Building, Reality, Caring: What Nurses in Three Australian Psychogeriatric Assessment Units Say about the Built Environment

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A thesis submitted in fulfilment of the requirements

for the degree of Doctor of Philosophy

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School of Behavioural and Community Health Sciences

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I certify that this thesis entitled *Building, reality, caring: what nurses in three Australian psychogeriatric assessment units say about the built environment* and submitted for the degree of Doctor of Philosophy has not been submitted for a higher degree to any other university or institution. I also certify that this thesis has been written by me and that any help I received in preparing the thesis, and all sources used, are acknowledged within the thesis.

Signed .....

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Abstract

The belief that 'purpose-built' environments will diminish some of the challenging behaviors exhibited by older people with dementia or psychiatric conditions is widespread. This belief is focussed on outcomes, but how nurses experience the built environment in the course of caring for people exhibiting these behaviors is rarely spoken of. This study aims to explore and understand what hands-on nurses in psychogeriatric assessment units experience and think of the built environment as a part of their day to day work.

I conducted twenty-one unstructured interviews with nurses at three psychogeriatric assessment units. I chose the units to maximize contrast in building styles. These ranged from an ancient adapted building to contemporary 'purpose-built' facilities. I began the research using a 'grounded theory' approach to categorize and describe phenomena. However the emergent necessity to explore the nurses' point of view led me to develop an approach drawn mainly from Hans-Georg Gadamer's writings on hermeneutics.

The principal findings were that nurses think of the built environment in relation to the care needs of their patients. They found bureaucratic restrictions on adapting the built environment to care needs more frustrating, than the shortcomings of their particular environments. In search of a deeper interpretation, the findings led to an

airing of the implicit polemics arising from nurses' sense of frustration. These placed nurses' experiences in relation to the surrounding socio-historical context, in which nurses felt themselves, together with their patients, to be 'outcasts' or victims of those with money and power.

The study concludes with suggestions for challenging the status quo, but also considers that being regarded as 'outcasts' allows opportunities to avoid being overly impressed by technological marvels. After all, living is not a matter of outcomes, but of encounters.

Acknowledgements

I am deeply in debt to my beloved, Anastasia, for putting up with years of abstraction, frustration, and for her understanding of my not understanding. Finished with love and rage for my friend and activist colleague Peter McGregor, who had the courage to choose to end his life with dignity Friday, January 11th, 2008, aged 60.

Style Conventions and Abbreviations

The following style conventions are used in this thesis:

Double quotation marks indicate direct quotes from published literature, interview transcripts or the author's recollection of conversations.

Square brackets enclosing the letter 'p' ([p]) are transcriptions of pauses in interviews.

Three ellipsis points (…) indicate that material has been omitted from a quote.

Single quotation marks indicate an emphasis on a word or phrase.

Abbreviations are defined the first time they occur, however, the following two commonly occurring abbreviations used that may perplex readers:
PAUs (Psychogeriatric Assessment Units) which are acute inpatient wards; and
SCUs (Special Care Units) which offer long term residential care to people with dementia.

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Introduction

As its population ages, Australia is witnessing a building boom of aged care facilities. These facilities are more than mere housing: they advertise themselves as ‘purpose-built’, ‘state of the art’. They carve out niche markets ranging from ‘resort-style retirement living’ to ‘assisted living’ to ‘dementia-specific’ facilities. We can no longer say that aged care is being neglected. It has become a growth industry for pharmaceutical firms, interior decorators, equipment manufacturers, computer firms, laundry and cooking contractors, education and training organizations, personnel management, and architects. While human inventiveness has found fertile ground in designing solutions to all the problems and ills that the flesh is heir to, this influence of design on aged care and health is only a case of the wider application of design to society, and the planet itself.

What it means is that we live in the age of Design. It is a new form of power that has emerged from the combination of advanced mechanistic science and mass organization in the service of Capital. Everywhere we turn, whether at home, at school, at work or at play, we encounter systems that direct or prohibit us. These systems always impress upon us their rationality that what they command or provide is for our own good and the good of society. The difference is that in our cybernetic age, they are no longer the moral strictures of the past, which we could ignore. Instead they saturate society, compelling our participation. Design has gone beyond the dreams of the industrial revolution, the imitation of craftwork and its mass production. Now it invents both the products and the ways of life to ensure those products are consumed.

In the cybernetic field, Hookway (1999) identifies this transition as the contrast between ‘record-playback’ and ‘numerical control’ systems. In record-playback systems designers studied how people did things, and built systems that imitated those actions. In numerical control systems, designers decide from the very outset what will be produced and how it will be produced. This shift can be seen in the rise of Internet banking at the expense of the branch teller. The underlying dream being marketed is one of efficiency and reduced costs, and the promise to the consumer of convenience. In reality, it makes possible the automatic and anonymous control of banking by the designer at the command of the Board. Even opportunities for customers to complain directly to the tellers and the managers have been designed out. Should they insist, their complaints are deflected by another numerical control system, the telephone menu at the call centre.

The same dream of a mechanism that will operate efficiently, irrespective of who is working the machine, underlies the modern idea of ‘purpose-built’ aged care facilities. The idea of the purpose-built facility has its justification in the idea that the built environment can maximize the residual strengths and minimize the disabilities of the frail and confused elderly. Instead of labour-intensive care, with all the headaches of training, rostering and paying staff, a well-designed building would work around the clock and reduce the need for staff. This idea of replacing individual human intervention with an efficient apparatus is not new; it is a development of the institutional tradition made possible by new technologies. Electronic covert surveillance, for instance, can replace direct observation. This allows the consumer to take some risks, yet permits intervention when deemed necessary. If consumers are

permitted to exercise choice, then they are residents in a ‘facility’, rather than inmates of an institution.

I work as a ‘hands-on’ enrolled nurse[1] in an area that - because it is difficult, unattractive and takes care of only a few people who fall through the cracks between aged care and psychiatric systems - will never be of overriding importance. Psychogeriatric Assessment Units (PAUs) are a handful of ad hoc units that admit older people with serious psychiatric problems or those exhibiting challenging behaviours as a result of dementia. When I trained as a nurse twenty-five years ago, such patients were housed in the run down ‘back wards’ of large psychiatric hospitals. Some back wards survive but, since most of the large psychiatric institutions have been closed, PAUs can be found in a mixture of modern ‘purpose-built’ and adapted settings. My experience of the day-to-day material realities in traditional and modern versions of these places lead me to doubt whether the designer dreams of the present are any different to the institutional promises of the past.

I found my nursing colleagues echoed these doubts in tearoom talk from time to time. These conversations sometimes became a chorus of heated agreement as we each recounted stories of institutional absurdities; but then they would subside. At work, there is no time for concerted analysis. I found that rather than dispelling doubts, existing research regarding the built environment and health care added to them, its dominant concern being with correlating behaviour to the built environment, rather

[1] In Australia, enrolled nurses receive less training and work under the supervision of registered nurses, although much of their work is similar.

than with the significance of the built environment in the daily lives of those who live and work in these places. It is for these reasons that I took up this study.

This study will not only be a study of how nurses think of buildings in the ordinary course of their work in PAUs, but will also play with the possibilities of where uneasiness with that thinking could lead. It begins with a reminder of the fundamental assumptions that shape our social world, in the words of those most qualified to speak - Chief Executive Officers (CEOs), their policy-makers and those functionaries who do their bidding. I then review the extravagant promises of contemporary health care research concerned with the built environment. After describing the contemporary status of PAUs, I provide a brief history of the asylum to remind us of its equally extravagant promises of cure, which are now forgotten. These delusions lead me to the little-known body of literature that reveals lapses at the heart of design and suggests the methodology for the study. This is a radical approach in the sense that it pursues concepts and problems to their roots well beyond the immediate situation, raising further and often contradictory implications.

This study asks:

1. What do people working as hands-on psychogeriatric nurses say about the built environment in which they work?
2. In what ways are these views the same or different between facilities utilising traditional institutional style-built environments and those housed in modern purpose-built settings?
3. What is conventionally accepted and what is indicative of unease in these accounts?

4. How does this unease relate to the broader socio-historical context?

The first study question serves as a way to begin unstructured interviews with people working as hands-on psychogeriatric nurses in traditional and modern in-patient settings. The ‘Grounded Theory’ method of constantly comparing emerging concepts with the data is used to describe what nurses typically say. The comparison between traditional and modern settings in the second question uses a case-study approach. Here, what is said is used to typify the facilities themselves as ‘cases’ that can be compared and contrasted. The third question returns the study findings to tearoom polemics. It gathers up the preceding descriptions and comparisons within an increasingly critical and provocative interpretation that could be loosely termed ‘critical hermeneutics’. It argues that nurses reveal an implicit unease in what they say about the built environment. Teasing out this unease to reveal the social issues involved demands a resolute polemic that refuses to be disqualified or to rest content with easy answers. It is this teasing that satisfies the fourth study goal.

Chapter 1: Background

Overview

Mills (1983:9-11) wrote that people often uneasily sense that their private lives are a series of traps, that their visions and powers are bounded by their private and everyday world, and they are powerless spectators unable to make connections between the patterns of their own lives and the massive, impersonal forces that shape the world they live in. To stand against a sea of troubles, he argues, involves being able to translate personal troubles and unease into public issues. The Psychogeriatric Assessment Unit (PAU) is an example of a small-scale milieu riddled with immediate pressing troubles that, in concerning only a handful of people, has little consequence in the broader scheme of things. The aim of this chapter is to locate the PAU within this broader context, and to give the reader some preliminary idea of its pressing troubles in order to begin the work of relating the immediacy of everyday life to the broad social forces shaping our times.

I begin the background to this study by imagining how our present society in Australia, as an instance of Western society, could be described by someone standing outside it, far way, from another time and place. I will work my way downwards, from a grand schema that, by posing the profit motive in the hands of Capital as the motor of the present, will probably provoke readers to charge me with outrageous bias. From there I will argue that the professional classes serve profit for the best and the worst of reasons. The science these classes practise is a blend of self-serving politics and technological problem solving bound to a naïve realism that has lost sight

of our need to understand the world we live in. Throughout these arguments, the PAU is glimpsed from far off - as a tiny troubled ship tossed upon a vast and troubled ocean.

Mills (1983) also writes that people do, nonetheless, make their own history even if it is, as Marx famously observed, under conditions not of their own choosing. Much of Foucault's writings help us to understand that milieux are not only shaped by external, massive forces, but by microscopic forces from within. Looked at in this way, the PAU is no longer a tiny fragment of society but instead looms large, reflecting the dynamics and history of society within it. Inside, individuals adapt to and struggle against circumstances that are given and yet, contestable. The problem, as Marcuse (1968) argues, is that doubts about the social order we inhabit are immediately thrown up to an impossibly high level of abstraction: the very same plane on which the Background began. On this point the Background chapter leads into the next chapter which is concerned with how to explore personal unease in a way that reveals public issues.

Postcards from above

I will not begin at the beginning where

> … all the ladders start,
>
> In the foul rag-and-bone shop of the heart. (W.B. Yeats, *The Circus Animals' Desertion)*

but at the top, with the masterful images and enchanting spells of our times. Glossy journals respectfully carrying the latest pronouncements of CEOs are a treasure trove of this culture. As an example, I have created a suite of ‘postcards’, as if a nurse from the PAU were touring the world as seen through the headings and by-lines of *Australian Health & Aged Care*, and the *National Healthcare Journal*. Imagine a group of nurses huddled briefly in their tearoom, receiving these snippets of wisdom from a colleague touring the happy lands above.

In postcard form, the phrases used these days by those who so freely command the resources of the world take on poetical, dreamlike qualities. Journals select titles for their power to immediately convey economic arguments, and accompany them with captions justifying the arguments in a glance. These executive summaries combine the compression of poetry with the evocativeness of dreams. This is not surprising, since the business of CEOs is to deliver dreams to shareholders. The blundering efforts towards a society where people cared mutually for each other is no match for the idea of populations as a source of profit. In a flash the past is eclipsed, we have before us revolutionary solutions illuminating a landscape of opportunities.

CORPORATISATION OF AGED CARE

As Australia's population ages, the business of taking care of the aged is undergoing a revolution of its own…

… Here we detail how Aevum's aged care business underwent significant change as it transformed itself from a mutual society with a "not for loss" approach into a public company owned by shareholders expecting regular dividends and capital growth.

Simon Owen, Chief Operating Officer, Aevum Limited.

Figure 1 Corporatisation of Aged Care (Owen, 2005:21).

Capital growth does not occur spontaneously; it has to be nurtured, protected against loss. A principal way to avoid loss is to cut costs. Strategically divesting responsibilities yet controlling assets is an excellent way of maximizing income. This strategy was pioneered in the shipping industry with the leasing of cheap 'flag of convenience' vessels to skirt the coasts of responsibilities (such as crewing costs and shipwreck). If we look at the post card below, we can see that in a competitive market beset by complex operating requirements, there are many good reasons to lease:

Aged Care Facility Owners:

New Opportunity to LEASE Your Business

10 GOOD REASONS TO LEASE:

Guaranteed cash flow.

Retain 100% equity.

Stakeholders continue to benefit from capital growth.

Staff become a member of a much larger family that has a strong focus on running facilities well.

The lessee answers directly to authorities and stakeholders.

Access to economies of scale.

Accreditation no longer your responsibility.

Long leases more attractive to lenders.

More buyers for your facilities that have a lease.

Reduced risks, eg. OH&S is not your responsibility.

Sam Fung, Managing Director, Garrison Ash.

Figure 2 Opportunities (Fung, 2005:26).

Leasing is only one of many opportunities. If we care to look, we find opportunities to make more revenue in every direction. Just as a foetus is 'plugged into' its mother via the umbilical cord, the foetus of profit can be 'plugged into' nourishing fund lines from government, the community and corporations. It does not

stop there. The foetus can be metamorphosed. Whatever mentality or models of aged care, these can be invented anew with a new consciousness, a ‘service mentality’. Why not develop the much-abused tired old ‘medical model’ into a ‘medical care model’ and combine it with a ‘hotel model’? When we care to look in this way, everything we once took for granted can be developed into a new form, granting it a new lease of life. It is only natural then that even nurses should be re-invented. In the seminar invitation below, if nurses are to grow, then it is not enough to be ‘just’ a nurse anymore:

EVERY AGED CARE FACILITY CAN MAKE

$500,000

MORE REVENUE EVERY YEAR…

This is not about grabbing more money from government.

This is a cultural change.

The introduction of a service mentality.

The introduction of a hotel and medical care model.

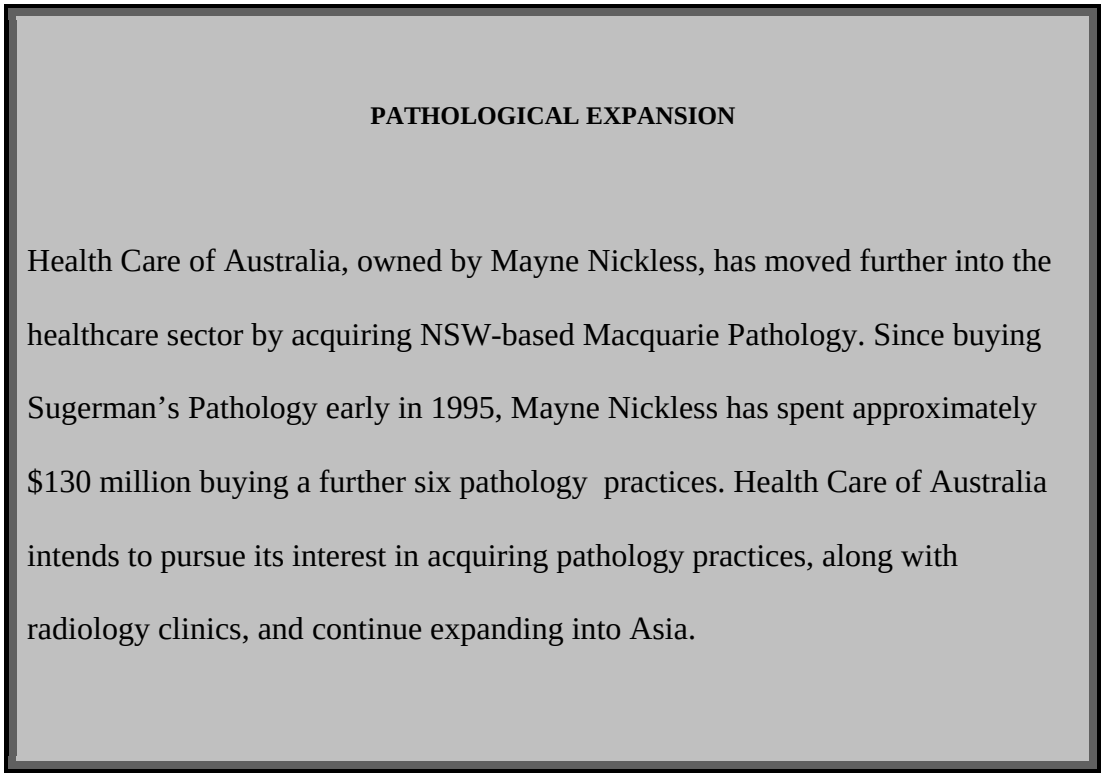
Where to find and tap into community funds.

How to plug into corporate and private fund lines to enhance revenue.

It is not enough to just be a nurse any more. All DONs/Site Directors must imbue their staff with a service culture.

Figure 3 Not enough to be a nurse anymore ($500,000 More Revenue Seminar, 2001).

Dreams dissipate, but the ones we remember have strong features. Similarly in the commercial world, for dreams to survive, it is wise to focus on a particular (or memorable) product and extend its reach. The title of the next postcard is a poor pun, but the strategy following upon it is bound to give shareholders confident expectations of riches:



PATHOLOGICAL EXPANSION

Health Care of Australia, owned by Mayne Nickless, has moved further into the healthcare sector by acquiring NSW-based Macquarie Pathology. Since buying Sugerman's Pathology early in 1995, Mayne Nickless has spent approximately $130 million buying a further six pathology practices. Health Care of Australia intends to pursue its interest in acquiring pathology practices, along with radiology clinics, and continue expanding into Asia.

Figure 4 Pathological Expansion (Anon, 1998:14).

Strategies of expansion depend on services of some kind being delivered, and we can see from the above that this relies on what is another miracle of growth: technology. If we want to know the shape of the future we are often told to look at California, the trend-setting state of the US:

CALIFORNIA: HEALTHCARE TECHNOLOGY DRIVES ECONOMIC GROWTH

A report by the California Health Institute (CHI) and KPMG Peat Marwick has found that healthcare technology now represents one of California's fastest-growing and highest-paid industries.

Figure 5 Healthcare Growth (Anon, 1998:18).

Combining populations with technology is such a promising investment prospect that thinking of Capital as ownership of factories and mineral resources will doubtless become outmoded. Once upon a time, hospitals and nursing homes were regarded as a cost upon society. Now the market can redesign society according to its desires and what was once a cost is becoming recognized as a 'legitimate' investment.

PROPERTY FUND MANAGERS LOOK TOWARDS HOSPITALS

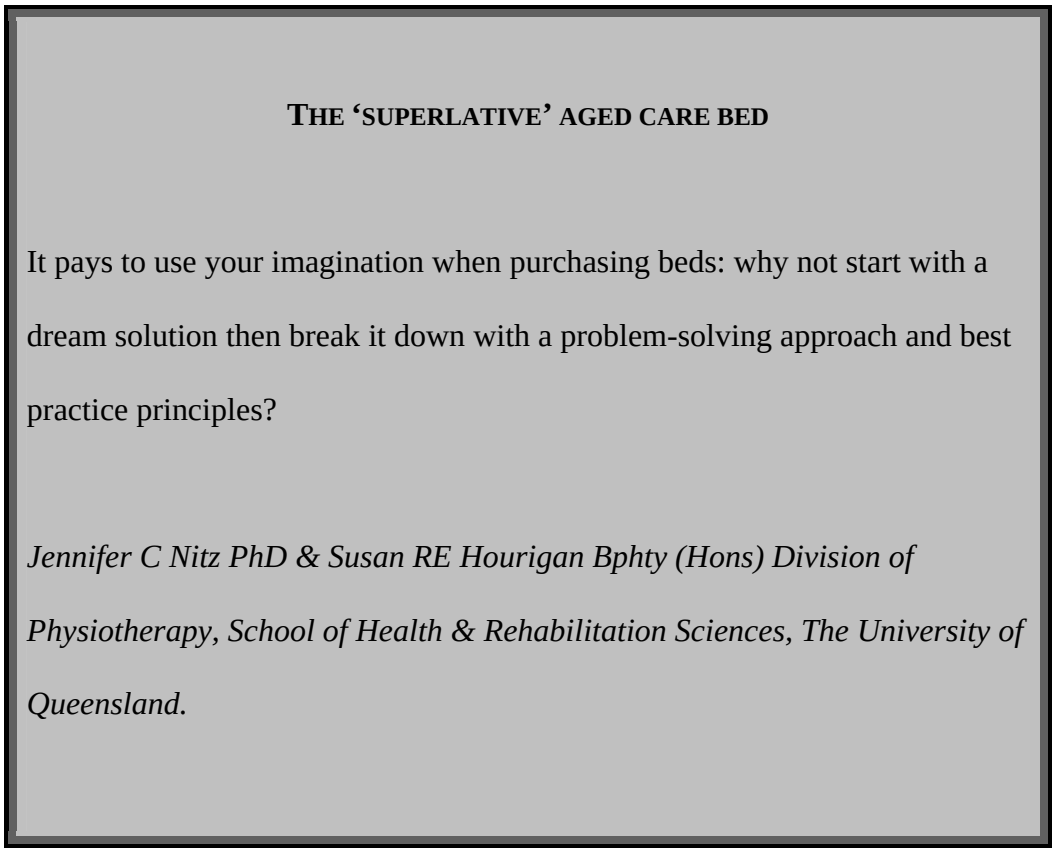
Considering the change in thinking about what constitutes property, there is every likelihood private hospitals and nursing homes will become a legitimate part of investment portfolios in Australia.

Figure 6 Legitimate Investments (Anon, 1998:10).

Boldly feminist, Waring (1988) regarded the concept of the 'Gross Domestic Product' as insane, because in it women's labour and the unpolluted environment are regarded as economically unproductive. She reminded readers that the GDP was not 'natural'. It was something invented by men, a way to pay for World War II. In it things that kill life are valued, but things that produce it are not. Now though, with the expansion of markets in every direction, who knows if investing in crises such as 'The Environment' or 'Aged Care' might turn out to be a road to an economics of sustainability and fairness that Waring dreamt about? Investment, like life, has always been a gamble. Once upon a time, sinners would gamble that they could save their souls by buying pardons from the Church. Legend has it that the stock market originated with gambling on the tulips market in Holland. These days, corporate polluters gamble on saving the environment by buying carbon credits. In the aged care market, the gamble lies in identifying alternatives to its seeming unviability:

Figure 7 What Old People Are For (Neeleman, 2005:35).

Considering crisis as opportunity involves strategies of growth that rely on rock-solid technology, but at some point we have to begin to think of those who actually operate the machines. In keeping with the piercing vision of our times, it pays to use the imagination first. Imagination is the new raw material that science can then 'break down' to produce the best machines and the best ways to use them. With this approach, an otherwise humdrum item such as the bed of aged care is transformed into a superlative relation between machine, occupant and carer.



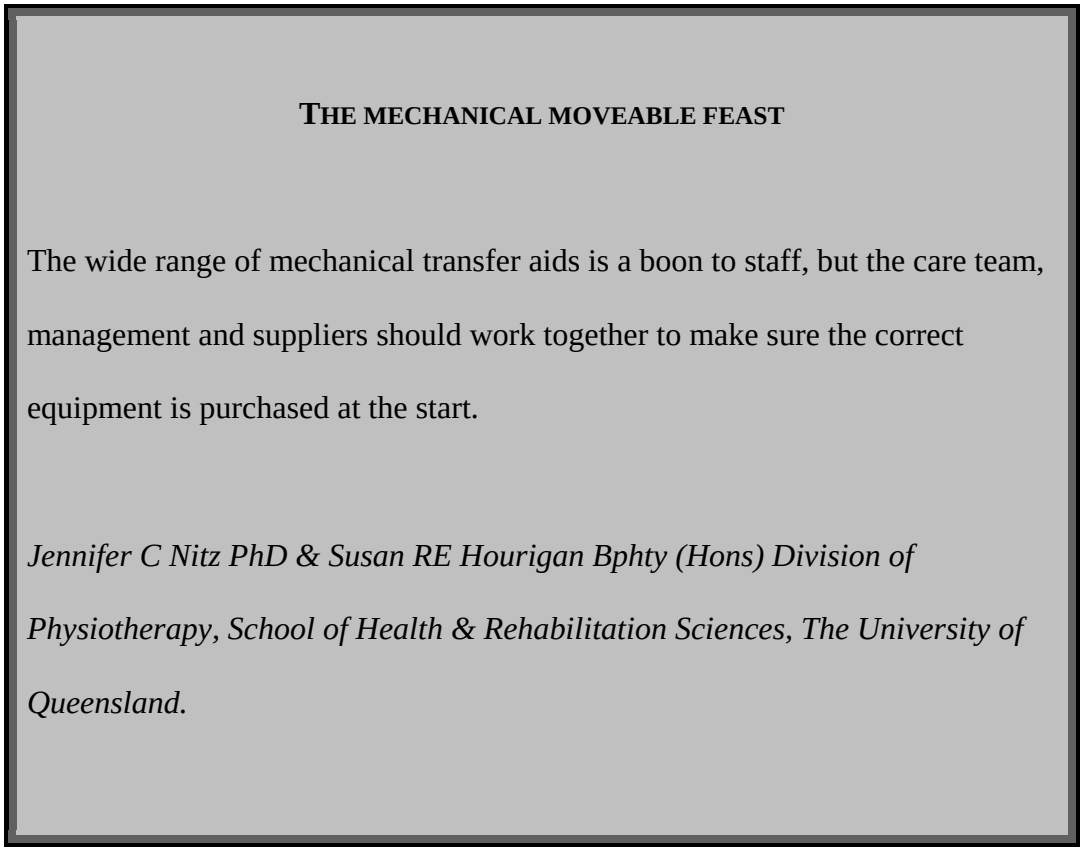
THE 'SUPERLATIVE' AGED CARE BED

It pays to use your imagination when purchasing beds: why not start with a dream solution then break it down with a problem-solving approach and best practice principles?

Jennifer C Nitz PhD & Susan RE Hourigan Bphty (Hons) Division of Physiotherapy, School of Health & Rehabilitation Sciences, The University of Queensland.

Figure 8 Superlativity (Nitz & Hourigan, 2005:61)

A word of caution to the wise: 'top-down' decisions by managers may not result in the best solutions. 'Bottom-up' approaches drawing on workers' knowledge ensure CEOs and shareholders can rest easy knowing everyone is working on their behalf.



THE MECHANICAL MOVEABLE FEAST

The wide range of mechanical transfer aids is a boon to staff, but the care team, management and suppliers should work together to make sure the correct equipment is purchased at the start.

Jennifer C Nitz PhD & Susan RE Hourigan Bphty (Hons) Division of Physiotherapy, School of Health & Rehabilitation Sciences, The University of Queensland.

Figure 9 A Mechanical Feast (Nitz & Hourigan, 2005:63).

The bottom line is that to contribute to this innovative order, nurses need to think not just as nurses, but in a way that can be used to efficiently (and therefore intelligently) reach the targets demanded of the facilities by their absent landlords. The next postcard celebrates the image of enlightened leaders utilizing the artillery of thinking nurses to conquer the unviable terrain of aged care. The victory of the 'thinking nurses', though, is over themselves since it is their wages that constitute a sizeable part of the terrain. Victors typically claim the spoils - but these nurses meekly wait to be given something. The correct analogy, then, should not be militaristic at all. A more faithful one would be with a circus where, if the animals dutifully turn in a profitable performance, they may get fed well.

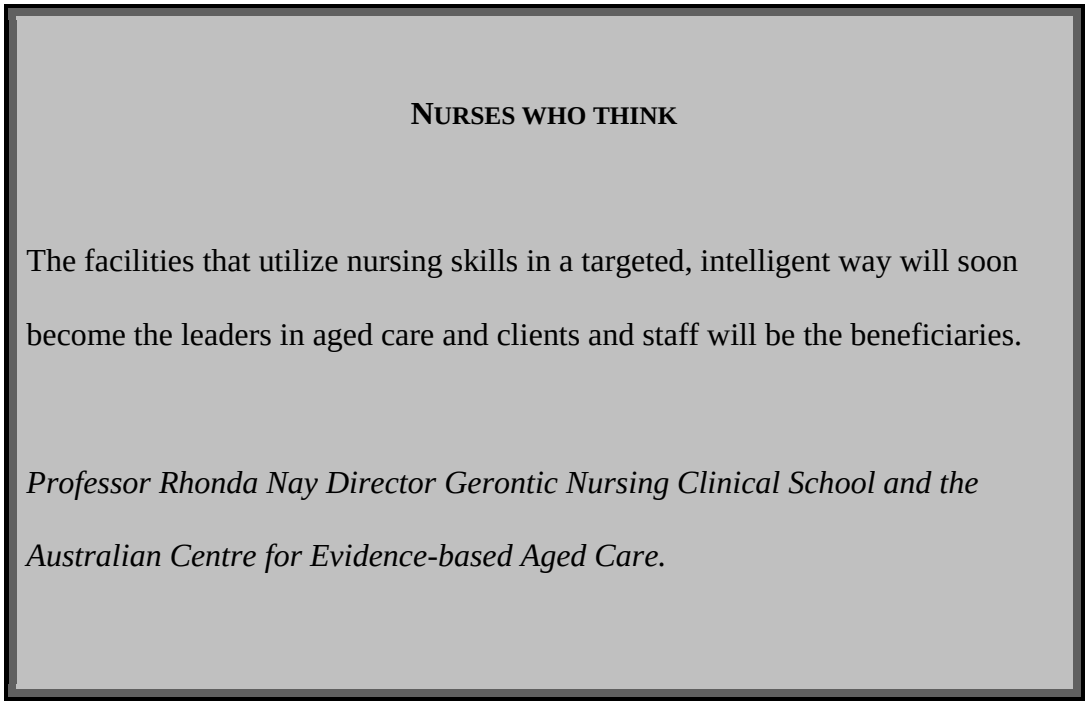


Figure 10 Nursing Thought for Food (Nay, 2005:34).

These happy snaps are all rational,

> like theology: everything about it is rational if you accept sin, immaculate conception, incarnation (Deleuze & Guattari, 1996).

If we accept that profit is the oxygen circulated by the life-blood of money around the organs of this society, then these postcards make sense. Otherwise they would be completely mad - and that is not unusual. The idea of the irrational masquerading as rational is commonplace in our history, and our experience. That is why Deleuze and Guattari can compare theology with the stock market:

> The stock market is certainly rational; one can understand it, study it, the capitalists know how to use it, and yet it is completely delirious, it's mad (Deleuze & Guattari, 1996).

Rationality, they observe, is constructed by those interests that define the structure of society, but

> down below, there are desires, investments of desire that cannot be confused with the

> investments of interest, and on which interests depend in their determination and distribution (Deleuze & Guattari, 1996).

‘Down below’ is the unruly place where all ladders start: the heart. The desire for things to be as rational as they appear to be within the given schemes of things denies the desperation in the world below. Yet even its blandest pronouncements reveal it. In the next postcard the idea of ‘person-centred care’ is claimed by an organization to be its own. Thus it invents a history, insinuating that the idea of person-centred care has been limited by being approached through neuropsychiatry and biological medicine. It is really rather desperate: the very names of these sciences show they have nothing whatsoever to do with person-centred care. Certainly their application is problematic; something that is due to arrangements in the society in which they occur. These very same arrangements, however, permit the idea of person-centred care to be marketable. Ah, but the organization would never admit that its justification is hack science, its promises of personhood to clients quackery, its denial of personhood to staff hypocrisy. Nor would it admit that its future is likely to be that of a fad. Instead, it overcomes its fear of insufficiency through the power of naming and the deprecation of others. So, blessed with deluded quasi-theological authority, it deems which qualities of the rude, bestial personhood of carers can be turned into something worthwhile. Judging by its appearance in such a worthy glossy journal, its theological robes are passable enough for CEOs and, so, for everyone else.

TRAINING AND EDUCATION FOR PERSON-CENTRED CARE

Person-centred ideas and practice have focussed on training in the biomedical or neuro-psychiatric aspects of dementia care. But it must also look to the qualities of the carer.

Murna Downs, Bradford Dementia Group.

Figure 11 Trained to Care (Downs, 2005:72).

The circus animals desert this enterprise, sooner or later. So our tourist sends us a last postcard. It's completely blank! Let our imagination complete it. In our mind's eye, starting at the bottom, visualise the empty corridor and open back door of an abandoned home. We can never go back, the good-time promises and dreams of the past have vanished into the madness of the present. In the middle, a caricature of our rational selves, perhaps an architect, holds up plans for the future. Enter into the blueprint: a ladder of clouds puffs us upward and we alight on the floor above. At first it looks like the same house is simply being extended. Once the colours are filled in, we are meant to see perfection. Instead, we notice the corridors are empty, the gardens deserted. It is then we realize that with this upgrade the future begins. For those in the happy world above, there is nothing wrong with their dream. For those in the world below, there's something wrong with the reality. The two are joined yet separated in a whirling delirium of ideas that begin and end in wreckage:

> Old kettles, old bottles, and a broken can,
>
> Old iron, old bones, old rags, that raving slut
>
> Who keeps the till. (W.B. Yeats, *The Circus Animals' Desertion*)

Conscientious professionals

Let us not descend quite so far - at least not just yet. There are plenty of "raving sluts who keep the till" on the way down - and most of them, as Waring (1988) points out, are men. Descending to the level of health care professionals involved in policy-making, I recall the address a few years ago of Professor Len Grey to a meeting of the Australian Association of Gerontology in Newcastle about the difficulties of funding high-care dementia beds in residential aged care facilities. I had not read Waring's book at the time. I asked Professor Grey why spending money on a local military dockyard was regarded as an investment, when it only made destructive things, but spending money on aged care was regarded as a cost. He ignored the titter from the audience and replied earnestly:

> That's a very good question. I wish I knew the answer.

Now, when I reflect back, it is the nervousness of the titter that stands out for me: I could not imagine that such an audience would permit a display of the postcards above that suggest answers to the question. Not because they would agree or disagree, but because they would be afraid of even daring to look.

Yet the tradition of thinking of health care solely as a cost is being overturned. There is an economic revolution taking place in aged care generally, one made possible

through the application of technological design. This gives the revolution a particular nature. If we look through corporate journals such as *Australian Health Care*, the financial pronouncements are a preliminary to what is fundamentally a task-orientated approach to care. The majority of articles and the bulk of advertising deal with products to cover almost every task. Together with the managerial fads to get the most out of staff, these reveal a sticking point: minimizing staff costs. If wages cannot be reduced, staff can. Replacing staff with machines should reduce running costs to being lower relative to fixed costs, and additionally there are tax-advantages in the depreciation of equipment. It follows that it is far easier to make profits from those whose needs can be readily serviced by technological innovation. Some areas of health care are as yet beyond the reach of technology and so staff costs remain high. In such cases, expensive skilled staff can be replaced with unskilled staff who are trained just enough to keep themselves, residents and the organization out of trouble. This has been the solution in many ‘dementia-specific’ and non-government mental health organizations. However, when older people display serious behavioural and/or serious mental health problems, skilled nurses are needed.

They are needed in Psychogeriatric Assessment Units (PAUs), because that is where these two groups of clients come together. As a result, PAUs are doubly unattractive to funders and present a challenge to designers. Before I turn to the issue of design, I would like to provide some sense of the status of PAUs among health care services. It is important because it illustrates that divesting onerous responsibilities and shifting costs is not entirely new. Its contemporary twists are a reworking of an old story, inherited from the asylums of a bygone era. Yet both the old and the new stories lead to the idea of technological innovation as a panacea.

The remarks below were made by health care professionals on a now-defunct public email discussion group (e-list), concerned with the health care of the elderly. They vividly describe the difficulties surrounding psychogeriatric care in Australia today. In Australia, the Commonwealth government funds dementia care as part of medical care, and State governments fund psychiatric care. This contributes to discontinuities as services seek to shift the cost of care to either the State, or the Commonwealth (Snowdon & Airie, 2002). For instance, it is possible for a State-funded psychiatric service to deny admission to someone with Parkinson's disease, as it is a medical diagnosis, and hence a Commonwealth responsibility:

> The Extended Care psychogeriatric ward… appears to focus on people with a long history of mental illness, who have gone on to develop a dementia and challenging behaviours. Even so, recently they were not willing to take a man with a lifelong history of schizophrenia, who now has dementia and Parkinson's, stating that the Parkinson's was considered to now be the primary diagnosis. What happens to the PERSON in amongst all of this to-ing and fro-ing??!! (Assistant Director of Social Work, Queensland)

"What happens" is that the funding rules take precedence and diagnostic criteria are used to give these rules an air of rationality. We see this at work in an explanatory brochure for the concerned relatives of prospective admissions to a PAU. Here the authority of medical terms glosses over the underlying politics of funding:

> Admissions are available to patients:
>
> - who are ambulant and
> - who have combined organic and psychiatric features or
> - have organic brain impairment and marked secondary behavioural disturbance

(i.e., agitation, wandering and aggression).

> Elderly patients with depression, schizophrenia and other disorders not related to a dementing illness may be admitted to the General Adult Psychiatric Service if appropriate (PAU Information brochure, NSW).

The brochure does not go on to explain that the community outreach team attached to this unit will not follow up patients who are discharged if they have dementia. It would be in poor taste to explain to distressed relatives that the community team is funded by the State, and so can only follow up people who have a psychiatric disorder not related to a dementing illness. The fact that a State-funded PAU which primarily admits people with dementia exists at all is an act of irrationality (or generosity by the State) that violates the rules.

It is a general problem across most states in Australia, as the following example makes clear. Yet this example introduces a puzzle. Another contribution to the e-list identifies the division between what is ‘medical’ and what is ‘psychiatric’ as a problem but blames bureaucrats and mental health professionals for it, rather than the politics of funding between the Commonwealth and State governments:

> I think that it is a sad indictment of some mental health professionals and the mental health bureaucracy that they continue to promulgate this fantasy [that dementia is a medical responsibility]. Dementia sometimes… produces severe behavioural disturbance best dealt with by professionals trained to deal with these challenging behaviours. The people most expert are those trained in psychogeriatrics (mental health of old age). It is just ageist nonsense that some people in mental health think they can save a few dollars by defining dementia as a "non-psychiatric" diagnosis (Professor of Geriatric Medicine, Western Australia).

The state of Victoria is the exception. Some time ago it took advantage of a Commonwealth funding offer to set up what are termed ‘psychogeriatric’ nursing homes. As a result, it appears the problem of funding on the basis of diagnosis has been resolved there. An Assistant Director of Nursing in a Psychogeriatric Nursing home explained to the e-list that:

> Psychogeriatric Nursing homes in Victoria have been developed to provide residential support to people with long term mental illness with significant behavioural disturbance and high level care needs, as well as people with dementia and serious and ongoing challenging behaviours (Assistant Director of Nursing, Psychogeriatric Nursing Home, Victoria).

Although these issues originate from the politics of funding, politics disappear behind immediate clinical concerns. What is political becomes ‘given’, fixed. Under these conditions, the PAU is a zone of repulsion that no one wants to ‘own’ or, in today’s currency, to invest in. The solution becomes a matter of design. The Assistant Director of Nursing quoted above goes on to explain the importance of staff expertise and the built environment in coping with challenging behaviours:

> at times nothing much will make a difference to behaviour other than ongoing expert and specialised interventions… the units are set up generally with 2 or three discreet "houses" where residents can be clustered according to behaviours/needs. This reduces some of the concerns about risk (Assistant Director of Nursing, Psychogeriatric Nursing Home, Victoria).

The importance of the built environment is even more strongly emphasized by a private hospital executive whose facility did not have access to a PAU-type service. Instead, it had access to a type of unit that has become increasingly common: a ‘transitional care’ unit. The emergence of these transitional units represents a stop-gap

solution to the shortage of high-care residential beds. Here, the built environment is seen as solving behavioural problems:

> We have a transition unit… some patients awaiting aged care, rehabilitation, general medical beds, some waiting for residential care, some referred due to behavioural disturbance/dementia/wandering… Most of the rooms are private rooms as we find that many behaviours can be eliminated by moving pts [patients] out of 4 bed bays to decreased stimulation [on nights] particularly and normalise sleep/wake cycles… There is also a communal dining room/day area… particularly good for mimicking routines that are familiar to a patient with dementia who has come from an SRS[?] /Hostel who has become disorientated out of their normal environment (Nursing Director, private hospital, Victoria).

Even though the transitional unit was not dedicated to psychiatry, the ability of the built environment to 'mimic' familiar routines of a 'normal' environment was seen to be therapeutic. A nurse manager in Queensland explains that if the built environment cannot be adapted to the needs of patients, then patients have to be made to 'fit' the environment. This implies a challenge to nursing care that perhaps only those involved could imagine:

> Our psych unit refuses to have anything to do with this group of people [with dementia]… We have to nurse them in environments where we have to make their behaviour fit the environment - because they are accommodated in acute settings (Nurse Manager, general hospital, Queensland).

These accounts support the findings from one of the few studies of PAUs. Mott (1994) reviewed Australian demographic data to estimate that 60% of those who make up the resident population in nursing homes and aged care units in psychiatric hospitals suffer from dementia. She conducted an ethnographic study of a unit that mirrored this proportion, housing people with dementia as well as other mental health problems. She concluded that these two groups did not cohabit well with each other,

since people with other mental health problems were:

> usually orientated to time, place and person and, therefore, able to enjoy a wide range of recreational activities. The wandering exhibited by residents with dementia was perceived as trespassing by other residents, and resulted in fights on a daily basis. (Mott, 1994:108)

It would be easier to ask how the challenge to design a unit that 'fits' PAU patients has been taken up but for now, I wish to speculate about the state of affairs surrounding the PAU. Descriptions of mental health issues in the US (Brown, 1985) and the UK (Tomlinson, 1991) suggest that the battle between different funding bodies, such as state versus federal, is universal rather than unique to Australia. In the face of problems that defy resolution, it is tempting to substitute interim solutions. As Gestalt psychologists have observed, when faced with ambiguity, people tend to 'fill in' the details to resolve it in terms of what is familiar to them. However, there is a cost to this comprehension. The French philosopher Bachelard writes that our tendency to immediately describe a home as an object, a mere house, obscures from us the less readily perceptible qualities of home. These qualities are a mixture of imagination and memory, which move us at an "unimaginable depth" (1997:92). Here though, rather than the elasticity of a personal response, it is the complexity of a political problem that vanishes, replaced by a desire for an immediate, practical solution. Thwarted by politics and under pressure to do their work, professionals turn to design as a solution. It is a believable picture, the scenario is common enough, and in it we are tempted to cast these professionals as heroes, working under intolerable pressure. But it is not the complete picture.

Clever professionals

Brown (1985) relates a history of US mental health policy and concludes that in practice it is driven by three main factors:

- Political-economic factors, driven by the profit motive. Even non-profit organizations, he observes, generate profit for businesses and communities.
- Professionals. He confines his discussion of this to the role of mental health professionals. He argues that their monopoly over knowledge constituted in individualist terms rather than social terms combined with the faith people have in professionals serves to perpetuate existing race, class and gender inequalities within the existing order.
- Institutional factors, operating at the facility level. He regards organizations as comprised of small groups, each with their own leaders. These groups have a common interest in maintaining the 'system', but their own survival needs come first. As a result, organizations work together in a fragmented rather than cohesive way.

His account is well-researched and his conclusions are broadly convincing. Commentators in other fields, such as public health, come to similar conclusions (Stevenson & Burke, 1992). While Brown laments that the ideal of de-institutionalization, the replacement of custodial institutions with community care, has fallen prey to commercial self-interests or 'commodification', he does not examine the relations between those who exercise power in the political-economic sphere (which I call Capital) with professionals. His analysis views the gap between policy ideals and practice as giving rise to cycles of institutional reforms that are doomed to fail, because lessons are not learnt from previous cycles. He recommends that rather

than attempting to visualize the goals of players, we should pay closer attention to what they have done, and what they do.

Rothman (1971) does precisely this in his history of the asylum in the US. He describes the uncritical use of statistics to promise cure rates of 80-100% as a part of the 'cult of asylum' that swept the US in the early 1800s. Asylums were built because cities were keen to build them - and that was because of the employment and trade they generated. Medical superintendents toured each other's facilities and went abroad, in search of ideas. They were disappointed to find asylums in Europe were "frequently nothing other than a new name carved in an carved in ancient doorway'" (Rothman, 1971:135). In Europe many asylums were housed in abandoned monasteries, barracks and prisons. In the US, the built environment itself was a part of an innovative therapy based on the model of the disciplined family. Asylums were designed to reflect this discipline in stone. As there were few architects or builders experienced in this field, medical superintendents took the lead, working closely with architects. They busied themselves with every aspect of the asylum from its design and plumbing through to the training of attendants. The catch phrase of the times was a "well-organized environment" (Rothman, 1971:138). We can glimpse in this activity the origins of institutional psychiatry, statistics, nursing, and the conference circuit, as well as a prelude to the catch phrase of our times: the 'home-like environment'. When the statistics were revealed as false, when funding for attendants dried up, the 'cult' of asylum became inertia, and the ideal of turning confinement into care lapsed into custodialism and convenience (Rothman, 1971).

We may know history according to Rothman and analysis according to Brown, but those lessons evaporate in the nursing context. As Cott (1997) puts it in her study of nurses in relation to other professionals, nurses are used to being told by others: “We decide, you carry it out”. Perhaps one of the reasons that it is difficult to make sense of the broader context from within the small-scale milieux is that those in the corridors of power give the impression that they posses some vastly superior knowledge of things, a view from the top of the mountain that gives them a privileged, rational perspective. If we take up the documents produced by these authorities, we should look for the clues to uncover the hypocrisy that analyses by authors such as Brown and Rothman suggest lie hidden beneath appearances. The investigative, muck-raking journalist is said to have a nose for what is fishy in the detail. The nose is the best guide to sniff it out and describe hypocrisy (Miller, 1996). What better place to start than with what is immediately at hand within the milieu? In twenty-five years of nursing, I have never accidentally ‘nosed out’ a better example of how seriously the problem of mental health and the built environment is taken by health care professionals close to government than the following report whose title and authorship I cite in full, as they are rich with implications:

> *The effect of the built and natural environment of Mental Health Units on mental health outcomes and the quality of life of the patients, the staff and the visitors.*
>
> NSW Department of Health, 2005, Prepared by Warwick Coombes + Penelope Coombes Pty Ltd trading as The People for Places and Spaces

I will take up the implications of the authorship in Chapter Five, however the title is plain enough. It is easy to express it algebraically:

> Result ‘y’ is a product of factor ‘x’ working on substance ‘z’, where:
>
> ‘y’ = mental health outcomes and quality of life
>
> ‘x’ = built and natural environments of Mental Health Units
>
> ‘z’ = the patients, the staff and the visitors.

The title expresses a promising idea namely, that the building itself can somehow organize everyone who enters it into doing things that are critical for what another policy document calls ‘our mission’ (Hunter New England Health NSW, 2006). It can be called ‘architectural determinism’. The title turns out to be misleading, and the truth is found in the subtitle: it is ‘A literature review’. Still, it promises to teach something, as it looks rather thick. A quick flick shows plenty of white space, and short blocks of text: easy work. Another flick, this time through the references: it cannot be a literature review - there are simply not enough references. With a random glance at the contents the smell hits hard, “you gasp, as though some nausea choked your soul” (Aeschylus, cited in Miller, 1996).

Dr Roger Ulrich has become an influential spokesperson for architectural determinism since the immensely successful reception of his 1984 article correlating window views and surgery outcomes. If he needed testimonials, this might do: in the 50-odd pages of this so-called ‘review’, there are over 50 references to Ulrich’s opinions. The other opinions are similarly deterministic. Of these, the most extraordinary is the claim by Thayer that

> [w]e’re able to tie physical environments to mental state and physical state. We’re able to tie physical state and mental state together. We’re able to do this using architectural, engineering and neuroscience principles. (Thayer, cited in Coombes & Coombes

2005:23)

One would expect the source for such a significant and confident claim to be adequately referenced. The source is given as “Thayer (2002) Rubin et al (1998)” (ibid), but only Thayer is mentioned in the succeeding paragraphs. It is surprising that the full citation for Thayer (2002) is not given. As the scientific basis for the claim (a handful of physiological correlations with room temperature) is ludicrous, it is tempting to speculate that the careless referencing constitutes a ‘Freudian slip’, unconsciously retracting the claim. However closer analysis will show that carelessness and absurdity are the most productive aspect of this review. They permit a lofty confidence to reign unchallenged over any scientific doubts.

What methods were used to select articles, how was the labour of analysis coordinated among the partners and staff employed by “The People for Places and Spaces”? In the section that supposedly explains their methodology, there is only a word salad. The terms ‘reliability’, ‘validity’, ‘significance’, ‘methodology’ and ‘method’ are tossed together, without any regard for the technical meanings they have in social science research. They are used only to give a scientific flavour. Reading on, it turns out that few of the articles are actually concerned with mental health facilities. Most deal with other fields, such as aged care, private-for-profit medical facilities and office design. Findings from other studies and opinions from other authors are presented as if they were universal facts. Here and there they compete for space with recommendations. Some of these are, frankly, hilarious: I have never seen a “wall-mounted” desk in my life. Come to think of it, I do not think I have even seen a picture of one. Some are glaringly obvious: adequate supply of telephones, for instance, or avoiding poisonous plants. Deluding themselves, the authors complacently assume all this nonsense will

be accepted as Gospel truth by others. To avoid disappointing these naïve readers, they add that a qualification to the effect that the results may differ because of "cultural bias" and so "further contextualisation work" is needed.

It is hard to believe these experts who, according to their website, roam the world giving valuable advice on every subject could not find any studies on safety in Mental Health Units. It is also hard to understand why all the experts they consulted in sourcing the literature were based overseas. What few 'relevant' studies they found are offered in a solitary appendix. The only Australian study in it must have been given to them, since it is extremely difficult to find through electronic searching. My sister picked up a copy of Greene et al.'s (1986) study of Sydney hospitals some years ago, in a second-hand bookshop, thinking I might be interested in it. It is not concerned with mental health at all - but it is one of the finest pieces of environment-behaviour research I have come across. Enough nosing about! It is clear they had not read Green and associates' conclusion. This suggests that even if by some miracle the assertion that architecture, neuroscience and engineering could be used to "tie" mental and physical state together, it is not particularly important to people who use places, since:

> [f]rom the users' point of view there is evidence that design is not all that important anyway, as long as one has the freedom to vary one's behaviour according to one's perception of the likely outcomes (Green et al., 1986:214).

Striem, Oslin and Katz (1997:287) write that the "nursing home has served as the most productive laboratory for the study of the mental health problems of late life". This productivity will take precedence over doubts such as those of Sweeting and Gilhooly (1992) who regard commitment to institutions for the chronically ill as

‘social death’, equivalent to a death sentence. In their view, efforts to provide care that attempt to enable the institution to avoid charges of ‘warehousing’ inhabitants is a futile denial of reality: the rehabilitation constitutes a fantasy that is “impatient of dependence needs" (1992:257). Writing of the funeral home, or rather the idealized villas of Santa Barbara, a suburb for the well-to-do in the U.S., Baudrillard (1997:212-220) senses that despite these modern places being “the tragedy of a utopian dream made reality”, they also constitute a “laboratory of practical fiction”. Those who work behind the scenes in this world experience an “imploding” violence within themselves that is difficult to analyse. Setterlund links the experience of care staff to distant forces standing outside their milieux, pointing out that:

> [R]esidential care is shaped by principles of economic rationalism, involving financial accountability and proven effectiveness of care strategies as measured by staff performance indicators and quantifiable outcomes of care.... As a consequence, care staff are likely to experience tensions and contradictions surrounding their attempts to provide both physical and emotional care. (1998:135)

Social death, stifling labour, utopian desires dashed - it makes no difference if we feel repulsion or optimism. The underlying activities are all opportunities and thus a source of continuing demands for policy-writing, educational programs, performance studies - and psychiatrists - to deal with all these tensions people experience. We have to pinch ourselves to realize that for all this hand-wringing by those who profit out of tragedy, it does not matter whether they are honestly concerned for others or only for themselves, the enterprise itself remains productive and is therefore practical. The theorist Adorno writes:

> Society deceives us when it says that it allows things to appear as if they are there by mankind's will. In fact, they are produced for profit's sake; they satisfy human needs only incidentally (1997:17).

Having thus cleared the air, reason is free to tease out a disturbing implication of its own. These authors, along with their approving colleagues, must share a similar conception of mental health as something that can be ‘tied together’ through forms of biological engineering. It is a (fortunately) incompetent attempt to continue a quest to find Newtonian laws that explain, predict and ultimately control what people do. With no insult intended toward people with autism, it is the concept of autism as ‘mindblindness’, a blindness to the “thoughts, beliefs, knowledge, desires, and intentions, which for most of us self-evidently underlie behaviour” (Baron-Cohen, 1995:1) that best explains what occurs here. It must be widespread: I rang the authors to ask if their report was being used, and was told the architects currently designing a purpose-built mental health unit were very impressed with it, and were using it. At first, this seems a logical impossibility. To understand it, a picture of architects is needed - even if it turns out to be a caricature.

Architects

Nurses are used to encountering charges that they are ‘task-centred’, or lack skills in x or do not do enough of y - they are familiar with constantly receiving recommendations and being urged to attend courses on self-improvement. Architects, on the other hand, are constantly told - and tell each other - that they are imaginative, sensitive listeners, perceptive, wide-knowing experts who display ethical concerns of the highest order. Stevens (1998) offers an amusing example of how psychologist MacKinnon described architects. Despite his study of 120 architects indicating that

architects had a strong desire to be in control and showed an indifference to economic concerns, McKinnon rhapsodised to the professional psychological press that architects see themselves as imaginative, committed to creative endeavour, aesthetically sensitive, independent spirits free from crippling restraint, spontaneous, and

> One is struck by the accuracy of self-perception, by the degree to which architects see themselves as they really are, and by the remarkable consistency with which they conform in their thought and in their behaviour to the type of person they see themselves as being (MacKinnon in Stevens, 1998:10) .

The boom in aged care construction has spawned a plethora of disciplines out of architecture, and each one of these has inherited these qualities. Rather than performed by a single person, the architect designing and overlooking the construction of buildings, these functions are now dispersed as specialized areas among a team. The Church of Christ Homes and Community Services Inc. (Turner, 2004) provide an example of this trend. Table 1 (below) lists the extraordinary range of areas the internal project's team describes itself as managing:

Table 1 Extraordinary Range of Architectural Work

- Organizational change and development
- Activity-based costing and modelling
- Design consulting
- Tendering - selection, relationship management
- Australian Standards Contract processing and documentation
- Aged care systems and infrastructure
- Demographic Econometric Predictive Models
- Aged Care Allocation Round
- Capital cash flow models and funds management
- Construction program management

These experts can predict the future. They do predictive modelling to identify optimal size and configurations of new facilities and key factors such as occupancy, hours of care per resident, time to fill a facility, and capital costs (Turner, 2004). Having such experts on tap not only provides predictable competence, but can cope with the unpredictable. In his speech given at the opening of an aged care facility in Victoria, Phillip Viney, of Viney Consulting Ltd, pointed out that project managers can hire experts just for the length of time and purpose that they are needed. For instance when a citizen lodged an objection to the development proposal, Viney Consulting didn't waste time or take risks. They simply got the "best in the business to handle it to make sure we didn't lose" (Viney, 16th March 1999).

Project managers Paynter Dixon point to Kelvin and Maggie White, owners of the White House facility in Brisbane, as clients who appreciate their services. Kelvin White says, "as a former construction engineer myself, I know the value of professional project management" (Curtiss, 2005:34). Maggie White adds that from

her experience of working as a nurse she was aware nurses were “not very good at articulating their needs to architects” and as a result nursing needs were not “acknowledged in the design” (ibid). Paynter Dixon are “passionately” certain that they “do the right thing” in overcoming these problems because their team “sit down and listen and then we talk” (ibid). Confidence is a hallmark of these experts. Perhaps it comes from looking back on the past. Interior design consultant Roberts reflects that “When I started designing for aged care 12 years ago there were some pretty awful, very drab, facilities” (Redman, 2006:30). Presumably the field was waiting for her wisdom.

There are few studies of how architects actually think and set about design - neither twelve years ago when Roberts banished drabness from facilities nor even now - but Darke’s study (1984) is a meticulous, well-organized example of empirical social science. She interviewed eight architects and designers of public housing estates in depth, and conducted further interviews with the occupants of the estates. She concluded architects held stereotypical views of households as “a family with few conflicts and few secrets” (1984*a*:399). Rather than accessing knowledge, architects projected their own experience to guide their designs. They were not conscious that their mainly upper-class experiences were a world away from the impoverished backgrounds of the future occupiers of the estates. They made no attempt to talk directly with these people. They did not consider social science research to be useful. One architect commented that social scientists were mostly “failed dropouts” who only encouraged “another layer of protest”. What architects needed to know was how people enjoyed different sorts of buildings. The act of projecting their own

experiences gave them a faith in themselves: “the final skill comes from the deep ability of the designer” (1984*b*:409-410).

Darke concluded that architects did not want to acknowledge design failure. In one anecdote, she reported to the architect that a female occupant of the housing estate he had designed said she felt it was very drab and prison-like. The architect’s response was that the woman had probably had closer experiences with prison than he had. Another architect claimed children frequented the playgrounds he had designed, and only played on the road sometimes because they enjoyed the excitement of it. In fact children played on the road because the playgrounds were generally waterlogged. Still another architect blamed vandalism on the estate on the children from large families who “would have been better off on a Peat Bog in Ireland running around with the chickens” (Darke, 1984*a*:396).

The same year that Darke published her work, Ulrich’s (1984) article suggesting the benefits of having a view from a window in recovering from illness marked what could be called the start of contemporary research into the relationship between health and environment. I will describe and analyse this in the next section. What is important here is to understand how architects do things and, accordingly, how science comes into their work in the first place. It does so, through its patrons.

Organizations such as the Moran Aged Care Group are appreciative of science. CEO Doug Moran justified the endowment of the Moran Chair for Older Australians at Sydney University, stating: “the best way to lobby any government is to show them university research and to educate them” (Elliott, 2004:7). Moran does not confine his

philanthropy to science but includes the arts as well, sponsoring the Moran equivalent of the Archibald Prize (a biennial award for the best Australian portrait). Enterprises such as this appear to have stimulated prompt governmental responses. A year later in 2005, Minister for Ageing Julie Bishop initiated the National Speaker Series, *A Community for all Ages - Building the Future*. The series would garner the talents needed to take up the opportunities presented to planners and builders by the ageing of the Baby Boomers. The economically powerful Baby Boomers would have greater expectations of the amenity, of privacy, security and lifestyle though private rooms, en-suites, theatrettes, libraries, computer centres and restaurant style dining (Bishop, 2005:39). Acknowledging the increasing numbers of Baby Boomers who will survive only to encounter dementia, Professor Chenoweth said during the National Speaker Series that designers should:

> [P]romote the person's sense of identity, which is often bound up in childhood. Usually the more demented they get, the more they regress, so you might provide old-fashioned curtains, chairs, tables, and photos, and recreate the way houses looked in the 1920s, 30s, and 40s... rather than modern things, which they don't identify with at all (Bernstone, 2006:34).

This psychology of design is commonplace. The days when architects could design by projecting their own experiences are in the past; modern architects respond to objective, demographic demands. Many aged care facilities are proud of how their facilities are 'themed' to reflect an era or a culture. The MacKenzie Aged Care Group describe their Tweed Heads facility, located in an area with many war veterans, as modelled on the Raffles Hotel in Singapore (Redman, 2006). The 'heritage' theme includes displays of significant items such as the Australian flag secretly patched by Australian WWII POWs in Changi Prison. Clearly the intention is to convey a

reflective reconciliation rather than to re-evoke traumatic memories (there are no secret tunnels between buildings). Their facility at the Gold Coast is French-themed, in keeping with that area's tradition of aspiring to Cote d'Azure status. Montefiore Homes (Bernstone, 2006) has taken an even bolder step.

Here the theme taken up is the Jewish identity in response to the Holocaust. Staff receive a two-day orientation which includes training in specialised care for Holocaust Survivors. Montefiori Homes describe their new facility in Randwick as a 'masterpiece'. Looking at the artist's rendition (Figure 12 below), the master plan consists of twelve three-storey blocks arranged in a crucifix shape. Roof-lines along the body of the cross have a slight curvature, reminiscent of homely oven-baked bread[2].

Figure 12 Master plan (Bernstone, 2006:32)

Inside (Figure 13 below) the lobby takes up this evocation of memory and reconciliation. The large entry foyer looks into a waiting lounge and, across a broad

[2] I have since learnt that the chimney from former brickworks, preserved as an historical monument, is clearly visible from the campus.

space, a reception desk. There is a mezzanine floor above with a scatter of cocktail tables and chairs. The first impression is of three flesh-toned columns piercing the mezzanine floor as they ascend. Where they join the ceiling, they constrict into a clerical white collar. Electric lights from seven-branched candelabras suspended before this trinity shine up onto the ceiling, as if illuminating glimpses of paradise. It is an uncanny blend of Jewish and Christian images. Down in the forefront to the left, a shaft of light falls, as if from a window high up, onto a dark figure. This slight, contorted figure stands in the place where beasts that traditionally guard palace gateways would stand. Its body is keyed up in an agonized posture that suggests that even in old age, here and now, it is still the effort that sets us free. Turning from the theme of Christian reconciliation, it is evocative of some of Leni Riefenstahl's famous photos of the 1936 Berlin Olympics. One is reminded of black athlete Jessie Owen's famous victory over the myth of Aryan superiority. It could be a black javelin thrower or the body of a charred inmate clinging to a bar from the cell, still attempting to flee. But perhaps I have worked in dementia for too long, and my imagination runs riot with ambiguous possibilities.

Figure 13 Lobby (Bernstone, 2006:33)

From its Olympic-sized pool and other amenities (it has the largest hydrotherapy pool in the Southern hemisphere, for therapeutic and recreational use) to its rooms with

Foxtel, Internet access, fridge and microwave, with its “culture of excellence” and “incorporation of innovative ideas”, Montefiore Homes President Mr Freeman promises clients a future that includes “participation in cutting-edge, aged-related research” (Bernstone, 2006:35). He is banking that his clients will agree that ‘cutting-edge’ research will set them free of the thousand ills their flesh is heir to.

Let us review the picture we have so far. Barrages of slogans smother doubts, and CEOs reassure us with heartfelt smiles all is well. Thus when architect Keith Suter sums up the 2005 National Speaker Series *A Community for all Ages - Building the Future* as “all very pleasant… there was no blame or finger pointing” (Bernstone, 2006:32), it seems churlish to wonder if there should have been. In the photomontage by Peter Lyssiotis (Figure 14 below), pleasantness is weaponry.

Figure 14 Short Interviews with History (Lyssiotis, 2004)

We can see that the boom in building aged care facilities is echoed by a boom in professional specialization. We can sense in the fundamental agreement between social scientists such as Professor Chenoweth and the diversity of specialists doing

architectural things that design has progressed from mere faith in the abilities of the designer to a more scientific footing. There is another sophistication as well: facilities are no longer ‘over-built’. The asylums of yesteryear were built to endure. That was wasteful, the equivalent of over-capitalisation. Modern facilities are constructed with an eye on demographics, with life spans of between 15 and 30 years.

This survey of major currents also shows how remote the PAU is from mainstream issues. The concept of the PAU is so minor it does not register a mention (although the final sections of *National Healthcare Journal* always features a few articles on dementia contributed by Hammond Healthcare, who maintain close ties with the journal). But we are no closer to understanding the problem we started with in this section. How could an apparently absurd policy document, such as that written by Coombes and Coombes (2005), be useful to an architect? Obviously, description alone has not been enough, and further reflection is needed.

Darke’s (1984*b*) finding that architects did not talk to future users resonates with Maggie White’s personal experience that nurses were not very good at talking to architects (Curtiss, 2005:34). If we restate this, then we can say that architects are not very good at finding out from nurses what it is that they need. It seems that Darke’s findings still hold. Indeed, Kernohan (1992) observes that generally speaking, current design and management practice is not well attuned to addressing the day-to-day issues important to building users. Users rarely play any part in decision-making about the buildings they live and work in. Darke (1984*b*) writes that architects lack insight into their own shortcomings, seeking only confirmation of their own views and taking a role as ‘moral entrepreneurs’ for granted. In other words, whatever

architects choose to do is justified because they live on a high moral plane. Perhaps the extent of architect Suter's feeling of harmony among colleagues (Bernstone, 2006) is a continuation of this, no longer as the self-interest of an individual but as mutual self-interest amongst many specialisations. It is a self-interest that is not concerned with self-criticism. The *National Health Journal* does not publish post-occupancy evaluations (POEs), nor does any other journal as far as I am aware. POEs could point out design failures that would cause mutual embarrassment – and, of course, undermine the principle of 'commercial-in-confidence'. Indeed, the only hints of collegial criticism published in these issues of the *National Health Journal* are two brief comments by Steven Judd, CEO of Hammond Care. He regards design as having gone backward over the past five years because the "bean counters" are driving it. He wonders what the philosophy of care is behind "these huge new aged care cities" (Bernstone, 2006:34). These criticisms have not been taken any further.

Yet there is something undeniably sinister in what I have described. Just as in the opening section, by repeating the pronouncements from the *National Health Journal*, this time within context, there is a sense of parody, as if our very seriousness about scientific progress and enlightenment in these times were mocking us. Take Chenoweth's (Bernstone, 2006) view that people with dementia 'regress'. Whatever its scientific status, is this a simplification that can be used to justify a program, much like the eugenic notion of racial superiority or the ideal of a well-disciplined family were once used? In this scheme, design replaces genes or discipline. Would it be acceptable for instance, to imagine a nursing home for Palestinian refugees based upon their 'tradition' of occupying ruins? Or themed as a shantytown for Aboriginal elders? There is something stereotypical and offensive about the generalisation of

'regressing', that its superficiality mocks and belittles individual tragedies. Perhaps these opinions about how much things have improved, and the scientific basis for this, sounds ultimately unconvincing because the purpose of a trade journal is, after all, to facilitate business.

Many aged care authorities belong to the prestigious Australian Association of Gerontology (AAG) and contribute to its scholarly peer-reviewed journal, the *Australasian Journal on Ageing* (AJA). One would think if there was an impartial rationality to be found, it would be found there. I recall reading a contribution by architect Paul Archibald in the 'opinion piece' section that often opens AJA issues. It was titled *Housing for All Ages: Adaptable Design* (Archibald, 1999). At the time I skimmed it, but as it did not address the PAU specifically I had no further interest in it. However, when I returned to it, I gasped with horror, nausea choked my soul - again. It continues the determination that Darke (1984*b*) discovered amongst architects, namely, to find only those cheery ways in which people enjoy buildings. Archibald repeats over and over that old people deserve the best and that this means looking forward to a "tomorrow" of "new things". No hint of the afflictions they endure, of the crisis implied in moving to these new places. Archibald gives himself the authority to declare that properly designed "Tomorrow buildings" may be

> large or small, new or old or adjustable pre-designed 'family homes'… bedrooms and living spaces in these building should be able to grow, contract or regrow again, or simply be interchanged or relocated… (1999:106).

He claims this will "date proof" design. A benefit of this is that designs can be "naturalised" by being immersed in adjustable landscaping. As if old people were abandoned cinemas, design will "reopen" them and "project them into a new lease of life". Inside light should be natural, gentle, permeating buildings. Outside the site

should “collect sun from all directions”. He declares, “Future buildings should use future technology”. This includes glass, aluminium, steel, plastics, plywood, pre-cast concrete, and “ponds with plants and with or without goldfish, tadpoles, frogs”. This technology is more “realistic” than bricks and mortar dressed up with “unnecessary, irrelevant, nostalgic details”. Through such buildings, Archibald argues, Australians will “look forward to a future… with a sense of purpose which is socially and economically relevant” (1999:107).

Archibald is an all-too-common example of the architect who, seated at the drawing board, will never feel the chill wind of mortality on his forearms, never imagine that one day he will not be an architect but someone in dire need of care (Willis, 1998). Sancar (1999) writes that architects are expected to give hypothetico-rationalistic explanations of their work. Archibald’s self-portrait of architecture with its light and shade, technique and tradition, is an attempt to do just that. It must be a convincing impression since it was published by a peer-reviewed journal. Now we are in a position to understand what at first appeared to be a logical impossibility: how an absurd policy document can be ‘used’ by an architect.

It is a simple trick. We assume if something is being used, that it is being useful. Now though, we can imagine a portrait in which the document is held prominently in one hand, lending a subtle impression of wide-ranging knowledge, expertise and authority to the architect. Or perhaps we can imagine it, its title boldly stamped on its spine, on a shelf behind the architect’s shoulder. When we question the appearances of policies and of architectural pronouncements, we see an “edifice complex” (Green et al., 1986:13) that has probably not changed all that much since the cult of asylum first

made its mark. Yet despite these absurdities, there does seem to be a new cult that perhaps has something more to offer. Leaving the absurdities of professionals behind, what is it that scientific knowledge has to offer?

Big reviews of the 'scientific' research

The most recent large-scale review of the relationship between the built environment and health care is that by Ulrich et al. (2004). Neither its recency nor its self-proclaimed bigness means it is better than previous reviews. In fact, I will demonstrate that it reaches a low point. If there was a high point in the scientific history of this topic since the 1950s, it passed unnoticed in 1989. Keen's (1989) review was probably the only review that, even though it restricted itself to the subject of dementia, actually contained not only science but sense. Anyone who is curious about what is 'known' about health and environment will have to encounter mountains of what some would boast is 'scientific' evidence. These mountains speak volumes through their famous figures, venerable institutes and associated journals. Their grand pronouncements, impressive terms and statistics, reveal a fascination with only one simple idea: that the built environment can determine behaviour. It is an idea they spell out over and over. It has become what I will call in this paper, the 'person-environment fit' (P-E fit) canon. In literature, the canon is the descent of major works that build on each other in struggling to understand the consciousness of people and their society. One cannot understand the culture of a society without having some understanding of its canon. The health and environment literature constitutes a canon, but one which is a parody. It demands agreement and avoids conflict, and so inhibits scientific consciousness.

Keen (1989) points out that the three major difficulties in investigating the influence of the built environment are: determinism, separating the social from the physical aspects of the environment, and adequately describing the environment. At the time he was writing, some of the instruments used to describe the built environment were undeniably crude. Keen remarks that the 'MEAP' (which stands for the rather awesome sounding 'Multi-Phasic Environmental Assessment Protocol'), an instrument published by Moos and Lemke in 1988, attempted to provide a conceptual framework for evaluating residential treatment environments, but it was an admixture of scales that were overtly deterministic. The presence or absence of features alone determined the score, regardless of whether they were or were not important. Moos and Lemke must have remained unaware of Keen's review or else chose to ignore it. In 1996 they republished the scale together with examples of its use. They must have attracted considerable funding since they present normative data based on surveys of over 300 community and residential facilities. These data are presented in ways to suggest there could be an integral relation between measures such as 'physical attractiveness', 'facility size', 'resident characteristics' and 'staff functioning'. To make this suggestion more compelling, the text often refers to measures as 'indices' as if they were accurate summations of vast complexities, such as the 'social' component of an environment. The MEAP seems to have died a natural death since then.

Better instruments have been published since. Of particular note is the *Environment-Behaviour Checklist*, designed to be applied to dementia care units (Zeisel, Hyde & Levkkoff, 1994). This provides a rationale for the importance and desirability of each

feature, the degree to which the feature is present, and also a way to describe the performance of the feature in use. The authors suggest designers and clients can use it to plan and review designs and evaluate existing facilities. Additionally, developments in micro-electronic technology have no doubt facilitated mapping approaches. Thus there has been some progress in methods used to describe the built environment. The problem now is with the other two issues that Keen identified, i.e. distinguishing the physical and social aspects of environment, and the expectations of determinism. Keen argues that the influences of the social and physical environment in matters such as feeling at home, privacy and personal space still needed a lot of conceptual analysis as well as empirical investigation. However, before this problem can be addressed, the issue of determinism needs to be clarified, since it colours how we conceive of society, the individual, and the built environment.

Broady (1968) argues that architects are idealists who believe that they can bring about social effects through building. He does not have any illusions about architects; he regards their social theory as a blend of simplistic survey data and straight waffle, with a dash of aesthetic dogma thrown in. He argues that despite this, architects and planners have to rely on simple, reliable explanations that are in accord with cultural expectations. In their role as experts they not only had a desire to avoid amateur control, but also an expectation of governing over passive, acquiescent populations. Their analyses reflected this desire for a simple, easily manipulated world. They analysed things backwards: slum dwellings for instance, lead to slum dwellers. Create ideal buildings, bulldoze the slums, and the problem would be solved. When the ideal buildings failed to solve the problem of slums, then the inhabitants were blamed (Broady, 1968). There have been many spectacular failures of deterministic

expectations, one of the most famous resulting in the demolition of the prize-winning Pruitt-Ighoe housing complex in St Louis in 1973. As an attempt to solve issues of violence and theft, it was a dismal failure from the moment it was inhabited. No one wants to be associated with failure, and this may explain why waffle is so important in making the present appear to have progressed such a long way from the past. In the field of health care, the very words ‘residential care’ are an attempt to disassociate contemporary enterprises from the failed intentions of asylum building.

Keen explains that because determinism appears to be such a general idea, authors either fail to recognize it or think it does not have to be addressed. Those few authors who have responded to the issue of determinism point out that the influence of the environment over people is not a simple, predictable cause-and-effect relationship. People create and modify their environments - indeed, it is people who design the built environment in the first place (Broady, 1968). Similarly, Canter and Kenny acknowledge that while the built environment may accentuate problems on housing estates, it is ludicrous to regard it as either the cause or cure of such problems. They argue:

> The mechanical relationship between man and his environment assumes that man is a passive organism, responding to his environment in a simple and direct way. A more appropriate picture is that of man as an adaptive, goal oriented being (1975:163).

Keen suggests resolving the issue of determinism along similar lines. Rather than whatever effect it may have on direct outcomes, the physical environment is important for the constraints and opportunities, the way in which it may or may not be used. Thus objects may have direct effects - a doorknob requires people to turn it in a particular way, for instance. Objects also have indirect effects. The style of a doorknob may suggest elegance or ugliness. With larger and more diffuse objects,

such as ‘home’, the objects can range from what appear to be indirect meanings such as status or familiarity through to direct opportunities for personal control over privacy or territory. Thus a notion such as ‘privacy’ can be as physical as a wall, or as cultural as a courtesy. We can anticipate at this point what will need to be discussed later, that a tension arises between what is social and what is physical in the relationship between people and the built environment.

Steinfeld and Danford point out that the theoretical assumptions surrounding person-environment theories draw on the classic concept proposed by Kurt Lewin, of ‘life space’ defined by the equation:

$B = f(PE)$.

In this equation, (B) is a function (*f*) of the interaction of personality and individual factors (P) and the perceived environment of the individual (E). They explain how the influential theorist Lawton used this model in the early 1980s to present the environment as exerting supportive or challenging pressure on the person. The consequences of that pressure depend on the competence of the person, and the outcome is described as a person-environment fit (1997:38). They stress that this ‘fit’ is not a point but rather a zone of adaptation. Using Bandura’s notion of ‘dynamic reciprocal determinism’, they characterise it as a relationship that is tolerated by individuals.

Unfortunately for science, it seems that this idea is too complex for the majority of those engaged in person-environment research. Zeisel and associates (1994) remark that the state of the art in science is represented by agreement in the “published literature and conference papers”. In the field of environment and behaviour, the ‘state

of the art' is represented by two reviews conducted for the Centre for Health Design (CHD). The first is by Rubin and associates (1998) while the second is purportedly a follow-up review by Ulrich et al. (2004). The CHD is the "Who's Who" of health-related design in the USA and its Board of Trustees and Research Committees include Zeisel and Ulrich. It attracts endorsements and sponsorships from healthcare, architectural and even computing organizations. Whatever pronouncements the CHD makes, are therefore sometimes more influential than whatever the facts may be. I have claimed that Ulrich et al.'s review is a low point, and I will start from there.

Ulrich et al. begin their review without any theoretical considerations. The dimensions of the problem are obvious to them. Medical errors and hospital-acquired infections kill more US citizens than car accidents. Hospital building in the USA is booming. This is an opportunity to reduce death by improving care. Reducing staff and patient stress and fatigue will improve care. Just as medicine has moved to evidence based practice, they argue, so should the design of healthcare. Accordingly they ask:

> What can research tell us about "good" and "bad" hospital design?

This black and white 'can do' approach to innovation, reminiscent of the simple desire to rule described by Broady (1968), is the road to Pruitt-Ighoe. Ulrich et al. breezily describe the research process as if it were really of no interest. Their team searched "scores" of databases at Texas A&M (whatever A& M is, it must be big if it is in Texas) and "elsewhere". This was in pursuit of studies that were "rigorous", which they explain, means they had something called a "degree of control". Oblivious of any sense of bias, they also sought studies that gave good, positive results - in their

language “high impact”. ‘High impact’ is the sort of thing that is more important than facts. It means what is important to healthcare “decision-makers” as well as patients, clinicians, and society. As we pause to wonder who would be the most important out of these people, a familiar smell starts to assail us. They boast that using similar criteria, Rubin and associates found 84 only “rigorous” studies, but six years later, they found “more than 600”. They are not just boasting about size, but also pointing to their prowess as they surf the leading edge of a wave of research. The results are divided into outcomes that suggest immediate results: reductions in staff stress, improvements in patient safety, reductions in patient stress, and “improvements in overall health quality” - presumably some miscellaneous category of research.

Ulrich et al. explain that nursing shortages were a contributing factor in 24% of unnecessary deaths. Apparently this shortage is due to poor physical working conditions, lack of support and low wages. Without dwelling on this, they declare that a “healing environment” will reduce staff stress, leaving us to assume that it will also solve the nursing shortage. Such naivety is unbelievable. It has a smell to it that reminds me of Hookway’s (1999) tale describing a managerial innovation known as the *Andon Board*. In the 1980s, a US car plant introduced the *Andon Board* in a move to cut wage costs yet increase production. Assembly line workers were told they could receive bonuses if production was sped up. However, to be humane, if the pace was too fast for them they could press a button that would light up on a board (the *Andon* Board) so the supervisor could slow down the process. The overseer’s job was to keep the lights flashing continuously. It would not be surprising if those supporting CHD work had some similar goal in mind.

Ulrich et al. simply report the findings from study after study as if these were facts. Like Coombes and Coombes (2005), they take no particular care with referencing, despite publishing a companion of abstracts to accompany the review. For instance, in three different locations they refer to three separate studies by an "A. Hendrich". Not one of these appears in the abstract. There is another similarity. Just as Coombes and Coombes (2005) do, they too confidently wave the big magic wand of science. Their language is incantatory: they speak of "scientifically credible" "scientific articles" in "top peer-reviewed journals" reporting "scientific studies", a "growing scientific literature". In lay terms, it amounts to what a dog would hear: "blah, blah, blah". There is little point in going much further with this review.

Rubin and associate's Review is also concerned with high-impact outcomes. The introduction, written by a David Weber, quotes approvingly from what E. Todd Wheeler, apparently a notable hospital architect, wrote in 1971:

> Eventually scientific findings will go beyond subjective responses… the doctor will then know how to write a prescription for environment even as he now does for drugs (1998:x).

We could excuse this crude determinism as quaintness, except that it is taken seriously. Rubin and associates are not alone. Even veteran authors in the field, such as Nasar and Preiser keep such absurdities alive. In their edited compilation (1999) they reprint Archea's behavioural views of privacy. Perhaps it is a tongue-in-cheek exercise, to help understand how determinists view the world. Originally published in 1977, Keen (1989) only mentioned Archea's paper in passing as an example of widespread concern with the importance of privacy to those in residential settings. Archea regards physical objects as having intrinsic characteristics that "make it what it is". The attributes that objects display when being used for something are "only

conventions". He concludes that if designers had the same commitment as behavioural scientists (I presume he means Behaviouralist) then designers could "untangle a working understanding of behaviour from the heights of kitchen cabinets" (Archea, 1999:8).

Unlike Ulrich et al., Rubin and associates reported some of the search strategies and inclusion criteria they used. Studies dealing with staff morale and performance were excluded, as the degree of their contribution to patient outcomes was outside the scope of the review. Comparing the studies included in these two reviews counters the impression Ulrich et al. give of the 600 high-quality studies published since Rubin and associate's Review. It transpires that they included older studies that Rubin and associates had excluded, one of them being by Ulrich himself - a 1991 study utilising videotapes. Interestingly, Rubin and associates gave Ulrich's classic 1984 study a rating of four, while Ulrich et al. rated it highly as an 'A minus' in their review. Rubin and associates graded studies from a high of 'one' as the most credible design, the randomised controlled trial, down to a low of 'four' for naturalistic observational studies. Ulrich et al. do not explain their ratings, but they appear to be roughly parallel. Thus their 'A' rating can be seen as equivalent to Rubin and associate's 'one', their 'D' rating equivalent to Rubin and associate's 'four'. Incidentally, Ulrich et al. include another three studies by Ulrich in their review. These could not be included in Rubin's review, as they were published after 1998. Of these, two were literature reviews. Ulrich et al. do not grade the credibility of literature reviews.

Rubin and associate's chapter on the state of knowledge is barely three pages long. It lists a mere half-page of features that were found by at least one study to influence a

health outcome. This includes diverse interventions such as exposure to outdoor sunlight, tapes of therapeutic suggestion, intensity of artificial lighting, and bedside computers. They do not attempt to explain how these contributed to outcomes nor even how they were related to the built environment. They do not address the methodological issues confronting the subject as a whole. Instead, they devote the remaining space to pointing out the more general defects of the studies included in their review. Out of the 84 articles, only 23 were randomised controlled trials, the remainder being primarily observational studies. Few studies described participants adequately, assessed validity, or tested reliability. Rubin and associates note that in many studies researchers were not 'blinded', raising the possibility that they obtained the results they wanted to see. Yet they argued that because so many investigators agreed that the built environment affects health outcomes, they must be right on the basis of their number alone. Thus the opinions of scientists become fact.

As a response to these shortcomings, Rubin and associates then conducted focus groups with experts at a healthcare design symposium. These experts first had to define a vulnerable patient population who were "unable to act on their own behalf" and an outcome that would make a "big difference to people" yet be generalizable to others, one that would also have "political appeal" and resonate with administrators (1998:18). They identified the frail but cognitively intact elderly in long-term care facilities, and seriously ill children. The focus group decided that randomised controlled trials would be undertaken in these fields on the assumption that:

> assigning the same subjects to different conditions in random sequence with paired data analysis… [will] definitively demonstrate whether or not a change in the healthcare environment will improve important health outcomes (Rubin et al., 1998:22).

The outcome of this naïve empirical substitute for thoughtful analysis was a nine-year plan to conduct and document a set of studies on each group. The idea must have had some approval to be published in the review, but it appeared to have evaporated by the time Ulrich et al. published their follow-up review six years later.

But enough of these preliminaries. What did Rubin and associates actually publish in their abstract, what sorts of 'rigorous' studies (ones that count things rather than seek to interpret things) did they find? One of the studies rated as a 'one' has eight subjects. Eight? Yes, eight. Over a dozen of the studies included had sample sizes less than the minimum 23 subjects generally considered credible for generating statistics. How the built environment was measured did not matter to Rubin and associates. From reading Moos and Lemke (1996) I recognized one of the included studies as having used the MEAP. Rubin and associates made no comment on the inadequacy of the MEAP. Attempting to ignore these glaring errors, I looked for studies relevant to dementia and psychiatry. Given the keen interest in person-environment fit studies comparing special care dementia units with traditional nursing homes, I was stunned to find only one study that considered a nursing home - the one mentioned above, with eight subjects. The variable though was not the built environment, it was music.

As I sit now and laboriously write this material, I feel as if some oppressive cloud is being lifted from my soul. When I first encountered these two reviews, I skimmed them and felt confused, as if I did not understand and was lacking in comprehension. Perhaps it was their size, or the tables in them, or the technical terms they used. I felt certain that if I read them again some other time, I would gain some insight into how the built environment actually 'worked'. Now I find something completely

unexpected: depths of deceit, incompetence, opportunism - anything but honesty and truthfulness. Even aside from these details, there was something else, something missing. Was I mad in expecting to find studies relevant to psychiatry, aged care, dementia, in-patients and residential aged care facilities? Was I insane to have imagined there had been a great explosion in such studies since at least the 1980s? Were all these invisible studies of such wretched quality that not one of them was worth including? I trawled again through Ulrich et al. There were only eleven studies that were vaguely relevant to residential or psychiatric aged care. The variable of interest in many of these was not the built environment, but factors such as bird noises, the presence or absence of a roommate, the consumption of alcohol or psychotropic drugs.

The true poverty of Rubin and associates' 'master plan' is that these authorities have learnt nothing from the past; they are incapable of understanding history. Their master plan ignores what commentators such as Broady (1968), Canter and Kenny (1975), Keen (1989) and Steinfeld and Danford (1997) have been trying to explain. Their efforts have been in vain because, for the authorities, only the master plan can "validate the hypothesis that the environment matters". When these authorities have been convinced, they will "move the field toward the ultimate development" - these pronouncements are so breathtaking, I must pause before writing more, to let its full impact sink in. The "ultimate development" consists of "appropriate design standards and guidelines" (Rubin et al., 1998:21). If only the world had had guidelines before hospitals were built! Then there would have been no medical errors, no nursing shortages. But why stop with design standards? In their review, Ulrich et al. (2005) declare that "art" contributes to medical outcomes, and

> [t]he limited amount of art research supports the conclusion that art selection for healthcare facilities should be evidence-based.

Art surrounds us everywhere we look - on TV, billboards, it is inescapable. Imagine, if all art was to be evidence-based then medical outcomes would be affected without art even needing to be selected in the first place! The savings in terms of building, use of medicines and nursing staff would be staggering. Forgive my humorous lapse, it is the sort of levity someone experiences on being told they do not have a fatal condition after all. Alas, all too often the euphoria causes them to be run over by a bus. There was a corrective to Ulrich et al.: a paper presented at the Environmental Design Research Association (EDRA) forum. It was a review of the literature on colour in health care environments. The authors concluded:

> The popular press and the design community have promoted the oversimplification of the psychological responses to colour. Many guidelines authors tend to make sweeping statements that are supported by myths or personal beliefs (Tofle, Schwartz & Max-Royale, 2003)

It is a reminder that personal beliefs do play a role in research, and suggests that people who have a more personal interest in specific areas may undertake research with more care.

Actual studies about real places

The volume of research on special care units for dementia (SCUs) and the broad overlap with issues in PAUs suggests that studies in this area, just as studies of the influence of the built environment in in-patient psychiatric units, should be generalizable to the topic of the PAU. A review commissioned by the US Congress summed up the state of knowledge regarding SCUs with a particular focus on the built

environment (Maslow, 1994). Maslow found that most SCUs had opened since 1983. She found 17 descriptive studies of SCUs. The difficulty she encountered with these was that they relied on narrative data, making meaningful comparisons between facilities difficult. The SCUs they described varied immensely in their programs, staffing and the built environment. Many of them claimed SCU status simply because they had installed alarms on the doors. Despite the plethora of guidelines on SCU environments, these were rarely described in practice. SCUs were more expensive to run because they generally had higher staff-to-resident ratios than standard nursing homes. SCU residents were more likely to pay higher fees, be male and white than nursing home residents.

Maslow also reviewed 15 studies comparing nursing home and SCU environments. These were characterised by small sample sizes and short evaluation time frames, failed to adequately describe subjects or interventions, and were often carried out by people with vested interests in planning or running the SCU under study. Researchers tended to base conclusions upon their personal opinions rather than the evidence. Maslow examined nine studies out of this group that did not have a comparison group, using a before-and-after design in which studies served as their own controls. Her scepticism about the validity of the findings led her to exclude contradictory findings, and list those where studies showed agreement. This indicated that SCU residents experienced decreased night time waking, improved hygiene and weight gain. In the remaining six studies that had a comparison group, four found no statistically significant differences between SCU residents and comparable nursing home subjects in cognitive abilities, activities of daily living, behavioural symptoms, and hospitalisation rates. Two studies indicated SCU residents experienced a slower

decline in self-care skills and had fewer catastrophic reactions. One study found a reduction in stress and burnout scores in SCU staff. In view of the conviction expressed by many that SCUs were in many respects better than standard nursing homes, Maslow was surprised to find so few positive results from the research. She nevertheless managed to overlook the shortcomings of the research to say these studies "constitute credible research in an area in which good research is difficult to design and construct" (1994:32). She was being kind. Only three of the nine studies without a comparison group included more than 24 subjects. In most studies, the evaluation period was only a few months. Only four of the six studies with a comparison group involved more than 14 residents, although evaluation periods were generally over a year.

None of the studies cited by Maslow (1994) were included in the reviews by Rubin or Ulrich. However, Maslow's (1994) review has been widely cited elsewhere. It is reasonable to assume researchers would draw some lessons from Maslow's work. It is also reasonable to consider that researchers standing closer to a topic would display more care in conducting research than reviewers who would have to take a more global, abstract perspective. I offer two studies that set out to investigate the effects of changes in the built environment on behaviours of patients, residents and/or staff in SCUs: Thomas (1996) and Kovach, Weisman, Chaudbury and Calkins (1997).

Thomas (1996) includes a reference to Mace, asserting there is a need to demonstrate the efficacy of SCUs because it is "of primary concern to consumers who increasingly demand accountability for health delivery services" (1996:8). In fact, it is unlikely Mace would have support this view. Mace criticised the idea of delivering "health" as

if it were a product, that the “normal activities of everyday life are acceptable only when they are labelled as therapies” (1993:17). Instead she promoted the idea of a therapeutic milieu that

> by using humane and ego-supporting methods, grows in its capacity to respond to the constantly changing needs of residents (Mace, 1993:22).

Thomas does not press his reference to Mace any further. Instead he takes up Maslow’s (1994) question asking what differentiates SCUs from traditional nursing home care. It is surprising, given the similarity even in the phrasing of the question, that he attributes the source to the lay press. The point is that it is unlikely that Thomas could have remained ignorant of Maslow’s work, and presumably he would have been informed of the problems she identified in existing studies. At any rate, Thomas declares that his aims are to describe the unique components that identify the unit under study as an SCU, and to assess their effects.

Thomas states there were five special components, namely philosophy, staffing levels, staff training, reducing stimulus and installing locks. His description of the philosophy is simply a statement that the management corporation was committed to creativity and autonomy. Staffing was an extraordinary CNA to resident ratio of 7:1. His carelessness in inverting the ratio is a sign of more to come. “CNAs” are presumbly certified nursing assistants, the US equivalent of Australian Assistants in Nursing (AINs). AINs typically have minimal training of a few months at the most. The length and effectiveness of the additional training provided for CNAs is not described. Declaring “the entire 24-hour day was considered potential programming time” Thomas tables the SCU’s daily routine, set out in 15-minute blocks for staff, without explaining how it contributes to the uniquely creative aspects of the SCU

(1996:9). The routine specifies what is to be done, when it is to be done and who will be doing it from the moment residents are scheduled to rise to the moment they are scheduled to sleep. Rather than a testimony of management commitment to creativity and autonomy, it is evidence of an obsession with managerial efficiency. It suggests that perhaps Sweeting and Gilhooly (1992) were right to suspect that what is presented as rehabilitative - or in this context, 'special' - disguises a profound impatience with dependency needs. There is nothing 'creative' here at all. The reality is that, as a staff member said in an Australian context, "there is routine and routine and that is all" (Mitchell & Koch, 1997). The schedule is in reality a form of *Andon* board, giving the appearance of supporting autonomy but distributing staff efforts with a maximum of efficiency.

The special component that Thomas devoted attention to describing and measuring related to changes in the physical environment, and therefore did not have any relevance to the other four components that he described as making the SCU 'special'. The research measured five out of a lengthy list of potential outcomes posted in the appendix of Zeisel and associates' (1994) article. The purpose of that article was to theorize specific outcomes in relation to particular attributes of the physical environment. From the description Thomas provides, the major difference between the physical environments of the nursing unit and the special care unit is that locks were installed, and discordant noisy stimuli reduced. According to Zeisel and associates' (1994) article, instituting immediate and highly visible controls over exit seeking would constitute more invitations for residents to leave. The result would be an increase in catastrophic reactions as well as more stress for staff. They also hypothesise that if an environment contained more comprehensible rather than

discordant stimuli, residents would more likely engage in meaningful independent activities. Thomas' measures were combativeness, weight, use of restraint, falls and Activities of Daily Living scores. These ignore the theoretical content, and Thomas does not explain how they would be relevant to the changes in the physical environment. These criteria are also unrelated in another sense. Only high-functioning residents were eligible for admission to the SCU and so were unlikely to pose a high falls risk or demonstrate dramatic weight changes during the short evaluation period. The data were extracted from the medical records three months prior and three months after subjects moved from standard care units to the special care unit in the facility. Although Thomas did remark that staff in the SCU might demonstrate the 'Hawthorne' effect (change in the behaviour of staff due to their awareness of receiving particular attention as a result of being involved in a research project), he did not explain who extracted the data, and if all the data over the three-month period was used, or if only data on a census date was used.

The study contained only 15 subjects which cannot result in any statistical or even clinical credibility that could be generalized to one's own practice context. No frequencies or scatter plots are given, only statistics drawn from paired analysis and significance testing. Imagine: if no subjects fell over before moving to the SCU, and one subject fell over afterwards, this could be calculated as being 'statistically significant'. Such statistics cannot offer any basis for knowledge, but Thomas' discussion of them reveals some interesting contradictions. He refers to having conducted interviews across the site. These interviews were not a part of the specified design. He uses them to offer opinions about staff attitudes, noting that they were 'positive' about the SCU and this attitude decreased restraint use. He is concerned that

despite removing identified trip hazards, the number of falls had increased. He does not raise any ethical concern that having identified trip hazards within a facility but only removing them in the SCU deliberately exposes residents in the traditional care part of the facility to a higher risk. Thomas speculates that staff in the traditional unit used to put residents to bed early for their own convenience. For some reason, in the SCU, despite the reduced staffing levels in the evening, staff let residents stay up later. Thus residents became tired and fell. It is all rather tiresome and opportunistic on Thomas' part. The final straw is the description of staff training that emerges in the discussion.

Thomas describes how staff were taught to analyse tasks so that by giving prompts to residents they would be able to "stimulate a habitual response", resulting in the resident completing the task unassisted. The example he gives is teaching staff to draw a sock on over a resident's toes, thus stimulating the resident to complete the task of pulling the sock on. The reference he gives for this is "Aredt (1997)". At first I thought this was some behaviourist I was unfamiliar with. Surely it could not be the famous philosopher Hannah Arendt: even the spelling was different. The reference is in fact to her. Arendt (1997) is famous for her study of 'the banality of evil'. Reporting on the Nazi war-crime trials, she was struck by how ordinary and unthinking the accused Nazi war criminal Adolph Eichmann seemed. She concluded that evil was not necessarily a matter of deep personal motivation. Its ability to be widespread and to produce horrors such as Auschwitz was due to its superficiality. Ordinary people could easily adopt an unthinking superficial attitude, just like Eichmann, if they wanted to, or if they had to. Thomas is referring to the training given as somehow fostering the habitual component that allowed both guards and

prisoners to so efficiently acquiesce to the Auschwitz program. Normal habits are excellent for this purpose. Familiar phrases such as, “you are only having a shower”, or typical aspirations such as “work will set you free” send shivers down our backs when used in conjunction with the Nazi concentration camps, but Thomas is not referring to Arendt’s critique at all. These CNAs are being taught, with Thomas’ approval, the same lessons that Eichmann was taught in order to become a functionary in the concentration camp bureaucracy. Thomas’ reference to Arendt is a breathtaking culmination of the carelessness that was apparent from the very first sentence, and so easily done. I do not have Arendt’s capacity to wonder why.

The lead author of the next article, Kovach, is in the company of luminaries Weisman, Chaudbury and Calkins (1997). Here one expects the best of both worlds: the grand authorities guiding someone who presumably must be passionate enough to study a particular place. Kovach and associates begin by summarising some of the issues Maslow (1994) identified regarding the diversity of SCUs and the problems in researching them. Then they cite opinions from the very studies that Maslow complained were often cited in spite of their weak scientific and evidentiary basis as if they were facts. Reversing Maslow’s concern that evaluations of SCUs were typically made by people with a vested interest in them, Kovach and associates declare that their involvement in planning the unit is an opportunity to evaluate it. Maslow’s caution that some special care units similar to the *Corrine Dolan Alzheimer Centre* appeared to be set up to avoid nursing home regulations is also ignored. The authors proudly state the unit they are about to evaluate is similar to ‘model’ facilities such as the *Corrine Dolan Alzheimer Centre*. It seems Kovach and associates only cite Maslow in order to give the impression that research has progressed.

The purpose of Kovach and associate's study is to explore the influences of the different physical environment between a traditional nursing facility and an innovative dementia care unit on residents' behavioural patterns. I tabulate the differences to illustrate that the adjectives used in contrasting the two units seem to contribute as much contrast as presumably the buildings themselves do:

Table 2 Terms Used to Compare 'Traditional' and 'Innovative' Units

TRADITIONAL	INNOVATIVE
• Four storey	• On the second floor
• Institutional ambience	• Welcoming, warm entrance
• Double loaded corridors	• Wandering path, continuous loop
• Hygiene and efficiency	• Medications handed out on a tray
• Surveillance, central nursing station	• Kitchen bench - informal surveillance
• Activity room	• Living room, activity areas

It is rather surprising, given the intention to measure the influence of environmental features, that the co-authors did not suggest using an existing formal instrument, such as the *Environment-Behaviour Checklist* (Zeisel et al., 1994). Indeed, during this time Weisman would have been involved in developing a similar instrument, the *Professional Environment Assessment Protocol* (Norris-Baker, Weisman, Lawton et al. 1999).

The research design intended to map the behaviour of 14 residents as well as staff, a month before and two months after moving to the new unit. Inexplicably, nine additional residents who were admitted to the new unit were also included in the

study. Rather than a paired before and after analysis, only a weaker pooled analysis is possible. No significance testing of the difference between the additional and previous residents was carried out. Since the SCU only admitted fairly high-functioning residents, it is likely these new admissions would have skewed the scores in a favourable direction. The number and characteristics of staff were not described, despite the intention to observe and record their behaviours as well. Despite claiming the mapping techniques derived from early work by Zeisel, the checklist did not draw on his later (1994) work. Instead it appears to have been put together on the basis of expert opinions. That is why the clichéd category of ‘task oriented behaviour’ is listed. It is the sort of sweeping opinion that experts must express from time to time to remind others of their authority.

Kovach and associates state non-parametric statistics were used as the results did not conform to the normal distribution. This means the results were skewed. They did not provide any scatter plots, ranges, means, frequencies or confidence intervals so that readers might have a better idea of the distribution of scores. The Friedman F statistic (roughly a ratio of the difference between groups divided by the difference within groups) is given. When there is little difference, this approaches one. The p-value, the probability of the results not being different, is also given. The only instance in which a high F value and a p-value of less than 0.05 occur is in the reduction in bedroom occupancy in the dementia unit.

Curiously, Kovach and associates do not discuss bedroom use by residents, nor do they remark that according to the data, staff in both units spent no time at all in the bedrooms! In fact, there are other strange results: Residents in both units spent

roughly 50% of their time in social interaction and active participation. This seems a much higher proportion than I have encountered. It is mildly amusing to see that in both units nurses spend about 20% of their time doing ‘task oriented’ activities. I suppose those who spent less time doing so, would have been fired - a sort of selection bias. Kovach and associates devote more attention to the increase (a small F-statistic) in the use of dining and activity areas in the dementia unit. It is not surprising: the floor plan for the SCU shows that these are essentially the same room, and the only place to go that is readily accessible. We cannot tell what the rooms on the floor plans for the nursing unit are, as there are no labels given.

Then, just as Thomas did, Kovach and associates proceed to ignore the data and use ‘anecdotal evidence’ and ‘qualitative observation’ to express opinions. On this basis, they assert staff are “much less frequently required” to orientate residents, and are more “interactive than assistive” in the dementia unit (1997:109). Just like Thomas, they mention the possibility of researcher bias, but without explicitly relating it to themselves. Likewise, the lack of a ‘true control group’ is not attributed to their inclusion of an additional nine subjects, a violation of the ‘before-and-after’ design. Like Thomas, if the data do not suffice, they must find something else to be the cause of all these behaviours. Kovach and associates offer ‘factors’ such as resident history, staff training, and quality of staff-resident interaction. Despite their assembled expertise, the way this paper is written gives the charming impression that before conducting the study, these experts had no idea of other ‘factors’ that could have affected behaviour. We could never imagine these experts admitting that their expectations were, in the end, crudely deterministic. The only words that would make

any sense to the ordinary thinking person reading this study lie in the closing statement:

> [O]ne needs to recognize that the two physical settings were built in different times with different philosophies of care which calls for a more historic analysis for a better understanding of the temporal contexts (Kovach et al., 1997:109).

It seems that there is no getting away from the smug assurance that the present represents progress, and the past is a folly that we can look upon with benevolent understanding, rather in the way that enlightened colonialists would have looked upon the quaint habits of natives. Even though some twenty odd years of admittedly rather poor research has not led to instantly recognizable findings, there seems to be an unshakable confidence that confirmation of this progress is merely a matter of time. It is the unthinking aspirations of footballers at work. Without insulting footballers, the hope is to crash through the opposition and confirm one's superiority by scoring points. One would think that, even with all the biases and shoddy designs, if sufficiently dramatic differences in the statistics have not emerged, then researchers would have spent more effort in analysing their assumptions. Surely, if someone had managed to pull off the perfect study that confirmed the expectations of authorities such as Ulrich, then it would be famous by now and everyone would know about it? With my intense interest in the field, surely I would have run across some reference to it. Obviously the perfect study does not exist and, almost as obviously, researchers have not questioned the assumptions. There must be other interests driving this form of research, other interests keeping the idea of a crude person-environment fit alive. Kovach and associates have unwittingly suggested an answer in their closing sentence. It is not the history of building though, but the descent and architecture of the ideas it represents that we need to recognize. I want to bring this background to an

end by outlining the descent of crude determinism from its promising origins, and how it comes to be maintained today. From this point I will then go on in the next section to explain how the philosophy and methods for this study emerged.

The fate of determinism

After World War II had ended with its big and distinctly alarming bang, sociology grew

> at a more rapid rate than ever before… sociologists were exposed to new pressures, temptations, and opportunities…[they] grew more numerous, more worldly, more experienced, more affluent, more powerful, and more academically secure (Gouldner, 1971:23).

There was a boom in the social sciences in the immediate post-war period in the US that paralleled that of the physical sciences. In such a climate, investigators such as Barker managed to attract funding for extensive and groundbreaking field studies.

Barker (1968) reports on prolonged field studies of observations of people's behaviour in a variety of locales such as shops, schools and open spaces. He notes that people's behaviours varied more according to the locale than according to the individuals' characteristics. Thus, people generally acted in similar ways in public places or 'behaviour settings' such as banks, schools and playgrounds:

> People, en masse, [are] remarkably compliant to the forces of behaviour settings (Barker, 1968:164).

The exceptions he notes are that:

> When an individual's behaviour deviates from the pattern of a setting, it is usually symptomatic of mental or physical illness, or the normal incapacities of extreme youth

> and age (Barker, 1968:164).

In his view, the built environment is not a passive, probabilistic arena but a highly structured improbable arrangement of objects and events that coerce behaviour. A person stands as an identifiable entity linking yet separating a psychological interior from a world of non-psychological external phenomena that he terms the 'ecological environment'. The ecological environment refers to the objective, real-life settings in which people behave. They experience it, however, as what Barker calls 'life-space': or the world as a particular person sees it and is otherwise affected by it. Thus, 'catching a ball' is a momentary action that takes place in the course of a person's life space. But the rules of the ball game, together with where it takes place, constitute the ecological environment. The relationships are always there, always complex. It may sound strange to say that this US scientist, with a view of society and humanity that has no dark secrets, still recognized mysteriousness and complexity. His statement that the behaviour we see consists of "bounded manifolds of individual elements" (1968:12) could have been written by Koestler. At much the same time that Barker was out in the field, Koestler (1967) was working on his theory of the 'holon'. A holon is both a system in itself ('whole') and a part of the surrounding system. The dynamics of 'life-space' are similar to the holon.

Koestler's (1967) theory of the holon offered no immediate prospects of practical application. He had developed the idea of the holon in a way that emphasised its dual nature. He argued that human beings have an 'integrative tendency' or a desire to belong to society, and an opposing 'self-assertive' tendency emphasising their unique qualities of individualism and competitiveness. For Koestler, it was the integrative tendency that enabled the catastrophe of our history, of being able to butcher each

other with a rightful conscience in the name of righteous ideals such as nationalism, freedom or democracy. Barker managed to avoid being trapped by anything in the ‘bounded manifolds’. Instead he slipped into the same broad pathway that Vygotsky, in his critique of Watson’s common sense methods of behaviourist investigations, had called “half-hearted behaviourism”:

> he slips into the viewpoint of the ‘common man’, understanding by this latter not the basic feature of human practice but the common sense of the average American businessman. In his opinion the common man must welcome behaviourism. Ordinary life has taught him to act that way. (Vygotsky, 1927)

Whatever the origins of Barker’s work - whether the concept of ‘life-space’ derived from Lewin, the influence of Gestalt or other theorists – they did not matter to the history that followed. The fascination for those who decided to follow up Barker’s work was not his theoretical musings, but his methods. The glimpse of regularity in behaviours was also a vision of a correspondence between environment and behaviour, offering the prospect of being able to ‘map’ behaviour. Authors such as Tuan (1974) could write about the relationship between person and place not as variables and coercion, but as a ‘love of place’. Tuan points out that the judgments of natives and visitors rarely overlap because they have different purposes. He goes further, pouring cold water on the passionate dreams of science: "Reality is not exhaustively known by any number of human perspectives...” (1974: 248). His colleagues may have nodded, but for them behavioural mapping had more appeal than any vague ideas about love of place. It is the simplifications of science we inherit.

Somner (1969) had mapped behaviour in relation to furniture in a psychiatric ward in a paper that was to become probably one of the most popularly cited articles in the field. It was the elusive proof, the Northwest Passage, scientists had been looking for, the dramatic correlation between environment and behaviour. By the 1970s the simplistic idea of the person-environment fit conceived of as the environment producing behaviour had become the canon of science. Behaviour 'mapping' had become all the rage. Proshansky, Ittelson and Rivlin, in a massive volume they also edited (1970), explained that behaviour mapping was an empirical tool that was useful for describing, comparing and predicting behaviour. They even posed a law, the 'conservation of behaviour'. Similar to the law of conservation of energy in the field of physics that states that energy can be neither created nor destroyed, the law of conservation of behaviour holds that if changes to a physical setting are not conducive to a pattern of behaviour that has been typical of a setting, that behaviour will express itself at a new time and/or locus (Proshansky, Ittelson & Rivlin, 1970). Behavioural mapping featured prominently among the impressive collection of papers presented at the Second Environmental Design Research Associates (EDRA), with claims by some contributors that mapping could reliably discriminate "at a level of interdependence corresponding to the lived experience of their inhabitants" (LeCompte & Willems, 1970: 237). When Ulrich published his famous 1984 paper correlating the presence of a view from a window with the speed of recovery after surgery, it was not the content but the clear correlation that excited everyone. It was the equivalent of finding the Northwest Passage, again. That is why in the P-E fit canon there is no hint of self-doubt: these scientists know there is a correlation between behaviour and environment. For them the entrancement is with the manner of science, the kudos of proving it. Their repetition and reworking of the idea of behavioural mapping, from

Barker in the 1950s, through the developments and variations of 1960s and 70s, and on into the present, reveals their habitual, ritualised “range of expectations” (Kuhn, 1970:35).

When the data do not confirm the theory, yet it persists in the apparent absence of any other way of thinking about it, then this constitutes what Kuhn (1970) calls a ‘paradigm’. He explains that a scientific paradigm exhibits consensus about what is admitted as scientific. The consensus view becomes a philosophy, a methodological directive. As a time-tested and group-licensed way of seeing, it resists disconfirming evidence. Chalmers (1978) combines Kuhn’s notion of a ‘paradigm’ with Lakatos’ concept of a research ‘programme’. Chalmers explains that in a research programme, the core assumptions must not be modified. They are protected from attack by a belt of auxiliary hypotheses. Thus challenges to the paradigm can be contained within it. We can see this at work in Steinfeld and Danford’s (1997) theory of ‘dynamic reciprocal determinism’ which is really a contemporaneous version of what appeared in Keen (1989) as a caution that things were not so simple. When hopes of a simplistic correlation between environment and behaviour are dashed, then ‘dynamic reciprocal determinism’ can be invoked to add the cunning of a feedback mechanism that cannot be pinned down, just yet. Even so, it is unlikely that it will receive little more than a nod of acknowledgement. Like Keen (1989) or Tuan’s (1974) work, it is likely to be a dead branch. Truthfulness is not necessary for a theory to survive but usefulness is. Even Kuhn’s exposure of the essentially non-scientific nature of the conduct of science has proved to be a dead branch. Like Keen, or Tuan, or even Maslow, it has had no influence on contemporary researchers such as Kovach and associates (1997) or Thomas (1996). Kuhn’s *The Structure of Scientific Revolutions*

produced a flurry of self-examination within scientific circles for a decade or so before science returned to business as usual. Perhaps because, like Koestler's holon, it brought dark suspicions of our nature rather than faith in scientific progress, the very word 'paradigm' is now unfashionable. It is used apologetically, by students rather than authorities. If the old Nazi slogans still send a shiver, slogans such as 'subvert the dominant paradigm' result in a cringe of distaste among the elite.

There is an even simpler process that ensures the survival of simplistic notions such as environmental determinism. It has nothing to do with the promise of predictable results, or auxiliary hypotheses, or strategies to minimize contradictions. Kuhn also describes the scientific community as blinkered by its textbooks which truncate the uncertainty of the historical formation of ideas by giving the impression that scientists always "worked upon the same set of fixed problems" (1970:138). The result is that human idiosyncrasy, error and confusion are obscured by the appearance of an orderly progressive solution of a well-defined problem. It is thus a false picture, the idea of a 'tradition' rather than profound doubt that students are taught and inherit. Is Kuhn's suggestion too restricted? Surely, 'textbooks' are only one aspect of a culture that supports a certain frame of view. As we have seen, naïve determinism does not even depend on whether it is scientifically verified. It is a belief that is useful, a form of adaptation that is needed. Scientists have failed to engage with the issues raised by determinism. In the field of health care in general and aged care in particular, determinism is treated as if it were a fact of nature rather than a social expectation. If we stand back, we see these opinions represent a fundamental carelessness of attitudes and thinking that is widespread amongst researchers, architects, designers and those who write policies. It seems as if we live in an age in which (to paraphrase Deleuze

and Guattari, 1996) everything is permissible, yet nothing is admissible. Carelessness and unthinkingness make no difference to capital works. They prosper, for today and tomorrow is only another day. As if in a dream

> In succession
>
> Houses rise and fall, crumble, are extended,
>
> Are removed, destroyed, restored, or in their place
>
> Is an open field (T.S. Eliot, *East Coker*)

If we believe what is now on offer, we too can take our place in the proud succession of the new over the old. We too can cultivate within ourselves those adaptive qualities that are the only thing necessary to achieve privileged status (Gadamer, 1982). But if we sense that the core of social reason, solidarity, is in tatters, are we condemned to carry on in silence, trapped within our private unease? We appear to act as if we each had a private reason, as if that were sensible and adequate: "but," Gadamer asks, "does this have to remain this way?" (1982:86).

Chapter 2: Natural History of this project

Overview

I open the natural history of this project at a point just after the beginning, with conventional descriptors of the fieldwork. This describes how many people were interviewed, and where they were interviewed. However, the primary intent of this chapter is to give the reader an idea of how the research question originated and developed. This has had implications for the choice of methods used in interpreting the data, and beyond that, for the inferences drawn from the study. The question I began with was a straightforward matter of measurement, derived from Rubin and associates (1998). I adapted their review title to ask: “Does the built environment of PAUs affect medical outcomes?” I will explain that the motivation in asking it was not purely scientific but was intended to ‘show up’ ancient crumbling facilities in comparison to modern ‘purpose-built’ units. This section also explains how I came to regard the interpretations of nurses as more relevant, which in turn leads to the question that eventually guided this study to its completion: to explore what is performatively at play in the practical experience of understanding the built environment by PAU nurses in the course of their work. I relate how I began the fieldwork utilising the grounded theory approach with the intention of comparing and generating theory that would describe and explain how nurses viewed these contrasting environments. However, through a combination of fieldwork and reading, I came to radically doubt the value of the idea of science as a process of finding out and then offering theories or facts. Instead, I came to hold it as a more worthwhile end

to write the study up in a way that would provoke doubt and open discussion on what we, as a society, know and do.

Conventional research descriptors

I conducted unstructured interviews at three PAUs located in three different cities in two Australian States. Two of these sites were selected because of their contrasting design (traditional vs. modern) while the third was selected because colleagues told me it was new. I gave these sites descriptive pseudonyms. *Putria* is the traditional ward, *Milduria* is the purpose-built ward, and *Tempuria-Eternia* is the new ward. A convenience sample of nurses was selected on the basis of availability. Nurses were approached and, if they were interested in participating, presented with the Subject Information sheet (Appendix A). I then explained the purpose of the study. If they were agreeable, they were then given an Informed Consent Form (Appendix B) and the ethics committee requirements concerning the study were explained. A total of 19 nurses participated. These included both Registered Nurses (RNs) who undergo more extensive nursing education than Enrolled Nurses (ENs). The majority of nurses interviewed were female RNs (see Table 3 below).

Table 3 Gender and Nursing Role of Participants

Putria		*Milduria*		*Tempuria-Eternia*	
Female	Male	Female	Male	Female	Male
1 RN	2 RN	5 RN	3 RN	2 RN	1 RN
1 EN	1 EN	1 EN	1 EN	1 EN	

Five of the one-to-one interviews conducted in *Putria*, and four in *Tempuria-Eternia*, were taped and transcribed in full. Four one-to-one interviews conducted in *Milduria* were taped and transcribed in full. A female EN in *Milduria* refused permission for the interview to be taped but allowed me to take notes instead. An impromptu encounter with an RN and her male EN colleague in *Milduria* developed into an interview that could not be taped due to technical problems, so I took notes instead. Another impromptu encounter in *Milduria* with two female RNs and one male RN resulted in an interview that was taped and transcribed in full. I have used pseudonyms to conceal the identity of participants, but where my speech is included it is identified by my initials, NL.

Interviews lasted from ten minutes to an hour, but generally lasted about twenty minutes. They were all conducted at the sites during quiet periods at work. Most interviews were conducted on late afternoon or early night shifts. Interviewing at each site ceased when I had the feeling that nurses were not likely to bring up new major themes. This is a variation of standard grounded theory procedure, which specifies interviews continue until no new concepts emerge, theoretical categories have been sufficiently consolidated, and deviant cases have been investigated for their bearing on the phenomenon in question. There was also a second reason to cease interviewing: it was when I felt I had enough range of material to hold it all in my head.

After each interview I would jot down my impressions and then listen to the tape, making notes before transcribing. I converted all the audiotapes into MP3 format and placed all these on one CD with a backup copy. This gives greater security over the

audio data, as one CD is easier to keep secure than sixteen cassettes. The cassettes were erased and then taped over with music.

While I was doing fieldwork, I was following the grounded theory method. I also suspended nursing and took up part-time project work, which serendipitously allowed me access to NVivo software. This software was ideal for marking and coding transcripts according to a variety of different coding strategies. This was invaluable in that it allowed me to become familiar with the data by approaching it from many directions. Once I returned to nursing work I no longer had access to the software, however, by then I had adopted a different theoretical approach and was no longer reliant on coding schemas.

Origins of the research question

With the original question “Does the built environment affect medical outcomes?” my intention was to prove that the built environment of PAUs did affect medical outcomes. It relied on precisely the same logic that Moran (Elliott, 2004) used: that the best way to lobby governments is to show them research. Faced with working in a PAU where the living conditions probably would not even have been acceptable in Victorian times, I thought I was taking a problem from life and cleverly solving a scientific and social problem at the same time. Governments would read my research showing the superiority of modern purpose-built settings over the ancient relics adapted for the purposes of the PAU, and they would of course be shocked at the conditions people endured in those ancient places. They would immediately respond by replacing these with something purpose-built.

The only concern I had was to disguise my expectation that simply comparing a Victorian era setting with a modern purpose-built one would show the superiority of the purpose-built. As a dutiful student of statistics, I had learnt that assuming the null hypothesis (the attitude that the intervention showed no difference) was the key to credibility. I would present my findings in an impeccably objective fashion, with an air of impartiality and surprise. I was confident I could overcome measurement problems because I considered Zeisel and associate's (1994) instrument and its proposed use as a way of discussing and achieving a consensus evaluation of the built environment, represented an immense progress from earlier instruments. As a bonus, it would probably be one of the earliest uses of it in Australia.

If I had not attended the opening of a new aged care facility, *Hyperboxia* (a descriptive pseudonym) but had remained 'task centred', it would have been done in record time. Imagine: a rating carried out of a modern purpose-built setting and compared with one from an ancient setting, a few statistics about psychotropic medication use, restraints and aggression, and the case would be proved. The visit to *Hyperboxia* aired concerns that had been bottled up for years, concerns which I had dismissed as too messy and un-scientific.

Hyperboxia blended in with the surrounding houses in a middle-class suburb, a good walk along a busy road from the station and shopping centre. Indeed, the facility did not have a distinct name, using its street address as a way of stressing how 'home-like' it was. The wing where the ceremony was to take place was hidden behind the spacious entrance. Speakers representing management and the architectural team

praised their own work as the epitome of consultation and collaboration. It was to be an opportunity for ‘cultural change’ away from a ‘medical model’. They would bring only a minimum of nursing staff from the old facility that was being closed down. They would employ new staff, freshly trained by the local technical college to be multi-skilled. They extolled the virtues of the ‘home-like’ chairs they had purchased. Was there a hint of ancient feudal powers when the Director of Nursing said she would make sure that if residents were incontinent, the staff would wipe over the chairs immediately, as they were very expensive? When someone commented that male residents would use basin-like protuberances along the corridors to pee in, it was instantly denied. They provided a homely touch; flowers would be put in them we were told. I had thought they were for holy water. When someone commented that the wings looked similar, it was explained that the decorative friezes along the wards were specific to each wing. Residents would be orientated by learning to associate the Tudor, Georgian and Victorian styles with each wing. Embarrassingly the architect conducting the tour managed to get the whole group lost, until a workman passed by. Uneasily, I caught the overnight train home.

Through the night, phrases I had heard returned. They had said that the gardens were “not just gaps between buildings” but were to give the residents “solace”. But the garden beds were squeezed in and sloped steeply between the different buildings - the whole site sloped. It all felt as if one could go tumbling down. Where it did not slope, it squeezed, there was hardly room for one person to stand. Here, the idea of ‘solace’ in sitting outside seemed more like self-imposed solitude, a reflection of abandonment in a place from which there was no prospect of escape. Then there was the phrase about making sure staff “immediately” wiped over the chairs, because they were

"very expensive". But the experienced staff had been spilled; they had been replaced by multi-skilled low-paid workers from the technical college, with 76 hours of training. The staffing ratio would be one staff to fifteen residents. With the long corridors, staff would walk miles every shift. They would be serving meals, doing washing, handing out medications, writing notes. Yet these executives were talking about staffing and the few miserly hours of second-rate training as having a magical effect in the phrase "what happens when you raise the lowest common denominator". To them it was as if they were varying the parameters in a game, and they had the unquestioned right to judge whatever aspect they chose to about my peers. I felt frustration at the thought of these people sitting high on their thrones, whilst the menials scurried about with serving dishes and flannels below.

I gave a paper on my proposed survey method at an Australian Association of Gerontology conference. It felt lifeless and boring, with an objectivity that barely disguised the distraction of attention turned elsewhere. The visit to *Hyperboxia* and the paper worked on each other to show me that I had taken a problem with important human dimensions and turned it into a technical abstraction that I despised. It dawned on me that my plan to survey, measure and compare was not a clever piece of Machiavellian strategy. I was naïve to think purpose-built settings would provide a solution to concerns that were so broad, fragmentary, common, and strangely invisible. I had blinded myself with what looked like science. I was even more naïve to think that anyone in government would be in the least bit interested in yet another PhD that attempted to solve the problems of - well, its particular world.

I began to read texts to draw out my doubts and gripes, my own incompletely articulated experiences. I looked for works that matched the turmoil I was admitting to myself. I looked for and found the craziest, wildest stuff about the built environment. Late at night, statements like Bataille's "the good people vegetate far from the slaughterhouses" (1997:21) meant more to me than studies that set out to measure things but only left a sense that they were in fact obscuring things. I read about methodology with an increasing feeling that I needed to find some way in which the problem I could only sense could at least be roughly posed. My hope was that by putting the problem in some interim format, it would emerge later.

I realised the problem I was trying to pose was bound up with my point of view as a hands-on nurse within a PAU and with my curiosity at what my colleagues 'really' thought of things. One issue that seemed to stand apart from the complexity of care, was a frustration with the built environment that at times seemed to boil over in team room talk. That was why I had settled on the built environment as a topic for inquiry. At this time I only vaguely realised that my colleagues' experience of the built environment was the subject of inquiry, but the direction of my interest - the target - was the background of whatever forces, social, historical, that led to the creation of the circumstances we found ourselves in. This relationship between the phenomenon being studied and its broader social context is what Jaffe and Miller call "structural embeddedness" (1994:51). Unfortunately, Jaffe and Miller concentrate mainly on the position of the researcher in relation to the subjects of research, and do not effectively problematize the significance of this notion. Without pre-empting the research, I point out that structural embeddedness, in referring to the relationship between small scale milieu to the larger forces in their surrounding milieu, covers the ground of

puzzlement that the individual experiences unease about. Mills (1983) talks about individuals being ‘sunk’ within their milieu; ‘structural embeddedness’ is a similar metaphor.

I have given a particular view of this background surrounding the PAU in the previous chapter. It intended to show this background is a “linguistically constituted worldview so closely identified with world order that it cannot conceive of itself as an interpretation” (Habermas, 1984:49). It accepts its rationality and assumption of progress as real. However, the effect of simply displaying the statements of its leaders and their followers demonstrates an absurdity that because of its command over resources, must be taken seriously and questioned. It claims the authority to rule off the past, to name things in the present, and to be able to manipulate these things to produce progress. The tendency to rule off the past is becoming ever more pronounced. It is astonishing that a peer-reviewed journal can, for instance, publish assertions such as the one by Tyson, Lambert and Beattie (2002) that therapists only recognized the importance of the physical environment in therapy after the 1970s, without any evidence given in support of the claim. Without any hint of history, or even the current historical context in which the research occurs, findings take on an air of objectivity and universal fact (Kuhn, 1970). This gives those associated with them far greater authority to make judgements than they should have. Their authority ultimately derives not from the service they render science, but from the services they perform for Capital. There is a similar authority given as a result of naming things. We can see this in Kovach and associates’ use of adjectives as a means of simply declaring differences between traditional nursing units and SCUs. The subsequent discussion is not concerned with phenomena at all but with reductive searches for

'factors'. It is little different to Gould's extensive analysis of 'reification', or things that are bought into being by naming. The test to measure 'intelligence' led scientists to search for contributing variables, rather than questions regarding the concept itself. Gould labelled what passed for knowledge as a result of this enterprise "shared dogma masquerading as objectivity" (1982:279). However, the idea itself was not used innocently as a description. The idea that 'intelligence' was something inherited rather than culturally acquired was political capital for those desiring selective breeding programs. Perhaps in this study we may find that the idea of the 'purpose-built aged care facility' is an idea that serves economic and political interests more than it serves those who dwell there.

Ruling off the past and naming things also contributes to the impression that what is named today must be modern and therefore an advance on the past. Knowing what something is also implies we know the parts that make up its whole. Changes to the parts will therefore produce changes to the whole. Thus the built environment is conceived of as something that can be manipulated to produce superior results to those associated with the crude, unenlightened past. It is a worldview, Lorimer (1999) argues, in which there may be some feedback allowed between causes and effects but in which there is no ambiguity about cause and effect. With its peculiarities that are hard to normalize away, its location within a zone of repulsion, and its unimportance in the overall scheme of things, the PAU stands in a subordinate relation to this world of knowledgeable authority. Those with knowledgeable authority cannot see the world from a subordinate position, are blinded to insights that perhaps can only originate from a subordinate view (Jaffe & Miller, 1994:56). From this perspective, the PAU is a point from which it is relatively easy to take the moral high-ground and

press for a vigorous rather than complacent critique. The critique may begin with a sense of unease, of shortcomings within the PAU itself, but its target is the distant, untouchable, remote, anonymous, superordinate context with its vectors of disdain and exclusion for what it deems unimportant. However, this involves struggling against the pressure of what Kuhn calls (1968)'normal science'. Normal science proceeds with a well-identified problem to solve and the conventionally accepted methods with which to solve it. This critique deals with a problem that is hard to define in the court of reason but appeals rather to recognition by those who share a similar sense of unease. It transgresses what Kuhn calls:

> [o]ne of the strongest, if still unwritten, rules… the prohibition of appeals… to the populace at large in matters of science. (1968:168)

These unwritten rules strongly inhibit the thoughts and directions of someone embarking on what is called scientific research. As I look back at my notes, I can see that within the first year of beginning this study, I had read the texts that would be most important in shifting my outlook - and had even sketched out the ideas I would come back to years later, as I write this study up. In the intervening years though, I could not escape the influence of the P-E fit canon with its notion that there was some sort of secret formula that only had to be discovered to show how environment produced behaviour, and once discovered, could be measured. My radical doubts that were there from the very beginning were kept within respectable limits for years.

Thus I read empirical studies of the built environment, such as those published by Proshansky and associates (1970) and Barker (1968). Their material would be simplified and taken over by those whose aim is to publish first and do science

second: their work forms the body of the P-E fit canon. At the same time, I read the incredibly rich and profoundly disturbing overviews of social and cultural theory written by Blaikie (1993) and Crotty (1998). This was followed by texts concerned with qualitative research methods such as interviewing, or analysing narratives - while at the same time combing through my statistics texts and PC programmes and thinking about how to use Zeisel and associate's (1994) *Environment-Behaviour Checklist* instrument as the basis for a survey approach. Cleverly, at one stage I thought to combine survey measures with interviews about the survey questions. I would read nursing theorists, or rather people I assumed had the right to write about nursing, such as Thomas (1996), without checking to see if they were nurses. I would agonize over how to measure the organizational climate at the same time as reading Gubrium's (1974) description of how nurses had to answer to both resident and manager demands, or Diamond's (1992) study of how the dollar determined care work. I would read Eco's (1980) ideas about denotative and connotative decoding of the built environment, and at the same time be reading Barthe's (1972) exposé of depoliticising myths in our everyday language. It seemed to go on forever; yet within a year, I had dropped the survey approach and had settled on the aim: to adopt a theoretical attitude to what was "performatively at play in the practical experience of understanding" (Gadamer, 1982:112).

In a sense it was like a wrestling match: a straightforward empiricism being challenged by uncertain doubt about what was straightforward. Gubrium's (1974) study of the multiple realities staff experience in nursing home work was an eye-opener in this respect. He describes how nurses ("floor staff") in addition to the often-demanding pressures of care work have to answer to the demands of administrators

("top staff"). Top staff and patients each have their own distinctive views of how things should be - but it is only nurses who have to defer to both of these views. Thus nurses at times have to break the rules of top staff in giving care. Nurses depend on the absence of top staff to be able to ignore routine tasks in resolving care dilemmas. However, if invited to meetings with top staff, nurses are typically invited alone when, readily intimidated, they acquiesce with the views of top staff. The point Gubrium makes is that "multiple definitions emerge of what is officially defined as a common concern" (1974:97). That is where the sense of unease arises: that what is so often assumed to be a common concern is often the concern of top staff presented as if it was the concern of floor staff - and floor staff are easily intimidated, duped into agreeing. Despite a gap of some twenty years, Diamond's (1992) study of hands-on care workers in US nursing homes showed that these same distinct relations still held. Reading these, I no longer felt that my own misgivings were trivial, not worthy of investigation.

Symbolic interactionism

At this stage, early in the career of this research project, I searched for the most conventional and seemingly respectable and hence unassailable perspective. Statements like those of Bataille cited above seemed too wild. I restricted my sense of unease to focus on finding out the sincere, truthful opinions my colleagues had of the built environment. Reading general texts about social inquiry by Blaikie (1993) and Crotty (1998) in addition to my previous education in research methods suggested the grounded theory (G.T.) method was appropriate. This method considers the ways in which people make sense of their environment as they set out to do things. It is

derived from the philosophy Blumer called ‘symbolic interactionism’, which in turn stems from Marx to Mead (Hutchinson and Wilson, 1991). I will return to G.T. texts in a moment, but first I want to explain how I understood symbolic interactionism at that time.

Blumer made some powerful statements that reflected both my concern with the survey approach I had in mind as well as the misgivings raised by visiting *Hyperboxia*. He pointed out that ‘meaning’ was taken for granted, as a neutral link between factors responsible for behaviour. He argued that:

> To ignore the meaning of the things towards which people act is seen as falsifying the behaviour under study (Blumer, 1969:3).

Blumer’s specific point in making this statement was that the meaning of things was not inherent in the things themselves, but created, bestowed and sustained by people. In contrast to this, traditional realists hold that a chair, for instance, is intrinsically or ‘naturally’ a chair; and psychologists regard meaning as originating in the perceptions and attitudes of the person viewing the thing. Even Blumer’s choice of a chair for his example was apt, in view of the protectiveness the Nursing Unit Manager of *Hyperboxia* had shown towards chairs as opposed to his indifference towards staff. The process of applying meaning involves the person indicating to themselves the nature of the things, and then selecting and applying the meaning in the light of the situation and direction of action required. Human groups or society seen in this light exist as actions that occur in response to each other, and it is actions that are the starting point and returning point of analysis.

The survey approach I was proposing would have set out such factors as role demands, local management culture, the inherent properties of certain things in the built environment, and sought to relate them to 'outcomes'. The outcomes I had in mind were immediately measureable - such as reduction in psychotropic drug use, or intrusiveness. Blumer's writing appeared almost in the way Gadamer (1982) writes of Christians receiving the Gospel as a direct, personal address to them. In my notes I wrote that explanation in terms of factors such as those suggested by the P-E fit canon, could not suffice because they were not, to cite Blumer, "paying attention to the social interaction that their play necessarily supposes… One jumps from such causative factors to the behaviour they are supposed to produce." (1969:7)

If behaviour was not the direct outcome of some inherent coercive force emanating from things, then I had to think of how the meaning involved in directing behaviour was bestowed. Blumer explained that "behaviour… is an action that arises of out the interpretation made through the process of self-indication …[and] the human being who is engaging in self-indication is not a mere responding organism, but an acting organism" (1969:14-15). Next it seemed that Blumer peered into the very depths of the miserable wretched souls of myself and colleagues. He could see us running up and down corridors with wiping cloths and solutions for expensive chairs owned by others in order to earn our miserly daily bread. He could see the pressure in our lives that extended beyond the immediate wiping of chairs just in time and on demand. He wrote that rather than confronting an environment to which we respond as if we were merely biological entities, instead we confront a world that we must interpret. Blumer's example is of a man who

> has to construct and guide his action instead of merely releasing it in response to factors

> playing on him or operating through him. He may do a miserable job in constructing his action, but he has to construct it (1969:15).

This applies not only to the individual, but also to the individual as a member of a group. Even within a group or culture where actions are so regular they can be predictably related to factors, they still must be individually constructed.

During the course of this study the implications of these notions unfolded. Engels wrote that the persistence of investigations that viewed "things as given, as fixed and stable" arose from the natural sciences, but did not learn the lesson from the natural sciences that "the world is not to be comprehended as a complex of ready made things, but as a complex of processes" (Marx & Engels, 1950:351). It is about facing this complex of processes, that Marx wrote

> Men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past… (Marx & Engels, 1950:225).

For empirical science, this means grappling with the obduracy of an empirical world that is not fixed, but "talks back" and therefore methodology must cover "the principles that underlie and guide the full process of studying the obdurate character of the given empirical world" (Blumer, 1969:23). The particular implication Blumer drew and repeatedly stressed, was that the conception of a world in which the nature of things was fixed and had to be explained in terms of the advanced physical sciences was "particularly pernicious in its effect on social and psychological science…[it is] philosophical doctrinizing and does not represent the approach of a genuine empirical science" (1969:23). There is an element of 'cultural cringe' in this

statement. Blumer is at pains to focus on social science and seeks to avoid or distinguish it from what he suggests is an arbitrary activity, social philosophising. Gadamer is the author who places science and philosophy into a meaningful relation for this study and I will discuss this later in the chapter. It was Blumer's repeated criticism of the use of *a priori* theoretical schemes and canonical procedures that led me to identify and group together those studies I called the P-E fit canon. In the absence of canonical protocols, the familiarity of the researcher with the empirical world under study becomes vital. Without realising it at the time, I stopped interviewing when I felt I had enough variety but reached the limit of material that I could remember. This is distinct from the grounded theory suggestion that interviews essentially cease when no new concepts seem to be emerging from the data.

Blumer considered research into the empirical social world to consist of two fundamental activities: "exploration" and "inspection". The emphasis in exploration was to become familiar with the world under study so that "the problem, direction of inquiry, data, analytical relations and interpretations arise out of, and remain grounded in, the empirical life under study" (Blumer, 1969:40). He recommended that discussion with a small group was particularly valuable - advice that I overlooked at the time, but something that was to accidentally occur during the course of the interviews and confirm his assessment. A second point Blumer made was that the researcher should be "constantly alert to the need of testing and revising his images, beliefs, and conceptions of the area of life he is studying" (1969:41). Again, at the time I read these words, I did not realise how important they would become.

Comprehensive and intimate description may sometimes be sufficient to answer questions, but generally the next step involves "inspection". This involves "casting the problem in theoretical form… unearthing generic relations… sharpening connotative references of his [sic] concepts, and… formulating theoretical propositions" (Blumer, 1969:43). These notions are approached in a variety of ways, viewed from different angles and subjected to many different questions. Blumer stresses that as a mode of inquiry, this flexible, imaginative, creative approach is the antithesis of routine science with its emphasis on operationalizing concepts.

The final point that Blumer makes in his chapter on the methodological position of symbolic interactionism returns to and develops his opening point with a focus on organizational life. It is a powerful statement that moulded my attitude towards the study, one that always insisted that I leave things open, rather than seek definitive explanations:

> Beneath the norms and rules that specify the type of action to be engaged in at any given point in the organizational complex there are two concurrent processes in which people are defining each other's perspectives and the individual… is redefining his own perspective. What takes place in these two processes largely determines the status and the fate of the norms or rules (1969:59).

So I began to realise through studying the symbolic-interactionist principles (Crotty, 1998) that:

- human beings act towards things on the basis of the meaning that things have for them;
- the meaning of such things is derived from, and arises out of, the social interaction that one has with one's fellows; and

- these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things they encounter.

It was good enough to justify the choice of interpretative methods in the proposal. The sense that this was still naive began with reading in Crotty (1998) that our understandings are transmitted over time and through generations; they take deep root and we find ourselves victims of the 'tyranny of the familiar'. Despite the assertions of symbolic interactionism that we act towards things on the basis of the meanings those things have for us, those meanings are not existential realities after all. They are theoretical deposits, and so, in the words of Ortega y Gassett, we are "living on top of a culture that has already become false" (Crotty, 1998:59). In other words, our experience was duped even before it became our experience. I adopted the symbolic interactionist perspective, just as I was to adopt the grounded theory method, not because I understood it, but because it encourages any way –so long as it is ethical – that enables us to grasp something elusive and puzzling about experience.

Experience is undeniable: taking narratives seriously

It is undeniable that our experience is all we have. It is from this point that Mills (1983) locates the origin of the sociological quest, to make sense of the world that is not only structured in ways we cannot readily see, but that also contains a history we cannot readily see from our singular point in time. Gadamer (1982) would see our experience as an attempt to develop an interpretation that crosses the gulf between the horizon we perceive, and that of others. Bachelard (1997) sees experience as something running deep back into our experience of our own origins, bound up with the memories and sensations of childhood. Silverman (2000) draws the notion of a

relationship with others and one's own personal experience together, when he suggests taking problems from everyday experience rather than from policy makers and not seeking causes but key features of the institutional framework. Although the experience of the built environment is an everyday aspect of work in the PAU, it is not one to which colleagues explicitly devote much time. One of the reasons why I was doing the research was because it was a way to focus on the topic with colleagues, to find out what they thought. Holstein and Gubrium explain that interviews are a good way to explore incompletely articulated aspects of experience, particularly if they are "not casually topical" out of the contingencies as well as the resources at hand (1995:8). I could imagine seizing opportunities to conduct interviews during quiet lapses in the work setting, in which the very feeling of seizing the moment to talk would somehow reflect the experience of experience being, as they put it, "incompletely articulated".

The method would use interviews, but would also have to pay attention to the fact that interviews tend to shape what is being said (Holstein & Gubrium, 1995). If interviewers ask abstract questions, they are likely to miss out on the story that people want most to tell. Chase (1995) elaborates this phenomenon by describing how Sacks, in investigating female militancy in the workplace, asked women sociological questions about their families. Their replies were uninformative and abstract. It was not until she invited people to tell her about their experiences of work and what it meant to them, that she could learn about the distinct experiences of the women in their workplace. I forgot all about this: in my nervous preparations I had drawn up a list of questions and topics to ask. In practice, I rarely probed, and when I asked questions it was more like turn-taking in a conversation than questions directed at

clarifying particular points of view. I found that listening allowed me to hear how my colleagues typically thought, and came to find their natural flow more fascinating than worrying if all the conceptual bases I had identified were being covered. As well, the grounded theory recommendation of drawing material and ideas from the first interview and coding as interviews progressed, kept me too preoccupied with trying to develop schemes to ask too many questions. At first I thought my lack of skill in encouraging colleagues to develop their points of view a limitation. In retrospect, it was a happy limitation preventing me from imposing pre-existing ideas that have the effect of "effacing the intending individual" (Josselson, 1995:29). I noticed in myself the temptation to supply words when interviewing colleagues who spoke in a hesitant manner, and had to tell myself to wait, reminding myself that the primary purpose was to listen.

I found later that a useful technique to help me 'listen' when reading the transcripts was to edit out whatever I said. I found by doing so that I was not so much struck by facts or analysable features, but rather by a sense that the interviews were also narratives in which the narrators were also in a dialogue with themselves (Josselson, 1995). The impression was that they were telling a story that while it may have had its routines or scripts of material held in common, it also had elements in which the story was being framed as if for the first time. These routine or script-like elements are what Gubrium and Holstein (1995; see also Quinn and Holland, 1987) call the circumstantially recognizable resources of local culture. Josselson (1995) describes the latter aspect, the sense I was to feel of someone pausing just before they spoke, as an attempt by an individual to frame their story in a way that serves themselves in the present as a "self in conversation with itself and with its world over time" (1995:33).

Josselson indicates that contradictions within narratives are important. The attentive researcher who listens to contradictions is "witnessing the working-through of an internal contradiction" and so is "at the heartbeat of psychological organization". There is something suspiciously triumphant about this passage, as if the interview was equivalent to an X-ray or the medical wonders of surgery, particularly when Josseleson continues that it is "the key to psychological entry into another…" (1995:37). However, I am running ahead of myself here. At the time I first read Josselson, my interest was in learning more about interviewing than taking a critical view.

I settled upon the idea of a Grounded Theory (Glaser and Strauss, 1967) approach. It had many advantages. It had become respectable, meaning I would not have to indulge in complex demystifications and counter justifications. It offered clear procedures, even if its authors insisted the methods were not a cookbook approach. Its focus on producing 'substantive' theories of how people did things in particular places was attractive. By identifying and relating the things that people said in a hierarchical way, one could divine a 'Basic Social Process' (BSP) at the root of it all. The BSP might prove in a non-statistical way how differently nurses thought of the built environment in purpose-built as opposed to traditional settings. I assumed that interviews in traditional settings would reveal the depersonalising horror of being treated as inmates of 'total institutions' (Goffman, 1961). In contrast, modern purpose-built settings would reveal a heaven of unconditional positive regard for consumers. Determinism had slipped into sheep's clothing. It would also be sexy and fast, with the easy to use graphically based NVivo software that had recently been released. Indeed, it was possible to export table data from NVivo to statistical

programs such as SPSS. Instead of carrying out a quantitative survey with a few qualitative questions tossed in, I would be able to carry out qualitative interviews but be able to extract some nicely confirmative statistics! Why stop with Grounded Theory? I could extract words from transcripts and cross-tabulate their occurrence and context against gender, or age, or setting. Even with a handful of interviews I would be able to extract immense numbers of countable events, and instantly seek confirmation of any hunch. Are nurses in purpose-built settings more patient-focussed than nurses in traditional settings? Find a few adjectives, a few pronouns or whatever sorts of words are relevant, export them to a computerized statistical programme such as *SPSS*, and, ping!

My attempts to simply find out from participants' own words what really mattered led me to create an immense range of codes out of the first few interviews. I intended to use these to fit data from subsequent interviews into. Seduced by the ease with which interview transcripts could be manipulated on the computer, I was confident that in time the mass of rough codes I had would naturally acquire some overall coherence. I anticipated then being able to reduce the number of codes I had, giving them abstract names, relating the component parts to each other, and then even finding the relevant bits and pieces of existing theory for them. Instead I was simply baffled by codes that meant nothing to me.

I took up the suggestions by Strauss and Corbin (1990) for 'fracturing' interview data by using pre-existing theoretical frameworks. I tried several schemes. The first derived from Bennis (1966). Bennis wrote that an organization could be viewed in four different ways. These were

- the ‘manifest’ organization, or how it is publicly described through its documents. An example of this is the description of the PAU according to its brochure in Chapter One;
- the ‘requisite’ organization, or what it should ideally be like. The glossy pronouncements of CEOs, policy writers, architects and health care executives given in Chapter One are an example;
- the ‘assumed’ organization, or how members explain how things actually happen; and
- the ‘extant’ organization, or how it would be described through observational study

This schema was helpful in separating out the various ways in which PAUs could be described. The notion of the ‘assumed’ and ‘extant’ organization led me to think about what sorts of architectural critiques could emerge from these perspectives.

Another coding scheme I tried derived from Attoe’s (1978) typology of architectural criticism. In summary,

- ‘normative’ critiques are based on adages, such as ‘form follows function’ and may be operationalized. The P-E fit canon, including its efforts to specify and measure variables, is an example of this.
- Interpretive and evocative critiques draw on meaning and its metaphors, often advocating a change of view. Thus critiques according to the P-E fit canon can be combined with an interpretative approach, advocating a ‘home-like’ rather than ‘institutional’ environment for aged care settings. They can also point out the shortcomings of buildings in the experience of those who dwell or work in

them. A metaphor I often encountered in the data was describing the institution as ‘prison-like’.

- Descriptive critiques can be ‘static’ or ‘dynamic’. Static descriptions simply record what is there to be found. However, dynamic descriptions can range from mapping how a place is used to broader considerations. These can include how a place came to be built in the first place, and what social processes surround its history, such as gentrification or decay. It is this latter aspect of historical change that has important implications. The idea of the modern purpose-built unit is that it is ‘progress’: it rules off the past.
- Lay critiques. Although Attoe provides this category, it is not elaborated to the extent that the normative and doctrinal categories are. However, it is the ‘lay’ element in critiques offered by nurses, rather than their attempts to anticipate the sorts of critiques that architects might offer, that should be representative of their most deeply personal and authentic thoughts.

I attempted to use Attoe’s schema as a way to categorize the interview data. I found that most insights gained from the exercise did not relate to the data but to the idea of thinking about buildings in broader ways - as a social phenomenon rather than the extent to which they fulfilled their purposes or even the aesthetic experiences of their occupants. Fearing that I was becoming too abstract, that my analysis was becoming ‘ungrounded’, too distant from what people said, I tried an anthropological schema.

Holland and Quinn (1987) explain that people use culturally acquired ‘models’ to frame experiences and to guide their actions. They identify two basic types of models or ‘schemas’. These are ‘propositional’ schemas and ‘image’ schemas. Propositional schemas are very similar in form to what we know as natural science. They are readily

articulated and show functional clarity in relating cause and effect. Image schemas rely on visual or kinaesthetic explanations that are more folksy than scientific in form. This approach was productive in seeing which issues were more abstract, or regarded in a propositional way, and which, expressed through image schemas, were more personal.

Only later did I realise that this search for ways to fracture the data was also the expression of the insistent thought that buildings and what goes on in them are the product of a culture that is already false. At the time though, these schemas reassured me of the flexibility and promise of the grounded theory method in rapidly obtaining results. Despite these different ways of playing with or fracturing the data, there was one other fundamental aspect of the study aside from interviews. This was the work of comparing ancient, adapted settings with modern, purpose-built settings.

A case study approach to comparison

The comparisons between the ancient and the modern could be thought of as being a comparison between two cases. Yin (2003) states that the case study approach is ideal for investigating a contemporary phenomenon within its real-life context, particularly when the boundary between phenomenon and context is not clearly evident. Others echo a similar view. Marshall and Rossman (1995) propose that demonstrating a specific setting as a case of a large concept defines problems in terms of larger theoretical concerns. In their view, human behaviour cannot be understood without understanding the broader framework in which it takes place. Research questions should include general questions that do not unduly constrict the study. General

questions allow for flexibility in the choice and application of methods, with the idea of research being directed towards discovery rather than solely towards confirming hypotheses. Marshall and Rossman suggest that “often the primary goal is to discover the very questions that are most probing and insightful” (1995:20). Yin (2003) also describes case study as not so much a technique as a strategy in which multiple sources of evidence can be used and the unit of analysis can change with the discoveries made during research. Even if Yin had been more restrictive regarding what a case study was and was not, I thought I would have had to modify it so that it would embody such flexibility. All I knew was that I wanted to compare some aspect of doing stressful and unusual work in an old and apparently primitive setting, to doing the same sort of work in somewhere that was tailor-made for it.

My rationale in choosing PAUs as the unit of study, Yin would argue, was because they were extreme cases of the phenomenon (aged care), and they had a revelatory potential with their angle on the context of our times. He made the vital point that they were not selected because they were typical and so could be generalised statistically to other cases. Instead, they were selected because of their analytical potential to be generalized to theory. This is where the unique position of the PAU as a zone of repulsion, rather than as somewhere that is in some way typical of aged care, revealed itself as important. If we are considering the setting itself (including its built environment), then the zone of repulsion is the real-life context and not the phenomena that occur inside it.

Yin suggests that: “Playing with the data can be a fruitful activity… [and] the descriptive approach may help to identify the appropriate causal links to be analysed”

(2003:111-114). Given the state of my perplexity, there was no doubt I would have to do this. Yin also suggests ways of writing up case study research. He argues that each case should be narrated separately followed by a section of cross-case analysis. The narration should be selective in offering the most critical evidence, yet with a blend of supporting as well as challenging data "so that a reader can reach an independent judgement regarding the merits of analysis" (2003:164). I have tried to follow these principles, which is why Chapter Three contains numerous direct quotes from the interviews. They are necessary if the reader is to be able to challenge the cross-case analysis and discussion I present in Chapter Four.

The idea that I had chosen these cases in order to generalise to theory began to take on a life of its own. I had to remember I was not attempting to show that these PAUs were typical. Rather, I was going to tell their story in both old and new settings to make some point about the broad context. My earlier focus on relating the era of the building to what was happening inside, some quasi-Goffmanesque narration of architectural determinism, was slipping away. I was slowly starting to feel my own determination that the eventual point of the research was to have bearings on the society outside, not the culture within. There were two reasons for this: The comparison still involved old and new settings, but now the idea of Time itself, rather than what had been made during a certain era, began to demand attention. At the same time, I was becoming acutely conscious of the degree to which research findings were used as a way of maintaining authority over hands-on nurses.

Time

Before I even had any data to play with, the idea started to play on me that perhaps I was not comparing ‘places’, I was comparing ‘time’. Now that it was no longer the medical outcomes from different units that were being compared, but rather the background context that was being questioned, the sense of era started to make itself felt. The idea of the ultra-modern progressive here-and-now against the idea of a primitive past that had been ruled off had been an underlying assumption supporting the thought that outcomes would be better in the modern unit than in the old unit. Now though, the idea of ‘present’ and ‘modern’, of ‘past’ and ‘outmoded’, no longer seemed such a black and white division. After all, ancient locales were still being used as PAUs in the ultra-modern present. As I reflected more critically on my own experience of working in ultra-modern purpose-built PAUs, not everything about them was heavenly.

I would not be able to say much more until I had the data to play with. Like most ideas, at the time each would seem to offer the most profound explanation or promise the very best way of finding out. This succession of ideas that suddenly explained the whole world, drowning out the ideas of last week, the domination of ideas that when you first encounter them out of the mist of personal uncertainty are a sign of the student, of the inherent naivety of immaturity. I can no longer tell if I have really systematically and adequately analysed the traces of different eras in the PAUs. That is something that can only be decided in the concluding chapter. Here my task is to lay out the assumptions, suspicions, and motivations that led to the conduct of the study.

The idea of comparing eras arose from Buck-Morss' (1989) exposition of the philosophy of Walter Benjamin. It was a philosophy that was never written as a whole but existed only in fragments. However, Buck-Morss studied the fragments Benjamin left behind to reconstruct a plausible account of his philosophy. Let me explain it briefly, in my own words: Objects that survive from the past, such as the buildings from the 19th century, contain traces of the dreams of that time. Objects that we create today contain our dreams for the future but they are also mired in memories of the past. For instance, the internal combustion engine made possible applications that looked forward to the future. But its first embodiment was an adaptation of an old form, the horseless carriage. It took a long time before the sleek concept of the present car evolved from its historical origins. It is as if we are unable to rise immediately to the challenge of the now, to change things so that we step immediately into a future that is entirely different. Instead we hold on to the failed, decaying material of the past. Alternatively, we seek assurances that we are modern, up-to- date, we become distracted shoppers whereby our consumption or even window-shopping becomes a substitute for the revolutionary action we would now rather forget.

According to Buck-Morss, Benjamin regarded material objects as holding signs of such a struggle. Benjamin was fascinated by the decaying glass and steel arcades that still survived in Paris, Berlin, Moscow and other cities. These arcades were originally built in the late 1800s to showcase the latest technological wonders of the time. Things in them were not so much for sale as for display. The ideal creature to appreciate this display was the *flaneur*. A form of upper class voyeur without desire, the *flaneur* would stroll at a pace dictated by his pet turtle, looking at the crowds who

thronged to see the displays. The *flaneur* represented the impotent failure of humanity to overcome its past that resulted in a fascination with the possession, consumption or dream of material objects as a substitute. In other words, having failed to achieve mastery over our own nature, we were absorbed by the illusion of gaining mastery over nature through productive technology instead.

It is a complex philosophy that I have mangled here. The point though is not the degree of correctness or fidelity to either Buck-Morss or Benjamin but its impetus as a sensitizing notion in this study. I could see in Benjamin's *flaneur* the traces of the objective, detached professional coolly calculating what to do and what not to do but never admitting the fear of being passionately committed and of failing. The failed nature of the arcades, the sense of something that was recently modern but was now in decay, forced me to think more clearly about the PAUs I was comparing. The example of the purpose-built PAU I had in mind was by this time some 15 years old. When I last worked there five years before, I saw that it was acquiring a battered air. The ancient PAU, the example of a "new name carved in an ancient doorway" as Rothman (1971) had remarked, no longer seemed so battered, alien and inhospitable in my mind. In this deepened sense of comparison, it had aspects of being a venerable survivor of the vicissitudes of fashion. So, from this unexpected source, the cultural criticism of a Jew fleeing Nazi Germany who insisted that wherever we looked there were signs of our failure, my confident 'objectivity' that I was comparing the new against the old, eroded away. Beneath the differences of appearances, the misgiving lurks that there is nothing new under the sun. Rather than expecting people to behave differently because they were in a modern unit, I should look for a fundamental sameness. If time is in the dream of the future and the judgement of the past that is

buried in the present, it all becomes too irreducibly complicated. How could I play out these ideas, how could I compare eras?

I chose the first trick in the book: naming. Bestowing earthy pseudonyms on the facilities would infuse analysis with a nagging sense of suspicion, much as the act of quoting the airy pronouncements of CEOs revealed a gratuitousness that inherently mocked their ostensibly rational nature. Instead of embarking on an analysis that was too abstract and would obscure nuances in the experiences that nurses related, the force inherent in shameful pseudonyms could serve to amplify nuances instead. It was not until I had completed the interviews that I realised the names would have to have some sort of common link to time, as well as referring to the actual locale. I jump ahead of myself here, but the clue came from the analysis of the interviews. The relation of time was one of decay. There were different forms of decay. One was of a decay that was so permanent there was little hope of reversing its putrefaction. Another was of a genteel decay, rather like the first traces of mould in a bathroom which, with a little care, can be wiped away to restore the appearance of newness. Then there was the desire to escape from the world of decay, to return to an eternal heavenly Garden of Eden. More pragmatic and more common was the expectation of the continual upgrade, a temporary escape from decay. So *Putria* is a place that is emblematic of the ancient past, which has outlasted generations of futile attempts to demolish it. *Milduria*, the modern 'purpose-built' unit is decaying after a mere 15 years. *Tempuria-Eternia* are two names for the one unit. *Tempuria* is always being moved, a testimony to whiteboard castles and organizational fibrillation. *Eternia* is the memory *Tempuria*'s staff hold of the ideal unit they left behind, and which they want to return to.

I had not even thought of places like *Tempuria-Eternia* before the interviews. With *Tempuria-Eternia* perhaps we do see something in the present that is entirely new: buildings that are no longer static. Here we encounter the 'windshield view', where the world becomes a flat screen, just as the whiteboard is. Illich describes the windshield view in a radio interview as a perpetual expectation of arrival:

> You're looking at what lies ahead, where we are not yet, which of course makes us with terrible feeling like when you are with somebody and he always wants to know where we will be next week, where we will be the next hour, instead of being right here. It makes facing each other increasingly more difficult because people can't detach themselves anymore from the idea… (Lumley 1999).

It is so tempting to simply measure the attributes of places, rather than describe them. With measurement we can immediately proceed to analysis revealing functional correlations. If the study focus had remained on PAUs as cases that were typical of other PAUs – then certainly I would have developed acronyms indicating functions rather than names. Instead, I decided to invent descriptive names that would somehow mingle decay with the sense of being alive, the here and now. I trusted that pseudonyms like *Putria* and *Tempuria* would not convey the windshield view that flashes past, but rather roll the reader off the road in a cloud of dust, to a stop. Then, I dramatized for the reader the moment of entering these places as if it was for the first time, with a feeling of decay and absurdity.

As I dramatized, I could visualize just how easy it was to confer a superiority of vision upon oneself, and describe nurses in their institutional habitat as if they were animals in a zoo. Something else started to emerge as well - the power of speech

itself. Goffman's (1971) *The Presentation of the Self in Everyday Life* made me realise that experience was not simply a matter of facts, but something that worked through emotions. For waiters there is a world of difference between how they present themselves 'on-stage' when they are serving clients, and how they are behind the scenes at ease with fellow waiters and out of the public eye. It reminded me it was the same with nurses. The feelings in the tearoom, the bitterness of critique that surfaced in there, are a world apart from the cheerful, concerned professionalism we project out on the ward. I looked more closely at texts about qualitative research, and found there were plenty of warnings about taking narrative data at face value (Wainwright, 1997; Kahn, 1999 and Grbich, 1999). I gradually came to realize that not only do we tend to present our best face under some circumstances, but that others have the power to present us in a way that suits themselves. Thus my very own descriptions of places were not really all that different from the fakery presented by the rest of the world. At first I had relied on the idea of 'backstage talk' as giving my interviews the sort of authenticity that arose in the tearoom. Now I was starting to wonder how much of the backstage honesty was inherited from a culture that was 'already false'?

My superiority - the montage I presented as the background, the dramatization of seeing these places for the first time - forced me to recognize that I was applying the same sorts of techniques that had been applied to me. This did not deter me of course, since I am neither a CEO nor a manager, but it gave me a vivid sense of how whatever it is we study 'turns' on the subject. Studies about nurses, for instance, are used to oppress them. This realisation became a vital consideration in this study. It did not change the conduct of the study itself since, by the time it assumed such

importance, the interviews had already been done. It was important in the subsequent analysis, and in the style of its overall presentation.

Authority, research and radical qualification

It would be interesting to tabulate and categorize the number of studies and the ways that they 'turn' on nurses. It is an old pattern that someone will research nurses in order to emancipate them in some way. The fate of such research is that it will be used to oppress them. One of the earliest and deadliest instances is the use that was made of the classic study by Menzies-Lyth (1988) in the 1950s to find out why so many nurses resigned from their job. It still remains a problem today. Menzies-Lyth described the experience of 'organizational anxiety' that nurses endured in the hospital context. Nurses were treated like objects: thrown into situations with little preparation, expected to follow absurd orders (such as waking patients up to give them a sleeping pill), confronted death and pain unable to do much about it, were forced to wear bizarre uniforms and were always having to conform with others' expectations of what their role should be. She identified numerous defensive techniques that nurses employed. I have assembled some of these in Table 4 below. I encourage the reader to perform a thought-experiment and pick one phrase that we instantly recognize today as being typical of nurses:

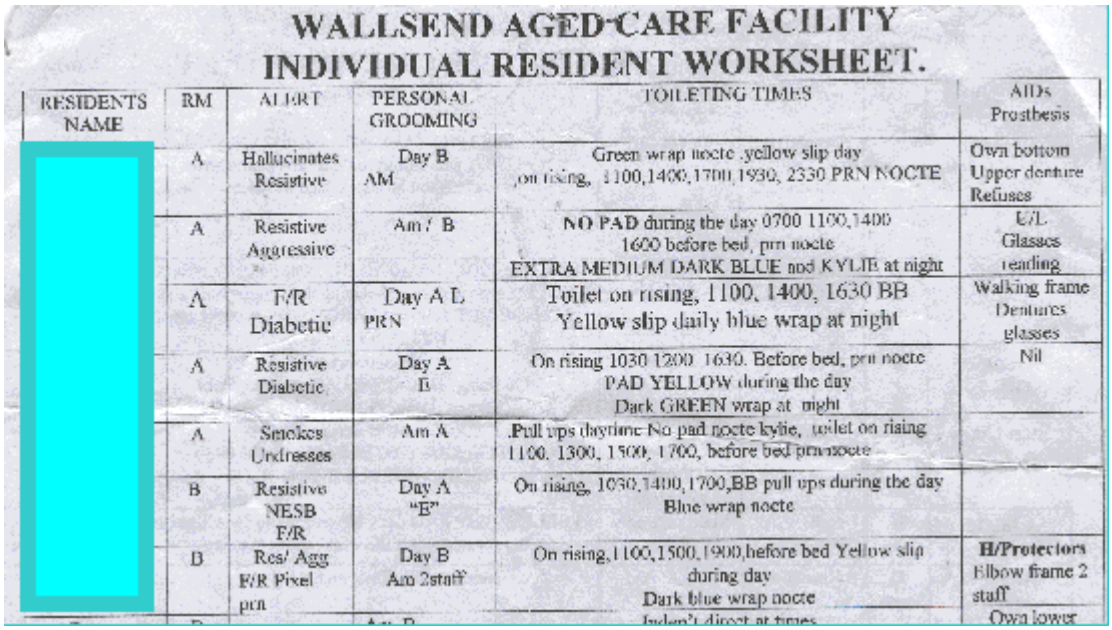
Table 4 Symptoms of Organisational Anxiety (derived from Menzies-Lyth, 1988)

• Reducing the impact of responsibility by delegation to superiors	• Depersonalization, categorisation, and denial of the significance of the individual
• Attempting to eliminate decisions by ritual task-performance	• Collusive social redistribution of responsibility and irresponsibility
• Purposeful obscurity in the formal distribution of responsibility	• Splitting up the nurse-patient relationship
• Idealisation and underestimation of personal development possibilities	• Reducing the weight of responsibility in decision-making by checks and counter-checks
• Avoidance of change	• Detachment and denial of feelings

The phrase ‘task-performance’ is undoubtedly the one most readers will recognize. Keen (1989) states studies that assume a naïve architectural determinism litter the literature. If that is so, then studies that assume nurses are task-centred saturate it. The hypocrisy in such studies is breath-taking (as hypocrisy always should be). I have pointed this out in relation to Kovach and associates (1997) and Thomas (1996). One of my favourite examples concerns an author who was quite proud to publish their name as well as the name of the facility where they conducted their intervention. What makes it such a favourite is that it is not only breath-taking, it is also personal:

Walker, Nursing Unit Manager, Wallsend Aged Care Facility, describe the Buchanan ward as “a typical aged care unit governed by time and task” (Walker, 2000). Although it advertised itself in terms similar to an SCU, Walker wanted it to become “a nursing home with a modern approach, where our residents had a choice”.

Walker's idea of doing this was to allow residents to sleep in until 10 am rather than having to be up for breakfast by 8 am. Walker regarded the nursing staff in Buchanan as chronically task-centred. Staff had to be led (by Walker) to think of residents as being human, like themselves: "As part of the discussion, I also asked my staff what time did they get out of bed at home". It is a pity Walker did not follow up this article with another innovation by Walker, the *Wallsend Aged Care Facility Individual Resident Worksheet* (see Figure 15 below).



WALLSEND AGED CARE FACILITY
INDIVIDUAL RESIDENT WORKSHEET.

RESIDENTS NAME	RM	ALERT	PERSONAL GROOMING	TOILETING TIMES	AIDS Prosthesis
	A	Hallucinates Resistive	Day B AM	Green wrap nocte .yellow slip day ,on rising, 1100,1400,1700,1930, 2330 PRN NOCTE	Own bottom Upper denture Refuses
	A	Resistive Aggressive	Am / B	NO PAD during the day 0700 1100,1400 1600 before bed, prn nocte EXTRA MEDIUM DARK BLUE and KYLIE at night	E/L Glasses reading
	A	F/R Diabetic	Day A L PRN	Toilet on rising, 1100, 1400, 1630 BB Yellow slip daily blue wrap at night	Walking frame Dentures glasses
	A	Resistive Diabetic	Day A B	On rising 1030 1200 1630. Before bed, prn nocte PAD YELLOW during the day Dark GREEN wrap at night	Nil
	A	Smokes Undresses	Am A	.Pull ups daytime No pad nocte kylie, toilet on rising 1100. 1300, 1500, 1700, before bed prn nocte	
	B	Resistive NESB F/R	Day A "E"	On rising, 1030,1400,1700,BB pull ups during the day Blue wrap nocte	
	B	Res/ Agg F/R Pixel prn	Day B Am 2staff	On rising,1100,1500,1900,before bed Yellow slip during day Dark blue wrap nocte	H/Protectors Elbow frame 2 staff Own lower

Figure 15 Worksheet for Nurses

The worksheets become crumpled and nearly illegible after being taken in and out of one's pocket while working. They specify what is to be done, when it is to be done and who will be doing it from the moment residents are scheduled to rise to the moment they are scheduled to sleep. In the column marked Personal Grooming, Day "A" and "B" refer to the odd and even days of the calendar. Codes on the sheet specify if the resident will be showered in the morning or evening. The nurse who will

shower particular residents is identified by the name of the shift they happen to be on. The “E” nurse for instance, is hired to work from 1 pm to 9pm. When I last worked there, Walker and colleagues had worked their way through the alphabet to a “P” shift nurse, employed for a few hours to help with afternoon toileting. The casualization of the nursing work force and the introduction of shorter shifts is ideal for such management techniques. The criticism of Thomas’ (1996) interpretation of the SCU routine in Chapter One applies here as well: that rather than a testimony of management commitment to creativity and autonomy, these efforts reveal an obsession with managerial efficiency.

Menzies-Lyth’s (1988) study had not helped to diminish organizational anxiety in hands-on nurses at all. It served to diminish the anxiety and provide opportunities for the self-advancement of the Walkers of this world instead. Of course Menzies-Lyth had not set out to do such a thing. I wonder what she would have done differently had she come across the notion of ‘radical qualification’. Grbich (1999) describes radical qualification as asking questions such as:

- Who will this research serve?
- What is the position of the researcher versus the researched?
- Whose knowledge is being articulated in the field?
- Whose voice dominates, and whose voices are not being heard?

For me this is not an abstract checklist: the idea of radical qualification is a strategy, a way to prevent research from being useful to those who write postcards from the happy lands above. The more I read about building and healthcare, the more I saw the simplistic P-E fit canon serving corporations, bureaucrats and academics, the more I

became determined that this research would not serve nor be remotely useful to those who would exercise control over nursing. It became a *de facto* aim of this research.

I adopted two methods for achieving this aim. The first was to ruthlessly expose the hypocrisy of those above from the outset, so that the research would be dismissed on sight as the ravings of a left-wing radical by most of the self-serving strata. The second derived from Habermas' (1984) analysis of the role of the social scientist. He distinguishes the sorts of 'truth claims' we associate with the tradition of the natural sciences from the 'validity claims' of the social sciences. In investigating the social world, the social scientist is not dealing with objective natural phenomena but is trying to understand social phenomena. Habermas argues this effort occurs "against the background of a culturally ingrained preunderstanding" that applies not only to those being researched, but to researchers as well (1984:100). Both social scientists and their subjects live within what Habermas calls the 'lifeworld' and 'system'. It is the possibility for emancipation from 'system' that is of interest here. It made me realise that the 'grounded theory' approach could not defend itself against being useful to those who would exercise control over nursing.

Problems with grounded theory

The 'lifeworld' is that arena in which we like to think people live authentically as autonomous individuals, choosing to do or to think things on the basis of who they are as individuals. These, Habermas argues, are 'idealising fictions' and in practice, it is the 'system' that is in command (1984). The system is the powerful world that colonizes whatever it touches in the service of profit and power. The system

dominates the lifeworld through organization and bureaucracy. The ‘idealizing fictions’ are resources that the system can use for its own ends. Believing that we act authentically as individuals we delude ourselves, overestimating our motivations and underplaying the influence of the system. It is a belief that can be used by the system to keep us busy examining our own motivations, believing they arise out of our nature, rather than examining their historical descent and social origins. We have seen such an example in relation to the use made of Menzies-Lyth’s investigations of the techniques nurses use to manage organizational anxiety (1988). Whether her findings are true or not is not the point. The point is that they have been used successfully to keep nurses preoccupied with the charge that they are ‘task centred’. It is nursing managers and others who make the charge gain status, since by diagnosing the failures of nursing they are by implication superior beings. They become indispensable to carrying out the dictates of the system, not because their insight is correct but because they have acquired authority through it.

Habermas (1984) points out that as an interpreter, the social scientist sets out to explain how people’s actions are typically coordinated. He argues that the private intentions individuals may have are secondary goals in social science. The primary concern is to describe and explain normative expectations of behaviour and how behaviours are co-ordinated. Whether the emphasis is on substantive theory related to how people do things in particular circumstances, or broader and more general theory about how people do things in more general circumstances, the possibility remains for it to be misused. It cannot be denied that the description and explanation of phenomena in the lifeworld produces knowledge that can be colonized to further the interests of the system.

Up until this point, I had in mind an idea of research that had come to focus on comparing the day-to-day experiences of users within contemporary purpose-built settings with those of users in ancient, adapted settings. The grounded theory method would rely on the frank backstage accounts of participants to show what was 'really' happening. The method seemed ideal for doing such a project with a minimum of interviews and plenty of suggestions for constructing theory. It had enough of a track record and arguments that I would not have to devote much attention to issues of validity or credibility or whatever criticisms could be made of the methods used. By now I had conducted interviews at three locales, and had tried to follow grounded theory guidelines as closely as I could. Interviewing essentially ceases, according to grounded theory methods, when no new concepts emerge. I convinced myself at the time that this was the reason. Now I realise that in fact I had, without admitting it to myself, parted from the grounded theory method. The underlying truth was that I felt I had enough to satisfy my original curiosity about what my colleagues thought. The amount of data from the interviews was small enough for me to become familiar with all of them, yet large enough for considerable contrasts to be present. I had just enough data to be able to hold it and think of it in different ways in my mind. To me this meant thinking of the data, the so-called phenomena of interest, but at the same time becoming sceptical about the context. The reader will encounter the vestiges of this at the beginning of Chapter Four where it serves as the point of departure for the remainder of the chapter.

However, I could not pass from describing what people do and move on to the search for a 'basic social process' (BSP). When grounded theorists talk about a BSP, what

they are describing is how people adapt to circumstances (Strauss & Corbin, 1990) rather than how uneasy or critical they may feel about them. The method does not suggest placing the broader context in doubt, but rather implicitly pressures the investigator to uncritically accept things as they are given. This forced me to think of the general idea of turning personal unease into a public issue more carefully. In adopting an interpretative approach, I had thought that one of the difficulties I would find in interviews and their analysis would be the feelings on the part of participants as well as myself that subjective material was somehow illegitimate. How can the personal, subjective "beat feeling that all is somehow not right" (Mills, 1983:18) possibly be transferred into its opposite: a logical, objective, public definition of explicit issues? Now, with a growing awareness of the issue of colonization, I was coming to see the problem no longer as one of overcoming feelings of illegitimacy or of protecting the interests of participants, but of a radical qualification which applied to science itself. It shifted the focus of the research towards the dynamics of colonization that seems to be implicit within what we accept as normal. Using a few precautionary statements or techniques could not dismiss it; it needed to be outwitted. In the idea of a critical hermeneutic, the context itself became open to question, and not just the phenomena contained within it. To put it another way: was it possible to examine the broader context by using the phenomena, rather than questioning the phenomena themselves?

How could I explore the broader context when the study was focussed on the daily practical experience of individuals? Some elements of the work I had done were appropriate to this emerging sense of problem. For instance, comparing the physical material nature of the built environment itself certainly would make visible the

historical and temporal context we tend to take for granted. I came to realise that the study had a sense of the problem of colonization and could to some extent describe it, but not a coherent grasp to guide analysis. In a way it had things back to front. Although I had identified the problem from daily life and was describing it from that perspective, its analysis should really start by reversing the whole problematic. Rather than developing from individuals' unease within their milieux towards some idea of a public issue, it was the background of these milieux that needed to be subject to suspicion, even before analysis could begin.

Habermas in *The Theory of Communicative Action* was concerned with developing a theory of modernity that accounted for its pathologies to suggest redirection. He regarded 'philosophical hermeneutics' (a philosophical approach to interpretation of human speech and activity) as having an emancipatory potential in this regard. Philosophical hermeneutics is concerned with the exceptional accomplishment of "how speaking and acting subjects make incomprehensible utterances in an alien environment comprehensible" (1984:130). In other words, it is concerned with how ordinary people make sense out of things when they are in "pathologically deformed" areas of life. Somehow they are able to make sense of things even when "the certainties of a culturally stable background break down and normal means of reaching understanding fail" (1984:131). A 'philosophical' attitude means looking carefully at the relations between what is said in the light of its background. If a philosophical interpretation deals with what we want to take as objective facts or interpretative validity, it does so sceptically, only to identify and do something about what we sense is false, pathological. My understanding of philosophical hermeneutics was murky but it seemed to allow interpretation to take place with a wary eye on

colonization. I decided I would adopt this sort of approach. Rather than 'philosophical' hermeneutics, I decided to call my approach 'critical hermeneutics' since my primary motive was to resist oppression rather than a search for facts, explanation, or even for understanding the world as it normally appears to be. However, with the very word 'hermeneutics', I had stepped off the ground and into a possibly bottomless ocean. Was I going to drown in philosophy? Was this no longer science?

Between the last interview (in 2001) and 2005, I was still attempting to produce a grounded theory analysis but had to eventually admit that I had 'lost focus', as people say. Having thus lost my way, I retraced my steps, returning to my original question and early notes in search of guidance. As is typical, the clues had been there from the very beginning. I was amazed to look back at two essays by Gadamer (1982) from which my research question came, and discover how little of them I had understood. For ease of narration, I will vary convention and cite these two essays using an abbreviation and page number. I abbreviate Gadamer's (1983) essay *What is Practice? The Conditions of Social* Reason to WP, and the subsequent essay *Hermeneutics as Practical Philosophy,* to HP. It was HP that first caught my eye and from which the core phrase in my research question was to come: "what is performatively at play in the practical experience of understanding". Yet when I returned to it, I found that many of the assumptions I needed to make to understand it were contained in WP. I can see now their reciprocal relationship to each other, as practice and theory. In what follows, I will concentrate on HP but will need to include some material from WP. In Chapter Five of this study, I will return and reverse the focus, emphasising the essay on practice.

Critical hermeneutics

When I first read these essays I only seized on the phrase “what is performatively at play” and missed the significance of it. Instead, I came to have misgivings regarding the authenticity of experience and the vulnerability of its description of colonization through other sources, such as Blaike (1998), Crotty (1993) and Habermas (1994). As these doubts emerged, I became uneasy with the methods I was using. It seemed I was conducting a study that could extend from a description of experience to a search for regularities, even if it no longer relied on a naïve architectural determinism. I was forced to recognize my interests had vectors that took the study outside the normal expectations of scientific inquiry.

My aim here is not to attempt to turn Gadamer’s essays into a method but to understand the views he was expressing. The essays seem to me to be a complete, condensed expression of a view of the world in a thoroughly thoughtful way. They were written late in life, and are a compact reflection on themes from his major work, *Truth and Method*. However, their strongest claim to credibility arises from the style in which they are written: they have a clarity, precision and suppleness of expression that stands in the tradition of masters who truly have hold of their subject. At times he makes statements that are so startling and eloquently put they have the force of poetry, they go beyond truth. For instance, in HP he writes: “Words are slogans. They often express what is missing and what should be” (Gadamer, 1982:102). The difficulty I have in explaining the influence of these two essays on the research is not the ideas in themselves - they are not so much difficult as unfamiliar at first - but in paraphrasing the economy and immensity of Gadamer’s expression. Thus I ask the

reader to forgive me for not offering a précis. Instead I intend to quote as fully from HP as is necessary to give the reader a sense of the firm grasp coupled with immense latitude that Gadamer's writing offers.

In these two essays, Gadamer shifts between the ancient times of Greek philosophy exemplified through Aristotle, and modern times exemplified through science after Gallileo. He points out in both essays differences in how theory, practice and science are conceived of between these times. He declares "in starting from the modern notion of science when we talk about practice, we have been forced in the direction of thinking of the application of science" (Gadamer, 1982:69). Although the modern distinction between theory and practice was also known to the ancients, these days theory has "lost its dignity" and become reduced to "a notion instrumental to the investigation of truth and a way of garnering knowledge" (ibid). Together, theory and practice as they are now thought of are the basis of our technocratic society. In this technocracy, we renounce our freedom, losing our flexibility to act. This is because technocracy requires individuals to be functionaries dedicated to running things smoothly. In our technocracy technical expertise substitutes for practical and political experience and mass media steers public opinion, but this immense amount of information does not strengthen social reason. Instead, much as Mills (1983) wrote of the individual who feels trapped, the "individual in society who feels dependent and helpless in the face of its technically mediated life forms becomes incapable of establishing an identity" (Gadamer, 1982:73).

Gadamer makes it clear that practice conceived of as a technical skill is not practice in the sense of choosing, in the sense of deciding for something on the basis of the good.

He describes technical skill as “mere resourcefulness that for any given ends finds the right means with almost inhuman skillfulness… This sharpness of the operator is no real “practical reason”. (Gadamer, 1982:81) It is the inhumane resourcefulness we have seen at work in Chapter One that underlies the unease motivating this study. Certainly what Gadamer has to say (particularly in WP) regarding practice, technology and society, encourages a more speculative grounding for the study, and will be considered in more depth towards its conclusion. Here I only adopt them as a preliminary to his discussion of practice and interpretation in the subsequent essay (HP).

He begins by creating room in the notion of practice for theory, rather than posing it in opposition to practice:

> The conceptual range in which the word and concept *practice* have their proper place is not primarily defined by its opposition to theory as an application of theory (Gadamer, 1982:90, italics in original).

Instead practice includes theory. This is because practice “formulates that mode of behaviour of that which is living in the broadest sense. Practice, as the character of being alive, stands between activity and situatedness” (ibid). In being distinctively human, being alive is not a matter of routines, of mechanics, of something fixed by nature, but of “knowingly preferring one thing to another and consciously choosing” (Gadamer, 1982:91). Choosing has a “specific emphasis” in guiding conduct. This is not just a matter of “pleasure, or power and honour, or knowledge” but also other differences “in the political makeup of human life together” (ibid). This recognizes the diversity in relations such as those between “husband and wife, the elderly and the child, dependents and those who are independent” (ibid). He concludes this section on choosing by stressing that:

> [T]he whole *arête* (performative excellence) of human beings is utterly diverse in each case, even though the whole *arête* that rests upon knowing and choosing is only realised fully in the free status of the citizen of the polis (Gadamer, 1982:91, italics in original).

Despite the importance of the practical basis of economic life, the idea of practice was not delimited against theory but against "production based on knowledge" (ibid.). It is a challenge for us in modern times to imagine an idea of practice that was "not a matter of the 'lower servile' arts but of the kind a free man can engage in without disqualification" (ibid.). The "lower servile arts" are presumably techniques that can be studied, rather than deliberation on particular situations and relations encountered in living. Gadamer now extends the word "practice" to "practical philosophy" which has the task of raising to awareness not only the trait of having choice but which "has to be accountable with its knowledge…[for] the relationship to the good" (Gadamer, 1982:92). This involves choosing in the present, and "no learned and mastered technique can spare us the task of deliberation" (ibid.). Deliberations of this sort are "neither theoretical science… nor expert know-how in the sense of a knowledgeable mastery of operational procedures but a unique sort of science" (ibid.).

The point Gadamer insists on is that practical knowledge must "arise from practice itself and, with all the typical generalizations that it brings to explicit consciousness, be related back to practice" (ibid.). It sounds easy enough except for the relationship between the specificity of a small-scale milieu and the immensity of social forces and history within which it is embedded. It is tempting to find theories that explain and predict phenomena at the local level and to think this is knowledge. Gadamer is aware of the temptation to find in constantly changing situations and conduct within them, regularities and averageness that because of their "teachable knowledge of typical

structures [have] the character of real knowledge" (1982:93). Even hermeneutics itself was not immune to the lure of technique. Gadamer relates that in the development of hermeneutics, technical skill in the interpretation of texts was regarded as similar to

> the mounting logical self-awareness of the inductive sciences… Just as in natural scientific research the experiment that could be repeated by anyone affords the basis of verification, so too in the interpretation of texts one sought to apply procedures that anyone could check" (Gadamer, 1982:99).

This is still very much the situation as it stands today. For the very best of reasons, social science research does try to follow the model of the natural sciences, if not directly in its footsteps, at least in trying to draw parallels. Gadamer does not remark on it yet it is curious that at the same time as the certainties of the natural sciences flourished, so too did the seeds of doubt begin to undermine these certainties. For Gadamer, radical doubt and critique owe a debt to Nietzsche, who demanded "that one doubt more profoundly and fundamentally than Descartes, who had considered the ultimate unshakable foundation of all certitude to be explicit self-consciousness" (1982:100). It also owed a debt to Marxist analysis, which claims "the theoretical teachings of the sciences reflect with an intrinsic necessity the interests of the dominant social class" (ibid.). Thus radical doubt questioned individual self-consciousness and also demanded that understanding of economic and social life "get behind the self-interpretations of bourgeois culture, which invoke the objectivity of science" (Gadamer, 1982:101). Later in the essay he sums up that "[w]e have to repudiate the illusion of completely illuminating the darkness of our motivations and tendencies" (Gadamer, 1982:104).

We can now appreciate the density of the task facing hermeneutics:

> The description of the inner structure and coherence of a given text and the mere repetition of what the author says is not yet real understanding. One has to bring his speaking back to life again, and for this one has to become familiar with the realities about which the text speaks (Gadamer, 1982:98).

Now that we doubt the testimony of self-consciousness, and even the appearances of culture, then "interpretation refers not only to the explication of the actual intention of the text. Interpretation becomes an expression for getting behind the surface phenomena and data" (Gadamer, 1982:100). This is the origin of an insistent tension between the experience of the individual and the nature of the context. It is perhaps with this insight that we can begin to turn the sense of individual unease that Mills spoke of, towards his suggestion of discovering and communicating the implicit public issues. It is not an easy task. On the one hand, there are the undeniable intentions of people and on the other, there are the radical doubts that can apply to all of the culture we inherit. Here there is a radical career of the concept of interpretation that "has its philosophic grounding in the well-justified mistrust of the traditional framework whose basic terms are not so obvious and presuppositionless as they pretend to be" (Gadamer, 1982:101). When I ceased interviewing, feeling that I had plenty to keep in memory, I anticipated what Gadamer suggests later as a technique of a "growing familiarity" between ourselves and the text. The growing familiarity is with more than the text though; it is also a growing familiarity with the whole concept of mistrust.

Mistrust hinges on what we take as being 'obvious'. Gadamer writes that Heidegger broke through "the aura of obviousness with which the Greek thinkers used the concept of being" (ibid.). According to Gadamer, Heidegger argued that the Greeks concealed a certain consciousness of being. If I read this correctly, the Greeks did not

doubt things as they appeared to be but constructed their "edifice of metaphysics from the concept of being as the circumscribed already-out-there-now" (ibid.). This straightforward world is tripped and tossed topsy-turvy by Heidegger's question, *What is Metaphysics?* The "secret emphasis borne by the word *is*… what metaphysics really is in contrast with what metaphysics wants to be and with what it understands itself to be" (Gadamer, 1982:101) is the catch that extends beyond metaphysics.

I find it startling to have run across almost the same notions in Bennis (1966). Without any reference to either Gadamer or Heidegger, he offers a typology of organizational identity that mirrors this emphasis. Bennis writes how an organization can be studied as the 'manifest' organization, how it is publicly described. There is also the 'assumed' organization, how members would explain how things actually happen. The 'extant' organization is the system as it exists and could be discovered through study. Finally, there is the 'requisite' organization, the ideal of what it should be. I had attempted to use this as yet another a coding scheme in trying to 'fracture the data' in addition to the schemes I have described earlier in this chapter, but abandoned it on the purely subjective ground that it did not feel right. Gadamer observes that this 'secret' emphasis has a provocative force that implies new concepts for understanding. It is not only human experience but also the nature of society - "the world of dominant social prejudices" (Gadamer, 1982:104) - that comes in for investigation. We might be proud, thinking we've covered everything by such a broad formulation, but mistrust runs deep: "when we examine the range of these new insights… we need to cast a critical eye upon just what sort of untested presuppositions of a traditional kind are still at work in them" (ibid.).

Gadamer takes his mistrust of investigative technique seriously, alert to the possibility that, in spite of the profound doubts ushered in by Nietzsche and Marx, interpretation is still tempted to emulate the natural sciences. So he asks whether "the dynamic law of human life can be conceived adequately in terms of progress, of a continual advance from the unknown into the known, and whether the course of human culture is actually a linear progression from mythology to enlightenment" (Gadamer, 1982:104). It leads to a completely different notion: "whether the movement of human existence does not issue in a relentless inner tension between illumination and concealment" (ibid.). From this view of interpretation as a struggle, he asks a question that starts to head back towards the issue of the modern world as a technocracy:

> Might it not be just a prejudice of modern times that the notion of progress that is in fact constitutive for the spirit of scientific research should be transferable to the whole of human living and human culture… [and] is it at all consonant with the conditions of human existence in general? (Gadamer, 1982:105).

It is at this point that Gadamer takes a step that no student of scientific research would dare take. In the face of radical doubt "it becomes more important to trace the interests guiding us with respect to a given subject matter than simply to interpret the evident content of a statement" (Gadamer, 1982:106). He explains that statements should be seen as the response to a question. However, this question "has its own direction of meaning and is by no means to be gotten hold of through a network of background motivations" (ibid.). In other words, it is not some neutral, objective question but one about which we should be alert, asking ourselves: "Where does our effort to understand begin?" (ibid.) One thing is certain, "there are always both conscious and unconscious interests at play determining us" (ibid.). The answer can never be fixed, "it will always be the case that we have to ask ourselves why a text

stirs our interest" (Gadamer, 1982:107). While Gadamer suggests it stirs out of a dynamic, he expresses it in a way that is reminiscent of Mills' concern that in our times, many individuals feel indifference rather than unease: "Without an inner tension between our anticipation of meaning and the all-pervasive opinions and without a critical interest in the prevailing opinions, there would be no questions at all" (ibid.).

He then makes some suggestions that we could regard as necessary techniques. He stresses that the inner tension between anticipation of meaning and critical interest is fundamental to any research, yet it "has a unique element to it. The first guiding insight is to admit to the endlessness of the task" (Gadamer, 1982:108). He intimates that, faced with an endless task, we sense futility and it disempowers us. Thus he declares, "it remains a legitimate task to clarify what lies at the basis of our interests as far as possible" (ibid.). The value of this is not along the lines of the outcomes we expect from natural science investigations. Instead, we come to a self-understanding. So by clarifying our interests "we are in a position to understand the statements with which we are concerned, precisely insofar as we recognize our own questions in them" (ibid.). However, he also draws us away from thinking that it is merely a personal task on the part of the investigator: "we must realize that the unconscious and the implicit do not simply make up the polar opposite of our conscious human existence" (ibid.). This means that neither psychological explanations relying on the unconscious nor social explanations drawing on implicitly shared consciousness are enough. Understanding is resolutely an active concept, taking in all these things but "explicating them in the direction and limits indicated by our hermeneutic interest" (Gadamer, 1982:108).

These limits are actively encountered as the “elaboration of the hermeneutic situation”. This is not more description of the phenomenon. Instead, it is an interpretative intensity, when one “can sharpen any hermeneutic situation to this limit of despairing of meaning and of needing to get behind the manifest meaning” (ibid.). In this, there is never “a complete concord between the tendencies of our unconscious and our conscious motivations… [but neither]… is it always a matter of complete concealment and distortion” (Gadamer, 1982:109). He characterizes the tension between these poles as a “resistance offered by statements or texts and brought to an end by the regaining of a shared possession of meaning” (ibid.).

Despite this claim of regaining a shared meaning or a “fusion of horizons” (Gadamer, 1982:111), understanding “always remains a risk and never leaves room for the simple application of a general knowledge of rules to the statements or texts to be understood” (ibid.). Understanding is an “adventure”, a “new experience”, a “growth in inner awareness”. The idea of interpretation as the intention of the text is “not adequate to what is most essential to the process of understanding to the extent that it is a process of communication” (Gadamer, 1982:110). At the risk of belabouring the point, this forces us to check any expectations we may raise of a reliable, quasi-mechanical explanation along the lines of natural science. Gadamer insists that the idea of understanding is the enrichment of lived experience through “a process of growing familiarity between the determinate experience, or the ‘text’, and ourselves” (ibid.).

By putting the word “text” in inverted commas, Gadamer is making an emphasis that is at first peculiar. Surely most readers would assume by now that by ‘text’ he means any human phenomenon, not just written material? The reason becomes clear in the next sentence. Understanding is textual in the sense that it is tied up with the very way in which we express our thoughts. Humans cannot stop communicating: the “intrinsically linguistic condition of all our understanding implies that the vague representations of meaning that bear us along get brought word by word to articulation and so become communicable” (ibid.).

It is tempting to argue that Gadamer is offering an idea of understanding that relies too much on language, but his intention is to offer a communicable, philosophical form of understanding. He argues “the situation of a conversation is a fertile model even where a mute text is brought to speech first by the questions of an interpreter” (Gadamer, 1982:111). The “mute speech” in this thesis consists of what is implicit in what people ordinarily say about their situation. Gadamer’s essay encourages the interpreter to interpret with a hermeneutic resolve, a “heightened theoretic awareness about the experience of understanding and the practice of understanding” (1982:112). It is a limited understanding still, a theoretic stance that “only makes us aware reflectively of what is performatively at play in the practical experience of understanding” (ibid.).

This returns us to the conditions of practice raised in the preceding essay. Gadamer argues that language, in its ability to coordinate action that goes beyond our common survival or utilitarian needs, characterises a certain distance in our relation to things, it brings about “presence” (1982:76). We “hold fast” to language; it projects “binding

norms" that are "intrinsically social". Even in the light of insights from Nietzsche and Marx that cause us to suspect language as profoundly deformed, people still hold fast to it. The proof of this, Gadamer asserts, is that witnesses feel compelled to tell the truth in a trial, even without a religiously sanctioned oath binding them. Yet the deformation of language is undeniable, and it suggests the need to restore it. Gadamer introduces this with a discussion of Habermas' notion of restoring language as the task of achieving communicative competence. Gadamer uses the ideal of communicative competence to raise the notion of "utopia" as a form of "provocative inventions". He argues that utopian ideals are not merely a wish for some ideal state of affairs. Instead, they are intended to critique the present, and point out the distinction between wishing for a state of affairs, and choosing. In this way they heighten reflection, leading to resolve and so to practice. However, language does more than bind us with norms, overcome its deformations, bring about 'presence', and describe and contrast the present with an ideal: Language is an integral part of what Gadamer calls 'social reason'.

Social reason arises from a relationship with things that is enhanced by being shared, that "in virtue of its overwhelming presence is accessible to all in common… [and]… the more those involved discover themselves in this common reality… [the more they]… possess freedom in the positive sense, they have their true identity in that common reality" (Gadamer, 1982:77). This presence is something found both within the self and in each other. For it to be held in common entails a form of communicability, and "[i]n the end, this is the birth of the concept of reason" (ibid.). What is shared and communicated connotes another concept even more fundamental than reason and under threat today: It is solidarity, and "[p]ractice is conducting

oneself and acting in solidarity. Solidarity, however, is the decisive condition and basis for all social reason…" (Gadamer, 1982:87). Then in a master stroke, Gadamer grasps both the subjective feelings and objective circumstances of unease to declare – not ask: "people behave as if each had a private reason. Does this have to remain this way?" (ibid.).

So we may leave Gadamer, for the time being. To recapitulate, the problem I was facing was the need for some form of analysis that would not 'turn' on nurses in the sense of taking what they said and then using it to diagnose their shortcomings. Rather, I needed some way to take what they said and use it to analyse the circumstances surrounding them. It was not so much a method as an outlook, a disposition. These two essays encouraged a critical attitude that played between ancient and modern ideas of science, theory, and practice. These in turn suggested a critique of technology, language and interpretation that kept the relationship between the individual and society as something open to radical change rather than as a set of rules to be discovered. At the time, I stumbled into fieldwork with the most modest and conservative approach to data gathering - of simply going to listen - I had only the slightest grasp of the notions mentioned in this chapter. I only knew that I was uneasy, and the only way to learn why would be to listen to my colleagues and then to dwell on what they said. So the next chapter will describe what it is that I heard and saw.

Chapter 3: What the Nurses Said

A picture of the three locales

Putria, *Milduria* and *Tempuria-Eternia* are pseudonyms for three psychogeriatric units. The names suggest their age and their material state: *Putria* (rotted away), *Milduria* (modern but mildewing) and *Tempuria-Eternia* (an ethereal pair of which *Tempuria* is temporarily occupied, but *Eternia* is both its origin and destination). I will provide brief, impressionistic sketches of them. Photographs would be misleading. The truth, for this study, lies somewhere in what nurses say about these places.

Putria was built as a barracks in the 1800s. It was quickly converted into a psychiatric ward, evolving over the last 20 years into a psychogeriatric unit with an 18-bed dormitory and a dayroom. Roundly condemned by all during the past two decades, plans for its imminent replacement are ‘commercial in confidence’. In a regional city, a stone’s throw from where Australia exports one third of its coal, it remains a crude reminder that Western civilization is also a history of barbarism.

In another state, also rich with mineral exports, *Milduria* was designed and built as a ‘state of the art’ psychogeriatric unit in the mid 1980s. It sprawled over two wings with three wards in each. Each ward had eight beds, in single and twin-bed rooms, opening onto a lounge and dining area and leading out to secure courtyards. A decade later, one wing was cut and an extra bed squeezed into the remaining wards. The other wing sheltered the overflow from the geriatric hospital, expanding across the road.

At the turn of this century, I heard of *Eternia,* a new ‘state-of-the-art’ facility. It turned out to be an old building, refurbished two years previously. By the time I got there, it had again closed for refurbishing. It was temporarily relocated into *Tempuria,* a tiny four-bed unit in a brand-new purpose-built adult psychiatry facility. This was its fourth move in seven years. On this campus, a major teaching hospital, the primary activity seems to be permanent reconstruction.

Walking into ancient Putria

From the rail station, *Putria* is a walk up the hill, the ocean on one side. Turning in at the entrance, you look across a green playing field ringed with trees. Avoid looking at the modern low-lying building on one side, the adult psychiatric unit. Just over ten years old, it is a failure and due to be replaced soon. Avoid looking at the abandoned round building, ridiculous with its broken windows and falling concrete. It is another failure, built in the seventies and condemned ten years later. Look across the playing field and approach a convict-era stone building. Then walk up the back passage to the front door, past the museum of wreckage that has lain undisturbed for years. Old beds, radiators, broken wheelchairs, desiccated rubbish. Closer to the entrance, some signs of life. Wet slippers hung out to dry, plastic cups with water and cigarette butts, open the door…

Outrage

Once inside you step into a venturi, plastered with notices. Staff of all designations whirl and cluster around a counter, telephones ringing, deliveries, visitors. Down one

way to the dormitory, deserted by day. Turn back the other way and there, behind the locked door, all the patients in two dayrooms and a courtyard. This is where they spend the entire day. It is surprising that only one speaker is outraged:

> Nita: I think it's horrible, I think it's a dump, absolutely a dump [p] it's horrible really [p] it's old, its poorly maintained, it's it's [sic] cavernous, and the way - you know - you've got those two dayrooms and we mainly use the one big dayroom, and the furniture's cold and it's a cold atmosphere [p] and it smells as well

Her judgement is encompassing. A "dump" is where everything, all sorts of things end up. Old things, things that can no longer be fixed, useless things, uncared for things, dead things. Her remark about it being "poorly maintained" refers to a whole world of detail that strangely, does not surface in other accounts. The mirrors in the bathrooms fell off years ago and have still not been replaced. There are taps that do not work. She describes the futility of the effort to keep up appearances; a functioning that occurs in what is a "cavernous" void:

> Nita: as you walk in [p] there's all that cracking and peeling cement, looks like it might have some cancer rot - like the walls even after you repaint them, they don't scrub up real well, you can see that they've been patched and repatched and, you know, the ceilings are so high - gives you a lot of space, you know, there's no curtains on the windows, the furniture's all [p] practical, the way it's set up, you know, just around the outside with that row of chairs in the middle, the TV's of course up high so they can't get at it, it's sort of really sterile, you know, there's a few old prints on the walls which are obviously really, really old - they're kind of like 40 years old - it's just sterile. It's so unhomely

In this dump, things have been dead for so long that even the “cancer rot” has acquired sterility. The void of height and space she refers to surrounds her work with an aura of unease. She conveys this sense of unease even when she attributes her confusion to the complexity of trying to make patients feel at home and clinically assessing them. The unease is in her phrase, “this is supposed to be”:

> Nita: sometimes I think I get mixed up between a nursing home and say “this is supposed to be an acute assessment thing”

When we think of “assessment”, we assume some sort of non-threatening environment, allowing a space for a calm, objective focus on the person. Here, assessment takes place within a “thing” that violates this assumption:

> Nita: some of the ladies are really thrown by the environment, by that room [p] because it’s just so horrible and they’re upset anyway [p] and in that case, it’s not just the building is it? it’s what’s going on in the dayroom as well, I ‘spose, all those people in the one room

She describes how the “building” and “what’s going on” are tied together, producing situations she cannot prevent:

> Nita: the doors are so far away from the toilet that they can’t stop anyone from coming in [p] and the men can just come in and sit on their knee

She understands and struggles to overcome the shock she senses some patients feel:

> Nita: I feel a bit sorry for them, I probably do try that bit hard to make it a bit easier for them because of the lack in the surroundings [p] some of the girls get upset you know, when the boys walk in on them you know [p] understandably so

She also confronts her own despair:

> Nita: other places that I've worked at you know at the end of the shift I've mopped the floor and wiped down the chairs [p] and at the end of the night everything would be nice and fresh again. I very rarely do that in *Putria*. You just don't want to put that sort of effort into a place like that, it's a dump.

Her sense of working alone, of isolated experience, is unique in the set of *Putria* interviews. She explains,

> Nita: I might say it's a dump but I haven't heard a lot of people say it's a dump. They say it's badly planned

She is uncertain:

> Nita: I don't know whether [p] if it is because a lot of the staff don't know any better maybe because they haven't been anywhere else

and then settles on a more fundamental explanation. Her experiences of the ward are intermittent, compared to those of permanent staff. She grants that it is quite possible for her to come to share their perspective:

> Nita: you get used to working under those conditions [p] and because I come and go I might get used to it

She compresses this explanation:

> Nita: yeah, you become desensitized if you're over there all the time I think

The question of staff's experiences and the conditions they work under are taken up in the next section.

Smelling the routine

In other accounts, the prior experience of working in institutional settings is raised. An experienced nurse explains how he is used to *Putria*, because it is an "institutional type building":

> Kurt: I've only ever worked in old buildings like that so [p] I guess I've been in institutional type buildings all my career

A nurse who, having completed a round of clinical placements in a variety of settings after recently graduating, selected a similarly old and decrepit long-stay psychogeriatric setting to compare *Putria* with:

> Phil: other than that no, I haven't been to anywhere else

Out of the variety of their experiences, people compare *Putria* with similarly 'institutional' places, rather than contrast it with different places. In these comparisons, similarities between institutions outweigh their differences:

> Sue: When I first came here, which was nine or ten years ago now, my first thought was 'mm, this is similar to [names old developmental disability institution]', same sort of setup

The "setup" is how the building is used on a daily basis:

> Sue the same routine with the clothes, stuff like that you know

Her phrase "stuff like that you know" is a gesture to me. She knows that as I work there, I recognize this world of routine use.

This ability to recognize something in a particular way becomes second nature. It pushes aside the shock and isolation of seeing a place as unique with an immediate

and general sense of familiarity. Thus when Kurt recapitulates his career of working in "institutional type buildings", he runs through the places he worked in and concludes:

> Kurt: the buildings are exactly the same [p] and the newer ones are exactly the same as [p] they've just got that feel about them, that's what institutional old buildings are

Even new buildings in his schema, become the "same". The "feel" of these places is the sense of smell that is universal to them, irrespective of their "type":

> Kurt: the minute you walk in the door they smell the same. I don't just mean the urine the cleaning fluids they use especially in these old buildings and the newer type wards - say the [adult psychiatric unit] and the newer wards at [disability hospital] which were built in the seventies, they smell exactly like the wards at [psychiatric hospital]

For Kurt, smell is not a shock, it is a return to the familiar, after a fifteen-year absence from nursing:

> Kurt: just walking through the door and smelling it [p] it was like I hadn't been away from it at all

In the territory of the familiar, smell does not linger. It suffuses the nature of the job:

> Paul: I'm just probably a typical nurse you don't really notice it when you walk in [p] cause we're, we're sort of used to it, just part of the job.

Becoming "used to it" does not mean that the smell of *Putria* is pushed entirely out of his awareness:

> Paul: if they go to the toilet which is just off the dayroom, it can be quite, you know, quite offensive-

It is an offensiveness that affects others, rather than his nursing colleagues:

Paul: I reckon the patients probably smell it a lot more than we do, 'cause we're, we're sort of used to it

The act of recognition, of orientating oneself to a type of locale, generalizes to all other aspects that make up an "institution". The next extract draws in all the staff - those who float on the fringes as well as those directly involved, patients, furnishings, everything:

Kurt: the people were the same, the wall colours were the same champagne colour, the curtains were half off, the clients were sort of the same

I turn from what disappears into recognition, to what is explicit in the relationship between the "job" and the built environment.

Behaviouralism and affordance

In contrast to the bare walls of the dayroom, there are posters plastered all over the lobby. Occupational Health and Safety exhortations, announcements of the Official Visitors Program, morning tea rosters, take-away food menus, photographs, thank you cards and postcards, fire orders, memoranda to staff, framed prints, are pinned or taped over, against, beside, under, above and below each other. Unnoticeable among this flourishing disorder is a laminated pronouncement declaring *Putria* to be a "least restrictive environment".

An awareness of such irony is needed to appreciate the following extract. Here, Kurt applies a combination of behaviouralism and farming to the functioning of *Putria*:

Kurt: I don't know what sort of psychologist you are - like a

> Behaviouralist, but when you build a cattle yard and you want cattle to go over here, you turn the water off in these other yards so they traipse away and around to find the water in this one, or you have big solid walls that means that they can't see through, and they'll just follow the curves... it's like [names patient] he can't see out of one eye, so he walks in this right hand arc, so like cattle and sheep, so if you want them to go somewhere, you send them into a funnel or wedge-shaped thing and they'll go for that little bit of green that they can see or each animal they can follow they will see, especially sheep. I don't know if you can apply that to poor demented people, but I reckon it works, with good sheep it works really well.

This is the gritty core of the 'person-environment fit' theory, stripped of any genteel pretensions. Others give examples that embody these principles. For instance, in the extract below, "noise" replaces "water":

> Phil: we have two televisions in two different rooms. If we have a patient who is more agitated by the television, we may turn that one off and turn the other one on, and encourage patients to use the other room

Or the intervention of "taking patients out" replaces the "curved wall" as a way of leading to greener pastures:

> Phil: we do use the environment to our advantage when we can, to reduce stimulus to the patients during their more agitated periods [p] by using isolation or taking the patients out into the courtyard for a walk

What these principles are and how they are applied has to be learnt. Nurses collaborate by discussing the environment and what needs to be done in order to find a method. It involves trial and error:

> Phil: you learn to adapt to different environments [p] what might be

> different in one ward [is] due to the way it's structured…we usually discuss what seems to be the best method. If some will suggest one method, most staff members will agree to it, observe how it goes

The flexibility of trial and error is needed because situations may be either similar,

> Phil: Depending on how the patients respond, it's likely to encourage other staff members to do that down the track on other occasions

or unique:

> Phil: there's not always just one answer to how to manage a situation

The dark secret, spoken in a backstage language that will rarely be heard, is an assessment of the patient:

> Kurt: there's certain people you don't trust [p] you got a degree of trust in the patients that you know, you think they're mad but they can make some decisions for themselves

An everyday situation, for example, may require the Wisdom of Solomon:

> Phil: we usually have one of the doors opening from the dayroom to the courtyard and this seems to be a focus for a lot of the patients who either open and shut the door, or demand the door to be shut, while others demand that it be open

A variation of this scenario occurs when the act of moving the door, rather than it being either open or shut, becomes the focus of activity. Actions such as pushing the door

> to and fro, to and fro, to and fro, to and fro, to and fro, to and fro, to and fro,

rather than using the door for its conventional purposes, are frequent. They constitute what Eco (1980) would call 'illegal use' arising from 'aberrant decoding'. Gibson

(Greeno, 1994) considered the usage of objects as straightforward opportunity that he called ‘affordance’. Thus, large open spaces for children ‘afford’ a place for running, or a tree ‘affords’ climbing, a log ‘affords’ balancing. The point is not whether the object is interpreted in a legal or illegal way, but how it can be manipulated. There is a startling aspect in how people with dementia sometimes consider objects. I will always recall a particular incident when I was checking on a patient in the toilet. When I walked in, she looked up and said, “My wee just slipped down the light globe, darling”. Another patient gestured to the cupboard and kept asking me for some “fish”. Eventually it dawned on me that she was asking for her packet of cigarettes that we stored in the cupboard. In these instances, the terms “light globe” and “fish” are metaphors. The light globe shares similarities with the toilet bowl, being white, smooth, curved. “Fish”, in the sense of sardines packed in a tin, has a similar form to cigarettes in a box. But what happens more frequently is the act of simply handling something:

> Phil: some patients will push the door backwards and forwards, which creates a lot of noise with the doorstopper, and that agitates other patients, which unsettles the rest of the ward

But there are also times when patients know what thing it is that they want, but are not sure if they have recognized it correctly:

> Kurt: you can have a picture of a toilet there and only one or two doors in the room but they still can’t find the toilet even though the floor is tiled and you can see a toilet bowl there, but they can’t get it together to use it [p] like people that are together in sort of one level but not, cognitively still pretty limited, they still get up, catch your eye and say ‘is that where the toilet is?’ even though it’s got a picture of a toilet there

Some forms of illegal use present risk. For instance, a patient can use an object in an unexpected way to attack other people. In the next extract, there is no question of aberrant decoding. Phil explains that he regularly checks the courtyard and removes branches. This resourcefulness is necessary because moveable objects, such as fallen branches, can be used as weapons:

> Phil: not only are they a risk to the patients having an injury to themselves but also, they can be weapons used on staff or other patients

This topic of illegal use raised by nurses is not adequately addressed by the literature. The literature is concerned with ways to maximize conventional behaviour, rather than the challenges arising from varieties of unconventional behaviour. These extracts show that places and things can invite or afford a range of uses. Affordance, though, also involves risk. Risk is the topic of the next section.

Risk

Work in *Putria* generally involves both the task at hand and constant awareness of what is happening elsewhere. For instance, the nurse assigned to give morning medications does so alone, in the locked dayroom. The other two nurses on duty work in the dormitory area, helping patients to shower and dress:

> Phil: at this time you have patients who are coming from the showers after getting up [p] and while this is happening you have control of the drug trolley, and also you have patients who may be agitated and attempting to leave, who may be standing around doorways or moving furniture or other sorts of activities

If the nurse dispensing medications needs to intervene in a situation, it is not easy to do so immediately:

> Phil: you have to close the trolley and put it in a position where it can't be reached by other patients, and to do that you either have to take it into the second dayroom or the toilets or take it out through the dayroom door into the office, and that's not necessarily straightforward, you have to move around chairs, patients

Even during the course of the day, when all the patients and nurses are in the locked dayroom area, it remains difficult to focus solely on what is being done:

> Phil: it's very difficult to nurse someone who needs pressure area care and other nursing care in the dayroom because you have intrusive patients and you spend a lot of time redirecting other patients

Calm in the face of turmoil, Paul's description of "what goes on" glosses Nita's passionate phrase "it's awful, they're all in one room" with an understatement:

> Paul: it seems to be a little bit crowded at times when you have a number of people [p] I think they're sort of a bit on top of each other

His elaboration below barely dwells on the particular dramas in this confined space. The space is like a cloud. Within it are people like particles, floating, circulating, congregating, in transient and partial, but peevish interactions. Although he speaks in level tones, he can sense every tug of this matrix of stresses:

> Paul: when you've got 14 people and 3 nurses in there, it's 17 people in there - most of them seem to congregate in dayroom one and occasionally float through dayroom two [p] a lot of them are walking around, and the men, they like to do a bit of removalist work, push their chairs around [p] like tonight, one of them pushed their chair

into another one's legs and they got a bit upset

This matrix, with its tensions of colliding cross-purposes, can tighten until all sense of individuality compacts into a whirling mass:

Phil: When you have agitated patients in a room [p] they're going to agitate other patients, it's a snowball sort of effect

Often, during afternoon shifts in this unit, a line I heard Barbara Streisand song floats distantly through my mind:

Sailors! Fighting in the dance hall

With all the patients in the dayroom, it is possible to see everyone while giving individual attention, and so it is

Paul: good visually for the nurses [p] you can get on top of any situation pretty quickly.

But at the same time, it has its disadvantages. The "snowball" effect does not arise only from collisions between patients, but also from a substrate of boredom:

Phil: we seem to be lacking - too many people sit around with nothing to do, there's nowhere for them to go and do anything else

The sense of boredom and compaction is reflected by another nurse:

Sue Well they're locked in there, there's nothing for them to do, it's not a big area, they've got no room to walk around, you know what I mean?

What happens at night is also risky. *Putria* has a crude yet complex dormitory arrangement. Low dividers separate many of the beds. Some beds are in distinct

rooms, and others abut directly onto the corridor. Getting to the toilet at night involves navigating this arrangement, before walking up the corridor. Buckets are put beside male beds, and there is one commode chair for females. As a result of the circumstances, as well as dementia, impaired mobility, or simple urgency, patients often void on the floor. Puddles of urine are difficult to see and treacherous on the linoleum floor. With the nurses' night station some distance from the dormitory, nurses agree that *Putria* is

> Sue — not set up for these sort of people on night duty [p] you should be able to see the patients all the time rather than having that mirror thing 'cause you can't see all the way down the ward

What Sue means by "these sort of people" is people who present serious risk – throughout the day as well as at night. The next section describes the two 'sorts of people' in *Putria*: those who create risk, and those who are at risk. It is important to point out this distinction as it has direct implications for the management of risk in the environment of *Putria*.

With it/ not with it

Older people with psychiatric problems are admitted to the adult psychiatric unit on the campus, and those with dementia are admitted to *Putria*. However, within *Putria* a further division of patients is made, into people who are 'with it', and people who are 'not with it'. The distinction is not as simple as it seems. Notice how the way it is said is tied in with years of observation: that people who get better move on, and people who don't, tend to be 'not with it':

> Sue — We get people who are demented, but still have a little bit of - what

> would you say - a little bit of knowledge like [p] they're still a bit with it right, and you've got people who are not with it and you can't combine the two together, 'cause it's not fair on the other patient, do you know what I mean? [p] Or people who get better, people who get better, and they should be moved on more quicklier [sic] than being here

In the next two extracts, Paul uses this distinction to explain why the two types "don't mix". Firstly, 'not with it' people do not necessarily have a goal in mind, they are simply doing something which happens to offend:

> Paul: there's other people who are quite with it and the sight of a naked man walking down the hallway at night time and strolling into their room is a bit, is a bit rude

Secondly, this offence is experienced by 'with it people' and viewed by staff as intrusive:

> Paul: Here you've got people who are functioning well at times and [p] you've always got someone who's walking in on someone in the toilet

In *Putria*, 'with it' people are seen to have lost the right to exercise their autonomy as well as freedom from unwanted intrusion in executing it:

> Sue they should still have their, their independence, you know what I mean? So [names patient] should be allowed to go down and sit on her bed [p] or - she likes writing - and do her writing [p] without people who are so intrusive to her

The sense of outrage that Nita expressed in the opening extracts, that seemed to disappear with habituation or escaped into wry humour, resurfaces in a sense of unfairness. Yet, it has its arm twisted. For instance, although Sue wants to allow 'with it' people the freedom to get away from intrusive people, she cannot do so:

> Sue we can't just open that door and say "well you can go there in your room and you can go and have a lay down on your bed and you can go and do what you want" cause there's no staff down there to watch them

The advantages and disadvantages of having everyone in the one room have been indicated above. Keeping all patients in sight at all times condenses to a frustrating rule:

> Paul: you know whether you could let someone have a nap, but you can't supervise them you can't leave them on their own

In the ordinary use of this building, these minor tragedies recur daily. It is a tragedy because, on the other side of the wall, is the lobby with its press of multi-disciplinary staff who are free to come and go. For them, the law must be that: "if you can leave them, then you can't supervise them". I was initially puzzled when reading the data that the multi-disciplinary team and administrative staff were not mentioned. I thought perhaps it was because nurses stuck literally to the topic of the built environment. But as I reread the data, it was clear the topic of the built environment was bound to its pragmatic experience. What the data were telling me was what ordinary words would not dare to say: The nurses in *Putria* are alone with all their patients, in the dayroom by day and in the dormitory by night. The multi-disciplinary team and administrative staff are peripheral to this material reality.

In *Putria*, nurses have inherited an environment that has been socially condemned yet tolerated for many years. In *Putria*, the illegal use of the environment by 'not with it' patients presents an aura of ever-present risk. This aura is extended to those patients who are 'with it', giving them no prospect of being able to exercise the right to privacy and autonomy. Despite this, there is an appreciation of the qualities of *Putria*. I turn to this in the next section.

Qualities of old Putria

In the preceding section, I deduced the irrelevance of the proximity of the multi-disciplinary team and administrative staff. There is, however, a relevant proximity:

> Kurt: one of the things I like about *Putria* is not the building physically but just its position, that it's in close proximity to the rest of the site

This "proximity" is a metaphor for a strong sense of camaraderie that comes out of a shared sense of determination:

> Kurt: You know I work with lots of people who couldn't set foot outside one of these places to work anywhere else [p] there is a security in being part of you know, the understanding, the camaraderie - that sort of thing, like psych nursing is very misunderstood in a general hospital [p] you know, we're straight into affirmation, we just grit our teeth and get them to do what we want to do

Putria's location is enjoyable for nurses for the opportunities it offers:

> Paul: It's nice to have the hospital in the city, close to the beach, it's good for the staff as well. The staff can go to the beach at lunchtime for 30 minutes and de-stress

Its outlook is also pleasant for patients:

Paul: the people look out from the dayroom across the courtyard, they've got a nice view

Nurses recognize the strengths and limits of *Putria*:

Paul: it's good in some ways, and it has its limits in others

Much of what is "good" yet limited refers to the ability to see all patients in the dayroom, and the inability to see them directly in the dormitory. It also refers to the limitation of having to concentrate nursing staff at one end of the building during the day, and the other at night. What is a limit is simultaneously a strength:

Paul: actually *Putria* works quite well - we've got the two dayrooms, the dining rooms, and the bedrooms down one end - but that's so, so you can really only nurse one end at a time sort of thing

The problem of having two groups of people who don't mix well together cannot be solved:

Paul: unless you get a new building and then we probably could change it

Just what kind of change is promised by a new building, is the subject of the next section.

New Putria

After decades of indecision, the new unit is to be built on the campus of a major general hospital. This is inland, amongst suburban houses and away from any shopping zone. Comparing it with *Putria*'s location, Paul echoes the commonly held view that the new unit:

Paul: won't be in as good a position as *Putria* is

This is not only because of access,

> Paul: there's always a problem with parking up there whenever I've been up there, so it could make it hard for the relatives - they would have to give a lot of attention to that

but because of location:

> Paul: I can't see them [patients] getting much of a view at [new campus], maybe a car park or something like that, or a brick wall of another building.

Curiously, despite the extraordinary demands of nursing *Putria*'s 'clientele', and the years of widespread talk about a new building, hands-on nursing staff have not been invited to participate in planning. This exclusion, as well as the evidence of architectural ineptitude on the site, may explain why one staff member does not speculate on the new *Putria*. He confines his speculations to his discussions with other nursing staff about modifying the existing *Putria*:

> Phil: we've discussed amongst ourselves what areas of the ward would be beneficial to change

There is a vacuum between those who plan the future and those who work in the present. It is a vacuum that is - naturally - populated by "they", the experts:

> Paul: I don't really know what they'll do I'm not an expert in the way that it should be built [p] I don't really know how they'll build it to make it more functional

The crudeness of *Putria* implies that any replacement would be an improvement. But this does not explain the faith professed in the ability of distant experts, who have never seen or spoken to those who work there, to understand what they do:

> Paul: it'd be better, in a sense it should be a purpose-built unit to suit what we do.

In the above extracts, nurses imagine that a new *Putria* should perform the same things, in a "better" way than it currently does. They just find it difficult to imagine how, and their challenge is for both architects and those who commission a building to "really concentrate" on this:

> Sue all depends on how they're gonna run it, if they're gonna run it like this [p] they should really concentrate on how they're gonna build it and you know things are gonna be situated

The phrase "they should really concentrate on" at first glance seems trivially obvious. The job of architects and planners is to concentrate on these things. It does suggest, given the shortcomings of existing site, that extra care will need to be given. After all, the new site was originally a local hospital serving a local community. It was not intended to serve the region. However, underneath this apparent innocuousness is a powerful and blunt meaning we don't normally pay direct attention to, because it is so damning. That is, every day, when nurses go to work, they go through a campus that demonstrates failures of design and planning. Let us go through it again: On the hill above the playing fields stands the derelict, two-storey concrete and glass psychiatric unit built in the 70's, and abandoned within a decade. Below the playing fields, sinking below the road, is the low-lying and loathed adult psychiatric unit built in the 1990s, which is to be replaced before *Putria* will be. The walk to *Putria* is past dynasties of failure. *Putria* is the most ancient of these, surviving and defying the plans of sincere reformers and careerists alike. It would be an overwhelming dampener to practical desires to labour the failures that, after all, litter not only this campus, but the world and its history.

Returning to the practical problem of how things are to be run, of managing ‘with it’ and ‘not with it’ people in the same setting, one nurse resolves it very simply:

> Sue — you have two different units, you have an independent unit and a non-independent unit

This is, in effect, maintaining but refining current streaming patterns, as they are to be found now. ‘Streaming’ as a solution is at work on the other two sites in this study.

But to what purpose?

Talk about the new unit is schismatic. It either concentrates on the needs of ‘with it’ patients, or switches to the needs of ‘not with it’ patients. It does not explicitly address how both sets of needs can be met within the same unit. Regrettably, it seems the experts will be even less explicit. Indications are that the new *Putria* will be planned to admit elderly psychiatric patients rather than routinely admit people with serious behavioural problems related to dementia. This section will conclude with a selection of extracts illustrating the desired features for each group of patients.

The overwhelming view expressed in the healthcare literature is that consumers expect aged care facilities to support a domestic lifestyle. In line with this view, the common expectation that the new unit would have single rooms was justified as being

> Paul: — the standard with modern accommodation [p] it’s just the privacy and the dignity

Single rooms are mandatory, but satisfying other aspects of lifestyle are optional. The problem of boredom as experienced by some patients in *Putria* is solved by providing activity areas in the new unit:

> Paul: I'd like to see areas where they can have all sorts of activities… [for] the ones that are with it enough

Talk about existing *Putria* did not raise the topic of rehabilitation. In the new *Putria*, rehabilitation becomes a possibility:

> Paul: single rooms, maybe en-suite accommodation because we've still got a few people here who can shower themselves, maybe dress themselves at the moment

In the current *Putria*, patients are confined to one large room, unable to escape from each other. The new *Putria* reverses every aspect of this, and is envisaged as a place where patients can choose solitude:

> Nita: I'd like to see some single rooms I don't think there's any doubt about that [p] it should be more homely, more comfortable, you know, smaller areas, a few areas where people could get away from each other if they needed to

So far, these ideals are concerned with meeting the needs of patients who are 'with it'. However, the idea of people getting "away from each other if they needed to" re-opens the problem of intrusion by 'not with it' people. Single rooms are desirable for 'not with it' people because

> Kurt: if somebody is wandering they're only going to be wandering round and around in the room rather than – they're not going to disturb the person next to them

This is generalized to a need for

> Paul: some sort of areas where you can isolate them if they're really agitated and when they can be aggressive to other patients

‘With it’ patients can manage themselves - they shower, dress, perform activities, choose solitude. In contrast, ‘not with it’ patients do things that make ‘homely’ areas problematic:

> Kurt: if it was more like a lounge-room at home, with nice chairs and carpet, it just wouldn’t work there’s even, there’s even more things to pee in, pillows to defecate under, there’s more to confuse them

Having fewer things would diminish this problem:

> Kurt: as for the way of managing them, having a pretty stark sort of building is fewer ah, sort of things to confuse them

This threatens the assumption underlying the ‘modern standard’ of a home-like, comfortable place with its domestic bric-a-brac. However, there is a concern that “starkness” as a device used by nursing staff should not be unfairly judged:

> Kurt: the starkness of that low-stimulus environment is certainly not a bad thing

This recognition validates the reality that ‘not with it’ patients may create their own reality, imagining *Putria* to be their home or club:

> Kurt: a lot of them, you know how they hallucinate, anyway they think they’re in their lounge-room [p] or “I’m still sitting here, the waiter hasn’t come with me beer”

We see, then, how the ideal of a new *Putria* contains simultaneous empathies. On the one hand, there is concern for the privacy and dignity of ‘with it’ patients. On the other, there is recognition of the experiences of ‘not with it’ patients. In the next

section, I describe the case of *Milduria*. As a purpose-built unit, it can be regarded as the dream of *Putria* made reality.

Walking into modern Milduria

An immense two storey traditional Victorian asylum set atop a hill over a panorama of grounds. Enormous wards. A dozen dormitories of 50 beds, piped through showers and toilets into dayrooms. A full-scale kitchen to cook for them all, a cafeteria for all the staff. A grand staircase ascending to administration. A *Putria* of 600 beds. Crudity on a massive scale. In early 1980, it was demolished. A walled wealthy township patrolled by security guards rose over the old ghosts. The ghosts diffused through the suburbs north, south and west of the city, finding asylum in low-lying purpose-built units. One of these, *Milduria*, constitutes the next case.

Cross the four-lane highway in the shadow of another, thundering overhead and you reach a landscape where a demented god is at play, wilfully shaping a medicalized representation of the human body, from concrete. The road, once along a straggle of old houses and vacant blocks is now engorged with private health-care suites - dental, scanning, pathology, physiotherapy, doctors' rooms. This oesophagus abruptly branches into major organs: the new child and adult psychiatry buildings and the geriatric complex, the old general and maternity hospital and, finally, the psychogeriatric unit. Purpose-built, still modern, hidden by a long, dark brown brick wall. Not far from where it ends, an aperture. Turn here.

Turning into the alleyway that leads to *Milduria*, I gulped against the expulsion of linen, food and refuse trolleys, swarming, waiting to be taken away. I pressed the button beside a glass door that looked into a cold void of brown carpet, an empty corridor. And waited. Beside me, a glassed-in courtyard. Within it, the polyps of broken chairs and equipment I saw eight years ago, the same careless piles. Someone opened the door and the pungent smell of stale urine hit me. It seemed as if I had never left, as though I was returning from holidays. By the time I reached the wards, I had already forgotten the smell. In the back of my head, though, I remembered that it was not supposed to smell like an institution. The reason for this came back to me later, when someone reminded me that *Milduria* was built according to a philosophy called 'normalization'.

This is so stupid!

The opening remarks of nurses dealt with the faults in *Milduria*'s functional requirements:

June: you do get used to it, but some days you think "Oh, this is so stupid"

Barb: I don't spend a lot of time thinking about it, the environment, when you're working so, you just get used to what you've got, I suppose, but [p] more visual access to the passage way would be beneficial

They all mentioned the bathrooms. The two toilets and showers for the nine patients in each wing were insufficient. The doorways were too small to allow easy entry for two staff with a patient on a hoist. The bathrooms themselves were too small, and became rapidly crowded:

What the nurses said

Kenny: We've got two toilets and showers in each wing. They're inadequate. Where I'm coming from there is that we have hoists [p] at this moment in time we're not using a hoist

Will: often with hoists we have two or three people [p] these bathrooms are not designed to fit that many people comfortably

Inward opening doors made manoeuvring even harder:

June: the door is no good it would be better if they had a sliding door because when you're hoisting people around the corner to the toilet

Perhaps there was a reason for not fitting such doors, but even simple modifications were lacking:

June: oh there's not enough shelving and things for the shower for their clothes

These views are not only widely shared, they are also deeply held. The speaker below selects examples and pairs each one to a design concept, in a judgement setting out the totality of design failure. He does this fluently, with authority, in one crisp statement:

Will: you've got clean towels in the corner, but dirty linen bags in there and that's the layout thing [p] toilets and showers should be separate [p] faeces tends to move, not always in the direction of the toilet. So there's a hygiene issue, there's also a size issue, just with the present setup, and there's also a temperature issue - it can be very hot and humid [p] and also cold, really cold in the winter

One nurse reasons the inadequate size of the bathrooms could not have been foreseen when the ward was designed:

Barb: we're using equipment, we didn't use it going back about ten years or

> something, we probably only had one between the whole hospital

Aside from the design of the bathrooms themselves, their relationship to other spaces causes difficulties. In the extract below, the point being made is not that the pan-room itself is not functional, but the spatial relation between it and the bathroom is non-functional:

> June: I don't think the pan room is that functional [p] if [p] you're working here [indicates bathroom] and you need something in the pan room, you have got to leave the ward

The privacy afforded by single rooms is compromised by having to traverse the corridor in order to have a shower:

> June: well they've got the shared bathrooms, they've got to walk to their bathrooms, they haven't got the luxury of having the bathrooms in their bedrooms like a lot of places

These problems with the bathrooms are the beginning of a flood that covers almost every aspect of *Milduria*'s design. Another feature on which all speakers remarked was the "curved wall". The bedroom and bathroom areas line both sides of a short, broad corridor. A thick cement wall slopes down from ceiling to chest height and curls away from the corridor and these areas, partially enfolding the lounge. Several nurses refer to this as a "cutting off" effect, as it

> Barb: cuts you off, your visual space, you can't really see what's going on on the other side

The cutting off effect extends to sound, as well as sight, resulting in consequences:

> April: you've got to be able to hear her 'cause if she calls out she's going to

climb out of bed immediately, in no time, and she'll fall

Will: having the lounge areas and your bedroom areas separated by this wall cuts it off [p] you can't see, you can't hear, the sound comes down the wall and if it's just a thud and no noise, you miss it, you don't hear it if you've got TV going and they're a bit agitated

Will blends theoretical and practical reasoning to explain that the wall

Will: was obviously an architect's design, at some stage he's come up with this idea of functionally separating it from their point of view a living area and a sleeping area. From a practical point of view, that's probably responsible for some incidents of harm to people by the sheer fact that you can't see what's going on

Its functional and aesthetic intentions are irrelevant, since it

Will: doesn't give you a practical quiet area [p] because if you take them up into the bedroom area where it's quieter you're then isolated from everything else that's happening

April states this as a principle, together with its corollary, that if:

April: you can't see them you can't do anything about it [p] [and] you might only have eight patients and two staff but somebody's going to fall over, you can't be everywhere at once

Will sums up the curved wall as just one of those things, a class of failures:

Will: it's one of those things, there was possibly a concept behind it but it hasn't, I don't think it's worked, personally

The aura of design failure

The concepts behind *Milduria* that have not worked extend from design failure to concepts that are not permitted to work due to material neglect and programme decay.

Material neglect and programme decay will be examined separately. Here, design failure permeates *Milduria* with an aura of failure from its very foundations to its furnishings.

The aura of design failure is demonstrated by the attitude of one nurse towards the verandah. The verandahs run off from the dining area of each ward. They have a tin roofs and a dark brick floors, and are enclosed along the outside with fly mesh. The verandah can only be seen into from the dining room door. To what extent does the illegal use, unpleasantness and impracticality described below, arise from the qualities of the verandah itself?

> Will: the men go out there to have a pee when they can't find the toilet, or staff smoking again [p] [but] it's cold in winter and it's hot in summer, it's not practical, it doesn't perform any practical function that in my time here that I can see

This view is perplexing. Peeing on the verandah is surely preferable to peeing on the carpet. On the verandah, nurses can socialise with each other, smoke and chat without being seen or heard. Feeling cold, feeling hot, is to be alive. Rather than being considered as serving a particular function, the verandah could be judged by the opportunities it offers. That it is not, can be understood by remembering how design has failed in important areas. The bathrooms, the curved wall - these features dominate and influence how minor features are regarded. The discomfort of the bathrooms, the "cutting off" by the curved wall, are objective facts that have the power to cast shadows. Rather than an opportunity, the verandah is an indeterminate space between the failures inside, and the failures outside. The verandah confronts a garden, which confronts it in return, with yet another failure:

> Kenny: there's not enough shade [p] how can you take elderly people out there in summer and not have any shade?

Design failure is not a one-off affair limited to the drawing board. It is either uncorrected, as in the matter of shelving and bathroom doors, or perpetuated. Into the already cramped nursing stations, where even two people can get in each other's way, bulky desktop computers have been introduced, with their trailing monitors, keyboards, mice, and - strangely primitive, in this age of the electronic office - their equally bulky printer/scanners:

> Barb: I think they're quite inappropriately placed on these types of desks you know we really don't have enough room for them but I don't know where else they could put them

Similarly, in a parody of progress, when the original dining tables were replaced, the new tables were too big to fit in the dining area, and could not accommodate the chairs:

> June: they bought big tables but they're too big for the area [p] and also the place that they put the legs in, if you try to put more chairs around the table they don't go under 'cause the legs here, it's just a silly design, they're too close to the edge of the table

The final example deals with the innovative locks on the bedroom doors. The doors can be locked from the outside by twisting a small disc with a channel cut in it. The purpose of the channel is to allow a 20c coin to turn the lock (it is too narrow to use the edge of a key, but this is a minor inconvenience). The design

> Barb: works reasonably well with the more demented type people, and I

> guess they're the people that you want to keep out of their room, but when you've got quite high-functioning people that maybe you're trying to keep them from isolating themselves in there in their rooms [p] that doesn't become so functional

The functioning of the locks depends on the 'type of people' in the ward, and it appears that the innovation was partially successful. However, in psychogeriatric units, design confronts 'wicked problems' (Sancar, 1999). Wicked problems are problems that are not well-behaved and readily specifiable. What some people do, combined with a lack of maintenance, means the locks can be easily turned by hand, defeating their purpose:

> Kenny: dementia patients will play around and fiddle, these locks are totally inadequate because they get slack [p] because of the amount of usage the locks are past their use-by date, they need to be replaced

These last two extracts contain themes that will be examined in more detail below. Firstly, intrusiveness in *Milduria* involves property, such as fiddling with locks, rather than with people as is the case in *Putria*. The concept of affordance, touched on briefly in *Putria*, is broadened here. Secondly, the wear and tear of locks is associated with the topic of neglect. Neglect is a major concern, equally as important as design failure. Thirdly, the distinction made in *Putria* between 'with it' and 'not with it' patients is also made in *Milduria*, and is expressed in connection with the ability to stream patients between wards. In the next section, I will describe and develop the topic of affordance.

The politics of affordance

Things are not what they seem. They reflect possibilities beyond what they stand for. Conventionally, the wall around the gardens was to provide privacy

> Kenny: it gives them a bit of privacy, the things that go on within the walls of a psychiatric hospital to do with the patients

But the long, brown wall along the street is also an invitation to transgress:

> Kenny: the people outside, they see it as a challenge to see what's behind that wall and climb the wall to find out what's inside

The same occurs on the other side of the wall:

> Kenny: a wall's a wall - psychiatric patients will jump walls [p] they see something and climb

The problem of the wall is one of complex division, in which the appearance is every bit as important as the material:

> Kenny: what do you place that's socially acceptable to the outside world, and they feel comfortable from the inside as well [p] you don't want a high security fence that makes it look like a security fence

Taking transgressions that come from the outside first, in the surrounding suburb many people are unemployed and there are few attractions:

> Kenny: there's a lot of people in this area that have got nothing to do [p] there's been people in the roof here, you know, cars get bashed broken into - we can't see

Behind the wall, staff cannot see their cars parked on the street. The 'safe' area officially provided for staff parking is far way, behind the general hospital building

across the road. *Milduria*'s car park is reserved for government vehicles. The next extract shows how bureaucratic power merely adds to transgression, and earns an income at the same time:

> Kenny: There is parking for government cars [p] we've got to park out in the road and [p] if you park in a parking zone you're not supposed to park in, you get a $50 fine

Going inside, in the heart of each ward, the nursing station's long counter, meant to keep patients out, also invites transgression. In the next three extracts, we see first an example of an individual patient taking things, then an identification of this as "stereotypical" of patients with dementia, and lastly a concern that any patient is capable of transgression:

> Barb: [patients] fiddle around with everything and you couldn't leave things on the desk

> Will: they'd lean over and pick up the files and shifting grabbing - stereotypical behaviour

> Kenny: I think with the elderly in general I think that they need to be under observation at all times. I think that the TVs need to be out of reach, I think electrical wires need to be into the walls

Just like the people outside, they do not necessarily have a purpose in mind, but want something to do. But what patients may want to do runs counter to conventions of material order:

> Kenny: sometimes the men they'll want something [to do] they'll rake [p] they'll just do it it's like there's a mess [p] but they don't do it as a job to make it nice and neat

> Kenny: with privatisation the cleaning services and things like that patients were expected to have a clean room to go into if you get people going in they mess them about and things like that because of the nature of patients, you know the room gets clean, it gets dirtied up with soiling, with urination, you don't need that, that gives an extra workload for cleaning staff and nursing staff

Having something to do can be more pressing than privacy, and so vital it will not tolerate interruption:

> April: you can walk in on him in the bathroom, he doesn't care - but if you walk in and he's stealing something, he's in the cupboards, he'll try and beat the crap out of you

Making a mess, stealing things from bathrooms or bedrooms was a minor problem. It created extra cleaning up work, or it was a problem to lock things up when the locks were so worn that dementia patients could easily unlock them. However, the nursing counter served critical functions. It housed important documents and vulnerable equipment within reach of patients. Nursing handovers were conducted here but care had to be taken when visitors or relatives - or even patients - were within earshot. Also, in the absence of a duress system, it was the only barrier against aggressive patients from which staff could phone for help. Despite years of requests for an unbreakable screen, nothing was done. It was not until

> Will: a doctor got intimidated and thought he was going to get his lights punched out then this just sped up, it'd been in the pipeline for a long time

that unbreakable Perspex screens were fitted to the nursing stations.

These examples demonstrate the variety of use that all people, outside, inside, demented or not, make of things. Things are used opportunistically from the actors'

point of view but appear unreasonable, illegal or unconventional from other points of view. As a phenomenon, these multiplicities of use and response are a fertile ground for researchers who may become weary of the functionalist 'person-fit' theory straightjacket. In practice, nurses in *Milduria* are able to exert a therapeutic autonomy that would be unthinkable in *Putria*, where the rules are unbreakable:

> Will: that depends on the staff, you know my philosophy has mellowed over the years. You know I thought that the rules I was trained with were the rules, 30 years later I don't have much time for them, the rules. They're old people, you know, if they want to go and lie down and lie on their beds it depends on whether we're offering them a practical programme as an alternative, if we aren't, why shouldn't they? [p] I certainly therapeutically intervene after an hour or so because I don't want them to end up with an inverted sleep pattern, and then they sleep all day and they're awake at night, you take that into account

The study of affordance as a phenomenon is beyond the scope of this study. What is important in this study is the absurdities of official responses, from the perspective of nursing staff. The sense of an everyday official disdain conveyed by these extracts leads to the topic of neglect.

Neglect

In *Putria*, we encountered the daily tragedy of a few 'with it' patients who could not leave the dayroom and go down to their own rooms because nurses were unavailable to supervise them. In *Milduria*, tragedy is redefined and becomes more plebeian. One nurse uses the description of a rich garden as a contrast to the poverty of *Milduria*'s gardens, and to point out how little it takes to transform a garden:

> Geoff: the pathway was set up so it would leave at the backdoor and end up at the backdoor so they couldn't get lost they just walked in this maze in this garden and there would be bus-stops and little paths and something else along the way and they'd have the fixed delusion about having to catch the bus every day off they'd go down the pathway and they'd sit for hours waiting for this bus that'd never come, I mean that satisfied their need

That *Milduria* "used to have" things was sometimes said to show how patients could be continually engaged with things in their own way:

> Will: there used to be [p] a shed there and tyres and an old motor and stuff like that you know, these are anecdotal, they used to go out there and strip it down and put it back together again

At other times it was used to refer to the anonymous "they", who only engaged with things briefly, and then never again.

> Kenny: the pergola out there, it's got no seats, the seats were rotten they took the planks down for safety but they've done nothing to replace it

Having things is not only a struggle against nature and bureaucracy, but against patients as well:

> Kenny: the patients go in and they sort of pull out bushes once they're well

> established [p] if they put in smaller bushes they're up to them and they have to plant more and bigger bushes

There are no signs of replanting among the few spindly bushes that survive. The desolate garden produces a sense of missed opportunity and of sorrow:

> Will: it's a waste, absolute waste. I look at that land out there, and a number of things it could be used for, could set up all sorts of sensory awareness experiences, well what you could achieve with a bit of imagination, it could be really good

Even things that patients did not touch were worn out. In the bathroom,

> Will: I believe at one stage they had heaters, wall mounted heaters, they don't exist anymore [p] the original system broke down after 10 years and it only came up in the budget at the end of last year

These stories pile up on each other to paint a picture of modern material decay. But this decay is only the outward sign of rottenness at the very core of *Milduria*. Nurses call it the 'contracture'.

Contracture

In one wing, the decayed state of outdoor fittings means that patients can only wander freely in the garden if nurses are out there with them. This means in practice that for staff in that particular wing:

> April: they've got the worst patients in there, their major problem is not being able to let people out in the garden [p] the more aggressive and physically orientated they are, they want to be out in the garden

The "worst patients" are those who are unattractive and difficult, who can only be housed in *Milduria*

Kenny: I've had to leave the door open because he's denying the fact that he urinates in his room and that's why I keep the door open he doesn't like it, but I've got no choice it's an inhibitor [p] he's in his 80's, he's not manageable any place else, nobody wants to know about [him], excuses are made for not wanting to take him, there's easier patients to handle, so we just keep him here

Nobody wanted to know these patients from the very beginning. *Milduria* was opened as a triumph of architectural innovation and governmental concern:

Geoff: well it's interesting - when they opened up this new dementia unit because they had all the bigwigs from the Shire and the Health Minister came, so what she [Nursing Unit Manager] did was hire a bus and got all the patients out

Louise: don't let them see the patients!

However, nobody really wanted contact with anybody else from the very beginning of *Milduria*'s design. Just who influenced the design, what the designer took into consideration - even who the designers were - remains a mystery:

Geoff: I know when they was closing [original psychogeriatrics hospital] one of the big wigs [p] was sent to the UK to have a look at some of the setups over there, and all of the ideas he came back with, they came up with these which is how they wanted to build it anyway so it was a wasted trip because these ideas were never adapted

Clearly, those designing the building must have had complete confidence in knowing just how nurses would use it:

Geoff: we wasn't, we wasn't even shown [*Milduria*] these units at all until it was actually built and we was then taken

This confidence was not matched by those commissioning the building:

What the nurses said

> Geoff: we went out as a group to view the actual site and the first words that came out of the guy's mouth was, "I didn't design this" - they was already backing away from it [p] it was too late for any of those structural changes, it was already designed built completed forgotten

This lack of confidence was justified, but the opportunity to correct errors in the building stage was lost.

> Geoff: it was too late, it was already built, they had a form for emergency input

Even so, at first *Milduria* was perceived to work well. Many people expressed the view that the nature of patients had changed:

> Peter: when the ward was originally built, it worked fine for the clientele at the time. Since then, the admission criteria seems to have changed, and now people who are a) medically frailer, and require the use of lifting devices or b) people who are younger, stronger and more aggressive are being admitted.

Originally, *Milduria* consisted of two identical wings, with three wards of eight beds each. The common understanding of staff who worked there was that the wing arrangements allowed patients to be streamed in a similar way on each wing, into high, mixed and low-functioning wards. They also were aware that *Milduria* was intended to contrast with the old institutional setting, by facilitating 'normalization'. This was integral to the design of *Milduria,* with features meant to provide privacy and freedom of movement both within and outside the ward. Its history since it was built includes the emergence of design failure and a pervasive lack of maintenance. However it extends further, to a constriction of its streaming ability and an erosion of its philosophy of 'normalization'. These are trends that were evident from its very

opening, as indicated by the extracts above. Given their complexity and importance, I will explore the topic of streaming and normalization in two separate sub-sections immediately below.

Streaming

As in *Putria*, the nature of patients has significant implications for the environment. One nurse explains that the high-functioning ward is fitted with

> Barb: carpet on the floor because you're dealing with high-functioning patients whereas in the other wards the carpet wouldn't be appropriate with inappropriate urinating, spillages, so this is definitely a warmer ward [p] you can have flowers on benches and little pots on tables whereas in the other ward you can't have that because patients misunderstand it

A few years ago, one wing of *Milduria* was closed to save money, and after a year was taken over by geriatric medicine. *Milduria* is now reduced to one wing with an extra bed squeezed into each ward. This has seriously impaired its ability to stream patients into particular wards on the basis of their behaviour. Numerous accounts reveal just how critical this division is. The next two extracts show this problem in particular and general terms. One nurse explains the problem posed by having a low functioning patient in the high-functioning ward. In another interview, another nurse explains it as a general principle:

> Will: with the contraction, ah one side's closed down, one wing [ward] was having continual trouble with a patient, he steals everything, he'd go through the drawers, you'd go into his room his mattress is sort of piled up with stuff, old underwear and so that was the problem in that particular wing

What the nurses said

April: It's mainly in the high-functioning wing that privacy's an issue it depends on the level of dementia, most of them here, they don't even notice

Nurses in the impromptu group interview drew out the implications of the contracture

Sally: you have your high-functioning and then you have your two wards that are behavioural, it works out and they're trying to maintain that

Louise: but will it work out now that it's been shrunk?

Sally: it doesn't because this is the problem now, you don't have enough high-functioning, or somebody who's high-functioning who has to be in a low functioning ward because there is no bed available [p] a few weeks ago we had this grossly confused woman in the high-functioning who kept going into all their bedrooms

The ironic stage management of *Milduria*'s opening, the lapsed normalization programme, the constricted ability to stream patients, the design failure, the chronic and widespread neglect, lead staff to the conclusion that:

Will: that's the funding pile, you know Mental Health's at the bottom of the funding pile and we're at the bottom of the Mental Health funding pile, that's the way it is

It is a burial in relation to the heath system as a whole, and it is deeply felt:

Kenny: if you look at who rules the roost for money these days it's...people in the general thing [general medicine] that are in a position, distributing the money to psychiatry, and psychiatry gets it, so much, and psychogeriatrics are the worst at the end of the row so they get the least

The refurbishment of *Milduria*'s wing for the geriatric service is evidence for the claim that psychogeriatrics "get the least".

> Barb: it wasn't fair [p] they got things like hand basins put in every room, they got the bathrooms redone and they considered the floors that were in there too slippery for the patients and they redid all the floors but we still have the same no hand basins, they got brand new furniture they just gutted the whole place took the furniture and just disposed of it everything that was in there, repainted all new furniture

In their relations with other nurses on the site, they feel both misunderstood and disliked:

> Kenny: I said to the [general] nurse, "injection, please don't muck about"… gave him an injection… and said to him, "Now please, can you get into bed and just lie there", and he was as nice as nice

> Kenny: they [other nurses] have to be forced to come to us [p] because you're cleaning shit and they don't want to do that, and everybody thinks that they're above that, it's OK with babies but not with adults

Even within the ward, they have to phrase their requests in the language of other nursing branches. For instance, the acuity of the ward is dependent on the behaviour of patients. Sometimes they need an extra nurse,

> Kenny: because it's heavy - you know, showering and dressing, breakfast, feeding - you could do with an extra staff member in the morning, but that fluctuates

However, the argument that is formally presented to management for extra staff is different. Rather than describing the difficulties in coping with the existing patient load, it relies on waiting until after accidents have happened, when

> Will: we just present the number of incidents accidents falls that were

> directly attributable to not having enough staff … we have a case for the extra staff member

Against this background, the events associated with the contracture compound the sense of being isolated and neglected. It extends from the functioning of *Milduria*

> Sally: nobody ever questioned the fact that we lost three wards, only the nursing staff, nobody cared

to the value of their professional experience. With the contracture, the resultant surplus of staff meant that:

> Sally: staff who had worked in psychogeriatrics for 20 years was suddenly been put in acute without any training or any in-service

Many staff felt their particular abilities were ignored and so, after a lifetime of work, they expelled themselves:

> Sally: people decided to - I mean you had the likes of [names two staff] they all left, they retired they said they had enough

These extracts show that ‘streaming’ allowed patients to be grouped so that they would not interfere with each other, and allowed the environment to be tailored to suit the different types of patients. The effect of the contracture was to impair streaming ability, and was demoralizing. In turn, this had a profound effect on the philosophy of Mildura, ‘normalization’.

Normalization

Having single rooms with locks that could be operated by higher-functioning patients was intended to allow for a ‘normal’ as opposed to a rigidly structured institutional lifestyle, by making it easier for them to choose what area they would be in. Sally explained this as the “choice system”, and Louise added that choice is a “part of normalization”:

Sally: you get now see the choice system, people rest now [p] they sort of know their own needs and [p] they get to choose if they want an evening shower

Louise: that’s a part of normalization, it’s not as structured

Choice is an aspect of normalization that is implicitly contrasted to the rigidity of highly structured institutional routine. Once upon a time, everyone was showered every day in the morning, whether they wanted to be or not. Those days are over, not only for patients but also for staff who had to drive the routine.

Louise: it’s because they weren’t allowed to, the days of hosing down people in the courtyard semi-naked are gone

Sally: I mean if people don’t want to have a shower, no they can’t be forced to, you have to wait and bide your time

NL: did that change with the building though

Louise: it changed before

Geoff: it was a policy brought into play

Sally: people were allowed to be more responsible as well attitudes changed

Another nurse dismisses the idea as pretentious:

> Doreen: Normalization - is just a word - our job is to keep their bums clean and their bellies full

This view, that pragmatic realism comes first, before any impression management, is widely shared. In the following extract, I had just said that visitors are not allowed into *Putria*'s ward, whereas they often are in *Milduria*'s. The rationale for this in *Putria* is that it could offend visitors. Sally and Louise replied that anything becomes normal in its own particular way, once you are used to it:

> Sally: we used to have plenty of strippers, I mean you told people you've got some person here, sometimes he takes off his clothes and we're just letting you know in case he does it and then they resolved part of those problems by getting the theatre gowns
>
> Louise: the backward trousers!
>
> Sally: you could put a casual jumper over it and it would take a while to undress there was one man in particular and he had a thing about stripping, he just didn't want to wear clothes at all and eventually he was permanently dressed in theatre garments but if you tell people, what do you expect? I mean it's like people going to nursing homes you get used to it [p] people get used to what they see, if you go into a general hospital nowadays you can see anything, I mean my poor mum nearly died that time she had her op and woke up beside this man in intensive care

Pragmatic reality can be managed in a way that is not only understood by those who are "outside", but can also be imaginatively contributed to:

What the nurses said

Sally: to normalize anything you have to have outside involvement

Louise: because you get ideas from outside involvement

Sally explains how relatives take part in normalizing unusual care arrangements:

Sally: this person had MS and she had one of these cot beds and it was more like a Japanese bed it was on the ground so she was always afraid of falling [p] [and] the beds were quite high

She goes on to show how the normal can also extend beyond pragmatic reality:

Sally: they used to come in at all odd hours, no matter what time they came in and fed her and took her around for a spin up to the beach, you know there was no - it was quite normal for her to go for an afternoon stroll every day at 4 o'clock, the daughter used to take her out

These accounts suggest a trajectory of decline from a high point in the past. Will recalls that a decade ago,

Will: it was considered state-of-the-art, they had all the facilities [p] we used to have a bar there [p] I remember we used to take the olds down after tea for a drink and a dance

The trajectory has passed the apex and missed the target; not the aim, but its execution could have been better. And it turns out the decline, the material decay, is only a sign of a deeper decay:

Kenny: it's a good unit to work in, it could be better

Will: there's a philosophy underneath it, this place has fallen apart, it involved normalization [p] going to the bar after dinner, it was

following a pattern, patterns of behaviour at home, having a drink, and they'd have someone playing the piano

Will relates that the conduct of normal kinds of activities was motivated by individual staff:

Will: there used to be [p] a shed there and tyres and an old motor and stuff like that you know, these are anecdotal, they used to go out there and strip it down and put it back together again - that's motivated by staff, their own interests, but it's contracted to fairly basic from what I can see

With the erosion of support for activities, the motivation of staff has evaporated

Will: it's custodial, the nursing is custodian, meet basic needs [p] just do physical work and depending on your point of view as to just how involved you get with the patients

Nita recounted a story that illustrates how the motives of nurses are frustrated and defeated by bureaucracy. Nurses raised money and bought pavers for a derelict courtyard. They were volunteering to complete the job, and had organized:

Nita: the delivery of sand, compacting, hire of a brick cutter etc… the problems started when our inhumane resources fire and safety bloke refused to allow staff to take part in the project due to insurance liabilities.

As a result, the pavers sat in the courtyard for 18 months.

Staff doubt whether the idea of providing the appearance of bourgeois normality was ever realistic:

April: very few of them think they're at home. It doesn't work that they think they're at home because when you think of it, at home for most people their age, it's cluttered with all the memories - like they've

> still got, a lot of them have got their long term memory so in their home they've got the things that they remember, whereas here there isn't anything [p] no I don't think it's like home, I don't think that's a realistic goal to aim for either

Some doubt whether it ever worked. Below, Louise argues that the bedrooms were stark and clinical, and Sally counters that this was offset by relatives coming in

> Louise: you go into a room and it's still, stark and clinical so I don't know if there was any normalization there because there was no personal aspect to it
>
> Sally: there was to a certain extent because you had the curtains and the relatives brought in photographs and they hung them up on the wall

They returned to the dialectic between the pragmatic functions the ward needs to serve, and aspects that extend beyond the pragmatic:

> Louise: thing is that there's a fine line between functional and safety and - they're trying to make it like, with what they're trying to do here you know. Do you, is it a hospital first or is it a home, or is it, do you know what I mean? they're trying to incorporate everything and sometimes it doesn't work

In an echo of what was said in *Putria* regarding 'not with it' patients, Geoff gives an example that shows why providing things that look normal is not realistic:

> Geoff: at Jacaranda they set up this geriatric unit, a dementia unit for the folks that was more wanders and behavioural disturbances but they tried, the woman who set it up she tried to make it like a home and they had all this beautiful furniture and cloth seats and it cost them a fortune those patients were incontinent, they'd be wetting all these cloth chairs and you can't clean them, I mean where do you draw the line at say practical functioning and something that's - I mean these patients, they wouldn't recognize it as a home as such

He goes on to explain that the social nature of a ward, rather than its material qualities, is the essential therapeutic element. He gives another example to demonstrate this. Here he recalls how the behaviour of one patient was radically different in two different social environments, a “high-functioning” one and its opposite, a “back ward”:

> Geoff: we had [names ward] which was the high-functioning and [names other ward] was the back ward, there was this patient there she was as manic as the day is born [p] if she was left at [back ward] that was like ‘my ticket to be mad’ and she would be as mad as a hatter but if you took her out of [back ward] and put her into [high-functioning ward] where there was expectations, there was peer pressure, she would buckle under the pressure and she would be well behaved

Sally responds to his vignette. She understands that it is not simply a case of being high-functioning or low-functioning, but rather that the “ticket to be mad” is

> Sally: like having a licence, isn’t it?
>
> Geoff: yeah, it’s like having a licence to be mad

Just as having a licence to drive requires people to obey road rules, so did the notion of “licence” in the above extract almost immediately lead to a consideration of the abstract quality of having a licence. Rather than pursing madness, the topic pursued was the responsibilities of having a licence to nurse. The meaning of licence as freedom to act, to be mad, was dropped. The obligation to adapt to the rules of the situation became the focus. This meant the effort of how nurses collectively used things, rather than the qualities of things in themselves.

> Sally: Life is not fair - get over it… I think that a building is only as good as

> the people that work in it in all areas, in any area you got to have a good team effort there [p] [and] things they, they just fall into patterns

This sense of a wholeness or Gestalt that relied on contributions from all of those involved was critical if a building was to realise the opportunities it presented. Louise takes up Sally's account (above) and continues:

> Louise: you look at any new building, you look at this new building [p] what an opportunity to start something really good, what do they do, they give you old baggage from the old place

Her argument is that the building is merely an appearance, but the opportunity is lost if the organizational bedrock, the "old baggage", does not evolve. In her rejoinder, Sally sheets home the responsibility for the failing trajectory of *Milduria*:

> Sally: they've done the full circle haven't they? [p] they just change the bed linen they don't change the mattress

The metaphor of bed linen and mattress is powerful, suggesting multiple layers swaddling an obscure, vulnerable core. Just who are "they" and what the "mattress" could be, shifts the focus from *Milduria* itself to the surrounding social and organizational context. The theme of just what 'normalization' is supposed to mean is explored further afield. So far, *Milduria* has elicited comparisons with places that are quite different, such as general hospitals, nursing homes, and ordinary houses. The linen, the investment of determination as well as capital in institutions comes at the cost of providing resources within the community. The choices made over such investments in society are the result of political influence and monetary power. This broadening of focus begins when Louise sums up the dialectic between types of patients, the implications for nursing staff within a particular environment, the

involvement of relatives, officials, and saying that in the end, ‘normalization’ depends on point of view:

> Louise: that’s what I mean with normalization, you’d have to look at it as completely different for someone who’s living there to somebody who’s just going in and out

She illustrates this by recollecting:

> Louise: I have been asked, “are you a real nurse, why don’t you have a uniform? this isn’t a real hospital, it’s more like a hotel, I want my relative to come into a hospital not a hotel” [p] isn’t that normalization “I want the hospital to look like a hospital”?

This return to the point of view of those ‘outside’ is developed to take into account the subject of money and normalization:

> Louise: as soon as you start factoring in money so they have to pay for their stay and everything, then the standards and the stakes get higher because the relatives will expect an incredible lot more than what they’re getting, so that in itself might bring about, you can’t go 15 years without maintaining the building you know, in your own house you have to maintain it every couple of years so maybe the standards will get higher

The subject of money immediately becomes political, as Sally elaborates:

> Sally: the money, the money was there but the money was going elsewhere, I mean this is administration, this is human resources who supposedly give you money but it doesn’t ever get there it’s just been deviated to other areas

Geoff chimes in, pointing out that unless money is involved relatives tend not to take an active interest. He gives an example

> Geoff: when they closed [old psychogeriatric ward] [p] the old geriatrics was placed into nursing homes and such, some of those patients had been there for 3 or 4 years that I knew of and some even longer, they'd never ever seen any of the relatives, never been near them, but the moment they were being moved out and they had to go to a nursing home and they had to pay, whooo! Those relatives were coming in droves and they were bucking the system, they didn't want their relatives moved

The management of money within the hospital should be similar to the management of money at home:

> Sally: we all have to do our own budget so that is normalization isn't it

Louise agrees, arguing that privatisation may normalize money relations between relatives and hospitals:

> Louise: but isn't this the way that they're trying to go with privatisation [p] they start having to pay for their stay and then it becomes a business operation

She follows this thread to the conclusion that the business relationship then imposes priorities of its own, becoming money-orientated for another reason:

> Louise: it also becomes a lot more money-orientated because they want to make a profit

Milduria's low status and corresponding lack of political influence has been described above. Together with the discussion on profit, the themes point towards an ideal of how society should invest in health

What the nurses said

Sally: when it boils down to everything people should really be nursed at home shouldn't they, in a normal environment if it's possible

What she means is that society is investing in institutions, rather than directing resources into the community itself:

Sally: but a lot of people when you're talking about buildings and structures and things like that - I mean there is a lot of people who would be able to keep a relative at home if they had the facilities available to them

Waste

With the contracture, the entrance to *Milduria* is now:

Sally: a night entry, you're going into an area where the bins are collected, and one of the relatives said to me one day "isn't this disgusting"

Louise: lovely, welcome to your new home

Louise and Sally generalize their comments regarding their sense of waste beyond *Milduria* to the newly built child and adolescent psychiatry unit. From the road, this looks like yet another new official building. But inside the same processes that *Milduria* witnessed are at work. In yet another state-of-the-art unit, money was poured away into a building that staff, from the moment they saw it, declared to be a failure:

Louise: you go over there and there's a lot of money

Sally: a lot of money

Louise: that was poured into children… did you see the keys, they've gone back to the old asylum keys

What the nurses said

Louise: no they have like a little courtyard

Sally: and you couldn't swing a cat in it, it's just enough to walk in and have a smoke

Sally: I mean the design, from the beginning everybody said it's absolutely shocking, where you have kids you need space you need to get rid of the energies they have

Louise: but anyone, anyone needs their space. Everyone [p] when you're at home, in the family situation you like time out by yourself, you like to get away from the kids and that sort of thing they want too

The reality may be that some children have a lot in common with some elderly adults. Nobody wants them and, it seems, nobody cares. The extract below echoes what was said in *Putria*, as well as in *Milduria*:

Sally: you have kids in a locked area for 10 weeks

Louise: they're there for months and months and months

Maybe the experience of nurses in acute psychogeriatric assessment units is more generalizable than we care to think.

Milduria was quite different to *Putria* in some dimensions. In the former, patients had their own rooms, and even patients with psychiatric diagnoses as well as dementia could be accommodated. However, as an ideal, *Milduria* did not step away from the institutional, custodial constraints of *Putria* into a materialization of progress. Its purpose-built nature, its philosophy of normalization, had not survived the test of use. *Milduria* presented a lost opportunity. The failure of design and the lack of

maintenance were important, yet not the fundamental cause of this loss. The fundamental cause was a lack of care and attention by the anonymous entities responsible for its every aspect. From the moment it was planned to its present operation, it was simply not possible for nurses to have any effective relationship with those who had the power and authority to modify the design, maintain it, or support the programmes required to turn its philosophy into reality. *Milduria* is a manifestation of a social, political and economic complex that gives the illusion of autonomy to patients and of professional autonomy to nurses. What it in fact does, is institute a smoother, less demanding custodianship than *Putria*.

Perhaps, after a decade and a half of operation, *Milduria* was too old. Maybe there were more recent places that had learnt from the failures of former ‘state-of-the-art’ facilities. Surely there was some brand new, you-beaut, purpose-built unit to be found? Surely there had to be a place that would form both an ideal, as well as real contrast to *Putria*? In search of the ideal, I went to *Tempuria*.

Looking for contemporary Tempuria

Going in

Several colleagues mentioned a purpose-built psychogeriatric unit, opened only two years ago at a major hospital in a State capital. Some of Australia's pre-eminent psycho-geriatricians were associated with this unit. I reasoned that this combination of internationally recognized authorities and newness should be a place where the ideal and the practical could be found. With this hope, I arranged to visit *Eternia* only to find, when I rang to arrange the visit, that it was no longer there. *Eternia* was being refurbished and had been temporarily relocated to *Tempuria* on the same campus. I decided to visit anyway, as it was staff's experiences that I was interested in. Under the circumstances, their recollections would have to do.

The bus crawled for half an hour through clogged inner-city arteries to the edge of the campus. The whole block of polyglot, large, multi-storeyed hospital buildings was rimmed by heavy traffic. Jets thundered incessantly overhead. Cranes and construction work added to the chaotic din. In the absence of any maps, it took me another 15 minutes of walking to find the main hospital entrance, concealed by a multilevel car park. The receptionist tried to explain where *Tempuria* was. She eventually took me to the front door, pointing in a direction and saying "You'll find a road over the hill there, it's about halfway down. It's a new building".

I found a narrow footpath next to a road cut deep below it, running steeply down a hill. Eventually a roof and wall emerged out of the slope, and ran alongside. I reached

a glass door and, looking in, could see a receptionist and people waiting. They ignored me. I then noticed a small sign stuck to the glass with the direction: “ENTRY AROUND CORNER”. I turned the corner:

A moment of sheer, unexpected vertigo. The ground drops out of sight, down some two storeys below. Across a wide, bare, windswept concourse, a view of the sky through enormous, stark, dark grey concrete squares towering above, like gigantic window frames devoid of glass. In the distance, the ocean, just on the horizon.

I found an alcove sheltering a glass doorway with two buttons beside it. I pressed both. There was no sound to indicate if they were working. Someone returning let me in, and I turned back through glass baffles and doors to where I first saw the receptionist. I saw others using the first door anyway.

When I stepped into *Tempuria*, it was entering a new kind of world. It was not a psychogeriatric world; there was no smell. The doors opened into a short corridor. The intense blue of the lino floor swam halfway up the wall to a handrail, the wall above it a pale, grubby pink, meeting a yellowed ceiling.

These are, of course, the sort of impressionistic statements that reflect first visits. The sorts of impressions that, once you are used to a place, you no longer notice. Go back over them: the crowding of the streets, the noise of the campus, the steepness of the hill, the moment of vertigo, the sheerness of the concourse, the baffling nature of glass and views into the interior - and now, in this hallway, despite the evident newness of the building, the remarkable achievement of a grubby shade of pink, the

precise hue of a heavily nicotine-stained ceiling, and the incredibly vivid blueness giving the impression of wading waist deep through blue water. What science or art can capture this? Truly, as the poet wrote:

> Who can truly recapture that first, fine, careless rapture?

People pay money to experience things like this, in carefully constructed virtual-reality games. Here, it is carelessly thrust upon you, for free.

The corridor, with two bedrooms on each side, ends in a cluttered lounge and dining room. In this tiny space, a table with four chairs. Squeezed behind it, two large sofas close up against the TV. Against the walls, a fridge, a sideboard. A miniscule office, crowded with chairs, desks, medical equipment. Pictures and notices randomly plastered over the walls. Things still in boxes, waiting to be unpacked. The sun streaming through coarsely-woven curtains from the courtyard. The courtyard was also strange, and I will describe this in detail below.

No one mentioned the strangeness of this baffling, jarring jumble of effects. Curious, I broke the thread of an interview to ask about the concourse. While the nurse was gathering her thoughts, the social worker [SW] who had just walked in, interrupted to confidently explain its functional purpose:

NL: do you see those great big square things on that verandah out there - you know that curious - it looks like 4 or 5 huge windows without glass except they're 20 foot tall?

Iris: oh the sculpture thing

NL: yeah do you see that from those bedroom windows?

What the nurses said

SW: that grey thing that dark grey

Iris: I can't think of what thing

SW: yeah it's just like the wall but it's got windows outdoor windows cut into it

Iris: oh yeah, yeah

SW: that's an attempt [p] to break the harshness of that side of the building

The exterior harshness was acknowledged by the nurse but peripheral to her story. Similarly, she brushed aside the strangeness of the courtyard, remarking rather on its usefulness:

Iris: this outdoor space I think is great to have

NL: what about that surface for walking on?

Iris: I think it's horrible

NL: but you haven't had any trips out there?

Iris: no, no it's safe, just not very pleasant

This courtyard was a masterpiece of (to use the social worker's terminology) broken harshness. Its three sheer walls of bronze-coloured metal and red brick were joined at sky level by a massive triangular white sail, shading most of it. From a helicopter, it would have looked like the refugee shelter on the *Tampa*, a tarpaulin stretched between containers on a green deck. At ground level, the entire courtyard was covered

with a spongy, synthetic, bright green and slightly fibrous material. It felt like walking in shoes with wet socks. Or, one could imagine the same soft, slow bounce as something astronauts would experience walking on the moon. There is a pervasive strangeness at work in every sense: from the visual impressions of massive verticality – the sense of suspension high up above the earth on the verandah, the towering height of the sky funnelled up beyond the sheerness of the courtyard walls, down to the clumsy, inept work of turning the ground of the courtyard into a square, squelchy, sock. Cursorily dismissed as people go about their ordinary business, it is nevertheless like a spell of strangeness enshrouding the whole unit.

Even that most ordinary of objects, the TV, is not immune to its magic. There are no shows on this television. It is a snow dome, a fish tank, a porthole with heads inside, their lips mouthing inaudible bubbles. It displays an intensity of red that, compared to other colours, thrusts the lips forward beyond the screen so they appear to float freely away from the faces they belong to. The effect is like gazing into outer space through a porthole, at ships that have arrived from a future age. The contours of lips become pods, drifting about the indefinite faces of their mother-ships. The TV not only gazes out into an alien world, but also gazes out onto this one.

A foreign place

This strangeness is not analysed to the same degree as the design failures of *Milduria* were, but it is dwelt on. Perhaps the baffling glass partitions, like an airlock, are the substrate for the metaphor Iris uses of being in a space-ship:

Iris: this is your space-age dinner on a tray

What the nurses said

Iris: this is your foreign bubble that you go into when you're sick

For Helen, the confines of the courtyard evoke the prison yard:

Helen: when I first came down here, it sort of reminded me of like, you know, isolation in a prison, not that I've ever been in one but you know, the four walls

Both metaphors imply a rigid institutional order that is uncaring.

Iris: I don't think it feels very caring this type of environment, because it feels very institutional

What is institutional, is uncaring, would drive anyone mad:

Helen: they could've done this place a bit more consumer-friendly [p] 'cause you know, office buildings and stuff well they make them so so nice and then, this is just very plain and like, prison-like … I think it'd make the patients worse, like I came in to a place like this, I think it'd make me go mad

Both of these nurses refer to the ideal as being the reverse of *Tempuria*. Helen recalls another ward that was in a

Helen: big old mansion and it was just lovely, it had a bay window and like it had several people to one room [p] you had this big communal dining table, it was just lovely it was really home-like and I think it'd be better than something like this [p] this is very prison-like and I think those old buildings have got something like those heritage buildings, have got something to say for them

Iris recalls a rehabilitation clinic housed in

Iris: a big old terrace house, two houses side by side and they've just got normal couches and when they get too grubby they throw them out and get another normal couch

Ordinary things

The ‘normal’ couch is a symbol of objects and colours that contrast with the décor and furnishings of *Tempuria*

> Iris: ordinary people don't buy anything where the fabric’s going to last for hundreds of years, nothing is this colour and that peach colour [points to surrounds] [p] nobody has this in their house

In *Milduria*, talk of the ‘ordinary’ was bound to a critique of normalization and its failure. Here, instead of dubious philosophies, talk of the ‘ordinary’ leads to further appreciation of it. Decorative objects are not only ordinary, but convey something extra

> Iris: things like a glass fruit bowl [p] things that make it feel more like an ordinary house, it’s got personality

Ordinary things have personality not only because they are ordinary as opposed to institutional in nature, but also because nurses have chosen to bring them into the ward:

> Iris: we got together and said "what do we want to make it" and they got money together and they did things

Things are chosen not only because they are ordinary, but because they have

> Iris: personality that’s not "you're in an institution so we're going to paint everything dark aqua and light aqua"

Although they are only in *Tempuria* temporarily, in the two weeks since they’ve moved in, they have taken action to make it feel more caring. This is at first justified by a utilitarian rationale:

What the nurses said

> Helen: there was no curtains but the sun shines in and so we thought, you know, it's going to get pretty hot in the summer

The utilitarian is complemented with an aesthetic rationale. By choosing fabrics that will not last hundreds of years, the result is a homely feel

> Helen: it's quite homely now, like we've put curtains up, like we've made it… yeah I know they're pretty old

Even the courtyard has received a 'touch' of homeliness

> Helen: it's a lot nicer now with a few plants

The idea that it is the people who are dwelling there who are 'making it' also has a dimension that is relevant to patients. In the next two extracts, Iris describes her effort to continue normal activities that happen in the world outside. She then goes on to reveal her therapeutic objective. Her use of the word "even" echoes a world of effort, of the possibilities that were denied in *Milduria*

> Iris: these people are not keen eaters with their depression… I said "right! we'll make a night of it, it's Friday night. We'll get popcorn. Any orders? I'm going up the road", and then people went, "oh, oh I'm not that hungry". "Do you want me to get a cake?" "No" [p]

> Iris: even just [to] have a gardening workshop and grow some plants or something that people say "I did that"

Following this line of thought, she comes to a generalization that sidelines the technical expertise of decoration consultants:

> Iris: each person feels that sort of right to be actively involved in creating the environment as well

What makes this dialogue possible in this extraordinary place, though, is the ordinary nature of the patients in *Tempuria*:

> Iris: the people here don't wreck things, they clean up after themselves and they are neater than housemates

Unlike the disruptive patients in *Putria* or those in the low-functioning ward in *Milduria*,

> Helen: they don't really bother each other, I suppose if we had disruptive patients it would be different, we haven't had any yet

Claustrophobia

There are only four patients in *Tempuria*. They are well-behaved, not bothered by the confines of the ward:

> Helen: being elderly, I don't think they need to move around much, like they're sort of happy being, you know

This view draws on what patients themselves say about *Tempuria*:

> Mary: they said it's very small but it's cosy

They are the reverse of the "classical dementia" patients, such as those in *Putria*:

> Tom: there isn't anybody here who is a classical dementia… if they're going to be behaviourally challenging we're not equipped for that, geared for that, not in this temporary accommodation

For nurses, however, it is a different story. They take turns to go out

> Tom: I have to get out, you can't stay on the ward the whole time

This was because they

> Tom: sometimes feel like “here we go again”, sort of stuck between four walls and this is four walls not looking at anything, that’s sort of [p] isolated

But for both nurses and their patients, there is nowhere for them to go together:

> Tom: there’s nothing, you can actually take the patient by the hand and say “let’s go for a bit of a walk”, you couldn’t go really

The only opportunity for outings is once a month when the hospital has ‘reduced activity’ days. Then, the static confines of the ward are exchanged for the static interior of a bus. An outing becomes a complex affair of inter-departmental negotiation:

> Tom: we have to contact Transport… they come with a little bus - that takes a lot of time

Even brief, spontaneous outings are subject to distant bureaucratic dictates:

> Tom: we’re on a slope… we’re told, you cannot put a patient in a wheelchair and wheel them... you know, the risk that you’re taking in case there’s an accident

Nurses in *Putria* and *Milduria* did not talk about outings. Both wards have level surrounds. Nurses or relatives commonly went out walking with patients. In *Milduria*, patients are easily transported to X-ray or other diagnostic departments by wheel chair. In *Putria*, they have a 20-minute drive to the regional hospital. It seems absurd that in the grounds of a tertiary hospital, not only do patients have to be driven to appointments within the campus but there is not even rudimentary protection against the weather as they transfer into the car:

What the nurses said

Tom: when it’s wet, raining and cold… you’re not under cover as you put them into an ambulance

Enforced intimacy

Everything happens at the same time in the same space,

Iris: like cleaning and music therapy

Even on rising:

Iris: there's only one bathroom and one en-suite and we've had to say "stop cleaning your teeth and please move out because this person urgently needs to go to the toilet" which is quite... in your face

Talking privately with a patient requires tactical resourcefulness:

Tom: if I wanted to talk to a patient privately, I’d have to take the person around to their room or bring them out here in the courtyard [p] now if it was like the other morning, very cold, we’d have to wear a coat or I could take them round to the nurses station and have a chat with them but then again, you’ve got the phones ringing and people coming in and out

Substituting time for space is one solution:

Iris: when other people [patients] have gone to bed and the [remaining] patient's sitting at the table doing their jigsaw and then [we] start talking about light things and then leading into much deeper things [p] that's reflecting on the space, you can't really tell everybody everything about yourself do you just because you're in a unit

For staff, there are no ‘backstage’ areas where they can talk amongst themselves

Tom: there’s nowhere private to go like, we haven’t got a staff room

The need to speak with patients without being overheard yet also not being excessively intimate emerges from the extract below. I asked about the use of the "Interview Room" and was told:

> Tom: forget about what's written on the door, it's four beds, that's how we were given [p] it used to be an interview room before we took over but it's a bedroom and there's no room here where you can take someone and talk to them in private - subsequently that's why we're sitting out here in the courtyard

Iris spoke of needing a space that is neither totally private nor totally public, saying:

> Iris: it's not always appropriate to take them into their rooms with the door closed [p] [but] they can't get away from each other without going into their rooms [p] in the other unit we have two or three lounge rooms so you could

The "other unit" is *Eternia*.

Memories of Eternia

Implicit comparisons and references to *Eternia* are common. *Tempuria* is very small compared to *Eternia*, but bearable because it is temporary

> Iris: it's not ideal but in a transition place it's all right

and so they survive, waiting for transition:

> Mary: down here is very small compared to *Eternia* [p] so we're surviving but [p] it's OK, well they said we're only here for 6 months

Nurses loved *Eternia*, saying it

> Helen: was only a couple of years old. like they've just done it up and now

> they're pulling it all apart and doing it up again and I quite liked it, I thought it was lovely the way it was

In words reminiscent of the model nursing home mentioned in *Milduria*, its wandering spaces were ideal;

> Helen: if we did get demented patients or anyone that wandered or anything they got a lot of space to wander and that was a circle and they could just wander around and around and around there was no dead ends

Eternia patients could choose degrees of separation between themselves and others:

> Helen: there was just more space to get lost in, like patients could go to their room [p] but like they had different lounge rooms to go to

Eternia patients orientated themselves into groups of their own accord. Some patients gathered in the dining room, while others went into the TV lounge;

> Helen: the dining room was close by and they'd sit in there sometimes [p] the psychogeriatrics they tended to congregate… in the TV room

Everyone enjoyed the garden. It was a centre of activity and interest:

> Helen: the barbeque was held out there and there was a bird as well, a galah in a cage, and a big tree

It was enclosed by a low fence that could be easily jumped over, but patients did not run away:

> Iris: when the removalist came we just opened the doors to the unit and they were saying "aren't people going to run away" and we said "no, they like it"

Perhaps there was another reason they did not run away. Extra staff or "specials" were hired to keep difficult patients out of trouble:

> Helen: we usually had to get a special to sort of pace about with them (laughs) and you know keep them out of trouble

Purpose-built

Despite what my colleagues had said, *Eternia* was not a purpose-built psychogeriatric ward:

> Tom: it was never a unit, a specific psychogeriatric unit [p] and where we will be going to will be a specific psychogeriatric unit of eight beds

It was hard to work out just what *Eternia*'s purpose was.

> Helen: we mainly get depression and like we did get a few demented ones we weren't supposed to [p] we weren't just a psychogeriatric ward, we had like six psych [psychiatric] patients two neuropsych [neuropsychiatric patients] so but if we had any difficult ones, we'd have a special [p] we had a few manic patients, they were pretty disruptive, yeah they were, especially the young ones [p] you get a lot of PD [personality disorder] and things like that as well, like they've sort of got other problems as well so they sort of, um, they're quite difficult neuropsych patients

In *Milduria*, getting extra staff required evidence of accidents, such as falls. In contrast, *Eternia* was well resourced. 'Difficult' patients were assigned an extra staff member to look after them. However, in common with *Putria* and *Milduria*, nobody wanted difficult patients. They stayed longer than other patients, and were eventually discharged to the equivalent of a long-stay *Putria*, some 40 km away.

> Helen: they seem to stay on our ward for ages but they do eventually go

The intrusions common to *Putria* and *Milduria* occurred in *Eternia* as well:

What the nurses said

> Helen: some of the wanderers used to wander into other people's rooms and some of the little old ladies used to get really upset – like if a big man with Korsakoff's came wandering into your room, you would get upset

Whatever problems *Eternia* may have had, they were buried beneath praise. In their recollections, it was a playground. Yet, it had a darker side. There was the confusing layout

> Helen: I don't think I would've had so many corridors but 'cause you do get disorientated, I mean when I first came onto the ward, like I was disorientated myself so imagine how the patients feel, like especially elderly patients who are a bit demented

The toilets had been overlooked when the ward was refurbished

> Helen: the toilets were pretty old like that was the only part that hadn't been done up [p] it could be slippery, like if there was water on the floor, you had to be careful, like we had a few falls

In the recently 'done up' ward, the bedroom doors had

> Helen: handles on the inside but none on the outside, you had to push them in, they sort of didn't shut, you couldn't shut them properly because they had no handles, I don't know why

The problem of shutting the door was overcome by using

> Helen: a pillowslip on top of the door to get them to shut and swing 'em shut

After a patient used an inside handle for hanging and committed suicide, the doorhandles were removed.

Diaspora in search of a purpose

In his *Inferno* Dante describes one of the circles of Hell where souls are blown about at random by the wind. *Eternia*'s fate was to surf the whims plotted on paper and whiteboards. It was moved four times in seven years including relocation from another campus. Unlike the souls in Hell, however, nurses in *Tempuria* hoped:

> Helen: this new ward's going to be good because they're spending so much money

This hope is hope indeed, given *Eternia*'s history as well as the vagueness of the recent present. In the move to *Tempuria*, nurses were given

> Tom: a couple of months notice but it always differed in so far as "we're going to move" and it didn't happen, and then we were told we were going to move again and then it didn't happen and then we got eventually moved

Nurses are not interested, or are no longer interested, in whatever reasoning underlies these moves. When I raised this topic with one nurse, she dismissed it saying:

> Mary: I am not interested I just want to finish the place and move back

Just as in *Putria* and *Milduria*, others had made plans, and nurses were eventually told.

> Mary: I think yeah that in the beginning before we moved or when they first started to talk about moving, they did get out a plan of how they were going to set it up

An occupational therapist overhearing this in passing explained the plan. Her concern was that the 'plan' meant her patient load would increase from four to six, and she wasn't sure if she could cope. She said she knew that

> OT: there are plans up in the [Nursing Unit Manager's] office but generally the level of knowledge of staff is nonexistent

I had asked the Nursing Unit Manager earlier if she had a plan of the new *Eternia*. She showed me a blueprint. Neither of us could make head or tail of what was a wiring diagram for the proposed security system. Ignorance is bliss, and probably strength, when worrying is futile. Whatever the plans were, nurses would occupy it, until next time.

After my experiences of *Putria* and *Milduria*, I would have been surprised had nurses actually had any idea of what was planned - and flabbergasted if they were involved. However, I remain puzzled that in a unit associated with some of Australia's pre-eminent psycho-geriatricians, the very idea of what constitutes 'psychogeriatrics' remained vague. On the one hand, it was concerned with patients who were

> Tom: over 65, they've got plus or minus a psychotic illness plus or minus a depression

But patients who had dementia were not regarded as 'true' psychogeriatrics in *Eternia.* Even more mystifying was the claim made in regard to a particular patient admitted to *Tempuria* who had

> Tom: a diagnosis of a bipolar affective disorder, so she's not [p] a psychogeriatric patient, might be over 65

Perhaps the eclectic mix of patients in *Eternia*, combined with its fragmentary career, contributes to this. What psychogeriatrics appears to be, in *Tempuria-Eternia*, is the overflow of patients that other wards don't want:

> Tom: because there was no beds in the other area for her and because she needed a little bit more nursing input [p] it was suggested we nurse her because we had a vacancy and to complement beds, to fill beds up, so that lady was put in here short term until our type of patient came in for admission

It is hard to imagine what the 'purpose-built' plan for *Eternia* might be, if nobody had any idea of its mission statement. In the trajectory of the chaotic career of *Eternia* and the contracture of *Milduria*, it seems that the unkindest words spoken in *Putria* might be the truest:

> Nita: it's a dump.

Summary

In accepting patients with both dementia and psychiatric diagnoses, *Milduria* stands midway between *Putria*, which mainly accepts patients with dementia, and *Tempuria-Eternia*, where patients with dementia are regarded as not 'psychogeriatric'.

Despite being more modern than *Putria*, as buildings *Milduria* and *Tempuria-Eternia* are both much closer to the ancient model of *Putria* than their appearances suggest. All three are bound together, alternatively buffeted and becalmed by what appear to be bureaucratic whims.

The nurses in *Putria* have a faith in experts that has yet to be put to the test. The nurses in *Milduria* have seen how experts betray the promises they make. The nurses in *Tempuria* long to be left alone again.

Chapter 4: Discussion

Introduction: "You get used to what you've got"

In all locales, nurses often said words to the effect that 'you just get used to what you've got'. At first it would seem that what nurses have 'got' is dramatically different in each place. Ancient, crumbling *Putria* with its swarm of unruly 'not with it' patients, appears totally opposite to *Tempuria*. *Tempuria* temporarily occupies a brand-new building, with only four well-behaved patients in single rooms. *Milduria* stands midway. Modern, purpose-built, but falling into decay, it combines the best of each and avoids the worst of both.

I will begin this discussion with the most frequently mentioned problem of reducing the risks posed by behaviourally challenging patients. This reveals how the built environment figures in 'rules of thumb' used by nurses at all three locales to manage risks. Yet, it is strange and deeply disturbing work. In ways that are characteristic of each locale, fragmentary expressions of irritation, resignation, hope and doubt surround the rules of thumb.

The majority of the discussion is taken up with these fragmentary expressions. In *Putria* and *Tempuria* irritations resolve into pride at overcoming adversity. Although they have not been consulted, nurses pin their hopes on technological solutions in future 'purpose-built' units. In *Milduria*, these fragments tend towards a skepticism regarding technological solutions and the idea of the 'purpose-built' itself.

The play of similarities and contrasts between these three locales brings to light a sense of trouble that is not casually topical. Both optimism and skepticism reveal a deeply felt unease. This strange and deeply disturbing work poses challenges that cannot be addressed by the technological solutions that building offers. At stake is the transgression of the inalienable right to be actively involved in shaping one's circumstances.

The pressing problem: managing 'not with it' patients

All interviews were dominated by the problem of 'not with it' patients. These are patients whose behaviour presents serious risks to themselves, to others, or to property. We can regard the management of these patients as the immediate problem whereby nurses firstly determine whether patients are 'with it' or 'not with it'. Then they consider what the practical issues are in relation to the particular built environment they occupy:

> they're still a bit with it, right, and you've got people who are not with it and you can't combine the two together [Putria]

> this is the problem now... [you've got] somebody who's high-functioning who has to be in a low functioning ward because there is no bed available [Milduria]

> if they're going to be behaviourally challenging we're not equipped for that… in this temporary accommodation [Tempuria]

Because they are not dangerous, 'with it' patients can be trusted not to misuse plants, curtains, and decorations. Therefore the ward is warmer, more comfortable and home-like. In contrast, 'not with it' patients need constant watching, as they frequently endanger themselves, other people, and property. Nurses try to prevent agitation by

maintaining a low-stimulus environment. As part of this process, they keep the ward bare of things patients could misuse. Consequently wards occupied by ‘not with it’ patients appear cold and institutional.

Two concepts are important in caring for ‘not with it’ patients. These are the structure or ‘layout’ of the ward, and the ways in which it is used, the ‘setup’. The two go together:

> you’ve got clean towels in the corner, but dirty linen bags in there and that’s the layout thing [*Milduria*]

Old hands look for and instantly pick out routines, based on their previous experiences:

> Same sort of setup… the same routine with the clothes, stuff like that [*Putria*]

Newcomers learn how the layout and setup relate to nursing goals:

> you learn to adapt to different environments [p] what might be different in one ward [is] due to the way it’s structured…we usually discuss what seems to be the best method…[and] observe how it goes [*Putria*]

“Observe how it goes” reflects the importance of being able to see. If

> you can’t see them you can’t do anything about it [*Milduria*]

The need to be able to see what all ‘not with it’ patients were doing came up in almost every interview. But being able to see is not enough, nurses have to position themselves to be able to respond quickly:

> you’ve got to be able to hear her ‘cause if she calls out, she’s going to climb out of bed immediately and she’ll fall [*Milduria*]

Positioning oneself in the environment is a strategic decision:

> you might only have eight patients and two staff but somebody's going to fall over, you can't be everywhere at once [*Milduria*]

It is a dilemma experienced nurses teach to neophytes:

> one woman died in her chair, and I said, "well what you gonna do now, you've got a patient in the shower?" [*Milduria*]

The sense of readiness taught here is part of a generalized aura of vigilance. Vigilance was justified by the rules of thumb applied to 'not with it' patients. In each place, vigilance was extended to 'with it' patients as well. In *Putria*, 'with it' patients cannot leave the dayroom because they will be unobserved. Similarly, in *Milduria* a nurse cautioned that

> with the elderly in general, I think that they need to be under observation at all times

and even in *Tempuria*, nurses felt uneasy at not being able to see the ward from the nursing office.

There is another side to 'seeing', and that is 'being seen'. In *Putria*, a patient does not confirm the existence of a toilet until he has caught the nurse's eye:

> they still can't find the toilet, even though the floor is tiled and you can see a toilet bowl… they… get up catch your eye

'Seeing' and 'being seen' are implicit in the notion of privacy, and its violation. The prospect of seeing naked strangers, and being seen by them, is probably the fundamental reason why nurses in *Putria* feel it is unfair to house 'with it' patients in the same place as 'not with it' patients. It also has subtler dimensions. Nurses in *Tempuria* feel that bedrooms are too private to have conversations with patients, and

prefer to talk in open areas. They empathize with their patients' right to privacy as exercising control over self-disclosure:

> you can't really tell everybody everything about yourself, do you, just because you're in a unit

This right also applies to themselves as they feel the lack of a staffroom where they could talk amongst themselves. There is an inhibition that results from being seen, that is understood without saying. It extends from an empathy for other people's need for privacy, to collegial privacy. It can also be applied as a managerial technique. A nurse in *Milduria* relies on this understanding when he deliberately leaves one patient's bedroom door open, to stop him from urinating in his room:

> he doesn't like it, but I've got no choice, it's an inhibitor

Time and time again, nurses observed that privacy was a concern for 'with it' patients. 'Not with it' patients were generally more protective about what they were interested in doing, rather than concerned with protecting their privacy:

> you can walk in on him in the bathroom, he doesn't care - but if you walk in and he's stealing something, he's in the cupboards, he'll try and beat the crap out of you [*Milduria*]

Several nurses in *Putria* also pointed out that while concentrating patients in one area made it easier for nurses to see and intervene, it also resulted in more conflict due to crowding. Being crowded together was regarded as creating excessive stimulus. In *Putria* nurses lead patients away from the usually crowded main dayroom into the garden or second dayroom. In *Milduria* they were frustrated because they didn't have distinct quiet areas to separate patients into. In the low-functioning ward they couldn't

even use the garden because it was derelict and unsafe. In *Tempuria,* they explained the layout of their former ward, *Eternia,* was ideal because patients had had many areas to get away from each other, or in which they could form congenial groups. The general principle is the use of the environment as a way to control stimulation:

> we use the environment to our advantage, when we can, to reduce stimulus [*Putria*]

Having a stark environment was another way of reducing stimulus. Many nurses explained that keeping things to a bare minimum in low-functioning wards, prevented their misuse:

> having a pretty stark sort of building is fewer ah, sort of things to confuse them [*Putria*]

It is arithmetically correct that having fewer things around reduces the opportunities for misadventure. Having fewer things means what there is, is more likely to be interpreted correctly. There is also a Behaviouralist style of thought in use. If we look back at the extract above, the idea of ‘stark’ refers to reduced stimuli, and ‘confuse’ to incorrect responses. However, the Behaviouralist notion of reinforcement is absent. ‘Not with it’ patients appear to be immune to stimuli intended to elicit particular behaviour. Many examples were given of how such patients destroyed or ruined things:

> if it was more like a lounge-room at home with nice chairs and carpet, it just wouldn't work, there's even, there's even more things to pee in, pillows to defecate under, there's more to confuse them [*Putria*]

In contrast, ‘with it’ patients appreciated things. *Milduria*’s higher functioning ward could have a warmer atmosphere with

> flowers on benches and little pots on tables, whereas in the other ward you can’t have that because patients misunderstand it [*Milduria*]

Nurses generally agree that caring for ‘not with it’ patients is very difficult

> there’s easier patients to handle

The difficulty of looking after these patients requires nurses to work together to manage risk, which in turn produces a shared sense of determination or camaraderie. Those who don’t work in these units cannot understand that determination:

> you know we’re straight into affirmation, we just grit our teeth and get them to do what we want to do [*Putria*]

> I said to the [general] nurse, “Injection, please don’t muck about”… gave him an injection [*Milduria*]

The implication is that others may prefer social niceties, but PAU nurses understand that at times they need to be in control of the situation.

The basic rules at work in using the built environment while caring for a group of predominantly ‘not with it’ patients can be immediately digested in dot point format:

- ‘with it’ and ‘not with it’ patients should be nursed separately
- ‘not with it’ patients present serious risk to everybody and everything
- Nurses adapt to the setup (routines) and lay out (physical features) of individual wards
- Patients need to be under constant observation
- Nurses need to be able to intervene immediately
- Stimulus needs to be reduced
- The environment needs to be bare
- Nurses must be in control

Nurses said relatively little about rules for ‘with it’ patients. Perhaps that is because, by definition, ‘with it’ patients do not present a problem in relation to the built environment. If anything, the problem for ‘with it’ patients arises from the intrusions they witness and experience when ‘not with it’ patients are housed in the same place.

The literature regarding Special Care Units (SCUs), i.e. dementia-specific environments in aged care, reveals similar concerns with balancing autonomy needs against risk. The SCU literature generally seeks to translate these concerns into design problems. There is also considerable interest in developing instrumentation to evaluate the outcomes of design solutions. However, this approach is necessarily limited to what is observable. It does not take up how people working in a hands-on capacity in aged care experience the environment. This discussion will now turn to this experience.

Becoming typical

It would be hard to face places like *Putria* for the first time, but harder still to face it on a daily basis. Recall the dramatic statement that *Putria* is a “dump”:

> I think it’s horrible, I think it’s a dump, absolutely a dump…it’s old, it’s poorly maintained, it’s it’s cavernous… the furniture’s cold and it’s a cold atmosphere… [and] it’s not just the building is it, it’s what’s going on in the dayroom as well

It is not just the crumbling, putrid, building, but “what’s going on in the dayroom as well”, the destructive chaos, that turns it into a dump. The horror of this reality is too much to admit. In the end, the nurse who spoke of this horror turned to a Behaviouralist concept to explain that

> you become desensitized if you're over there all the time

Becoming 'desensitized' suggests that first impressions are lost, that something has disappeared from thinking. Rather than reacting with horror, the situation is presented as somehow natural:

> Life's not fair, get over it [*Milduria*]

The response becomes a practical matter of learning the 'setup' of different 'layouts' and of getting on with the job. However, the sense of unfairness is not eliminated. In *Putria* the sense of unfairness is focussed on the plight of 'with it' patients who encounter a horror that is difficult for anyone to get over:

> It's not just the building but what goes on in the dayroom as well

In *Tempuria*, it lingers in the feelings of nurses, rather than patients. After all, the patients in *Tempuria*

> Don't really bother each other… they're just happy being

It is the nurses who were initially shocked at its smallness. They felt it was prison-like, alien, and oppressive. One nurse went so far as to say that

> like I came in to a place like this, I think it'd make me go mad

Another described going to work as a regular test of endurance, in the way a performer might describe appearing on stage in a long-running show:

> I sort of sometimes feel like "here we go again" ah sort of stuck between four walls

They get over the oppression of being confined in such a small space by remembering that it is temporary:

> It's not ideal but in a transition place it's all right

This theme of ‘getting over’ unfairness is a turning away from the fact that the environment nurses encounter is one that they do not have any power to change. The horror of *Putria* is unchangeable:

> unless you get a new building and then we probably could change it

Similarly, the prison of *Tempuria* is a decree, carried out by anonymous authorities:

> we were told we were going to move again and then it didn’t happen and then we got eventually moved

In *Milduria*, there is no prospect of change. The imperative is to

> just get used to what you’ve got

In all locales, rather than nursing work being a matter of adapting the built environment to suit, the emphasis is in the other direction:

> you learn to adapt to different environments [*Putria*]

Despite the individuality of different environments, the end result is an instantly recognizable typicality. Other nurses do not call *Putria* a dump; they recognize it as an institution. They immediately recognize the ‘setup’ or routines, the smell, the curtains, the people, the buildings. Irrespective of their age, in all these places

> the buildings are exactly the same [p] and the newer ones are exactly the same [p] they’ve just got that feel about them [*Putria*]

Nurses instantly recognize them as typical places to work in, because the work of adapting to them is intended to produce similar results:

> this is similar to [names old developmental disability institution], same sort of setup [*Putria*]

In these typical spaces, ‘getting used to’ the way things are shifts discussion to working methods. Schemas of typical spaces, and typical relations absorb the experience of work. Nurses become used to typical spaces and what typically goes on in them.

In the process of ‘getting used to it’, nurses come to see themselves as ‘typical nurses’. For instance, in talking about unpleasant odours, a nurse remarks that he is, like his colleagues

> a typical nurse… we’re sort of used to it, just part of the job

This absorbs the charge that nurses become ‘desensitized’ if they have to endure these conditions for any length of time. Rather than seeing themselves as desensitized, seeing themselves as typical confers a sense of being normal. Yet the security of fellowship has a defensive ring:

> I work with lots of people who couldn’t set foot outside one of these places to work anywhere else [p] there is a security in being part of, you know, the understanding, the camaraderie

The camaraderie takes a different form at each locale. In *Putria*, the camaraderie extends to nurses across the campus. This campus is dedicated to psychiatry and, over the years, most of the nurses have rotated through *Putria* at some time. In *Milduria*, the sense of camaraderie is restricted to those within *Milduria*. This is likely to be due to its history. *Milduria* is a relatively recent arrival on a general medical campus. It came with its own staffing and management and remained separate for a number of years. In succession, geriatric medicine, adult psychiatry and most recently, child

psychiatry units arrived on the campus, each with their own staff and management. As a result, few nurses from other units have ever set foot in *Milduria*. They

> have to be forced to come to us [p] because you're cleaning shit and they don't want to do that… it's OK with babies but not with adults

In *Tempuria* nurses do not mention any feeling of camaraderie with nurses elsewhere on the campus. Instead they experience a feeling of intense isolation that becomes expressed as a mutual longing for a space where they can be at ease in company with each other:

> there's nowhere private to go, like we haven't got a staff room

Without a common space, they take turns going out to the shopping centre. The closeness of the ward is too much to bear all day:

> you can't stay on the ward the whole time

Their quick trips outside are a form of breathing while they swim the distance

> we're surviving but [p] it's OK, well they said we're only here for six months

In the interest of giving this discussion a quick and early direction, I ask the reader to forgive the following "blitzkrieg". Sometimes it is necessary to establish a beachhead. Camaraderie, like nationalism or other forms of group identity, is a form of what Koestler (1967) termed the 'integrative principle'. The integrative principle is the tendency of people to conform, to cooperate. Koestler posed a rarer counter-tendency which is self-transcendence. Self-transcendence is the ability of some individuals to take stock and seek to overcome their circumstances. Koestler held that the greatest crimes against humanity did not arise from self-transcendent individuals such as Hitler, despotically ruling over others. Rather, it was the integrative tendency of the

majority that made genocide possible. Here, camaraderie suggests an integrative tendency that is a way for life to go on, by ignoring a horror that is not only a place, but a form of employment as well. Surely it is an offensive and somewhat distant parallel to draw between genocide, and the camaraderie of care workers? It is - but it helps us sense that, surrounding the idea of camaraderie, is a sense of complicity in something that makes us feel uneasy, the sense of something that is normal yet also monstrous:

> I've been in institutional type buildings all my career…the people were the same, the wall colours were the same champagne colour, the curtains were half off, the clients were sort of the same

Finding people or things to be 'the same' is of course an absurdity. This statement does not set out to be a statement of fact, rather it is advice. It advises of the attitude needed to work in these places. Its purpose is to deny any individual qualities that may make a personal claim on us. It is not an easy thing to do. If we take a look at the joke below, we see that the denial of anxiety within it borders on dissociation:

> We're straight into affirmation, we just grit our teeth and get them to do what we want them to do [*Putria*]

Why "grit"? What is the disquiet in these words? The sense of unfairness is not dispelled by applying rules of thumb, learning the setup and adapting to the layout. These activities are a matter of 'getting used to what you've got'. The camaraderie acquired by mastering these techniques gives the impression of nurses acting with confidence. Yet within this very grit, this determination to achieve a goal, there is another meaning. It comes from grind, a matter of an unwilling compliance. It is a paradox: self-affirmation under circumstances beyond one's control.

Is there a resistance at the heart of our supposed integrative tendency? Is it something that is revealed only if we take a sterner look at the clichés we use, the jokes we make? Broad theoretical notions such as the 'integrative tendency' and the 'self-transcendent' individual are useful in breaking up the solidarity of appearances, but too general for wrestling with the particulars. Rather than focus on the immediately visible phenomena of adaptation and camaraderie, I want to dwell on the differences and similarities of what is said within these locales without settling on a theoretical orientation that offers a ready universal explanation. In fact, the point of this discussion is not to discover some new facts or invent some new theory - or even to buttress an old one. The purpose is to dwell on what is said, to play with it seriously, to draw it into play. No doubt I will fail - who can resist the pressure to find order in chaos - but hopefully, whatever theory does insist on emerging will be inadequate enough to send the reader in search of another. After all, as the psychoanalyst Winnicott wrote: "The task of reality-acceptance is never completed… no human being is free from the strain of relating inner and outer reality" (2005:18), except that reality-acceptance turns out not to be that dull a thing, a 'task'. Instead it is a form of playing, and

> playing is… always a creative experience… a basic form of living. The precariousness of play belongs to the fact that it is always on the theoretical line between the subjective and what is objectively perceived (Winnicott, 2005:68).

This discussion will try to draw out what is at play in the more fragmentary statements of what is said about these locales. We will see the contrasts between old *Putria* and new *Tempuria* become superficial. We will find that *Milduria* is not some kind of midway position between the old and the new.

Putria: the farm

Nurses in *Putria* had a strong empathy for the plight of 'with it' patients. There is a strong sense of how unfair it is when someone who does not present any risk to others is denied the opportunity to choose their own company:

> She should be allowed to go down and sit on her bed… without people who are so intrusive to her

Yet nurses do not have the authority in *Putria* to let 'with it' patients be on their own in other parts of the ward, because

> there's no one down there to watch them

This constant unfairness is part of the tradition that those who work in these settings learn. The work consists of:

> dormitory sleeping, get 'em up, shower them en masse, and pop them all into a big room together

Doubtless many other units regard themselves as 'modern', and the conference circuit is full of those who promote individualized care. *Putria* has remained unaffected by claims of modernity and the boasts of the conference circuit over the past twenty years. Here in this chaos, nurses derive some satisfaction from being able to reduce it - for most of the time - to the occasional disruption:

> you know we do well considering it's so open, and confused people wandering around

Even *Putria* itself basks in the rosy glow of their efforts:

> actually *Putria* works quite well… you can really only nurse one end at a time sort of thing

This achievement reveals a rhythm at work. Just as in the beginning the land divided the firmament, so here there is a sense of open, swirling chaos that is somehow

divided and stabilised. The uses of adversity are sweet: *Putria* itself lends one end at a time to this rhythmic division, creating order out of chaos. But we must speak quietly, with the surprised meekness contained in the word “actually”.

There is a certain delicacy, or carefulness of speech about this “sort of thing”. To take too much pleasure from mastering these techniques is in poor taste. It is closely related to the sin of taking pleasure from the misfortunes of others. It is something we all know. The Germans have a word for it: *Schadenfreude*. We can see it at work in an extended comparison of *Putria* with the management of livestock on a farm. Here a nurse plays upon this niceness. A picture may be worth a thousand words, but the nuanced comparison of *Putria* with a farm mocks a few thousand years of animal husbandry. For convenience I quote the analogy in full:

> I don’t know what sort of psychologist you are - like a behaviouralist, but when you build a cattle yard and you want cattle to go over here, you turn the water off in these other yards so they traipse away and around to find the water in this one, or you have big solid walls that means that they can’t see through, and they’ll just follow the curves... it’s like [names patient], he can’t see out of one eye, so he walks in this right hand arc, so like cattle and sheep, so if you want them to go somewhere you send them into a funnel or wedge-shaped thing and they’ll go for that little bit of green that they can see or each animal they can follow they will see, especially sheep. I don’t know if you can apply that to poor demented people, but I reckon it works, with good sheep it works really well.

The retraction of “I don’t know if you can apply that to poor demented people” avoids giving offence. Yet that was the implication that was being drawn from the beginning. The coy sidestepping of the expected conclusion makes us reconsider what was said. Now when we return to thinking of what was said, we can see the nurse is innocent.

He is a person who has to act practically in a situation he did not design. Is our grand science, our behaviouralism, capable of offering anything better? The nurse presents himself self-deprecatingly as a practical person, a doer, in contrast to a thinker (a "psychologist")

> I don't know what sort of psychologist you are - like a Behaviouralist - but

He's poking fun at 'Behaviouralism', essentially saying it's just another name for farming, for domestication of beasts. But Behaviouralism is not the target. The joke points out what is, in effect, a play. It looks at those in *Putria* as if they were playing roles. We have the Behaviouralist shepherd, tending the flock of good ('with it') and, by implication, bad (or 'not with it') sheep. No attempt at window-dressing will transform it into something other than a Behaviouralist farm. It dares us to skirt with other comparisons and other taboos. The obvious one is the 'funny farm'. The self-deprecating posture, the meek ending, undermines this riotous direction. It is not a funny joke; it is not a cheap laugh. It suggests that it does not matter what type of farm it is. The farmer is the issue. The farmer has to get on with the job. He is one of those

> people who couldn't set foot outside one of these places to work anywhere else

What is at the heart of this joke is a profound sense of pity for our society in which places like *Putria* are necessary. The promises of science, of cure and salvation, are revealed to be a crude, meaningless and despotic utility. Despite the daily continuities of food, drink, shelter, waking and sleeping, the farm is profoundly ruined. It is a sort of joke that can only be made amongst those who feel they have little option but to make the best of misfortune.

The joke is a lament for something that has been lost. It suggests, for a moment, the possibility of a revolt against institutional order, but then collapses into a humour that does not threaten it. Marcuse (1968) calls this style of humour 'repressive desublimation'. It is the laughter we hear from viewers of clever TV shows like *The Simpsons*, that encourage us to laugh at ourselves and our rulers. Rather than outrage at the injustices we witness, injustice is transformed into easy laughs that mock but do not threaten the established order. This transformation into pleasure is desublimation, its repressiveness consists of the collapse of any real opposition to an unjust order. In *Putria*, the antagonism between the overwhelming rationality that we have to 'get used to' and the deep sense of unfairness is converted into a satisfying technique. The reason that *Putria* works 'quite well' is because a rhythm has been found, 'nursing one end at a time', so that "things swing rather than oppress, and they swing the human instrument - not only its body but also its mind and even its soul" (Marcuse, 1968:37).

Repressive desublimation is, Marcuse points out, incredibly productive: not only is racing the outboard motor and speeding the automobile fun, but such fun can also amount to a 'scientific management of the libido' in a society that "turns everything it touches into a potential source of progress and exploitation" (1968:71-2). Nurses in *Putria* may employ it, but it really comes into its own as a tool for promoting a corporatization of reality. The joke about a Behaviouralist farm pales into an infantile naivety when we encounter its more sophisticated, glossy brethren from our 'higher-ups'. A spectacularly crass example features on the cover of the January-February (2007) issue of the *Australian Healthcare Journal*. Clothed to resemble ordinary workers, the CEOs and managers of a corporatized residential aged care facility are

photographed as if they were serving food, except that they hold the plates in such a way as to display the food clearly to the camera. Banner headlines blare the punch line:

SERVICE CULTURE FROM THE TOP DOWN

Isn't there something so unexpectedly wild, sexy, desublimated and contemporaneous in the impression that our managers are out there in the field with us, getting their hands 'dirty'? The idea is to spread a sense of bonhomie with a touch of scientific management, to give us confidence, reassuring us we are all in the swim together. 'Swing' is universal. The non-nursing clinical staff have their own version of swing, that gives them their own sense of control over things in *Putria*. This group of twenty or so professionals descend from their offices above and hold a ward 'round' once weekly. Patients do not attend, nor are they seen, as the round takes place away from the dayroom in a carpeted meeting room. After working very hard all the morning these professionals pop out to take a tea-break in *Putria*'s dining area, and it is then that pleasure swings into action. For this half-hour, they draw together the scatter of square tables, to create a communal setting. For the occasion they bring in fruit cake, cold chicken, cold tongue, cold ham, cold beef, pickled gherkins, salad, French rolls, cress sandwiches, potted meat, savouries and exotic cheeses. Their banter at this merry banquet is non-clinical. They bandy the names that appear on the postcards decorating the lobby, names of glamorous places in foreign lands. Their holidays, spouses, children are all subjects for their witty chitchat.

It is a witty relation between these people, backed by the glossy proof in the form of photographs, official pronouncements and postcards on display in the lobby. It is also

a stabilisation, a structure or, in its material bricks and mortar form, an architecture in the service of functionalism. What is stabilised out in the lobby just as much as within the dayroom is "an anonymous relation of activities, without the system's existence having necessarily been called for or even noticed by any of the participants" (Habermas, 1997:233). It is a wittiness that we have inherited. Kracuer (1997:60-62) gives a fine example of this in his description of a pre-war employment agency in Nazi Germany. Inside, the concepts governing it “ooze through all the pores", the "postcards from above" displayed on the walls. Safety posters declared: "Workers! Think of your mothers!” The purpose of these directives is not to safeguard us, but to compel obedience. These postcards are an example of how society "fences us in" with language that "fulfils instructions that it has not been informed of, and erects bastions in the unconscious”. The workers were not aware that their health was valued for purposes they had not been informed of: the desire for conquest. Decades later, the innocent witty chitchat supports the same system.

Yet in its background, and what makes it all possible in the first place, ‘swing’ is universal and ancient. Preceding its concrete rigidity, its crude behaviouralism, the witticisms of its blithe professionals, *Putria* belongs within a libidinous history of life and death that cares for nothing but its own immediate pleasures. It is a history that does not appear in textbooks. Only poets speak of the past as it was in its living season:

> In that open field
>
> If you do not come too close, if you do not come too close,
>
> On a summer midnight, you can hear the music

> Of the weak pipe and the little drum
>
> And see them dancing around the bonfire (T.S. Eliot, *East Coker*)

The joke that *Putria* is like a farm run by Behaviouralist has a ring of truth about it. Although nurses felt powerless to offer autonomy to 'with it' patients, they managed to set up a safe, efficient and pleasant routine. In the moribund layout of *Putria*, this was an achievement to celebrate. But the very achievement cheats and blinds the imagination. It limits expectations of a future according to its own terms into thinking that a

> new unit should be better... a purpose-built unit to suit what we do

These expectations are shot through with inconsistencies. They utilize a jargon that masquerades as thought, a jargon that takes repression to a novel boundary: that of dissociation.

The current rumour is that the new *Putria* will be built on the campus of a general hospital. They explain that it is notorious for its difficult access and lack of parking. Unconsciously parodying Ulrich's famous (1984) article about the benefits of a view of nature in recovery from surgery, one nurse says of the proposed relocation:

> I can't see them getting much of a view…maybe… a brick wall of another building

What nurses thought as desirable in a 'purpose-built' unit diverged into two sets of features. The most frequently mentioned set contained features that would be relevant to the care of 'with it' patients. This included en-suite bathrooms, single rooms, kitchens that patients could use, and homely

> areas where people could get away from each other if they needed to

The minor set was an after-thought about ‘not with it’ patients. This implied a stark environment that was not like a “lounge-room at home” where there were “more things to confuse them”. In this alternate set, there would also be

> areas where you can isolate them if they're really agitated and when they can be aggressive to other patients

It was as if when thinking about the future, there was a trend away from the current dilemmas of care. It was as if in the future, ‘not with it’ patients were somehow cured.

When pressed, a nurse acknowledged that these different needs could not be accommodated within a single unit and declared:

> you have two different units, you have an independent unit and a non-independent unit

Yet these problems of location and purpose were pushed aside by a faith in “modern” material standards:

> it’s the standard with modern accommodation [p] it’s just the privacy and the dignity [*Putria*]

This faith was accompanied by a trust in experts:

> I don’t really know what they’ll do I’m not an expert in the way that it should be built

Giddens (1990) argues that experts conceal mistakes and elements of luck. They project ‘unflappability’ that provides a stereotyped reassurance to lay people. In return, lay people respond with ‘faceless commitment’. The benefit for lay people is being able to have confidence that things will work well. Perhaps. Certainly *Putria*’s campus and its Health Authority are awash with experts of all types, who occasionally bicker over *Putria*’s future.

In *Putria* we find a repressive desublimation clothing the present, and a dissociation clouding notions of the future. The magical cure of problematic behaviour, the mantra of the ‘modern standard’, the faith in experts - these are not a reluctance to admit reality but a denial of it. Some might argue that it is only natural: after all, nurses did not report any meaningful inclusion in planning for the future. Yet nurses themselves did not remark on this exclusion. It is reasonable to regard it as a form of dissociation. What is disturbing is that the same idea - that of moving to a purpose-built unit where things will magically be better - emerges equally without any reasonable foundation, in *Tempuria*.

Tempuria: the garden

According to the nurses in *Tempuria*, their patients don’t need

> to move around much like they’re sort of happy being

Unlike the rowdy sailors ruining the dance hall in *Putria*, patients in *Tempuria*

> don't wreck things, they clean up after themselves and they are neater than housemates

The problem is that they have lost their gusto:

> these people are not keen eaters with their depression

Nursing work involves overcoming depressive apathy:

> we'll make a night of it, it’s Friday night, we'll get popcorn

Even the weakest effort, the littlest outcome,

> even just a gardening workshop and grow some plants

restores a sense of health that is grounded in a universal right:

> each person feels that sort of right to be actively involved in creating the environment

In *Putria*, nurses felt an empathy for ‘with it’ patients, tossed into a swirling mass. In *Tempuria*, the empathy nurses feel is for their own plight. The well-behaved patients are

> just happy being

but for nurses working in *Tempuria*, “being” has an air of weary futility to it:

> here we go again…

It was the inalienable right to have some say over one's destiny which nurses felt was transgressed by being moved to *Tempuria*. It was an arbitrary move, after numerous failed announcements. The repetition that it will be “only six months” sounds like a petition for release. All of them refer to *Tempuria* as being “prison-like”, “alien” and “unfriendly”. Just as a prisoner deprived of a greater right to create their circumstances might personalize their cell to help endure their sentence, so too did nurses exercise remnants of their right to be ‘actively involved’ in creating their environment:

> It’s quite homely now, like we’ve put curtains up, like we’ve made it

This is not 'window-dressing', a concern with what others will make of appearances. What is “homely” is its communal nature. It is something “we've” put up. The delight of creation is also shared, as in “we’ve made it”. But a few curtains and some pots are not enough to transform *Tempuria*. That is because what is ‘homely’ is not only made together, but over a long time:

> I think those old buildings… have got something to say for them

What old buildings “say” is a delight in community, in coming together:

> it was just lovely it had a bay window and like it had several people to one room [p] you had this big communal dining table

This nostalgia contrasts with *Tempuria*, point by point.

With its drab institutional colours, *Tempuria* is not ‘lovely’. Its window into a featureless courtyard eerily manifests the view expressed in *Putria* that the new unit will probably have a view of a car park, or a brick wall. It is not the outlook one imagines from a bay window. In *Tempuria*, rather than communality, people intrude on each other when they most desire privacy:

> there's only one bathroom and one en-suite and we've had to say "stop cleaning your teeth and please move out because this person urgently needs to go to the toilet”

Rather than breaking bread together they have a

> space-age dinner on a tray

Being with others is a matter of being quarantined:

> this is your foreign bubble that you go into when you're sick

The oppressiveness is intensified by the surrounding landscape. It has nothing to offer, nowhere to go, hand in hand:

> there’s nothing, you can actually take the patient by the hand and say “let’s go for a bit of a walk”

Tempuria is not a place. It doesn’t stand still long enough. Nobody belongs to it. It is a viewless space-port carpeted in astro-turf, a prison high above the world. The experience of being

> ah sort of stuck between four walls… not looking at anything

runs contrary to the desire to bring this alien interior closer to the communal. The most that is permitted is a few flowers in pots, a scrounged curtain that is more a memento than a shield. Rather than camaraderie, they share a memory of other places, other times, other things.

They constantly interrupted their talk of *Tempuria* to recall *Eternia* with fond nostalgia. It is as if dwelling in *Eternia* defied the impractical realities. The slippery lino floors of the old bathrooms, the lack of door handles, were only incidental features that had not bothered them. Even its practicalities had not really mattered that much. Certainly, nurses had been able to see the patients through the glass hexagonal nursing station. Certainly, their occasional 'not with it' patient had had lots of spaces to wander about in, and they had had the additional luxury of assigning a single staff member to watch over them. But these functionalities were not the source of their affections for it. It was something else, apart from how it had been 'done up':

> now they're pulling it all apart and doing it up again and I quite liked it, I thought it was lovely the way it was

When they speak of *Eternia*, we can see the old houses that have 'something to say' come back to life. In *Eternia*, patients gathered in their spaces and staff gathered in theirs. They met without the effort of having to find somewhere else to go for a walk, without having to go out and order pizza in an attempt to create a ceremonious sense of community. *Eternia* contained its piazza, where different groups could gather together to play, joke, pass the time, court, show off, and care for each other. It contained a space for playing in: Fred the galah, the big tree, the barbecue, the low

fence, and the outlook to the horizon. We can imagine the outlook over that low wall, and the garden where

> the barbeque was held… and there was a bird as well, a galah in a cage, and a big tree

It was a place where even the patients voluntarily remained, from which they were reluctantly moved:

> when the removalist came we just opened the doors to the unit and they were saying "aren't people going to run away" and we said "no, they like it"

The idyllic sense of being at home brings the house, its people, and the world it looks out upon, together. Bachelard writes of such places:

> The house shelters daydreaming, the house protects the dreamer, the house allows one to dream in peace. Daydreaming… derives direct pleasure from its own being (1997:88).

As if in a dream, nurses believe that they will return to it. The promise of the new *Eternia* has merged with the desire for the old. It is intoxicating. Reality does not disturb it. When doubts are raised about the way things were or might be, the response from a dreamer is:

> I am not interested I just want to…move back

All they know of this return to *Eternia* is that

> in the beginning… they did get out a plan of how they were going to set it up

This "in the beginning" has the sound of a Papal decree: majestic, sweeping, yet out of touch with the daily lives of most people. This "plan" was for a "specifically psychogeriatric" unit. It was hard to work out just what was meant by "specifically psychogeriatric". No formal definition of it was given. What nurses took the term to mean was derived from their experience of *Eternia*, which was not 'specifically'

psychogeriatric. *Eternia* was not ‘supposed to take’ patients with dementia, but sometimes did. They were discharged as soon as possible, to a crumbling ruin on the opposite side of the city, a long-stay version of *Putria*. According to this view, it follows that a ‘specifically psychogeriatric unit’ would exclude people with dementia. This thinking is similar to the preference for nurses in *Putria* to visualize the features of their new unit as primarily suitable for well-behaved clients, rather than unruly patients. The dissociation in thinking of a future in which patients are well-behaved is not quite as surprising in *Tempuria* as it was in *Putria*. After all, who would want to go backwards, to deal with the impossible dilemma of housing both ‘with it’ and ‘not with it’ patients under the same roof? Somewhere, no matter how far away, a *Putria* is always to be found.

Perhaps this dissociation has inserted itself into the very word ‘psychogeriatric’. It is extraordinary that in a locale where some of the great medical authorities of psychogeriatrics in Australia practice so much uncertainty should exist about what ‘psychogeriatric’ means. The relevance of this uncertainty is that without a mission statement not only tied to the blueprints but also commonly understood, the belief that the unit will be ‘purpose-built’ is not credible. Yet this belief persisted. In another dimension of dissociation, nurses overlooked what they knew. They knew the new *Eternia* was another refurbishment and not a brand-new building. Nor was it a refurbishment of the unit they previously occupied. It was in a different part of the old building. Nevertheless, they wished for a building that would be

> a bit more consumer friendly… [like] office buildings and stuff, well they make them so so nice

And they hope

> this new ward's gonna be good because they're spending so much money

But who are "they" who are spending "so much money"? Whose money is it? What is it being spent on? These hopes for a 'good' ward are fantasies. Winnicott (2005) differentiates fantasy from dream. He argues that dreaming and living may be difficult to access, but nevertheless contribute to object-relating in the real world. Fantasy, on the other hand, is marked by dissociation. In fantasy, omnipotence is retained and wonderful things can be achieved. Everything happens immediately - except that it does not happen at all. Fantasy has 'no poetic value' in contrast to the dream which has "layer upon layer of meaning related to past, present and future, and to inner and outer" (Winnicott, 2005:49). These fantasies make no further contribution to understanding; instead they mark the limit of what is said in *Tempuria*.

INTERLUDE

For all the differences in the objective circumstances of nurses in *Putria* and *Tempuria*, these modes of talk reveal similarities. In both units nurses long for what is warm and homely. They have faith in experts to build them a purpose-built unit. They glaze over disconcerting details, doubts and contradictions. They fantasize about an ideal future. In this future, the pervasive sense that things are not fair will vanish. The 'purpose-built' unit will be the solution to make things 'better'. In *Putria* the fantasy develops along the lines of the existing Behaviouralist ethos. In *Tempuria* the fantasy is bound with nostalgia for the garden of *Eternia*. Whatever shape these fantasies may have, their wish is for a compliant docility. Yet the years of fruitless plans to replace

Putria are equivalent to the years of *Tempuria*'s rootlessness as it is moved from building to building. In both places, their history escapes attention.

Turning to the circumstances themselves, the occasional remark threatens to expose things as they are but then retreats. In *Putria* it shrugs off its subversiveness as a joke. In *Tempuria* it hardly speaks before silencing itself with the remark that the situation is "only temporary". The emphasis remains on getting used to the given and to get on with the immediate work of nursing. The dissociated hopes for the future in *Putria* and *Tempuria* express a sense of futility. Nothing can be changed for people in *Putria* and *Tempuria* unless it is changed by others who will build them a new building. There is something abject about this passive acceptance, spoken in *Tempuria*. For example, a nurse hopes the new unit will be more like some of the modern offices that are so "consumer-friendly". This comparison of a nursing unit for people who do not have long to live with the self-indulgent comforts of commerce cries out for its irony to be remarked on. Instead, she continues that "they're spending so much money" before softly demurring, "I quite liked it the way it was". Perhaps I am wrong and this is not dissociation, fantasy, but rather the grace of accepting what one has little power to change. We will always witness and be powerless to do anything about the stereotypical follies of experts and their sponsors. If so, I am wrong in the right company. Illich (1977) links the refusal to admit reality with the desire for magical cures. He diagnoses the reliance on technological wizardry to cure what ails us as 'cultural iatrogenesis'. Cultural iatrogenesis defines the harm that the miracles of medicine cause by weakening our culturally acquired abilities to cope with our afflictions. Yet I am reminded of my earlier caution: not to rush ahead into a watertight explanation. The softly spoken demurral above should not be taken as an

opportunity to conduct research that tightly defines theoretical constructs such as ‘dissociation’ or ‘fantasy’ or ‘cultural iatrogenesis’. Rather, these are terms that should be used to bring more explicit consciousness to what may be said quietly but is nevertheless real:

> In a tantalizing way many individuals have experienced just enough of creative living to recognize that for most of the time they are living uncreatively, as if caught up in the creativity of someone else, or a machine [Winnicott, 2005:87].

I have said that these fantasies of the future are a limit such that “our introspective words for motives are rough, short-hand descriptions for certain typical patterns of discrepant and conflicting stimuli”(Burke, cited in Mills, 1984:14). The degree of patterning, the basic ‘rules of thumb’, the becoming ‘typical’, the camaraderie, the fantasies held, are all a measure of a hidden unease. Thus:

> Even in the most extreme case of compliance and the establishment of a false personality, hidden away somewhere there exists a secret life that is satisfactory because of its being creative or original to that human being. Its unsatisfactoriness must be measured in terms of its being hidden… [Winnicott, 2005:92]

The uniformity of what is said within *Putria* and *Tempuria* suggests a common stock repertoire. It is what the persona of a ‘typical nurse’ is supposed to use in the typical workplace. It is a pragmatic ‘vocabulary of motives’ used to coordinate actions in social settings (Mills, 1984). ‘Motive’ here does not refer to individual desires, but to the conventions that typically accompany the particular type of situation. Mills argues these motives serve as a guide to choosing actions. As such they contain implicit questions but also with answers that anticipate the consequences of actions. These questions and answers are both expressed in vocabularies of motive that are ‘appropriate’ to their institutional situation. Although his work on this point is

abstract, Mills remarks at one point that “the terms in which the question is asked often will contain both alternatives: ‘Love or Duty?’, ‘Business or Pleasure?’” (1984:15).

If we look back now, we can see the questions and their answers in the form of “With it” or “Not with it” have implications for autonomy and control in the conduct of care giving. What follows is not ‘why’ but ‘how’ normative actions are to be carried out. The formation of typicality and, along with it, camaraderie, becomes an ancillary motive that enrols allies and strengthens the determination to act. In *Putria* and *Tempuria* these strategies and tactics take the form of “we’re into affirmation”, and, “here we go again”. The motives allowable in this vocabulary are no longer concerned with the causes of the particular problem, but “promote continued integrated participation” (Mills, 1984:17).

What is disturbing about these findings is that they are drawn from private conversations among nurses. As Goffman (1971) points out that conversation which occurs when those who work in public places, such as nurses, are alone with each other can differ from what is said in public. He calls this ‘backstage talk’, where insiders can admit the publicly inadmissible without censure. The jokes about behaviouralism in *Putria*, the tagging of *Tempuria* as a prison, are unlikely to be made to visiting officials. Yet these ruptures of correctness, with tantalizing hints of something else that emerged backstage, only momentarily interrupted the vocabulary of motives. Is that all there is? The picture is of a rationalization subject only to a vague unease. Given the existence of this unease, the more fundamental limit is not in

what was said, but in the questions asked along the lines of “what’s it like for you, working here?” As a nurse in *Tempuria* remarked about patients:

> you can't really tell everybody everything about yourself… just because you're in a unit

Opportunistic interviews, even if conducted by an ‘insider’, are not the basis for an in-depth exploration of deeply personal views that are difficult to express anyway. As it stands, the data in this study can only speculate about this unease not explore it.

If these conclusions about the ‘vocabulary of motives’ persisting in backstage talks were to be sufficient, then what was said in *Milduria* would surely confirm it. *Milduria* lies midway between *Putria* and *Tempuria* in every respect. It houses both types of patients. It is neither ancient nor contemporary. It does not have the solidified permanence of *Putria*, nor the diaspora of *Tempuria*. Yet, what is said in *Milduria* contrasts significantly with these places. In *Milduria* backstage talk exposes the history, motives and circumstances of *Milduria* not from any theoretical perspective, but from being sunk deep within its milieux.

Milduria: playground

In contrast to *Putria* and *Tempuria*, the ‘story’ of *Milduria* is more like a soap opera in Wonderland, where things might just take off who knows where, where any revelations are possible. Cracks appear between what is practical in the nurses’ own experience and what is regarded by experts as being functional, resulting in a critique of architects. Architects are not the only target. The lack of maintenance, the foolish purchasing decisions made by administration are also pointed out. *Milduria* is not a place that has progressed from a hyped-up ‘state-of-the-art’ facility into a settled

maturity. Instead, its history and its circumstances become more vivid with a sense that things could have turned out differently. *Milduria* is like a circus without an audience, a playground without children, shunned because the antics and the props were a flop.

Shortcomings of both the building and how it was used were given in much more detail in *Milduria*. Two features that were often mentioned were the curved wall and the bathrooms. The story of the curved wall explains the difference between what an architect might regard as ‘functional’, and what nurses consider to be practical.

> [the] idea of functionally separating it from their [the architects’] point of view, a living area and a sleeping area. From a practical point of view, that’s probably responsible for some incidents of harm to people by the sheer fact that you can’t see what’s going on

They find it “stupid” that a professional should overlook the elementary requirement of being able to see. As a consequence, because patients cannot be observed in them unless staff leave other patients unobserved, the bedrooms cannot be used to provide a practical quiet area during the day. At night the wall cuts off both vision and hearing. The practical response is for a nurse to spend night duty sitting in the corridor rather than at the nursing station. This curved wall is only one example of design failure. It is

> one of those things, there was possibly a concept behind it but it hasn’t... worked

The bedrooms, the open living areas, the bathrooms, the verandahs and the now desolate garden area are further examples of ‘one of those things’ that haven’t worked.

As these issues were raised, attention moved from those who designed the things to those who were responsible for maintaining and modifying them. The bathrooms were too small when they were first designed, and lacked separation between clean and dirty areas. In *Milduria*, nurses continue to work in a confined space with inadequate shelving. They often have to leave patients in this dangerous area to get supplies from the store which is outside the ward. The air-conditioning within the bathrooms broke down years ago and was not replaced until recently. The descriptions lead from design failures to inadequate maintenance. Instances of inadequate maintenance are as plentiful as examples of design failure. For instance, the pergola in the low-functioning ward was removed after white ants were found in the seats. It was not replaced. Just as design failure created problems for nursing care, so did inadequate maintenance. In the heat of summer there was no shade in the garden of the low-functioning ward. Nurses were not able

> to let people out into the garden [p] the more aggressive and physically orientated they are, they want to be out in the garden

Tales of inadequate maintenance led to tales of other frustrations, such as procuring adequate equipment. Nurses had asked for the nursing station to be modified by adding security screens to protect people as well as sensitive documents - without result. Instead, computers and peripherals were installed on the counter, making it even more inviting for patients to ‘fiddle’ with things. Screens were only installed after a doctor was intimidated by a patient. As nurses narrated these follies of so-called ‘experts’, they used two styles of narrative. One relied on a logic of conventional justification, the other on factual recounting.

We can see both forms of narrative when nurses talked about the problem with crowding in the bathrooms. It was difficult for several staff to attend agitated patients within this confined space. The need to do this was common, however, they used the example of manoeuvring lifting devices in a small space as a justification. This was a rare event, and at the time of the interviews they did not have any patients who needed such devices. The popular image people have about patients in hospitals is that many of them are debilitated and need to be moved about on a variety of wheelchairs, stretchers or lifters. Facts again contradicted justification when nurses explained the need for extra staff when the ward was ‘heavy’. Particularly in the lower functioning unit within *Milduria*, many patients are

> fit people who... are aggressive and they are quick

In *Milduria*, it is the level of aggressiveness that is the primary experience of the ward as being ‘heavy’. However, nurses buttressed the term ‘heavy’ with the argument that extra nurses were needed because patients were at risk of falling, which poses a relatively minor risk. Falls prevention is a stock scenario drawn from the same image of older people being debilitated. It is borrowed to project a credible image, while the reality stands like a shadow behind it. Nurses were, in effect, translating their experience of the facts into images that others, particularly administrators responsible for the unit, would understand and respond to. They were offering a credible vocabulary of motives, congruent with the image they felt others had of their situation. There is a play, a slippage or looseness between what is experienced and how it can be spoken of. When nurses say it is hard to think about the built environment, they may mean it is hard to translate their experience into this justificatory format.

In *Milduria*, nurses labour against a flow of impractical functionality. In the bathrooms what is clean becomes dirty. The verandah is not used to sit in, but to pee in. The gardens are a desolation, out of bounds. The justificatory format becomes overwhelmed by these facts. Eventually the facts are turned into a polemical re-evaluation of *Milduria*. Before we come to that though, let us linger a little longer in this milieu of absurdities. It is like lingering in a joke-telling session until a really satisfying joke has been told and it becomes time to move on. Perhaps the best tale involves that element nostalgically identified in *Tempuria* as the "communal dining table". In *Milduria,* the communal dining table turns out to be a swindle that brings together designers and procurers:

> they bought big tables but they're too big for the area [p] also the place that they put the legs in, if you try to put more chairs around the table they don't go under 'cause the legs here, it's just a silly design

After 15 years, the original tables were finally replaced with tables that are too big to fit comfortably in the dining alcove. The positioning of the table legs prevents extra chairs from being used. Thus, the additional space gained from the larger size, cannot be used. They are also too heavy to move in and out, so most people tend to sit on the edge that juts outside the dining alcove. In a joke-telling session we would laugh at this nonsense. Here, it begs for reflection. What went on in the minds of those who designed, built and purchased these tables? Let us gather around an imaginary table and pour some wine for some imaginary company of authorities. We will have some German philosophers, some French social theorists, and leave the final words to an Englishman, reputedly a mathematician.

The humble table has had a long history in philosophy. Philosophers have been at great pains to distinguish the table from the cow. However, Marx changed this by giving greater attention to the table itself, rather than its number of legs. The moment it is no longer a plain, useful and sensible thing but a commodity, a table changes from something simple and useful into something transcendent. With glassy eyes, Marx rhapsodizes that

> it not only stands with its feet on the ground, but, in relation to all other commodities, it stands on its head, and evolves out of its wooden brain grotesque ideas, far more wonderful than "table-turning" ever was (1988: 163).

Drawing his chair up, Nietzsche slams his drink down. Pounding the surface with his fist he declares that the table is a meeting of forces that

> has as many meanings as there are forces capable of seizing it (Massumi, 1992: 10)

Woken up by the racket, Heidegger lifts up his dreaming head to tell a story, slow and thick as treacle, of dwelling:

> Let us think for a while of a farmhouse in the Black Forest, which was built two hundred years ago by the dwelling of peasants… It did not forget the altar corner behind the community table… it designed for the different generations under one roof the character of their journey through time…(1997: 108)

It is likely to be a long and boring monologue. It is also on Bataille's territory. His eye cuts Heidegger. His story is short. These are not communal tables. They stand in a place that is "cursed and quarantined like a boat carrying cholera" by "good people" who

> vegetate as far as possible from the slaughterhouses... in an amorphous world, where there is no longer anything terrible, and where, enduring the ineradicable obsession with ignominy, they are reduced to eating cheese (Bataille, 1997: 22).

Laughing, to get us out of this dark core, this inadmissible truth, Lyotard diplomatically joins these slaughterhouses with good people through a community of work. It is good enough to be practical, even if in this bucolic tableaux

> the common work is haunted by disaster. The respect is feigned, the hospitality despotic, common sense obsessed by the banishing of the mad (Lyotard, 1997: 273).

It is time to move on, but is it not quite a mad tea-party:

> The table was a large one, but the three were all crowded together at one corner of it. "No room! No room!" They cried out when they saw Alice coming. "There's *plenty* of room!" said Alice indignantly, and she sat down in a large armchair at one end of the table.
>
> "Have some wine," the March Hare said in an encouraging tone (Carroll, 1975:32).

Climactic experience: The contracture

That was a study in a worn-out Monty-Pythonesque fashion. But why is there this sense of being fed-up with nonsense in *Milduria*, but not in *Putria* or *Tempuria* where they endure the same absurdities under much the same, if not worse, conditions? The difference is that nurses in *Milduria* have had insult added to injury and, in addition, have had their hopes dashed. The insult and injury occurred during an event they call the 'Contracture', which I will discuss here. Their hopes were raised by the philosophy called 'normalization' which *Milduria* was supposed to embody. I will discuss normalization in the next section.

Until recently, *Milduria* functioned relatively well in resolving the primary problem of psychogeriatrics. This was achieved by caring for 'high-functioning' and 'low-

functioning' patients in separate wards. *Milduria* had two 'wings' with three wards in each. In both wings, patients could be streamed into high, mid and low functioning wards. The Contracture occurred when one wing was closed. With the reduced number of beds *Milduria* could not 'stream' patients as well as it used to:

> Will it work now that it's been shrunk?

The Contracture also revealed the lowly status of psychogeriatrics as a discipline:

> nobody ever questioned the fact that we lost three wards, only the nursing staff, nobody cared

The wing remained unused for over a year whereafter it was given to the Department of Geriatric Medicine (DGM). New furniture was bought, wash basins added to the bed-rooms, new carpet laid, and it was freshly painted. Nurses looking on from *Milduria* experienced the Cinderella syndrome. They had got nothing:

> it wasn't fair [p] they [the DGM] got things like hand basins put in every room… but we still have the same, no hand basins

There is nothing new under the sun. The famous architect Le Corbusier was commissioned to design the capital of Brazil. Brasilia was supposed to be an egalitarian city. It spanned both sides of the river and the intention was that the rich and poor would live, work and play side by side in the same neighbourhoods. It turned out to be two cities. The rich live in the part that was built first, before the money ran out, the part with all the amenities. The poor live in the other, a ghetto. In this microcosmic Brasilia, since the Contracture, the wings are entirely separate. The staff and administration of the DGM are completely separate from those of the PAU. As a result, what was once a back entry is now the most commonly used entry into the

PAU. The wreckage of old furniture and fittings discarded from the DGM wing lies besides this entry, adding a touch of careless irony.

With the Contracture, half of the nursing staff became surplus. They were told they would be working in adult psychiatry, an area few of them had any experience in. No retraining was offered. Many of them, after a lifetime of working in psychogeriatrics, felt unvalued and left in disgust. They attributed their fate to the low status of psychogeriatric nursing. This theme came up frequently in *Milduria*, with the explanation:

> that's the funding pile, you know, Mental Health's at the bottom of the funding pile and we're at the bottom of the Mental Health funding pile

Status and funding were not mentioned in *Putria* or *Tempuria*. These injuries and insults may have motivated staff towards a more explicit critique of their circumstances than was the case in *Putria* and *Tempuria*. As a consequence, any belief in *Milduria*'s claim to be a state-of-the-art facility evaporated. The truth was that nothing much had changed, that society could not be changed merely by changing the sheets:

> they just change the bed linen, they don't change the mattress

In the Old Testament, the Fall resulted in expulsion from the Garden of Eden, labouring for bread, and nostalgia for the ideal. The Contracture is like the Fall, a cataclysmic event that explains why things are the way they are now. It forces a re-examination of the past and in doing so exposes the philosophy of 'normalization' as myth.

Normalization

Milduria's origin, a large, traditional and austere institution, was situated on what became prime land. It was sold to finance the building of *Milduria* and similar satellite units. In its place a walled town was built, guarding the 'haves' within from the 'have-nots' without. Transported to the poorer suburbs, the grand promise of *Milduria* and its sister units was to realize a philosophy of 'normalization' that involved following

> patterns of behaviour at home

Nurses told two tales about normalization. One was idyllic, the other realistic. The idyllic tale describes social evenings, where patients from both wings met in the central bar and lounge for drinks, dances and piano music. For those a-social 'not with it' patients, normalization involved sensory richness, such as pottering in a shed with an old motor. *Milduria* 'worked well' by streaming the clientele. Both patients and staff had more choice in what they wanted to do, and when they could do it. Nurses were allowed more autonomy, and so could allow their patients to make choices, such as when they wanted to shower or whether to spend time in their rooms. These are nostalgic recollections of a by-gone golden era. In the realistic tale, the description of the numerous things *Milduria* once had that now no longer work, are old or worn out, or of things that are no longer done, details a fall from grace. The present emerges as a labour of care that has

> contracted to … meet basic needs

After the optimistic view of the future in *Putria* and *Tempuria*, this sombre outlook was unexpected. After all, *Milduria* resembled the future envisaged in *Putria* and *Tempuria*. It was 'purpose-built'. Late one night, waiting to interview staff in *Milduria*, I looked up three colleagues who used to work there. After the Contracture they had been moved to adult psychiatry. It turned out to be an impromptu group interview. Rather than a joke-telling session, it was one of those rare nights in which backstage talk has full sway, seizing on its revelations to make further points. In this session, a much darker tale was told. By the time staff set foot in *Milduria* it

> was already designed built completed forgotten

There is a sense of fury, of being duped by a confidence trick from the very beginning:

> the first words that came out of the guy's mouth was, "I didn't design this" – they was already backing away from it

One by one, nurses shared their experiences of hypocrisy:

> Geoff: when they opened up [*Milduria*] they had all the bigwigs from the Shire and the Health Minister came so what she [Nursing Unit Manager] did was hire a bus and got all the patients out

> Louise: don't let them see the patients!

Normality is not fixed in place with cosy talk of familiar patterns from home, or hazy recollections of dances and old sheds with motors in them. As they vented their polemics, an analysis of *Milduria* emerged. It charged that the more things change, the more they stay the same. The present is a lost opportunity:

> Louise: to start something really good, what do they do? They give you old baggage from the old place…

> Sally: they've done the full circle haven't they?

The consistency of what was said in individual interviews, from the irritation with things to the view of *Milduria* as a return to its institutional origins, reveals that the conventional 'vocabulary of motives' that dominate speech in *Putria* and *Tempuria* does not hold here. Instead, we hear a more sophisticated as well as practical opinion of institutional circumstances. The notion of the 'total institution', drawn from Goffman's (1961) work in *Asylums* and which by its own admission, survives in *Putria*, is revealed as something that is present, in a greater or lesser degree. Thus *Milduria* is

> institutional to a degree - what do you expect when you have two staff looking after 10 patients?

This no-nonsense attitude then dismisses promises or betrayals with the observation that

> normalization - is just a word - our job is to keep their bums clean and their bellies full

Keeping "their bums clean and their bellies full" is a statement of nursing work that is in deliberate contrast to the abstract notion of normalization, of following routines established at home. It is also an overstatement. In the phrase "institutional to a degree", the word "degree" is a leeway. Whether as a professional or as a 'bum-wiper', the issue that confronts these nurses is the extent to which they can offer choices to patients in *Milduria*. When staff talk about the problems worn-out bedroom locks pose for patients who want time to themselves, it is clear that *Milduria* has indeed stepped some distance away from the traditional asylum model. They may not be practising the ideal of normalization, but they have certainly not retreated to the

custodial model as they claim. If that were the case, the following statement would not be possible:

> I thought that the rules I was trained with were the rules, 30 years later I don't have much time for them

As we saw in *Putria*, such a statement is not possible:

> we can't just open that door and say "well you can go there in your room..."

Instead, this 'no-nonsense' attitude takes into account the needs of bellies, bums and minds against the silliness and stupidity of tables, toilets, the inability to supervise and the need to be able to immediately intervene. It crosses the experience of work, against those who have the luxury to philosophise about normal appearances, to ask:

> is it a hospital first or is it a home or is it?… they're trying to incorporate everything and sometimes it doesn't work

The story of the "backwards trousers" answers the question of what *Milduria* "is":

> Sally: sometimes he takes off his clothes and we're just letting you know in case he does it
>
> Louise: the backwards trousers!
>
> Sally: people get used to what they see

That is, ordinary people understand the necessity for the 'backwards trousers'. They admitted their loved one because

> "I want my relative to come into a hospital not a hotel" [p] isn't that normalization, I want the hospital to look like a hospital

Normality is created through an engagement in care, rather than being built by design. As an engagement in care, though, the encounter above shows there is still pressure to

‘normalize’ care through expectations according to the idea of ‘hospital’. The ‘backwards trousers’ is a novel salvation of appearances, but stops shy of engaging with the experience of patients themselves, and approaching the matter from their perspective. I need to digress a little, to make this point clearer.

What I am arguing here is that the pleasure in things for their own sake is a right that is extended to ‘with it’ patients, who can ‘appreciate things’ in a conventional fashion. It is not extended to ‘not with it’ patients:

> they’ll rake... but they won’t do it as a job to make it nice and neat

Raking for pleasure is not a ‘job’. The pleasure that ‘not with it’ people have in things or actions for their own sake is a nuisance or a risk. In *Putria*, starkness was advocated because it reduced risk and ambiguity. It must be a general view, not confined to nurses, because most places housing such people are kept bare. That is the case in *Milduria*’s low-functioning ward:

> it’s a waste, absolute waste. I look at that land out there, and a number of things it could be used for, could set up all sorts of sensory awareness experiences

‘Not with it’ patients may rake, understandably producing a mess, but it remains a mystery why bureaucracy stereotypically produces its own mess. ‘Not with it’ patients may violate the banality of mundane objects, but the shadowy work of distant authorities violates banality itself, with absurdities. Adapting to the stupid works that experts produce and bureaucrats foster tends to dampen any desire to engage authentically with the world that people with dementia experience. The relation between ‘function’ and what is practical is difficult enough; it goes without saying that for an employee to introduce aesthetics is unthinkable. Nurses, just like most people, understand that this is how the world operates. They translate what they can.

They understand that hospitals are intended to be mercilessly practical places rather than places to reflect upon mortality (Willis, 1999).

Yet isn't the warmth of aesthetics what the dream in *Putria* and *Tempuria* is really about? Wasn't *Milduria* supposed to remember, to keep the inherent aesthetics of normality alive?

> see them dancing around the bonfire...
>
> Keeping time,
>
> Keeping the rhythm in their dancing
>
> As in their living in the living seasons (T.S. Eliot, *East Coker*)

Summing up

Whatever this experience of the built environment while working is, whether it is 'backwards trousers', or keeping things out of reach, or putting flowers on tables, it is not solely care nor problem-solving, nor even carefulness about propriety. It is not a concern with being institutionalized or normalized. This is the case even in *Putria*, where if we listen carefully to the claims made about being institutionalized: it is offering an asylum from the inhospitable society that has created it and maintains it. In *Milduria*, the Contracture, the idyllic and the dark tales about normalization, progressively loosen the influence of stereotypical views held by designers and procurers of the 'vocabulary of motives' that is inherited by nurses over the pragmatic aspects of nursing work. There what was said came to a head in the impromptu interview. It tended towards a coherence born out of solidarity rather than functions:

> in any area you got to have a good team effort there [p] [and] things, they just fall into patterns

The effort, rather than the operational patterns with their ‘vocabulary of motives’, is the elusive tantalizing point. Beneath the vocabulary of motives that operates these places, or rather the politics of motives, effort is something that is personally demanding. In *Putria* a nurse remarked:

> You just don’t want to put... effort into a place like that, it’s a dump

But listen carefully, because she does put an effort into it:

> I probably do try that bit hard [sic] to make it a bit easier for them because of the lack in the surroundings

They all do. In *Tempuria*, the nurses

> got together and said “what do we want to make it?”

In Milduria nurses raised money and purchased pavers to end the mess of the neglected courtyards. They volunteered to lay them in an attempt to make *Milduria* beautiful. They were prevented by the Occupational Health and Safety concerns of the *Milduria* Beautification Committee. ‘Effort’ is not solely the work of directly doing something, but also points towards the motivation needed to combat bureaucratic inertia.

In *Milduria* nurses have witnessed the reality of what was dreamed about in *Putria* and *Tempuria*. Their sense of betrayal has led them to the view that it is not technological mastery over nature that is required, but rather a mastery over our efforts:

> a building is only as good as the people that work in it in all areas

What is meant by a "good" effort is not restricted to the immediate work at hand:

> you can't go fifteen years without maintaining the building you know, in your own house you have to maintain it

A good effort requires a broader imagination than only thinking about buildings:

> when you're talking about buildings and structures… there is a lot of people who would be able to keep a relative at home if they had the facilities available to them

Mills (1983) argues that people sense their private lives are a "series of traps" and, sunk in their milieux, they are "seldom aware of the intricate connection between the patterns of their own lives and the course… of the societies in which they live (1983:1-2). Forty years later, Bent (1999) applies a similar view to nursing:

> A view of the environment as a person's immediate circumstances… keeps nurses from examining relationships of social, political, economic, and cultural conditions that influence health and illness. (Bent, 1999)

In *Milduria*, in their backstage talk, nurses bring these intricate connections to explicit consciousness. Their experience of the Contracture becomes a historical awareness. Nurses use its dramatic compression of events to illustrate that a building is a product of social and historical forces. As these forces fail the promises of philosophy in *Milduria*, we can also sense their presence concealed in what was said about *Putria* and *Tempuria*. In all of these places, nurses have no choice but to adapt to circumstances as they are. As typical nurses rather than as free citizens of the polis, they have no authority other than that conferred by the nursing role they are employed to perform. These three locales may differ in age, type of patient, and even in what is said about them, but the forces surrounding them are the same.

The presenting problem of the building in psychogeriatric care started out as the problem of how to care for radically different patients. In *Putria* we have seen the solution stated as a design problem:

> you have two different units… [an] independent unit and a non-independent unit

We have learnt from *Milduria* that design is not a solution we can have any faith in, and that pleasure is banished unless it is practical. We found in *Tempuria* a statement of an inalienable right, a cherished value, that everyone be actively involved in creating their environment.

The deeper problem of working and dwelling in these places is that its conditions of practice are determined by historical, social and economic forces beyond its influence. In other words, the solution - finding something 'good' - does not lie in practice itself. It lies outside. That brings us to the hurdle of consciousness between personal unease and the public issues it relates to. There is no magic invocation with which to wave this problem away. I remarked above that I was puzzled by the air of gloom I sensed in *Milduria* in contrast to the unfounded optimism in *Putria* and *Tempuria*. If I have listened well enough to the play in what was said, this air of gloom arises from a deep sense of unfairness that is also present, but obscured by optimism, in *Putria* and *Tempuria*. The wreckage of these places reveals them as backwards, rejected and despised by society. However, the ministering angels of care working in them have eyes that see more than they can say. Perhaps these words of the German philosopher Walter Benjamin (Buck-Morss, 1989:95) may say what they see:

> A Klee painting named 'Angelus Novus' shows an angel looking as though he is about to move away from something he is fixedly contemplating. His eyes are staring, his

mouth is open, his wings are spread. This is how one pictures the angel of history. His face is turned toward the past. Where we perceive a chain of events, he sees one single catastrophe which keeps piling wreckage and hurls it in front of his feet. The angel would like to stay, awaken the dead, and make whole what has been smashed. But a storm is blowing in from Paradise; it has got caught in his wings with such a violence that the angel can no longer close them. The storm irresistibly propels him into the future to which his back is turned, while the pile of debris before him grows skyward. This storm is what we call progress.

Chapter 5: Conclusion

How the question evolved through this work

The question asked in the research interviews, “What do you think about this place as you are working?” did not know what it would find. At first, research uncovered the unique biography of each place, its history and its people. Then it came to find hopes for the future, and disappointment when the promises for the future were betrayed. It discovered a value, largely hidden in background expectations: that everyone should have the right to be actively involved in creating their environment. Facts and values collided. To draw this out, the question came to ask of the data “What is at play in what nurses say about the built environment”? Here, as we come to the end of this study, it broadens to ask more generally, “What is at play in what we say?”

What is at play in what we say is not just the phenomena of differing points of view by individuals or from within particular disciplines (Gubrium & Holstein, 1990). What is at play is also what is at stake in our participation with each other and with society. In this very real game, we tend to categorize the strengths and weaknesses of all sides. We are tempted to seek explanations in terms of power, status, economics, disciplinary orientation, historical traditions and novel technologies. We invent concepts to describe what we see. We talk of being ‘institutionalized’ as we may call the ordinary rationales workers use an ‘institutional vocabulary of motives’, we identify society itself as sick and call that ‘social iatrogenesis’. Popular terms jostle alongside their more obscure forbearers. All too often the debate then becomes one in which we argue over the definition of terms, rather than with them (Mills, 1983).

What becomes lost in the fascination with composing water-tight explanations is something rather simple. Here it is, as it was said, during an interview:

> I thought that the rules I was trained with were the rules, 30 years later I don't have much time for them, the rules

A colleague wrote to me, reflecting on a draft of the discussion chapter I had sent him. He wrote that at first he had trouble understanding it until

> I re-read the introduction, 'what is at play'… etc.

Then he reflected not on the hypnotic insistence of routines, but on the promises of 'new units':

> I think our human reliance on external solutions to mediate the problems we encounter from day to day, within our profession, is a cop out… do we all reflect our powerlessness for persuasion and compromise or our abilities to invoke change because what we're left with has always been a preconceived notion that we actually have no say regardless?

It is the play that is the thing - our play. The preconditions, the rules, the attributes and factors are all important material, but the challenge lies in what we say. It is very much a challenge and not only because it is difficult to say how we should rise up to confront our circumstances. It is certainly not easy to think in the way my colleague wrote above. Beyond this though, lies the challenge to follow this thinking through. We have an uncanny, fiendish ability to draw ourselves up one minute, and then to collapse the next. My colleague concluded:

> This was more of a whinge than a critique.

"More of a whinge" devalues and disqualifies what he wrote, according to some preconceived and inhibitory idea of a 'critique'. It demonstrates what Jaggar (1989) called 'outlaw emotion'. As a 'whinge' it disqualifies itself by implying that it is an

emotional regression to some earlier, more primitive, childlike form of thought. Perhaps it is – and even as such, it has value. For instance, Koestler (1967) describes ‘paedomorphisis’, a regression back to earlier forms in nature, as a ‘drawing back to leap’, an evolutionary episode that overcomes environmental obstacles for the organism. Against the idea of a ‘critique’ as something that appears rational, objective and progressive, a whinge, or paedomorphisis, seems an unjustifiable invitation to lose all the benefits of rationality. So the challenge of putting our thoughts into play is to keep playing, without defeating ourselves.

The resoluteness needed to keep playing without defeating ourselves is to make more of the whinge, to bring the whinge closer towards the political action it implies. Viewed this way, a ‘critique’ recedes into more or less satisfactory explanations of how things are. It can explain how the world is divided into those who are ‘with it’ and those who are ‘not with it’, or into the ‘haves’ and the ‘have nots’, but it cannot step beyond explanation to take up a cause. The moment it does so, it becomes partial, it enters the territory of the whinge or, to give it a stronger and more familiar name, the polemic.

A colleague pointed out that polemics only take those who are willing to go with it, the converted. The implication is that the non-polemical, such as a judicious critique, will persuade a broader range of people to accept what is being argued. It is a tricky argument, because at first glance it appears to make sense. We like to think we are sensible people to be persuaded by rational arguments rather than emotions. However, it is not true. Kuhn (1970) makes it clear that scientists cling to theories even when they do not explain the facts. Gould, for instance, amusingly suggests that scientists

working in the so-called ‘soft’ sciences “search for simplifying laws” because they suffer from “physics envy” (1984:262). The issues that turn out to be at stake in this study are not facts, but values. The whinge originates from a scatter of frustrations, a sense of unfairness that momentarily comes into our conversations and debunks what passes for rationality in our times. As it strengthens and becomes polemical, it may or may not persuade others to doubt their theories or attitudes. It may though, hopefully, fan our individual desire to creatively participate in making the world. It may give us the resolve and defiance to withstand the inhibitions we have inherited from our society that censor our thought and expression (Newmann, 1994).

The polemic alone is not enough since it can lead to a sense that somehow, behind facts and values, there is a complete, perfect explanation as well as a way of being. The idea that we have ‘arrived’ at some solution is tempting: we always seek to solve problems. We must always look back over our shoulders. It is the idea that the current arrangements can be perfected with a touch of tinkering policy that has produced the situation we find ourselves in. In their time, what we now call the traditional institutions were the pinnacle of reason and science. As Rothman (1971) demonstrated, under the leadership of the Psychiatrist and the Matron, and with the skills of the Architect, there was no problem that rational authorities could not cure. The benevolent institution was in charge, a community of agreement, and the unruly barbaric past was ruled off. Is it so different in our time? We have teams of experts, declarations of best practice, outcome measures, and we have ruled off the past. Will this unease, its emergent polemic, lead to another ruling off of the past, another grand and perfect scheme?

This has taken us far from the concrete origins of the question. The question has reversed itself: rather than examining how the built environment is used, it has a tension that insists on turning to look at what society builds. Now I will look at how this tension emerged from the data and then from the literature.

Learning from the data

There are many schemes for analysing data, and many authors recommend being flexible with analytic schemes. Perhaps I may have read this advice in the methodological literature, perhaps not: “Know your data!” When I began interviewing, the method I had in mind for analysis was the grounded theory method. I intended to categorize the data, explore its dimensions, place categories in relation, and find at the very root a simple explanation. Dutifully, from the very first interview, I set out to code. The results meant nothing to me. I tried using ‘in-vivo’ codes drawn from the participants’ words, which resulted in an enormous number of categories. I then tried fitting the data into a typology of architectural criticisms, such as idealistic, functional and emotive. Again, the results meant nothing to me.

In a state of frustration, by chance I encountered three former colleagues and began an ‘off-the-cuff’ interview simply by telling them what I felt, namely that the nurses in the ancient unit *Putria* were surprisingly optimistic, while those in the modern unit seemed pessimistic. The resultant group interview was, in retrospect, the climactic interview. The content of it contributed enormously to interpretation but also showed that I knew my data: I had practically memorized the interviews. I could replay them backwards and forwards, from statement to statement, comparing them, contrasting

them, playing with their nuances in my mind. I also learnt from this climactic interview that by letting myself go, the participants let themselves go too. Their anger, their flagrant metaphors and polemics, led me to realise my own anger and tendency to polemic. This attitude did not fit with the idea of dispassionate coding.

The passions raised in this interview pressured me to realise I had duped myself. It was unavoidable that in adopting the initial theoretical perspective of symbolic interactionism and the grounded theory method, I would have to begin from naivety. The theoretical perspective was little more than a "vague stereotype", and the method "only a device for ordering or arranging empirical instances" (Blumer, 1969:151). Thus I partially abandoned the grounded theory technique as I understood it according to Glaser and Strauss (1967), but retained the idea of remaining 'grounded', close to the data. It was a valuable corrective since, at the time, I was also ranging both widely and wildly through the psychological, sociological, architectural and any other literature that could help me make sense of things. The danger of this lay in prematurely using some other scheme to fit the data into, instead of facing the difficulty of bringing theoretical concepts into a "close and self-correcting relation with its empirical world" (Blumer, 1969:151). For some years I had, in effect, two separate sets of data: the interviews and the literature. It only gradually dawned on me that just as I could treat the interviews as a whole set of ideas to play with, so too could I treat the literature.

Participants in the climactic interview accused anonymous authorities of being self-serving. The heat with which these accusations were made demanded an edgy response. I consciously turned to what Grbich (1999) calls a radical orientation.

‘Radical’ for me meant restless, questioning at every turn: “Who or what does ‘it’ (whatever it may be), serve?” I looked outside the climactic interview to see if these issues were raised elsewhere. I only found fragmentary instances. It was these fragments that made me look at the data differently. They contrasted with the majority of the data, with what was easily said. Mills (1959) says that trapped within our own milieux, we find it difficult to relate to the wider surrounding context. Gadamer (1982) suggests that, although our interests tend to be implicit in our consciousness, they can be called to consciousness. I was too slow off the mark to apply this insight, and, in any case, I was not experienced enough as an interviewer to sail into deep waters. Writing is my forte, not speech. The problem became how to examine these fragments of what is only partially said. Gestalt theory offered a hint. In the context of Gestalt therapy, Polster (1974) advises ‘playing’ with resistance to make it talk. Winnicott’s (1971) theories and notes about valuing play in itself, for its own sake, also helped to sustain the idea that the wild polemical metaphors in the climactic interview were an invitation to do so.

At first these analyses were very tame, and did not lead beyond their immediate subject. In the Discussion, the themes of becoming a typical nurse, the sense of unfairness, the right to create, originated from an analysis that stayed close to the data. All the time though, the polemic was insistently querying: who does this serve? The discussion had settled down, the themes were all in place, the analysis revealed a group of people who were limited at every turn and who, with some grumbling, accepted their lot. It was a complete, technical explanation or description that would tell nurses absolutely nothing they didn’t already know, in words they would never use. Then, using a pretext, my country invaded Iraq in 2003. Our prime minister

dismissed the most massive demonstrations by an outraged citizenry as the actions of a ‘mob’. Wasn’t there something of the same, between the self-serving arrogance of corporate rulers and their puppet governments, each with their imperious bureaucrats, administrators, architects and obedient experts? Isn’t there something similar in the situation of nurses, outraged citizens, or innocent Iraqi civilians - whose voice is ignored and who are eventually disposed of when they are in the way?

Gadamer (1982) writes that hermeneutics is a ‘miniature’ of a ‘successful’ discussion. The participants come to share common views and part from each other as changed individuals. What possible change can result from offering a more or less technically correct explanation? The common view that results from such an explanation is nothing more than our pre-existing background assumptions, lay terms dressed up in technical language. The war of aggression in Iraq and the denial by the Australian Government to acknowledge the protests of Australian citizens forced me to realise that it was vital to try and extend the analysis from the workplace through to the issues of world history. It was not a question of technique, of methods, or even some ideal of playing for its own sake, but a philosophical necessity to follow the polemic, as well as the concepts used in ordinary talk, right through to their extreme forms. I was not alone; I stepped into the vast literature that resolutely questions appearances, with readings from Barthes (1997) and Bachelard (1997). Perhaps I would not be able to make any sense of it all in my mind, but bringing what I found into discussion would be a start.

Through chaotic association I began a pursuit of the miniature. I played with the ordinary explanations and fragments of unease, wrestling them out of their context

and putting them on a timeless and universal stage. I saw them as a drama played out in everyday life (Goffman, 1971). It became a pleasure in itself to unfix these words, to put them in the spotlight and see the vast shadows behind them. I heard words, listened to and was haunted by them - and came to 'see' them. Take the idea of 'becoming typical' and its immediate referent of being institutionalized. I threw out whatever focused on nurses themselves, whatever pinned them down to the rigidity of a role. I looked at the typical material attributes of the institution. One of the most commonly found features is chairs arranged in rows along the wall. Somner (1969) characterises this as a 'sociofugal' arrangement, because it makes it hard for people to talk to each other. Who is responsible for the arrangement of chairs? I looked at the relationships within the institution, and then at the institution's relationship to the outside. Goffman (1961) describes how 'total' institutions have walls, how they are a separate world. What difference is there between the arrangement of chairs, and the arrangement of walls? Sociofugality, along with many of the phenomena I have discussed, such as *Schadenfreude* and repressive desublimation, does not arise solely from within the milieux. Rearranging chairs and tables inside does not solve a problem that originates elsewhere. Naming these phenomena with abstract words does not turn them into abstract factors: they are something done by people.

Certainly, we could identify the anonymous authorities we typically blame for our circumstances, the bureaucrats, politicians, administrators, interior decorators and architects, and drag them all the long way back to the institutions they have so successfully distanced themselves from. Yet, what would be the point? They have inherited our same social structures, even though they may profit more from them (Friere, 1972). Whatever role anonymous authorities may play derives from traditions

that precede them. These did not emerge miraculously but, as Foucault remarked, through the “hazardous play of dominations” (Rabinow, 1984: 83).

Of this descent, Ortega y Gasset says that we are living in a society that is based on a society that is already false (Crotty, 1998). Baudrillard (1997) talks of society as being a simulacrum: a copy without an original. Language is similar to society. It falsely presents its meanings as if they were fixed and natural, hiding its layers upon layers of metaphorical chains and historical origins (Barthes, 1972). It guides us, prohibiting some thoughts while allowing others, building deep bastions in our subconscious (Kracuer, 1997). Words lose their earlier, primal meaning (Heidegger, 1972).

Even thought itself displays a history. Adorno (1997) writes of the demand for thought to be immediately practical so that it breaks off before it can reach a conceptual dialectical level (which in plain language means, it breaks off before it can start to seriously question itself). Marcuse (1968) explains that with our technological mastery we think we have arrived at the end of history. We are generally confident that everything can be solved through technology and rationality and so the universe of discourse has closed. Society acquiesces rather than doubts this scheme of things. As a result both language and thinking turn out to be ‘one-dimensional’. Mills (1983) arrives at a similar conclusion through a different route. Individuals feel trapped within their milieux and feel they are passive spectators, unable to exert any influence on world affairs. Blaming anonymous authorities is a step towards overcoming social acquiescence and individual indifference, but if it is taken as only a momentary

reaction, or a mere stylistic rebellion, it is futile. How can we talk about and do something about this vast sea of troubles?

Friere (1972) advocates ‘conscientization’, whereby people come together to talk of their oppression. Their purpose is to name oppression in their own words. Gadamer (1982) talks of ‘hermeneutics’, an interpretation that seeks to understand what is implicit to our interests, so they can be understood by others. Both lead to comparing what is said in one context with what is said in another, of questioning appearances using not only facts, but values. Our background assumptions, the ground we stand on, are drawn into comparisons, and so thrown into question. These are not techniques, but attitudes. I found that restlessly comparing the fragments of unease between each locale led towards the rough identification of phenomena such as *Schadenfreude*, repressive desublimation and the frustration of promises betrayed and opportunities denied. Comparing these abstractions led to an understanding that, deep beneath the obvious differences of clientele and local history, people working in these places faced fundamentally similar problems. This poses a question: if three superficially different places turn out to be similar, are they really all that different from society in general? Or, drawing on Vygotsky (1927), are these places only instances along a whole continuum of pathological locales that constitute society?

Just as I unfixed what was said from its immediate meaning and tried to ‘see’ it in terms of possibilities of meanings, so I began to ‘unfix’ the idea of these places being psychiatric wards and to ‘see’ them as a manifestation of society. I had not foreseen that I would come to a point at which I was no longer interpreting the data, but was starting to toy with the implications of their interpretation. Or to put it another way,

the interpretations I had made no longer needed to refer back to the data, but to that immense memory of doubt called the ‘critical literature’. Rather than puzzling over how my colleagues thought about these places during the course of their work, I was starting to wonder what they would make of this unfamiliar literature in relation to their circumstances. Had I come to the end of the question I set out to answer, and was I opening up another?

Working with the literature

There are two literatures. One constitutes the P-E fit canon. The other is the critical literature. The naivety of the P-E fit canon was exposed in Chapter One. It is of interest here only as a part of the more general phenomenon. This is the widespread tendency towards organization and management based on technical criteria, on the assumption that this is fundamentally rational. It would be an interesting exercise to study the characteristic features of the P-E fit canon, much in the same way as students are taught to interpret statistics. Offhand, the indications that something belongs to the P-E fit canon are the following:

- The use of the word ‘impact’ in the heading or sub-heading
- Its appearance in a peer-reviewed journal
- The recommendation that more research is needed
- Multiple authors with post-graduate qualifications

Of course, it should be an exercise undertaken purely for pleasure. As long as the P-E fit canon remains naïve, it is easy to demolish. A sophisticated canon, on the other hand, is an unknown quantity.

Conclusion

The critical literature is not a canon. It is a vast fugue, ranging from intensely theoretical writers such as Adorno to letters by ordinary workers that question the way things are. It de-sanitises critique and only deals with convention on its own terms. It questions and interprets the world by inverting and combining its parts in unexpected ways. It includes poetry, plays, novels - or is included by them. Listen to the opening of an Italian poem titled *E lasciatemi divertire*[3]. It must be read with a touch of brogue emphasising the r's:

E LASCIATEMI DIVERTIRE

Tri tri tri,

fru fru fru,

ihu ihu ihu,

uhi uhi uhi!

Il poeta si diverte,

pazzamente,

smisuratamente!

Non lo state a insolentire,

[3] My translation of this is *Hey, let me have fun.* Pronounce the title with a lot of froth and lusciousness as *Ey, lush-charter-me dee-vert-earer*.

lasciatelo divertire

poveretto,

queste piccole corbellerie

sono il suo diletto… (Palazzeschi, 1910)

In the second verse, Palazzeschi is saying the poet is amusing himself, madly – he is out of control! But don't you stand about insulting him, let him have fun, poor soul, these little tricks are his delight.

Do not dismiss this as irrelevant. Palazzeschi is mocking the idea of language as the serious servant of technology that thinks of itself as progress, with its professors guarding every gate, watching you. "Tri-tri-tri" is life itself, refusing to obey the accredited rationale. Listen how close this poem is to this real life (that is what the critical literature does); it bubbles with laughter. Hear its echoes in one of those open communal bathrooms typical of institutions, as a patient joins in my attempt to teach a colleague how to say 'fart' in Italian:

Colleague: 'sko-reg-ee-o'

NL: No, you've got to emphasise the rrrr, to give it a flourish, 'sko-rrreJo!'

Patient: Ma questo non e bene. Si dice, io farti, tu farti, noi fartiamo (but this is not right. One says, I fart, you fart, we fart).

NL: *(to patient)* You should be the one teaching him Italian

Patient: Questi cosi non mi importa. Adesso solo vuole vivere (these things

are not important to me. Now I only want to be living)

Similarly, the French critical theorist Bataille (2006) often reversed and played with images of the sun in works that set out to dethrone what passes for reason. Rather than the sun radiating light, and by implication rational enlightenment, his images suggest it excretes light. The result is a pornography that offends - and yet, it comes close to understanding something we ordinarily do not understand. One day, a patient sitting on the toilet looked up at me and said:

> My wee slipped down the light-globe, darling.

It is Bataille's attitude, rather than that of the professors guarding the door, that bathes such statements in an uncommon light of understanding.

Marcuse (1968) called for the 'Great Refusal' of the one-dimensional rationality that makes us less human. Foucault may have been making this statement more pointed, declaring our task to be to "separate out, from the contingency that has made us… the possibility of no longer being… what we are" (1984:42). Their more serious words are not so remote from the seriousness we find buried in anonymous letters to industrial journals. In their freedom of expression, these letters are equivalent to the 'backstage talk' (Goffman, 1971) of colleagues speaking freely to each other when they sense they are amongst themselves. In a recent issue of the *Australian Nursing Journal*, a letter writer asked:

> we can no longer be who we are - nurses… why are we not trusted? (Anon, 2007:3)

while another wrote of

> the plight of residents in this well-appointed colour coordinated facility… abandoned in this meaningless maze… what are we doing? (Anon, 2007:3)

Without the critical literature, the immediate problems of diminishing risk and providing autonomy would have dominated the analysis. The result would have been some sort of theory to account for and predict behaviour. In the light of the critical literature, this would have short-circuited thinking with premature generalizations. The questions of ‘who are we’ and ‘what are we doing’ would have been answered in terms of roles and techniques, without any sense of the something amiss in our living that gave rise to them. The critical literature admits to shit and piss, as well as pleasure.

In rethinking issues and posing challenges, the critical literature encourages us to extend the historical and conceptual reach of our thinking beyond the conventional boundaries of abstraction found in those studies that identify ‘factors’ on the basis of what is immediately apparent. Coulson (1993), for example, takes the immediate context of nursing homes and hostels to be the ‘Total Environment’ (Goffman, in the light of his work on ‘total institutions’, would be amused). She then sets about trying to measure and correlate environment with behaviour. In a similar fashion, we could regard the nurses quoted above as ‘users’ who fulfil certain criteria and carry out particular functions. Whatever they say or think is essentially irrelevant. In the scheme of things ushered in by the concept of ‘users’, what is important is the efficiency with they carry out their duties. It is an importance that is identified and measured by those who claim the right to do so on the basis of their position in the hierarchy. For them, abstraction has completed its job, and the result is a bureaucratic system, a machine. ‘Users’ are then deprived of a target. As someone remarked,

during a workshop on Frierian methods (*Kothitanga O Nga Whakaaro,* 1987), in a bureaucracy "there's people acting upon you and there's no way of acting back". Unlike the conventional abstractions described above, critical abstraction is not an end in itself, it is as much a tactic as taking a polemical attitude is. For pinning down the target, the historical, philosophical, sociological, psychological, poetical and polemical critique offered by the literature is indispensable. What it offers is also extraordinary in another way: eventually, it brings us back. When we come back to reconsider our situation, we no longer think of it in the same way as we did before. We are not as bound to conventions and assumptions as we were before. What appeared to be unchangeable, is no longer so. The situation is revealed as a political, social and personal challenge.

It is not easy literature to read. By challenging convention and assumptions, by reaching back into history and even by its having been written in earlier times, in foreign places and in other languages, it is difficult, puzzling. It is hard to live with the uncertainty it creates. Using it is not a technical exercise. Critical writers warn their work is to not to be used as a set of rules, but as an aid to reflection (Gadamer, 1982). Even those who describe a particular method of inquiry stress that it should be used creatively rather than to embrace immediate 'juicy' concepts (Glasser, 1998). Reading this literature takes time, and repetition, and demands growing familiarity. Bachelard writes that in the first reading of phenomenological works (works that attempt to convey the essence of personal experience), the reader is passive like "a child who is entertained by reading" (1997:96). He continues: "After the sketchiness of the first reading comes the creative work of reading … the second, then the third reading… give us, little by little, the solution to [the] problem." It is also one that sets

a trap: it demands a phenomenological attitude in the sense of patience and growing familiarity with the theoretical debates that the work relates to. However, the critical literature is also conceptual, abstract. Here I return to a caution that I overlooked at the beginning of this study: many of the concepts I have used should not be taken to be definitive, but rather to be sensitizing. Blumer (1969) explains that most of our concepts are social in nature; they are guides suggesting how we should look at our every-day experience rather than definitive, and that operationalizing them in social science is an error and misses the certain characteristics of our nature. First, "we seem forced to reach what is common by accepting and using what is distinctive to the given empirical instance" and then "[o]ne moves out from the concept to the concrete distinctiveness of the instance instead of embracing the instance in the abstract framework of the concept" (ibid.:148-149).

Blumer and Bachelard are authors who stand worlds apart: there is little common ground between American and European social theorists. Yet they similarly suggest: dwelling on the event, using ideas to think more deeply about an event, thinking of it not as an abstraction but as an engagement through "careful and imaginative study of the stubborn world to which such concepts are addressed" (Blumer, 1969:150). Let me put this in my own experience, as I came to understand it. I came to learn an unwritten lesson: you must come to love your literature.

When you develop an approval of a text, its "aha!" quotes and earth-shattering ideas, that is only the start of a romantic encounter, of eyes meeting across a room, a reading that stretches into space. It is not just any text, it is 'the' text, for the moment. Falling in love with 'the' text, is a preparation for some companion text. A love, or passion

for companion texts is needed to sustain what Mills (1983) calls the sense of "significant problem". It demands the reading and rereading of the parts in between the "aha!" quotes, and demands the texts play upon each other without any immediate purpose. Just as in coming to know the data, some words and phrases leap out first, gradually other words and phrases that lay dormant come alive. What attracted you at first leads to discovering what is quietly said - and that is sometimes more meaningful. I found a limit here: I concentrated on trying to understand particular texts as well as I could, rather than trying to understand an author's whole output. The reader will notice that, with Mills and Gadamer, I focus mainly on two of their works, *The Sociological Imagination* (1983) and *Reason in the Age of Science* (1982) respectively. The danger of such concentration is that I have possibly interpreted these works naively.

There is another limit too. Silverman (2000) talks of 'narrowing down' a theory, of gaining a 'settled theoretical orientation'. This implies that some sort of logical process is at work of cutting away whatever is not essential, so that the analysis is clear. For explanatory and predictive purposes, this is not only inevitable but correct and necessary. Using widespread theories may be productive when first approaching a subject, but continuing to use a scattering of theories in its analysis is a form of opportunism: Whatever does not fit one theory, can be explained by using parts of another. The P-E fit canon often demonstrates this weakness. If behaviour cannot be correlated with the environment, the explanation is that some social factor must be a co-variable. If social factors do not explain morale, then the built environment or psychological factors must be variables. However, I became acutely aware of the danger of premature generalization of settling down too early to a theoretical

orientation. Adopting a theoretical orientation simply because it promises a maximum explanation for a specific range of data is also a form of opportunism. It censors the implications; it sets firm limits on the discussion. My purpose was to produce discussion, not theory. The limit I found was that I could not follow the ideas in the companion texts further. The desire to return to the pressing problems raised by what nurses had to say set its own frontier.

Vygotsky (1927) suggests an extremely powerful method of cross-examination. Distinguishing what is historically necessary from what is logically necessary, places any scientific investigation well and truly in the dock. Under such examination, unexpected truths will surely out. My admission, that I have come to over time, is that loving these companion texts is neither logically, or historically necessary; it is a personal necessity. They are texts that make me feel I have a chance of understanding the world and that make me want to share that understanding with others. I explained that at the beginning and throughout most if its duration, this inquiry was driven by a restless curiosity to know what my colleagues made of the state of affairs. As the discussion took shape, that curiosity was gradually resolved. What drove the inquiry onwards, yet made it difficult, was that I learnt from these texts that it was important to avoid giving a convincing explanation. The point of critique was not to aim for an explanation that would be taken as more or less truthful, but for statements that would provoke readers into taking up the issues.

Mills' (1983) blistering critiques of grand theory, abstracted empiricism and what he calls 'illiberal practicality' have arguably influenced the stream of social science research. Today, we read an increasing numbers of studies concerned with developing

mid-range or substantive theories. These tackle real-life issues that people encounter, and examine how they do things such as cope with particular health conditions. They are intended to be immediately useful in helping people manage. The problem I see with such studies is that, while they do well in explaining the immediate pressures and associated issues, they are restricted to what is immediate. They represent the start of a new tradition, perhaps, one that has its eyes strictly on the common sense we make of the present. The theories these studies produce are ripe material for commercial exploitation. The extent to which a study promises immediately useful results is most likely in direct proportion to the likelihood of it being approved, funded, published - and offering its author a career.

As a measure of this, many people are now familiar with the terms ‘grounded theory’ and ‘qualitative methods’. The hidden problem behind this trend is that, all too often, in addition to their vulnerability to commercial exploitation, they also provide those in authority with the means to window-dress a problem. As I have doubtless said a few times by now, Kitwood’s (1997) work on ‘dementia care mapping’ was the ideal material for a managerial fad. By giving the impression something was being done, it may even have worsened the fate of those abandoned in “meaningless mazes” (Anon, 2007:3). I now want to look at the art of impression management we call policy, and consider how this work stands in relation to it.

From policy to polemical practice

Does caprice indulge policy?

Sunk deep in our milieu, ‘policy’ is not part of our work. In the twenty interviews conducted, the word ‘policy’ itself occurred once. This was in the impromptu group interview in *Milduria*. It was so fleeting that I missed it in discussing the findings. Now though, after the discussion, these ordinary words become beautiful, revealing a flight of ideas. Let’s hear them again:

Louise: the days of hosing down people in the courtyard semi-naked are gone

Sally: they can’t be forced to [shower], you have to wait and bide your time

NL: did that change with the building?

Louise: it changed before

Geoff: it was a policy brought into play

Sally: people were allowed to be more responsible as well attitudes changed

So it was not building that ended those days. But does saying that policy was “brought into play” mean that ‘Policy’ alone was necessary and sufficient? It is ambiguous: did people allow themselves to be more responsible, did their attitudes change, or was this too a decision made by something called ‘Policy’? Against the distinctness of ‘Policy’, stands the vagueness of “people” whose “attitudes changed”. It indicates that ‘Policy’ did not, of course, do anything. Rather, ‘Policy’ was something that people - for whatever reasons - decided to adopt en masse. Did people tire of the idea of institutions, the century or more of traditions and authority that nobody dared

disobey? Was it caprice that people exercised, permitting themselves to be more responsible, permitting themselves to adopt ‘Policy’? Does caprice as an unnoticed and marginal background event render policy irrelevant at decisive moments, and then quietly withdraw leaving the impression that ‘Policy’ had been responsible for the decisiveness? That is not how Policy would see things.

Is policy King of the Sandpit?

It was the fashion for architects to talk of building as ‘the living envelope’. Perhaps appreciative of the idea that the architects’ design influences how the building is lived in, it is the fashion these days for Policymakers to talk of their Policy as a ‘living document’. The point is that we come to see Policy as if it were alive, as if it did things.

The nature of Policy insists that it has considered all the facts and the issues for us, and directs us to a resultant course of action we can take up with confidence. Figure 16 below depicting a policy titled the *Balanced Scorecard* (Hunter New England Health, 2006) illustrates this. Headed “Benefits and Purpose of Making Strategy Everyone’s Job”, the graphic displays a group of people beneath the labels “Strategic Business Units” and “Support Units” beside of a set of stairs. Their leader holds a briefcase in one hand and points upstairs with the other. Opposite, beneath the labels “Corporate” and “Individual”, a man dressed in suit and tie holds up a certificate of achievement. Arrows point up the stairs. The stairs end before what appears to be an elongated ice-cube with an eye looking out from its centre. Over the eye are the words “Corporate Vision”. At the foot of the stairs, one a person hesitates, gazing upward. That is You. The others are gazing not up the stairs, but at You. They expect that:

> After implementation of the Balanced Scorecard within your service, you will continue to be busy but you will be busy with the things that are of critical importance for us to achieve our mission (Hunter New England Health, 2006).

Figure 16 Corporate Vision (Hunter New England NSW Health, 2006)

Therefore, when we come to Policy, we should cast our doubts and prejudices aside and try to see things the way it does. We put aside our practices deep in our milieu, that we may be illuminated by the superiority of Policy. Then, departing as enlightened individuals, we return and change our practice. As we gaze upon the Eye, the stairs, and the people below, we gaze upon a congruence between the people and the architecture of their surroundings. Whatever would threaten this picture has been eliminated. The people who are a part of the picture, part of the whole, are those who have chosen to obey. Bataille may have had the Eye, the Ideal Omniscient Father holding the *Balanced Scorecard*, in mind when he wrote:

> In practice, only the ideal being of society, that which orders and prohibits with authority, expresses itself in what are architectural compositions… pitting the logic of majesty and authority against all the shady elements. (1997:21)

Is the utopian ideal self-emasculating?

The ‘shady elements’ are capricious, unruly and difficult to contain. Their very existence invites the existence of their opposite, of a majesty to be pitted against them. This majesty and authority over the disorderly elements of human nature is a heavenly ideal for those Bataille calls the ‘good people’ who are uncomfortable with a dirty world whose populace hose each other down semi-nude in public or else, judging the moment to be propitious, pounce on each other in private. Repelled by this grubbiness they “exile themselves, by way of antidote, in an amorphous world, where there is no longer anything terrible” (Bataille, 1997:22). Baudrillard takes up Bataille’s polemical baton, broadcasting the amorphousness and vegetativeness of these good people, when they murmur to each other in a world where there is no longer anything terrible, “What are you doing after the orgy?” (1997:220-221) Perhaps to make up for their lack of nerve, the good people offer their very souls without question, within their idealized workplaces. Their private desires are always available for servicing the mission given to them by Policy. Their positions in these idealised places need no

> private place to work. Standing and on the move, the staff effects a laid-back, flexible style… But seated in their cubicles… they strain to secrete an artificial solitude, to spin themselves a bubble (Baudrillard,1997:210).

Our society dreams and designs ideal places on a whiteboard, but leaves behind whatever does happen to get built, hastily moving on to the next project. If we watch those left behind, we sense in them a tension working inwards instead of outwards, an “implosive violence”(Baudrillard, 1997:216). The beautiful dream we may have had of what Willis (1997) described as an architecture facilitating a magic transfer of our desires into reality, seems foolish, untranslatable into whiteboard terminology.

Tempuria-Eternia is such a model of our society. In there, denied any opportunity to be backstage together, yet unable to escape company, the staff relieve the strain of working in a bubble through brief forays up to the shops. Their nostalgia for ‘those old places’ that ‘had something’ - the communal table, the decorative bowl - clings to the ideal of a purpose-built unit that will combine function and memory. Their desires are not unique. They are typical, universal.

Streim and Oslem (1997) saw the nursing home as the most productive laboratory for the problems of old age. Their view was too restrictive. The ultimate laboratory is in the “heartland of wealth and liberation” (Baudrillard, 1997:220). Here, among the villas of Santa Barbara, is born the idyllic consumerist lifestyle that sets the standard the rest of the world aspires to. This is the ultimate laboratory, the "laboratory of practical fiction" (Baudrillard, 1997:212). Here life has become a form of death, at home in “the tragedy of a utopian dream made reality" (Baudrillard, 1997:220). It is an orgy, a cure worse than any disease, a utopian antidote to the shady elements that can never burst the bubbles of an artificially induced solitude. From Baudrillard’s claim that “all dwellings have something of the grave about them” (1997:220) we can go further to say, with the poet, that

> The whole earth is our hospital
>
> Endowed by the ruined millionaire,
>
> Wherein, if we do well, we shall
>
> Die of the absolute paternal care
>
> That will not leave us, but prevents us everywhere. (T.S. Eliot, *East Coker*)

This new reality designed in the laboratory is a “simulacrum”, a “copy without an original”. Its authenticity is stolen from the past: "an order of simulacra is maintained only by the alibi of a preceding order" (Baudrillard, 1997:212). As every marketer knows, the strength of a convincing alibi or gesture outweighs the physical properties of any product. With the idea of simulacra, the very idea of building becomes obsolete. To confine our descriptions to what has actually been built and how people actually behave in there is to miss what is really going on. Electronic techniques and organization mean our society is no longer enclosed within the specific spaces of bricks and mortar. The disciplines of the past within their grubby walls of home, hospital, school or factory parlour have been replaced by societies of control that are a

> modulation throughout spaces… mechanisms of control in the community equal to the harshest of confinements. The factory was a body, the corporation is a gas (Deleuze, 1997:309).

Even the idea of a gas is too physical. Not only has architecture, the permanence of bricks and mortar, disappeared; so too has time itself. Space is no longer a matter of physical boundaries but of electronic surveillance, of perspectives without horizons. Time as a series of chronological events and a historical record is also no longer a matter of boundaries but has also become electronic, instantaneous, turned on, logged into, logged out of. It

> has no relation to any calendar of events nor to any collective memory. It is pure computer time, and as such helps construct a permanent presence, an unbounded, timeless intensity (Virilio, 1997:384).

The present has ‘taken off’ on its own autonomous course. Yet, something remains untamed.

Polemical power over policy

No matter how much Policy may demand our compliance, some days within *Tempuria-Eternia*, *Milduria* and *Putria*, there is still something shady. Some days, people “don’t have time for the rules”, some days they think it is “all so stupid”. Rather than “getting used to it”, some days they ask, “what do *we* want to make of it”? Policy in the permanent presence of the all-seeing Eye is there to guard us against those days when the ‘strong thought’ of reason is unhoused by ‘weak thought’. Weak thought is “an unnoticed and marginal background event... It is capable of enduring not because of its force... but because of its weakness" (Vattimo, 1997:159). I am only playing with the idea that caprice, that tired of things as they were and allowed things to change, is a momentary expression of weak thought. Caprice comes out of a persistent, background frustration, a momentary bubbling over of frustration with obedience and the artificial strain it imposes on our shady nature. Is it possible that weak thought is always quietly knowledgeable of all the loud and dramatic declamations by polemicists such as Bataille and Baudrillard, and simply bides its time?

This study cannot answer that question. However, we can observe that there is incisiveness in these polemics, a surgical exposure that carves up the evidence in a way that ordinary scholarship cannot. For instance, when Attoe allowed for a lay category of architectural critique, he had in mind the meek, deferential, uncertain critique ‘users’ might offer to some distant, all-powerful architect. These polemics overpower any tame categorizations. They are the actions of citizens speaking without fear of disqualification. When they speak in this polemical way, they move from description and explanation towards politics. Could this be the birth of a science, or a

philosophy? Is it a science that challenges our conception of Science? Blumer (1969) repeatedly warns of the temptation to adopt prescribed and circumscribed scientific protocols, of presenting 'fixed' and 'clearly structured' problems. He argues that the purpose of exploration is to move towards a clearer understanding of how one's problem is to be posed, and that the essence of inspection is "close shifting scrutiny". This close scrutiny is "flexible, imaginative, creative, and free to take new directions" (Blumer, 1969:39-44). Is this not just what happens when we decide to take up a polemic attitude? Then concepts are no longer definitive, but as Blumer and so many other theorists of qualitative methods are keen to say, they are 'sensitizing'.

From 'sensitizing' to radical linking

The sensitizing concept is an abstraction derived from the empirical social phenomena under study. As a scientific concept, it differs from common-sense concepts. Blumer points out that common-sense concepts are simply accepted as they are given or sensed, their abstraction is limited. In science, the concept is extended by abstraction and attempts are made to relate it to other concepts. Scientific concepts have a "career, changing their meaning from time to time…" (Blumer, 1969:163). In this talk of polemics, caprice and weak thought, there is a 'concept' that stands incomplete and poorly expressed against the definitiveness of Policy. This glimpse of weak thought did not emerge from some pre-existing schema but from being interested in what my colleagues typically thought - and yet, I had no notion of the shady, political beast out there that pounces without our even knowing it has done so. No imagination of a capricious force that could forestall, or else allow, Policy to think of itself as being in charge. For all its loudness and apparent impatience, polemics is not a shortcut, not a superficial irritable response. It is grounded in weak thought, in caprice, but it

becomes a vigorously expressed form of inspection that by its very provocativeness disturbs any notion of the context as it is generally accepted. It forces new and radical links with history and society that demand

> recognition of the fact that human beings in carrying on their collective life form very different kinds of worlds … [and therefore]… no theorizing, how ever ingenious, and no observance of scientific protocol, no matter how meticulous, are substitutes for developing a familiarity with what is actually going on in the sphere of life under study (Blumer, 1969:39).

The reason why Blumer (1969) reiterates warnings about adopting protocols and pre-existing ideas is that when we study human group life, we have a persistent tendency to avoid confronting the 'peculiar' difficulties involved in applying concepts to human conduct. We resort to conventional concepts. We can see policy as precisely that sort of concept that demands slavish adherence to its methods and, standing by its side to provide an apparently scientific justification, are those forms of social science that are similar to the P-E fit canon. As Chapter One illustrated, in the P-E fit canon cause leads to behaviour with no consideration for meaning. The problem that emerges when the P-E fit canon is allied with policy is that it suggests that anyone following similar methods is doing something called science. It then promises that this science will give answers that will be as useful as (typically) Newton's Laws of Motion. This fixity of ideas becomes authoritative, disqualifying anything to the contrary. Thus what appears to be social science, conducted in the authoritative manner of the natural sciences, quietly leaves the realm of Science. As we saw in Chapters Three and Four, it becomes a form of common sense ruled over by experts too distant to question.

This tendency occurs throughout history: the dominance of an idea until it is eventually overthrown. In our times, Blumer (1969) argues, we have not only inherited the uncritical application of science, but also an inhibition against any criticism of its promises or usages. Worse yet, instead of the breadth of understanding we should entertain towards the empirical social world, the notion of 'explanation' has become bound to the idea of a parsimonious, inherent formulae, similar to the laws of natural science. Blumer notes that many explanations of behaviour involve absurd 'compressions' of behaviour, such as the idea that society is driven by co-operative desires, or by conflict. In the nursing world, we see this in the assumption that nurses are 'task-centred' or, by implication, are so stupid they need policy to guide them. The search for laws that compress explanations of behaviour becomes an expectation that inhibits our ability to express to each other our complex motivations and understandings. It prepares us to become docile subjects for designers to enlist in the service of alien objectives, it prepares us to fit ourselves to the demand that we 'just get used to it'.

As fairly universal concerns, these notions of Blumer are expressed in other forms by many other authors. Gadamer more explicitly and directly addresses the relationship between what we take as theory and practice, and reminds us of a tradition that now seems alien. In the ancient schema of the Greeks, theory and practice stood in direct relation to each other, rather than being distinct. Yet, as Blumer points out, the Greeks "on the point of observing the world experimentally" lost their nerve and "relapsed into comfortable cogitation over the inherent forms of things" (1969:154). As a result, we have inherited a tradition descended "from ancient Greek philosophy and medieval scholasticism which favours the gaining of knowledge through elaboration of the

concept" (Blumer, 1969:168). Mills (1983) also points out the fatal tendencies of science to be seduced by concepts ('Grand Theory'), uncritical methods ('abstracted empiricism'), and the service such scientists perform for the established order (the 'bureaucratic ethos'). All three authors point out how the result is rationality without reason, and each in their own way points out the importance of choosing to think carefully. Here then, we turn once again to polemics.

If we seriously take Blumer's advice of refusing to follow protocols simply because they are in vogue, and try instead to become more familiar with the empirical world under study, if we try to pass from description to an analysis that admits it is on unfamiliar and peculiar territory, then the polemic attitude has more to offer science than the conventions of science. There is, of course, a judicious element to the polemic. Blumer expressed this judiciousness in relation to the concept, but we can imagine its use in preventing the polemic from becoming - like Policy has - totally convinced of its own truths. Blumer points out that concepts have a history of coercing judgment and determining how things are seen, and so we need "to safeguard ourselves by viewing concepts as hypothetical and by widening our experience in the field to which they apply" (1969:182). He argues that "definitive concepts provide prescriptions of what to see [whereas] sensitizing concepts merely suggest directions along which to look" (1969:148). The difficulty this distinction reveals consists of bringing concepts and accompanying theory into "a close and self-correcting relation with its empirical world" (1969:151).

Not laughing but singing

Adams (2007) reports that nurses typically laugh off their doubts about their experiences. ‘Laughing it off’ is a form of the same disavowal of their knowledge that Menzies-Lyth (1988) found in her classic study first published in 1959. Do we, in our ordinary words, just get used to it and ‘laugh it off’? Or can we gather a readiness and wiliness to progressively apply our unease to the political issues we face? We have seen interests emerge out of self-deprecatory fragments. Ordinary words now have implications for milieux, social structures, history, economics, politics, architecture and philosophy. Ordinary words have reached into the domain of the abstract. In this study we have not ‘laughed off’ our unease, and we have rejected our self-diagnosis of being ‘institutionalized’ as a mere symptom of an inhospitable society that flees from itself. We have done all of this by keeping our ordinary words, and bringing them forward out of their immediate context. There is a reciprocal motion at work in this: words from the literature, abstract words, have been made concrete. Now we find they mean much more than they did when first said. They are no longer background whispers or private whinges, but instead present us with a strong practical challenges and philosophical questions. There are two abstract words we need here.

‘Hegemony’ is the first. Used judiciously it is a ‘right’ word, in that it compresses the trouble of milieux and the resultant issue into a ‘thing’ or concept we can point at. We come to take our accomplishment and expectations of smooth functioning as if it were our main desire, we regard it as something “normal, natural, and in no need of explanation” (Newman, 1994:71). In doing so, we forget that it is what the *Balanced Scorecard*, in all of its historical guises, demands of us even before we were born. We also forget our most cherished value: the inalienable right to actively participate in

creating our environment. We are born and grow into the language, ideas and modes of behaviour that pervade society, but that serve the elite. This almost imperceptible invasion of our thought and being, of an inherited and imposed and seemingly natural order, is hegemony. Its exposure, and our refusal of it, requires a second word: dialectics.

I have used the terms ‘discussion’ and ‘polemic’ to refer to the work of expanding ordinary words, of challenging convention. They are familiar but not quite the right words. In a discussion, people talk comfortably with each other to the limits of their comfort. When people speak polemically, no matter how justified their outrage, they are always aware that they are outraged, and then reason follows. It points to a process that has a name that is ancient: dialectics. Beginning with disbelieving laughter, it found similarities and differences in the fragments beneath appearances. Rather than a lawful order, it found ‘interpenetrating problems’ (Friere, 1972), ideas from different worlds that would normally ‘talk past’ each other (Kuhn, 1970), and forced them into uncomfortable encounters. It confronted what appeared to be natural with its history. Where logic would not work, it used emotion. Where emotion would not work, it resorted to history, and where history would not work, it turned to the material facts of the present. It came to insist: no individual without society, no society without individuals - and neither without politics. If it found naïve realism, or abstract empiricism, or lofty idealism, it responded with vulgar materialism. It did not stop at ideas themselves, it played with expression, the very metaphors we take for granted and - to mangle two phrases of Goethe - sought to always make links, without haste, but without rest. All this is what was once called ‘dialectics’. It refers to the playing of opposites against each other. It pushes discussion beyond its boundaries to

the polemic, and pushes the polemic into discussion. Here it originated from sporadic comments that seemed at first sight to be inconsequential, trivial, mere clichés. Although we have inherited a long tradition of philosophy, in this study its restless motive and radical doubt was sustained not by the philosophy of Karl Marx or Hans-Georg Gadamer, or Blumer, or Marcuse, or Benjamin - but from a ditty I sing under my breath whenever I encounter Policy, or Design, or Science. It was sung by Groucho Marx:

> *"Whatever it is, I'm against it!"*

Ditties, even if they remind us of hegemony and dialectic, are not enough to counter the harm caused by policy. Perhaps the reader has already guessed what I am only just coming to see in this evolving contrast between polemics and policy: It is that polemics is the illegitimate sibling of policy. And so it has every right to know what it was that it, and policy, inherited. It has the right to know just how policy conducts itself in the company of its 'legitimate' kin. Blumer argues that the student of human group life should develop a

> rich and intimate familiarity with the kind of conduct that is being studied and in employing whatever relevant imagination observers may fortunately possess (1969:182)

Investigating the sort of relation the polemical would see policy having with those it serves means having some idea of what policymakers are like when they are 'backstage', in their natural habitat. To put it simply, to move polemics further towards emancipation requires taking the step of 'naming the enemy' (Newman, 1994). It is an old idea, stated by Gadamer, Habermas, Marcuse and Friere and, of course, many others. The difference is Newman's level of specificity. He recommends finding out the name, address and telephone numbers of those we could regard as 'the

enemy', but then his background is as an employee advocate in the field of industrial relations. Our targets are rarely as clear and, as Friere points out, the oppressors too are oppressed by the very concepts they use. However, we can, as an exercise, take up a policy-maker, and see what they do say when they are at ease amongst their fellows. Let us play with naming the enemy - kindly, judiciously, see them at play in their own empirical social world.

The principle author of the review of mental health units (Coomes and Coombes, 2005) discussed in Chapter One, will do as a form of Newman's (1994) 'enemy'. For this exercise, I take up his light-hearted report (Coombes, 2001) of a seminar and dinner held by his colleagues in the *Royal Australian and New Zealand College of Psychiatry*. As it is a short article, I will not give page references. Its jocular 'matey' tone replete with family photographs of attendees suggests the same sort of ease amongst colleagues that Goffman (1971) identified as characteristic of 'backstage talk'. It provides us with a window whereby we can see that type of person who is invited to the table of policy makers and architects, frolicking with their fellows.

The heading, "Looking Outwards: Psychiatry in Society" is a misnomer. What follows is not concerned with society at all but, as the reader may guess, with the Fellows. The article immediately heads in an upward direction by evoking a sense of the lofty heights above the world these Fellows occupy. The conference room was "suspended" in the Moreton Bay figs. Infantile ploys serve to give this boasting charm, as Coombes writes that "better than a cubby-house, we had tree-house". Perhaps embarrassed, remembering mother's injunctions that one must share, he makes the joke that it was "shared with… the irregular taps of the skate-boarders

below us". The joke is one of those that rely on the truth being the opposite of what was said. The truth is that the skate-boarders were irritating, their tap-taps became "more insistent", and finally, "intrusive". The educational component of the seminar was dispatched briskly. These "three-score Fellows" went "cantering" through "clinical work", a case presentation on a "mixed anxiety-depressive state". After morning tea they had a "lively romp" workshopping Almodovar's film *The Story of My Mother*, chasing "links between identity, gender, sexuality, having one or even getting one". Freud might take offence at this irreverent disregard for the Oedipus Complex, its shameless *Schadenfreude*. What is more offensive is the borrowing of the skateboarders' adolescent virility to invigorate these Fellows with the image of surfboarders collectively tossing themselves off a wave:

> There was a lot of chattering as we surged to the dining room overlooking Pitt Street where we were launched onto a bewilderingly varied choice of food.

"Society" is touched on in the after-lunch amusements, a debate as to whether psychiatrists should act as agents of social change. They have more immediate concerns: the "tap-tap-tAP-TAPS were getting more intrusive", and soon they would have to saunter over to the annual dinner. They would have to quit their tree-house. Like children after a day at the beach, tired and happy, they had a "refreshing day of great fun, learning and entertainment". One can imagine just how eminently reasonable a conclusion it is that these fine well-fed Fellows, tired from their efforts, decide to "hold back from social action just at present".

When we look at ourselves, we see how we remain sunk and bewildered in the walled-off secure back wards far below. The title of the seminar report is inane down

here. These psychiatrists are not “in” our Society. They are not “looking outwards”, nor even looking downwards. In their rush to latch upon the ample breasts lovingly offered to them, their eyes are closed, their mouths agape. They are ‘unweaned dependents’ (Mills, 1983) in their secure romper room. Their artificially refined cocoon may be an elevated tree house, but it is every bit as socio-fugal as any back ward in a lunatic asylum. Just like those people in the back wards, patients, nurses, orderlies - these fine Fellows are not set apart from Society. They are, on the contrary, an example of it - straining to secrete an artificial communality, spinning their bubble, affecting a laid-back attitude.

Yet they are not buried in the back wards, not self-defeating: the resources of the world are given to them to play with, to express opinions on. It is not hard to imagine those who commission and build ‘edifice complexes’ lunching with them as they decide what to build and what policies to write. Their lofty carelessness and absence of shame is an effortless decoy that snares our attention. Our attempts to castigate them for the inadequacies of their policies, their failure to describe and understand us, are merely the tap-tap-taps of distant skateboarders. The more seriously we try to make our criticisms, the more polemical and histrionic we become. Our efforts deflect our attention away from deepening our caprice, our ability to change our attitude to institutional continuity, to social structure, to science and economics. We have seen the ease and glimpsed the universal ease with which people reach for definitive routines and cling to images. The illegitimate aura that accompanies polemics does not stem from its being outrageously subjective or in poor taste - but rather because it challenges these widespread tendencies. There is something we dare not admit, a dark secret that not even Goffman’s (1971) characters would admit to backstage amongst

their fellows. Polemics, if we do not constrain its over-familiarity, brings us face to face with our *Litost*. How the character of our practice stands in relation to policy, and to what our world has built, originates from *Litost*. What is *Litost*?

Now we confront ourselves…

The Czech novelist Milan Kundera writes that

> Litost is an untranslatable Czech word. Its first syllable, which is long and stressed, sounds like the wail of an abandoned dog... it is a state of torment created by the sudden sight of one's own misery (1996:167).

It originates in youth. A lover experiences *Litost* when their inferiority is laid bare, and they feel humbled. The lover reacts, finding an excuse to hurt the other, or failing that, themselves. With the passing of time, *Litost* no longer lurks in love affairs, but insinuates itself in our other aspirations, our work at making something of ourselves and the world, in what "we conventionally call the history of mankind" (Kundera, 1996:206). Our counterparts are no longer the readily identifiable individuals, they are the bewildering immensity of circumstances that beset us.

When Mills (1983) writes that people feel their private lives are a series of traps, that within their everyday world they cannot overcome their troubles, he is describing *Litost*. He argues that for social scientists to turn their concern into "problems open to reason", they need to cultivate an awareness of the "sensibilities" people already have. 'Sensibilities' include people's skills and their sense of values, and

> more besides: it includes a sort of therapy in the ancient sense of clarifying one's knowledge of self (Mills, 1983:206)

Conclusion

Litost clarifies for us our inadmissible history of self-defeating, futile reactions. Kundera explains that when the Spartans were defeated by the Persians in battle they were

> … blinded by tears of rage and refused to take any reasonable action, being capable neither of fighting better not of surrendering or fleeing, and it is through Litost that they allowed themselves to be killed to the last man (1996:207)

Bearing a sensibility riddled with *Litost*, we struggle against those who pronounce policy and decide what will be built, who control the resources, who prohibit and command us, who set our wages, and who define our roles. It is, Trotsky (1937) wrote,

> incomprehensible - at least with a rational approach to history - how and why a faction the least rich of all in ideas, and the most burdened with mistakes, should have gained the upper hand over all other groups (1937:44).

His thesis was that the opportunities of the Russian Revolution were lost because for some reason workers allowed bureaucrats to take charge. He argued that policy should be judged not by its claims, but by the actual role it plays amongst those who are actually producing - the workers. Polemics can clarify our knowledge of ourselves, refuses the tears of rage, and exposes the frauds used by those fine Fellows who are least rich in ideas. Polemics is a form of hermeneutics that is resolutely and radically critical, that senses betrayal and defeat, and our desire for certainty, and our hunger and frailty, and refuses to shelter them. Polemics does not build places, it opens them, challenging us to bare what is common to us all, saying and asking in a way our well-bred science would never dare to:

> people behave as if each had a private reason. Does this have to remain this way? (Gadamer, 1982:86)

Buried within polemics is the demand that, as individuals, we should shoulder responsibility for the society we inhabit.

From personal to political action

With these words in mind, when our colleagues write letters to their union journals stating that bureaucratic and administrative demands are such that “we can no longer be who we are - nurses”, we see it as a profound political issue, one that we realize is coming to a head in our time. It is not confined to our immediate milieux, or to nursing. It concerns our failures in practice as citizens. The response to it is to refuse what we have become. Practice, in the end, belongs to us. Our practice does not just face social arrangements that are inept, that do not meet our desires. It faces the ecological crisis Gadamer (1982) foresaw would envelop the earth itself. Practice demands dialectical politics, if we are to survive a hegemony that is making our world sick.

That is the sort of grand statement we expect from conclusions. But as Trotsky remarked citing Lenin: history is not an inexorable progress. It is a struggle of living forces against an officialdom that “is a parasite stopping up the living pores” (Trotsky, 1937:50). For officialdom we can substitute the fantasy of policy and building, the dreams of society that are dreamt by those who own and control its resources.

And now, an end to it!

Down in the underworld, our whingeing, polemic or dialectic struggles to claim a space beyond lip service. The PAU has not been completely colonized as yet. Some of the ancient places still survive, far from the reaches of policy. With their unwanted

occupants, they are not yet attractive to commerce. They may be an instance of society - but they are forgotten. In the poverty of their surroundings and crudity of their institutional routines, the expectation of the ‘modern standard’ for individualism is levelled by a camaraderie that has a humbled appreciation of being. Dostoyevsky once wrote of a funeral in

> an old and rather poor church; many of the ikons were without settings; but such churches are the best for praying in (Dostoyevsky, 1880).

Perhaps the same could be said about care in the common poverty of these forgotten and unwanted places. This is not a study about care. I can see now, though, that it stands behind this study. Between the very big and the very small, between the very near and the very far, between the political and the personal, another suspicion is emerging. A person who had dementia first put it into words for me:

> It’s when they try to make your head work, that’s when you go down

That statement stands at the far point in the orbit of our understanding, the *aphelion*, the point at which we either return, or go beyond. A point where we might hesitate, moving the door

> to and fro, to and fro, to and fro, to and fro, to and fro, to and fro, to and fro…

remembering

> *Tri tri tri,*
>
> *fru fru fru,*
>
> *ihu ihu ihu,*
>
> *uhi uhi uhi!*

Sooner or later we leave our schemes and our architecture and our *Litost* behind:

> dark dark dark. They all go into the dark,
>
> The vacant interstellar spaces, the vacant into the vacant,
>
> The captains, merchant bankers, eminent men of letters,
>
> The generous patrons of art, the statesmen and the rulers… (T.S. Eliot, *East Coker*)

Buber wrote it down, to remind us - for that is, after all, the function of writing it down - to remind us, the living, that while we are living:

> all actual life is encounter… the You knows no system of coordinates (1970:62, 80).

It is a point that Kitwood and architects miss when they try to design and prefabricate dementia care. Kundera tells a story about the invasion of Prague. With Russian tanks everywhere, the whole population was in a panic, except for “Mama” who was offended because she had invited the pharmacist to come and pick, pick, pick her pears, but he never came. Her son was furious; she cared only about her pears. Years later,

> he began to feel a secret sympathy for Mama’s perspective, which had a big pear tree in the foreground and somewhere in the distance a tank no bigger than a ladybug, ready at any moment to fly away out of sight. Ah yes! In reality it’s Mama who is right: tanks are perishable, pears are eternal (Kundera, 1996:41).

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Appendix A: Subject Information Statement

School of Behavioural & Community Health Sciences
Subject Information and Invitation Statement

Cumberland Campus C42
East Street (PO Box 170)
Lidcombe NSW 1825
Telephone: +61 29351 9228
Facsimile: +61 29351 9540

"Interpreting the built environment for the purpose of doing nursing work"

Dear _____,

I'm inviting you to take part in research I'm doing on the above topic. I would like to talk with you about the building you work in. Most research on "building use" looks at patterns of behaviour, rather than how people's intentions respond to buildings. What I am interested in is individual stories of how people working in difficult situations consider the building as part of their work.

The research would involve a one hour private meeting, at a time and place convenient to you. If you agree, this would be taped. You have the right to withdraw your consent in full or in part at any time without question, and to request that all material arising directly from the meeting be destroyed. The only person other than myself authorized to access any material is my supervisor, Dr. Cherry Russell. To ensure confidentiality, pseudonyms for persons and places will be used, and original material will be kept under lock and key for five years, then shredded. Analysis of these meetings will be part of my research project for the Doctor of Philosophy degree at the University of Sydney. Some exerpts may be quoted in the paper I write, and I may write shorter papers for publications in journals. However I stress that I will take particular care that places and individuals cannot be identified.

The meeting will be unstructured, as I am not after answers to specific questions. Rather, what I am interested in is hearing you talk about whatever aspects of the building you feel is relevant. For example, you might feel that there are significant differences in how the building is used during different shifts, or by different staff, or how some aspects of it are problematic with particular patients. You may feel that in your scheme of things, the actual building only a minor part, and so explain its relationship to the whole. To help in describing the building, or what happens, I will provide paper for drawing or diagrams. With your permission, I will retain these, as they may be helpful for analysis. If time is too short, or if you or I feel we might like to explore some ideas further, we could arrange another meeting.

Should you wish to participate, please keep this statement for reference, and return the completed consent form to me. Dr. Russell or I will be happy to answer any of your inquiries concerning the aims and methods of the research. If you have any concerns regarding the ethical conduct of the research, you are welcome to contact the University of Sydney Ethics committee, for an independent view.

Yours sincerely,
Niko Leka

Niko Leka, 55 Fitzroy St. Mayfield NSW 2304	*Dr. Cherry Russell, c/o Cumberland College*	*University Ethics Committee*
Telephone: (02) 49683232 Email: niko@idl.com.au	*(02) 96466129 c.russell@cchs.usyd.edu.au*	*(02) 93519228*

Appendix B: Informed Consent Form

School of Behavioural & Community Health Sciences

Cumberland Campus C42
East Street (PO Box 170)
Lidcombe NSW 1825
Telephone: +61 29351 9228
Facsimile: +61 29351 9540

Consent Form

"Interpreting the built environment for the purpose of doing nursing work"

I, _____, hereby voluntarily consent to participate in the research entitled: 'Interpreting the built environment', conducted by Dr. Cherry Russell and Mr. Niko Leka.

I understand that the information obtained from this research may be published. However, my right to privacy will be retained, i.e., personal details will not be revealed, nor will the identity of participating institutions be revealed. The procedure as set out in the attached information sheet has been explained to me, and I understand what is expected of me and the benefits and risks involved. I acknowledge that I have the right to withdraw from the research at any time without this being held against me.

Signature of the Participant: _____Date: _____

Preferred contact details:

_____

_____

_____