those patients who for whatever reason are viewed negatively. These labels, as has been illustrated, offer insight into the wider cultural relations that make up medical settings. They provide a starting point from which the researcher may be able to understand how staff negotiate the boundaries of their working responsibilities to include the treatment of particular patients and, in a variety of ways and for a multitude of purposes, exclude the treatment of others.

The 'Socials', the 'A-Copias' and the 'Crap'

During the research, the use of negative labels for patients was common. However, the meaning and function of these labels differed greatly. This section seeks to critically analyse these negative labels, with specific reference to their use in constructing those older patients who often fell victim to such negative categorisation. It is important to recognise that the use of these labels in staff accounts are not fixed stereotypes, rather these labels can shift and alter according to the context and purpose of the account being made. Also, as discussed in more detail later, it is possible for

patients themselves to negotiate their placement into a particular staff constituted patient category.

The following examples are taken from field notes and illustrate some of the ways in which negative labels are used.

'That's where the social go'

After lunch there were a few junior doctors gathered in Assessment room one, talking about what shifts they were on. They talked about how tired they were and how they weren't able to do anything other than sleep and work.

One of the male doctors, Doctor Glass turned to me and asked, 'so who are you, are you a student?'

I replied by saying yes, but not a medical student. I told him about my research, in the same way I had described it to Nurse Morris, that I was interested in Older patients who attend A&E, as although they are in need of emergency medical care, their problems are often more complex and may relate to chronic conditions and their social circumstances as well as their emergency medical needs.

Dr Glass responded with: *So you're interested in the social. You'll wanna go to the trolley bay. That's where the social go. They're what the cynical, depressed medical students call crap* (he looked at the others and laughed and they smiled and laughed with him).

'A-copias'

Whilst describing my research to another doctor in the assessment room, Nurse Price who had become a useful source of information when on duty, told me that what I am really interested in are the 'a-copias'. I look confused and he goes on to explain that in medical terminology every word that begins with an 'a', the 'a' refers to without/nothing and so an 'a-copia' is someone who can't cope. He chuckles and says *It's probably made up but it sounds good doesn't it?*

Significantly, it was my own place as a researcher that, in part, encouraged these accounts of 'the socials' and the 'a-copias'. The conversation described in the first extract develops from my being noticed and questioned as an outsider to the group. The questioning over who I am from Doctor Glass is another example, among many, of how my role at the hospital needed to be continually legitimated (see Chapter Four). Through Dr Glass' response, the patients described as 'socials' are not the only ones in danger of becoming 'crap', the worth of my research and my worth as the researcher, being associated with 'the socials', were also under attack.

These examples indicate how for the medical staff, older patients and 'the socials' are so often viewed synonymously. In the first extract it is additionally clear that these

ways of thinking akin to medical knowledge practices begin during study and training and are reinforced once practice begins (Good 1994; Atkinson 1997). When I described my interest in older patients in need of emergency medical treatment who may also suffer with complex health and social care needs, the doctor in the first example responded by labelling what I was interested in as 'the socials' or 'the crap'. These terms, along with others such as 'trivia' and 'a-copias' as described in the second extract, encompass all cases where the patients are negatively categorised by staff because, for various reasons, they are not in their interests to have as patients (Becker et al 1961). They are deemed to be 'trivia', 'boring' and 'day to day' or their problems are viewed as inappropriate to the service of emergency medicine. Significantly, these labels not only help individual medical staff to perform identity work but also help in the overall performance of emergency medicine, in setting and producing the boundaries and limits to what this may include or exclude.

At first glance these labels may seem interchangeable and to some extent they are. However, the research identified that each term can have quite specific and distinct meanings for staff. The 'socials', for example, are different from the 'trivia' or the 'crap'. Whereas the 'trivia' or the 'crap' may involve some patients who also could be described as 'a social', they can also include patients who are not necessarily 'social' but are perceived to be clinically boring or mundane. These include cases that are seen daily; a patient attending A&E with a fractured ankle would be a good example of 'trivia'. These are not necessarily labelled as 'social', although depending upon the interpretation of the patient's circumstances they could be. 'The socials' on the other hand must suffer with difficulties that are perceived by staff to be social in nature. For staff to label a patient a social, their social needs must in some way *negate* their medical needs. As Latimer (1999) suggests, this can be particularly true for older people whose medical needs are transformed as being a reflection of their old age, thus relegating their needs to the domain of the social rather than the medical, excluding them from medical services.

The 'crap' can also have distinct characteristics depending upon the context in which it is used. As Jeffrey's (1979) study suggests, when describing the crap there is often a moral underpinning, that these patients are in some way responsible for their attending problem. Patients perceived to have conditions and circumstances beyond

the direct remit of emergency medicine, such as alcoholism, homelessness, suicide attempts or self-harm fall under the label 'the crap'. However, it can be used, as the extract above shows, as a more general term that encompasses all patients who fall under negative staff constituted categories.

The term 'a-copias' is interesting as it is slightly different to the more traditional labels of 'trivia' and 'crap' that have been documented in the work of previous ethnographies of A&E departments (Jeffrey 1979; Roth and Douglas 1983). It is similar to 'the socials' in that it is a term referring to those who staff believe are not appropriate attendees of A&E; as with 'the socials' their problems are not understood in clinical terms. However, the reason for the term 'a-copias' as distinct from 'the socials' is staff's perception of the particular patient's use of A&E as a source of emotional or psychological support. It is therefore not simply that the patient's problem is perceived to be social. The problem for staff is in their perceived purpose for attending A&E and how A&E as a service is perceived to be used as a result. The idea that A&E should be thought of and worse still used as anything but a service for those 'true' emergency patients in need of expert clinical attention is treated extremely negatively by staff members.

Older patients often find themselves falling under this label. Staff descriptions of people who are unable to cope with an elderly ill relative who use A&E as a means through which to reach out for more support, or descriptions of lonely older people who some staff suggest simply attend A&E in need of company are extremely common. These cases would all fall under the label of 'a-copias'. That is not to say however, that 'a-copias' are exclusively older patients; another example may be self-harmers or those suffering with anxiety or stress. These are other groups of people who A&E staff may describe as 'a-copias' as they can also be described as using the service for emotional, social or psychological support, none of which are viewed by staff to be within the boundaries of the responsibility of A&E as a service to provide, they do not help staff to perform 'real' emergency medicine.

A-copias, bumps, bruises and reassurance

The last assessment I observed on my first day involved Mrs Melody, a woman in her early eighties. She enters assessment room one with a friend helping her along, after

being called by Nurse Morris. She has cuts and scrapes all over her face and quite a bloody mouth. She is obviously shaken and leans heavily on her friend for support. Nurse Morris looks at the scrapes briefly and seems satisfied that there is no need for any further examination on these. She spends more time looking inside Mrs Melody's mouth, to her discomfort. Nurse Morris apologises for hurting her but is worried that she may need stitches. She decides that Mrs Melody does need stitches and sends her off to the treatment room with her friend helping her once again.

Meanwhile Dr Lovering, an SHO (Senior House Officer) who had been present earlier when Dr Glass had asked me about my research, enters the assessment room, after treating another elderly woman who had had a fall. He explains to me that,

Most people here have nothing wrong with them, well nothing we can do anything about anyway, bumps and bruises. All we can do is give them some attention, it makes them feel better...I'm sure it does. Although the problem is that it does reinforce why people come to A&E which is not good for us.

The extract above illustrates that for some members of staff, such as Dr Lovering, there is a perception that the majority of patients who attend A&E, or at least those who access the service through self presentation, are unlikely to have any *real* emergency medical need, they have 'nothing wrong with them'. For Dr Lovering they mostly fall under the label 'a-copias'. Having bumps and bruises, as in the case of Mrs Melody, often requires care and attention. For Dr Lovering, this need reduces staffs ability to perform medical expertise and therefore relegates not only the patient's problem to being 'nothing' but also the treatment of the patient to 'nothing'. According to Dr Lovering's account, to indulge these patients would result in the encouragement of these perceived inappropriate attendances. Interestingly, this example illustrates the way in which patients who are excluded from the production of 'real' emergency medicine are more at risk of being effaced. Proximity is lost in these cases due to the shifting out of aspects of care so that 'real' clinical work and 'real' clinical patients assume primacy.

What is particularly interesting in this case is that Dr Lovering makes this observation following Mrs Melody's assessment who is, as Nurse Morris found, in need of treatment that the A&E service is there to provide (stitches for a cut in her mouth). This suggests that it is not only 'a-copias' who are viewed to be inappropriate to the A&E service, but also those who fall under the label 'trivia'. Perhaps patient's appropriateness remains to a large extent related to staff identities; Mrs Melody's stitches do not provide good medical materials through which to perform clinical

expertise and therefore are relegated and incorporated into a group of patients who 'have nothing wrong with them'.

This example further demonstrates how staff's accounts construct and legitimate the parameters of their roles as medical professionals. It exemplifies how these boundaries function to include and exclude certain activities from the roles of doctors and nurses and how these are mirrored in the perceived role of A&E as an institution and service provider. For Dr Lovering, elements of care including providing reassurance are not included in these processes. That is not to say that comfort and reassurance no longer exist in the social relations of A&E, but that these are not explicitly included or referred to by staff as part of the important activities of practitioners but are more often (as in the case of Dr Lovering) explicitly placed outside the role of medical staff. This is also a reflection of their omission from what is understood to be the role of A&E as a service provider.

The notion of 'a-copias' as being typified as in need of reassurance fits well with Armstrong's (1983, see Chapter Two) account of the shift in medical perception towards patients as particular kinds of subjects. For Armstrong, patients as subjects were constituted upon the particular difficulties that patients as personalities presented in allowing the patient as object to be read. In the context of A&E, Dr Lovering constitutes patients as subjects in need of enlightenment and reassurance and as such, these patients are deemed problematic to the service of A&E.

These examples are also useful in seeking to understand how calls to care, reassure and give attention to patients as full persons are effaced by staff not only as means with which to cope with the pressures placed upon them through the specific organisation of social relations at the threshold mediated by clinical governance guidelines and practices of managing resources (as described in the previous chapter), but also through the performance of 'real' emergency medicine. This performance is produced in the above accounts, where staff set the boundaries and parameters of their own and the institution's role and responsibilities.

It is important to recognise that 'a-copias' are viewed negatively, not because of their perceived social, emotional or long-term medical problems but rather because of the

course of action these patients choose to take as a result of them. The notion that patients seek out and use A&E as a service that can provide a crutch of support in times of difficulty, one that is always open and available, is what constitutes a patient as an 'a-copia' for staff. The negative status of 'a-copias' is then often further compounded by their inability to provide medical practitioners with good clinical materials to perform competencies and expertise.

Interestingly, Dr Lovering was one of the first doctors that I had come in to contact with in the A&E department. He is a Senior House Officer and he began and remained suspicious of my research and my observations. The accounts he offered were therefore always of a particular kind. They were either offered as a defence of doctors working in A&E: 'we are the only ones willing to provide around the clock access to treatment' for example. Or, he would provide lessons in the realities of working in emergency medicine: 'this is the way it is on the ground'. The following extract is an example of how Dr Lovering positioned me during my time in the field.

I saw an SHO who I had met previously in minor injuries, Dr Lovering. He looked at me and said *'Ah yes you're the one who thinks old people get a hard time'* I laughed and shook my head as if to suggest that although he was joking I wasn't agreeing with him either. He said *'I'm with a 60 year old man does he count'* I said 'yes' hoping that this would mean he would lead me towards his patient for me to observe his assessment but instead he turned away from me, input some notes on to Jonah and left without a word.

Although I may not have been able to observe Dr Lovering 'in action' with his patients, the conversations that we had as a result of his perception of me and my research, as illustrated in the example earlier, revealed a great deal about what and who was valued in the cultural domain of emergency medicine.

The following extract forms part of an assessment of Mrs Preston, a woman who has attended A&E after a fall and another example of a possible 'social'.

Falling and remembering

An elderly woman, Mrs Preston who is in her 80s enters nursing assessment room one. She has a bloody nose and mouth and is holding a handkerchief to her face to try and stop the bleeding. She is slightly dishevelled and seems a little shaky. She is helped in by another woman who looks slightly younger than Mrs Preston. Nurse Harbury motions for her to sit down on the chair in front of her as she says hello. As Mrs Preston is sitting down she explains to the nurse that she fell down in the park.

Nurse Harbury: *Do you remember everything?*

Mrs Preston: *What do you mean everything? Uh, yes I think so.*

Nurse Harbury: *What happened after you fell, do you remember?*

Mrs Preston: *I remember being in a neighbour's house...*

Nurse Harbury: (Interrupts) *So you remember being on the floor?*

Mrs Preston: (Tentatively) *Yes*

After Nurse Harbury had finished examining Mrs Preston she asks her if she would like to clean up a bit at the sink, as she has quite a lot of blood over her face. Her friend helps her to the sink and then Nurse Harbury gives her a dressing just to hold on her face until she can get her stitches done.

In this example Nurse Harbury attempts to provide the answers for Mrs Preston. It is clear that initially Mrs Preston is unsure of how much she remembers and exactly what she remembers. She is quite vague, stating that she remembers being in a neighbour's house, and yet Nurse Harbury suggests to her from this that she remembers being on the floor which is not at all suggested by Mrs Preston. Also, significantly, Nurse Harbury does not attend to Mrs Preston's face. Mrs Preston, clearly shaken and distressed is asked if she would like to use the sink and clean up her face herself. This is a further illustration of Dr Lovering's account that sets the boundaries of medical staff's responsibilities that explicitly excludes particular activities of care. Once the task of assessing Mrs Preston's head injury has been carried out, the cleaning of Mrs Preston's wounds was explicitly made distinct from the process of assessment, clearly demarcating it as outside the domain of A&E work.

These exclusions could be viewed as another means through which staff seek to distance themselves from practices that may elicit emotion or moral proximity bringing them closer to patients as full persons. This example is particularly poignant as a person's face is symbolic of their personhood and therefore the intimate care and attention involved in the process of cleaning facial wounds may break the possibility of moral distancing and proximity may be restored (see Chapter Five).

Negotiating Patients

The second section of this chapter focuses upon how these typifications come into play, in particular through the processes of negotiation that occur between patients and medical staff in the access of emergency medical resources. This chapter highlights the ways in which medical staff, particularly nurses at the threshold, work to perform 'real' emergency medicine through attending to patients as 'knowable individuals' (May 1992). The means with which staff accomplish the 'real' is in part

through the constitution of patients as subjects. However, this attention to patients as whole persons is not accomplished through the rejection of the patient as object, as has been illustrated in previous research; there remains a constant tension in medical knowledge practices between reading the patient as either object or subject (Silverman 1987; May 1992). Rather, this reading of patients as subjects attends specifically to particular attributes that make up their personhood (Armstrong 1983). Furthermore, as attempts to 'know' patients as individuals is premised upon patient's talk, patients' own accounts are of particular significance in the ordering work described (May 1992).

This section attends to the ordering work undertaken by staff through analysis of not only the actions and activities of staff themselves, but also through the deployment of 'good reasons' or justifications made by patients to aid their passing (Garfinkel 1968); that is, to pass from one status (that of a member of the public yet to become a legitimate patient) to another (a legitimate A&E patient). The ways in which this ordering work is accomplished is the central focus of the analysis, which seeks to show how notions of personhood, made available through discourses of citizenship, are drawn upon by both staff and patients in these processes. The analysis demonstrates that notions of citizenship such as responsibility, self reliance, and duty are deployed by staff and patients as practices of identity work, in their negotiations around access to services.

It is the premise of this research that these discourses of citizenship form part of the means through which patients succeed or fail in gaining access to emergency medical services. The arguments put forward in this chapter have built in part from Foucault's (1978/1991) conception of governmentality that has shifted our understanding of the work of governing away from the narrow confines of Politics and has reframed governing as a phenomenon that exists in all areas of social life. The everyday, mundane activities of daily life are mediated by discourses of governing that shape and regulate our behaviour. This shift in understanding is useful for understanding how patients in A&E are enrolled in the performance of citizenship through the accounts they provide to legitimate their attendance at A&E.

Governmentality is also particularly useful in thinking about the conception of the citizen as a central focus of governmental techniques. For Foucault, population became the ultimate end of government; its purpose was turned to the welfare of the population, its overall wealth, health and longevity.

‘the population is the subject of needs, of aspirations, but it is also the object in the hands of the government, aware, vis-à-vis the government, of what it wants, but ignorant of what is being done to it.’ (Foucault 1978: 100).

As a result, the development and growth of technologies that sought to make visible and regulatory the actions of this population, its citizens, becomes clear and logical in its endeavour; we can begin to understand how the development and significance of ‘the citizen’ began:

‘the conduct of individual citizens must be governed in the interests of the nation and that, despite all their hesitations, even a liberal state must take some steps to actively govern the moral order of citizens, to create citizens who would govern themselves.’ (Rose 1999: 102).

The understanding of subjects as certain types of possible or desirable subjects is dependent upon the particular beliefs and understandings of a given time and culture. It is being suggested here that the current meanings attached to the notion of good citizenship may be a way of understanding how A&E patients negotiate access to emergency health services.

Historically, citizenship has been constructed upon a combination of personal freedom and liberty (Stuart Mill 1924/1994), bound up with economic freedom (Marx 1844/1994), and moral decency (Marshall 1964). As Williams (2004) argues citizenship in recent Political conceptions has been ‘employed as a way of emphasizing the need for community vigilance on crime, disorder and other signs of moral degeneration and decay’ (p. 243), rather than as a notion for securing rights to health and welfare provision.

Paradoxically, at the same time that economic freedom was embedded within citizenship notions of personal liberty, the moral became an increasingly legitimate area of government intervention. The moral became ‘located within a wider space of the character of a people as a whole’ (Rose 1999: 103), reflecting government’s concern for populations. This moral domain is of particular relevance to the creation and maintenance of good citizenship in the current context.

The extent to which these notions of citizenship are deployed by staff and patients will affect the placement of patients into staff constituted patient categories of 'good', 'bad', 'appropriate', 'inappropriate', 'legitimate', or 'illegitimate'. As has been established through previous research (Jeffrey 1979; Roth and Douglas 1983; Dodier and Camus 1998 and others, see Chapter Two), the placement of patients into positive or negative categories has significant consequences for their access to important health services. In the case of A&E this can manifest itself in shorter or faster waiting times, different levels of access to doctor or consultant assessments and differing outcomes regarding whether or not tests and examinations are carried out.

In this analysis the specific means through which these notions of citizenship are taken up by medical staff and patients, creating new categories with which to order patients, are made explicit. The analysis shows how forms of knowledge around what it means to be a 'good citizen' are performed in processes of negotiation that partly help to determine patients' access to assessments, examinations and treatments.

A&E as a Site of Regulation

It is the contention of this work that A&E as a public institution is a site in which discourses aligned to aspects of citizenship are becoming more dominant. Foucault's (1973/1991) genealogical analysis shows us how moral technologies carried out through institutions such as asylums and reformatory prisons were put into place in order to shape the character and conscience of those who were to be moral subjects and hence mould their conduct,

'Social danger was recast as a violation of norms of respectable citizenship and a new way was invented for collecting and confining those who in one way or another could introduce chaos into the social order.' (Rose 1999: 103).

In understanding A&E as a contemporary space of contestation it remains an important institution through which such moral technologies may be carried out.

As this chapter shows, discourses of the citizen have become a significant component for the organising principles by which action and interaction can take place. Although the actions and behaviours that result from the enrolment of individuals in A&E to a

mode of ordering around aspects of citizenship may not necessarily be the reaction desired (the desired consequences of governmental tactics and technologies), the existence of such discourses and the increasing enrolment of staff and patients in their (re)production remains significant in shifting the possibilities for action. This chapter shows how governmental tactics and moral technologies manifest themselves in aspects of self-presentation and identity work. The following extracts seek to examine the ways in which staff and patients regulate their behaviour and the behaviour of others through recourse to the images and values of what it might mean to be a successful citizen.

Effacing Health Needs

A significant skill for the performance of the good citizen in providing good reasons and justifications for accessing health services in A&E is to efface notions or suggestions of rights to health care services, while at the same time promoting an awareness and understanding of a moral duty to be responsible for health and well being. This is significant for the perception of the individual patients' moral worth, in illustrating their autonomy, as well as for legitimating of their attendance and their claims to health resources. The following extract from the field tells the story Mrs Johnson's visit to A&E, where her presentation of self succeeds in providing the difficult balance between the denial of rights to services, while appearing worthy of obtaining them.

Mrs Johnson: 'an oldie but goodie'

Later that morning, two paramedics arrived at the door of assessment room one with a patient assessment form for an 89 year old woman who they'd brought in with a fractured foot. They both raved about how lovely she was and how she had fallen a week earlier. One of them explains to the nurse that, *she didn't want to bother anyone you know*. Nurse Morris turned to me and said *there you are you see*. Quite pleased that Mrs Johnson (the 89 year old woman) had proven her point that elderly patients have more faith in their GPs.

The paramedics then wheeled Mrs Johnson in on a chair for Nurse Morris to assess her. Mrs Johnson was clearly very frail, but she was also very well turned out, neatly dressed and her hair was combed and tied neatly at her neck. Nurse Morris smiled, said hello and asked her how she was feeling:

Mrs Johnson: *I'm 90 tomorrow so I can't complain; I'm in good health really.*

Nurse Morris: *So what happened to you? Why didn't you come in and see us sooner?*

Mrs Johnson: *Well I see on the news about how terrible it is here and I err ..I didn't want to take up space you see.....its just that I'm living alone that's the trouble you see*

Firstly Mrs Johnson, although old and frail is well spoken, sharp and pleasant to the medical staff. She has a calm and friendly demeanour and abides by the correct rules of patient behaviour, unlike Mrs Williams described in the next chapter (p.195). Interestingly, other patients who had suffered pain for long periods of time before arriving at the emergency unit were often reprimanded for not seeking advice from their GP at an earlier time thus avoiding attendance at A&E, or at least obtaining a referral by the GP in order to show that appropriate service use has been followed. As one nurse explained to me, by definition if a person has been suffering pain for a long period of time, the patient is no longer deemed the sufferer of an accident or an emergency¹. Mrs Johnson, on the other hand has the added benefit of being knowledgeable of her responsibilities as a citizen to be autonomous. She understands her duty to refrain from making claims to services and to look after herself wherever possible, and in this case even when it is not possible (her ankle is found to be fractured). Mrs Johnson's narrative, describing why she had not come to the emergency unit sooner shows her eagerness to limit what she perceives to be her burden on hospital services, regardless of her clear need for them.

To ask for help would in some way be a failure of carrying out these responsibilities. As she said, 'she didn't want to bother anyone'. This is partly due to her experience of watching the news about 'how terrible it is'. The discourses of crisis that surround NHS provision, with continual recourse to the need to ration and in particular the difficulty emergency departments experience in trying to cope with increasing demands are constantly in the public domain. Furthermore, older people's attendance are often sited as one of the major factors in accounting for this crisis (Klein 2006; Scuffham, Chaplin and Legood 2003). For those patients, unlike Mrs Johnson, who have not been imparted with such knowledge and understanding of this crisis prior to attending A&E, there are many means with which to rectify this once they arrive, as

¹ The issue of patients being refused treatment at emergency services on the basis of the duration of their problem is something that has been previously documented in Vassy's (2001) study of a French emergency room. See Chapter Two p.37

this crisis discourse is also reflected within A&E as an institutional space. Not only does it exist in general conversation but it is also reflected in hospital materials such as the leaflets left in the waiting area that provide information on triaging (discussed in more detail later the chapter) or the electronic notice above the waiting area that displays the waiting time; a means of regulation as well as information. It can be experienced in the mediation of technologies for administering, rationing, auditing and regulating described earlier in the thesis, which shape staff patient interactions and also through the socio-spatial organisation of the service (see Chapters Five, Six, and Eight).

Mrs Johnson's further comment that she did not want to take up space is also interesting. There is a sense in which she understands her claim to space, and subsequently the services of emergency medicine, as being somehow less legitimate than those of claims made by others. These have come from what she has seen on the news but may have been substantiated by other mediums that could relate to her age. The needs of older people are often highlighted in both medical and policy arenas as particularly problematic in the plight of the health services (Evers 1993; Sidell 1995). It is also more difficult for older people to present the successful moral citizen, as self-sufficiency and 'active participation' (normally framed around economic productivity) is so integral to this success. However, it is this presentation of knowledge, knowledge regarding the moral duties of citizens in relation to health services, which aids Mrs Johnson's case with Nurse Morris and the paramedics.

The positive reaction to the presentation of such knowledge leads to Mrs Johnson being rewarded. She is given a higher priority of care and treatment; she is brought straight into the assessment room by the paramedics rather than being placed in the waiting area as would normally be the case. This priority results from the successful presentation of good citizenship. This presentation is successful because it is understood that a good citizen must efface any need for services and highlight their responsibility to limit the burden upon health services.

Knowing the system

Forms of knowledge are found to be highly significant for patients in order to present their justifications for attendance at A&E. The means through which patients and relatives are able to show their worth as moral citizens can more successfully be accomplished if there is a demonstrated understanding of different institutions and sectors of health care systems and how they, as patients, fit within these systems most appropriately. In order to show concern for limiting the burden on health services, there must be an understanding of which services should be approached, when and by whom.

'It's not their fault so I've put a category four'

Earlier in the day I had met a male nurse in his late thirties, Nurse Price. He is a very jovial character is very talkative, often popping his head into the assessment room to tell a joke he's just heard, or to bring some chocolates round. He had been very enthusiastic about helping with my research and had promised that when he assessed any older patients he would be sure to find me so that I could sit in and observe, and as he promised, later he did find me and we went to Assessment room 2 where he was triaging Jesse, an 89 year old woman who had been brought in by her daughter, Valerie. Jesse is in a wheelchair and looks very frail and withdrawn. Valerie pulls Jesse in through the door and takes a seat next to her and starts explaining to Nurse Price what the problem is.

Valerie: *She's had a bit of a fall out of bed in the night, my sister called the ambulance because the GP refused to come out and see her. I think she panicked to be honest; we're probably wasting everybody's time.... Her wee is a little smelly too...the GP had said she needed another catheter but she's been passing water fine.*

Nurse Price: *There's no need for that, it's most likely she's just got a urinary infection.*

Nurse Price (raising his voice): *Jesse, what is your date of birth, can you tell me?*

Jesse (straining to hear): *Oh um its err the sixteenth of March, nineteen sixteen.*

Valerie: *She is a little confused, not bad on long term memory but her short term memory isn't so good'.*

Nurse Price: *Okay, that's fine. If I just give you this (hands Valerie a glass for a urine sample) so that we can check your mum's urine. The ladies toilets are just back out onto the corridor and on your left. If you could just pop it back in to us when you're done and we'll get the doctor to call you back once we're ready for you, okay.*

Once Valerie and Jesse had left the room, Nurse Price turns to me and says *Classic case of they shouldn't be here but it's not their fault. It's outrageous that the GP wouldn't see them. Really this should be a category 5 case but it's not their fault so I've put a category 4.*

Glynis is very frail; she is confused and has difficulty hearing. Almost immediately the conversation occurs between Valerie (Glynis' daughter) and Nurse Peters. In other cases where there was no relative or carer present, Glynis may have become far more problematic for the staff to assess. Without Valerie's justifications for their

attendance, it is likely that Glynis would have simply become another 'social', a victim of poor social circumstances thus negating her clinical needs making her inappropriate to A&E services. As Nurse Peters comments, 'they shouldn't be here'.

However, Valerie gives an account of their reasons for attendance. In her account there is an attempt to justify and make legitimate their claim to A&E services and she does this significantly through focussing on their use of services. Firstly, as in the case of Mrs Johnson, there is no assumption during her account that they will and should receive access to these services, again there is an element of effacing any rights to health services. However in Glynis' case, it is through making clear that they have attempted to see the general practitioner before attending A&E that ensures their success in gaining access. In the performance of correct service use, accomplished through Valerie's account that the most appropriate route through which to see a doctor had failed, the responsibility for inappropriate attendance shifts from being Glynis' or Valerie's and becomes the fault of the general practitioner and more generally the primary care sector.

This example indicates how one of the ways in which staff and patients negotiate access is on the basis of perceived service use. Ordering on this basis is done as part of a wider notion of responsibility, the responsibility patients, as consumers of health services (Sointu 2005), have to limit and make appropriate this use. Valerie also refers to wasting staff's time which concedes further to an understanding of this responsibility to limit claims to services, especially those in high demand such as A&E. Again, in a similar way to Mrs Johnson, there is an understanding, even before entering the Emergency unit that there is a need to legitimate any claims that are made to access services.

The response to this legitimisation is to reward Glynis and Valerie to a higher triage category than the perception of the patients' clinical condition may otherwise have warranted. This reward manifests itself as a shorter waiting time, a doctor's assessment and the testing of a urine sample, all things that may have been denied to the patient, if she had been placed in triage category five where, as one nurse explained to me, '*Patients generally don't get seen, we just let them wait for hours in the hope that they'll go home.*'

Disciplining 'Bad' Citizens

Perhaps the focus upon the need for patients to negotiate and perform identity work in their interactions with staff was as much derived from my own experiences of being out of place as they were from the observations of patient assessments. Therefore, what I noted from both my own experiences and those of patients was that if good reasons and justifications are not made to successfully perform as a good, moral citizen there may be negative consequences. These often occur as forms of discipline. My own disciplining came in the form of being ignored or my research being redefined or devalued. For patients, this disciplining not only has significant consequences for accessing hospital services, but also for regulating patients so that they are made aware of their responsibilities in the future; they are imparted with knowledge of what determines a responsible health care user as part of a wider project of successful citizenship. This is not only seen in the interactions between staff and patients; more subtle forms of disciplining that attempt to shape the behaviour of those in A&E are also evident. One example of this is the leaflets that are placed on waiting room chairs that explain to attending patients who read them that a triage system is being used to prioritise patients. These leaflets serve many purposes and read as follows:

Why do I have to wait? Information for patients and relatives

As soon as possible after arrival each patient is seen and assessed by an experienced qualified nurse who will decide how urgently the patient requires treatment.

This process is called Triage.

The Triage Nurse is trained in prioritising the needs of each patient in degrees of urgency, varying from non-urgent to those in need of life saving treatment.

Therefore patients are seen in order of urgency and not in order of arrival.

The Trust uses a Triage Scale and therefore patients are categorised as follows –

1. Immediate – Patients in need of urgent treatment for preservation of life. These patients are seen and treated immediately.
2. Very Urgent – Seriously ill patients are seen within ten minutes of arrival.
3. Urgent – Patients with serious injuries and illness but who are stable we aim to see within one hour.
4. Standard – Accident and Emergency patients without immediate danger. Non urgent illness or injury, although we aim to see all patients within two hours, this depends upon both the number of patients in the Department and those needing immediate treatment.

5. Non-Urgent – Patients who are not true Accident and Emergency cases. If your injury or illness is over 48 hours old you may be advised to contact your family doctor (GP) or another more appropriate service. Although we aim to see these patients within 4 hours there may be further delay while patients from category 1-4 are seen.

One significant function of these leaflets is not only to appease patients who are frustrated by how long they have to wait, or by seeing people who may have arrived after them being seen before them (this appeasing work also forms a significant part of the nurses management of turbulence at the threshold – see Chapter Five), they also work to regulate those patients who may fall into category five. These leaflets are not merely imparting information; there is an attempt to discipline those who are ‘not true Accident and Emergency cases’.

These leaflets may not be read by all who arrive at A&E but for those who do read them, there is a sense in which not only should all patients attending A&E question their own needs for services, but they also help to reinforce the crisis discourse discussed previously. The very need to prioritise suggests a need to ration resources of time and treatment. It establishes for patients an understanding of their responsibility to justify their attendance. Perhaps those who do read these leaflets are more likely to have the knowledge they need to successfully put into play the identity work needed to perform the legitimate A&E patient.

The practices of ordering patients into triage categories are not based upon unpolluted clinical concerns. Which particular categories of priority patients are ordered into can vary greatly depending upon the specific performance of emergency medicine being enacted and the situated context in which this enactment is taking place. For example, the time of day or night that a patient arrives at the department could mean the difference between placement into one category or another depending upon how many other patients have been triaged into categories of more or less urgency. Furthermore, as the next chapter shows, the usefulness of assessments for staff identity work, or the means with which they may help re-accomplish medical dominance, will also shift the performance of emergency medicine. This chapter shows is that in part, the system of triage is available as a means through which to discipline and reward patients on the basis of their presentation as dutiful moral citizens or irresponsible, inappropriate users of health services and failed citizens.

The extract below describes a more explicit form of disciplining that occurs for those patients who, according to staff, should not have attended A&E at all.

Room eight and clinical solutions

It was this visit that I discovered room eight. Two patients were sent to a room eight in the space of an hour towards the end of my evening at the emergency unit. Room eight, as it is explained to the patients, is for 'clinical solutions'. Basically, it is for those patients who present at A&E with problems that are deemed to be more appropriate to primary care. Room eight simply consists of a phone where the patient is able to call the GP out of hours' service.

I heard Sister Smith talking about the first patient who was sent to room eight. I had not seen her being assessed but from Sister Smith's conversation with Nurse Harbury, the patient was a young woman who had come in to the department with cystitis, which as clearly pointed out 'is not an A&E problem'.

The second young woman, who was in her early twenties, was suffering from what seemed to be flu like symptoms. During her initial examination and assessment with Sister Smith she had told her that she was generally fit and well. The nurse, not understanding why someone with flu symptoms had arrived at A&E, therefore sent her to room eight to contact her GP. Later, the girl came back to the assessment room, to see Sister Smith to explain that the practice nurse at her GPs surgery had told her to come to A&E and ask for the HIV consultant. She told her that she is HIV positive and that the nurse at her GP surgery had felt that her symptoms were serious enough because she also suffers from having a heart defect. Sister Smith tells the girl to wait, to go back outside and wait. Once the girl had left the assessment room, she turns to Nurse Harbury and says *'I can't understand why she didn't tell me that in the first place, well if she feels that she should be seen by the consultant, she will have to be referred by the GP'*.

In Sister Smith's conversation of the first case to be sent to room eight there seemed to be no hesitation that this was the correct course of action to take. Cystitis was firmly in the category of 'not an A&E problem'. In this case, like the leaflets on the waiting room chairs had warned, there is a need to discipline the patient in order to encourage behaviour that better demonstrates an understanding of their moral duty as citizens to use services appropriately and sparingly.

For Claire however, the young woman who is HIV positive, it is not necessarily her perceived clinical needs that warrant the discipline of being sent to room eight as the risks of serious ill health seem to be higher than would normally warrant sending a patient to room eight. It is rather the account that Claire provides that merits this disciplining. She does not attempt to show knowledge of her own responsibility for

her illness. She does not show recognition of her need to manage her illness and use the most appropriate services for her needs at the correct time. Unlike Valerie, she does not demonstrate knowledge of the system in which there are set routes that must be followed in order to gain particular services, especially those as sought after as a consultant examination.

Furthermore, it is not simply that she failed to show knowledge of these responsibilities, but she also gave off impressions of behaviours unfitting to a morally dutiful citizen. First there was the inappropriate route through which Claire had attempted to gain access to an assessment by a consultant. As Sister Smith notes, 'if she wants to be seen by a consultant, she must get a GP referral'. This is significant; for Claire to seek this alternative route indicates expectations of rights to such a service, or that her needs exist outside the problems of waiting lists and limited resources. This is not the behaviour of a successful citizen, who understands their responsibilities to reduce burdening an already stretched emergency health service.

Secondly, there was the perceived deception with which Claire had presented her reasons for her attendance which contributed to her problematic presentation. Although failing to mention her HIV status in a room where other staff members and patients were also present may be easily understandable, in this case there is a perceived lack of health management that is viewed negatively as a result of this dishonesty. By initially concealing her illness there is not only a resultant distrust between herself and Sister Smith, but also a feeling of time wasting resulting in an inability to appropriately manage her health needs.

Both aspects of Claire's self presentation mean that her placement into category five and subsequently her being sent to room eight could be legitimised. Had she performed the sort of self-responsible conduct (Sointu 2005) of those such as Mrs Johnson or Valerie, she may have experienced a more successful negotiation and would not have found herself the subject of such disciplining action.

Upon reflection on the discipline that Claire encounters, I began to realise that perhaps I too was in room eight. In a similar way to those patients who were not able to successfully present themselves as legitimate, self-responsible health service users,

I was also unable to present myself and my research as purposeful, useful and scientifically viable.

Medical Knowledge and Educating the Citizen

As has already been established a successful citizen must have knowledge of their duties and responsibilities in relation to health care services, and in order to fully realise these duties they must also have knowledge of the health care system itself. These two forms of knowledge, even presented together in the accounting work of patients are sometimes lacking in the necessary understanding needed to be successful as a morally aware citizen. As the following example shows, there is also the need to have, or at the least to seek, knowledge of one's own health and well being in order to assess and manage one's own health needs.

Mohammed: the family panic

One of the young nurses, Nurse Flower said that another patient Mohammed may also be interesting too. She explains that: *he shouldn't really be here. He'd had a stroke previously but the family were worried as there had been little change so they called an ambulance... so he's been on a trolley in the corridor for 2 hours when he could've been at home with his family. Families don't realise that in a lot of stroke cases, little change is quite normal.*

For Mohammed, it is his family who do not have the necessary knowledge to understand and therefore manage their relative's illness themselves. There is a sense in which the reliance the family has on hospital services is misplaced and should be directed towards building their own competencies in managing Mohammed's illness in order to care for him outside the health service.

Staff's discussions of the need to educate patients on their uses of health care services was found in Vassy's (2001) study of a French emergency service. However, these accounts were not implicated in the forms of assessments that occurred between medical staff and patients. Vassy also failed to consider how the practices of accounting for service use may be a means with which patients can attempt to successfully negotiate access to emergency services.

Similarly in the extract that follows, one of the nurses describes to me her understanding of the problem of ‘social’ patients attending A&E. Her understanding is that it is a lack of education both of ordinary citizens and those in general practice about what is best for particular patients.

Nurse Fowler: it’s a lack of education

After a while the same nurse, Nurse Fowler who had introduced me to Beth came over and we began talking. I explained what my research was about in a bit more detail and she responded by telling me a bit about her background...

I used to work in primary care; I was a care worker for 10 years. I’m a great believer in primary care; so much can be done at home these days even for the most ill of patients. There seems to be an idea these days that you’re better off in hospital. A friend of mine had a hysterectomy and she said the worst thing about the whole experience wasn’t the pain at all; it was having to go to the toilet with just a curtain around you. They pump you full of air when you have abdominal surgery to separate everything out so you have the most terrible wind and it was the lack of dignity and the humiliation of having to open your bowels with only the privacy of a curtain. For older patients often we just get UTIs (urinary tract infections) where GPs or families think, oh they’d be better in hospital. You should’ve been here last night. We had a couple in last night who shouldn’t really have ended up here. There was one little old lady in here, she was aggressive, she was violent. She was well known at, (she turns to a health care support worker who was stood near by) what’s the name of the psychiatric hospital called? Anyway, she was hallucinating, UTIs can cause hallucinations. But off course I think part of the problem is that she’s confused anyway and then they bring her in here, she doesn’t know where she is or who anyone is and it just makes the problem worse.

I asked why she thought this happens. Is it because there are gaps in primary care or is it shifts in attitudes; that people just feel they should go to hospital.

Well, I think it’s a lack of education. I mean, how many socials do we see in here?
(She asks the support worker again)

The support worker answers *Oh, quite a few*

She continues *GPs don’t know or don’t bother to find other services that people may need so they end up in hospital.*

In this example inappropriate patients, or ‘socials’ are those who misunderstand what A&E as a service is there to provide. There is a sense in which there is blame apportioned to primary care, as well as misinformed citizens, as the ‘GPs don’t know or don’t bother to find other services that people may need so they end up in hospital.’ In Nurse Fowler’s account she works to redefine A&E as a site of real emergency, not only through alignment to discourses that help produce a site of first class emergency medicine, but also through discourses that help develop the patient as a subject. In order to displace the needs of ‘the socials’ who attend A&E as needs that would be

best fulfilled by other services. As Latimer (2004) suggests, it is through the shifts that clinicians make between creating the patient as object, and then moving the world in order to understand them as subject, that enables them to reproduce medical dominance. Thus, it is through Nurse Fowler's work in shifting the ground onto the subjective experiences of A&E patients that works to (re)accomplish A&E as a site for acute trauma patients.

'Good Citizens' and Responsible Service Use

The extracts above are useful in bringing to light a general shift in notions of health services and their uses. There has been a growing emphasis on 'self-responsible' conduct (Sointu 2005), whereby patients are more aware of their personal obligation to manage their health and well being. This research shows how self-responsible conduct has become central to the process of ordering work undertaken by both staff and patients in A&E. The individual citizen is increasingly required to self-regulate and manage their personal health risks as part of a moral order that views individual regulation and limitation of health risks as paramount to the good of the nation as a whole. The shift in health responsibility from the state to the citizen is becoming increasingly common, particularly in primary care (McDonald et al 2007). This thesis shows that A&E, as a threshold space between hospitals and primary care, is apparently becoming a place in which patients can be disciplined so that they are imparted with the knowledge of 'correct' and morally responsible service use.

The links being made here between current conceptions of citizenship and the accessing of emergency health services can be better appreciated if we understand citizenship as being produced in language and accomplished through the discursive practices of those who choose to account for their actions through its deployment. Thus, citizenship is shifted away from being a trope of Political ideology but is rather a means through which the ordering of social relations can be accomplished.

This moral order is not entirely distinct from some of the orderings produced in medical knowledge practices. Greco (1993) argues that Parsons' unconscious motivational component to every illness situation implies a responsibility of the afflicted for the disease. This means that the illness or condition itself does not hold

within it an intrinsic property of non-responsibility or guiltlessness. Rather the acquisition of guiltlessness rests upon a term of contract between the doctor and patient that is contingent upon the other terms being met: 'Disease will be treated as if it were an accident so long as authority of the physician is not put into question and is effectively complied with' (p. 386).

Furthermore, Greco suggests that, in our time, the unconscious motivational component has become explicit and amenable to some kind of rational decision. In part this has resulted from the media being able to make this motivational component collectively visible and conscious, something that medicine was unable to achieve for each individual. The description of Mrs Johnson and her concern with the news stories is a good example of the way in which rational choice and responsibility over individual health care have become an integral part of wider understandings of illness. Although the authority of medicine remains in the judgement of the 'reality' of a medical problem, the media, businesses and individuals have become increasingly responsible and able to certify the 'reality' unhealthy and of managing it. This has resulted in a health that is contingent on the will of individuals so that physical health has become an,

'objective witness to his or her suitability to function as a free and rational agent....A moral responsibility has become associated with prevention which represents an extension of the duties Parsons described as those incumbent upon the sick role so that the duty to get well has become the duty to stay well (Greco 1993: 370).

As Greco (1993) therefore suggests disease always implied a personal fault, yet the patient must always be excused. As this chapter has shown, the connotation of Greco's argument is that A&E, as a site of contestation and negotiation, is where the work of accomplishing being excused is carried out. The duties needed to be deployed have become greater than simply the desire to get well but must also include the performance of duties and responsibilities to manage the risks of becoming unwell.

Summary and Discussion

This chapter has revisited the ways in which patients are typified in the ordering work carried out by medical staff. Negative patient labels such as 'crap', 'trivia' and

'socials' are explored in order to elicit some of their meanings in the current context of A&E. 'A-copias', a label that is perhaps specific to this local site, is also considered for what this may tell us about how staff seek to construct emergency medicine. These labels show how particular types of patients, through their complex relations with particular types of A&E work, are identified by staff as being positioned inside or outside the boundaries of 'real' emergency medicine.

These boundaries are not fixed as the 'real' and can shift and alter depending upon the purposes of their performances. In the first section of this chapter the extracts are drawn mainly from staff accounts of A&E as an overall service provider or from accounts of patients in general. Accounts of specific assessments, or interactions in which patient disposals are accomplished, are described in the second section of this chapter. These first accounts demonstrate the performance of a heightened 'real' emergency medicine into which these negatively labelled patients do not fit. In these heightened performances of the 'real' it is easier for staff to produce a coherent, singular and unpolluted notion of emergency medicine, with 'virtual' (Mol 2002) patients that have equally unpolluted, purely clinical needs. Other performances of the 'real' described in the second part of this chapter and those described in detail in the next chapter, are more flexible and shift in order to accommodate the different realities of A&E that are produced in the everyday ordering of patients.

This chapter further contributes to the work produced on the typification of patients through providing a more detailed account of the possible means through which patients themselves may negotiate their placement into staff constituted patient categories. In particular, the accounts that patients make in producing their case for attendance have been examined in order to elicit the ordering work that patients themselves undertake to gain access to emergency medical resources. Arguably, the ways in which patients enter into these negotiation processes have yet to be thoroughly unpacked in the previous literature. As Strauss et al (1963) have put it 'a single hospital, after all, is only a point through which multiple careers stream – including the patients' careers' (p.167). Some offerings of patient participation in categorical work are discussed in Chapter Two and have been formative in the development of this thesis' arguments (Lorber 1975; Latimer 1997; White 2002). However, what this thesis further contributes is a detailed analysis of patient's own

accounts and, in particular what possible modes of ordering these justifications may be aligned to and how these might fit or jar with the performance of 'real' emergency medicine.

This chapter argues that patients may accomplish access in a site of contestation such as A&E through a particular mode of ordering aligned to notions of good citizenship. The analysis elicits how notions of personhood are drawn upon by both staff and patients in processes of assessment in order to undertake categorical work. The most significant of these notions is that of responsibility, specifically the responsibility citizens have in their use of services. The link between notions of citizenship, and the ordering of patients' into categories of priority of need can be understood particularly through the shift that has occurred towards citizens as active and responsible managers of their personal health and well being.

This chapter demonstrates how the interactions of staff and patients during the processes of assessment and the subsequent placement of patients into staff constituted patient categories alludes to the existence between them of a shared mode of ordering aligned to aspects of 'good' citizenship. A good citizen, in the context of A&E, is shown to understand their duties in relation to their individual health and the subsequent responsibility to health care services and performs accordingly. Accounts of this nature made by patients are more successful during moments of accessing at the threshold where the negotiation over emergency medical services is mediated by technologies that seek to manage patients (see Chapter Five). Where this is not understood and justified appropriately by a patient, as in the case of Claire, a form of disciplining occurs, like being sent to room eight.

It is important to make clear that it is not the intention of this chapter to suggest that judgements are made on the basis of set types or stereotypes of patients, as has been criticised in the case of Jeffrey's (1979) study where Glynis would be labelled simply as 'normal rubbish'. The analysis shows how Glynis, although clinically a trivial case, was on the contrary able to negotiate her placement into a positive category through Valerie's good reasons and justifications (Garfinkel 1967) for their attendance through a performance of self-responsible conduct and the 'good citizen'.

The arguments of this chapter are not seeking to produce another account for how medicine is social (see Chapter Two), but rather to show how the ordering of patients according to aspects of citizenship offers a further means with which staff are able to perform 'real' emergency medicine and furthermore, through practices of disciplining, patients are also enrolled in this performance. The next chapter seeks to explore in more detail medicine's relations to discourses of managing that have been shown to mediate the work of A&E staff and more specifically, how the relations between these modes of ordering aid the performance of 'real' emergency medicine.

Chapter 8

Medicine and Management in Practice

'It was this constant gaze upon the patient, this age-old, yet ever renewed attention that enabled medicine not to disappear entirely with each new speculation, but to preserve itself, to assume little by little the figure of a truth that is definitive, if not completed, in short, to develop, below the level of the noisy episodes of its history, in a continuous historicity. In the non-variable of the clinic, medicine, it was thought, had bound truth and time together.' (Michel Foucault 1973: 54-55).

Introduction

The interplay between medicine and management described in the previous chapters appears so far to be quite unproblematic: while recognising that they are both integral to the work undertaken by medical staff in Accident and Emergency (A&E), they are constructed as separate knowledge practices that make distinct calls upon staff to act. This chapter seeks to explore the ways in which medical and managerial knowledges are performed in the everyday practices of those working within A&E. The material is taken mainly from fieldnotes of recorded interactions. These include: assessments of patients by doctors and nurses, conversations between the researcher and members of staff, and conversations between staff members. There are also some extracts from interview transcripts. In addition to these interactions, extracts from fieldnotes focussing specifically on members' relations with objects and materials, including computer systems, documents, and medical equipment are considered.

This chapter exemplifies how medicine performs itself, through the discourses and practical enactments of A&E work, as that of 'real' emergency medicine. Medical staff attempt to make up the 'real' work of emergency medicine through the construction of a virtual patient whose needs are not only purely clinical but are immediate and life threatening: a 'true' emergency. This was shown in some of the accounts described in the previous chapter. This chapter, however, identifies the means with which staff accomplish 'real' emergency medicine in the everyday practices of assessment work in A&E. Its aim is to 'pay adequate attention to how routine knowledge is made and shared' (Atkinson 1995: 46).

The research materials placed alongside one another begin to reconstruct the ways in which staff understand and account for their work. The deployment and production of medical perception is examined for how and what it is able to accomplish. Furthermore, this ordering is shown to be mediated by other discourses that are more closely aligned to the managing of health care. What is significant in the accounts of staff is that there are some cases in which clinical orderings are shifted and reconstituted onto managerial grounds and others in which managerial discourses are shifted onto clinical grounds. This analysis therefore provides an exploration of instances where work carried out by A&E staff is undertaken in order to re-produce 'real' emergency medicine while often accounting for this work through recourse to managerial as well as medical orderings. The actions and accounts made by staff in their productions of 'real' emergency medicine are therefore shown to hold in play and align two ways of producing emergency medicine: medicine as purely clinical and medicine as managerial.

What is shown is that those managerial discourses are present not in the legislative structure of A&E, but are existent in and are produced through the guidelines and regulations of clinical governance. The practices of self-checking produced in such forms of clinical governance are shown to be closely aligned to some of the guiding principles of medicine as purely clinical and therefore allow for an increasingly close relationship between these two discourses that are integral to the performance of 'real' emergency medicine.

In order to elicit a coming together of biomedical (medicine as purely clinical) and managerial discourses in the accounts made by staff it is important to recognise what these systems of ordering accomplish for the performance of 'real' emergency medicine. In what moments and in what circumstances do these discourses take precedence?

Medicine and Governance

Often when identifying political shifts within and between governments at different times and the effects these have upon health service delivery, there is the separation of medicine from the political, suggesting that the tasks of undertaking clinical work

have been made more difficult as a result of the surrounding organisational bureaucracies of government policies seeking to reorganise the provision of health care. In recent years this separation may not be useful. Osborne (1993) argues that to simply understand the power of the state as being restricted to the organisation and administration of medical provision is to underestimate the influence that recent regulation has had.

It must be acknowledged that much of the instigation for the influx of clinical guidelines have occurred in part as a result of a substantial crisis of confidence from the general public regarding the profession's ability to remain responsible to itself by way of the imperatives of clinical 'truth'. This questioning of the lack of control over the medical profession came about as the result of a combination of factors. One such factor was the concerns that arose from consumer groups as patients who began questioning the basis of interest from which the medical profession make their decisions. This became particularly significant when cases arose such as those in Bristol, where there were unusually high death rates in a paediatric cardiac unit, and in Canterbury where numerous mistakes were made when diagnosing in a breast and cervical cancer screening service (Flynn 2002). This questioning also came from government concern with the pressures of increasing costs of old age, chronic illness, AIDs and technological developments (Osborne 1993).

We have already seen in previous governments the role of the state in laying the foundations for the infiltration of managerial, market led practices within the health service and how these have at times been met with conflict from the medical profession on the basis that they have worked against the pre-eminence of 'clinical truth' as a means for making clinical decisions (Whitehead 1993; Ahmad & Harrison 2000; Drakeford 2000). Osborne (1993) suggests that more recent regulation, in the form of clinical governance, has attempted to enrol practitioners in aspects of managing through imparting these managerial ways of thinking to the medical profession. Further still, he suggests that clinical governance has attempted to make these ways of thinking part of medicine 'itself', thus having real influence over actual instances of medical assessment, treatment and diagnosis.

In this chapter's analysis, Osborne's argument is considered through an analysis of how medical staff in A&E account for and practice the work of emergency medicine that is, as previous chapters have shown, mediated by technologies of managing and forms of clinical governance.

Regularities and Biomedicine

The following extract is taken from fieldnotes written whilst observing in the trauma unit of A&E during 'clinic'. Clinic is specifically for returning A&E patients. It is the only service A&E provides that exists outside the strict definition of responding to either accidents or emergencies; patients are given appointment times that are arranged prior to their arrival. I was observing a consultant, Dr Prichard, who was in charge of the clinic. The significance of these extracts is to show the particular conception of trauma in the body that is being constructed in the consultant's account. The particular form of medical knowledge that is being brought into play reflects an understanding of the importance within 'medical science' of understanding regularities (for a more detailed account of the production of medicine as science, see Chapter Two).

Wrists and high risk

Dr Prichard explains before we see the patient that there is a tendon in the wrist that goes up the arm and into the hand that if damaged, needs to be carefully treated and rested as it could cause arthritis later in life. Missing this damage is one of the major causes of law suits against the hospital. Wrists are therefore a high risk problem and this means that even when they are not broken, if they are particularly swollen, bruised and tender to move and touch, they are kept in plaster.

A young man in his early twenties, Chris, later attends with a similar injury as Merrill (a patient seen earlier that morning); he had had a fall from his motorcycle. His wrist is bruised and swollen and he was in a great deal of pain and had restricted movement. Dr Prichard does not hesitate in sending him to be re-plastered. Afterwards he explains to me that this particular problem that he had described about the damage caused to the wrist only occurs among those between 16 and 65 and so, with his symptoms and being in this age bracket, it was the sensible course of action. I asked if there was any particular reason why the problem only occurs in this age range, he replies that, *no it's just a problem restricted to these ages.*

Before the specific conceptual notions that frame Dr Prichard's account are analysed, this example tells us something about issues of accountability, resource management

and clinical decision making. What is immediately made explicit is that wrists are high risk (the risk being both that of litigation against the NHS Trust and the risk of arthritis in the patient's later life) as illustrated by Dr. Prichard's comment that 'even if the bone is not broken' we will often put it in plaster. Interestingly, in this particular context Dr Prichard is performing specific work to present himself as Director of Emergency Care while, at the same time, defining the situation (Goffman 1959) of the trauma Clinic. Had the context been different, Dr Prichard may have performed quite different identity work, where the risk of litigation may not have been included in his accounts of clinical outcomes. However, while working within Clinic, a site specifically used for the separation and sectioning off of returning patients from the 'true' work of emergency medicine which prioritises new patients, it is important for Dr Prichard to establish his capabilities and competencies to manage clinical resources as well as performing his clinical capabilities as a physician.

It is not being suggested that the decision about whether to keep Chris' wrist in plaster is based upon concerns of accountability, rather there is a complex interplay occurring between various available knowledges and responsibilities. The clinical concern of avoiding the risk of arthritis in later life is accounted for alongside the financial consequences that would be incurred by the Trust if this risk were to materialise. The responsibilities at play are therefore towards the patient as a person whose health is in jeopardy but also towards the hospital and to the Trust to avoid financial damages. There is therefore also a conflict within this discursive account between understanding the patient as a full person and understanding the patients as a future claimant (see Chapter Six). The inclusion of accountability in Dr Prichard's account is based upon its relevance to the auditor's projects (Garfinkel 1967); it fits the particular project for which Dr Prichard is currently (re)constructing, that of the Clinic as a site of managing.

Perhaps Dr Prichard's project of constructing the clinic as a site of managing as well as being a site of clinical work is partly due to Dr Prichard's positioning of me. His work of redefining or refocusing my research interests in line with aspects of 'real' clinical needs and concerns (see Chapter Four) played an important role in his accounting for the work that he does and the way the department as a whole functioned.

Once the site of 'Clinic' has been established and Dr Prichard's competencies as a manager secured, there is also a great deal that can be said about the particular form or understanding of medicine that is being deployed. There is no sense in which Dr Prichard attempts to explain to me why damage to this specific tendon causes arthritis only for those within this age range. His curt response and his look of confusion suggest that this is in fact not a question that is of any use or relevance to the form of medical knowledge practice that he is producing. On the contrary for the 'medical science' that is being performed here, Dr Prichard's understanding and subsequent practice has been arrived at from what he and others within the profession have experienced previously and through those recorded cases studied and learned during educational training. It is this that provides the knowledge and understanding necessary to make decisions regarding subsequent patients who experience these problems. This, for Dr Prichard, in this moment is medicine, as it is the particular form of medicine through which he is able to best account for his actions.

It is therefore the tendencies of what happens, the events that have been documented or simply viewed through clinical experience, that are an integral part, as Canguilhem (1966) explains, of the clinical gaze and it is this way of seeing that is of importance rather than any fundamental essence of the disease. In other words, in this particular understanding, medicine has no ontological existence; rather it is only existent in the experience of the sufferer, more specifically in the body of the sufferer and further still in the observations of the practitioner who views this body in relation to those other bodies that have shown similar manifestations on previous occasions.

This particular construction of medicine, one that is inherently bound up with the experience of the trained observer as well as the experience of the disease in the body of particular individuals, makes medicine somewhat elusive as a body of knowledge that can be learned and acquired. In accounting for his actions in this way, Dr Prichard is able to re-accomplish medical power, reifying the inaccessible nature of medicine to those non-professionals, like myself. He does not explain why he knows what he knows, because this is not possible. It is simply enough to make clear that he knows that in this clinical situation these are the facts of the matter from which to act.

Medicine thus becomes a self-fulfilling prophesy of the medical profession as it is only those within the profession who have the experienced gaze that can bring together the specific and particular forms of scientific knowledge alongside the indeterminacy of the experience of disease in the body. Unlike other sciences, diseases do not exist in an abstract form and therefore cannot be learned as such. They must be understood in relation to their situation within the body and their manifestation in the body can be different in each individual case. This construction of disease is a means with which medicine performs itself around the ideal of clinical experience in order to produce and reproduce its dominance as the legitimate profession for understanding health and illness.

Osborne (1993) argues that this way of understanding medicine and the medical profession reflects the foundations of the concept of the liberal professions. As Osborne explains, liberalism and medicine as ways of knowing have been historically complimentary. To understand politics and medicine (or the specific construction of biomedicine) as always having been in opposition, jockeying for power, is to neglect some of the ideological foundations of both. Within the liberal professions, power and authority are legitimated from within the ranks of the profession itself as it exists in a continual process of self checking. For medicine, once clinical truth became known to be objectively revealed on the surface of the body, it was truth itself which governed the medical profession. The profession therefore came to embody this truth. It is this particularly liberal yet medical construction that is being deployed in Dr Prichard's account.

Similarly, in the following extract taken from fieldnotes from my time spent in the Assessment Unit of A&E, Dr. Parker explains how angina cannot be understood outside of its representation in the body. As she makes clear, *everybody* experiences it differently.

'Some people are textbook'

One of the female junior doctors, Dr Parker, took me with her to observe while she examined and assessed Mr Fenner, a man in his seventies. He was laid on one of the trolleys in a cubicle wearing his pyjamas and dressing gown. His wife was sat on a chair in front of him. He was breathing quite heavily, was visibly tired, and was very restricted in his movement.

Dr Parker: *So what's the matter with you?*

Mr Fenner: *I woke up in the morning and was feeling breathless so I took a couple of sprays of the angina spray but it didn't seem to make much difference so later on I took another couple of sprays. A while later I decided to be good and do some washing up...*

Mrs Fenner (interrupting): *Well, breakfast things, you know a small plate, a couple of cups...*

Mr Fenner: *Nothing too full on. Anyway, I started to feel really short of breath and eventually I slipped off the stool.*

Mrs Fenner: *At first he was slumped over the counter.*

Dr Parker: *Did you lose consciousness or do you not remember?*

Mr Fenner: *I don't think so.*

Mrs Fenner: *He couldn't talk but I knew he was conscious because I could hear him groaning.*

Dr Parker: *So, do you have any chest pain?*

Mr Fenner: *No*

Dr Parker: *You had a heart attack in the past, did you have pain in the chest then?*

Mr Fenner: *Uh, yes I did*

Dr Parker: *So, would you say you suffer with angina?*

Mr Fenner: *Well, I may have this wrong but I thought when I get this breathlessness, that's what it was.*

Dr Parker: *Well everyone experiences angina differently. Some people are textbook and have chest pain, the works, but you may be one of those people who have it a little differently.*

Dr Parker in her statement that everyone experiences angina differently is destroying any notion that medicine deals in diseases that have their own existence, which can be understood as being abstracted from their manifestation in the body. These appearances and experiences can, however, only be properly read by those with both clinical knowledge and experience. It is through the previous revelations of the disease on and in the body of other patients that frame the gaze, but it is the attempt to reach the underlying disease manifestation in the current patient that is the focus of the gaze.

This particular performance of medicine secures the dominance of the clinic and the experiences of medical professionals in the practices of medical work. This is quite distinct from other performances of medical science where 'real' medicine is carried out in the laboratory. For A&E, 'real' emergency medicine is performed as expert clinical practice that involves quick responses to life threatening problems.

The distinction made in Dr Parker's account of those who are 'textbook' and those who experience angina slightly differently is important to this particular performance

of medicine. The 'textbook' cases she refers to work to re-affirm the knowledge and skills gained through education and training while extending this knowledge to include those who experience it slightly differently works, in a similar way to the account made by Dr Prichard, to draw attention to the uniqueness of medical knowledge, that must bring together objectification of scientific specifics with the indeterminacy of disease situated within individual bodies.

What is significant about Dr Parker's interaction with Mr Fenner is that she does not enter into a discussion about his symptoms. When he states that *well, I may have this wrong but...* she does not suggest that he is either right or wrong, or that the breathlessness might be related to his previous heart attack, or that it may be something entirely different. Through re-affirming medicine as this unique and elusive form of knowledge, Dr Parker also works to re-create the distance and distinction between the patient as sufferer and the doctor as practitioner. In this performance, Mr Fenner need not know and indeed cannot know or understand his symptoms in the way that Dr Parker does. It is therefore not affirmed that Mr Fenner is right in his understandings of his symptoms and their meanings as this is not useful to the account of medicine that Dr Parker is performing.

The following example illustrates the process through which the patient is viewed as object, whereby the focus of the clinician's gaze is towards the disease, as it manifests in the patient's body. It is shown that it is not Mrs William's subjective experience of the disease that is of importance to Dr Chessman but the representation of disease in her body. Once this particular understanding of medicine is elicited from the interaction, the subsequent analysis shows that the performance of this particular medical knowledge practice is responsive to the context in which this interaction took place.

Mrs Williams, 'only a mini one'

Later, Mrs Williams, a woman in her nineties came into the assessment room. She was clearly shaken. Her clothes looked dishevelled and she was finding it difficult to talk or answer the questions that Nurse Morris was posing to her. When Nurse Morris looked at Mrs Williams' initial assessment form she turned to Mrs Williams and said:

Nurse Morris: *So you had an outpatients appointment today then?*

Mrs Williams: *Uh, sorry, oh yes*

Nurse Morris immediately calls the outpatients department, saying *let's find out why you've ended up here then*. During the telephone conversation Nurse Morris discovered that Mrs Williams had been due to have an iron injection, however while she was waiting for her treatment she had suffered some sort of fit and was sent over to A&E. When Nurse Morris comes off the telephone she turns back to Mrs Williams and says, *so you had a fit? Do you remember what happened?* Mrs Williams responded by saying, *well um... only a mini one*.

Nurse Morris, turns to Dr. Chessman, a young female SHO (Senior House Officer) who was writing up some notes in the assessment room, and asks her if she would mind, while she was there, having a look at her so that she doesn't have to wait around any longer. Dr. Chessman is happy to oblige and turns to assess Mrs Williams, who is looking increasingly uncomfortable.

Dr. Chessman: *Hi, Mrs Williams, I'm Dr. Chessman. How are you feeling?*

Mrs Williams: *Can I go home, I want to go home.*

Dr. Chessman: *So you say it was a mini one this time, does this happen a lot?*

Mrs Williams: *Well, um they're only mini ones...its just that the inside shelf on the door of my fridge came off...and oh all the milk you see, it went everywhere and I tried to clean it up and well, my neck went and uh... oh well it sparked off a big one. (Mrs Williams is wearing a neck brace).*

Dr. Chessman: *So what happened this time, what happened while you were waiting for your treatment?*

Mrs Williams: *Well, um.. I was waiting for such a long time over there you see...and it was very cold, with that blast coming through and I needed my injection but oh...*

Doctor Chessman (interrupts): *Yes but what actually happened, what did this lead up to?*

Mrs Williams: *Well... um that's when it happened, but it was only a mini one..*

Doctor Chessman examines Mrs Williams and decides that she is not in any danger and that the best thing for her would be to reschedule her treatment for another day so that she can go home. Mrs Williams is very relieved and says *'Yes, I just want to go home... this place gives me the heebeegeebies.'*

Although Doctor Chessman does take a case history from Mrs Williams, there is little interest in the detail of how the disease interacts with Mrs Williams. Doctor Chessman, in undertaking the case history is interested in regularities, how often this has happened previously. It is not how the disease affects the working of, and interaction with Mrs William's body that is of interest. Rather it is the manifestation itself that becomes the disease. It is therefore those events or moments of manifestation that Doctor Chessman is focussed upon revealing. This particular formulation of the case history is quite contrary to the type of case history founded upon Hippocratic writings, where it was the very interactive process between disease and person that was of interest. For Dr Chessman, the case becomes the disease itself so that disease has no abstract essence; it becomes events that can be recorded to inform disease regularities (Osborne 1998; Porter 1997, see Chapter Two).

When Mrs Williams describes the moment leading up to the attack and the circumstances that may have precipitated the attack occurring, Dr. Chessman focuses her attention back to, the event itself. It is this event that constitutes the disease, set alongside other specific cases of when this happened before. This is evident throughout the assessment as Dr Chessman repeats ‘what happened this time’ and ‘what actually happened?’ These questions limit the information Mrs Williams is able to provide as part of the case history to the information that would record the particular physical occurrence in line with those that had occurred previously, with little interest in the surrounding ‘case’. The case that Mrs Williams begins to explore, on the contrary, offers much more detail, involving the peculiarities of the interactions between disease and Mrs Williams’ embodied experience of it.

Had the case history been used in the way in which it is understood in Hippocratic writings where the case history was indeed constructed as a way of revealing how the disease interacts with the particular patient and patient’s environment, (Porter 1997) Dr. Chessman would be more concerned with details such as the cold air in the waiting area and the Mrs Williams spilled milk, as these would provide more information regarding the ways in which the disease interacts specifically with Mrs Williams.

It is important to recognise and discuss the context of this interaction a little further. As the extract explains, Mrs Williams is not a formally registered A&E patient; she has arrived directly from the outpatients department. This has a number of consequences for understanding the purpose of this interaction and the work that is being done. Ordinarily (as described in detail in Chapter Five), every patient arriving in A&E would have been entered and registered into various systems that organise processes of assessment: they would have an initial assessment form generated, they would be triaged and entered into Jonah. This was not the case for Mrs Williams. This, coupled with the fact that this interaction occurred mid morning when A&E is generally at it’s quietist, a time when nurses are able to take stock and prepare for busier more stressful times to come, meant that Nurse Morris took the opportunity to clear this patient, to achieve a quick disposal and avoid another patient ‘blocking up the system’. Dr Chessman therefore, in her reading of Mrs Williams as an object is

attempting to accomplish a quick disposal that does not allow for the patient as subject to be read.

Dr Chessman and Dr Prichard's performance of medicine that focuses upon regularities, instances or occurrences of the physical manifestation of a particular problem is one particular element of biomedicine that has to some extent been built upon in clinical governance programmes. The notion of evidence-based medicine sits peculiarly well alongside the values upheld in this understanding of biomedicine, in particular the medical practice of regularities and the pre-eminence of an almost numerical understanding of the building of medical knowledge practice. Therefore the introduction of the idea of evidence-based medicine is in this sense far from being a new idea for biomedicine. In fact the notion of medical practice not being responsive to evidence would be highly problematic for most within the profession (Ahmed & Harrison 2000).

Evidence-based upon such regularities has previously been viewed simply as an integral part of clinical experience, not as something that is formally recorded (other than those cases recorded for educational purposes). This kind of evidence was therefore framed as part of the skills and experiences gained by physicians through the very practice of medicine. What has been criticised within evidence-based medicine is the extent to which the recording of medical research can become so important that particular courses of action or decisions become standardised on the basis of what has been already been established. This would erode the very notion of the indeterminacy of medicine, the specific experience of disease in the body that must use the knowledge of regularities to inform the particular experience being assessed. Such erosion could indeed threaten the autonomy of medical professionals, as it is this indeterminacy, mastered through the clinical gaze, which helps reproduce medicine's position of power.

However, this erosion of indeterminacy in the performance of medicine is not reflected in the previous illustrations, whereby the particular construction of medicine as the guardian of clinical truth takes precedence over this more political manoeuvre to standardise in the name of greater accountability. Both Dr Prichard and Dr Parker are enrolled in the work of re-constructing an evidence-based discourse, however the

alignments to such a discourse are made for the purposes of re-accomplishing medicine as a dominant knowledge base that is unique and elusive and therefore the political intentions of such alignments are subverted.

Emergency Medical-Management

Whether forms of clinical governance have become embroiled in the everyday performances of medical knowledge practices and as a consequence have worked to enrol medicine in the reproduction of rationing and auditing as part of 'real' emergency medicine is difficult to decipher. Perhaps within emergency medicine there may be more chance of such a merger appearing. It is suggested that within hospitals there has been an increasingly close relationship between managers and clinicians, with many cases of individuals taking on both these roles simultaneously (Llewellyn 2001). Also, A&E medicine is a 'service under strain' (Giddens 1984) in that there is a perceived growing demand for emergency medicine, alongside an increasing rationalisation of the service within health policy and medicine itself towards the treatment of acute, trauma patients (see chapter One). Emergency medicine may therefore be a setting in which, if a merging of medical and managerial discourses is possible, the consequences of such a phenomenon would perhaps be most apparent in its organisation of social relations.

This does not take away from the difficulty of eliciting such a merger of conceptual frameworks. The analysis that follows illustrates moments in which, through the social relations and discursive practices of medical staff, it may be possible to identify the production of both medical knowledge and managerial concern. The extracts show how these two ways of knowing and acting within A&E have become entwined in the practices and accounts of staff.

The extract below describes an object that is used as a tool during triage assessments to help better classify patients on the basis of their presenting symptoms.

Managing medicine and clinical guidelines

In a quiet moment I notice a red file on one of the desks called 'National Triage Presentational Flow Chart'. This file seeks to provide symptom signs that will allow

for a more accurate placement of patients into appropriate triage categories so that, as stated on the inside cover of the file, 'the more severe pathologies are appropriately triaged'. Inside the file are plastic wallets containing individual flow charts for specific presenting problems that a patient may attend A&E with. These flow charts ask a series of questions and provide possible responses. By following the responses a patient may give through this flow chart, a triage category is reached.

Before reflecting on the file's possible influence in mediating moments of clinical decision making with standardised responses to particular symptoms, it is important to recognise that the file also represents an understanding of disease as collated events that are view-able in the body, rather than an understanding of disease as having essence in and of itself.

The questions in this file and the subsequent courses of action recommended are based upon a collation of patients' disease/illness/trauma experiences at a national level. The file can therefore be seen as a symbolic representation of medicine as epistemologically concerned with experience while, at the same time, objectifying these experiences in relation to the experiences of others. Part of this objectification of experience provides the clinician with a numerical approach with which to make decisions.

Significantly, the file is also a material representation of a political endeavour that seeks to favour medical decisions based upon external research findings or, as part of the wider political movement of clinical governance, to provide clinical guidelines that represent an accumulation of clinical experience through processes of self auditing practices, performance indicators and other numerically decipherable data. It is this coming together of these two ways of thinking that makes medicine and management, in some cases and at particular moments, dependent upon one another, as Ahmad & Harrison (2000).

As the focus of this chapter is the everyday practices of medical professionals in their work of administering medicine in A&E, it is important to recognise that these ways of thinking may be produced in texts and materials and may also be deployed in a variety of ways through the social relations and discourses of medical staff. However, the way people interact with these materials or become enrolled in emergency medical

management in aspects of talk may work to accomplish quite different outcomes to those politically intended, a point that shall be returned to later in the chapter.

The computer system Jonah (described in detail in Chapter Five p.121) provides a good example of the forms of self-auditing practices based around clinical guidelines, which, as part of the clinical governance programmes, attempts to steer individual clinical decision making towards a pre-comprehension of national guidelines. As with all clinical guidelines, they are just what the name suggests and are therefore not intrusive to the extent of making requirements for clinicians to make medical decisions on the basis of political/state legislation. However, they are forms of regulation that seek to place the management of medical provision at the centre of medical work so that they become an inherent part of the overall process of clinical decision making (Strathern 2000, Rose 1999 see Chapter Five).

The voluntary adoption of Jonah as a system of auditing means that at every stage of assessing and treating patients, action taken and decisions made must be recorded. What is significant is that in the very process of recording itself, there is an inherent self regulation that occurs. This self-regulation allows for the infiltration of discourses that relate to efficiency, throughput, and resource management (including the resource of time) into the process of clinical decision making. These concerns are not explicitly separated and placed in contrast to the making of a clinical decision; rather through clinical governance they become embroiled in the process itself.

As suggested earlier, it is important to recognise that both the National Triage Presentational Flow Chart and the Jonah computer system are only meaningful in their relations with staff and patients. Although they produce a possible merger of medical knowledge and managerial concern, it is how these are interpreted and deployed by medical staff that establishes their social meaning. Such materials may serve a multitude of different purposes, which may differ according to the specifics of space, time and context. The following extract shows how the interpretation of these objects can be taken up within social relations that shift its meaning in order to accomplish work that is not necessarily aligned to either medicine or management.

Reverse flow

The National Triage Presentational Flow Chart file was used during an assessment of James, a young man who had attended A&E due to his hypo-glycaemia. Nurse Peters picked up the file and turned to the patient and said *let's try and get you through a bit quicker*. After looking at the presentation flow chart on diabetes, Nurse Peters filled in the triage assessment form. After the patient left the assessment room Nurse Peters looked at me and commented that *I did him a favour...tried to get him seen a bit quicker*.

In this example, the file has been used in the reverse way to its proposed purpose. Nurse Peters had decided upon the triage category that the patient was to be placed in and had subsequently worked backwards in the flow chart in order to present the correct signs and symptoms to legitimate this decision. As Berg (1992) similarly illustrated in his study of medical assessments, both patient histories and examination data can be given more or less validity depending on their usefulness in determining the desired transformation. In Berg's study the transformation referred to the construction of a specific disposal that enabled a patients' problem to become solvable. In this example, it refers to the construction of a priority of need that enabled the patient to be rewarded with placement into a higher triage category, thus obtaining faster access to services. Therefore, although there may be an existent merger of conceptual frameworks apparent in the discourses of the file itself, Nurse Peters uses the file as a tool to legitimate a decision that has already been made. This priority of need was not based on pure clinical concern as the symptoms recorded were those that best matched the symptoms described in the file that would warrant a patient being to be triaged in the category that had already been chosen by Nurse Peters. The action was also not based upon managerial concern, as placing a patient higher up the triage scale allows them access to desirable and intensely rationed resources.

Unfortunately I was not present at the beginning of this assessment and cannot offer an explanation as to why Nurse Peters used the file in such a way. However, the previous chapter has shown the complexity apparent in the negotiation of access that occurs during assessments. Such complex negotiations would be difficult to reduce to causal factors relating to the intrusion of clinical governance into the practices of medical staff. However, this discussion remains useful in identifying the ways in which such governing processes have their effects and what these affects may be. Although Nurse Peters uses the file for purposes that are outside the intended

consequences of the governing practice, the very process of using this material means that Nurse Peters is enrolled in and being governed through the processes of understanding and utilizing clinical guidelines as a means with which to legitimate a patient's priority of need. This governance therefore works to mediate and limit the possibilities for action for staff who have become enrolled in their practices.

The following extracts are taken from one morning spent at Clinic. Clinic, as discussed earlier refers to a particular time during the week when patients who were treated at A&E previously may return to be assessed further. The first extract provides an explanation, given to me by the consultant in charge, of the 'Clinic' and its purposes for the organisation of emergency care. It shows how the construction of Clinic given in his account is produced through alignment to both medical and managerial forms of knowledge.

Out with the old & In with the new

The purpose of the clinic, as Dr Prichard explained to me, is to reduce the number of returning patients being seen by the trauma section of the Emergency Unit. Before clinic was created, all patients were seen through the same system whether they were new emergency patients or if they were simply returning to have a wound checked, a break or swelling assessed, or an old burn dressed. He goes on to explain that this was something to be avoided as the priority of doctors and consultants working in the Emergency Unit should always be to the new cases and not to returning patients. The Clinic was therefore set up specifically for returning patients who were told to return at these specific times.

The Consultant explains that,

'In most cases the patients simply need to have their plaster off or whatever and be sent home'

He went on to explain that once the new consultants start (posts for three new consultants have been advertised – this was something I had learned from Mrs Brown, who was the person in charge of organising the recruitment) another clinic may be set up on a Tuesday to take more of these kinds of patients from the doctors working in the Unit.

Dr Prichard then asked Nurse Cohen to have a think about the kinds of patients that are taking up doctors' time that would be better suited to the Clinic. They discussed the possibility of incorporating burns patients in the Clinic as a way of taking the load off doctors. Nurse Cohen helps with the running and organisation of the department. I had met him a couple of times previously, mostly feverishly tapping away on one of the computer systems. I had rarely seen him dealing with patients.

Firstly, it is important to note that in A&E important managerial tasks are rarely undertaken by those external to the medical profession. Nurse Cohen, alongside the consultant, Dr. Prichard, is responsible for the overall management of the Emergency unit. This is significant because often more respect is given to medical staff as

managers for having a better grasp of medical concerns (Llewellyn 2001; Ahmad and Harrison 2000), but more significantly managerial and medical concerns are becoming less easy to separate. There is, as a result, absorption of managerial practices within what it means to be a nurse or a doctor. As has already been suggested in the literature there is a sense in which to be successful as a nurse or a doctor, one must understand and take on roles that would have previously been understood to exist outside the realm of medicine (Llewellyn 2001).

The description provided by Dr Prichard of Clinic, in a similar way to his concern over accountability in the previous illustration, further demonstrates his competencies and concerns as a director and manager, as well as a clinician. It also works to re-accomplish the definition of the situation, of 'real' emergency medicine as a space in which medical expertise is directed towards those acute trauma patients. The separation of returning patients to Clinic, already established as legitimate attendees as a result of their appointments, while at the same time remaining low priority in contrast to those newly attending and possible 'true' emergency cases (they are only possible 'true' patients as they are yet to be established as such through the triage and assessment process), is another example of the way in which the performance of A&E as a space of 'real' emergency medicine is facilitated by both its socio-spatial and temporal organisation.

Dr Prichard's account, therefore, works to accomplish the success and competency of the institution on both clinical and managerial grounds. The separation of patients in this way helps to retain emergency medicine as responsive to trauma while at the same time provides details of providing extra limited resources to expand the Clinic in order to remove more non A&E patients- those not true emergency cases- from the system thus freeing up more time and resources for those of the highest priority.

The construction of another Clinic in Dr Prichard's account is a good example of the ways in which medicine and management meet in the decisions made by clinicians. Medical knowledge is produced as being integral to the organisation of emergency medical provisioning such as Clinic- administrative or managerial knowledge alone would be insufficient to most efficiently organise returning patients. There must be a medical understanding of patients' needs that can only be obtained through a collation

of clinical experiences and these must be applied through practices of management that efficiently organise time and resources.

The following extract exemplifies the ways in which manifestations in the body are visualised and understood in relation to clinical experience of past manifestations of a similar nature in other bodies (as discussed earlier, this refers to the importance of regularities in the performance of biomedicine). This particular way of seeing has important linkages to the recent political endeavour to construct a form of medical decision making that must be justified through reference to external research findings. This perhaps aids the production of what Ahmad and Harrison (2000) term scientific-bureaucratic medicine.

Success rates

One of the first patients to attend the clinic that morning is a young female student, Emma, who is on crutches for her ankle. She explains that she has twisted it quite badly in the past and it has never been quite right and that it recently went again on a field trip in Tenerife (Emma is a geography student). After assessing Emma, feeling her ankle and asking her where it hurts Dr Prichard then asks her to try walking without her crutches. Dr Prichard decides that she has badly damaged the ligament in her ankle which has meant that it has tended to twist and bend fairly easily. He decides to refer Emma to Physiotherapy in order to try and strengthen the muscles around the ankle to protect it from bending and twisting so easily. He explains to me following the assessment that *you could operate to shorten the ligament but Physiotherapy has a 60-70% success rate in this kind of injury so it's best to try that first. It's very clever; there are lots of balancing exercises that specifically work the set of muscles that will protect her ligament. It seems to work better for younger patients, statistically*

In a similar way to the example of Chris' wrist referred to earlier in the chapter, Dr Prichard's account performs medical practice as the unveiling of clinical facts, facts that are derived from clinical experience, medical training, but also, and importantly, that are objectively assessed through the expertise of the clinician. Furthermore, in this example there is a more direct reference made to past research findings through the reference to statistics in the account of his decision making process and recommendations for treatment. This reference accomplishes the performance of medical science that objectifies and collates occurrences of disease experience in the body. However, his account is also, in part, enrolled in and helps to re-produce 'evidence-based' medicine through legitimating his decision making process on the basis of past research evidence. This is therefore not only a clinical account but one

that is embroiled in a discourse that seeks to safeguard the notion of accountability through subjecting clinical decisions to the rigour of previous evidence. It is the blurring of these two conceptual frames in Dr Prichard's account that suggests that perhaps it is through the regulatory work of clinical governance, whereby actions are not controlled but rather are encouraged through practices of self-checking, that help fuse the medical and managerial increasingly together.

The following data extract is taken from an interview undertaken with the clinical director of A&E.

Clinical management

I think it's a combination of things because if you take chronic disease management which is a key thing for the elderly because they've got significant problems such as repeated hypotension or chronic obstructed airways disease or after a stroke or diabetes, they need repeated assessments, careful monitoring of those diseases and adjustment to their therapy and reassurance in many cases and the problem is if they get a problem which precipitated them to an admission to hospital and attendance to hospital, when they go home I think we have to question whether the whole system is joined up, in that do we, as a hospital, provide the general practitioner in a very timely fashion a management plan for that patient: the following has been done, the following needs to be done on a regular basis if A happens this should be treated with the following things, if B happens this should happen and if C then we need to see them again. And there's a lot of evidence suggesting that unless, following a discharge from hospital, that unless a general practitioner has a management plan from the hospital and actually also sees the patient within a week of going home from hospital then there's a high rate of re admission.

So re admission is a major issue in chronic disease management but it's a joined up thing with proper discharge planning and proper management plans of chronic diseases and I think the management of chronic diseases can be much better now for undertaking and I think there are various models of care. The GMS (General Medical Services) contract in some ways is actually geared to making better management plans for chronic diseases 'cause the general practitioners remuneration depends on meeting targets related to chronic disease surveillance and so on, so there is that. NHS direct might be able to have a role in monitoring chronic diseases and following up people albeit across a phone to see how they've been getting and what's going on. So I think chronic disease management could certainly reduce attendance to hospital and admissions to hospital.

Dr Prichard's account of GMS could almost be analogous with the business strategy of performance pay, suggesting that the remuneration for general practitioners is dependent upon targets regarding the surveillance of chronic health care, thus shaping their focus towards practices of prevention and palliative care. The account brings together the clinical concern for the proper management of chronic health care, with

managerial discourses that refer to practices of building efficiency and incentive for proper working. His use of language throughout this extract and the interview is one that shifts continually from discourses of the clinic to political and managerial discourses of efficient health care delivery. His reference to 'joined-up' services a New Labour slogan for health and welfare services is the most explicit example of this.

The problem of re-admission is also central to this account. This problem encompasses both clinical concern for individual patients' health care and treatment, as well as a managerial concern for establishing appropriate and efficient service use, so that patients do not attend, and, in particular, re-attend A&E when another service should be providing for their needs (the notion of appropriate service use is particularly important to the performance of 'real' emergency medicine as has been illustrated in the previous chapter). The description of chronic disease management that is provided by the consultant shows an important duality inherent in the role of the clinical director. The Clinical Director's role represents the blurring boundary between the two domains of medicine and management within health service provision. In his description of chronic disease management there is little, if any, distinction made between management on the basis of health need and management on the basis of scarce resources. The problem of re-admission to hospital relates both to the individual health needs of those recently discharged, as well as to the efficient use of hospital services' resources. This combination is perhaps generated by the responsibilities of such a role that encourages a coming together of clinical and managerial concern.

Llewellyn (2001) puts forward the case that Clinical directors can be best understood through the metaphor of the two-way window: they exist at a boundary point between two domains of medicine and management. Llewellyn makes the argument that through their role at this boundary point they bring together sets of ideas from both clinical practice and management and thus allow the possibility to create a new area of expertise, medical management:

'Contentious medical/management decisions have to be made and justified. Delivering health-care to a fixed budget, rationing performance review and risk management (in an increasingly litigious environment) are all tasks that draw on medical and management knowledge. There are now both people and organizational

tasks that cross the boundaries between medicine and management. This new organizational context is constituted in the 'two-way' nature of the clinical directorate role: clinical directors mediate medicine and management.' (Llewellyn 2001: 594).

For Llewellyn, there has been a shift from the traditional differentiation between clinical and managerial work, with clinicians and managers working with different sets of ideas in separate 'communities of knowing' to clinical governance. Through clinical governance, she suggests, there is much more emphasis on collaborative working, cross boundary tasks of budgeting, rationing, performance review and risk management, so that the boundaries between the domains of medicine and management are not merely in continual battle, but actually have become blurred and have merged into one another.

The following extract is from a conversation I had with a senior registrar regarding my research. His explanation of the 'medical solution to the problem' is particularly interesting.

'The medical solution to the problem'

After coming back from a break I get speaking to a doctor who asks me about my research project. I tell him briefly about the issues I'm interested in. He responds by asking if I know about the IDCS. I tell him that I don't and he replies by saying that I should know about it. He explains: *It's the Interdisciplinary Care Service whereby any patient seen to be at risk of re-attendance to A&E, for whatever reason, is seen by other relevant professionals such as an OC (occupational therapist), social worker, psychiatrist or whoever will help their situation and prevent them ending up back here.* I tell him about my contacts with Age Concern, as an interesting link to what he was talking about, discussing their work with helping recently discharged patients, providing a fill for the often difficult gap between being discharged from hospital and having the services that are provided by social services. *Well, he replies, you should look into the IDCS as this is the medical solution to the problem.*

Aside from this being another example of the reframing and reinterpretation of my research by participants, as discussed in detail in Chapter Four, the doctor is performing some important work in the establishment of both medicine and management. To provide a little more context, I had provided my shortened pitch to the doctor to attempt to legitimate my presence and my research. This pitch was simply that I was interested in the assessment, care and treatment of older people with complex health and social care needs who attend A&E. This framing is interpreted unsurprisingly as those at risk of re-attending. Interestingly, this leads him to describe

an interdisciplinary scheme through which patients viewed to be at risk of re-attending are given the proper care they need.

This description does not offer an account of the contributions that other professions can make to the treatment of patients through such a scheme. The other professions are in part constructed as further protectors of 'real' emergency medicine, that do the work of sorting patients that the nurses at the threshold accomplish within A&E prior to patients reaching the hospital. Through shifting the performance of medicine to a more holistic view of health care, through referring to such an interdisciplinary scheme as being specifically medical, the doctor is able to accomplish emergency medicine's dominance. In this account, the other disciplines become mere subsidiaries of a clinically driven solution. It is a medically driven managing scheme that seeks to remove those patients who are not 'real' emergencies (or those at risk or re-attending) from the domain of emergency services. Furthermore, the managerial skill and expertise is driven by clinical knowledge and experience; 'it is the medical solution to the problem'. In this example, managing as a mode of ordering is deployed as a means of re-accomplishing medicine as the dominant means of organising health care. As Latimer (2004) suggests, in multi-disciplinary work doctors are able to shift between different modes of ordering, in this case between medicine and multi-disciplinary care management, in order to re-accomplish medicine's position of power.

Summary and Discussion

The research material provided in this chapter constructs a picture of A&E as a space in which the performance of medical science which prioritises disease as that which exists in the body, without essence in and of itself, is being continually accomplished through the assessment work and accounts of medical staff. This way of seeing sits alongside the particular processes of objectification carried out by doctors and nurses in their need to manage the indeterminacy that arises in the practice of medicine, reflecting the problem that no disease picture ever appears the same. Thus, medical professionals do in part deal in regularities, numerical instances of disease that are also, as the accounts provided have shown, enrolled in and help to (re)produce particular forms of clinical governance.

Material objects understood as texts, such as the National Triage Presentational Flow Charts, produce combined medical and managerial discourses that establish a possible means with which to order the relations of A&E. This merging has also been elicited in the accounts of medical staff, particularly those who have specific managerial roles to play. However, the meanings attributed to such materials and accounts, as they are played out in the social relations of A&E, must be understood in the context of what these accounts can accomplish for those who put them into play. Often these accounts work to re-affirm medicine through managerial means.

The extent to which the merging of these discourses occurs as a means of accomplishing medical decision making depends, therefore, upon a number of other factors: how useful they are to the (re)accomplishment of medical dominance; how important these discursive practices are to the identity and membership work of those working in A&E; the introduction of managerial values into the meaning of good doctor, good nurse, or good clinical practice so that the performance of good management has become the possible means with which to achieve similar identity goals, as illustrated in the accounting work of Dr Prichard; whether or not these discourses are useful in providing a desired transformation (Berg 1992) or, in the case of Nurse Peters, can help legitimate a pre-determined assessment decision.

For those medical professionals with more explicit clinical and managerial responsibilities, the bringing together of medicine and management is more explicit in their accounts. This is in part to perform identity work. In establishing the clinical basis for the values inherent in management, it is possible to perform good clinical practice through the deployment of managerial orders. As Hunter (1994) explains, this merging could be the result of management being enrolled into the wants and desires of the medical profession, so that medicine is able to re-establish its powerful position while appeasing the attempts for further regulation, an argument that is supported to a limited extent by the previous analysis.

However, as Osborne (1993) suggests this could be a reflection of the close relationship between medicine and the political groundings of clinical governance which can thus be understood as an obvious repercussion of the similarity of these

two forms of knowledge. Osborne suggests that, at least in theory, the move to clinical governance was undertaken to regulate the medical profession in favour of more power being given to the consumer, the patient. However, this was not done simply, as is sometimes suggested, through disempowering the medical profession.

‘Rather it institutes a novel form of medical government in which physicians are enrolled alongside managers, certainly as something of administrators and economists themselves. It seeks, even in a classic document of ‘managerial’ neo-liberalism such as the Griffith’s Report of 1983, to bring about an alignment between clinical decisions and administrative decisions.’ (Griffiths 1983; Klein 1989 cited in Osborne 1993: 353).¹

In other words this form of regulation seeks to make clinical truth encompass administrative and economic efficiency in order to make economic rationality function as close as possible to the point of clinical decision making itself. Various initiatives that seek to bring together clinical and economic-administrative functions have infiltrated many areas of the health service. In the hospital setting in particular practices of self regulation that pervade many clinical practices and decision making such as audit and clinical governance guidelines have become increasingly normative. That is not to say that this is,

‘Simply a question of allowing the logic of money to take precedence over clinical truth. Rather, the former is to serve as a means of regulating the latter. Medical neo-liberalism is not about providing specific (e.g. financial) incentives to better, more efficient care, but about supplying the medical field with a vocabulary and rationality for being governed and simultaneously governing itself.’ (Osborne 1993: 354).

As this chapter has shown, the performance of the particular form of ‘medical science’ that is useful to the construction of ‘real’ emergency medicine is quite often well fitted to those that exist within a neo-liberal political and managerial framework. Evidence-based medicine has been suggested as one example of this. However, when paying closer attention to the everyday practices of social relations in A&E, the deployment of either mode of ordering, whether blurred together or distinct in the accounts of staff, must be seen within the wider context of their situated accomplishments.

¹ Osborne’s use of neo-liberalism in this context refers to a political discourse founded upon an ideal of self-regulation. Medicine as a professional practice that has historically been responsible for its own regulation (as a result of its ownership of clinical truth) is therefore understood by Osborne as sitting well alongside the politics of neo-liberalism. Clinical governance under this understanding simply becomes a consequence of this close relationship.

Thus, although staff may be enrolled in forms of regulation produced through clinical governance, these may be subverted or reinterpreted. However, the very existence of such forms of regulation and the continual work undertaken by staff in negotiating, and in some cases resisting them, means that although they may not produce the intended consequences of an increasingly self-governing medical profession that regulates its actions on the basis of government guidelines and regulations, they are still produced and reproduced in the very actions that seek to resist such regulation.

What this chapter has shown is that knowledges aligned to both medicine and governance are reproduced in talk, text and materials within A&E and in some cases the boundaries that separate them have become increasingly blurred. The meanings and interpretations attributed to such knowledge production however remains complex. Osborne's (1993) account of the increasingly shared ideologies of medicine and the neo-liberal principles aligned with clinical governance holds some sway. In this analysis, Osborne argues that there has been a loss of the liberal profession that worked as a buffer to the direct intervention from government into medical acts by non-medical authorities:

'neo-liberalism thinks it may be able to govern medicine without even governing it through the competence of physicians, but by programming it to be like a market, so that it can govern itself.' (Osborne 1993: 355).

However, the research material provided here also supports the analysis of Hunter (1994), who suggests that the power and autonomy of the medical profession remains through the shifting of managerial concerns to the wants and desires of medical professionals.

Where this research departs from both of these arguments is in showing how that the accounts and practices of medical professionals draw upon multiple modes of ordering in their work of producing 'real' emergency medicine. These include aspects of clinical governance and managerial orderings. This is not to appease political moves towards further regulation, nor is it entirely the result of a coming together of neo-liberal and biomedical ideologies, although both these arguments have been useful in formulating this analysis. Rather, these modes of ordering are drawn upon in order to re-assert medicine's status through re-constituting aspects of managing as forms of clinical reasoning, or clinical necessity.

As the examples provided in this chapter show, managerial orders are increasingly a part of the interactions medical staff have with patients and are also present in staff's accounting for their work. However, these orders are deployed in order to accomplish particular clinical attributes that help re-establish medicine's dominant position. Aspects of managing health care such as efficiency or multi-disciplinary work are re-constituted in order to show their dependence on clinical experience, an integral part of the performance of medicine as a unique and elusive knowledge form.

The work of medical professionals in practicing and accounting for medicine as a means with which to re-accomplish medical dominance is therefore carried out through continual shifts of alliance between different modes of ordering while also re-constituting these orderings as existing within the guiding principles of 'real' emergency medicine.

Chapter 9

Discussion and Conclusions

‘Dirt then, is never a unique, isolated event. Where there is dirt there is a system. Dirt is the by-product of a systematic ordering and classification of matter’ (Mary Douglas 1966: 35)

Through a concentration on critical moments in negotiating access to A&E, that I have referred to as ‘moments of accessing’, this thesis has provided a detailed description and analysis of the multiple ways in which ‘real’ emergency medicine is performed. This chapter brings together the different facets through which such a performance is accomplished, that have been drawn out and discussed in each chapter. In considering these different modes of ordering alongside one another it becomes clear that it is the relations between aspects of medicine, management, and moral worth that provide the materials with which A&E staff are able to produce emergency medicine. Furthermore, it is through the constitution of A&E as a threshold space that allows for these relations to be re-affirmed.

A&E is shown to be continually constituted as a threshold space, where the negotiation over access to the resources of emergency medicine occurs. As a space in-between, between the outside world of publics attempting to gain access to emergency treatment and the inside world of emergency medical expertise, it is a space through which patients must attempt to pass (Garfinkel 1967). Significantly, the constitution of this space also made it necessary for the researcher to attempt to pass. Although in a quite different position to those patients attending A&E, the researcher was also in a state of potential crisis whereby her role and legitimacy was being continually worked out in everyday interactions with those in A&E. The work of creating A&E as a threshold is shown to be accomplished in a multitude of ways by those within A&E. The organisation of space and the division of labour, or rather the ‘labour of division’ (Hetherington and Munro 1997), are shown to create a space in which the work of ordering can be done. The technologies of managing that mediate all parts of A&E work have been shown to provide further means with which to re-assert A&E as this space in-between where practices of ordering can be undertaken. Significantly, this involves not only the ordering of patients for treatment, but also the

sorting and ordering of medical work, emergency medical provision, the managing of emergency medicine and the categorising of patients as 'citizens'. Therefore, as the thesis has illustrated, by constituting A&E as a threshold space, staff are better able to perform and uphold the notion of 'real' emergency medicine.

For Douglas (1966), boundaries exist that uphold the wholeness or completeness of individual categories and keep them separate and distinctive from other categorised groups within the system. However, she suggests that in the social world, instead of there being definite hard barriers that separate one category from another, there are in fact other spaces that exist like 'margins' between categories. Those people or things that exist within these margins 'are somehow left out in the patterning of society... are placeless' (Douglas 1966: 96). Thus, in creating a marginal space where people and things become placeless, members of staff are able to carry out the work of placing them, of sorting out who and what fits where. It also allows staff to order patients, clinical work, aspects of managing and even researchers and their areas of interest in relations that best help establish emergency medicine as a space for clinical expertise and a space in which 'real' emergencies are attended to. This ordering work therefore serves not only to re-make the divisions between who and what does and does not constitute an 'emergency medical case' but also works to re-make the divisions between aspects of managing and medicine, that, as this thesis has shown, have become increasingly blurred in the roles and responsibilities of A&E staff.

The ambiguous position of the researcher as moving between being a partial member of A&E and being positioned as an outsider, through my interest in the 'socials' and the 'a-copias', brought to light how moments of accessing must be worked out, negotiated between staff and patients and that these moments were integral to the performance of emergency medicine. Such moments were important for establishing what held value and are shown to be produced through the constitution of A&E as a threshold; it is this constitution that induces in patients the need to provide accounts and legitimate their attendance. Processes through which access was granted or denied were integral to the way staff performed and accounted for the purpose of A&E as a service, their own competence as physicians, and most significantly the ordering work of patients.

In my own moments of accessing medical staff would work to shift and re-claim my research onto clinical grounds thus attempting to manage my research and its pollutants, 'the a-copias' being one, so that it could become a part of the performance of 'real' emergency medicine. Moments of accessing, produced through the creation of A&E as a threshold, provide staff with the materials through which to re-order patients and materials to separate the production of the purely clinical and keep it away from the pollutants of social or emotional need. Thus, medicine has been shown to be deeply implicated in the organisational politics of A&E which have important consequences for how patients are treated. It is the complex relations between the spaces, rhythms, administration, division of labour and management of A&E that are re-ordered by A&E staff to best fit the performance of 'real' emergency medicine.

Through the materials presented here, the argument set out at the beginning of this thesis (Chapter Two) holds, that medical knowledge cannot be understood outside of its practical and discursive enactments, or performances. These practical and discursive enactments have been elicited through the examination of the accounting work of A&E staff to show how A&E medicine differs according to the situational context in which accounts are brought into play. For example, the production of A&E medicine in an account of A&E as a service provider may differ from an account made to legitimate a particular clinical decision. However, what all these accounts show are the means with which medical staff shift their accounts, and may align themselves to different modes of ordering in order to re-establish the high expertise and importance of emergency medicine, as clinical work and as a service provider.

The maintenance of 'real' emergency medicine as a coherent whole involves a great deal of work for medical staff. The heterogeneity of medical and nursing knowledges and their local and material production makes the work of producing emergency medicine particularly precarious. The 'front stage' task of sorting and prioritising patients is the hard graft, where the danger posed by polluting patients who may threaten staff's performance of 'real' emergency medicine is experienced most intensely. Front stage is where staff divide and order patients according to how well they fit the 'definition of the situation' thus accomplishing both what real emergency medicine *is*, but also importantly what it is not. The work of providing the definition of the situation which both re-produces A&E as a threshold space and disciplines

patients according to 'good citizenship' is in part accomplished through the work of ordering patients. 'Real' emergency medicine is thus defined through patients' achievement or failure to gain access to emergency service provision.

The disciplining of patients, whereby patients are not simply excluded (placed in triage category five or sent to room eight) but rather are educated and enrolled in the production of the 'real' through moral technologies and governmental strategies, is a further means through which the performance of 'real' emergency medicine can be upheld. The managing of patients through the physical spaces of A&E re-asserts the separation made between the 'true' emergency cases and 'the crap'. The technologies of managing, such as auditing, regulations to meet government targets, clinical guidelines, and the general administration of A&E, are shown to bring to the fore the conflict between the delivery of emergency medical provision and the public's claims to these resources, providing further means through which A&E as a threshold space can be made.

The hard graft of ordering work carried out front stage is also highly desirable as it provides the tools through which A&E staff are able to re-set the boundaries of emergency medicine to show what is of value and what is not. It is only through such hard graft that the 'purely clinical' patient can be separated from the pollutants of 'trivia', 'a-copias' and 'socials' for example. Furthermore, this work is difficult. As discussed in Chapter Eight, management tasks are increasingly intruding into the performance of what is 'purely clinical'. The threshold space is therefore needed, so that staff are able to re-make the divisions (Hetherington and Munro 1997) by shifting managing work onto clinical grounds, thus re-accomplishing medical dominance and A&E as a space of clinical expertise.

It is unsurprising that the calls to ration and manage patients as a group claiming resources are most overtly made front stage. These tasks of sorting and prioritising continue once patients have entered into the legitimate space of A&E patient. Levels of legitimacy are continually being produced by nursing staff, so that the doctors' time is most 'efficiently' used for those patients deemed to be most in need. Staff thus create and re-create a space where ordering work can continue so that notions of

worth and notions of 'crap' can be re-affirmed in the everyday practices of assessing, treating and prioritising patients.

Two particular modes of ordering have come to the fore in bringing together and analysing these multiple accounts: a particular construction of medicine with aspects of managing that have become embedded in its production, and, the ordering of patients based upon notions of responsible citizenship. The performance of medicine is shown to be built upon a combination of the elusive experiences garnered from clinical practice and the objectification of disease in the body. What has been shown is that such a performance of medicine creates a knowledge that is more than the sum of its parts. Clinical truth is read and produced through the work of medical professionals, thus re-accomplishing medicine as a dominant and specialist knowledge base. It is suggested here that ideas pertaining to 'clinical' management which emerge from forms of clinical governance and the general systems of health services, can also be found embedded within these accounts of medicine.

This particular medical performance does not necessarily stand in opposition to the forms of regulation that exist within A&E. Rather than focussing on the question of clinical autonomy, the research has sought to analyse linkages in conceptual frames between aspects of governance and the particular performance of medicine's knowledge practices that have been observed. The specific practices undertaken as a consequence of forms of regulations have been analysed for how these discourses or texts sit alongside those of medicine. In particular the importance of regularities for the performance of medicine within A&E sits well with governance programmes that attempt to shape clinical decision-making on the basis of national guidelines or in the case of evidence-based informed regularities, on the basis of prior research findings.

In understanding medicine through its performance in practical enactments it is possible more fully to comprehend how medicine is capable of taking on other forms of knowing that may fit or aid its purposes. Therefore clinical governance, suggested as a more penetrable means of curtailing and regulating clinical autonomy, may on the contrary have become further means for accomplishing good medicine. Thus, forms of self-checking, auditing, and managing have become part of the everyday processes of medical decision making, however, these have quite different repercussions than

the loss of medical power. Furthermore, aspects of efficiency, throughput, and appropriate use of resources have increasingly become a part of what medical staff now understand and account for in their work of reproducing medicine. Some elements of the particular performance of medicine presented in this thesis have also been shown to sit well alongside discourses of managing, so that aspects of rationing resources become a part of defining and accomplishing medically pure, clinical emergencies.

Where this research contributes further to other accounts of the relationship between forms of governance and medical decision making is in showing that it is through the actions and interactions of medical staff themselves in practising and accounting for their work that both systems of ordering are produced and reproduced. Staff may deploy discourses aligned to either or both mode of ordering in order to show their competence, achieve a desired outcome, or re-accomplish medical dominance. It is therefore through the continual shifts of alliance between these different modes of ordering that a combined medical and managerial order is produced.

Perhaps even more significant is that although both discourses are apparent in the accounts of medical staff, they are re-constituted as ways of thinking that reflect the guiding principles of medicine, thus helping to reaffirm medicine's dominant position through the appropriation of managerial orders. Through the constitution of A&E as a threshold space, staff are able to re-create the divisions between medicine and managing by shifting around ideas and practices so that those belonging to the managing of health care are re-arranged to become principles of clinical work. Thus, multi-disciplinary work becomes 'the medical solution to the problem' and ideas of managing are re-made and become dependent upon clinical expertise and experience and being able to act upon clinical truths.

Osborne (1998) and Greco (2004) have suggested that in understanding medicine as ideological we are better able to understand its spread into and across other forms of knowledge outside medicine. In building upon and contributing to this work, this research shows how medicine understood as a performance practice is able to shift and alter its own boundaries so that other forms of knowledge can be enrolled and re-produced as medical ways of knowing.

The second mode of ordering that has emerged from this study of A&E is the ordering of patients according to aspects of citizenship or, more specifically, to aspects of citizenship that construct the individual's responsibility to manage their own risks of ill health: the 'health responsible citizen'. The health responsible citizen is shown to be continually made, not only in the actions and interactions of patients and medical staff, but also in the forms of disciplining that occur through the materials and spaces of the department. Personhood aligned to particular constructions of citizenship provides a further means with which staff are able to place patients into categories of 'good', 'bad', 'legitimate' or 'illegitimate'. These constructions work to produce moral orders of good citizenship, which have increasingly encompassed the responsibility and duty to manage health risks and to limit claims to health care services and resources. These must be accomplished by patients in their negotiations with staff to gain access. Knowledge and understanding of such duties must be deployed in the accounts of patients in order to achieve 'passing' (Garfinkel 1967), to gain entry to the role of legitimate A&E patient.

Ideas of governing health and health care at the level of the personal as well as the structural are not particularly new (Rose 1999, Sointu 2005). These contributions have to some extent reflected the shift in medical knowledge practice towards the construction of 'the whole person'. In these works this shift is positioned as a result of political developments in favour of not only individual choice and freedom (embedded in the Conservative governments of the 1980s and 90s) but also individual responsibility for promoting health and securing oneself against the risks of ill health. The impact these have had on the increased rationing of NHS resources is well documented. The responsibility to manage health risks through action such as changes in lifestyle choices, increased exercise, smoking cessation and improved diet have all become part of our responsibilities as individual citizens. This is reflected in British policy (DOH 2000) and has been mirrored in the policy strategies for Wales (Welsh Assembly Government 2005; 2004).

How this thesis has added to these debates is in showing how patients themselves are being enrolled in and subjected to forms of disciplining that encourage duties to manage and regulate their individual health risks, so that they are re-producing the

good citizen in their own accounts and justifications for claiming access to resources. A&E as an institution of moral technologies is revealed to produce forms of governance in the everyday negotiations over access to hospital services. These negotiations are therefore shown to enrol patients in discourses of good citizenship. Further still, these discourses connect to and (re)produce 'real' emergency medicine.

In understanding the boundaries between what we think and feel in relation to how we act, between the publicly and the privately concerned self, we are able to shed light on Foucault's 'mode of subjection, that is the way in which people are invited or incited to recognise their moral obligations' (Miller 1993: xii). In this sense personalities, subjectivities and 'relationships' are not private matters but are objects of power that are intensely governed (Rose 1989). These ideas are particularly salient for the argument being put forward here as patients are governed through disciplining practices that are not rules or formal practices of regulation, but instead make calls to patients' own recourse to discourses of responsibility and duty in relation to burdened health care resources. This is exemplified in materials such as the leaflets entitled 'Why Must I Wait' but also through interactions with medical staff, particularly during moments of accessing. It is through the creation of A&E as threshold that forms a place where it is not only medical staff who sort and order patients, but where patients 'sort themselves out' according to their responsibilities as health care users.

There is some disparity between the conception of the citizen, the self and their affects that is put forward by both Rose and Miller and the arguments of this thesis. Orderings aligned to particular aspects of citizenship form a specific governmental tactic or technique. Its power therefore is embedded within the social relations of discourses and practices that uphold such notions, particularly within apparatuses of security (Foucault 1978/1991) such as this A&E department. The citizen can therefore only exist and have affects in the language and practices of those making accounts. In a similar way 'the contemporary self' cannot exist as an objective truth but rather exists as a particular mode of ordering that disciplines those A&E patients who are enrolled in its (re)production.

The significance of what this thesis has shown is that these moral orderings can be elicited not only through forms of governance but also through the production of

medical knowledge practice. Entry into illness categories is accomplished through negotiations and interactions between patient and practitioner, where the patient's moral responsibility as a member of society must be adhered to. This research illustrates how medical discourse has come to extend such moral orders so that patients must display knowledge of their duties not only to want to get well but to stay well thus limiting the risks of becoming unwell and burdening already strained health services.

Morality and medicine have long been conceptually linked, most notably in the work of Parsons' (1951) and his notion of the sick role. Moral orders through which medical staff are able to assess and categorise patients has therefore long been noted as an important part of the way staff organise their work. Where this research contributes further to these ideas is in showing that moral orders are produced in and through forms of governance existent in the social relations of A&E. These are produced through particular forms of disciplining that work to encourage the self-regulation of those who are enrolled in them. Materials in the waiting area such as the 'why must I wait' leaflets outlining the prioritising of patients according to clinical need, must not be regarded as texts that merely present clinical truths regarding cases of more or less urgency. These texts are political manoeuvres that work to enrol patients who read them into the reproduction of A&E as a site of highly expert clinical practice that is heavily burdened: 'real' emergency medicine.

This research has thus identified these dominant modes of ordering as being important to understanding social relations within A&E: the health responsible citizen and the specific relations between medicine and management. Both these modes of ordering are important in helping staff to perform 'real' emergency medicine at different times and in specific contexts. As this thesis shows, these modes of ordering also link and map on to one another in important ways so that 'real' emergency medicine can remain dominant and can be successfully performed. The relations between these modes of ordering are therefore particularly significant for A&E patients who form an integral part of this production.

It was argued in Chapter Two that previous literatures on the ordering and categorical work of medical knowledge practice have paid little attention to the consequences of

knowledge production for patients, with a few notable exceptions (Latimer 1999; 2000; Mol 2002; Silverman 1987). This thesis builds upon work that demonstrates the important consequences that the production and performance of medicine has for patients. The technologies of administration that mediate and help accomplish a combined medical-management mode of ordering, particularly at the threshold are shown to create a space in which it is difficult for staff to respond to patients as full moral subjects.

The front stage area where the hard graft of sorting and managing patients is carried out has been shown to be a potential space of demoralisation. Calls upon medical staff to manage, order and prioritise patients are made on the basis of a particular performance of 'real' emergency medicine. This performance seeks to reproduce clinical authority while accommodating ideals of efficient service provision through the administrative technologies that mediate the relations between staff and patients and place in the foreground a concern for resources. It is the combination of these factors that create a space of moral lacking, where proximity between staff and patients is reduced.

Both the space of demoralisation and the practices of effacement that work to reproduce it are accomplished through the organisation of social relations in A&E. As has been previously stated, effacement work both responds to and further creates a space of demoralisation. The strategies employed by staff to efface patients as moral persons are in part informed through the two modes of ordering that have been brought to light in this thesis' analysis. These strategies of effacement are interrelated with 'modes of ordering' in important ways. First, the reduction of patients to claimants attempting to gain access to limited resources reflects the call to all medical staff, but particularly nurses at the threshold, to manage resources for those patients of 'real' clinical priority.

Secondly, the (re)production of negatively constituted attributes so that the patient may be dissembled and reduced from their full self and become a representation of this negative attribute has been shown to occur in part through the discursive alignments to aspects of good citizenship. Patients are shown to be more at risk of being effaced if they do not provide accounts that fit the definition of the situation and

aid the particular performance of 'real' emergency medicine. This is because notions of efficient care, resource rationing and pure clinical expertise make some patients particularly threatening to staff's success in performing 'real' emergency medicine. As a result these patients are shown to be less likely to be read as full moral subjects and are more likely to be reduced to an illegitimate claimant. The case of Mrs Preston (Chapter Seven, p.167) an elderly woman who is left to clean the blood from her face is a poignant example of how the performance of emergency medicine has important consequences for the care of A&E patients.

Finally, shifting moral responsibility towards the institution itself as the rational regulator of moral action is a means with which staff's accounts further produce A&E as an institution for educating and disciplining citizens. This institutional moral responsibility not only shapes the behaviours of the patients who are expected to provide persuasive accounts of their actions as good citizens, but also acts as a moral caretaker, safeguarding against individual practices that may be morally lacking.

Staff typifications of patients are also shown to be sustained through the performance of 'real' emergency medicine. The ways in which patients become particular types in staff's accounts and interactions with them are caught up in the continual reconstruction of emergency medicine as either purely clinical, efficiently managed, or a space of correct and responsible service use. It is through the performances of these medical knowledge practices that patients become 'crap', 'trivia' 'socials' or 'a-copias'. Patients are 'crap' because they threaten the success of the performance. A 'social', for example, threatens the performance of a purely clinical, highly expert emergency medicine in the same way that an 'a-copia' may threaten both an efficiently managed emergency medicine and emergency medicine as a space of responsible service use.

Where this research departs from earlier works that establish moral orders as forms of stereotyping, reducing patients to passive objects in assessment work, is in its focus upon processes of negotiation. The placement of patients into staff constituted patient categories is to a large extent reliant upon the accounts made by patients themselves: the good reasons and justifications for their attendance at an A&E department. These

are not easily accomplished and the implications for those unable to provide such persuasive accounts are significant.

The consequences of patients being ordered according to their ability to negotiate access through a performance of ‘good citizenship’ are highly significant. If it has become the responsibility of citizens to secure themselves against the risks of emergency health problems, the emphasis is placed not on their *absolute* need but on their duty to justify their need. The health service under this conception does still have some duty but its role changes and becomes a means of managing collective risks by taking on those risks that are shown to be unavoidable (Joyce 2001). The problem that arises, especially for older people, is that choices regarding the avoidance of health need are not always open to everyone.

This study has shown how patients are being expected to have knowledge of their responsibilities and duties as moral citizens to limit their claims to resources and furthermore this knowledge must be performed in specific ways. This performance is not easy and involves a great deal of work: patients’ needs for services must be explicit, while knowledge of their rights to these services must be effaced; knowledge of the health care system must be deployed in order to show appropriate service use, while knowledge of the best means of obtaining such services must be effaced.

The expectation of citizens to better oneself and ones family for the good of the nation has historically been part of what was considered good, decent, moral behaviour. Notions of betterment have thus been inherently linked to economic success and in contrast economic failure has been viewed synonymously with moral lacking. National and personal economic prosperity are individualised as part of a citizen’s moral responsibility:

‘The more you look on wealth as conclusive proof of merit, the more you incline to regard poverty as evidence of failure – but the penalty for failure may seem to be greater than the offence warrants.’ (Marshall 1964: 88).

In this thesis it is asserted that the national economic burden of health services have become individualised as the moral responsibility of potential A&E patients who must limit their personal contribution to this national burden. In the current context, where aspects of health and well being have been reconstituted as part of an individual’s

choice (Greco 1993) and moral responsibility as a good citizen, those who show themselves to be in need of health services, are deemed to be deviant and lacking in moral worth for failing to guard against the risks of ill health and thus increasing the burden on health services provision.

For Bauman (2001), this individualization of difficulties that have arisen due to wider social circumstances is increasing. People's troubles and misfortunes are individualized and understood as the 'inadequacy of the self' rather than being dependent upon conditions outside the realm of an individual's control.

'[This] helps either to defuse the resulting potentially disruptive anger, or to recast it into the passions of self-censure and self-disparagement or even to re-channel it into violence and torture aimed against one's own body.' (Bauman 2001: 5).

It is the frustration of governing our own actions and lives in order to take responsibility, be autonomous, free and respectable (the elements that make us full citizens), yet simultaneously suffering the fate of conditions that exist outside of the possibilities this allows for us, that Bauman is making reference to.

'Marx said, famously, that people make history but not under conditions of their choice. We may update that thesis as the times of 'life politics' demand and say that people make their lives but not under conditions of their choice.' (Bauman 2001: 7).

Bauman is suggesting that this pursuit of citizenship has shifted from simply being a question of rights and building a sense of community to encompass a quest for a self that is both personally and publicly acceptable. In establishing the values that uphold what it means to be a citizen there must inherently be a process of ordering, subsequently there will always be some who are deemed unfit or out of place as a result. This thesis has shown that those unable to account for their claims to services upon a personally and publicly acceptable self, upon the orders aligned to good citizenship, are being excluded in the ordering of patients for emergency health services.

Ideas of citizenship are being continually reconstructed, in the current context, to incorporate a personal responsibility towards economic success (helping to maintain national prosperity) and moral worth. These responsibilities are growing, to the extent that our biological make up is no longer outside of our field of influence (Rose and Novas 2005). This thesis has demonstrated that a central part of this

responsibility is the correct use of services. Patients and citizens are being constituted increasingly as consumers of health care services and, as such, hold a greater personal responsibility to use the services that are available effectively and appropriately. This has become part of their moral duty as citizens in order to limit their risks of ill health and therefore the burden on health care services generally. Part of this duty is to limit the risks of inappropriate use of services that can result in problems of bed blocking, increased waiting times, and further demands on medical staff to increase through-put and in the case of Accident and Emergency, to assess and dispose of more patients more quickly.

Those patients who are not able to perform the good citizen through the presentation of correct and limited service use, are at much higher risk of suffering the consequences of being placed in negative, staff constituted patient categories. The thesis has shown how patients can be disciplined. This disciplining can be in the form of refusal for treatment either through being sent to room eight or through simply being left to wait. Those patients who are left to wait are deemed worthy of punishment.

Being sent to room eight is also a punishment but one of a different kind. This punishment seeks to publicly embarrass the patient through explicitly and openly defining their problem as not worthy of emergency attention, it is also a means with which the patient is disciplined as they are passed on to the 'more appropriate service'. This punishment therefore attempts to help make good citizens by showing them how they are best able to manage their use of services in future.

Being left to wait in category five however, is a disciplining of a different kind. The patient is left to wait until such time as they come to realise that they are being left. This punishment is the waiting itself rather than the effect of the waiting, as not all patients will understand why they are being left. The increased concerns over accountability is important in staff's decisions about which patients are openly refused treatment and which patients are triaged under category five and left to wait. Patients refused treatment are more often patients whose condition is easily definable, so that a patient with cystitis is clearly 'not a true A&E patient'. However, a young

man with stomach pain, also perceived by staff to be illegitimate, is left to wait; his problem is less easily accounted for.

The thesis demonstrates that the categorising of patients as different types of ‘crap’ results in a variety of consequences, with the refusal of emergency services being the most overt of these. As well as being simply left, waiting with no hope of being seen, there are those who are not refused treatment and who gain entry into a triage category where they will be seen. However, they may be left to wait longer, they may be given less information, they may be less likely to get responses when asking for help or simply they may not be treated as kindly by staff as other patients. These practices of punishment and discipline, as well as acting as barriers to health services, have important consequences for patients’ experiences of care. Being left to wait indefinitely can leave patients feeling hopeless. Furthermore, the public refusal of access to emergency services works to re-affirm to patients that there are no rights to public care, that the receipt of care from public institutions is no longer given without patients working hard to justify their need.

There are also more subtle consequences of the performance of real emergency medicine that are highly significant for patients’ experiences. The descriptions offered in the previous chapters of medical staff’s accounts of the patients that ‘should not be here’ are also manifest in their interactions with patients. The reduction of patients from full persons to mere ‘socials’ or ‘a-copias’ makes it increasingly difficult for them to be treated as full persons. What this research has shown is that those patients who have become a mere representation of a negative type of patient, reduced from their full selves are at times being treated on this basis.

Mrs Preston (Chapter Seven, p.167) is treated not as older woman in need of care, reassurance and dignity but rather she is treated as a representation of another ‘social’, another older patient who has had a fall. The trauma of the fall is negated by the social circumstances of the patient’s age and thus threatens the performance of ‘real’ emergency medicine. The consequence of this for Mrs Preston’s care is that she is made to tend to herself: to sort herself out. It is the dominant modes of ordering that have been explored in this thesis that help constitute A&E as a threshold space in which Mrs Preston is made to tend to herself, thus re-affirming the ‘true’ purpose of

A&E. Indeed, contemporary health care organisation seems increasingly to shift responsibility and work onto patients, as people who should 'sort themselves out'.

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