THE UNIVERSITY *of* EDINBURGH

WRITING PATIENTS, WRITING NURSING:

THE SOCIAL CONSTRUCTION OF NURSING ASSESSMENT OF ELDERLY PATIENTS IN AN ACUTE MEDICAL UNIT

by

Joanna Latimer

A thesis submitted for the degree of Doctor of Philsophy

University of Edinburgh

June 1993

TABLE OF CONTENTS

PART TWO

ABSTRACT

The study examines nursing assessment in the context of questioning how nurses' encounters with patients become occasions for nursing. The focus of the study is on those occasions which constitute nursing assessment, in recognition that these occasions cannot be detached from other aspects of nurses' conduct.

To undertake this examination of nursing assessment, I have drawn on the work of Michel Foucault, with an approach to field research and the analysis of discourse which has developed from contemporary writings on communication, anthropology, ethnomethodology and ethnography. With its focus on examining how power effects are constituted within an acute medical ward, the position developed in the thesis seeks to integrate critical thinking in ethnography with a post-structuralist problematising of 'detachment' as an everyday feature of social conduct.

There are three parts to the study. The first part entails a textual analysis of how nursing assessment has been written in the literature. Nursing assessment has been conceptualised as a component of the nursing process; as a technical and cognitive activity. Representing nursing assessment in this way raises issues of knowledge and power. Writing nursing in terms of information processing, problem-solving 'models' is however less a representation of nursing reality and more a discursive practice, one with its own domain and locus of action. The nursing process detaches nursing assessment as a technology, separable from the organisation of patient care and autonomous from the social, but one designed to reconstitute the social through making nursing thinkable in a particular epistemic space.

The second part of the study, a detailed examination of the care of old people in an acute medical ward, suggests the particular development of nursing assessment as a cognitive and technical activity overlooks the heterogenous conditions in which nursing is practised, in which it is being written and in which the conditions of detachment that the nursing process, once in process, helps produce and reproduce. These include involving an instrumental-rationalist approach to research on health services, a managerialist climate which seeks to make nursing 'visible' in relation to cost and time; the professionalisation of nursing, which impacts on nurses as a call for nurses to make nursing 'professional', rational and distinct from other practices; and, instituted through fashionable talk of customer care and the care of the subject, a heightening of persons as individuated, accountable, knowing subjects. The analysis shows how the disposal of elderly persons is effected by nurses through a 'constituting of classes' and explicates the motility of these classes in response to the aforementioned pressures.

The final part of the thesis develops these themes. The nursing process appears to give the burden of knowing to the nurse as expert, always saving itself from appearing to be a congenitally failing technology through appeals for more and better training. Far from this being so, I illustrate how the burden of knowing falls upon the person; how as *patient*, persons must detach themselves from their everyday experience and seek modes of conduct appropriate to their disposal. By writing nurses as rational, scientific and professional practitioners, I suggest how the nursing process has been developed as a control technology which both disciplines patients to help accomplish their disposal and *manage* nurses through the institution of new forms of accountability and self-discipline.

ACKNOWLEDGEMENTS

Thanks to my parents: it was a condition of our upbringing to question what is conventional and not be afraid of authority. Then there are the many teachers and friends I have had: at Queen Mary College, University of London, where I studied English Literature and then at University College Hospital, London, where I did my nurse training. Special thanks to Roger Gard and Richard Holmes for helping me learn how to read texts. And to Judy Muir, of UCH, for her encouragement to take account of the social and to take patients' experiences as the heart of nursing practice.

I am not sure how to acknowledge all the patients and their families, the doctors, the nurses and other staff with whom I have worked over the years, both as a practitioner and in the research study. There are some from whom I have learnt so much, whom I shall never forget and to whom I will always be grateful.

I acknowledge the Scottish Office Home and Health Department who funded the first two years of this research project in the form of a SHHD Nursing Research Training Fellowship. Subsequently I was awarded a Van Dunlop Bursary by the University of Edinburgh. I thank Tom McGlew for his help in attaining this.

I have been especially fortunate in having Alison Tierney as my principal supervisor. As an 'actor' in my ethnography it has been extremely kind of her to make comment on a thesis which critically examines a conceptual framework through which she has helped re-write nursing.

Many thanks to fellow students Steve Tilley, Carl May, Inge Volstedt and Martha Macleod, who have all contributed to the development of the study. Also many thanks to Professor Sandy Stewart who helped me in the early days to see that nursing cannot be detached from social organization.

Very many thanks to John Holmwood, Desmond Ryan and Hugh Willmott for their readings: they helped to reshape and reconceptualise critical aspects of the thesis.

Thanks to all my friends and family who have supported me in very many ways, even down to proof reading; and particular, affectionate thanks to Fiona Barry.

I wish to express my acknowledgement and warmest appreciation of the collegiate friendship of both Mary Ellen Purkis and Maxine Mueller: their understandings of nursing inform these pages and their thoughtful and practical help with my children will always be remembered by me.

The person who has inspired me more than any other and whose insights continually help me to break new ground, is my husband, Rolland. This thesis is for you, and for our children, Jamie and Arabella, with my love and thanks.

PROLOGUE:

"PROBLEMS ON THE MEDICAL"

> The things which a nurse does for post-operative patients on the surgical floor are frequently of recognizable importance, even to patients who are strangers to hospital activities. For example, the patient sees his nurse changing bandages, swinging orthopaedic frames into place, and can realise that these are purposeful activities.
>
> .....
>
> Medical nursing is also highly skilled work...The physician's diagnosis must rest upon the careful observation of symptoms over time where the surgeon's are in larger part dependent on visible things. The lack of visibility creates problems on the medical. A patient will see his nurse stop at the next bed and chat for a moment or two with the patient there. He doesn't know that she is observing the shallowness of the breathing and colour and tone of skin. He thinks she is just visiting. So, alas, does his family who may thereupon decide that these nurses aren't very impressive. If the nurse spends more time at the next bed than his own, the patient may feel slighted.....The nurses are "wasting time" unless they are darting about doing some visible thing such as administering hypodermics.
>
> [Edith Lentz, 1954, "A comparison of Medical and Surgical Floors" in Goffman, 1958, p20].

Goffman [1958] stresses the importance for actors of demonstrating a purposefulness to their work. Goffman suggests that actors rely on making their work "visible" to do this [p21]. Through a manipulation of others' perceptions of the worker by the use of visible signs, people work to "dramatise" [Goffman, 1958, p19-20] aspects of what they do. Such performances help highlight the expression of themselves they wish to convey to others, their presentation of themselves.

Sometimes social actors can have problems dramatising their work: they appear to lack the visible signs with which to project what they are up to. Goffman cites the extracts above from Edith Lentz's [1954] study to illustrate how social actors can have difficulty dramatising their work. Through his use of these extracts Goffman is showing how the nurses, like all social actors, can give an account of themselves through their work because their work is visibly purposeful to others: the nurses rely on patients thinking they know what the nurses are up to through patients reading the signs of their activity. This relies on patients having the language to decode the meanings of the nurses' activities. The problems arise when the work is invisible: the

nurse has no sign equipment through which the patient can read the meaning of her activities as purposeful. These extracts reveal several important aspects about nurses' and patients' work. While these are not stressed by Goffman, they represent notions entertained by his work as a whole. Other aspects go beyond what is present in either Goffman or Lentz.

The extracts from Lentz quoted by Goffman illustrate more than a problem with the visibility of nurses' work in the medical ward. First, the irritation of the patient as the nurse visits other beds gives an indication of the work patients do to 'do patient'. To 'do patient' the patient reads and translates signs to make sense of what is going on around him, he acts to trust nurses and sustains with tact their performances where he can read those performances. But this is particularly difficult, as the example reveals, because some aspects of the environment are not "visible" to him, that is he does not recognise particular signs, in this case the nurses' visit and quick chat with another patient. Because of a lack of visibility the nurse can be construed as "wasting time" or the patient reads that he is being "slighted" in some way: he is left feeling irritable, and his family are not "impressed" by the nurses. There are "problems on the medical". This draws attention to the ever-present potential for misunderstandings in service institutions where there are institutional codes: like family codes, they are often hard to break. While the patient may be willing to conduct the work of 'doing patient', this does not mean that he is successful in grasping codes embedded in the workplace.

The second issue raised by these extracts concerns what constitutes the legitimate focus of nurses' work. Underpinning Lentz's view is a functionalism which is also typical of much nursing research. She attributes expectations to the patient and his family that nurses' work should be "purposeful" and that this "purpose" is intimately related to doctors' work. Implicit in this position appears to be a presupposition that legitimate activity for nurses must be goal-defined, and that these goals are constituted by what will be referred to in the current study as 'the medical': nurses' activities are either given significance through medical discourse (colour of skin, depth of respirations) and represent surveillance of patients status as manifestation of pathology, or are legitimated through being seen as supporting or implementing medical interventions in the disease process (changing bandages, giving injections etc). Both positions view nurses' work as in support of medical staffs' work and as defined by it (remember, this was 1954).

There is a further aspect of the "visible" which neither Goffman nor Lentz reveal here. Lentz states that the "physician's skill must rest on the careful observation of symptoms over time". There is an apparent contradiction in what she says, that medical diagnosis, relying on the "careful observation of symptoms over time" is not concerned with the visible, whereas the surgeon's (diagnosis) is dependent on "visible things". Symptoms are still an aspect of the

visible, they are the manifestations of disease made visible through medical discourse, the "medical gaze" [Foucault, 1973]. What Lentz has uncovered is that, in the medical ward, nurses have extended their role: a part of their activity has become an extension of the medical gaze. The issue is that nurses have not yet found a way of making the purpose of their actions visible. In the surgical ward nurses were still mainly concerned with activities which were in support of surgeons' interventions and were visible as 'work' - giving hypodermics, swinging orthopaedic frames, changing bandages - whereas in the medical ward nurses were concerned with work which contributes to the diagnostic process itself: the work of nursing has become instituted as part of the medical gaze. Nurses act as the doctors' eyes in their absence to observe patients over time and space. Becoming concerned with making disease visible, with the medical gaze, has subordinated her other work, but to others, who are "strangers to hospital activities" it has made her work invisible - she must be "wasting time" unless she is "darting about doing some visible thing such as administering hypodermics".

The relationship which Lentz establishes, is one between how nurses are under pressure to show their work, to make it visibly purposeful and that which is constructed as purposeful, that which has visibility, is work which is defined by the 'medical', either as in support of medical interventions or as an extension of the medical gaze. This relationship displaces other aspects of nurses' work.

What transpires from re-reading Goffman's and Lentz's emphases is the central role that the visible and mundane plays in the social construction of reality and the legitimation of practice in a hospital setting. From Lentz's interpretations of her research material, it would appear that certain aspects of nurses' work are marginalised as 'social' and are subordinate for everyone concerned. The 'social' here refers to aspects of nurses' work with patients which are not technical, administrative or in support of the medical.

This detachment of the 'social' and the 'technical', instantiates an antipathy between the terms as mutually exclusive. From the extracts cited above it would appear that a nurse visiting or having a chat with a patient may be construed as irrelevancies or favouritism, as "purposeless" and "time-wasting". First, by the patient as he watches irritably; second, by his family who begin to doubt the competence of the nurses; third, by the nurses who are imputed as having problems conveying the purposefulness of their "highly skilled" work of observing patients; and finally by Lentz herself. Just socialising with patients is meaningless, it has no place, except as evidence of time-wasting or favouritism. As will be discussed throughout this thesis this *disparaging of what is social is of extreme importance to understanding the nature of work in hospitals.*

These readings of the extracts open a gap. Lentz's study was published in 1954 and Goffman's in 1958. Add a further view of nurses' work as another condition of modern hospital

organisation in the 1970's and 1980's: the irritation of the manager as to whether these visits to the bed are in any way related to his goals - measurable outcomes and increased throughput. Meanwhile, the nurses in the medical ward are left with the problem of how to make their observation work visible, while the patient is left feeling irritable and slighted. It is at this point that a new technology can enter: the nursing process.

PART ONE

CHAPTER ONE

INTRODUCTION - THE OBJECTS OF STUDY AND THEIR CONTEXT

Traveller - there is no path
Paths are made by walking.

[Machad, Zimbabwe Poet]

To borrow a metaphor from Strathern [1991], the present study aims to pose questions and take views in such a way that the researcher and the reader are taken on a journey. The journey ends up in the same place, *nursing assessment*, as it started but the journey effectively constitutes that place as never being fully recoverable as it was seen and experienced at the beginning of the journey. The effect is to transform for both the researcher and the reader the place, 'nursing assessment'.

In this exploratory study I am particularly concerned with *detachment:* with studying what is displaced, excluded, made absent or silenced through nursing becoming written. The first part of the thesis develops the site of the study: an examination of how *nursing* assessment has been conceptualised as a problem-solving, information processing activity. This exploration involves a critical perspective of the ways in which nursing assessment is being written and researched. Drawing on the work of Foucault [1968, 1970, 1973, 1975, 1977, 1978, 1980a, 1984], Goffman [1955, 1958, 1961], Garfinkel [1967, 1974, 1986] and Giddens [1976, 1984], Chapter Three examines how the ways in which nursing assessment has been written are constitutive of and constituted by particular conditions of the organization of modern 'health care'. I suggest that the ways in which nursing assessment has been written implicates the nursing process as a *control technology*, which raises issues of power/knowledge relations. I advance an argument to suggest that re-writing nursing as a process institutes a particular disciplined nurse-patient relationship, which individuates nurses as expert and accountable practitioners.

The second part of the thesis entails presentation and analysis of research material drawn from an ethnographic study of the care of twenty elderly patients in an acute medical unit. Three chapters develop observation of ward interactions and organization. Chapter Five examines general features of admission and hospital organization drawing from

observation of interactions, nurses' accounts within interviews and documentary records. Chapter Six examines the general features of ward organization, drawing from observations of procedures and routines, and from documentary records, as well as from interactions among nurses, doctors and patients. Chapter Seven is an extensive examination of ward rounds, drawing from the nurses' accounts within interviews, their written records, observation of their interactions with each other at ward handovers, and from observation of doctor-nurse-patient interactions. The following three chapters develop observational material with respect to patients' and nurses' accounts within interviews, their interactions, and nurses' and doctors' documentary records. Chapter Eight, drawing on the nurses' accounts within interviews together with observations of them at work, unravels the methods nurses say they use to get to know what they say they need to know about patients. In Chapter Nine I contrast this material with an extended discussion, drawing from observation of interactions and on documentary records and nurses' handovers, as to how nurses manage their relations with patients. Chapter Ten draws on patients' accounts and nurse-patient interactions to explicate the work patients are required tc do to perform 'patient'.

Treating the research material in this way considerably extends the discussion beyond evidencing a more direct statement of 'findings'. I have chosen to present the material in this way, first, because I believe this to be the most interesting way to accomplish examination of the topic; second, because I believe this treatment captures the texture of ward life more adequately than I could achieve in other ways; third, because the study is attempting to reveal "complex linkages" between facets of ward life, which are both heterogenous and plural and only 'partially connected' [Strathern, 1991]; and fourth, because I wish the reader to be given a series of windows on the site prior to my moving to more general discussion and conclusions in the third and final part of the study, where I summarize and discuss important apects of the study in relation to both the first part of the study and in relation to wider issues of culture and organization. This is not to suggest that I lack confidence in the veracity of my account. Rather, that I have attempted to place the reader (and myself) in a position whereby a reader can survey part of the process of crosschecking through attention to the 'mundane' and the 'everyday', rather than rely solely on claims to have 'triangulated the data'. Further, I am stressing the journey as integral to the arrival.

The study is not principally directed at answering a research question in the usual sense. 'Nursing assessment' is developed in the study as a discursive and practical space, a 'site'. The site is constructed through examining nursing assessment as an aspect of nurses'

conduct. While this locates the study as focusing on nurses' practices, the term conduct has been chosen to suggest that nursing is socially embedded and accomplishes more than any technical or functional representation of nursing can imply. In addition to explicating for the reader the 'path' which nurses follow in this setting (nurses' conduct), I am also conscious of attempting to make a new path which other nursing researchers may choose to follow.

How conduct is accomplished is discussed in the present study as interrelated with discourses and practices. An aim of the study is to establish how nurses accomplish assessment of patients as embedded in a social/cultural context. Nursing assessment is examined in ways which assume it to be constructed and accomplished as an aspect of culture, and of social organisation. Nursing assessment is not seen as "detached" [Strathern, 1993] from culture, or from social organisation. Following Garfinkel [1967] it is not assumed in the study that nursing assessment is accomplished as some technical achievement. Critically, the form of nursing assessment is produced as an effect of context and helps to produce and reproduce that context.

Investigating nursing assessment and nurses' conduct as an interplay between object and context, is central to this thesis. The issue of 'visibility', raised in the Prologue, illustrates this central theme. 'Visibility' refers not only to an object in a gaze, but concerns *context as the construction of the perspective within which objects become viewed.* For example, until the advent of, say, the nursing process the patient cannot view the nurse's visit to the bed as work. This aspect of nurses' conduct and the construction of the visibility of objects is further explored drawing on Foucault's work in Chapter Two.

Constructing a Site

The aim of the study is to develop the object of the study, nursing assessment, as a site of critical interest through considering it as an aspect of nurses' conduct. Other writers in nursing have examined aspects of nursing critically. For example, Schrock [1987] has been concerned to construct nurses' professionalisation as a politically problematic issue. Schrock shows how embedded in particular forms of professionalism ("closed professionalism") are issues of power/knowledge and exclusion. More recently, Hiraki [1992] has examined nursing texts from a critical perspective to reveal how nursing is being written and passed on in nursing education as a technical and processual practice. The language in which nursing is being written, Hiraki claims, represents a particular political and cultural form, that of rational-instrumentalism and calculative reason. This desocialises the nurse-patient relationship and potentiates situations of coercion and domination. Both

these authors have drawn upon conceptualisations derived from philosophical, linguistic and social theory to give a view of aspects of nursing within which these aspects become problematised as issues for critical consideration. Arguments such as these suggest that the space in which aspects of nursing are being developed is 'disciplined' in particular ways, rather than others.

The present thesis entails examining the object of the study as having been developed in a "disciplined space". In particular the study sets out to uncover how nursing assessment as an aspect of nurses' conduct is being constructed in relations of power and matters of interest.

Dingwall *et al* [1988] draw an analogy between the social organization of work and the "development of a city" [p6]. The site upon which a city is to be built is considered as "the earlier foundations which run across the site and which may divide it in a very different fashion" from present attempts to develop the site, but which to some extent determine the present [p6]. Like an archaeologist the researcher attempts to uncover those earlier foundations, to develop understandings about how the present is different from, but also relates to and draws out of its history.

This analogy draws on Foucault's [1970, 1973, 1975] metaphors of archaeology and genealogy. How Foucault's approach constitutes a critical perspective is introduced below, referring to a comprehensive paper by Deetz [1992]. Deetz's position is one which develops the Schutzian [1967] argument that language, especially typifications, is the medium through which actors accomplish social organisation. Deetz articulates the disciplining effects of language as a medium and, drawing on the work of Foucault, he highlights the displacement effect which any social reality in its production and reproduction necessarily institutes.

Language: a Critical Perspective

A critical perspective does not take language at face value: language is not taken as simply representing "an absent, to be recalled object" [Deetz, 1992]. By referring to a person as a nurse, I am not referring to an object which has an identity constructed through natural divisions. I am placing that person in a particular context of meaning, which communicates or invokes historical, cultural, social, political implications. Umberto Eco [1984] refers to these as the "encyclopedic" aspects of language. How these meanings are layered and organised for persons occurs through the form and organisation of social practices, which includes reading and writing as forms of interlocution with 'others', although these latter interactions would not be described as situations of co-presence.

A critical perspective questions the effects of language as a system which represents objects in the world. It emphasises how the cultural and historical definitions which enable social organisation are invested in language. As Deetz [1992] defines it, language in a critical perspective is taken as a system which "holds forth the historically developed dimensions of interest" [p28]. Further, language as a system of distinction is also constituting: through language, as a system of distinction, classification and identity are produced, but not as the description of "natural divisions", but as constructs which "articulate choices with distinct political effect" [p29].

In producing particular classifications and identities, language as a system of distinction places objects so that the word "makes thematic a perspective against a hidden background of what it is not" [Deetz, 1992, p29]. For example, referring to someone as a 'nurse' classifies her within a system of distinctions and against a hidden background by which these distinctions take on particular meanings: she is not being referred to as a doctor, or a patient, or a friend, or a wife, or a mother (although she may be any or all of these). 'Nurse' may imply in one culture and social situation an identity composed of specific attributes: a set of tasks like making beds, dressing wounds, taking temperatures, wearing a uniform. In another culture 'nurse' may carry completely different organising meanings: like magic and spirit, healer and comforter.

Through language as a system, power and social organisation get relayed as it:

> puts into place certain kinds of social relations and values - that is certain things which are worthy of being distinguished from other things - and puts into play the attributes that will be utilized to make that distinction [Deetz, 1992, p29].

It is through language as a system of distinction that things get both ordered and in that ordering that displacement is possible. It is in this sense that language is disciplining: it defines a space in which things can be thought/experienced in particular ways rather than others. For example, Deetz asserts that language considered as a system of distinction does not unproblematically describe the 'out there', but "puts into play a way of paying attention to the 'out there'" [p29]. In this paying attention, language enables things in the world to become objects and to be placed in a particular order. As this takes place, other things get displaced. This is the basis for discourse:

> ..language is not a system of signs that represent. Rather language appears as discourse, a material practice which systematically forms that of which it speaks. [Deetz, 1992, p31]

It is in these senses that language as a system of distinction, as discourse, is

disciplining, is a medium of power. For example, Hiraki [1992] reveals how conceptualising nursing as a 'process', brings into play a range of possibilities for defining and thereby constituting nursing as a particular form of activity, as existing in a rational-instrumental conceptual space rather than in, say, an interpretive and interactive space.

From a critical perspective, social organisation is accomplished therefore through establishing and reworking systems of distinction and identity. Critical to the present study is to reveal how there is not one language system present in the social organisation of health care, of which nursing is an aspect, not one set of distinctions, but a fragmented and heterogenous series of presences, of different discourses, which bring into play in the life-world (the lived world of experience) [Schutz, 1967] of nurses' different (competing) interests and representations. One object of the study is to reveal how these different discourses relate with and impact nurses' discourses and practices.

Prior to a more specific discussion in Chapter Two, drawing on the work of Michel Foucault, of the disciplinary power of discourse, there is now a brief introduction to the specific site in which the study has been undertaken.

The Site for the Study

The setting for the study is the nursing assessment of elderly patients in an acute medical unit. This setting is developed as a site of critical interest. This section examines the conditions of possibility in which nurses develop their practices in such a setting.

The first set of conditions concern how the dominant discourses underpinning the setting are medical and managerial. This is well documented in Dingwall *et al's* [1988] study of the social history of nursing. However, what these discourses represent in terms of the disciplinary space in which nurses are practising requires further comment.

Giddens [1991] argues that modernity is distinguished by increasing emphasis on rational organisation, technology and accountability of individuals. The 'medical model' has been taken to be the paradigm for the organisation of patient care in acute care settings and the ways in which the effectiveness of these settings can be examined.

Underpinning this model is a belief in the possibility of objective knowledge and rational action. In the present study it is argued that this has constituted an ideology which seeks a transformation of the social through displacement of emotion as 'subjective'. This in turn facilitates a so-called objective view of patients and a concentration on diagnosis-treatment issues. The medical model is constituted by a method which relies upon examination of patients from a particular structured and coded point of view: a "medical

gaze" [Foucault, 1973]. Legitimation of the model is located in an ontological belief [Foucault, 1973] in 'rational action' and is underpinned by a moral narrative which postulates that 'to save life' [see also Schrock, 1987] is the rationale for the organisation of health care in modern Britain. As a consequence the greatest proportion of resources available to health care is allocated to the acute care sector [Mackay, 1989].

More recently an increasing managerialist climate in Britain has deeply penetrated the health services and the care professions. This has involved "examination" of the health service by accountants and managers [Dingwall *et al*, 1988; Broadbent *et al*, 1991]. This examination is marked by a move to "rationalise" resources and an outcomes approach to evaluation of service provision. An ethos has emerged in which management by objectives and the ability to measure the effects of patient care is what counts. It has been suggested that the impact of managerialism represents a further 'masculinization' of the health services [Webb, 1985]. The acute sector, which has vast resources in the form of ever-increasing technology, intensive staffing ratios and medical research facilities has to justify its share of resources by increasing throughput and making more effective use of technical facilities while maintaining standards. These factors will be shown in the present study to constitute a pressure for staff to conduct themselves in relation to more explicit accountability.

Increased emphasis on accountability, and the individuation of accountability through quality assurance methods and outcome measures, focuses scrutiny on each employee as an individual. Being made accountable enables a governmentality effect on staff [Rose and Miller, 1992]. To facilitate this governmentality effect, calculation is centralised at the same time as it appears to grant more autonomy, and has been considered a strategy for reducing the potency of medicine [Dingwall *et al*, 1988; Rose and Miller, 1992].

The managerialist climate which penetrates the health services is aimed at the elimination of work which cannot be shown to have clear objectives and which does not lead to measurable outcomes. Critically, managerialist thinking also introduces a new strategic value: throughput. This brings with it not just questions of cost but the issue of reducing 'turnaround' times. Through coupling cost with time, staffs' activities can be harnessed to organisational goals.

Both these discourses, the managerialist and the medical constitute different facets of an instrumental rationalism: they are based upon the notion that all work should be eliminated which does not tend to goal-fulfilment and that what constitutes 'method' is a form of *science*. In Chapter Two, drawing on Foucault's work, there is further discussion about how it is possible for these dominant discourses to discipline the space in which

nurses develop their discourses and their practices.

The second set of conditions interrelates with the first set and is concerned with developments in nurses' discourses on patient care. Nursing theorists and educationalists have staked a claim that nursing is constituted by a care focus [see for example, Benner and Wrubel, 1989; Bishop and Scudder, 1987; Kitson, 1986]. At the heart of the care focus is the notion of the individual as subject, with rights and a particular identity, who demands respect, and who is suffering, vulnerable, at risk and more or less dis-abled.

May [1991, 1992] has argued that this focus on the individual reflects a more general cultural movement expressed as individualisation. This he argues, drawing on the work of the new medical sociologists, is constituted in the field of health as a new discourse which now includes a notion of the patient/subject as experiencing and as one who feels. He describes it as not penetrating the heart of the medical model but as "value added" [1991, p199]. May argues that it has been left to nurses to pick up the tab: they are the ones who are left to care for the subject, but that this care must be constituted by them, accounted for by them, as 'work'. No longer can 'care' be left to the vicissitudes of the individual patient, as in Lentz's study: care is now to be made visible.

It is also possible that this emphasis on individualisation in nursing discourse may instantiate a consumer orientation introduced with the managerialist culture: as customers, patients are re-instructed to demand respect and care through the "service" orientation of management both within particular organisations, such as banks, and more generally in society at large. This shift parallels Hochschild's [1983] work on how feelings are commodified to give satisfaction in airlines to increase competitiveness.

While nursing discourse represents nursing as primarily concerned with caring for patients, complementing, rather than simply supporting the medical domain of curing patients, it also demands that nurses should be present as visibly 'professional'. 'Caring' becomes a matter to be organised by systematic assessment of individual patients' nursing requirements. Interventions become not only 'planned', but should be based upon research-based theory or on knowledge derived from practice which has been systematically evaluated. This trajectory for nursing is not without its problems. It will be argued in Chapter Three that a tension between managing and care is constituted through the nursing literature. It will be further argued that discourse on patient care and the focus on individualisation is deeply wrapped up in the pressure on and movement in nursing to reveal itself or constitute itself as professional practice. Further, it will be shown how in representing/conceptualising (writing) nursing in these ways to reconstitute nursing practice

there is potential for displacement.

The third set of conditions is concerned with both the previous two conditions. It concerns the ways in which the practice of nursing is being represented/conducted. In the Lentz [1954] study the nurse's visit to the patient's bed is represented as ontologically important - the patient works to understand what is going on and experiences the nurse's activity in a particular way. This constitutes an encounter, an interactive and interpretive dimension, locating understandings in a social context. But Lentz indicates how the actions of the nurse have to be understood as purposeful in relation to formal discourse: they have to have a rationale. How that rationale is being constructed is an aspect of the present study. 'The social' in nursing discourse is defined specifically as capable of impacting health and the management of patient care. A plethora of terms comes into play here: patient's "social situation", "his social support", "his social life". Nurses' practices are not simply being conceptualised as if they are somehow detached from the social. Simultaneously, if paradoxically, nurses, through their practices, are being called upon to reconstitute the social. How the social relates to how practices are developed or carried through is not conceptualised in mainstream nursing discourse. Instead, it will be shown in Chapter Three, it is marginalised. The extent to which this marginalisation of the social is supplementary to the accomplishment of the terms and conditions of practice set by the conditions of modern hospital organisation is another issue addressed by the current study. This situation locates 'knowledge' in nursing practice outside an interactive, interpretive tradition. The specific setting in which the study was undertaken is now discussed.

A Problematic Site: 'Old People', 'Acute Medicine' and 'Time'

The setting chosen to facilitate examination of nursing assessment as an aspect of nurses' conduct is the care of elderly patients admitted to an acute medical unit in a large regional, teaching hospital. This setting was chosen as it represents a critical site in health care in relation to the sets of conditions described above and for nursing practice in particular. This is now further discussed.

The setting exemplified a system, the health service, under "strain" [Giddens, 1984]. Pressure in the 'acute sector' of the health services was located in a number of different areas. First, as already indicated, a managerialist climate has penetrated the health service which has led to an 'examination' of the health service and the use of resources. Under this examination there was increasing pressure on staff to increase throughput, by making throughput a measure of efficiency and effectiveness.

Second, strain also arose from the tension created between the perceived purpose of the institution in question - the provision of "first class medicine" [*Professor of Medicine, field-notes, informal talk*], with maximum technology, for a class of patient termed the 'acutely ill' - and the limited resources available. Here there was opportunity to examine how in the health services a person is being constituted as 'acutely ill' as distinct from other ill persons.

Third, there was pressure from the presence of old people in the acute sector. The largest proportion of elderly patients it was claimed were cared for in the general areas of the health services and about half the population of general hospitals at any one time could be made up of people over the age of 65 [DHSS, 1981]. In 1975 three times as many patients over the age of 65 were treated in general medical/surgical and orthopaedic/trauma units as in geriatric medical sectors [DHSS, 1981, p41]. Of these, 266,130 patients over the age of 75 years were treated in the general areas as opposed to 157,320 treated in geriatric medical units. The presence of old people in the acute sector becomes a problem where there is pressure to increase turnover in the light of various claims: claims about an increasing elderly population; claims that old people get ill and are disabled more often than younger people; claims that old people take longer to get out of hospital than younger patients; and, finally, claims that old people require not just medical or technological but more so-called 'rehabilitative' and 'socially aware' care.

Fourth, the nursing process had been introduced into the acute sector, with its attendant demands on nurses to develop their practice and to demonstrate how their work is distinct from medical work and from domestic work [see also Dingwall *et al*, 1988]. This last aspect of the setting is discussed further in Chapter Three.

These conditions can be taken to represent a site which is 'internally' problematic. How this has been achieved is now discussed.

From the mid-seventies through to the mid 1980's there was extensive discussion and research, mainly in the medical and health services management literature and the Civil Service, to define who is best responsible for care of acutely ill elderly people, what is the nature of that care and how it differs from the care of acutely ill younger adults [King's Fund, 1982]. It was conceived of by some as the "geriatric imperative" [Joel, 1984; Rubenstein, 1984]. This discussion can be read as descriptive and as an aspect of a field of negotiation created to get at 'the problem' of old people in the acute sector.

The discussion can, however, be read in two other ways. First, as helping to constitute the problem. The discussion brings into play ways of pointing to the out there,

and therefore ways of seeing the out there: persons get categorised as geriatric, old gets linked with time and with special expertise, which constitute differences and by doing this, identities. People begin to see the world in relation to these identities and differences. An older patient who is very ill, bedbound, someone who may or may not die, can no longer be constituted as someone to be simply cared for but as someone taking time and resources. Whereas those looking after her require special understandings, new forms of knowledge and new practices. It creates the possibility for the constitution of new experts.

Second, the discussion can be read as at the same time recursively reproducing, with some adjustment, structures central to the ways in which medicine, that is acute medicine, represents itself and through these representations acts to maintain a particular disciplined space in which nurses are working. This is present in notions of difference: for example, the difference between people defined as 'acutely ill' and people defined as 'requiring rehabilitative care'.

If the narrative developed around old people in the acute sector is not simply describing natural divisions, that is the ways in which old people and their care differ from other ill people, then the different perspectives proffered (those of general physicians, civil servants, politicians, social service officials, geriatricians, nurses) can also be seen as concerning the articulations of people with different political interests, who are staking their claims and reworking their territory. These discussions can be read as doing reclamation and constitutive work. They are, from a critical perspective, "articulating choices with distinct political effect" [Deetz, 1992, p29].

The rhetoric concerning old people and their care in the acute sector of the health services does not simply portray different views of reality but rather, in the view of the present study, constitutes a discourse which reveals and articulates "dimensions utilized to produce classifications and thus produce groups and relations" [Deetz, 1992, p29]. The discussion not only raises issues of responsibility and care with respect to acutely ill old people, but also contributes to how old people can be seen within the health services as potential "bed-blockers" and how new experts, with their associated discourses and practices are required to alleviate/prevent this situation. Literature concerned with this is now briefly presented.

Trends in health care organisation in Britain during the mid 1970's through to the 1980's were being driven by the need to 'rationalise' health service resources [Dingwall *et al*, 1988]. One feature of this was to increase patient throughput by a reduction in length of stay: shorter lengths of hospital stay should result in higher rates of patient throughput in the

acute sector. While the elderly, it has been claimed accounted for about half the population of patients within the acute sector [DHSS, 1981], old people were identified as taking longer to get out of hospital than younger adults, especially patients aged 75 and over, and especially women [DHSS, 1981; Scottish Hospital Inpatient Statistics]. This gave rise to the notion of "bed blocking" and of old people as potential "bed blockers" [Barker *et al*, 1985; Coid and Crome, 1986; Donaldson, 1983; McArdle *et al*, 1975; Rubin and Davies, 1975; Seymour and Pringle, 1982].

In this way 'old people', becomes a specifically distinct category of person which is linked negatively with time, given the circumstances (a pressure to increase throughput). Old people are constituted in many different ways but an aspect of these identities is that they can pose a possible impediment to the effective and efficient management of the acute sector, where this is measured by shorter lengths of stay and increased throughput. Statistically, old people acting as a block [Goffman, 1961] can be identified as increasing the risk of failures over throughput. Individually, care of 'old persons' becomes a target to be managed.

In this context, claims concerning anticipated increases in the proportion of the population of old people aged 75 and over during the next forty years led to concerns over the use of health service resources [Alderson, 1986; Craig, 1983] especially in the acute sectors of general hospitals [DHSS, 1981; King's Fund, 1982]. Discussion was thus generated over who should be responsible for the care of the acutely ill elderly [Bouchier and Williamson, 1982; DHSS, 1981; Donaldson, 1983; King's Fund, 1982]. Managers have a need to know what is different about old people and the care they require.

Alternative and innovative arrangements were sought by many involved in the health care of elderly people. Among these alternatives were the use of community hospitals [North and Hall, 1984], special admissions and assessment wards for old people [Donaldson, 1983], geriatrician input into general wards [Bouchier and Williamson, 1982; Burley *et al*, 1979; Grimley-Evans, 1983] and augmented home care [Currie *et al*, 1979]. Nursing innovations included implementation of special assessment tools, educational programmes and systems for nursing in an acute medical environment [see for example, Hulter Asberg, 1986] and in special geriatric assessment wards [see for example, Bachman *et al*, 1987; Bachman and Collard, undated]. In retrospect it can now be argued that what was set in motion was a massive reorganisation of health services to take account of the "problem" of increasing numbers of ill or disabled old people, who had been identified as having the potential to block the flow through the beds.

While this literature is taken to reflect concerns deriving from practice, it also represents conceptualizations which make classifications and the production of identities appear neutral and "based in natural divisions" [Deetz, 1992, p29], even if there has to be negotiation over what precisely these divisions are. In this literature old people are being further distinguished from other people in relation to their health and the services they require. Some provisional aspects about how older people were being constituted as distinct are now presented.

The explanations for why length of hospital stay increases with advancing age are complex and relate to how old people were being constituted as distinct from other categories of patient. Underlying them is the claim that illness is more likely to be fatal or disabling in some way the older a person is. For example, it was noted that medical reason for admission is itself the main corollary of length of stay in old people [Maguire *et al*, 1986].

The literature reviewed suggested three groups of factors influencing length of stay of older patients in acute wards. The first group of factors relate to claims that physical and mental aspects of being old may inhibit or retard recovery. In addition to an increased likelihood of multiple health problems, disease in old age is claimed as frequently disabling and increasingly chronic in nature [Hamdy, 1984]. Further, old people, it is claimed, have less reserve capacity with which to cope with physical and mental stress [Brocklehurst, 1978 & 1982; Jolley, 1987; MacLennan, 1987]. This can result in a greater vulnerability to the disabling effects of acute episodes of illness, hospital admission and prolonged inactivity [Brocklehurst, 1978; Gillick *et al*, 1982; Hulter Asberg, 1986; Miller, 1984; Seymour and Pringle, 1982]. In this way the claims relate to producing classifications based upon physiological, that is 'natural', and acceptable, medical criteria for old peoples longer recovery. At the same time these distinctions place old people as potentially requiring different facilities from those represented by acute medicine. This opens a gap [Munro, forthcoming(b)]: that old people are not like acutely ill patients, they are different.

Secondly, it was argued that deficits in the medical and nursing "management" of the care of old people in the acute sectors may also contribute to prolonged hospital stays [Barker *et al*, 1985; Burley *et al*, 1979; Kings Fund, 1982; Rubin and Davies, 1975]. It was suggested that these deficits arise from the fact that assessment of need and organisation of care are not developed from a real understanding of the potential care requirements of acutely ill old people. These studies indicate that caring for old people requires additional expertise to that developed traditionally in the acute ward environment: old people require

so-called comprehensive assessment, with emphasis on rehabilitation, early discharge planning, and strong multi-disciplinary and community liaison.

The third area of factors claimed to influence length of stay of older patients related to the availability of alternative care arrangements. Inappropriate or insufficient facilities and support both inside and outside the hospital may result in inappropriate admission to hospital [Currie *et al*, 1979] and inhibit discharge arrangements [Bouchier and Williamson, 1982; Victor and Vetter, 1984 and 1985]. Within the hospital environment, in addition to medical and nursing care, resources which are important to the care of old people would include remedial therapies, medical social work, and the provision of appropriate equipment [Bouchier and Williamson, 1982; King's Fund, 1982]. Outside the acute hospital unit there was the question of the availability of alternative suitable accommodation in the geriatric, psychogeriatric, terminal care or social service sectors. There was also the question of the availability of community support: formal -- in relation to community nursing, day care, personal social services and voluntary organisations; and informal -- family, neighbours and friends. The problem here is that these 'facilities' a) may not be available and b) may not be utilized adequately even if they are [Burley *et al*, 1979; Rubin and Davies, 1975].

In summary, three possible sources of explanation for lengths of stay increasing with age are argued in the literature:

1 Complicated responses to and types of illness: multiple pathology, chronic and disabling diseases, greater vulnerability to stress. These legitimate the problem of old people as falling within a medical terrain.

2 Inadequate management of patient care. This indicates how there needs to be expertise of a different kind in developing efficient approaches to the care of elderly people. The emphasis is on comprehensive assessment and the interrelationship between medical issues and non-medical, that is home-life and support, as well as mental and emotional issues, which can affect the recovery and rehabilitation of elderly people.

3 'Misplacing' of the old as a result of insufficient or misused alternative care arrangements and resources.

Problematising and focusing on how to 'manage' the care of the elderly patient in the acute sector can be seen to configure not simply around the medical condition of the

patient but around time, provision and safety. The questions facing managers and staff at this time was how to prevent old people from being unnecessarily admitted to an acute hospital and how to speed up the process of getting old people through the hospital and out the other side at the same time as ensuring that they are properly and safely provided for.

The Present Study: Questions

These sorts of question raise however a further set of questions, questions which propel the present study: when does some effect become an illness, and more specifically an acute illness, and when does it stop being an acute illness? Who makes these distinctions and how are they made? And in being made, what or who gets displaced? How does this set of conditions impact nurses' assessment of elderly patients? How do they construct patients' identities in this kind of setting, and further, how does this relate to the delivery of nursing care?

Throughout this chapter there is a play between the extent to which "theories" can be taken as representation and how discourses as forms of re-presentation, as the terms in everyday use, are doing deeper, socially organising work. What these discourses are representing is called into question in the present study, while the central question being addressed is the extent to which they are constituting. The critical perspective taken in the current study entails some engagement with the play between these two potential views of language and discourse and their relations with practices.

To return for a moment to the Prologue. Present in Goffman's [1958] work and in his citation of Lentz's study is a suggestion that the nurse's world interpenetrates with demands and conditions which in some way she enacts. It also suggests a relationship between conduct, visibility and language. These relationships are central to the current thesis and are now discussed further drawing on the work of Michel Foucault.

CHAPTER TWO

THE CONSTITUTION OF CONDUCT

False happiness, since we know that we can use
Only the eye as faculty, that the mind
Is the eye, and that this landscape of the mind

Is a landscape only of the eye;

[Wallace Stevens, 1947]

Introduction

Nursing assessment is being examined in the present study as an aspect of nurses' conduct. Examining nursing assessment as an aspect of nurses' conduct in a particular, 'problematic' setting, constructs it (nursing assessment) as a site of critical interest. This chapter sets out an approach which is appropriate for such an exploration. Developing this approach draws heavily on the work of Michel Foucault.

Visibility

Foucault's work suggests there are two particular aspects to the relationship between discourses and practices effecting the disciplining of conduct. The first relates discourse to surveillance [Foucault, 1973, 1975, 1977]. The relations here have been extensively explored in the sociological and organizational literature [see for recent examples, Bloor and McIntosh, 1990; Fisher, 1991; Fox, 1993; Frank, 1990; Mumby and Stohl, 1991; Ochs and Taylor, 1992].

The second aspect relates to how discourse in placing things in the world in a particular order of things also *displaces* things in the world [Foucault, 1970, 1973]. This aspect of Foucault's work has received less attention although it emerges as a possibility in both May's [1991, 1992] and Tilley's [1990] studies.

In drawing attention to conduct as disciplined and disciplining my purpose is not to invert the importance of one aspect against the other. Rather I wish to underline Foucault's emphasis on a *simultaneous* presence of both aspects in the organization of every day life. Surveillance and displacement are for Foucault the media through which discourses affect conduct. Both are concerned with understanding what has 'visibility'. What is seen, as well as how it is seen, is affected in the day-to-day through an interplay between the effects of

surveillance and displacement.

As has already been suggested in the Prologue and in Chapter One, a concern in the current study is to show how the notion of 'visibility' may be central to the construction of day to day life in hospitals. As I go on to show, visibility is integral to what constitutes legitimate conduct in the day to day life of hospitals. For example, the nurse in Lentz's [1954] study cited in the Prologue is having problems because her patient cannot see what she is doing as work. Today, the nurse in present day hospital organization is having to make what she does visible in other ways: to managers. The visible is not, however, all that it seems. Some key aspects of visibility are now explored. These involve notions of representation, reflection and examination.

First, the on-looking patient and the nurse referred to in Lentz's study are predisposed to see the world in particular ways: their constructions are guided by particular discourse, they are disciplined to see and to interpret what they see in particular ways rather than others. Where the patient cannot account for the nurse's actions in relation to any other discourse than the medical, the patient sees the nurse as time-wasting or favouring the other patient. For the patient, the nurse's work is visible only when it is in support of the medical. This is how he makes sense of what he sees.

The nurse is looking at the patient in the next bed to assess his respiratory-circulatory status by observing the depth of his breathing and the colour of his skin. She is left with the problem of how can she enable the on-looking patient to make sense of what she is doing. Both the on-looking patient and the nurse are relying on being able to make entities visible through their translation of their experience through frames of meaning. These frames of meaning are partly constructed out of the sedimentation of various discourses and practices. But the example reveals something else (and this is Goffman's [1958] point): how the nurse is left with the problem of making her work visible to the onlooking patient, of righting the impression of herself. How can she show her practice (observation of the patients breathing and vital status)? To enable the patient and others to see, to make sense, she has to find some way to instruct him so that he can tell that what she is up to is 'disciplined'.

Matters are made more complex in the conditions of work in modern hospital organization in that the nurse is not called upon just to make her work visible to patients. Nurses have also to make their work visible in particular ways in order to legitimate their work to their superiors and establish what they do as professional work.

Second, visibility is implicated in relations of power. This is instituted through

making social actors' activities, or the activities of others, visible by measuring them against prescribed goals or outcomes. These goals and outcomes are not given, but are constructed and negotiated within relations of power from which they derive their 'good sense'. For example, the act of writing down the results of her observations on a chart at the end of the bed, increases the chances that the onlooking patient and the manager will interpret that what the nurse was up to constituted 'work': that she was, in fact, doing something legitimate and important.

Finally, visibility is implicated in relations of power through technologies to promote self-discipline. Technologies such as the nursing process as forms of writing, and as attempts to represent nursing in particular ways, enable nurses to measure their activities against inscriptions and prescriptions. Forms of writing make their activity visible through self-reflection, measurable against particular frames of meaning (in this case - problem, objective, action, outcome). By so doing they act like a mirror [Hutton, 1988; Roberts, 1991]. The act of writing makes the nurse look at her work, and see her work in relation to particular forms.

It also opens the past to inquiry by those superiors to whom she is accountable - her writing as a 'record of events' becomes a legal document, a mechanism for inspection and examination of her work. It constitutes a form of explicit surveillance and accountability.

Surveillance: the Eye of Power and Self-discipline

The term "surveillance" implies inspection and examination:

> When persons are moved in blocks, they can be supervised by personnel whose chief activity is not guidance or periodic inspection (as in many employer-employee relations) but rather surveillance - a seeing to it that everyone does what he is clearly told is required of him, under conditions where one person's infraction is likely to stand out in relief against the visible, constantly examined compliance of the others. [Goffman, 1961, p376]

Here Goffman is indicating that direct surveillance is constant and ongoing. Foucault's [1975, 1980a] work suggests how surveillance does not simply have a functional dimension - to check by looking that all is going along as planned or as regulated - but does in itself have a regulating effect. The fact of surveillance or the possibility of surveillance affects conduct in the presence of other understandings, such as are implied in the notion 'rules of conduct' or 'protocols for practice'. Foucault's [1975] work suggests how, to affect this aspect of surveillance, new technologies are developed which are aimed at an economy of effort.

For example, the presence of the video at the supermarket reminds shoppers that their activities are being (or are possibly being) scrutinised and recorded. The intended effect is to amplify law-abiding conduct: to supplement self-discipline. For others it may excite resistance, presenting a challenge to duck the video and shoplift despite the surveillance. Foucault [1975] takes these matters further. He has drawn out how surveillance, as a strategy over time, affects conduct so as to ensure its regulation even in the absence of the surveillance. Surveillance, in Foucault's sense, typically carries the force of this self-disciplining effect.

Foucault [1975, 1980a] captures the self-disciplining effects of surveillance in his analysis of the way in which the panoptican was designed, as a technology of surveillance. Bentham's panoptican is designed as a circular prison with individual cells arranged around a central well. In this well is a central observation tower with small blinded openings opposite the window in each cell's door. The prison warder (there need only be one) can look into each cell whenever he wishes, but he cannot be seen. The idea is that the prisoners do not know when they are being inspected, so regulate their behaviour as if they were being inspected. The design extends the effect of power with a minimum exercise of sanctions and an economy of labour:

> Hence the major effect of the panoptican: to induce in the inmate a state of consciousness and permanent visibility that assures the automatic functioning of power. So to arrange things that the surveillance is permanent in its effect, even if it is discontinuous in its action; that the perfection of power should render its exercise unnecessary...in short that the inmates are caught up in a power situation of which they are themselves the bearers. [1975, p201]

Visibility is a metaphor for a state of being: that the prisoner feels the possibility of exposure as continuous. Foucault's analysis of the panoptican suggests how practices and technologies can be designed which suggest permanent visibility but through which the need for actual surveillance is minimised. The technology acts to discipline through the possibility of visibility, in the end there is a transfer of power through self-discipline as a permanent effect in the presence of the technology (the tower) but not necessarily in the presence of a literal gaze.

Where there is hierarchical organization there is the need for inspection and examination - of surveillance - to check that things go on as they should be going on according to prescribed goals and procedures. Foucault made claims that we live in a panoptic society [Jay, 1986]. This claim refers to how many institutions were spatially constructed so as to afford opportunities for surveillance. But what is suggested by

Foucault's work as a whole is how technologies can be developed to effect disciplined conduct which act through the self and on others. In many diverse ways the practical disciplines constitute members who inspect and examine particular groups.

Alongside the individualisation of modern life (excited by rhetorics of privacy and autonomy) new technologies and practices have been developed to afford new opportunities for surveillance. For example, school nurses examine children, health visitors examine parenting, babies, the elderly and their homes.

The gaze extends through walls: practices have been developed to allow entrances to discipline the self which are of a different order than that made possible simply by spacial arrangements and a penetrating eye. It is this aspect that is missed where Foucault's emphasis on surveillance is mistaken for a literal emphasis on visual perception as detached from language and discourse [see for example, Jay, 1986].

How visibility for Foucault transcends optical inspection can be explicated by considering a study by Bloor and McIntosh [1990] of surveillance and concealment in health visiting and therapeutic communities. I shall mainly concentrate on the aspects of the study concerned with mothers and health visitors.

The authors draw on research material made up of mothers' accounts compiled through interviews with one of the researchers. The mothers accounts reveal how the mothers work out what the health visitors are up to, what their 'real' agenda is through reading their behaviour. The mothers believe that the health visitors come to check up on the adequacy of their care for their baby and that they are not doing their baby any harm. As one mother puts it:

> Ah think it's tae see if yer doin' everything right. They're just checking up to see the house is no' dirty and he's no got any black eyes or anything. [p169]

The health visitors, according to the mothers, have strategies for inspecting the house - asking to wash their hands so they can see the bathroom, or for a glass of water so they can see the kitchen. This inspection and examination of the mothers' conduct and way of life, according to Bloor and McIntosh, is extended through how the health visitor asks the mother to report on her infant care practices.

The authors explicate how the health visitors' practices constitute surveillance. Surveillance is instituted through how the mother's life-style (presumably representations of orderliness and cleanliness) and the baby's apparent cared-for-ness are being measured against particular:

> standards of child development, good and bad parenting, healthy and unhealthy life-styles, and appropriate and inappropriate child-care practices. [p163]

These standards are not constructed through the encounter between mother and health visitor but through the health visitors' discourse, their "model or episteme" [p163]. Through looking in a particular way the health visitors are evaluating the mothers' mothering. Further, the authors suggest that the health visitors have a double remit, to:

> establish a caring and supportive relationship with families, while, ... they are charged with the responsibility of monitoring the occurrence of abuse, neglect and inadequate parenting. [p164]

The authors claim these as contradictory agendas which greatly reduce the health visitors "acceptability and effectiveness", especially with working-class mothers. The health visitors' practices constitute surveillance through direct inspection under cover of naturalistic activities (but which the mothers took to be contrived) and through what the authors call "surveillance by proxy" or "report". What the authors do not develop is whether the mothers were predisposed to read the health visitors' behaviour in the light of their beliefs about the health visitors' 'policing' functions, or whether this was entirely communicated to the mothers through the health visitors strategies for facilitating surveillance.

Mothers' descriptions indicated they had strategies or 'techniques' of resistance, ways of avoiding or concealing their actual behaviour from the health visitors' evaluating gaze. Through these techniques of resistance Bloor and McIntosh appear to be claiming the mothers resisted instruction, they resisted being disciplined. Some mothers revealed how they avoid the health visitor by pretending not to be at home when she calls; others flatly refused their health visitor's advice, justifying this by denigrating the health visitor's knowledge as "ideologically" unsound (it comes out of books, not experience); other mothers concealed what they were actually doing with their baby by lying about it, and by giving the appearance of going along with what they had worked out the health visitor believed was the right way of mothering.

In their analysis Bloor and McIntosh concentrate on emphasising the resistance behaviours developed by the mothers. The mothers' perceptions of the health visitors strategies are that they constitute a form of "social control" [p169] at which the mothers express "resentment" [p170]. Bloor and MacIntosh do not draw out how this exemplifies the displacement effect of surveillance practices. They do not pursue how the surveillance constitutes changes in the mothers' behaviour: a new state of consciousness from which the resistance techniques may stem. Further, there is suggestion in the mothers' talk that the

health visitors do effect to discipline the mothers, even if this is not in the way the health visitor intends:

> Now ah leave the doors open so that, when she comes in, she can see that the house is clean. [p167]

The question arises did the mother clean the house because, or just in case, the health visitor might call? In concentrating on resistance techniques Bloor and McIntosh do not show how the health visitors gaze (their way of seeing the mothers) may effect to self-discipline the mothers through incurring in them a state of 'visibility'. The authors stress that the mothers are working class, but they do not suggest explicitly how the mother s may feel it as a matter of course to present themselves as resisters of middle class forms of social control which the health visitors may represent. In a more recent study of a mother and baby clinic in North America, Purkis [1993] has shown how the mothers, mainly middle-class women, are ready to be disciplined by the community nurses, are in fact pre-disposed to be instructed by them.

What Bloor and Macintosh's study does suggest is how, for there to be consistent disciplining effects through surveillance, there has to be a particular set of discursive and social practices which supplement the surveillance effect. This is particularly clear in the therapeutic community where various discursive and social practices act in concert to support the effects of surveillance.

For example, fellow patients acted to counteract a patient's resistance strategies at group therapy meetings: social control was exerted through patients rather than directly by staff, where staff orchestrate therapy and counteraction to enable this effect. Although this is not stressed by the authors, it gives some insight into how the combination of surveillance and other social and discursive practices act to maintain a particular form of compliance and order. As Foucault stated " the perfection of power should render its exercise unnecessary ... in short that the inmates are caught up in a power situation of which they are themselves the bearers".

There are three central issues in Foucault's thesis [1975, 1980a], suggested by, but not highlighted, in Bloor and MacIntosh's study, which are of concern to the present study.

First, that there is a relationship between forms of surveillance and subjects' receptivity to surveillance, culture, discursive and social practices.

Second, how surveillance, through which a social actor is subjected to gaze, effects displacement. The effect is to move the subject, and that implies change: in the actors relations' with himself (his feelings, the way he sees himself and his life-world) and in his

social practices and his relations with others.

Third, that in combination, where there is commitment (which was apparently lacking in the mothers and some patients and residents) and the development of technologies of surveillance there can be a permanent state of visibility through which the subject eventually disciplines himself: he acts to survey himself, to measure his practice against the set of practices and discourses through which he has been disciplined. His conduct can become self-disciplined.

How this is possible is now further explored in relation to the Foucault's history of the discourses and practices of medicine.

The Ontology of the Visible

The power any particular discourse achieves to affect social activity is related to cultural and historical phenomena. Foucault [1984] argues that 'modernity' constitutes an attitude which is in some respects determined by the 'Enlightenment'. Here the Enlightenment 'stands for' the establishment of the relationship between knowledge which is rational, and the liberty to act on the world in a rational manner rather than from superstition, prejudice, custom or habit [Foucault, 1984]. It has been argued that it is a feature of modernity to achieve subordination of the world by human domination, and to do so in the name of autonomy and self-discipline [Giddens, 1991]. This culture of modernity, or attitude, makes it possible for things to be said in particular ways rather than others. Knowledge for Foucault occurs in relation to what can be said at a particular time. Commenting on Foucault, Hacking [1986] exposes this as:

> The kinds of things to be said about the brain in 1780 are not the kinds of things to be said a quarter of a century later. That is not because we have different beliefs about brains, but because 'brain' denotes a new kind of object in the later discourse, and occurs in different sorts of sentences. [Hacking, 1986, p31]

That knowledge is embedded in a social and cultural time is important in the present context where nursing is in the position of having to show that the basis for its practices constitutes expert, rather than everyday or common sense, 'knowledge'. Nursing is limited to what it can say about itself and its patients by the social-cultural present (the conditions of possibility) where knowledge exists as what can be said. Knowledge, for Foucault, always exists in the space and time of the site, the episteme of culture [Foucault, 1970]. How the basis of knowledge for Foucault is connected with saying and writing, and how this is connected with culture, ontology and cosmology is now discussed in relation to his study

of medicine.

Practical systems or "disciplines", such as medicine, Foucault [1973] argues, have developed and maintained their power because their methodological positivism derives from a transformation of our ontology: that man, by making the "invisible visible" [p149] and by seeing with a pure, uncluttered gaze, can be free to think and act rationally, to understand the world and act in the world free of prejudice and superstition. Foucault [1973] describes this as the "fullness of positivism": while exposing death as inevitable, while examining the heart of man's finitude, medicine has also laid claims to establishing a method, an empirical science, which has given man "positive knowledge of himself" [p198].

Foucault gives clinical medicine a fundamental place in what he calls the "architecture of human sciences" [Foucault, 1973, p198]. It is fundamental because it is a discourse founded on "positive knowledge"; that is, knowledge derived from ostensible, actual observation and experience of the body and its pathologies as natural phenomena, rather than of disease as a "metaphysics of evil" [p196].

> ... illness, counter-nature, death, in short, the whole dark underside of disease came to light, at the same time illuminating and eliminating itself like night, in the deep, visible, solid, enclosed, but accessible space of the human body. What was fundamentally invisible is suddenly offered to the brightness of the gaze, in a movement of appearance so simple, so immediate that it seems to be the natural consequence of a more highly developed experience. [Foucault, 1973, p195]

Foucault is describing how medicine's methods were what set it apart as a new form of science. By making the body accessible and visible - by cutting it up, classifying and categorising its traits and parts, mapping out its structures and operations, directly observing the manifestations of disease, allowing them to run their natural course, to know them by seeing them, categorising their signs and symptoms - medicine saw the foundation of a positivism which continues to penetrate all human sciences and our belief in them today. This was the new myth, that man could know by seeing. It attempted to (and this remains at the heart of medical ideology) "free itself of theories and chimeras, to approach the object of their [clinical doctors'] experience with the purity of an unprejudiced gaze" [Foucault, 1973, p195].

Foucault [1973] argues that the clinic or hospital was developed as the place where disease could be observed taking its natural course within the body. Disease was like all natural phenomena, and only needed to be carefully observed and "listened to" for signs and symptoms, for its histories, spaces and courses to be described and defined. Central to the formation of a new order of knowledge is the abstraction of the patient as a social being:

> In order to know the truth of the pathological fact, the doctor must abstract the patient. [p8]

The foundations of the politics of the doctor-patient relationship were laid - the particulars of the patient, his social details, were transformed into phenomena which were likely to get in the way of understanding the disease. Medicine laid claims to establishing its positive knowledge by appearing to free knowledge about the body and disease from emotion, superstition and metaphysics, through basing its methods on observation, that is on direct experience of the real world, through seeing with a pure uncluttered gaze and by making the invisible visible. The transformatory power of this discourse in our ontology lies in this displacement of things: medicine changes the order of things and seeks to transform the social to construct a neutral, disciplined space.

Discourse and Displacement

A defining feature of any particular discourse is its development of a particular "set of rules of formation" [Foucault, 1968]. In the following extract, Foucault is referring to the changing discursive formations of medicine and the natural sciences at the turn of the nineteenth century:

> (a) the displacement of boundaries which define the field of possible objects (the medical object at the beginning of the nineteenth century ceases to be positioned on a surface of classification; it is mapped out in the three-dimensional space of the body); [Foucault, 1968, p56]

The association of anatomical-clinical medicine allowed the invisible - tissue, blood, internal structures - to become visible. In modernity, with the advancements in radiographic, fiberoptic, ultrasonic, electromagnetic and electronic techniques, more and more of the body's invisible mysteries can be made visible. Subjective signs and symptoms are not only no longer relied upon but have become considered to be increasingly unreliable in comparison with technical apparatus. A patient may say they experience great pain in their chest but it is of little account, if it is not made visible through blood tests and electrocardiographic techniques. If matters cannot be made visible through 'objective' forms of representation, then they may not be taken as real. Or they become translated through that other discursive map, psychosomatic illness. By drawing boundaries to mark what is to be included in any particular formation other 'things' are left out. This issue is now developed further.

The potential for power arises where this grid of boundaries is used in the practical disciplines supposedly concerned with experiential phenomena, such as nursing. For

example, the boundaries can be used to account to patients ('we do not include those phenomena in this way here, they are not relevant'). That is, the boundaries can be used to affect patients through an exclusion:

> An exclusion is an exercise of power. It is a putting away. [Hacking, 1986, p30]

This requires a discursive practice:

> (b) the new position and role occupied by the speaking subject in discourse (the subject in the discourse of eighteenth-century naturalists becomes exclusively a subject *looking* according to a grid of perceptions, and *noting* according to a code; it ceases to be a listening, interpreting, deciphering subject); [Foucault, 1968, p56]

The gaze is constructed and constructing: it defines the *space* in which things can be thought of, so that they are seen/noticed. A subject looking according to "a grid of perceptions" and "noting according to a code" is displacing the social aspects of his experience, the subject "listening, interpreting, deciphering". There is a desocialization of the subject. The subject - object divide is constituted through the gaze and the practice of examination. Through subjectification of the patient under examination, the examiner constitutes the patient as an object and himself as the subject who is objective (seeing according to a gaze which is supposedly stripped of emotion and social interpretation).

Further, it is important to recognise how Foucault turns it so that the discourse does not "penetrate" into things to "capture the language they secretly enclose" but imposes order through a coded language. The subject practising the discourse is acted upon as he develops a disciplined gaze. Through his 'seeing' (the visibility of objects viewed from a grid of perception) he desocialises himself as a presence in the presence of others. In this way forms of social distance can be affected through his perspectival seeing: through the gaze he constitutes any encounter with the other as concerned with particulars, as predecided by the discourse which he draws upon to constitute his gaze. The other, with his concerns and perspectives and beliefs, can be displaced. Through the gaze one actor can dominate the other to reconstitute social relations. This aspect of gaze is emphasised by May [1991, 1992]: nurses in constituting their relations with dying patients to include emotional and psychological therapies (the care of the subject), reconstitute encounters with patients as no longer holding the possibility of informal, unstructured relations: their gaze turns all contact with patients into a *diagnostic* possibility.

Foucault continues:

> (c) a new mode of functioning of language with respect to objects (beginning with Tournefort the role of naturalists' discourse is not to

> penetrate into things, to capture the language which they secretly enclose, to reveal it to the light of day; but to provide a surface of transcriptions where the form, the number, the size and the disposition of elements can be translated in a univocal manner); [Foucault, 1968, p56]

Foucault is emphasising how the human sciences, like medicine, which adopted the methods of the naturalist, developed to create a "gaze": by "looking according to a grid of perceptions", and "noting according to a code" the observer is not just displacing the social clutter of human beings and imposing order, he is also desocialising his actual view of the world. Further to this, Foucault is asserting the notion that this order in claiming representation is reductive: there is no longer penetration into things, to capture their secret language, there is no longer a *listening* subject but a looking and noting subject providing a "surface of transcriptions" upon which "to translate" the objects of his gaze in a "univocal manner".

What has been displaced by creating order, by looking for the same, is difference: through the gaze what is seen, and looked for, are signs which help confirm or predict. So this phenomenon is pretty much the same as that phenomenon. What is constructed by the gaze is the visibility of particular objects, but what is displaced is the social experiencing subject. Here there is the possibility to discipline and to be disciplined through particular discursive formations.

Foucault's purpose is to reveal that knowing by seeing and making the invisible visible, is a production of language and exemplifies the power of discourse to create order, to construct the world:

> it is the forms of visibility that have changed; the new medical spirit ..cannot be ascribed to an act of psychological and epistemological purification; it is nothing more than a syntactical reorganization of disease in which the limits of the visible and invisible follow a new pattern; the abyss beneath illness, which was the illness itself, has emerged into the light of language ... [Foucault, 1973, p195]

Here Foucault is stating that it is not through actually freeing the observer of theory or prejudice that medicine revealed the true facts about the body and its pathologies. Rather it is through language, through the construction of a syntax of representations and sign-systems, that order is imposed upon the body to re-say it.

Foucault is not allowing medical discourse any truth value, no more than the works of the Marquis de Sade to which he also refers:

> into the light of language - the same light no doubt, that illuminates the '120 Journees de Sodome', 'Juliette' and 'the Desastres de Soya' [- all works by the Marquis de Sade]. [Foucault, 1973, p195]

But neither is he discounting medical discourse. He is revealing the power of discourse to help construct the world: the construction of knowledge through language making objects visible. What has changed are the "limits of visibility and invisibility". Through the development of a new discourse, there is a new pattern through which different things are now invisible (discounted, displaced) and other things are visible (counted and placed).

It is not that the scientist actually knows the truth of objects because he can see them and experience them as they are. What he does, all he can do, is show by *saying* what he sees or thinks he sees:

> It was also necessary to open up language to a whole new domain: that of a perpetual and objectively based correlation of the visible and the expressable. An absolutely new use of scientific discourse was then defined: a use involving fidelity and unconditional subservience to the coloured content of experience - to say what one sees; but also a use involving the foundation and constitution of experience - showing by saying what one sees. [1973, p196]

This emphasis on 'to show by saying' is the critical matter stemming from Foucault's emphasis on discourse.

Hoskin [forthcoming] argues Foucault studies 'discourses', rather than theories, to stress knowledge as human practice. In the extract cited above, Foucault excavates the formation of a new discourse *and* practice. A condition of reality, the "foundation and constitution of experience", is thus guided by this new science: a construction of language which claims a "perpetual and objectively based correlation of the visible and the expressable". The scientist-naturalist makes objects knowable by making them visible through a construction of language. There is a new way of saying things; but this in turn disciplines, so that there is belief in the ways things are said and those who can say them. In this way there is the possibility for experts to constitute themselves as those who hold the title to say what can be seen: expertise is constituted through, not just language, but through language which says that it represents a particular knowing and seeing, that the speaker has *special sight.*

In his introduction to his research into the birth of the clinic and medical methodology, Foucault [1973] makes the claim that his project is both "historical and critical" and that it is concerned with "determining the conditions of possibility of medical experience in modern times" [p.xix]. Foucault reveals a possibility for how discourse in conjunction with a specific practice (the examination) is involved in the constitution of conduct designated as expertise.

He reveals how it is the particular forms of representation claimed as a particular

methodology that can make us believe in, or rely on, those who are able to appear to really "show" by "saying" that they 'see': we rely on the invisible in modernity, giving preference to those domains of knowledge which can make objects or activities visible through privileged modes of speech (forms of representation). We rely on, and use, this process to tell us to prefer, privilege or prioritise as 'real' or 'true' or 'valid' those entities which can 'positively' be shown by those privileged to say that they see them. Through discourse, medical people are given a special sight by which they can actually see that which the lay person cannot. We believe that they can actually see disease, and that what they see is importantly real. We do not experience medicine as a form of representation, nor as a form of re-presentation, but as presenting us with the reality of our condition.

According to this exposition the effects of discourse are wrapped up with both the production of signs, the constitution of meaning, the disciplining of conduct in social organization and the visibility of action as an account of the self.

Conceptions of the 'visibility' of human activity are implicated by Foucault in relations of power in several ways. First, visibility is related to 'knowledge'. The concern for the visibility of action as based upon knowledge affects what social actors 'count' to be in the world, as having status and substance, and affects what they discount, as lacking status or substance. What is seen is an interpretation of experience of the world in relation to different frames of meaning: that is, what is seen is wrapped up with what can be said, what can be accounted for. That which is 'seen' relates to that which is knowable and explainable in a particular fashion, orderable in relation to a particular discourse. Conversely what cannot be easily ordered and explained tends to remain unseen, to be overlooked and generally left out of account. Where the objects in a gaze are persons, the situation is complicated: Foucault is suggesting that a person who adopts a gaze does not only use the gaze to constitute his own identity (as one with special sight and knowledge, as an expert) but he uses it to construct the identity of the other, the person in the gaze. This constitutes the relationship between them as a power relationship of a particular kind.

The difficulty, as Foucault reveals it, is that discourses as particular forms of representation, and their associated practices (e.g. the examination), in their ordering of experience and the world *displace*, as well as construct, both meanings and persons, distinctions and identities. This is the worrying aspect of the knowledge/power relation: the possibility for exclusion and displacement. It is where these discourses and practices are institutionalised that power gets effected. What Foucault's work suggests is how conduct can be disciplined through discourses and practices; which taken together in a social context,

act to construct or define not simply ways of 'seeing' but what is seen, what can be said, how social relations are constituted and the identities of social actors.

Surveillance certainly helps to set up a field of visibility. However, it is through the conduct of actors, through the 'social' as interpenetrated with notions of expertise (*seeing is saying*), that the moving around of persons is accomplished. Foucault's work suggests how it is through discourse as *practised* that actors can displace, make absent and invisible. Configurations of visibility, language, action and identity are also critical to Goffman's [1955, 1958] work and to Garfinkel's [1967; Garfinkel and Sacks, 1969; Garfinkel, 1974; Garfinkel, 1986] work on accountability - what is "observable-reportable". These matters are discussed in detail in Chapter Four in relation to the methods of conduct and analysis of fieldwork. In the next chapter they are discussed in relation to the constitution of nursing discourse. The next chapter explores the development of nursing assessment in the discourses of nursing in relation to the rules of formation (method) and the practices they seek to institute.

CHAPTER THREE

THE NURSING PROCESS AND NURSING ASSESSMENT

> Culture is clearly becoming a drag. Indeed, anything identified with practices that have a past runs the risk of being the "culture" that slows the impetus of innovation.....technology frees one from and economic competition must work free of the trammels of tradition. Culture is a drag. [Strathern, 1993, p19]

Introduction

An aim of the current study is to develop an understanding of nurses' discourses and practices as undetached from culture and social organisation. An aspect of this is to suggest how the nursing process can be considered as a technology which as Strathern's essay goes on to suggest, can be considered an *artefact*:

> technology and economics are as much artefacts as anything else we make. [Strathern, 1993, p19]

This chapter gives a critical and historical view of how nursing assessment has been conceptualised as a technology designed to develop paradigms in nursing. This chapter examines how the concept, 'nursing assessment', constituted as a set of discourses and practices, detaches technology from culture. What constitutes 'nursing assessment' brings into play, in the literature, conceptions of nursing in relation to issues of method and knowledge, nurses' status and the purpose of nursing practices. It can be considered a focal point, therefore, as it is around what constitutes 'nursing assessment' that issues of nurses' identity and the relationship between this and wider cultural and societal forms are configured.

This chapter is not intended to be an exhaustive review of techniques for nursing assessment. Rather, nursing texts are examined in the light of the question, taken from Game [1991, p5]:

> How does this particular nursing text mean?

Taking a critical perspective, the phenomena under study in this chapter are the ways in which 'nursing assessment' has been constructed as a way of saying something about, and pointing to, things in the world, such as nurses' knowledge, the basis for nurses' actions in relation to patients, the patients themselves. This entails critiquing the literature to question conceptualizations of nursing assessment as systems of distinction, which help constitute

identities and difference. This involves a study of the language in which nursing assessment has been written.

The chapter begins with a brief overview of how nursing assessment has been conceptualised in the nursing literature. This is then followed by a discussion of the possible historical conditions which are background to conceptualisations of nursing assessment.

Then the work of a principle nursing writer concerned with conceptualising how nurses' should, or do, go about making decisions in practice is examined in detail. The work of Doris Carnevali [1983], has been selected as her work is taken to constitute a normative and cognitive approach to nursing assessment. The purpose of this detailed examination is to analyze how nursing and patients and the assessment of one by the other is being represented (written) through this paradigm. And further, to suggest what the possible effects of this are as a form of representation.

The next section examines studies which are concerned with implementation of models for nursing assessment. This literature reveals how problems with implementation of such models are conceptualised as problems with the 'context' of nurses' practices, sometimes referred to as "the culture of nursing".

Finally, in the fifth section it is suggested how models for nursing assessment, widely introduced into nursing education and nursing practice in Great Britain as an aspect of the nursing process, may be understood to constitute a 'technology'. The notion of a technology implies that nursing assessment has been developed as both an aspect of nursing discourse (a way of saying) and as a practice (a way of seeing and examining), both of which institute new ways of being with patients and of constructing nurses' and patients' identities. Further, that as discourse and practice, nursing assessment has been developed within the conditions of possibility suggested in Chapter One, to discipline nurses and change practice through reconstituting the social. This leads to a statement of the purpose and focus of fieldwork undertaken in the current study as a way of examining nursing assessment as an aspect of nurses' conduct.

'Nursing Assessment'

The term 'nursing assessment' occurs in the nursing literature as an aspect of the nursing process. In defending the nursing process against criticism from the medical profession, Tierney [1984] described it as a "method", the purpose of which is "a systematic approach to the provision of individualised nursing care" [p835]. The development and

introduction of the nursing process into British nursing practice and education began at the end of the 1970's [De La Cuesta, 1983; Dingwall *et al*, 1988].

The nursing process model favoured in Britain has been referred to as a "stages model of problem-solving" and is based on more generalist models of problem-solving and information-processing [Hurst *et al*, 1991]. Typically this approach describes four stages [see for example, Carnevali, 1983; Cormack, 1985; Hurst *et al*, 1991; Kratz, 1981; Roper *et al*, 1980 and 1981; Thiele *et al*, 1991]. These are:

1 assessment (data collection and problem identification)

2 planning (the clear statement of nursing actions with their objectives)

3 implementation (delivery of care)

4 evaluation and reassessment

In this way assessment is conceptualised as the exercise of data collection and problem identification and as separated from, but as enabling, the construction of a plan of care and the delivery of care. The process is normative in that it presupposes how nurses should conduct their approach to assessing patients and presupposes the possibility of prediction in relation to the outcomes of nursing activities. In management terms it institutes a way of managing (patient care) by objectives.

Typically, therefore, nursing models represent nursing assessment as one aspect of a 'process' and as essentially technical [Hiraki, 1992], to be learnt and applied, more and more expertly, with practice and experience [Carnevali, 1983]. This emphasis on the technical should be noted, as it implies detachment from and displacement of the interpretive, interactive and contextual aspects of nurses' understandings. It implies a particular set of relations between the social, as the context of action, and the technical; and that this relation is detached one from the other.

There is legitimation of conceptualising nursing as a problem-solving activity through claiming it is how "good" nurses have always worked [Roper *et al*, 1981, p11] or with empirical demonstration that it is actually how nurses work [Hurst and Dean, 1987; Hurst *et al*, 1991; Tanner *et al*, 1987]. The difficulty here is that this has led to a circular logic: a problem-solving, cognitive approach to practice is advocated because it is how 'good' nurses work at their best, when nurses are not doing problem-solving as per process, they are not nursing well. These conceptual models for nursing assessment do not derive from empirical studies of how nurses assess patients, but draw on the work done in cognitive psychology on conceptual models for human problem-solving [Hurst *et al*, 1991; Newell and

Simon, 1958] and information processing [Carnevali, 1983]. 'Nursing assessment' has only been examined empirically subsequent to its conceptual development as an aspect of a problem-solving, information-processing activity.

This empirical work takes a model for nursing assessment and examines how nurses or nursing practice 'matches' up to the model [for example, Bachman *et al*, 1987; Faulkner and Maguire, 1984; Gray, 1977; Hulter Asberg, 1986; Hurst *et al* 1991; Miller, 1984, 1985a; Morrison, 1989; Price, 1987; Thiele, 1991; Wells, 1980]. These studies suggest a normative relationship, rather than an interpenetrating relationship, between theoretical nursing assessment and nursing practice.

Benner [1984] has laid claims to developing a theory of nursing expertise, particularly of clinical decision-making and patient assessment, which is inductive (developed from practice). It would appear that she has taken the problem-solving model as the conceptual model from which nurses start to do nursing but which changes as they get experience through practising nursing to become experts. She is not refuting the problem-solving, information-processing model as the basis for practice, but builds upon it to reveal how practising nurses change over time to enhance and sometimes achieve a different way of assessing patients: their assessments are "holistic" and situated in a specific context. However, as discussed in Appendix One, Benner's (and her co-authors') methods reproduce an *individualistic* context: the methods are based only upon the narrative accounts of individual nurses from diverse settings. One objective in the current chapter is to explore how the relationship between nurses' understandings about patients and the context of practice is conceptualised in the nursing literature.

Nursing models estimate that assessment should be individualised and systematic [see for example, Carnevali, 1983; Cormack, 1985; Roper *et al*, 1980]. Methods for assessment are conceived of as entailing both observation and communication skills, which can be taught and practised [Carnevali, 1983; Cormack, 1985; Faulkner and Maguire, 1984; Roper *et al*, 1980, 1981]. Further, theoretically, nursing as per process, with its focus on the individual patient and his response to illness will complement the medical model and its attendant ideologies [see Carnevali, 1983] and will help empower nurses [see for example Dickson, 1982; De La Cuesta, 1983].

Underpinning models for nursing assessment are humanistic notions of the individual. This is effected in two ways. First, both in the sense that nursing assessment directs nurses to focus on the individual patient and that they should take account of patients' subjective experiences of illness and the meaning it has for them in relation to their

future [see for example, Carnevali, 1983; Cormack, 1985; Roper *et al*, 1980, 1981].

Typically, models for nursing assessment suggest the institution of assessment practices, such as an interview-type encounter between a patient and a nurse, as soon after their arrival as possible, although assessment and reassessment are conceived of as an ongoing process [Roper *et al*, 1980, 1981]. This interview is aimed at the completion of an assessment document or patient profile, through which the nurse collects information about the patient to enable identification of patients' problems ("potential" or "actual"). The structure of the assessment document varies in its specifics according to the model of nursing being proposed (an activities of daily living model, a systems model, etc) but covers what are termed the patients' usual health and functional status (a 'history', including their medical history), their emotional status and their social situation or lifestyle as well as their present status in relation to these things and their medical condition. In this way the nurse is directed through the structure of the nursing assessment to pay attention to the patient as an individual, focusing on what *impact* illness or trauma is having on them.

Second, it is humanistic in that the nurse is constituted as an individual who assesses a patient and develops a plan of care: she is constituted as an autonomous subject and as rational, as one who is able to see and plan in a particularly organised and systematic way.

Typically models for nursing process advocate that nurses write down all aspects of the process: the information they gather, the problems they identify and their planned interventions with their reasons and objectives, the patients' responses and progress and the nurses' evaluations of their interventions. This, along with a patient allocation system or a primary nursing system, should theoretically help enhance the humanistic aspects of the process. Pembrey [1980], for example, taking into account that British hospital wards are staffed by learners as well as qualified nurses, suggested that to help ensure individualisation of patient care through assessment and implementation of a care plan, evaluation and reassessment, the ward should be managed in particular ways. These included a patient allocation system of nursing, a daily 'assessment round' by the ward charge nurse and the institution of accountability (and feedback) practices through verbal and written reports.

Both the relationship aspects of the process (nurses acting to be responsible one to one with patients as individual subjects) and the increased accountability of the individual nurse are effected through this form of assessing patients. An aspect of this it has been suggested is to help ensure both appropriateness and continuity of care [see for example, Lindeman, 1981; Roper *et al*, 1981].

Specifically then, nursing assessment has been conceptualised in the literature as the

collection and review of information about patients which enables nurses to identify patients' problems and plan their nursing care.

It is important to stress the ambiguity in the literature over whether nursing assessment is to be understood as separate from 'clinical decision-making' or whether it is simply separated from this concept to facilitate its explanation as a conceptual model, and that in practice the two aspects are inseparable. Further, there is in the literature a separation or detachment of 'clinical decision-making' from other aspects of nurses' decisions: 'management decisions' and 'clinical decisions' appear to be conceived of as detachable from each other [see for example, Carnevali, 1983]. A critical aspect to the present study is to uncover the significance and effect of these separations and how they constitute the context of practice as represented by nursing discourse.

There follows an examination of the historical background in which the nursing process was developed. Relationships between this background and the ways in which nursing assessment has been conceptualised are suggested.

Historical Location of a Developing Discourse

As stated above, theories and models which conceptualise nursing as a process, present systematic and comprehensive nursing assessment of individual patients as a rational basis for planning nursing interventions. In this section the background features are explored in which conceptualising nursing as a 'process', and in particular the development of 'nursing assessment' has been developed. They entail nurses' satisfaction, the construction of their identity as 'professionals', methods for learning on the job and rationalising nursing practice to make it more humane and more efficient.

A study originally published in 1960 by Isabel Menzies Lyth of the nursing service of a London teaching hospital explored the problem of conflicting expectations. These were constituted as the provision of an adequate service to patients which relied upon student nurses as staff and for students to have the adequate practical experience to enable their training. The initial exploration revealed a "high level of tension, distress and anxiety in the nursing service" [p439]. The consequences were manifold: frequent withdrawal from duty, high sickness rates, a third of students dropping out of training, senior nurses changing their jobs more frequently than workers at similar levels in other occupations.

Lyth identifies the causes of anxiety as inherent to the nature of nursing work:

> Nurses face the reality of suffering and death as few lay people do. Their work involved carrying out tasks which by ordinary standards, are

> distasteful, disgusting and frightening. Intimate physical contact with patients arouses libidinal and erotic wishes which may be difficult to control. The work arouses strong and conflicting feelings: pity, compassion and love; guilt and anxiety; hatred and resentment of the patients who arouse these feelings; envy of the care they receive. [p440]

Patients and relatives on the other hand also expressed complicated feelings to nurses, often leaving them puzzled and distressed:

> Patients and relatives showed appreciation, gratitude, affection and respect; a touching relief that the hospital coped; helpfulness and concern for the nurses. But patients often resented their dependence; accepted grudgingly the discipline imposed by treatment and hospital routine; envied nurses their health and skills; were demanding, possessive and jealous. Patients, like nurses, found strong and erotic feelings stimulated by nursing care, and sometimes behaved in ways that increased the nurses' difficulties, for example by unnecessary physical exposure. Relatives could also be demanding and critical, the more so because they resented the feeling that hospitalization implied inadequacies in themselves. They envied the nurses their skill and jealously resented the nurses' intimate contact with "their" patient. [p441]

Lyth firmly places nurses and patients together in an emotional life-world: a world of experience where feelings are conflicting, multi-dimensional and multi-form. This is in contrast to conceptualizing the nurse-patient relationship as superficial (De La Cuesta, 1983). The interesting aspect for Lyth was, why did the anxiety levels not get dealt with? Why did they remain so high? Lyth claims that members of an organisation use the organisation in their "struggle against anxiety" [p443] by developing what she calls "socially structured defence mechanisms" [p443].

Lyth shows how organisational practices developed to defend against anxiety recursively reproduce the very conditions which exacerbate anxiety. The most important one in the present context was what Lyth refers to as the "splitting" up of the nurse-patient relationship. By organising work as lists of tasks, nurses were attempting protection from anxiety by restricting contact with patients. There were other devices to reinforce this system which operated at both a cultural and a structural level. Lyth describes these as "depersonalising" and eliminating individual distinctiveness, affecting both nurses and patients alike. She states that there was

> an almost explicit 'ethic' that any patient must be the same as any other patient. It must not matter to the nurses whom they nursed or what illness. [p444]

Nurses degraded patients self-identity by referring to patients by the pathology or organ under medical inspection and their geographical location in the wards: patients were

reduced to a metonymy - the "'liver in bed 10" or "'the pneumonia in bed 15'". Similarly it should not matter to the patient which nurse nursed them. The uniform was a symbol of this:

> a nurse became a kind of agglomeration of nursing skills, without individuality. [p444]

While Lyth subscribes to the notion that genuine detachment needs to be developed by any professional working with people in a 'therapeutic' relationship she does not associate this with repression of feelings by denial. She suggests detachment by splitting and denial was an implicit operational policy. Emotional detachment was taken by superiors as the sign of a good nurse. In this respect nurses were moved as the needs of the service required from area to area:

> The implicit rationale appeared to be that a student nurse would learn to be detached psychologically if given sufficient experience of being detached physically. [p445]

Relationships were denied by the system, systematically. There was also a "policy for inactivity". This was incurred by the diffuseness of responsibility and authority. There was delegation upward, so that low level tasks were carried out by nurses where they bore little relation to individual's skill, ability or position. Student nurses were seen to behave irresponsibly and their superiors were seen by them as disciplinarian. The result was a near breakdown of the nursing service.

Lyth's study illustrates how in nurses' and patients' life-worlds emotion, identity and organisation are inextricably linked. The study suggests how forms of organization interpenetrate with the socially constructed nature of relationships in particular settings and help constitute both patients' and nurses' identities. Lyth's study indicates difficulties with the ways in which nursing was being managed at the beginning of the sixties: that it was time for change. There were forms of distanciation created between patients and nurses which led to anxiety, low morale and dissatisfaction. The central issue was the way in which the nurse-patient relationship was being constructed through forms of organisation.

Lyth's study suggests that new systems of nursing needed to be developed which help organise nursing and the nurse-patient relationship to enhance nurses' satisfaction and discipline. It has been suggested that this was one of the issues which development of a system of nursing based upon the nursing process might help address [De La Cuesta, 1983]. The implication of Lyth's study is that systems of nursing need to be developed which focus nurses on patients as individuals, which help give nurses a sense of continuity and of their own individuality, but through which they can maintain a "professional detachment".

Through individuating nurses' practices and allowing them to develop responsible relationships with patients this should lead to greater involvement, but with professional detachment somehow built in, and then to nurses' satisfaction. It should be noted the impetus for the study was a manpower planning problem: nurses were dropping out.

Nurses have been criticized as hidebound by routine and a concentration on medical and physical aspects of nursing care which detracted from a focus on the individual patient and their specific needs. This is also implicit in the ways in which models for nursing are written.

Wells [1980], for example, in her empirical study of a geriatric nursing service identified that nursing care was organised as a series of tasks. She found that nurses did not focus on individuals and their physical needs, but that nurses' prime concern was "the completion of ward routines" [p128]. Wells attributes what she describes as the sometimes disturbing and inhuman lack of regard for patients and their needs, to nurses' poor knowledge and skill. She suggests that the situation could be rectified through improving nurses' knowledge and through teaching nurses analytic and problem-solving techniques.

Underpinning Wells' methods is a notion that knowledge is theoretical and taught:

> One of Florence Nightingale's [1859] major tenets was that good nurses did not arise through experience or inborn traits but through explicit teaching. Nurses needed to have knowledge in order to perform the functions and skills expected of them. [p29]

She claims in her study that the central difficulty arose from ignorance and the non-analytic nature of nursing practice:

> The central problem in geriatric nursing is the central problem in all of nursing: nurses do not know why they do what they do. It is not helpful to anyone if nurses base their work on principles of trial and error, custom and habit... Nurses have not been taught how to identify problems in patient care, how to take action to solve such problems, or how to evaluate the effects of nursing action. In order to do this nurses must be educated in problem-solving techniques and focused on the patient. [p129]

Here Wells is claiming that nursing was based upon "trial and error", "custom and habit". This is echoed by Pearson and Vaughan [1986] in their justification for the introduction of models for nursing discussed below. Wells is making the assumption that by teaching nurses "problem-solving techniques", by getting them to examine their practice and evaluate it they will "focus" on the patient and their practice will be improved, that it will not be based upon trial and error or custom and habit. Care will be managed better.

Wells' exposition exemplifies how nurses' reached for normative solutions to problems in practice. Further the study method detached nurses' practices and ward

management from wider issues. This point is made by Evers [1982] in a review of nursing research aimed at uncovering how ward management, including the nursing process, is a key issue in nursing practice. Evers states that Wells

> ... does not address the relationship between geriatric nursing work done in hospital wards, and the social and organisational context in which it is done; she looks at only the nursing component of geriatric care. [p23]

Evers argues that this was the problem with nursing research generally: the way in which problems were being conceptualised led to an isolation of nursing practice from wider social issues and to "neglect of the patients' interest and perspective" [p24].

The nursing process developed at a time then when there was seen to be a need to reform the organisation of nursing practice. So far this has emerged as having two possible facets: improving the experiences and satisfaction of nurses through redefining their relations with patients, and improving the quality of care through teaching nurses problem-solving techniques and analytic approaches to their work to enable them to evaluate what they do.

Nursing process developed at a time when there was an expressed need to help both formalise nurse-patient relations, to focus nurses on the individual and give them individual responsibility as well as introduce systematic, problem-solving techniques to enable nurses to be more analytic and reflexive. However, it has been suggested that the nursing process was developed as not just a method to help discipline nurses but also to emancipate both nurses and patients. This aspect is argued by De La Cuesta [1983] in her study of the development of the nursing process.

De La Cuesta [1983] sought to demonstrate the sociology of the development of the nursing process, both in America and Britain, by extensive examination of the extant literature and by talking with and observing nurses in both countries who worked using a nursing process model. De La Cuesta reveals differences in how the nursing process emerged and was seen in the different cultural contexts in terms of the work that nurses hoped adoption of the nursing process would do for them. In America, she argues, it was seen as a "professional strategy", to improve professional status, not simply as a method for changing practice.

According to De La Cuesta, the nursing process in Britain was adopted and modified by British theorists at a time when there was dissatisfaction with nursing practice: with a "task-orientated approach", "lack of individualised care", "low-level of job satisfaction" and "the superficial nature of the nurse-patient relationship" [p367] (all aspects present in Lyth's study). The nursing process was seen primarily as a method to improve practice both

through it's adoption as an educational method "as a device to understand and teach nursing" [p367] and it's application to nursing organization in practice -

> The nursing process was seen more in terms of a method to improve quality of care and the nurse's satisfaction than a vehicle to achieve professional status as it was described in the literature. [p368]

De La Cuesta is emphasising how the nursing process was adopted because of hopes for its potential to improve "quality of care" and improve nurses' feelings about their work, their sense of satisfaction. Both these aspects have been illustrated above by the studies of Lyth and Wells. De La Cuesta is suggesting that introduction of a nursing process could do just that through focusing individual nurses on individual patients, giving personal continuity to both.

De La Cuesta does not link development of the nursing process, with its focus on the individual and the inclusion of the subjective experience of illness and the 'social' background of the patient, with trends in society at large oriented to customer satisfaction and economic citizenship. Nor does she link the development of the nursing process to managerial requirements for goal-driven practice and visible rationales, as discussed in Chapter One and in the work of Dingwall *et al* [1988]. Further, by the early 1980's Britain was catching up with America in linking the development of the nursing process with strategies to professionalise and empower nursing [see Dickson, 1982; Dingwall *et al*, 1988; Melia, 1981; Read, 1989].

However, De La Cuesta stresses that the nursing process represents an "ideology". This is implicated in the introduction of the nursing process as an occupational strategy to change nurses' status [see for example, Dingwall *et al*, 1988; Melia, 1981; Read, 1989] and release them from the domination of their practice by the medical profession. It has also been stressed how in its attention to the patient as an individual, it will bring "power to the patient" [Roper *et al*, 1983].

That the nursing process represents an ideology is argued by Dickson [1982] and Pearson and Vaughan [1986]. Dickson [1982] suggests that the nursing process can be considered an 'ideology' because it represents the move away from focusing on the patient as a person suffering from a disease - "a cure ethos" - to focusing on them as a person, coping (or not) with their activities of daily living. In this way the nursing process, and in particular the notion of the individual (nurse/patient) central to its formation, constitutes a move to define the proper focus of nursing activity.

This aspect of redefining the focus of nursing as an ideological issue represents a

move away from medical domination and towards more humanistic conceptions of nursing. It enmeshes development of the nursing process with discourse on the professionalisation of nursing. This point is also emphasised by Dingwall *et al* [1988]. The literature concerned with how nursing is dominated by medicine is now discussed.

Nursing has been implicated as being dominated by medicine [see for example, Benner, 1984; Bishop and Scudder, 1987; Bond and Bond, 1986; Brink, 1991a; Carnevali, 1983; Mackay, 1989; Melia, 1981; Pearson and Vaughan, 1986] and that this domination is anti-nursing, anti-caring in some way.

Mackay's [1989] study of a nursing service in a District Health Authority, was undertaken by the University of Lancaster, at the request of the health authority, to investigate the problem of nurse wastage. Mackay identifies a "system in which nurses operate". The 'system' in which nurses operate she asserts, is dominated by the medical profession and a cure ethos, both of which are problematic for nurses. She correlates the greater resources allocated to the acute sector with domination of health care by a medical ethos, in that this is the area in which doctors are most active, because the cure ethos is at its most powerful and that doctors' activities are at their most visibly effective. Other areas of health care are less attractive because they do not demonstrate *medical* efficiency (the spectacle of medicine's effectiveness)

> ...the areas within health care which enjoy greatest prestige are those where the interventions of the medical profession are greatest. At the same time, the worst funded areas are, of course, those furthest from the curative process. Within a health service which is dominated by the acute sector, it is apparent that the medical profession occupies centre stage... the way in which resources are allocated within the health service, it is apparent that the 'cure' ethos of doctors completely overshadows the 'care' ethos of nurses. The Health Service is geared towards illness rather than health and towards acute health care rather than the needs of the long term sick. Yet nursing itself is geared toward the acute, hospital sector. [p47]

Mackay asserts that the dominance of the medical profession has become "virtually unassailable" [p47] and that nurses are "silent" and acquiescent partners, "schooled into subordination" [p46] by the hierarchical system in which they are socialised. She locates the problem in socio-economic and gender factors: nurses are mainly women, and doctors are mainly men who come from a traditionally superior class and educational background. While Mackay admits that nurses are partly implicated in their lack of power and in their subservient position she does not go further in investigating the issues involved in the structuring and reproduction of the dominance of medical authority. Further, to refer back to Chapter One, the focus on elderly people and their different needs suggests how a new

focus of patient management and care is being developed which is not centred on the *cure* ethos.

Bond and Bond [1986] propose ways in which medical domination can be understood. The authors suggest that hospitals can be considered as rational bureaucracies, as defined by Max Weber. There are two aspects of importance here. First, that bureaucracies rely upon each member of staff being trained in a rational manner so that there is an "ethos of objectivity". That is, discourse which counts must be developed from objective knowledge. Secondly, bureaucracies are organised as hierarchies. The authors claim, drawing on the work of Freidson [1975], that the medical profession is at the top of the hierarchy and the work of non-medical professional staff is organised by *doctors' orders*:

> At the top of the power hierarchy are senior doctors who have achieved their dominance by virtue of being regarded as having expert knowledge as well as holding socio-legal responsibility for patients. [Bond and Bond, p179, 1986]

They state that nurses are constrained by the medical profession and the administrative hierarchy alike, but are still able to exert power over patients.

Developing discourses and practices in nursing which reveal it as rational and based upon objective knowledge are therefore important if nurses are to enhance their status within hospitals and redress the balance of power between themselves and doctors. Another aspect affecting this balance of power is through the development of management structures through which nurses are finding greater representation. This aspect has been stressed by Shrock [1987]. It is being suggested in the present study that critical to the *particular ways* in which nursing discourse has been developing to construct nursing as a process is this issue of redressing the balance of power. Nursing has to re-present itself as scientific discourse, as having an expert and rational objective knowledge base but also show that its focus is distinct from that of medicine. To refer back to the discussion of Foucault's work in Chapter Two, nurses must be seen to know and do what others cannot see and know, and they can do this by developing new forms of (writing) representing nursing and their relationship to patients.

The development of the nursing process as helping to redress the ideological stronghold of medicine in health care is explicitly illustrated by the writing of Pearson and Vaughan [1986]. Pearson and Vaughan present an argument for using models of nursing which are based on humanistic notions of health care and which will redress the balance of power so that nurses get recognition for what they do and throw off the domination of nursing by medicine. They claim that nursing has been dominated by a bio-medical model:

> The most influential model for practice in health care over the last century has been this so-called 'bio-medical model'... [p19]

The authors claim that the bio-medical model is linked with reductionism, specialization and technology. In practice, they argue, it has led to particular forms of organization, in hospitals and in nursing practice itself. Nursing has become 'pragmatic':

> the skilled technical nurse extending her role to cope with the direct effects of new technical knowledge...associated with a practical approach to assessing situations and acting on them. [p20-21]

The authors claim that more currently "many people are now asking whether some of the essence of nursing has been lost through an over-emphasis" [p21] on nursing as a composition of technical skills and a trend towards specialization. The authors argue that the hierarchy of tasks and roles in nursing have developed because of the domination by the bio-medical model in nursing practice. In this hierarchy what is most valued are the aspects of nursing which are "cure-directed" (doctors' procedures, drugs and dressings) while what is least valued is physical care and emotional or "psycho-social care":

> The bio-medical model, therefore, has led to an emphasis on the technical, medically-related aspects of the nursing role and to a resulting devaluation of acts related to how individuals are experiencing their own illness or disabilities, such as listening, comforting or the offering of choices. [p23]

The authors assert that the medical model is no longer a choice for nursing practice because it is dualistic and reductionist, and not geared to the needs of the individual, but to the interests of health care professionals. With Capra [1982], the authors assert that the bio-medical model demands that the "doctor hold the power in all decision-making" and the role nurses play in "their healing contacts with patients" is not recognised - so that it devalues the "human side of health care" [p25]. The 'answer', according to the authors, is to change the focus of nursing practice. In other texts this 'human-side' of nursing is conceptualised as the "art" of nursing, to distinguish it from science (see for example, Holmes, 1992).

The authors claim this can be accomplished through throwing off the domination of the bio-medical model of health care, and developing and introducing more holistic models for nursing. These models are based on particular forms of patient assessment and care-planning, and constitute a problem-solving approach. The authors emphasise how these models should help nurses accomplish several things simultaneously: a focus on the patient as an individual, theory building, research-based nursing criteria, evaluative practice and nursing accountability. In short, through writing patients and nursing in particular ways nurses can make what they do more visibly rational.

It is suggested then that the ways in which the nursing process has been developed

is concerned with changing how the proper focus of nurses' practices have been traditionally legitimated by medical discourse. How the domination by the so-called medical model has been achieved is implicit in nursing texts on the nursing process.

I am suggesting that the nursing process can effect change through instituting new forms of signification and legitimation, the media of power [Giddens, 1984]. Through new forms of writing about nursing there is possibility of making nurses' knowledge and interventions visible through *writing* them as based upon different criteria from those of medicine. This is explicitly expressed by Roper *et al*, [1981] in their introductory textbook to learning the nursing process:

> If all nurses *begin to document and retain nursing data*, it will not only be useful for nursing subsequent patients, but it will provide evidence of:
>
> * *nursing's* body of knowledge
> * the value and prestige of the *nurse-initiated* components of nursing
> * the evaluated effectiveness of specific *nursing* interventions
> * the decision-making aspects underlying *nursing* activities, a criterion used by managers when assessing status and earnings
>
> [Roper *et al*, 1981, p1] [my emphasis]

In summary, development of an aspect of nursing, 'nursing assessment', is conceived of as forming a part of an overall nursing process. Conceptualising nursing as a problem-solving process represents a movement in nursing discourse to draw upon cognitive solutions to particular problems, constituted in the literature. These problems have been identified variously and configure around task-driven, routinised practices which waste time and are based upon custom and habit; poor nurse-patient relationships which lead to a disregard of patients as individual, experiencing persons and to nurses' anxiety, low morale and fall-out from the profession; ideological issues of domination by a bio-medical model and of domination of nurses by doctors; difficulties with showing the professional status of nursing. It has been noted that this emphasis on the effectiveness of cognitive solutions reflects a more general managerial ethos current at the time of the development of the nursing process [Dingwall *et al*, 1988; Read, 1989] and has also been attributed as no more than the productions of "academic professionalisers" [Melia, 1981].

It is recognised in the present study that the way in which nursing discourse has developed - writing nursing as a process - can be understood as enactment [Bantz, 1990; Wieck, 1979] of the conditions in which nurses work and reflect wider cultural issues.

These conditions create pressure on nurses to show nursing as having an independent, but cognitively based, that is 'rational', activity from medicine. This is central to a managerialist ethos. As Roper *et al*, [1981] suggest in their introduction, a nursing process, through writing in particular ways can reveal, and (I would argue) help construct, the independent therapeutic input of nursing to health care. Further the enactment is constituted through new permissions created by the impact of management on health services: patients can be viewed in relation to their past and their future to give a sense of individuality (customer orientation) and also to promote a focus on discharge potential.

It is being proposed in the present study that the methods which advocates of a nursing process put forward to humanise nursing, making it more visibly rational and therefore more rational, and which will liberate nursing from medical domination, represent a discourse developed to discipline nurses in particular ways. This discipline will also help reconstitute nurses' identity: nurses will be identifiable as self-disciplined and as autonomous, as rational and objective practitioners. Both through using the nursing process as a tool with which to teach nursing and as a system to organise practice, it can be taken as a discourse which disciplines.

However, as discussed in Chapter Two drawing on the work of Foucault, a discourse is disciplining and constitutive through how it makes objects in the world thinkable in particular ways (rather than others) and how it places objects in the world in an order. This makes particular connections possible, while displacing and detaching other things.

The next section is a detailed analysis of the ways in which 'nursing assessment' has been conceptualised and in what ways it represents nursing, nurses and patients (writes nurses, writes patients). This constitutes examination of the nursing process as the paradigm which has dominated British nursing practice and education since the 1980's. The paradigm represents nursing assessment as analytic and reflexive method, expressed by a normative model of nursing as a process. The analysis develops to illustrate how the forms in which 'nursing' are written constitute a language which establishes particular systems of distinction [Deetz, 1992] and which puts "into play a way of pointing to the 'out there'" [Deetz, 1992].

Analytic and Reflexive Nursing Assessment

Typically, theorists and researchers who have written about nursing assessment implicitly or explicitly draw upon theories of problem-solving and/or information-processing [see Hurst *et al*, 1991; Tanner *et al*, 1987]. These theories are underpinned by articulations

of ways of knowing, communicating and seeing. Carnevali's [1983] work is reviewed here as she makes explicit a problem-solving, information-processing approach in her model of nursing assessment.

Carnevali [1983] describes nursing assessment as concerned with enabling nurses to make effective "nursing diagnosis" and [clinical] "management decisions". She defines assessment as:

> ...deliberate, systematic and logical collection of data from presenting situations, together with the assignment of meaning to the input received. [p92]

It is an "active process of observation and critical thinking" [p92]. Nursing assessment is constructed as a "nursing history" or "data-base", mimicking the concept of a medical history, developed and utilised as a part of a system for managing nursing. Carnevali asserts that clients consult health-care professionals for "their discipline-specific knowledge and expertise" [p7]. She states that nursing is charged with defining the

> domain of knowledge and practice in such a way that it forms a clearly comprehensible focus to practising nurses for their data base, branching logic, diagnosis, prognosis, and treatment decisions. [p7]

This vocabulary represents a rhetoric: nursing information constitutes a 'data base', nurses are concerned with 'branching logic', 'prognoses', 'decisions', 'diagnoses', and 'treatments'. Through her use of language Carnevali, and this is at the heart of nursing process theories, is redefining the space in which nursing can be thought; it can be thought of as "deliberate systematic and logical". She is reconstructing nursing in terms of a system of thought, so that it can be thought of (and then presumably done) in particular ways. This has both ideological and epistemological connotations.

Carnevali is not simply proposing systems of action, methods and strategies, she is through language making nursing activity thinkable as positive, reasonable and rational. This is the critical point here, that nursing's failures and difficulties can be rectified through language: by changing the way nursing is thought of, so that it is thinkable as rational, scientific, positive, it will actually become rational, scientific, positive. Nursing is reconstituted in a new positive discursive space (see also Hiraki, 1992].

Carnevali draws upon cognitive theories of 'information-processing' and 'problem-solving' to underpin the "systems of action" which she proposes for nursing assessment. The systems of action which nurses can learn, she argues, must be practised in simulated experiential learning programmes or in real-life nurse-patient interactions; reading about these techniques is not enough. These systems for action, described as "strategies", involve

what Carnevali calls "cue identification" and "inferencing" [p62]. Carnevali emphasises how nurses need to learn to be reflexive: to be aware of how they perceive cues, how and when they are making inferences.

The basis of nursing care planning [p62], is the identification of cues and interpretations of their meanings made. Cues both "exist in the environment" [p65] and yet are

> a unit of sensory input - a single message that is noticed and usually named. The noticing .. is an outgrowth of knowledge, both theoretical and experiential. [p62]

Carnevali refers positively to "pre-entry influences" to any "diagnostic process", which will shape the "nature of the subsequent information acquisition, processing and labelling" [p.49]. These include the practitioner's discipline, "including its diagnostic classification system and the associated organization of all the diagnostician's clinical knowledge" [p51]:

> This body of knowledge and classification system profoundly and pervasively shape what will be noticed by the diagnostician, how the information will be organised, and the range of labels that will be applied. [p51]

In this way cues exist, as something out there, to be perceived by what Carnevali calls the "screen of sense organs" [p65] and cues are associated with the observer or perceptor as he looks, as a "unit of information" "noticed" because it is noticeable. Carnevali asserts that the diagnostician's set "will profoundly and pervasively shape" what is noticed, and yet the diagnostician is to be reflexive about what he notices and the inferences he draws. Nurses are to use a map to see patients, they are to routinise their assessment of patients, and yet they are also to remain aware of what they are doing, to reflect upon this process, which is to become routine. Assessment is in this way geared to a professional map, a way of seeing which is purified from the organizational context in which the nurses see. Clinical matters are divorced from other matters, such as time and cost. Clinical assessment is detached from the setting in which it occurs and the management of that situation.

While the nurse is the skilled diagnostician whom clients consult for "their discipline-specific knowledge and expertise" [p7], the body of nursing assessment is concerned with patients' "subjective data". In this area the patient is the "expert" [p93 and p137]:

> ..**the client is the expert**. He can share what he is experiencing, what there is in his background and environment that has implications, what his expectations and desires are. His body can give cues about how it is functioning under the circumstances. His environment can yield information about factors that influence his health. It has been suggested that if one

> listens to the client, he will provide the diagnosis. The subjective data give his intellectual and affective impressions, then objective data can be used to validate, modify, and refine these areas of diagnosis. [p137]

The client is divided up by Carnevali into his experiencing self, his body and his environment. The body, affect and intellect are divided up (much as Pearson and Vaughan and others divide patients into physical and psycho-social domains). The divided patient exists for the nurse in Carnevali's model as the "data field". Carnevali is not proposing the patient can actually tell you his diagnosis. Her whole approach to nursing assessment is concerned to 'professionalise' nurse-patient interaction through the objectification of the patient and the creation of a new nursing discursive space. She proposes that the patient can share his self with the nurse, his feelings, his background, while his body and his environment, as separate expressions of his self, can yield further cues and information. This objectification of the self is possible through seeing the patient and looking at the patient in particular ways and transforming the patient through language into aspects, traits and diagnoses. Yet at the same time Carnevali attempts to sustain some notion that the patient must be centred as the expert, as the one who knows and as the one who feels, who is responding in particular ways to illness or trauma.

Carnevali is treating the production and deconstruction or interpretation of signs as virtually unproblematic (reflexivity will clear up any wrong inferences or misread cues). Her approach presupposes a dualism, between the "outside", as context or environment, and the mind which perceives and interprets them, the "inside" or subject. She is privileging a cognitive subject who can make himself aware (reflexive) of his way of interpreting things in the world. The emphasis is on how the nurse can manage *herself.* At one moment Carnevali allows that the cue is a sign which exists in the environment (the divided "patient" and his world), at another moment the cue exists because it is noticed as a unit of information, a message, noticed and named, but what is noticed and named is shaped by the "diagnosticians' body of knowledge and system of classification". This is very close to Foucault's medical gaze, discussed in Chapter Two.

Carnevali is proposing that nurses, like other professionals, construct a gaze, ways of seeing and noting which are based on a body of knowledge and a system of classification - so that nurses should construct ways of seeing according to "a grid of perception" and ways of "noting according to a code". Carnevali is arguing that nurses act like natural scientists, observing for signs in the world that can be interpreted to support diagnoses. If nursing is supposed to have as its focus the individual and his response to illness, then the construction

of a gaze may lead to seeing what can be said, or written, and the displacement of the patient in the production of signs and the constitution of meaning.

This to some extent has been demonstrated by Tilley (1990) in his study of the accounts of conversations between nurses and neurotic patients: patients' meanings which cannot be incorporated and interpreted within the nurses' frames of meaning (structured to some extent by discursive formations and the setting) do not count as proper objects for nurses attention. If patients' meanings cannot get translated they get excluded, left out. This Tilley demonstrates causes patients pain and anger.

Carnevali [1983] is advocating that the nurse reads the data-field, looking from her particular discipline - her diagnostic set of classifications and particular body of so-called knowledge - so that the client and his experience and his environment and his body are surveyed for cues from which can be drawn inferences, coded by the specific body of knowledge and system of classification in which the nurse is steeped. Through particular forms of language the patient becomes thinkable in particular ways, as diagnoses or nursing problems and as the object of nursing activity. New practices are instituted: a nursing history and examination.

Carnevali [1983] is involving nurses in an attention to the patient as a 'subject', but the patient is also reduced to traits and parts: the patient is to be subjected to a gaze. There is little difference then in the method of nursing assessment from that of medical assessment: the nursing assessment constitutes a new form of *examination*, it is only some aspects of the direction and purpose of the examination which differ from the medical examination.

Referring back to Lyth's [1960] study, this type of approach to nursing assessment as a history and examination helps constitute the nurse-patient relationship as a form of *professional* relationship: there is an individualisation of the relationship but the nurse can, through her gaze, remain emotionally detached, demonstrably professional.

The effect is to reconstitute the nurse's relationship to the patient. This is illustrated by May [1991] in his study of nurses' accounts of their relationships with dying patients. May argues that incorporating the patient's emotions and experiences into nursing assessment represents a general move in hospital work: individualisation of patient care which constitutes "value added labour". But that the irony is, May argues, that

> the care of subjects relies on notions of informal and plastic therapeutic relationships that, paradoxically, have the effect of routinising personal encounters. ...the nurse-patient relationship has come to be constituted as a diagnostic 'moment' in which patients' psycho-social problems are to be identified and resolved. [p200]

Further, the "history and examination" helps to constitute the nurse-patient relationship as something other than a partnership. Dickson [1982] discusses a paradox in relation to the nursing process where it centres the nurse-patient relationship as a 'partnership'. This, she claims, is an aspect of what she refers to as the 'ideology' of the nursing process: the conceptualization of a partnership is to distinguish nurse-patient relationships from doctor-patient relationships, characterising them as concerned with caring and persons, rather than curing and disease. But Dickson points to how this very distinctiveness, that is the 'status' of 'partnership', may devalue the relationship as somehow less than professional. This problem is overcome by writing and practising nursing assessment as a 'history' and 'examination', as it is in normative models of nursing assessment, which Carnevali's work is taken to represent. Nursing assessment as examination constitutes a form of social distance and institutes the nurse-patient relationship as one aspect of a project: the identification of problems to allow for a plan.

Carnevali's approach presupposes there is a typology and classification of diagnosis upon which nurses can draw, about which nurses can learn and which corresponds in some way to how patients feel, how they experience their illness and how they respond to illness. There is an assumption that nursing knowledge is or can be 'well established', in a similar way to how other disciplines establish their knowledge, as positive and scientific. The construction of nursing diagnoses and nursing as a science, is well rehearsed in the literature [see for example, Gordon and Sweeney, 1979; Green, 1979].

Through writing nursing assessment as both a cognitive, analytic and reflective practice and as an aspect of a process there is displacement: a subordination of the social self, the "deciphering, listening subject penetrating into the heart of things" [Foucault, 1973] who in the presence of *others* constitutes meanings. There is a detachment of the nurse from the context in which she does nursing: the nurse is constituted primarily as a member of a profession rather than as a member of a particular organisation and society in which she does nursing in the presence of others.

In summary, the two main difficulties with normative models for nursing assessment relate to how they are reified away from patients' life-world. First, they do not take account of how the nurse's gaze is not simply constructed by normative discourse, but is constructed in a lived reality of the social. Giddens' [1984] asserts that a normative-functionalist view holds that social actors are like objects, and that social action is the product of:

> the pervasive influence of a normatively co-ordinated legitimate order as an overall determinant or 'programmer' of social conduct. [p30]

The normative view of nurses relies on determining social conduct through the teaching and programming of nurses: though disciplining nurses. And second, it risks objectification and distanciation of the patient from the assessment process, through making him the object and subject of the nurses' gaze.

These are the epistemological-ontological difficulties at the heart of processes of nursing and systems for nursing assessment, where nursing assessment is treated as something cognitive, and which appears to be detached from the social, the context of practice.

It is also to be noted how normative approaches to researching nursing practice (which take a model and see how practising nurses match up to it) miss the opportunity to uncover what nurses do indeed understand about their practice, why they prioritise what they do and on what 'bases' they give patients care. With social theorists such as Garfinkel [1967] and Giddens [1984] the position taken in the current thesis is that social actors operate with tacit and implicit knowledge. And further, that through their actions, their talk and their written accounts in their day to day world, their knowledge about why they do what they do is revealable, or as Giddens [1976 and 1984] and Garfinkel [1967] would put it, *accountable*. To make claims that nurses do not know why they do what they do risks displacing and ignoring their competencies as social beings. For example, the difficulty with Well's [1980] method is that it attempts to detach nurses' practices from the organisation and culture which nurses help accomplish. She did not seek to ask the question: what were nurses accomplishing through their methods of patient care and their relationships with patients as she saw them?

Some nursing theorists have been concerned to theorize nursing from uncovering what it is that nurses do know [cf. Benner, 1984; Meleis, 1985; Thiele *et al*, 1991] This approach has only recently impacted British nursing at a theoretical and educational level. It does not appear to have affected the 'nursing process'. Benner [1984] does not dispute the 'nursing process', although she considers it a learning process, suitable for 'novices' rather than 'experts'. Her program is to show a model *of* nursing expertise rather than a model *for* organising nursing. For these reasons a discussion of Benner's work, since it is germane to the thesis, is discussed fully in Appendix One.

By centring the knowing/experiencing nurse-subject, Benner and her co-authors reproduce the central managerialist ethos. The difficulty with both programmatic, problem-solving models for nursing and the so-called interpretive school is their conception of the individual acting *in* or *on* a context or an environment with what amounts to essentially

technical skills albeit learnt and improved through experience. The onus, both institutionally and morally, is on the nurse to see and to know what is right, to make choices, to match her 'inner' judgements, 'rightly' and 'correctly' with what is 'out there'. This constructs a subject-object divide.

Dividing the world this way leads to either a deterministic programme for nursing action or presupposes an ontological voluntarism. In addition to many other problems associated with these as philosophical positions both positions do not take account of how nursing is practised in an organizational context. The issues of 'context' in relation to the construction of nursing assessment are now addressed.

Problems with Context: Doing Nursing Work in Practical Settings

There are few empirical studies to examine nursing assessment in practice situations. Some studies take the form of action research and concentrate on the introduction and evaluation of a nursing assessment programme [Faulkner and Maguire, 1984], sometimes as an aspect of a wider programme introducing a nursing process [Bachman *et al*, 1987; Hulter Asberg, 1986]. Other studies have attempted to ascertain the effects of nursing assessment in practice as an aspect of the nursing process [De La Cuesta, 1983; Hurst, 1983; Miller, 1984 and 1985a; Morrison, 1989; Price, 1987; Ward, 1988]. A third group of studies have been concerned to examine, develop, introduce and test functional and behavioural assessment tools, in the areas of geriatric and psychogeriatric nursing, in order to rate need and monitor progress [for example, Mathieson, 1988; Panicucci, 1983; Wilkinson and Zissler, 1984].

Readings of nursing research have suggested that implementation of nursing assessment as an aspect of the model of a nursing process is problematic for a number of interrelated reasons. Three studies are examined in detail as they illustrate these issues; the first is by Faulkner and Maguire [1984], the second is by De La Cuesta [1983] and the third by Macleod Clark [1984].

Faulkner and Maguire [1984] implicate poor communication with patients as an impediment to systematic and relevant assessment of patients. Their experimental study was based on previous research findings which indicated that nurses' questioning techniques were poor, that nurses were unskilled at picking up patients' cues, that nurses avoided inquiring as to patients' 'psycho-social concerns and that nurses systematically block patients. They state that:

It has been found that these deficiencies in skills and in areas assessed have

> serious consequences. Many problems which are treatable remain hidden. For example, nearly one in four patients admitted to two General Medical Wards were found to have developed an anxiety state or depressive illness. These had been recognised by staff in less than half the patients. [Maguire *et al*, 1974, p133]

Further, Faulkner and Maguire claim that closed and leading questions carry value judgments which can position the patient. They place the patient in the position of being unable to disclose what they really think, feel or do.

The study experiment was based upon a notion that nurses can be trained in interview skills, be given an understanding of the psycho-social aspects of illness and updated knowledge in the areas of disease concerned (in this case patients with breast cancer, about to undergo mastectomy). By the authors' accounts the programme went well until the study was disrupted by moves within the hospital and upgrading. This disruption enabled the researchers to identify other aspects to the success of nursing assessment apart from training nurses in interviewing and observation skills. These involved aspects of local organization.

The authors describe the ward's "attitude" to the care of patients, which they claim is mainly constituted by the ward charge nurse, the position taken by the nursing administration on what constitute priorities, and the way in which patients are organised according to specialities or mixed groups of patients. These, the authors argue, affected possibilities for nursing assessment. While the authors do not give up their notion that training and support are what are required to improve nursing assessment skills, they do acknowledge the notion that nursing assessment is problematic because of the context in which nurses work and train:

> Similarly ward staff have been trained in an environment which gives priority to the completion of tasks. Talking to patients may even be seen as a waste of time, so that nurses could feel guilty giving time to assessment. [p141]

The authors seem to imply that the research programme legitimated listening to patients and a focus on patients' psycho-social needs. The nurses were also given a new autonomy, they were expected to make judgements about patients and were given permission to act on these judgements in respect of their psycho-social needs (for example, referring patients for psychiatric help). But when the nurses were moved to a ward where these aspects were not legitimate or significant, they simply did not continue to 'assess' patients in the same way - they no longer had 'permission'.

The researchers began by attributing poor assessment skills only to poor training in

communication skills and a deficit in background knowledge but they also hinted at an underlying assumption that nurses learn to communicate poorly through their general training:

> She [the trainee staff nurse in the study] had to begin by unlearning the inappropriate and unhelpful strategies inherited from her general training. These included the switching of topics, 'jollying patients along', and offering false or premature reassurance. [p135]

By the end of the study the authors have developed the possibility that nursing assessment is affected by context. There are several issues raised by the study.

First, the authors do not entertain the notion that the communication "strategies" learnt in general training might constitute competencies for 'doing nursing'. What the authors call "unhelpful" and "inappropriate" "strategies" may be nurses' methods for accomplishing other things, things which they have read as significant, signalled as legitimate practice within the settings. This is partly suggested by an earlier study of nurse-patient communication [Macleod Clark, 1984] which is discussed below.

Second, that the findings of this study may reveal that nurses rely on ways of knowing what to do for patients through forms that are more socially organised than a technical system for nursing assessment. And that these forms of organisation get their strength from the very fact that they are socially constructed and deeply embedded in culture. And finally, they do not conclude that nurses' failure to assess patients as per process may be the effect of nurses' competence to read settings and to assess patients in different ways which help maintain and reproduce the order/culture of the settings. This affect of context can be understood as 'socialization' and is suggested by the work of Melia [1981].

Both De La Cuesta [1983] and Hurst [1983] have approached the problem of evaluating the impact of the nursing process in practice, but in very different ways. De La Cuesta's study is of more interest to the present study as it contains material directly relating to the settings of nursing practice, which are absent from Hurst's work which involved a postal survey.

De La Cuesta interviewed nurses using a nursing process and observed nurses in settings where a 'process of nursing' was instituted. The purpose was to "study the implementation as seen by practitioners" [p366] and to "assess the extent to which the theory was implemented and identify the barriers to implementation". This aspect of the study was built on to an extensive "sociological" examination and analysis of the literature and biographies of the advocates of the nursing process [reviewed above in the second section].

De La Cuesta discusses how technical prescriptions were transformed. While emphasising how quickly the theory was transferred to practice, De La Cuesta points to particular "barriers" to its implementation in practice, which she relates to the "culture" of nursing and the experience of nurses.

In particular, she found that nursing profiles or "histories" were seen and treated as "reference sheets" of information about patients rather than as "foundations for nursing diagnosis and patient care plans" [p368]. The care plans themselves were not consistently written, and tended rarely to include nursing orders, but were largely concerned with medical orders or physical aspects, and were unrelated to the nursing histories. Nurses themselves stated that they found the care plans the most problematic aspect of the process: they found them "superfluous" and they "found it difficult to state problems, analyze data and express diagnostic concepts in writing" [p368]. The nurses in the study simply could not see the point - the patients were alive despite the process, was one expressed attitude. The documentation was seen as an administrative necessity rather than instrumental to practising nursing.

De La Cuesta asserts that the care plans represented "genuine accountability", and that this affected the nurses' views of their use:

> While her superiors may see this [care plans] as a means to help the nurse in giving more systematic and effective care, she may perceive it as a means to control her performance, hold her responsible for her actions and ultimately punish her for bad performance. [p368]

De La Cuesta does not pursue the nurses' view as a potentially valid one. De La Cuesta suggests that the nurses lacked confidence in writing down their plans because they lacked knowledge "she [the nurse] does not have a complete knowledge of nursing diagnoses and treatments" [p369]. She suggests that the problem may have been that nurses did not yet think in terms of a language of "diagnosis" and "treatment": they had not yet developed that sort of discourse except in relation to physical care and medical conditions. The difficulty with De La Cuesta's analysis is that she compounds discursive ability with practical know-how: that because the nurses did not have the language to put into words how they did their work or why they were doing their work, they did not have knowledge about why or how they were working.

Further, De La Cuesta points to how the nursing process model places responsibility on the individual to see and to know:

> She [a nurse] has to identify a nursing diagnosis and nursing prescriptions which are largely dependent on her own perception and intellectual abilities.

[p369]

In this way De La Cuesta reproduces the central strategy at the heart of the nursing process: the onus of knowing is the responsibility of the individual, being able to show by saying what you see, and discounts the socially constructed nature of action, meaning and understanding.

De La Cuesta points to two further problems with implementation of the process which are important to the current study. First, that the nurses did not have a "dynamic and flexible" approach to practice so that there was little regard for a "comprehensive and individualised" approach to patients' care: work was organised around tasks and routines. She found that in verbal reports, physical and medical aspects were emphasised while psycho-social aspects and patient coping mechanisms were hardly mentioned. Second, that patients did not participate or validate the care plans, and that nurse-patient interactions appeared to be "restricted to essentials" [p369].

De La Cuesta suggests why there were problems of implementation. She implicates both the structural properties of organization in the settings (e.g. manpower allocation recursively reproducing 'times' for work) and the legitimation of conduct through socially mobilised sanctions (e.g a chaotic ward is viewed by peers as evidence of an incompetent ward sister). However, her claims are underpinned by a notion that nurses' activities are determined by context: she advocates that it is not the process that does not fit practice, but that the settings of practice, the "culture", needs to change in order for the process to be implemented satisfactorily.

Both Faulkner and Maguire's [1984] and De La Cuesta's [1983] studies suggest that the technical system for nursing assessment did not work because of the culture of practice. They both entailed taking a view of practice, of how practice matched up to theory, constituted as a model for nursing assessment. They both suggest that there are aspects of the context of nursing which are problematic in relation to the implementation of a new system of nursing.

That context can be considered as inhibiting nurses practices is also suggested by Macleod Clark's [1984] study of communication in nursing practice. Macleod Clark's study illustrates how nurses have strategies and methods to "block" patients systematically from revealing aspects of themselves. MacLeod Clark discusses the superficial nature of nurse-patient conversation in terms of both a defensive mechanism against too much anxiety through getting involved with difficult and disturbing issues and in terms of their lack of authority and responsibility, in that medical staff particularly do not allow them to be

involved in discussion about diagnosis and treatment.

> Defensive behaviour may in consequence be developed in order to maintain distance and discourage involvement with patients. There is thus a mismatch between the stated ideal role of a nurse and the reality of the role a nurse must adhere to. [p70]

When questions of diagnosis arise, Macleod Clark states that:

> The preferred 'modus operandi' is often evasion and maintaining superficiality. However even the most knowledgeable nurse may not feel she has the autonomy or authority to give information and may fear rebuke, particularly from the medical staff. [p68]

Macleod Clark sites the problem of communication in two ways - it is a problem of lack of training in communication skills and that it is a problem of autonomy. Poor communication she claims results in superficial and non-involved relationships with patients which leads to patients' psycho-emotional needs being left undetected and unresolved, which in turn leads to the creation of anxiety in patients.

Here Macleod Clark is touching on an aspect of the culture in which nurses work which organises against nurses establishing an autonomous and independent relationship with patients and focuses talk on physical and routine aspects of care ('the job in hand') through moving patients around through talk. Macleod Clark is suggesting that these strategies are in fact competencies, developed by nurses as "defence against anxiety".

Macleod Clark appears to be suggesting that this has to do with permissions: what nurses feel they are allowed to get involved in, what she constitutes as their autonomy in relation to information and their relationships with patients. She is suggesting a relationship between power, autonomy and knowledge and how through communication strategies nurses construct their relationships with patients to "maintain distance".

Failures to implement processes of nursing, and nursing assessment in particular, have been attributed to social forms of organisation which in some way inhibit the production of nursing as per process and that in some way this maintains a falling short in nursing care. Neither De La Cuesta nor Faulkner and Maguire seriously consider how nurses may be knowing and doing in ways which are socially constructed. But both point to how the context of practice and forms of organisation act to impede the accomplishment of nursing assessment as per process. Macleod Clark's study suggests that nurses develop communication strategies as competencies given the relations of power and knowledge in which they work.

By contrast, Benner's and her co-author's work [Benner 1984; Benner and Tanner, 1987; Benner and Wrubel, 1989; Benner, 1991, Benner *et al*, 1992], discussed in Appendix

One, suggests that nurses' assessment of patients is virtually unproblematic, that it is a question of knowledge enhanced by experience. However, Benner's methods and forms of analysis, effectively decontextualise nursing practice. The effect is to detach nurses' discourses and practices from the social context in which they are constituted and which they help accomplish as particular forms of order. The narratives are taken unproblematically as representing reality, but the reality is subjective and individualistic.

What is suggested by the literature reviewed in this Chapter is that context is either unproblematic to nursing or is seen as a "drag" [Strathern, 1993] on developing nursing technique and skill. The way in which nursing is being conceptualised, both in normative models and the interpretive school, is as "detached" and "detachable" [Strathern, 1993] from social organisation. This entails viewing nurses as autonomous subjects with the burden of knowing, of nurses who can be taught to know and that through experience they can perfect their practice. There is emphasis on how nurses can be taught to know how they *should* behave in particular ways rather than others. Benner's work as explicated in Appendix One adds on the notion that it is through experience that this knowing can be perfected. The drag on nurses developing their practice and their discourse is the culture in which nurses' excellence and power is still not recognised.

I now turn to discuss a further view of the nursing process. This view, put forward by Walton [1986], situates the nursing process within more general interests in quality assurance as response to a social climate increasingly concerned with efficiency and cost effectiveness. In that she attempts to thereby go beyond a professional drive for improving nursing care Walton's analysis is of some interest and is now extensively discussed.

Nursing Process as Quality Assurance

Walton's [1986] discussion of the nursing process is based upon a review of extant literature. Walton indicates how the nursing process is usually reported as not being properly implemented in practice. Nurses (as stressed or lacking skills and knowledge), their managers or the context of practice become implicated as 'factors' or 'variables' which explain a poor implementation. If true, this of course mars attempts to evaluate the nursing process as a tool for improving and enhancing nursing.

Walton concentrates the main thrust of her review on the possibilities for extending the nursing process to enable evaluation of nursing interventions. She takes the nursing process to be essentially a process/outcomes approach which, if properly used, may help teach or organise a systematic and patient-centred approach to nursing (what I have referred

to as an aspect of managing by objectives). Walton raises questions as to the validity of an outcomes approach in any attempt to *evaluate* the effectiveness of nurses' practices. She extends this difficulty to discuss why the nursing process was developed and introduced into British nursing in the first place.

Walton draws out the importance of recognizing how the nursing process is a system which relies on, and indeed encourages, nurses' evaluating their own interventions, thereby setting up a situation in which nurses' analyse their own practices more reflexively. Further, she also emphasises how the nursing process may be implicated in a much wider pressure for nurses to facilitate *others'* evaluations of their interventions. This is an explicit function of the nursing process within American nursing where it is used as an audit tool. This aligns with my own emphasis (see for example, the Prologue and the discussion of Carnevali's work above) on how the nursing process emerges as a form of representation which will (supposedly) help make nursing *visible*, but in particular ways: as rational, purposeful and scientific. I have suggested that it is this visibility which will (supposedly) help nurses in the constitution of their identity as professionals, and protect 'nursing' from erosion.

In contrast to the current thesis, Walton's critique does not address the nursing process as a tool to aid logical thinking and planned care. Further, Walton does not particularly question the appropriateness of representing how social actors go along in their day to day practices with a problem-solving, information processing model, although she does mention how an interactionist approach may be more relevant to studying nurses' practices. Finally, she does not address herself particularly to investigate nursing assessment as an epistemological or ontological issue.

The 'nursing process', considered as a tool by which nursing interventions can be made visible and their effectiveness evaluated, also reflects hopes for the nursing process, discussed earlier in this chapter, to change and make nursing practice more systematic. Through examining nursing in terms of problem, objective, outcome, there will (supposedly) be more control over practice, through redirecting nurses: nurses should be able to organize their work to identify patients problems, so that individuated and planned interventions will save time and resources through avoiding routinised practices. That is, the structure of nursing as a process with outcomes will not simply become more explicit, but in using and applying the model hopes were to make nursing more structured and explicit in particular ways.

Walton [1986] stresses how the nursing process as a development within nursing

reflects the effects of particular social conditions which have impacted not just nurses' practices, but that its development is consistent with other effects within medicine and social work. What Walton is suggesting is how persons within the health and welfare services were becoming aware, at the end of the seventies and the beginning of the eighties, of having to justify their practices: they were having to find methods to give an account of themselves as efficient and cost effective, but also as giving a quality service to patients.

Within the medical literature, Walton states, there was an "increasing preoccupation with quality assurance" [p49]. She situates this preoccupation as springing from:

> - concern that if the profession [of medicine] does not find its own ways of demonstrating its effectiveness, measures may be imposed upon it from without. The proposed extension of the Health Service Commissioner's powers to matters of clinical judgement was seen as one such threat to its autonomy. The importance of nurses similarly setting their own standards and analysing their own work is recognised too - at least in some medical quarters;
> - concern to maintain standards in the face of budgetary restrictions and fears (expressed by nurses and social workers too) that the current emphasis on efficiency and cost containment will override quality considerations.[p49]

Walton implies that (some) doctors recognized the possibility of their professional discretion and their autonomy coming under threat from government. For Walton, the proposed extension of the Health Service Commissioner's powers to "matters of clinical judgement" gave credence to the idea that autonomy could disappear, "measures may be imposed upon it from without". In reaction the medical profession (or some of its members) reached for methods with which to make their work *visible in particular ways*. Walton's theme is to suggest how discussions of strategies and methods which begin to emerge within the medical literature are similar to those within the nursing literature.

Walton discusses how, within medicine, a number of methods and strategies were advocated, and sometimes put into practice, as the effects of pressures to justify medical practice and assure quality. Walton summarises these as:

> (i) the evolution of the 'medical audit' and the development of indices and criteria for quality measurement;
> (ii) the development of problem-oriented medical records;
> (iii) the increasing emphasis in medical education on the teaching of communication skills and patient-centred approaches to care. [p49]

The audit was, according to Walton, comprised of three components: "setting standards, assessing performance and modifying clinical practice" [p50]. Walton suggests that there were, within the medical literature, conflicting opinions over what criteria and indices could be agreed upon to set standards and measure quality. Some writers advocated

an outcomes approach, to both the setting of standards and the assessment of performance, while others supported a process view, on the grounds that medicine is probabilistic and therefore taking an outcomes approach to medical audit could produce 'overly harsh judgements'. Further, within the areas of chronic illness and general practice, she reports how there were arguments for criteria which could reflect how patients are feeling, experiencing subjects.

Walton states that the medical profession have been generally very reluctant to identify and accept explicitly defined criteria for standard setting. The difficulty appears to lie in, amongst other things, a fear that explicit criteria may produce a rigidity within practice as doctors conform, or feel under pressure, to conform to preset standards. However, Walton appears to agree that educationally the process of setting criteria may be of value, where it is located as an exercise between like-minded collegiate groups of doctors.

Improving records were, Walton reports, "considered the 'crunch-point' on which audit depends." [p55] It is through records that clinical performance can be assessed. Problem-orientated medical records (POMR) were, she asserts, the most widely advocated form of records for audit purposes and it was, according to Walton, this form of records upon which the nursing process was based. However, from Walton's report it appears that within medicine they were only introduced at a local level into medical practice (e.g. at Guy's hospital). She suggests that claims that POMRs are a valuable educational tool or that they "enhance quality of care" [p56] are not substantiated within the literature. While she is, along with members of the medical and nursing professions, dubious as to whether any form of records can be used to assess performance, Walton does state that the use of POMR "sponsors thoroughness", and that one of the purposes of POMR is how, "in promoting systematic thoroughness, more of the problems that affect patient care will be brought to the attention of clinicians" [p56].

Walton remarks how there was a reluctance within the medical profession to adopt either audit or problem-oriented medical records. Indeed, in a recent telephone call to the British Medical Association and the Department of Health there is no record of problem-oriented medical records. To the extent that medical audit is being introduced, it is through strategies of general management rather than through the medical profession itself [Bloomfield et al, 1992]. It is in these ways that these effects within the medical profession differ from those within nursing. The nursing process has been widely introduced into nursing education and practice, and, as discussed above, and by Walton herself, can be considered more an ideological move coming from within the nursing profession itself. To

speculate, this, as an important difference between the two professions, may stem from how nursing did not have a particular way of writing itself before the advent of the nursing process. In contrast, medicine has a long history of writing itself, as I have already discussed in Chapter Two drawing on the work of Michel Foucault, (including the avoidance of literally writing, as in the case of patient records - see for example, Garfinkel [1967] and Raffel [1979]).

Walton suggests how discussions and research within medicine concerned with the state of doctor-patient communication is reflected within nursing literature and with developments of the nursing process, as a (so-called) patient-centred approach to nursing. She raises how patient needs may not be met if either doctors or nurses do not communicate properly with their patients. Drawing on studies from medical sociology, Walton goes on to state

> The [medical] consultation is now seen in such terms as a situation of "mutual dependency"; or "a two-way process of social influence". It is a perspective of obvious relevance also for analysis of the 'nursing process' - similarly an interactive process, in which nurse and patient 'negotiate' how best to achieve agreed objectives.[p60]

Walton seems to be suggesting that a social interactionist approach to researching medical and nursing practice might be more in line with moves within both professions towards a more patient centred approach. A theme which emerges in her text concerns how medical and nursing interventions have a much greater interactional component than is usually represented in either an outcomes or a process approach to practice evaluation. However, there is some ambiguity here as to whether Walton is suggesting that medical practitioners themselves accept or even see their interactions with patients as situations of "mutual dependency" or "two-way processe[s] of social influence". Also, she does not substantiate whether some nurses and patients do indeed "'negotiate' how best to achieve agreed objectives". One of the objectives of the present study is to precisely examine the rhetoric of these claims in relation to how nurses, doctors and patients do interact.

Further, until very recently in the medical school related to the present setting, medical students received very little formal education as to doctor-patient communicative practices (something like one hour in their entire training period), whereas Walton speaks as if concern for this as a subject for medical education is widespread (she does not particularly substantiate this). The ward round and clinic consultation may indeed be the educational media through which doctors pass on their methods for communicating and interacting with patients. However, how these as aspects of doctors practices enter the clinical examination

of medical students is not discussed by Walton. Indeed, there is little empirical evidence in Walton's review of how (or whether) doctors practices have become more 'patient-centred' or collaborative. An explicit customer orientation does not always reflect how organizational arrangements work for the customer in practice! With May [1991, 1992], it might be safer to debate whether evidence of espoused theories concerned to promote a patient-centred orientation within medical and nursing discursive practices, reflects more modernist issues of individualism emanating and extending from a consumerist culture, which they help regenerate.

Walton [1986] goes on to report how there are 'similar' developments within the practices of social workers aimed at revealing the value of their interventions. These consist of:

> - the development of more structured methods of social work intervention and evaluation and correspondingly more systematic methods of recording;
> - the growth, in volume and sophistication, of 'client studies', and the increasing emphasis on the 'plurality of perspectives' to be sought in such research.[p62]

Walton argues how within social work, as in nursing, there have been moves towards a more structured approach to organising casework and client-practitioner relations. In particular, what has been widely adopted is, according to Walton, the "'task-centred' casework model", which, like the nursing process, apparently originated in America.

This model is also a problem-oriented model, designed to focus on the client and his particular concerns so that achievable goals can be set *with* him/her. The model has also been used in evaluative research concerned with the effectiveness of social work practices. Walton discusses how these studies (limited and uncontrolled), raise questions as to how the outcome model of evaluation is "fraught". Difficulties arise, she argues, because the context of practice is concerned with what she calls the "complex world of human action and reaction" [p63], where attempts to make causal linkages may be inadequate and simplistic.

Walton is setting the issues surrounding the nursing process as a tool for evaluating nursing interventions within a wider framework concerned with more general problems associated with evaluating health and welfare practices. She states that:

> The 'nursing process' is not an isolated phenomenon. It is a product and reflection of world-wide trends and concerns not only in nursing but in health and welfare services as a whole. Increasing public scepticism about the effectiveness of these services, and shifting boundaries of responsibility between them, have put pressure on individual professions to define and evaluate their interventions. In line with trends towards 'consumerism' and greater patient/ client participation generally, the *need* to take account of patient/client's own assessment of the quality of his care is now widely acknowledged. Considerations of quality have dominated the literature of

> the health and welfare services in recent years: not only how to define and measure quality, but also how to maintain or 'assure' it in the face of increasing demographic and economic demands. [p68, emphasis added]

For Walton, professionals needed to, and have, taken account of "the clients/patient's own assessment", of "public scepticism about the effectiveness" of their interventions, of "increasing demographic and economic demands". She appears to be placing the development of the nursing process within 'the profession' as *response* to consumer demand and a general move towards more patient/client centred care.

There are, however, three difficulties with Walton's analysis. First, Walton's argument relies upon oversimplification. In her analysis, 'the market', including consumer demand, has impacted professional practice to set up needs. Walton enlists notions of consumerism and market forces to underpin her argument in ways that rely on a functionalist division between 'professions', on the one hand, and 'consumers' on the other. Insisting on a causal relation between these groupings pays scant attention to the extent to which *persons* belong to both groups. In this way Walton detaches the health and welfare services and the persons operating within them from 'the market', from 'the economy'.

The functional nature of Walton's analysis also occludes effects precipitated by interventions from government. For example, she takes for granted that the consumer is the public, an assumption which predates Griffiths, and the government white paper of 1989, Working for Patients (HMSO), where the consumer becomes more clearly defined as the government, being the main 'purchaser'. Further, her claim that there is increasing public scepticism about the effectiveness of the health and welfare services worldwide is not evidenced by her. While there has been much discussion within the media, government, professional bodies and public organisations (such as WHO) about the cost and effectiveness of the health and welfare services, in the light of subsequent critical and Foucauldian analyses (see for example, Broadbent et al, 1991; May, 1991,1992; Rose & Miller, 1992; Silverman, 1989b) it is now difficult to accept that it was public scepticism which, along with economic trends and demographic changes, induced these particular effects.

Second, throughout her report Walton does not distinguish between discursive trends and practical arrangements. In the above extract she asserts that there are "trends towards 'consumerism'" and that there is "greater patient/ client participation generally", but in neither case does she evidence her claims. The difficulty here is over the nature of participation. That patients and clients participate is undoubtedly true (and always has been). As social theorists such as Goffman [1955,1958] have shown, participation is *unavoidable*, a condition of daily life. Participation has come to have a positive value in both a nursing and a management ethos, but Walton has no evidence with which to assert

that more participation takes place in conformity with nursing theorists' or managerialist exhortations.

Third, other 'techniques' which Walton associates with a general trend to define and measure quality as well as assure it, are two other problem orientated tools which were introduced into social work and medical practice at around the same time as the nursing process was introduced. Within social work practice she reports a fairly widespread introduction of the tool with fairly good results. From her writing it is more difficult to assess the extensiveness of the introduction of problem oriented medical records. Unfortunately, since Walton has provided no empirical evidence for the claim, we have to rely on her assertion that these were indeed similar techniques.

Walton's main critique for evaluating the effectiveness of nursing, social work and *some* medical interventions using a process/outcomes instrument alone is the possibility of detaching the effects of what nurses, social workers or doctors do with patients from the effects of the work of other professionals or from effects of the particular disease and its trajectory within the 'context' of a specific patient. Walton is essentially warning against an input/outcomes approach to evaluating effectiveness in what she sees as multi-dimensional, complex and interactive practices. She questions whether the nursing process (or indeed any other model or system for nursing) can be held up by researchers or managers as the measure by which nurses' practices can be evaluated, but she does not completely dismiss the possibility of a universal method for the evaluation of its implementation. Indeed, she holds on to the idea that within "pure medical" situations there is possibility of identifying cause and effect relationships.

Walton does not particularly question how problem-orientated tools such as the nursing process may be useful for teaching or organizing purposes. She does not raise the possibility of its having other, albeit unintended, disciplining effects or of how, once in use, the 'nursing process' may get translated and transformed to help nurses, with others, accomplish their organizing work in particular ways rather than others. Like the researchers discussed in previous sections, Walton does not really entertain the notion that nurses' 'failures' to implement the nursing process '*as written*' may actually represent social competencies and accomplishments.

While Walton also suggests that an interactive approach to understanding the nursing process (or rather the 'process of nursing') may be relevant, she does not offer a way of researching how nurses' practices go beyond a dyadic relation between patient and nurse conducted within a context. She does not really address the issue of how nurses' understandings about patients and their 'interventions' can be considered as products and

effects of wider cultural issues (as cultural performance). Nor does she consider how once in use, nurses, with others, use techniques and forms of representation like the nursing process as material and device within the day-to-day organizing of health care (within any 'process of nursing'). For example, Walton asserts that there are general trends in the health services towards holistic and ethical practices which centre on the patient and on staff as persons. Here, Walton's reliance upon the empirical work of others perhaps limits what she can say, but her own failure to distinguish between the rhetoric of espoused theories and the enactment of practice is crucial. As I intend to show, techniques like the nursing process get translated and transformed by actors in their day to day practices.

Walton stresses how the nursing process along with what she deems similar effects in medicine and social work reflect a justificatory context within the health services at the beginning of the nineteen eighties. I now want to discuss Walton's perspective on the nursing process in the context of more recent, 'critical' studies and in relation to the giving of accounts.

Broadbent et al [1991] review all the different changes which have been imposed upon the health services subsequent to extended (and continuing) examination of the health and welfare services by accountants on behalf of government. The authors argue that this examining and reorganizing of the health services constitutes a colonization of the health and welfare services by managerialism. This is of course well under way at the beginning of the nineteen nineties with much more sophisticated management technologies than, for example, POMR being put into place (such as marketization, resource management information systems and performance indicators). According to Broadbent et al, the effects of this colonization in relation to public good, cannot yet be evaluated.

Rose and Miller [1992] suggest that the effects of the moves made by government to 'rationalise' the health services, can be considered within a more general perspective concerned with attempts to reverse power relations between government and the professions. Previously, they argue, power flowed from government to the professions. The introduction of management accounting into the health services is an aspect of attempts to change this, so that power flows from the peripheries to the centre, from the professionals as they practice back to government. This analysis is, of course, ironic given government's claims to 'decentralise'.

I would like to emphasise an important issue at this point. This concerns the concepts of "enrolment" and "translation" [Callon and Latour, 1981; Callon and Law, 1982]. It is interesting to note how nurses, doctors and social workers appear to have reached for or enrolled managerialist tools to help them evaluate or evidence the effectiveness of their

practice. Problem-orientated records, the nursing process, medical audit, task-centred case-work can all be considered as having developed in line with a managerial ethos concerned with structured and explicit models (broadly speaking, managing by objectives). This interpenetration of the health and welfare professions by managerial devices precedes the introduction of general management into the health and welfare services, but comes at a time when there was an examination of the health and welfare services by accountants on behalf of government [see, Broadbent et al, 1991]. This suggests how, rather than speaking in terms simply as if there is a 'diffusion effect', as Broadbent et al do, where central objectives are diffused down through the organization of the health services, it might be more useful to consider how managerial technologies enrol actors and are enrolled by actors, and through this as an interactive process, technologies get generated and regenerated locally and specifically. To return to Walton's [1986] discussion, what emerges is how difficult it is to hold a view which distinguishes between what are supposedly 'locally' enacted versions of these as managerial products and what the products supposedly are in 'blueprint' (and how or where they do in fact exist, except as espoused theories or enacted practices).

That the health services operate locally, with very specific local organizational arrangements, is stressed by Loveridge and Starkey [1992]. Rather than treat variations at the local level as deviations from a norm or model, I would like to suggest that this feature of the health services illustrates instead a profound methodological issue: that in fact it is only locally, at specific sites of practice, that wider cultural and social effects are managed, and that these do in fact include the deployment or fabrication of *any* 'management technology'. For example, Bloomfield et al [1992] examine how directives to introduce management accounting technologies into NHS hospitals are implemented.

Bloomfield et al focus specifically on the development of Resource Management Systems (RM systems) in three different sites in the health services. The authors suggest RM systems are "responsibility accounting systems" and describe them as systems which:

> construct and make visible significant aspects of organisational reality....making possible new or more penetrating forms of organizational practice - such as Medical Audit. At the same time, a responsibility accounting system develops standards of behaviour such that "normal" practice cannot only be defined, but also measured, and deviations noted. What is also implied is that what is rendered visible, measured, and rewarded, gains legitimacy. Conversely, that which is not recognised by the formal system is often neither rewarded nor legitimate..[p199]

In the construction of RM systems the authors explicate the enrolment of doctors and state that:

> Hospitals have been faced with the task of simultaneously creating management information that could be acted on by doctors, and

> manoeuvring those doctors into defined positions where they accept such responsibility.[p199]

Within this process of enrolment of the doctors, the authors found an extraordinary diversity in the 'application' of RM systems. The authors stress:

> the dynamic and contested nature of the meaning and emergence of RM systems and the inherent interpretative flexibility of RM [p217].

Rather than hold that there is, through the introduction and implementation of RM systems, simply a *diffusion* of the meaning and purpose of RM (or deviations from those meanings and purposes), the authors show how through translation and enrolment managers and clinicians "fabricate" RM systems specific to the site. The authors emphasise, drawing on Latour and Callon's actor-network theory, translation rather than diffusion. At the extreme here, there need be no central objectives in any process of 'localised' network building. Objectives, aims or goals are as open to translation as are the deployment of other materials and devices. The authors suggest how:

> ..we should not be surprised at the variety of meanings associated with RM, nor should we view this variety simply as a reflection of local colour or interpretation. Rather, our focus should be on the potency of local translations to quite radically change any idea or machine constructed in the name of RM. [p208]

Social actors (nurses, doctors, social workers, etc), then, can be considered not just as deploying particular products ('audit', 'nursing process', 'task-centred case management', 'problem-orientated records') badly or well, but as fabricating these 'technologies' locally and specifically as materials and devices to help produce further effects and institute particular relations. As Bloomfield et al [1992] argue, there is

> a crucial difficulty inherent in the fabrication of any information system - namely, such systems do not reveal or objectively represent the world as it is, but rather, make visible a particular or partial view of activities.[p209]

I shall go on to discuss these issues further in the next section.

In summary, then, the intention in the present study is not to evaluate nurses' practices vis a vis the implementation or effectiveness of the nursing process. As is extensively discussed by Walton [1986], such a goal for research is highly problematic, not least, as Walton asserts, because it is impossible to separate the effects of nursing interventions from other effects (medical interventions, the nature and causation of disease itself within the context of a particular person, etc). The present study avoids any temptation to ascribe effects only to one source or activity, but develops a method whereby nurses practices can be considered as *always* interpenetrating with the practices of others and within a specific situation. With Foucault, the discourses and technologies used within nursing have their disciplining effects. In this respect, I would now like to turn the way in

which the nursing process can be considered and look at it not just as a product and effect of discourse and theoretical claims about nursing nor simply as a management tool, but as a technology of control and cultural artefact.

Technologies and Culture

Technology as another artefact 'made by us' can be realised, then, as constituted in culture and social organisation. And it is in this sense that technology is socially embedded, developed in particular conditions, and as such is undetachable from culture. But simultaneously technologies are the tools through which we attempt to reconstitute the social. It is in this sense that culture can be understood as pluralistic, not monolithic, [Strathern, 1992a] and as having motility [Fernandez, 1986].

The nursing process, considered as an artefact can be seen to address many of the particular pressures upon nurses raised in Chapter One and discussed in this Chapter as the background against which the nursing process has been developed. It can be seen as helping to show, through forms of representing nursing (writing), the rationale behind nurses' practices and further, the differences between doctors' work, domestic work and nursing work. This is an explicit objective expressed by Roper *et al*, [1981]:

> Often, however, she [the nurse] did not analyze what she was doing, nor did she verbalise the phases of the process as she carried out each nursing activity, so some learners found it difficult to appreciate the rapidly executed cognitive aspects of the task observed. Learners were often unaware that the experienced nurse had selected out of several possible alternatives, one particular regime for a particular patient, and were therefore unable to comprehend the reason.
>
> Nor was the rationale apparent to the non-nurses who studied the work of nurses in the 1950's and 60's. To them, much of nurses' work appeared simply as 'tasks' such as filling in patients' admission forms; preparing for, serving and clearing away meals; and doing domestic work in the wards. In the reports of these studies the term 'non-nursing' tasks was introduced and it was recommended, for example, that ward clerks and domestic supervisors should be appointed and that an independent meal-serving system be introduced. The wisdom of such developments is now being questioned in the light of current reconsiderations of nursing. [1981, p1]

As artefact the nursing process can help nurses to show the body of knowledge upon which they base their practice, accumulated and evaluated over time in the form of written records of care. This is also expressed by Roper *et al*, [1981, p1] cited earlier. Further, as forms of representing patients, the nurse can now be seen to view patients as not just a physical entity, a body, mapped only by a medical discourse, but as a subject who feels and one who has a lifestyle which he manages in particular ways rather than others. Nurses can

show that they view patients as persons with emotional, functional and social aspects. The focus of nurses' practices can be shown to be redirected to include a care focus. The nursing process helps make nurses' work visible as rational *and* caring work.

This leads to how considering the nursing process as a technology has other implications. It does not just 'show' nurses' practices but it can help institute new practices through giving nurses a new way of 'thinking' nursing, and 'thinking' patients.

A technology in Foucaults' [1981; Gordon, 1980] sense is taken to constitute a set of disciplined discourses and practices strategically developed within certain conditions of possibility. A technology can be understood as no more than artefacts which are a means to inhibit or enable movement. The nursing process as technology can be seen to effect changes in the social, as helping re-present and to reconstitute the social through inhibiting and enabling movement, nurses' thinking and their practices.

The forms in which the nursing process represent nursing and patients (writing nursing, writing patients) can be taken as a method of disciplining nurses and their relationships with patients. It can be considered as a new technology of control which appears to give nurses more autonomy, but which helps drive discipline down into the self. So while it represents a new mechanism for accountability, it simultaneously helps give nurses a new sense of identity and status: as autonomous, individual knowing subjects, who *examine* patients and *plan* care.

The control is instituted through the language of the nursing process, as a discourse which entails particular systems of distinction. This makes nursing and patients thinkable in particular ways. Hiraki [1992] asserts that the paradigm which holds that nursing care can be reduced to methods of problem-solving and information-processing has emerged as the dominant paradigm in nursing education and theory. Through a critical deconstruction of the language of nursing process textbooks Hiraki reveals these models as rationalist, essentially normative and as reducing nursing to a technical production. Taking a Habermasian perspective she argues that nursing process as "instrumental action" is aimed at "control and predictability". She claims that:

> When instrumental rationality is used to solve practical problems, power is manifested as domination and coercion. [p10]

Hiraki claims that adopting an instrument which attempts to make action rational denies the interactive nature of the production of meaning and constitutes a method for controlling and limiting nurse-patient relationships. The nursing process does this through language: by making nursing thinkable in an empiricist tradition of a calculating reason it denies the possibility of patients interacting to influence what is appropriate, to participate in the

production of meaning.

Further, following Latour [1987], Rose and Miller [1992] suggest that control is effected through the particular forms of writing introduced into the formal aspects of accounting mechanisms. Through the particular inscriptions for writing [Rose and Miller, 1992] a way of seeing and understanding can be effected against which ones own practice can be measured by oneself [Roberts, 1991]. The writing down of intentions and understandings constitutes a form of *self*-surveillance. This becomes a system for control. Through nurses writing accounts of what they do, through writing down each aspect of their work in particular ways, they will look at patients and their work more systematically, more reflectively, because they will be looking against particular indicators and measures, such as 'objective', 'progress' and 'outcome'.

It is being suggested, referring back to Chapter Two that the modalities of technologies for change are self-discipline and accountability. The technology acts to reexpress new forms of signification and legitimates new practices, but it also makes the individual (nurse) accountable for knowing and implementing. It is in this respect that the nursing process represents a form of accountability which drives discipline down into the self. Management gets freed up from direct inspection and examination: there can be managing at distance. This is suggested by the discussion of Foucaults' theory of the panoptican in Chapter Two. The control is exerted because the particular forms of accountability instituted through learning and writing the nursing process institute a form of self-surveillance, which helps constitute self-discipline through self-reflection.

Foucault [1978] calls the effects of strategies and technologies which act to mobilise self-discipline the "governmentality effect". Rose and Miller [1992] drawing on Foucault's work suggest this as a way of conceiving power as not "so much a matter of imposing constraints" as of "'making up' citizens capable of bearing a kind of regulated freedom" [p174]. Individuals are not merely seen as the "subjects of power" but as playing "a part in its operations" [Rose and Miller, 1992, p174].

The nursing process as a technology can be seen as a form of governmentality where

> ..governmentality is intrinsically linked to the activities of expertise, whose role is not one of weaving an all-pervasive web of 'social control', but of enacting assorted attempts at the calculated administration of diverse aspects of conduct through countless, often competing, local tactics of education, persuasion, inducement, management, incitement, motivation and encouragement. [Rose and Miller, 1992, p175]

The nursing process introduces new forms of accountability through which nurses can be managed through their managing themselves. The nursing process can be seen as another aspect of

> the complex of mundane programmes, calculations, techniques, apparatuses, documents and procedures through which authorities seek to embody and give effect to governmental ambitions. [Rose and Miller, 1992, p175]

It can be seen as an attempt to change nursing practice to make it more human, more satisfying, more caring, more located in the nurse-patient relationship. But through it nursing will become more visible, to managers and to the nurses themselves: the knowledge which it draws on and produces, as well as the outcomes of its action and interventions can be shown through saying.

In her study De La Cuesta [1983] revealed how some nurses did not write care plans. De La Cuesta suggests that the nurses may not yet have had the language to put in to words conceptions of diagnosis and treatment. That they did not yet have constructs for showing 'why this' nursing care. They were not prepared to, or could not, show by saying what they were doing. It is being suggested here that the nurses could also be seen as resisting this as a possible form of power: by making visible what they were doing they said that they could be called to account. Through writing - showing by saying what they were up to - their activities could be seen and surveyed. This is an important link: that the nurses themselves resisted because they experienced writing as a form of accountability. However, it can also be suggested that there are other forms of accountability in place in practice which have stronger claims on practising nurses.

Discourses in nursing, and in particular the nursing process, can be located in new conceptions of power and governmentality. That is, that the nursing process and in particular nursing assessment can be considered as a new form of representing nursing (writing nursing), and as instituting new practices: that it is a tool developed to reconstitute the social. However, as both Foucault's and Strathern's work suggest, culture is plural: how technologies are made to work in practice will be affected by other cultural-historical 'presences'; the contingent claims on actors as they accomplish social organisation. The present thesis examines nursing assessment as an everyday aspect of nurses' conduct. Nursing assessment is examined not as a technology nor as a professional practice, but as a set of practices and discourses undetachable from social organisation, which they help accomplish.

PART TWO

CHAPTER FOUR

REPRESENTING PRACTICE: AN ETHNOGRAPHIC APPROACH

> Culture is not simply an obstacle to innovations: it shapes them. Science thus emerges "from a world that is guided by commercial and political objectives [Newby, 1992]". [Strathern, 1993, p19]

Introduction

The previous chapter has examined the different ways in which nursing has been conceptualised to suggest that there has been a separation of nursing practice from particular social and cultural issues.

Some research which has examined nursing assessment in relation to models of nursing has not examined how or why nurses practice as they do, rather than as per the model. Researchers have taken nurses' failures as incompetencies and as symptomatic of a deficit in nurses' education and knowledge, or as symptomatic of the 'culture' in which nurses practise (where nurses are traditionally dominated by medicine, and prioritise technical and physical care and ward routines). The context of practice is constructed in this type of research as literally 'clinical' and detaches nursing as technical prowess from social organisation.

Where the failures of nurses in practice have been considered as 'competencies' they have been explained through application of theories of sociology [Price, 1987] and psychology [Macleod Clark, 1984]. The practices which have been uncovered have not been considered as competencies which help accomplish particular forms of social organisation, rather context remains in these approaches individualistic, located in relations between nurses and patients. Ward [1988] has discussed how nurses' failures to communicate with patients may help reproduce social relations to effect asymmetries in power relations. While Tilley [1990] and May [1991] both suggest how nurses' communicative practices produce and reproduce particular forms of nurse-patient relationships.

Benner, [Benner, 1984; Benner and Wrubel, 1989; Benner, 1991; Benner *et al*, 1992] amongst others, has claimed a method which takes practice as the site of understanding nurses' knowledge. The method entails the incurring and analysis of nurses'

narrative accounts of their practice. Using this method Benner [1984] claims to show how nurses' assessment and clinical decision-making is situated through context. Context, in taking nurses' narratives as true representations of practice and in separating 'clinical practices' from other aspects of nurses' work, like 'management' practices, is constructed by Benner's approach as subjective, relative and individualistic. This approach helps re-present nurses' constructed identities to constitute nurses as experts, through writing nursing and nurses as unproblematically 'there for the good of the patient'. Further, and equally importantly, by not taking into account patients' experiences and feelings, except as they are interpreted by nurses, Benner constructs context as reified away from patients' life-worlds. I have extensively debated Benner's (and her co-authors') work in Appendix One to conclude that, rather than representing an alternative paradigm, this approach reproduces, under the pre-text of phenomenology, issues central to managerialism.

The two issues addressed by the current study, and which are central to the difficulties of researching nurses' practices are, therefore, what constitutes *context*, and in what ways does this relate to nurses' practices?

Examining nursing as embedded in a social and organizational context has been advocated by a number of nursing writers. Melia [1979] suggests the relevance of sociology to nursing. Ragucci [1972], Evers [1982] and Read [1989] suggest how nursing is a social, relational and organizational issue and that social research methods, rather than those of natural science, are appropriate to the study of nursing as embedded in context. Ragucci [1972] and Evers [1982] also emphasise how nursing research should take account of the patient's view, where nursing is considered as an interactive (rather than technical) process.

In the current study a method was developed to avoid nursing assessment being detached from social organisation: the management of the hospital, the so-called culture of nursing, staff relations, the views of patients, the systems of nursing (both formal and informal), the structure of the wards, the ways in which space is utilised, routines, artefacts, nurse-patient interactions, have all been considered as interpenetrating with how nurses view patients and work to give 'nursing care'. At the same time the study allows for the possibility of nurses treating nursing assessment as a technology. That is, as detached from aspects which are marginalized as social.

It should be emphasised that I make no assumptions that nurses do in fact work to 'assess' individual patients in the manner prescribed by the nursing process. The objective of the current study is to examine nursing assessment as an aspect of nurses' conduct, to uncover the basis upon which nurses give patients 'nursing care'.

The study entails fieldwork in an acute hospital and a critical form of analysis. Ethnographic methods were selected as they allow 'context' to be constructed through the researcher's presence in the setting: as she or he listens to, observes and records the discourses and practices of those in the setting, the ways in which the setting is organized rather than other ways can be explored. 'Context' is constructed by the researcher through interpretation of the discourses and practices of those in the setting as they go about their work: the conduct of social actors.

In Chapters One and Two the relationship between discursive practices and the constitution of conduct has been discussed. In the present study nursing assessment is taken as the object of study which can be viewed in the context of nurses' conduct. Nurses' conduct refers to nurses' practices and discourses sustained over time which help accomplish particular forms of social organisation.

It is suggested, with Foucault and as discussed in Chapter Two, that nurses' conduct can be considered as disciplined in particular ways rather than others. It is the ways in which nurses are disciplined that effects the ways in which they see the world: it constructs what is seen. It is in this way that, as stated in the Introduction to the study, 'visibility' refers not only to an object in a gaze, to a visual perception. Foucault's work suggests how 'visibility' concerns context as the construction of the perspective within which objects become viewed. How nurses 'view' patients is contextually embedded: "culture is in the eye of the observer" [Strathern, 1993, p19]. It is in this respect that the actions and accounts of nurses have been taken as the source of research material to allow for their 'views' of patients to be explored.

Technique and technologies are often taken to be detached from culture, as detached from the social. As Strathern [1993] argues culture is often viewed as a "drag" on technology and innovation. In the previous Chapter how nursing assessment as an aspect of nursing process has been constituted by nursing writers as a technology for changing nursing practice, for reforming and improving practice, has been discussed. Culture or context has been cited by some authors [De La Cuesta, 1983; Faulkner and Maguire, 1984; Macleod Clark, 1984] as the reason for its poor implementation.

In the present study nursing assessment as an aspect of the nursing process is being considered as a technology, which has been developed and introduced as an aspect of culture to discipline nurses. Further, nursing assessment as forms of accountability help to give visibility to both nurses' practices and to patients. It has been developed and introduced into practice as a technology which, as an aspect of (new? developing) plural, and sometimes

heterogenous, culture will help reconstitute the social. How this occurs (or if it occurs) is one aspect of the present study. As Foucault [1980a] asserted, disciplining strategies

> never work out as planned ... there are in fact different strategies which are mutually opposed, composed and superposed so as to produce permanent and solid effects which can perfectly well be understood in terms of their rationality, even though they don't conform to the initial programming: this is what gives the resulting apparatus its solidity and suppleness. [p80-81]

The following Chapter is in two parts: the first part, presents the research methods used and discusses these in relation to the relationship between understandings, context and practice. The second part explains the method of analysis.

FIELDWORK: CONSTRUCTING A TEXT

The Focus of Fieldwork

> If, whenever housewives were let into a room, each one, on her own, went to some same spot and started to clean it, one might conclude that the spot surely needed cleaning. On the other hand, one might conclude that there is something about the spot and about the housewives that make the encounter of one by the other an occasion for cleaning, in which case the fact of the cleaning, instead of being evidence of dirt, would be itself a phenomenon. [Garfinkel and Sacks, 1969, p168]

The phenomenon which the study aims to explore is how encounters between persons, constituting themselves and each other in the setting as "patients" and "nurses", are constructed as "occasions" for nursing. The conduct of nurses is taken as an accomplishment, and as integral to the achievement of particular forms of organisation which nurses manage in their day-to-day encounters with others.

The two modalities through which actors manage organisation is through discourses, as systems of distinction [Deetz, 1992], and acts, as presentations of self, where identity is socially embedded [Goffman, 1958]. These two modalities are of course inseparable.

The central method in the present study is the compilation of *accounts* [Garfinkel, 1967], of both nurses' and patients', given in various situations and in the presence of various others. These accounts are both formal and informal, are constructed in the presence of different people (me, each other, doctors, etc) and are constructed in different forms - written and verbal.

I extend the research methods to include observation of nurses' and patients' actions

and their interactions with each other and with others. These observations include the tools and artefacts the nurses use and which sometimes become temporary extensions of patients (intra-venous infusion, monitors, urometers). And to include my general experiences and observations of people and situations.

Accounts are constructed by actors in their talk and are given in situations of co-presence [Goffman, 1958; Giddens, 1984] or in situations which represent the presence of absent persons (as in written records, whose format has been designed by someone and which will be read by others). Most conversations constitute accounts and can be taken to reveal social actors' knowledge and everyday understandings: their "stocks of knowledge" [Giddens, 1984, p29; Tilley, 1990].

Giddens [1984], drawing on Schutz [1967] states that actors not only draw upon "stocks of knowledge" to go on in their everyday interactions they draw upon these same stocks of knowledge to make sense of their actions (and the actions of others), to "make their accounts, offer reasons" [p29]. "Stocks of knowledge" involve the "interpretative schemes" which are the "modes of typification" which actors use to constitute meaning [p29] and are implicated in the communication of meaning. Giddens [1984] claims that communication of meaning in interactions is to a certain extent governed by the "structural ordering of sign-systems" [p30], but that "Signs exist only as the medium and outcome of communicative processes in interaction" [p31]. Further, I would add, that while actors know things their knowledge is carried through the social. This is a distinctive view of knowledge to that purported by rationalist discourse.

Action is also taken in the current study to constitute communicative events [Giddens, 1984], that is as accounts of the self, which convey an impression of the self to others [Goffman, 1958]. Studying accounts constructed in different situations and in different mediums entails studying the language and actions of social actors. It is language and action as accounts which enables the production and reproduction of everyday life to be managed in particular ways rather than others [Berger and Luckmann, 1966; Giddens, 1984].

This position assumes that the day-to-day activities and talk of actors in the setting can be interpreted and understood as the productions of persons as they construct and reproduce social reality:

> The difference between the social and natural world is that the latter does not constitute itself as 'meaningful': the meanings it has are produced by men in the course of their practical life, and as a consequence of their endeavours to understand or explain it for themselves. [Giddens, 1976, p79]

Giddens here is suggesting that social reality has meaning through both the production of

action, "practical life" and through the production of accounts, that is people's "endeavours to understand or explain it (the social world and their practical life in it) for themselves".

The accounts of social actors are not compiled in the present study to give subjective views of reality. It is through how nurses are "Naming, identifying, describing, explaining" [Garfinkel and Sacks, 1969, p170] patients and the work they do that I intend to uncover how nurses view patients and through this how they are constituting their identity. The present study aims to extend beyond a subjective/objective splitting of social reality. What the study is not is:

> An orgy of subjectivism, a self-indulgent enterprise in which perpetual methodological analysis and self-analysis leads to infinite regress, where the discovery of the ineffable qualities of the mind of the analyst and analysand and their private construction of reality serves to obscure the tangible qualities of the world 'out there'. [Coser, 1975, p306-307]

The position taken in this extract is underpinned by notions of the possibility of a merely subjective view of the world.

As discussed in relation to Foucault's work in Chapter Two, social actors are disciplined in particular ways. In the present study individuals count as knowledgeable, experiencing selves but their experience and their knowledge are taken to be socially constructed. Social actors' accounts do not represent their subjective authorship : "authorship" is not interpreted as entailing a voluntaristic or subjective self closed off from the social. This is what I have critiqued Benner's and others method for in Appendix One: taking accounts as importantly true rather than excavating them as written, as interpenetrated by social, organisational/cultural and discursive forms. As Jay [1986, p175] interprets Foucault:

> ..as Michel Foucault has taught us, authorial originality pales before the constraints of epistemic or discursive determinism.

The study is not underpinned by individualistic notions of social actors as voluntary subjects, as having "authorial originality". While it is recognised that ethnomethodology has its roots in phenomenology, and it is in this respect in the present study, social organisation and identity are conceived of as inseparable. However, the work of Garfinkel [1967] and Goffman [1955, 1958, 1961] suggests a phenomenology in which social actors are far from *autonomous* individuals. This is in contrast to a phenomenology which centres the experiences of an individual, atomic subject [see for example, Oiler, 1982; Parse, 1981]. That is to say, in the present study I am concerned with recognising the tension between conceptualising actors as experiencing selves through whose activities reality gets organized

in particular ways (as agents), and how these 'ways' are both enabled and constrained by "epistemic and discursive determinism". It is in this sense that nurses' and others' activities are described as conduct: that through them power and order are effected in particular ways, rather than others.

I want to avoid a position which suggests a dualism of structure and social actor, which Giddens [1984] seeks to avoid through his "structuration theory". His theoretical standpoint disposes of a dualism between 'out there' and 'in here'. Rather, a duality between social actor and structure is proposed, where structure is taken as the:

> medium and outcome of the conduct it recursively organizes; the structural properties of social systems do not exist outside of action but are chronically implicated in its production and reproduction. [Giddens, 1984, p374]

Structure, as forms of legitimation, signification and domination [Giddens, 1984], are taken as the factors and features that give organisation an overall "institutional alignment" [Giddens, 1984, p376]. That is, structure can be considered as the fabric of context: the conditions of possibility in which actors constitute meanings and which constitute their perspective, their views of things in the world, the visibility of objects. In their accounts social actors reproduce and communicate these conditions. It is in this sense that action and interactions constitute "communicative events" [Giddens, 1976, p104].

Giddens asserts that interaction as communicative event, has three "fundamental elements":

> its constitution as 'meaningful'; its constitution as a moral order; and its constitution as the operation of relations of power. [1976, p104]

Power, moral order and meaning are located in social interaction as the accomplishment of actors as communicative events. It is in this way that accounts do not simply relay experiences and individualistic values or beliefs, but constitute the fundamental method through which social actors convey meaning and help constitute social relations. Accounts are the medium of understanding, what Weber [1949] refers to as *verstehen*:

> The generation of descriptions of acts by everyday actors is not incidental to social life as ongoing *Praxis*, but is absolutely integral to its production and inseparable from it, since the characterization of what others do, and more narrowly their intentions and reasons for what they do, is what makes possible the intersubjectivity through which the transfer of communicative intent is realised. It is in these terms that *verstehen* must be regarded: not as a special method of entry to the social world peculiar to the social sciences, but as the ontological condition of human society as it is produced and reproduced by its members.[Giddens, 1976, p150]

I would add that accounts do not only involve descriptions of intentions and reasons but, to

refer back to Deetz's [1992] work discussed in Chapter One, they also can be considered as constructing systems of distinction.

As systems of distinction, accounts put into play a way of paying attention to the out there, and help (re)constitute identities and difference. Meaning is not fixed through "conventions of a speech community" rather:

> Every sign system contains the possibility of conflicting meanings: the fixing of signs against a plurality of meaning becomes the significant issue here. [Deetz, 1992, p29]

Nurses' and patients' accounts as systems of language alone cannot be taken in isolation to help reveal how meaning is produced to construct identities and social relations. Everyday practices, artefacts and routines, act to support any interpretation of accounts:

> Institutional forms are textual, they are human creations which, like language, position the subject and direct the construction of particular experiences with particular conflicts and opportunities for alternative perceptions. [Deetz, 1992, p33]

It is in this respect that the present study extended beyond the compilation of accounts to include action and other organizational features, such as routines and artefacts. Actors, as does the researcher, are taken to read these as textual to help construct context. It is this context which allows actors, and the field worker, to gain the perspective in which objects can become visible. It is in this way that 'visibility' refers not only to an object in a gaze but to how 'visibility' concerns context as the construction of the perspective within which objects become viewed.

It is Garfinkel [1967] who suggests how visibility and accountability are mutually constituting: accountability is that which is "observable-reportable" [p1]. Like Foucault, Garfinkel is suggesting a connection between what can be said, what can be seen and what can be done: what can be said constructs what can be seen and how objects can be understood. The objective of the field researcher is to uncover not just *what* has accountability/visibility but *how* visibility/accountability is accomplished and how it is constitutive of social practices. This is exemplified in Garfinkel's [1967] study of the Los Angeles Suicide Prevention Centre [SPC].

In this study Garfinkel identifies how actors develop procedures and methods to conduct their inquiries but that these inquiries are "In indefinitely many ways" "constituent features of the settings they analyze" [p9]:

> their [SPC members] inquiries were thereby intimately connected to the terms of employment, to various internal and external chains of reportage, supervision, and review, and to similar organizationally supplied priorities of

> relevance for assessments of what "realistically", "practically", or "reasonably" needed to be done and could be done, how quickly, with what resources, seeing whom, talking about what, for how long and so on.....i.e. of a *properly* and *visibly* rational account of the inquiry. [1967, p13]

Garfinkel is claiming that actors' accounts are themselves practical accomplishments and as such a feature of the settings in which the accountability occurs, that the setting in some way allows certain actions to be accountable because, within the terms of the setting, they are "proper" and "visible" and "rational". He is showing how actors discipline their conduct to make it integral with forms of accountability. The forms of communication are instituted through "chains of reportage", "supervision", and "review", "terms of employment", these help constitute "priorities of relevance", so that what "realistically", "practically" or "reasonably" in all the circumstances should get done, gets done. Garfinkel is linking the procedures and objects of members inquiries and what makes actions accountable with how these are in themselves constituted by the settings in which they occur.

Action and talk, artefacts and spatial arrangements in the setting are all made and used by social actors and all contribute to the communication of meaning. They are inseparable as the body is inseparable from mind or from emotion: it is not simply that one helps make sense of the other, any division is conceptual and socially constructed rather than actual [see also, Burkitt, 1991; Turner, 1992]. These matters are suggested by Goffman's work [1955, 1958].

Interactions, as Goffman [1958] reveals, constitute performances, they are expressions which are managed to give impressions of the self. These are socially constructed: performances are managed through social actors' perceptions of what constitutes proper conduct given the setting (or which he wishes to refuse). Background expectancies are communicated through the actions and accounts people give each other [see also Garfinkel, 1967] and they help maintain a particular order, what Garfinkel [1967] refers to as a moral order. Context helps construct and is constructed through actors, performances as accounts of the self. This entails showing not just what gets counted but what gets left out of accounts, what gets left unnoticed or is concealed to give "a good showing" [Goffman, 1958, p28].

Goffman [1958] suggests how social actors use artefacts as sign-vehicles or sign equipment to help manage their performances, their expressions of themselves. He suggests that the body is also managed by actors to convey impressions of the self through which he/she can be identified as such a one by others and which confirms self-identity. This is also suggested by the work of Giddens [1991] and by Hochschild [1983]. However,

Goffman [1958] is concerned to reveal how there are conditions of possibility which actors draw on to produce their performances and that their performances are sustained through social interaction. This is clearly illustrated in an earlier work of Goffman's [1955] on "face-work".

In this work Goffman explores how face is socially managed and socially managing. Face is not just a metaphor (e.g 'saving face') but the face as Goffman develops it helps constitute social performance and identity: it is through how social actors manage face that they can help give an account of the self to others *and* to themselves. Further, and importantly, through interactions social actors allow others to have (or not have) their face.

Goffmans' work illustrates how in managing face social actors are embedded in and reproduce cultural conventions and cosmologies. For example, looking sad when someone tells us they are gravely ill conveys an account of the self which maintains particular cultural forms: not just as a sympathetic person, but that illness is something to be grieved, to be sad about, it implies death which indicates loss. One can imagine a culture where illness is something to be welcomed, where death is a celebration as it releases one to God: where the news would be welcomed and a congratulatory smile would be appropriate.

Goffman [1955] is not suggesting that this management of face is necessarily reflexive: with Foucault [1975], it can be considered dressage, facial expressions are self-disciplined from birth (very small children can often be seen to practise face-work, sometimes with comic effect). But he is also suggesting how face is also deeply involved in our experience of ourselves and others and our self-social-identity. Face in Goffman's work constitutes:

> an image of self delineated in terms of approved social attributes....A person tends to experience an immediate emotional response to the face which contact with others allows him; he 'cathects his face; his feelings become attached to it. [p319]

One reason for social actors' commitment in social interaction, Goffman suggests, comes from social actors' attachment to confirming the image of self conveyed by the face, his/her own and that of others. Goffman is suggesting that self-identity is socially constructed and has to be perpetually maintained through social interactions. Further, it is the context of interaction which determines the extent of the commitment to confirming face:

> it is the rules of the group and the definition of the situation which determine how much feeling one is to have for face and how this feeling is to be distributed among other faces. [p320]

As one enters a busy shopping mall, for example, social actors avoid eye contact to avoid

the presence of others as a face, to constitute them as strangers [see also Bauman, 1990]. Also emotion can be simulated through face-work: in a poker game, sustaining a poker face hides the tell. Doctors and nurses are encouraged to wipe their faces clean of emotion when dealing with repulsive, frightening or even ludicrous situations.

However, Goffman's [1955] work suggests how in face-to-face interactions social actors employ strategies to construct the face of the other as some particular one. Social situations construct a context in which it is proper to sustain this image of self. Indeed, actors act to sustain an image of face constructed in their interactions with others, so that they can take decisions and perform in such a way as can be 'faced up to', and act to save 'loss of face'. Embarrassment and the possibility of shame in the face of others helps sustain particular forms of social behaviour. Goffman's work suggests how face becomes an artefact, with which we communicate and through which we are acted upon.

In the present study how performance, face and identity are managed in interactions, between nurses and doctors, between nurses and patients and between nurses and nurses, is critical to how social actors construct the context in which patients are viewed and in which they manage their face.

In the study artefacts are examined, including spatial arrangements and the form and content of documents, as constituting some form of presence and as of helping to communicate meaning. It is through the presence of artefacts, (documents, furniture, clothes, walls, equipment, signs) that the self (or a collectivity) can extend beyond the body to communicate with others, and thereby constitute social practice. This is also suggested by Fairclough:

> I shall use discourse to refer primarily to spoken or written language use, though I would also wish to extend it to include semiotic practice in other semiotic modalities such as photography and non-verbal (gestural) communication. But in referring to language use as discourse, I am signalling a wish to investigate it in a social-theoretically informed way, as a form of social practice. [Fairclough, 1993, p134]

In the present context, a hospital, artefacts are undetachable from discursive and organizational forms: they are designed and used for discursive and organisational 'reasons'. For example, removing patients' clothes, to put them in a hospital gown, constitutes a social practice. The explanation is that it is easier to examine a patient in a hospital gown, and if he is 'ill', there may be emissions of fluids (blood, vomit, urine), so the gown will save the patients' own clothes. However, clothes give the patient some particular identity, which is removed when their clothes are removed. The gown helps constitute a new identity: that

of patient.

Further, artefacts help constitute frames of meaning which go beyond situations of co-presence. Artefacts are informative and act on those using them or who are in their presence. I am suggesting that actors interact with artefacts, that they experience and interpret them to be moved by them in some way or another. To refer back to Foucault's [1975] work on the panoptican: the tower comes to convey the presence of a watchful other.

Traditionally there should be a difference between the way in which nurses' accounts and patients' accounts are compiled and treated in the study. Nurses can be taken as members of an organization (the health service, a hospital) and of an occupational institution (Nursing). Their accounts and activities as communicative events can be taken to help establish in what ways their conduct can be considered as *strategic* [Giddens, 1984]. This notion is taken by Giddens on from Goffman's work, where Goffman's works are treated as concerned to

> map out the intersections of presence and absence in social interaction [Giddens, 1984, p68]

Considering nurses' conduct as giving, not just an account of the self, but as helping to accomplish particular forms of social organisation is intended to help identify what the "mechanisms of social and system integration" [Giddens, 1984, p68] are. However, in the current study patients are 'treated' in very much the same ways as nurses. How they are constituted and how they constitute themselves in the setting is a critical aspect of the study. This position constitutes a form of "ethnomethodological indifference" [Garfinkel and Sacks, 1969, p166]. By this I mean that professional sociological reasoning is in no way privileged, although how professionals use discourse to account for their actions (or the actions of others) is taken as significant.

The 'Objects' of Study

> One ought to begin an analysis of power from the ground up, at the level of tiny local events where battles are unwittingly enacted by players who do not know what they are doing. [Hacking, 1986, p28]

Although my central focus is not that of power, it entails taking views which allow exploration of how the contingent claims upon nurses and others get communicated and of how they prioritise these claims. Further, as explicated in the Introduction to the study and in Chapter Two, where an order of things is maintained there will be displacement and subordination: it is in this sense that the current study takes a critical perspective to reveal not just what is made to be present, but what is made to be absent.

This suggests that there are processes of signification and legitimation, but with Giddens' [1984] these matters concern taking a view of power:

> Structures of signification always have to be grasped in connection with domination and legitimation. Once more this bears upon the pervasive influence of power in social life. [p31]

Giddens suggests a way of understanding signification, legitimation and domination as 'structures' which are recursively reproduced through day-to-day interactions. In this respect, 'nursing assessment' in entailing systems of distinction brings into play systems of signification and legitimation. Put simply, the questions raised are: what to nurses is significant about patients and how do they relay what has significance, how are their views legitimated and what practices do their views legitimate?

Nursing assessment involves nurses in taking views of patients. These views make patients visible in particular ways rather than others, and are constructed in a context. This involves understanding how nurses' views are constructed through not just nursing discourse or the technologies in the setting (the nursing process) but in situations of social relations. This approach suggests how nurses' views of patients and their conduct cannot be abstracted from relations of power. The current study situates nurses' conduct as helping to constitute power as an effect of their social relations. Power effected may or may not be benign.

From my review of the literature, and from my own experience as a practising nurse, I did not expect nurse-patient encounters or 'sources of information' to be necessarily the only or principal spaces in which nursing assessment occurs. I therefore constructed field work which would take account of the many possible conditions and situations which might affect the ways in which nurses and patients construct their encounters, and through which nursing assessment could be revealed. In this respect the object (nursing assessment) of study is viewed in a context (nurses' conduct) which comprises:

i nurses practices as they interpenetrate with medical and administrative practices (Chapters Five and Seven);

ii how nurses organize ward life (Chapter Six);

iii nurses' accounts of their practices (Chapter Eight);

iv nurses inter-relations with patients (Chapter Nine);

v patients' feelings and perspectives (Chapter Ten).

I did not treat nursing assessment and its operationalisation as a set of nursing techniques, in the local context of an hospital, although the technologies operationalised by nurses were examined as aspects of their conduct and of organisational/cultural forms. Field

work was developed to enable these five objects to come into focus. The specific way in which the study was structured is now briefly described.

Study Design

As already stated, the principal method in the present study is the compilation of accounts: nurses' and patients' accounts as they speak with and interact with each other and with doctors, with relatives and with me. The field work extended to include not just speech but also action, records and other artefacts, including spatial arrangements, ward routines etc.

In the study I have attempted a "subtle realism" [Hammersley, 1990, p61] rather than a naive realism [Porter, 1993]. That is, I make no claims to so-called objective knowledge or a neutral gaze but claim to represent the setting where the basis of my knowledge is that:

(a) No knowledge is certain, but knowledge claims can be judged reasonably accurately in terms of their likely truth.

(b) There are phenomena independent of us as researchers or readers of which we can have knowledge (but only in the sense defined above) [Hammersley, 1990, p60]

To underpin the validity of the study and to ensure rigour, different methods were used to enable triangulation in the analysis. The ways in which triangulation affects research methods is argued by Denzin [1978]:

> Triangulation forces the observer to combine multiple data sources, research methods, and theoretical schemes in the inspection and analysis of behavioural specimens. It forces him to *situationally* check the validity of his causal propositions...It forces him to *temporarily* specify the character of his hypothesis. [p21]

I have some objections to Denzin's rhetoric (such as "behavioural specimens") as they imply a naturalist's gaze. However, I have sympathy with the spirit of "triangulation". In the current study it has two dimensions in relation to the collection of research material: the first is in the sense of methods which enable different views of the objects of study (observation, interviewing, talk and action, official documents and records) and the second is in the sense of having two different sites (Ward One and Ward Two).

These methods enable crosschecks to be made across from one dimension or sign-system to another - say from talk, to action, to espoused positions, to what is reported or accounted for - and supports rigour in any interpretation of the meaning of actions and words. In the current study action and talk as communicative events involves an interpretation of events as signs and symbols in use. Interpretation of research material

involves a semiotic process, that is the deconstruction of sign-systems, constructed socially in the setting. This is not to imply that sign-systems (such as language) are taken to represent reality, but as discussed in Chapter One, they are taken as systems of distinction which convey meanings. The researcher can never definitively establish meaning but if claims to knowledge and understanding are to be considered then there must be rigour of some sort built in to the collection and analysis of research material. How this is achieved is now explicated drawing on the work of Eco [1976].

Eco [1976] stresses that signs are any entity which can be used to "tell" a lie. This radical break with earlier emphases on the truth content of signs implies there is no certain correspondence between the sign and its 'object'; that is, no equivalence between the signifier and the signified. Further, and importantly, the function of signs as lies emphasises the risk in making an inference on too little evidence. Eco argues that there never can be any certain correspondence between the sign and the object. It is, therefore, a crucial if minimal requirement for there to be more than one sign present to establish an inference as anything beyond mere guesswork. Where claims to knowledge are at stake, a conscious decision may be needed to suspend evaluation of the consequences of any inference (an interpretation) until more evidence has come to light to either confirm or dispute any implications the sign may have. Popper [1969] suggests that the scientist should act to look for what would refute the inference rather than to confirm it. In the study I built field work around this possibility: if I found something significant I searched through the material looking not just for like instances but also for signs which would disprove my original interpretation.

In this way, different views of the objects under study support claims to validity by allowing for a system of *crosschecks* to be developed in the interpretation of the research material during analysis. It is suggested here that any single method (such as interviewing nurses or observation alone) 'favours' particular perspectives. The advantage of using different ethnographic methods therefore is it not only allows the taking of different views [see for example, Smith and Cantley, 1985], but it also introduces a system of 'balances' into the interpretative aspects of the analysis. The research material collected reflects not simply so-called facts and figures amassed by the institution in the form of 'records', nor simply the researcher's perspective in the form of observations and field notes, but includes the actions, thoughts, perceptions and feelings of the patients and the nurses themselves.

Triangulation in the interpretation of the research material has also been possible by treating the two wards as separate sites. Field work took place in two wards, with the same

medical staff but different nursing staff. In the analysis the first site, Ward One, has been analyzed and research material from the second ward, Ward Two, has been used to check on findings from the first analysis and compare and explain any differences in the way in which nurses constructed nursing assessment and conducted themselves.

The field work was undertaken in a professorial medical unit in a large, regional teaching hospital in the centre of a British city, 'University Hospital'. Why this particular setting was selected has already been discussed in Chapter One.

The unit consisted of two wards. Ward One was for female patients (30 beds) and Ward Two was for male patients (28 beds). The specific unit was selected as it was designated a 'general medical' unit: there were few waiting-list or 'planned' admissions, most patients were admitted from accident and emergency, the admissions ward or from the cardiac care unit. The rationale behind this selection was that the patients were 'unexpected' and the forms of care would not be organized through set protocols as developed in specialised units. I considered this an advantage as it constituted greater demands on nurses to assess patients as they arrive, as 'unknown' to the wards and not as having a prediagnosis. It has also been claimed that the greatest proportion of elderly people are admitted to these general medical wards. Further, I was an experienced general medical Ward Sister and felt I would be able to understand what was going on from a 'clinical' point of view.

Field work took place over a six month period divided into two lots: I spent three months in Ward One and then three months in Ward Two. The wards shared the same medical staff (and some paramedical staff) but had a completely separate complement of nursing staff.

Fieldwork configured around the admission and subsequent in-patient 'care' of twenty patients aged seventy-five and over. Observations were made of their admission, subsequent periods of in-patient care, nursing handovers and doctors' ward rounds. I recorded all talk and action during these times. I also transcribed all in-patient documentation concerning the patient (eg. doctors' and nurses' notes). I undertook interviews with the patients and all qualified nurses in the two wards. I extended the study to make extensive notes as to the organizational features of the settings (eg. nurse allocation systems, spatial arrangements, usual times of reportage). A detailed account of how the study was structured and conducted can be found in Appendix Two.

Constructing a Text

Throughout fieldwork, following Schatzman and Strauss' [1973] guidelines for conducting fieldwork, I made both methodological and theoretical notes. These enabled me to make myself reflexively sensitive to both how I was conducting the study and to my impressions of the site. During fieldwork I transcribed field notes either in the setting (I had a laptop computer) or at the end of each day, while the images and impressions of the day's activities were fresh in my mind.

My observation notes consist of a word-for-word record of what was said during observation. Activity is also recorded but this was more difficult: in addition to recording what I saw, I am aware I may have missed some small details of action, particularly if nurses were working behind screens, where I felt I could not always enter. However, I recorded what amounted to two hundred hours of observation of patients, nurses and others as they worked and talked. Added to this I observed nurses' handovers and doctors' ward rounds, writing down word for word what people said to each other and as much of their movements, positions and tones as I could. I also took notes of informal talk and activities on the ward. I also transcribed all documentation (nurses' and doctors' records) for the twenty patients for their current admission. I have thirty interviews with staff and patients, about how they conducted their everyday lives. Added to this I have informal field notes and observations over a six month period. I am of the firm belief that this material, rigorously collected and transcribed, can be taken to represent regularised ward activities, that is, the usual ways of going on in the setting, as they were at the time of field work. I do not think I missed anything crucial to the research project.

I organized the research material into a text, observation material alongside transcriptions of formal documents (medical and nursing records), handovers etc, on a chronological basis, for each of the twenty patients.

I shall now discuss how this text was analyzed.

ANALYSIS

Representation and Reflexivity

I am aware of the irony of my central theme of accountability, visibility and forms of representation. My intentions are to show the reader by saying what others are accomplishing, and what they draw upon and create through their accomplishments.

However I do not claim to base my story about this setting only on what I saw or only on what I heard. The methods adopted to study the site were designed to enable the many different perspectives, meanings and understandings to emerge through which to interpret action and talk as the accounts of actors.

Strathern's [1991] work suggests that the main instrument in an ethnography is the ethnographer. As the researcher in the present study I am not constituting myself as an objective observer but as having been present in the site as well as having presence in the site.

Earlier in the chapter I have drawn on the work of Giddens and other social theorists to suggest that it is in the presence of others and the things they make that we are able to make understandings, *verstehen,* and this as Giddens remarks is the ontological condition of social life. It is in this respect that current ethnographic theory assumes that

> ..we are part of the social world we study. [Hammersley and Atkinson, 1983]

However, as suggested earlier this position does not presume a purely subjectivist position.

To know how to 'go on' in any setting we read the "background expectancies" present in the setting [Garfinkel, 1967]. This does not necessarily imply that reading is always reflexive. Researchers doing ethnographic research to understand social organization as the accomplishment of actors, adopt the same methods and strategies to read the background expectancies as social actors in the setting [Garfinkel, 1967]. However, what the ethnographer does not know before entering the field is how these background expectancies get communicated and how he or she can make themselves aware of these forms of communication. This raises the issue of reflexivity as an aspect of analytical method.

The ethnographic approach is exploratory. The approach allows the researcher to be present as an interpreter of signs in the same situations as the actors present in the setting are constructing and interpreting signs to make their readings and to know how to go on. This process of understanding has been explicated above in discussion of the work of Giddens, [1976, 1984], Goffman [1955 and 1958] and Garfinkel [1967, 1974].

This approach is distinct from that of naturalist inquiry or of methodological romanticism: the neutrality of the researcher is not assumed, on the contrary the researcher is taken as embedded in a social-cultural context to enable understanding [Giddens, 1976; Hammersley and Atkinson, 1983; Porter, 1993; Strathern, 1993].

Through presence in the setting advantages lie in overlaps in interpretive domains.

Any attempts to create a position of observer independence within a neutral space are not only epistemologically fallacious [see also Porter 1993] but such attempts seriously disenable the researcher from participating in the site: as a consequence so-called observer independence prevents the researcher from entering the natives world and finding out "what the devil he is up to" [Geertz, 1983]. As Strathern [1991] puts it

> An ethnographic account is conventionally the description of a particular society and culture known to be based at some point on the experiences and observations of a fieldworker 'who was there'. [p7]

But this begs the question of how an ethnographic account can constitute more than a subjective representation of events.

Strathern [1991], in her discussion of the problems of writing comparative anthropology, drawing on Tyler's [1986] work, raises his point that attempting representation is to be avoided as there is no

> 'object' which they [the ethnographer and reader] can both grasp, for the writer cannot 'represent' another society or another culture. [p7]

As a system of language ethnography can only re-present objects in the world. The ethnographer can but "invite the reader to participate in discourse" [Strathern, 1991, p7]. That is, the ethnographer can attempt through writing an "evocation" of the setting to "provide the reader with a connection to it" [Strathern, p7]. But Strathern goes on to suggest how ethnography cannot avoid representation. She discusses how ethnography gives and makes connections, that these are of course "partial" [Strathern, 1991], in both senses of the word, but suggests ways in which they can be more than the subjective representations of individuals.

The reflexivity of the researcher in their interpretation of research material has been cited as the tool through which representation can be achieved [Hammersley and Atkinson, 1983; Porter, 1993]. Strathern [1993] debates how reflexivity works. The reflexivity of the researcher helps "specify the conditions of knowledge" rather than "disembeds" the researcher [Strathern, 1993, p19]. Strathern's [1991, 1992, 1993] work suggests how through particular forms of both collecting research material and of analysis, representation is not assured but there can be attempt at partial connections. These forms are now discussed.

The first is not to detach things in the world. This is implicit in Strathern's [1992] essay "writing societies, writing persons", from which the title of this thesis derives. In writing persons one is writing societies: persons constitute society and are constituted by it,

including the researcher. Since, as Strathern points out, societies are already written, the researcher is always re-writing. In this respect the researcher can take account of how the setting is already written through the discourses and practices of its members. In this way the current analysis constitutes an interpretive act but through the particular methods adopted it has been constituted through a "multiple hermeneutic" to misquote Giddens [1984, p374]. The analysis is, as with all telling, a fiction [Game, 1992] but a fiction which takes into account a multiplicity and plurality of views.

This constitutes the second way in which the present study can be taken to connect with the setting which it cannot avoid re-presenting. While the form of analysis is "critical" as explicated in Chapters One and Two, the term critical is already in danger of losing its edge and is becoming attached to a particular ideological view of power and emancipation [see for example Allen, 1987; Holter, 1988; Lorenson, 1988; McLain, 1988; Thomas, 1993; Thompson, 1987; Van Dijk, 1993]. I have attempted to shed away any particular ideological or emancipatory agenda in recording the words and actions of those in the setting, I have created a text which contains their voices and their activities, in these voices and activities their understandings and expressions are preserved. However, maintaining a critical stance is a continuous process. Triangulation and crosschecks were built into the research methods as described above. I have also mentioned how I attempted to manage my reflexivity through making theoretical and methodological notes during fieldwork. Further, I have attempted during interpretation to foster an "analytic attitude". Sudnow [1967], drawing on Garfinkel, describes a problematic notion as a concept which enables the sociologist to maintain the "proper analytic attitude" [p60-61]. I have interpreted this as that I should take nothing, including my own interpretations and understandings as matters of fact, nor that I can reveal or rely on things as the facts of the matter. In the analysis I have examined the talk and interactions in the setting, including documents, in relation to what is made to be present, and what is made to be absent, and more importantly how these presences and absences are accomplished.

This has entailed my taking different views of the research material. While I have avoided attempting to establish causal or psychological relations, these views could be described as attempts to locate the setting in different dimensions. These dimensions are present in a synchronising way and are described by Strathern [1991] as "social" and "cultural",

> as giving a grasp of 'historical' location, of 'material' conditions, of 'social' relations [p47]

It is through writing the setting in relation to these dimensions and not as an homogenous narrative, that I wish to

> provide an illuminating context. [Strathern, 1991, p47]

The social and cultural dimensions are present in the text in the forms and orders of discourses and practices of those in the setting.

Analysing Text

The interpretations of the setting began when, or even before, I entered the setting. They continued as I transcribed research material and ordered it [see Blauner, 1987]. I am aware that I have interpreted the texts I have made through my experience of the setting and the people in the setting.

The analysis has not employed any particular textual or other analytical programmes but it has involved a form of discourse analysis. This analysis involves the ethnographic view of communication where meaning is located not simply in discursive events but in language, action and artefacts as constitutive of communicative practices [Fairclough, 1992, 1993; Hymes, 1964] and which all operate together to communicate a multiplicity of meanings. I have also taken a critical view of language: that it is a social practice which is constitutive:

> Viewing language as social practice implies, first, that it is a mode of action ... and, secondly, that it is always a socially and historically situated mode of action, in a dialectical relationship with other facets of 'the social' (its 'social context') -it is socially shaped, but it is also socially shaping, or constitutive. [Fairclough, 1993, p134]

In this respect accounts and actions have been analyzed as constituting communicative events which are also constitutive of social forms (hierarchies and identities, social relations, the development of particular skills, the ordering of priorities, the construction of routines, the application of technologies).

Critically the analysis has also examined how these forms, in constituting the social, displace, marginalize and silence. The texts which I have compiled from the accounts (written, verbal, to each other, to me, formal and informal) of those in the setting are analyzed in relation to both their forms, as *devices* and their content, as *materials* [Czarniawska-Joerges, forthcoming]. As devices and materials, the accounts have been critically examined for what they make present and what they make absent, for the identities and social relations they constitute and which constitute them.

The analysis of accounts has been directed at uncovering the ways in which people describe and refer to things in the world [Garfinkel and Sacks, 1969], to their discursive content and their characterisation. Further, accounts have been analyzed in relation to the reasons given for action and to the discourses which are enrolled [Latour, 1967; Callon and Law, 1982] to make up these reasons. The accounts have been examined in relation to the language effects used, in particular to the place of particular forms of discourse (e.g. medical and nursing) and to metaphor and metonymy. Quantitative measures, such as the extent of a description and the time spent on its delivery, have also been used. Through this examination processes of signification and legitimation have been revealed: these relay what is "reportable-observable" [Garfinkel, 1967, p1; Garfinkel and Sacks, 1969, p163], what has accountability and visibility.

Intertextual analysis is recommended by Fairclough [1992]. It includes such things as taking account of the order and genre (narrative, interview, examination, conversation) of discursive events. This is established through attention to such matters as how turn-taking and linguistic forms in interactions are operated by social actors to maintain identities and establish hierarchies in social relations. For example, when analysing nurses' interviews with patients I did not just look at what was said but looked at how (or if) the interview was characterised by the nurse to the patient; who speaks and when; and how do they speak to each other, in a question and answer format or in a conversational format, or do they go in and out of different genres; is the format controlled and by whom; do they use jokes, when do they use jokes and what do they convey/communicate when they use jokes?

I have examined the accounts which I have compiled of nurse-patient interactions in relation to the care that patients were given and in relation to their constitution as social relations. I then traced this back to uncover where that 'care came from'. I have then examined interactions in relation to the nurses' accounts of their practices, comparing what is written to what is said, to see what gets passed on and how it is characterised.

I have also consistently changed the scale [Strathern, 1991] through examining the discourses and practices of nurses in relation to one patient and compared this with other patients, other nurses, and on another ward. Further, I have compared different discursive events, say the ward round as compared with a nursing handover or a nurse-patient interview. These Fairclough [1993] refers to as the orders of discourse. As stated in the beginning of the Chapter, the objective of the study is to construct the context of the setting as it is constructed by those in the setting. Nursing assessment entails nurses taking views of patients. In examining how these views are constructed, through examining the

discourses and practices in the setting, I am examining culture, where culture is in the "eye of the observer" [Strathern, 1993].

Strathern [1991] discusses how the ethnographer holds the practices and discourses of those in the setting against various measures to reflect the plurality of the setting. In this way I have continuously held up the practices and discourses against theories and discourses to help, not evaluate, but locate them as cultural and social forms. These theories and discourses include nursing discourses, social theories, and theories of epistemology.

The following chapters constitute my representations of the setting. Through these representations I aim to locate nursing assessment as an aspect of nurses' conduct: as situated in a historical, cultural and social setting and as constructed by nurses through their everyday actions in the presence of others.

CHAPTER FIVE

SETTING THE SCENE

Introduction

The central focus of the thesis is nursing assessment as an aspect of nurses' conduct. The conduct of nurses is taken as a part of the organization which they manage in their day to day encounters with others.

The phenomenon I hope to show you is how encounters between persons, constituting themselves and each other in the setting as "patients" and "nurses", are constructed as "occasions" for nursing.

All proper names and dates relating to the setting are fictitious.

The Place

University Hospital is one of two large teaching hospitals serving a British city and its environs. The hospital covers the full range of medical specialties for adults.

The hospital is a place of education and training. It is associated with an internationally prestigious medical faculty and is the clinical setting for students from a nearby college for nursing education. The Ward Sisters are contracted to fulfil a ward-based teaching commitment, including student nurse assessment. Many of the medical staff are paid by the university and have commitments to the education of medical students and post-graduate research. Degree course nurses from the department of nursing studies in one of the cities universities and from a college of further education also have clinical placements in the hospital.

These aspects are a part of the day-to-day world of staff, and of patients. Staff organize their work to take account of the hospitals' different 'functions', not simply to enable the provision of care and treatments to patients. So for example, new admissions to the wards are sometimes "clerked" by medical students, who take a history and examine the patient as a part of their practical education, their work then being checked by the ward resident. Further, doctors' ward rounds are organized to accomplish more than just the so-called management of patients, they are constructed by members to accomplish the education of medical students where they are present. Many patients (through their records) are entered into research programmes while others are asked directly to participate in research projects (as with my own). All patients (through the records of their admission) serve as

evidence of work for staff and are used by government through collation into statistics.

Patients become a part of the medical and nursing students' education and training, and staff organize their work to accommodate these commitments. In these ways the hospital is not just a place for the sick to get well, but also for large numbers of students to get educated and qualified and for those already qualified to further and develop their expertise and experience. In the present study it is emphasised and to be kept in mind how almost all the people with whom patients come into contact (including myself) are present not simply to give them a service but because they have some vocational or professional interests of their own to accomplish regardless of the particular patient, but that requires the patient for its achievement. Patients provide signs, staff are consumers of signs. Both Sudnow [1967] and Foucault [1973] have emphasised these aspects of hospital work.

The medical unit in which field-work takes place consists of a female and a male ward - Wards One and Two. The wards are constructed as a unit for administration purposes. The notion of a unit is based around how the same medical staff serve both wards or, to put it another way, the four Consultants "have their beds" on these two wards. The wards also share the same senior nurse who holds unit meetings (she is responsible for four wards altogether), so the wards are administrated as a unit by nursing administration.

However, the ward staff do not 'act together' as a unity: the Sisters do not meet together, except at the nursing officer's meetings and the "social round", they do not share staff nor do they share ideas, feelings, or discuss their work together; patients do not mix together, and only minimal amounts of equipment are shared between the wards, such as heparin pumps. Informally they do not "have much to do with one another" (*Sister 2, Field Notes, Ward 2*); "ward night outs" are organized separately.

From the nursing point of view each ward acts in most respects as a 'self-contained unit', communicating up the hierarchy to those above, but not particularly along the hierarchy with peers in other wards or units: there did not appear to be a collegiate spirit amongst the Sisters. Also they do not share staff: appeals for help when staff feel short have to go through the central office, neither Sister nor the nurse-in-charge can appeal directly to their neighbours. This may reflect other organizational aspects of the place such as the nursing process, which will be discussed later: that in dividing wards one from the other there are changes in possibilities of collectivities and potentially nurses may be easier to 'rule'. Specialisation and isolation of each ward at a social level reflects possibilities for ambiguities in the balance between so-called autonomy and governmentality. This is further reflected in the introduction of formal accountability measures, the nursing process, which

individuate practice and potentially further divide nurses. This is suggested by Dingwall *et al* [1988] in their discussion of the affects of the nursing process and by May [1991].

There is a side ward off the corridor leading to the main ward area which has two cubicles at the entrance, and then four bays (referred to as "Bays One" to "Bay Four"), with beds arranged around the bays. The nurses' station is in the centre of the ward, on one side, along one side of Bay Three.

Each bedspace has a bed and a locker next to it. Curtains are hung so that each bedspace can be screened off. On the head of each bed is a holder for a name card. These cards are colour coded for each consultant and have the patients' names written on them (their title and surname, or sometimes also their forename, or just their forename and surname and no title). Also hanging on the wall above the bed is the observation chart. The patient's name is written on this and also recordings of temperature, pulse, blood pressure, respirations and occasionally bowel movements. The nurses said that the charts and name cards occupy these positions, on display, so they are easily visible, for doctors on their ward rounds, or for anyone else wanting to check who the patients are, what consultants they are under and how recordings of the patient's 'vital' signs are doing. At the end of the bed on a clipboard are hung the prescription sheets.

The public display of this personal information such as name, age, bowel movements etc is taken for granted by staff in the setting as facilitating easy identification of patients, and access to them and to basic information. Porters and other ancillary staff such as physiotherapists, do not have to approach nursing staff to locate patients nor do they have to be introduced to patients: they walk around the wards looking at the name cards until they find the person they are looking for.

This both constitutes and represents something about how people are working and constituting their relations with patients and each other: at one level it makes for less contact between staff, this gives less access for casual encounters and discussion. It also means patients are open to a wider variety of 'personnel', to whom they are not 'formally' introduced but who approach them directly.

At another level the charts and name cards are signs which act as mnemonics: nurses and doctors do not have to memorise names and *faces* as assiduously as in a situation where identifying information is not so readily available. In some way the face, as an identifying feature, may not come to matter so much: patients can be identified by the signs constructed to represent them, the face does not have to be attended to in the same way for recognition to occur. Where nurses work very closely with someone on a regular basis, this will not

necessarily be the case: they know the patient by their face and can recognise them where ever they are in the ward.

Further, it had not apparently occurred to anyone that these signs might constitute a breach of confidentiality. The public display of personal information it is suggested is one of the ways in which patients get inducted into the setting: through how *their* name, *their* age, *their* bowel movements, *their* temperature become signs they themselves become constituted as signs for public consumption. There is exposure here, and a subordination of privacy and confidentiality to expediency and convenience.

Of some further significance is the fact that the patients are not a party to the colour coding of their name cards: they are not given the key to the code to know that pink means 'under the care of Dr X', so while the cards help staff identify patients within the setting, the card does not give a mutual identification to patients of one aspect of their place in the setting (under whose care they are).

The Staff

There are groups of people in the unit working together to make it an organized work-place. These groups maintained their boundaries and their separateness, while also negotiating and interacting to order and organize ward life as it should be ordered and organized. In what follows I have preserved the groups as I think they are maintained by the actors in the settings.

The nursing complement for each ward includes two nursing auxiliaries, between seven and twelve students or learner nurses at different levels of the training trajectory, five staff nurses and a ward sister. The different levels of nurses wear different uniforms which are coded to represent their place in the hierarchy. Apart from differences in colour, the other uniform codes indicating a nurses' place in the hierarchy are quite subtle: they consist of things like the length of sleeve, type of cap worn and number of stripes on an epaulette. All doctors wear long white coats. All staff wear a small badge with their name and position written upon it.

It is not customary for nurses to introduce themselves to patients, while doctors do introduce themselves. The patients are not given any formal information as to the key to the uniform codes and as uniforms have become more like each other, it is less easy for patients to work out who people are in relation to their place in the hierarchy: they have to do the work of identification through informal relations with nurses and other patients. This came to my attention in talking with patients: they often simply did not know who people were in

terms of their functionary role, apart from the students and nursing auxiliaries who had worked closely with them.

The senior nurse visits the wards twice a day and checks the numbers of staff. An important aspect of her visits is to ascertain the potential numbers of empty beds. She usually stays by the nurses station during her visit and may chat with the nurse-in-charge. Typically she does not have anything to do with the patients directly.

One of the questions raised by the study is what indicators are being used by the senior nurse to establish the forms and standard of patient care. Whatever indicators are being used are not overt: there are no formal accountability practices in place so that for example, the ward nurses no longer had to write a report on patients for nursing administration. I regret not interviewing the senior nurse to uncover what she takes to be accountability practices and on what basis she assesses the ward nurses work and the standard of patient care. I leave this for another study.

It should be stressed that the ward nurses *in the main* are not young girls of seventeen, straight from school. I saw most of them as women doing important work. There was very little friction or discontent expressed between them. Some of the qualified nurses on the female ward were less satisfied with their job than the nurses on the second ward, and the qualified nurses on the second ward were more critical of the medical staff. As a group the nurses were willing, self-disciplined, orderly and responsible. Nobody attempted to rock the boat.

All the doctors except one resident were male. Each consultant has a team of doctors working under him. This consists of a senior lecturer or registrar for two of the consultants, lecturers and registrars and the three resident doctors. The doctors above resident level have responsibility for covering the A&E department, outpatient clinics, investigation units, as well as fulfilling commitments to research. When 'on the ward', but not directly involved with patients, the doctors work, teach or congregate in the doctors room, which is off the main ward, and a long way from the nurses' centre of activity and book work. The doctors, but not the consultants, often have coffee in the Sisters' offices, the nurses or the housekeeper prepare coffee for them. I frequently attended coffee time. This informal time is a time for the doctors to chat together, rarely about patients, and not really with the nurses. They very rarely in my presence discussed patients or their work together at this time.

A geriatrician and his senior registrar are attached to the unit in a consultative capacity. One or both of these doctors visits twice a week. They "pick up" [*geriatrician in*

conversation] all patients over the age of 65 on a Tuesday. According to the Consultant they check over their notes and then go and see each patient individually. He stated that they check them from a 'functional' and 'social' point of view and on their "pharmacology", i.e. the drugs they have been prescribed. They also check that there is not a dependent elderly relative at home who may need attention. They make their own records (which is also a part of their survey research) and bring them up on the Thursday ward round, called the "social round". If there is anything immediate that needs doing they will make their recommendations to Sister or whoever is appropriate there and then. I noted that they usually came round at visiting time, and that sometimes they would involve any relatives present. Doctor-nurse relations are discussed further in Chapter Seven.

Some of the other 'human resources' available in the hospital consist of what are called "paramedical staff". These include occupational therapy, physiotherapy, medical social work, dietetics, speech therapy, and a non-medical resource is chaplaincy. There are facilities outside the ward to which patients can be taken: a physiotherapy department, an occupational therapy department and a chapel. But much of the work of these departments actually takes place in the wards themselves. In this way members of these other departments are present in the wards, some more than others. Social work for example is a relatively scarce resource and the presence of the social worker is equally scarce. Other members, for example physiotherapy and occupational therapy are less scarce and are more present in the wards.

The ways in which members of these departments and patients come together are complex. Officially there are supposed to be formal referrals: a referral card completed by the medical staff giving the patients' age, diagnosis and outlined problem, except for the chaplain who is requested by the nursing staff on the back of the admission slip. This system is haphazard. Staff had developed informal ways of coming together with patients, these are primarily through talk and networking between staff or, in the case of the occupational therapist, the physiotherapist and the chaplains, they actually consult records directly to "pick up" patients, and one physiotherapist attended nurses' handovers. Nurses usually telephone the dietetic and social work department to give verbal referrals.

During field work both the physiotherapist and the occupational therapist changed, the replacements were less keen on taking informal referrals, they expected the medical or nursing staff to formally request their help with a patient and give their instructions in writing on referral cards. They claimed that the two difficulties with the 'informal' or unofficial version were the extent to which the paramedical staff had to chase up medical

staff to get referral cards completed and the extent to which they may be accredited with the work they did in any survey of the uptake of resources in the present context.

Other staff working on the unit are a housekeeper (who helps the nurses with ordering of meals and supplies and some of their telephone and paperwork), a visiting Chaplain and ministers, domestics, pharmacists, and maintenance people. The patients themselves are now presented.

The Patients and their Families

As will be seen in the chapters where the day-to-day activities and talk of the people who became patients is described, their 'patientness' is an accomplishment, an hermeneutic enterprise constructed between them, the place, the nurses, doctors and others. This had its pros and cons.

The twenty people around whom the study focused were all over the age of seventy-five. They were suffering from a multitude of health disruptions, which brought them to the Accident and Emergency department of University Hospital, and which can be categorised according to medical definitions. I shall now give a brief description of the kinds of diverse things the patients were suffering from.

Some patients like Mrs Violet, Mrs Adamson, Mr Blakely and Mrs Gardner, had terrible pains in their chests. Many of them also had trouble with their hearts on top of other things: their hearts were not beating hard enough or fast enough or too fast or irregularly, this made trouble breathing and with swelling of their legs. Mr Macgregor and Mr Malone had infections' and were highly feverish, with rigors and weakness. Mr Black and Mr Donald had had strokes making trouble thinking clearly, talking, walking or doing any of the usual things they did. Some had been generally unwell for several days, like Mrs Appleton, and had collapsed, in the street, in a shop or at home, and had vague symptoms, such as trouble with passing water. Mrs Marsh had inhaled a pea and suffered a "frightening" prolonged attack of choking and subsequent severe breathlessness, she also had trouble with swollen ankles, apparently her heart was not beating properly.

Some of these elderly people had a lot of trouble. Mrs Best had blood coming from an ulcer in the wall of her stomach, giving her black diarrhoea, making her sick, this was on top of a colostomy and severe arthritis which made her joints deformed so she walked with a stick; Mrs Best was so stiff she could hardly get up in the morning, or comb her hair, or cut up her food without her arthritis tablets, which were probably the cause of the ulcer in her stomach. Mrs Menzies had an open tumour in her breast, which she had concealed for

eight years, her cancer had grown in her body so that she had water in her abdomen, which could find no way out as her heart was failing, and she had diarrhoea and could not hold her urine or her stools. Mrs West, who was eighty-eighty, had been run over by a car, had broken a bone in her arm and her pelvis, and was covered with swelling and bruises; the shock had apparently made her bleed from her stomach.

Three of the patients, Miss Hepburn, Mr Donald and Mr MacIntosh lived on their own, had collapsed and laid all night on the floor. Two of these people, Miss Hepburn and Mr MacIntosh, were in their late eighties and when put in the hospital nobody knew what was wrong or was sure if they could think clearly enough to look after themselves any more at home, even with lots of support: their minds and their connection to the outside world were "borderline". They both did not make it home, but waited in the hospital to be placed elsewhere. One man, Mr Wallace, who was ninety, was severely disabled with Parkinson's Disease, he had collapsed at home and was semi-conscious. He was thought to have had a heart attack and pneumonia. He died a few days later.

All the patients had families. Some had busy and active social lives. Some lived on their own but had children or close relatives as well as neighbours, district nurses, home helps and others, such as the Church elders, deeply involved in their lives. Being at home for all the people I talked to was about *networking*. Like all people, they were dependent to some extent, but none were totally dependent but all had intricate social networks for 'going on' [Giddens, 1984]. These social networks were based around other people but also included activities such as cooking, talking, shopping, visiting, sharing meals (one woman's granddaughter came every day from school for her lunch), games, television (particularly for news), the telephone, newspapers, crosswords, books, sewing, knitting, sport, religion and music. As Mrs Best said, keeping young is about staying in touch, staying interested.

I want to stress how most of the people I talked with had lives rich with the present as well as the past. None of the women had men or children practically dependent upon them, but many were givers, emotionally wrapped in the lives of their families, they still constituted themselves as active mothers and grandmothers, caring and concerned for their children and grandchildren, doing things together and socialising intimately on a daily basis.

Several of the men had wives for whom they felt responsible and whom they described as being dependent upon them, emotionally as well as practically. One of the men, Mr Gibbon, felt profoundly trapped by his wife's physical and emotional dependence upon him. Most of the people I talked to were deeply concerned and worried by the idea of being any more dependent than they were, of being a burden, or of being unable to be

responsible for others, some said they would rather be dead or put in a home than be a burden to others. This theme will be developed in the thesis, and is very complex and relevant to how the patients work to allow nurses' and doctors' their work.

Access by families to patients is controlled in the hospital: as with all 'visitors' they are only allowed in at visiting times - two and half hours each day. "Family" is constructed as a resource by nurses and doctors in their evaluations of patients in relation to their discharge potential: this emerges as a central, ongoing aspect of the nurses' review of patients.

Family did work in the ward: they did the work of getting information about their relative to and from staff. Nursing staffs' appreciation of family is ambivalent: on the one hand staff work to make sense of the relations of "family" to the patient in terms of the support they are prepared to give, so family can be constructed both as a source of information and a source of support for discharge, in this way family can be valued as "good" where support is taken to be forthcoming.

But "relatives" are also seen as a "nuisance" when it comes to wanting information, because they are seen as interrupting the work of the ward. This may have been related to the difficulties that some nursing staff expressed concerning being kept up to date with information by doctors. Some nursing staff stated that they did not always have information about the overall medical plans for patients or their diagnoses, some felt undermined by this, so that it may have contributed to why relatives seeking information constituted a problem for them - the nurses can not deliver the goods and felt they lost face, one nurse said she found it "undermining".

Where a patient is constituted as dying then staff saw family as included in their domain of care: family become needy and nurses are there to help them in their need. But dying is constituted partly through a termination of treatment, where 'nature is allowed to take its course'. Then, family are given more open access to be with the dying patient. This relies of course on staff *realising* that 'nature is taking its course', that a patient is dying: they have to 'change gear' and their mode of activity, to reconstruct the patient as someone who is dying rather than as someone who is being treated. One patient was seen to die before staff had realised that she was dying and family were not included until after the event. This realisation and reconstruction is very complex and will be returned to throughout the thesis as central to the forms through which nurses assess patients and give care.

For those patients who had been in hospital a long time family were also allowed in

at irregular times, to take patients out, and provide what one nurse described as a "social" life, which they, the nurses, said they could not provide. Some of the nurses described how the ward had become "home" for these patients so this made it different, this made a social life something they needed.

Coming Together

This section is concerned to show how the very ways in which nurses and patients came together are an aspect of how nurses construct persons as patients in particular ways, while simultaneously reproducing and maintaining the order of the setting.

The hospital dealt in "beds","admissions" and "discharges". All these expressions are in the day-to-day talk of staff. They are metonymic, where a part of a system or process stands for the whole [Osterwalder, 1978]. For example, the expression "bed" signified many resources: a space available to place someone in, the hospitals' facilities, expertise, nurses, drinks, machines, cleaning, research, drugs, shelter, food, work. But importantly the use of the term "bed" was also metaphoric: it helped signify movement, movement through the hospital, the flow.

Getting a bed, gaining access to the hospital's resources and facilities, required naming and the construction of needs. This process involved staff in constructing a person as a patient who had "needs", and that these needs can be fulfilled in some ways by the facilities available in the hospital, so that they (the patient) "needed" to be admitted. Through this process persons are constructed as patients "needing" "admission".

"Needs" are the facts about someone which have been revealed through a history and examination, creating an imperative for action and a method for moving others around in relation to the allocation of resources. Constructing someone as a patient with needs within a hierarchy of need, which lead to prescriptions for treatment and care, as a form of account, makes it unavoidable that the need is fulfilled. There is enrolment of discourse (medical) based upon a hierarchy of need, so that what emerges are that some needs are more essential needs than others, less essential needs can be left without causing the patient too much harm. The construction of persons as patients with needs reflects and reproduces the underlying discourses of the setting and allows persons within the setting to justify the ways in which they move patients around. Epistemologically and ontologically it contrasts with and displaces any possibility of constructing someone in relation to their wants, wishes or desires.

Getting access to a bed can happen in a number of ways: a person goes to his G.P.

or calls his G.P. or someone calls the G.P. on his behalf; the G.P. refers the patient to an outpatients clinic or in what he took to be an 'acute' or emergency situation, sends the patient straightaway to the Accident and Emergency Department (A&E). Being 'ill', usually suddenly or severely, the person or their family or simply a passer-by can call for an ambulance and the ambulancemen can 'decide' to take them to A&E. Or the ill person can get a cab, or a bus or walk, and present themselves to A&E. The two routes into the hospital are therefore either via outpatients or via A&E, with or without a G.P. referral. Getting access to a bed through either of these routes means the person has to be constituted in some way and by certain means as an "admission". This involved staff in a process of 'naming'. How this occurs is now described.

Admission

The present thesis concentrated on elderly people who did not plan their admission to hospital (as far as I know), they had little or no warning about the fact that they would soon find themselves in hospital. They were all admitted via A&E. Once through A&E they became an "admission", designated an "acute" or an "emergency" admission. That is, they got constructed in ways which led to their immediate admission to the hospital. From the documentary evidence this process can take up to five hours. The person presenting at A&E, to get admitted to an "acute medical ward", had to be constituted by the medical staff as a medical admission, rather than any other type of admission.

On their arrival, people presenting to A&E are seen by the doctor on duty for A&E and then if he deems it appropriate they are referred to the "medical registrar" for his opinion. It is then up to the medical registrar to decide if the person is to be admitted to a medical ward (or the cardiac care unit) or whether the patient would be more appropriately sent home or should be referred to another specialty for their opinion.

In this way the person is not simply constituted an admission in A&E but is constituted as a type of admission - he or she is 'named' according to a code constructed by the hospital staff and this naming allows the person to be placed geographically, and assigned a place within the hospital. The way in which the hospital is organized in relation to the allocation of or the provision of the main resource, the 'beds', depends upon and is constructed by the naming and placing of people as patients according to, not just medical specialty, but according to their translation into hospital discourse. So the person becomes named as an entity which is organizable: an 'acute medical admission' can be placed within an acute medical ward.

This 'naming' and 'placing' is highly significant: the ward staff themselves measured patients against their interpretations of the category of patients for whom-they-are-supposed to 'exist'. This will emerge in the study as a critical aspect of how patients are assessed by the qualified nurses. The naming of patients begins prior to their arrival on the ward and, as will be shown, continues from there. But it will be argued that the name also signifies a value, the name designates the patient to a class.

At one level the whole ebb and flow of patients is pulled through the hospital by the *waiting system.* How this process works is now described because it is significant in terms of how nurses organize their relationships with patients and themselves.

Every fourth day one of the consultants on the unit is responsible for admitting patients with 'medical diagnosis' admitted from the Accident and Emergency department. They are also responsible for taking patients ready for transfer from the cardiac care unit.

"Waiting" means that from 8 a.m. on Waiting Day all patients coming into A&E considered to have possible medical problems by the casualty officer are referred to the medical registrar on duty. The medical registrar is either a lecturer or registrar or senior lecturer or a senior registrar attached to the consultants firm which is 'waiting' that day. Up until 3 pm patients needing admission to a medical ward are admitted to any ward which has beds and are then adopted by that ward's consultant. Between 3-9pm patients requiring admission to a medical ward are admitted to the 'waiting' ward itself. From 9 pm until 8 am the following day patients are admitted to the admission ward.

The "waiting" Consultant does a ward round with his medical staff and the Nurse in Charge of the Admissions Unit at 8am on "Post Waiting Day" on the Admissions ward and patients requiring further care are then transferred on to the waiting ward sometime during the morning. The waiting ward nursing staff have no control over who is admitted to their ward: they are not represented in A&E or on the Post Waiting Day ward round on the admissions ward.

These complex arrangements for the admission of patients to the 'main' hospital, to gaining access to a bed, have deep meanings for staff. They are associated with making sure the right sorts of patients get admitted to the right kinds of beds. This is exemplified in a conversation I had with several qualified nurses on Ward 1 soon after I commenced the study.

I asked Sister 1 what she thought the rationale is behind the opening of the admissions ward (up until recently patients were admitted onto the "main" wards during the night as well as during the day). She and two of the Staff Nurses are at the nurses' station:

Sister 1 - It's to stop the wards being disturbed at night.
Senior Staff Nurse - It's also so that some patients can be discharged straight home if necessary.

Senior Staff Nurse went on to say that they "need a geriatrician over there [on the admissions unit] as well".

Senior Staff Nurse - A lot of patients are geriatric and should never get to the medical wards.
Sister 1 - They're admitted because they've fallen at home and they need mobilising and rehabilitation, physiotherapy and occupational therapy. But they're admitted here and they're here for weeks. They don't have any medical problems.
JL - So what is a "geriatric" patient.
Sister 1 - Elderly.
Senior Staff Nurse - Frail, old, gone off their legs a bit.
[Another Staff Nurse who had been listening while at the drug trolley]:
Staff Nurse - Ward 10 [the geriatric assessment ward in the hospital] is always half empty and they're admitted here because they won't take acute admissions to the ward there, only referrals.

The nurses here are expressing the idea that there are inappropriately placed people in their ward. They are drawing on a discourse - that "geriatrics" require different care from people with "medical problems". Central to the way the hospital is organized is this concept of appropriateness which relies on naming. But the naming is taken by the nurses as to some extent 'given' and relates to the construction of needs, a patient is revealed as falling into a category, which is or is not appropriate, not that the patient is constructed as being in a particular category. A person is constructed as having "medical problems" rather than as a "geriatric", "gone off their legs" "frail","old". Being this particular type of patient is structured through geriatric discourse as having special "needs" which can be met through specific methods and facilities: "mobilising and rehabilitation, physiotherapy and occupational therapy". For example in the following extract the same Staff Nurse and Sister went on to talk about a patient who is "long-term".

Sister 1 - Take Jessie. She came to us as a purely social admission. She'd fallen at home and is incontinent. She had turned against her home help, refused to answer the door to let her in. She didn't become 91 over night, she's been old for a long time. She had been going downhill. She's been here ever since. She didn't have any medical problems. What is the GP doing, is what I would like to know. She should have been on the long term waiting list and assessed by the G.P and admitted there. Not here.
JL - So why did she come in?
Sister 1 - She had fallen. She is incontinent.
JL - What about the stroke? [Patients 'diagnosis' at report is cerebro-vascular accident - "CVA"]
Staff Nurse - Oh she had that <u>after</u> she came in. She's gone down-hill. She

used to walk with a zimmer and dress and wash herself. That's how she managed at home. Now she needs long term care.
Sister 1 - She is purely a social problem.
JL - So why did she fall ?
Staff Nurse - She had gone off her legs a bit, frail, you know, old and frail.

Having medical problems is different from the needs arising from being geriatric or being "social". But what emerges here is that critically how you are constructed, how you are named, is also a matter of time: "she had not become ninety-one overnight, she's been old for a long time", "she's been going down hill", "she needs long term care". Being old over time is different from being ill and being medical. In this way, time and naming are critical to how nurses view patients. At some level Sister is trying to account for the fact that the patient is stuck on the ward, is long-term, that she has a 'blocked bed': the flow through the beds has been interrupted. In her account she is doing a number of things: she defers blame onto others, and she marks out her territory. If patients are categorised according to typologies of appropriateness, then by reflection so are the nurses. Nurses' categorisations reflect their own identities. If patients are named then so are the nurses, and these nurses constitute themselves as acute medical nurses, not geriatric nurses. Their identities and that of the patients is wrapped together in particular ways. To justify the state of affairs Sister 1 enrols the notion of appropriateness to make her story: the patient is a "purely social admission", the blame lies with the patient herself, for refusing her home help and with the G.P, for not arranging care prior to an emergency.

There is apparent contradiction in how the two nurses are evidencing their claims: Sister, supports her account with the notion that the patient was already unable to manage at home, she was "going downhill" and "did not become 91 overnight". The Staff Nurse's claim that it is since she came in that she can no longer manage, that the patient used to be different from how she is now. This is highly significant as it reveals not simply how interpretive these matter are: these matters, treated as matters of fact in the setting, are accounts of events, which can be modified and changed to colour the present. For Sister time had worked on the patient prior to her admission, but for the Staff Nurse time had continued to work on the patient since admission. For both of them the patient is inappropriate. The nurses are using the past somehow to measure the fact of the event which led to the admission of Jessie and to their appreciation of her. She is reduced to something other than her self - her feelings, how it all works for her is not on their minds. It is also significant that this patient is referred to by her first name (patients are usually called by their title and surname): she is stuck on the ward, here to stay, she does belong in

however an unsatisfactory a position for all concerned but the use of her forename may not simply imply affection and familiarity but also reduced potency.

The question is how had time come to matter so much to the nurses in their assessment of patients appropriateness? Why did they focus on time to make patients visible in particular ways rather than others? I am suggesting that one way that time has come to matter is through the way in which the waiting system worked.

For example, in order to be able to take patients from A&E, CCU and from the Admissions ward, the waiting ward has to make beds available on both days. This means that they arrange for patients to be discharged on these days - discharges are 'staggered' by the nurses over the two days so that beds became available at the right time and are not 'taken' by other wards. Sometimes this means that discharges are planned to coincide with the need to have beds available. The nurses denied this aspect of how discharges are organized, but it came out in their talk, and as will be seen in Chapter Seven, in the ways in which ward rounds are organized.

In the following example, it is not Waiting Day which looms over the bedstate, but waiting-list admissions, though the principle is the same, only this time the nurses know how many patients they are expecting whereas on waiting day they organize for a number of beds to be available 'in case'. Mr Gibbon is supposed to be going home but the staff fear they will not have enough beds for their admissions the following day:

> **Sister 2** - He [Mr Gibbon] is not going home today?
> **Staff Nurse** - Well, L-- [the resident doctor] is not sure who is going home today - there are four tomorrow.
> **Sister 2** - I thought he was going home today.
> **Staff Nurse** - Well they keep admitting and they - we've got four coming in tomorrow. So they'll need the beds.

Sister 2 is questioning why Mr Gibbon is not going home, she thought he was to be discharged. Staff nurses' account reveals that the doctor is not sure who is going home because they need beds for the four admissions the following days and 'they' (the medical registrar in A&E) keep admitting: the implication is if Mr Gibbon goes home they will open up another bed and this might get taken by another admission from A&E before tomorrow. (NB It is not their waiting day so these are not 'their' admissions). From this example, it can be seen that the question of the specific time to discharge a patient is not just based on whether that patient is 'ready' to go but whether it is expedient yet to open up the bed, to make it available.

During a casual conversation with Sister 1 and the Senior Staff Nurse on Ward 1, it

became apparent that there is animosity and conflict is caused by the demand for empty beds. Sister 1 revealed that

> ..we [the sisters] have all been given the message from the Community Medicine Specialist that when every fourth waiting day comes we are to have ten beds empty

Sister 1 and the senior staff nurse claimed that frequently other wards do not declare their empty beds when they do become available. During the course of the research it became evident that the unit concerned take it as a matter of pride that they always have beds available when it is their turn. However, Sister 1 emphasised how sometimes it seemed that "they [the hospital and nursing administration] are only interested in beds". The pressure on staff over beds has been increased over a period of two years. Waiting one day in six, to, waiting one day in four. This exemplifies the tension between managing and care constantly surfacing in the setting. Waiting Day helps keep length of stay and discharge of patients in mind for nurses and doctors alike.

I would like to suggest how having beds available to take new admissions, "the acutely ill", to some extent dominates hospital life, for both staff and patients. For staff, having beds available on your 'waiting day' and the following day is a mark of your efficiency and ability to cope: it was one way that the effectiveness of and efficiency of nurses' work was made visible to managers and to themselves. Old people, who were potentially or actually 'immovable', could or did block the system and impede the attainment of these as goals: so that this is one way old people have become *visible* in relation to time.

The organizational forms in this chapter include discourses and practices instituted around the admissions of patients to the hospital and the typifications which staff use to help organize these admissions. How nurses and patients come together through these forms of organization can be seen as inextricably linked with how patients are constituted in the setting and how nurses construct their own identities. Further, how time and movement of patients directs nurses gaze has also been suggested as influencing the ways in which patients are viewed by nurses. The next chapter is concerned with how nurses organize themselves and patients.

CHAPTER SIX

GETTING ORGANIZED

Introduction

In this chapter particular aspects of how nurses in the study, with others, organize ward life is presented and discussed. The chapter concentrates on particular features of ward life which are of interest to understanding the basis for how encounters between patients and nurses become occasions for nursing.

The ways in which nurses organize ward life and their relations with others can be seen to be both constitutive of nurses' assessment and constituted by nurses' assessment of patients. This is not to say that nurses' assessment is necessarily of patients as 'individuals'.

The ways in which nurses read matters which help them give care are complex and interrelated: they cannot be detached one from the other. In presenting them for reading I am necessarily dividing up things which are not in practice separable. My object is in "demonstrating complex linkages between elements" [Strathern, 1991, pxiii] not to present a homogenous arrangement of practices, but to suggest how elements are undetachable each from the other. The difficulty is in speaking about them there is a risk of reduction, of rendering the place to bits and pieces. In the following chapter the different aspects of organization are understood to act together, in concert. The object of the study, nursing assessment of 'elderly patients', can be seen to be an on-going, organizationally and socially embedded activity, rather than a cognitive, planned, individual function.

In this chapter I am presenting the setting in which nurses give care as also helping to constitute the bases upon which they give care. I have divided up the organizational-social features through which nurses read patients to give care into interconnected facets: these facets act in two ways, informally and formally. The chapter shows how each facet has a formal and informal aspect to their affect. In this way 'systems of nursing', ward routines and nursing handovers are all shown to have formal affects on the assessment and delivery of patient care and informal affects. In Appendix Five, there is a brief guide to orient the reader to how the wards were organized in relation to routines and the division of labour.

Many activities in ward life are routinised, they are made to be repetitive and regularised activity. The question arises is how, within these routines, do nurses know which patients are for what kinds of care? This is now discussed first in relation to the

particular systems for nursing in the setting, constituted as a form of the nursing process and then in relation to other organizational features, such as nurses' handovers, the relationships between routines and materiality, space and place.

Nursing Process

A version of the nursing process had been introduced by the hospitals' nursing administration about four years before the current research took place. A senior nurse who was around at the time of its introduction stated in an informal talk with me, that it had been introduced because it was "fashionable". Prior to its introduction nurses collected a minimal amount of data for records. This senior nursed stated that they nursed patients according to their diagnosis and to ensure their "comfort". She stated that at the time of the introduction of the nursing process there was little 'training' as to how to use the assessment instrument for staff already in post.

In the wards the nursing process consists of forms of documentation. The nursing process documentation is called the "Nursing Record" (see Appendix Six) and has five parts:

i assessment tool

ii care plan

iii operations, investigations and special procedures

iv progress notes

v discharge checklist

All aspects of the nursing record are kept in a sectioned metal folder at the nurses station, which the nurses refer to as the "kardex". These records formed the basis of the nurses' handovers along with the admission record from A&E.

The different aspects of the records are completed at various times: the assessment is completed soon after the patients' admission, the care plan, if compiled, is completed the same day as the admission or more often the following day, the progress record is ongoing, completed at the end of each shift. While nurses are supposed to sign each entry, they do not always sign the care plan or the assessment record, but do sign the progress notes. The different aspects of the nursing record are now examined in detail.

Patients are 'assessed' on their admission to the wards. An admission procedure was constructed and introduced into the procedure manual [see Appendix Seven] kept on each ward, but this, as can be seen, does not particularly detail how the process is to be operationalised. This is discussed in detail in Chapter Eight.

There are two parts to the assessment 'instrument': the nursing "profile" and the

"care plan". The categories on the profile are organized according to a varied, but essentially normative-functionalist epistemological view of what nurses 'need' to know about patients.

The assessment tool was designed specifically for the hospital in question by members of nursing administration and college of nursing staff. It is based on a conceptual framework which is underpinned by a cyclical decision-making model. That is:

data collection -> problem identification ->

plan of action -> action -> evaluation - > reassessment

The patient profile constitutes the 'assessment tool'. It has four parts:

i Reason for admission, medical diagnosis, relevant medical history and current medications

ii Demographic information, including religion and next of kin

iii Physical assessment

iv Social/Psychological assessment

The categories relating to the nurses' assessment of the patients' current and past health status - reason for admission, medical diagnosis, relevant medical history and current medications - are grouped together. 'Health', or the absence of it, is made to correlate with what has been treated, with what has been medicalised. Through inscriptions on the form health is implicated as 'medical', it is thinkable as medical. This is a form of signification which legitimates a particular focus for nurses' attention.

The demographic categories pertain to the administrative view - name and address, date of birth, next of kin, personal belongings, G.P. - however, according to models of nursing assessment, this information can also contribute to nurses' understandings of patients' 'social' context.

Categories relating to the physical assessment of the patient adhere to a traditional systems view of the patient - 'bowel', 'bladder', 'skin condition','diet', 'respiratory' and 'cardiac function', 'allergies'. However, there are also categories relating to the functionalist view - 'sleep', 'mobility', 'hygiene', 'ability to communicate', 'sight/hearing'. As can be seen from the admission procedure manual, nurses are not expected to examine patients physically, except in relation to what are called their vital signs (blood pressure, pulse, temperature and respiration). And nurses in the study were not seen to do a formal physical examination of patients.

Finally, there are categories designed to give a so-called psychological/social view of the patient - 'social activities', 'occupation', 'emotional status', 'family support', 'health

services', 'social and voluntary services'.

While it did not adhere to an activities of living model of the patient the instrument is presumably designed to give nurses a view of the patient and their health in terms of physical, functional, emotional, social and psychological aspects. From this view of the patient, the nurse is supposed to be able to compile a care plan . In this the nurse is to identify a patient's "existing or potential problems", and "long/short-term aims", design "planned nursing action" and project at what time this can be evaluated.

In the admission procedure the care plan is constituted as a part of the 'admission procedure' [See Appendix Seven, point 10]. As can be seen, the care plan is underpinned by a problem-solving, decision-making cognitive model. Care plans are not consistently used in Ward 1. According to the procedure manual the nursing profile and nursing care plan are to be "compiled" as a separate item to the "collection" and documentation of "necessary" or "required" information ['Admission to Hospital', Appendix Seven, points 1 and 10].

Nurses complete some aspects of the profile in a mixture of descriptive and evaluative terms. For example, here is an extract from the profile of Miss Hepburn:

communication: becoming confused
mobility: okay indoors
bowel: eats lots of fruit regular
hygiene: wash down at sink
skin: dry

Some categories are completed in, not descriptive terms, but simply to record the result of the evaluation to indicate that there is 'no problem'. For example, here is an extract from the profile of Mr Donald:

Bladder: No problem.
Allergies: None known.
Sight/hearing: No problems.

Some categories are not completed and are left blank. These usually remain blank. The basis upon which these descriptions and evaluations are made are examined in detail in Chapter Eight.

It is worth noting at this point that the nurses on both wards sometimes create a separate category on the assessment form of elderly patients. This they entitle "Social History", in this they detail aspects of a persons life such as who they live with, the type of accommodation they lived in (e.g. whether they had stairs at home) and more general comments about how they are, for example 'confused' or 'upset'.

In Ward 1, shortly after commencing field work it became clear that the nurses did

not often use care plans, and that there was, rarely, explicit expression in the nursing progress report written at the end of each shift of what "problems" were being addressed. I therefore began to 'count' how many patients had care plans, this is detailed in Figure I:

Figure I

Care Plans			
	yes	**no**	**?**
Ward 1 [n=71]	18	46	7
Ward 2 [n=98]	73	20	4

Of the eighteen patients who had care plans in Ward 1, seven of these had been transferred with the patient from other wards, like CCU or the renal unit. Of the twenty patients included in the main study two women and eight men had care plans, while eight woman and two men did not have care plans.

During field-work, in Ward 2 it emerged that there was commitment to making care plans and reviewing the ways in which the nursing process was working, to "improve nursing care" [*Sister 2, interview*]. This commitment was focused around improving the ways in which the nursing documents were completed and to helping students understand how to complete and compile these documents. The clinical teacher had a high profile on this ward, and with Sister 2's encouragement, began to involve student nurses in discussion about their admissions and about the construction of care plans which led on from their admission of patients.

Where care plans are constructed they are not usually written by the student nurse who admitted the patient but by the nurse-in-charge, unless the admitting nurse is a senior student nurse, is working with the clinical teacher or is herself a qualified nurse.
Where there are care plans these are typically constructed around problems of a physical nature and sometimes, but not always, related to issues uncovered in the assessment profile. Often the care plans are directed at the nurses' assessment of patients' 'signs' and 'symptoms'. Typically patients' feelings are not included in the care plan.

Care plans are either directed at instituting a change - either in a patients' condition or in their behaviour - at preventing a change, or at monitoring for change. There is an example of a care plan constructed by a Staff Nurse on Ward 2 for Mr Donald in Appendix Eight.

As can be seen the care plan outlines assessment of the patient's 'problems', indicates projected outcomes or aims, and gives instructions as to the ways in which these are to be achieved in relation to nurses' and patients' activities. Some of these are to be carried out by the nurse as she assesses the patient in an on-going fashion: for example, she is to maintain Mr Donald's hygiene in relation to (her assessment of) his ability.

Typically where there is a care plan this is rarely updated: the care plan remains the same throughout the patients' stay and addresses issues concerned with the patient's immediate 'problems' as identified on admission or shortly after it. However, as stated, in Ward 1, care plans are infrequently used (two of the patients in the main study had care plans).

The section in the records for 'operations, investigations and special procedures' is used by nurses to indicate any specific observation or collection of specimens and whether these have been collected or completed. The discharge checklist is not used.

The other aspect of the nurses' records is the nursing progress report. This report is written at the end of each shift. At the end of the early shift the nurses write their own records about the patients for whom they have been responsible, at the end of other shifts the nurse-in-charge writes the report. The early and night report is written daily for all patients but the late report is only written for patients where there is some 'change'. The nurses take their writing very seriously and spend some considerable time sitting at the nurses' station writing these reports. The less experienced nurses often look back to what had been written before to know how to format their own report or discuss it with each other or ask a more senior nurse.

The progress record is supposed to be structured alongside the care plan: the problem number in the care plan is used to indicate the area of nursing being reported upon in relation to the nursing action taken and the patients' progress and the nurses' evaluation. An extract from Mr Donald's progress report is included in Appendix Eight. It can be seen from the progress report that the nurses write the progress report in relation to the problem and actions outlined in the care plan (denoted by the number at the left hand side of the page).

In Ward 1 where there are no care plans there are no explicitly identified problems. The nurses write their progress notes in a form where they state the action undertaken or the observation undertaken. Sometimes they also note what the affects of the actions are or their interpretations of the activity or observation in relation to the patient's condition or their overall progress. However, while there was no record of a specific, that is 'identified

problem', the problem emerges through the report and particular activities get connected to it. Although there is no particular statement of intent (aim or objective) in the record, the intent is made implicitly. Here for example is an extract from the progress report of Miss Hepburn:

Date	Prob. No.	Nursing Action Taken	Progress/Evaluation
2/1/87		Washed at sink in bathroom	Managed well, no assistance required. Still slightly confused.
3/1/87		Mobilised to toilet overnight. Big bath given. Had dressing practice with O.T. Mobilising well round the ward and socialising with fellow patients, very cheerful and friendly. Eating small amounts	

What emerges is that the focus of nurses' records is Miss Hepburn's mobility, her 'confusion' and her level of independence. Although there is no care plan in which these matters have been overtly stated as significant the nurses have picked up that these are the issues with regard to Miss Hepburn which are, at the time, of central nursing interest for the record. How this occurs is very complex and relates to the context in which the nurses' are viewing Miss Hepburn. This context is constructed through other forms apart from the official nursing process and are discussed in the rest of this chapter. It should also be noted that Miss Hepburn's behaviour is recorded in relation to observations of her mood; this is unusual in the records, but I am suggesting is legitimated because the patient is being observed in relation to 'confusion'.

How nurses write their progress notes is complex: they write them in relation to what is made significant through nursing handovers, what had already been written and their own interpretations of what should be written.

In summary then, in their records nurses are making particular things about patients present and others absent. They represent patients in relation to particular discursive spaces: hygiene, mobility, chest pain, temperature, self-care, etc. They are also representing themselves and their work in particular ways rather than others.

In writing their records they do not refer to themselves (there is no "I"), although

they do sign their records. The nurses record events or observations as detached from themselves and in doing so constitute themselves as neutral and as detached from patients. Further, there are almost no anecdotal forms in their writing.

Nurses report on events and changes in patients' behaviour, not explicitly as the affects of their nursing work but to imply that the ways in which they work with patients has affected a change (or prevented a negative change). The critical point here is how what the nurses evaluate is not *their* action but their assessment of a *patient's* progress or response (their observation of patients' behaviours as measured through objective measurements). So for example, in the report on Mr Donald it is not their own actions that the nurses' assess but they report their assessment of Mr Donald's progress - "minimum assistance required", "washed well in bathroom, managing well himself".

The ways in which the nurses write constructs implications, rather than overt claims, that what the nurses have done to or for patients affects a change in patients. Their authorship is implied rather than explicitly stated. The patient is written in their reports as the object of their gaze or their activity, as someone to be observed and acted upon, but is not constituted as an experiencing subject, his feelings and perceptions are rarely, if ever, recorded, except in relation to his response to the care he is given and as evidence of his behaviour.

The suggestion is, then, that the nurses' records are doing several things: they are forms of representation which act to help create a space in which nurses, nursing and patients can be thought. They give a view of nursing which suggests its affectiveness without laying overt claims to its effectiveness. As accounts they present nurses as achieving something. But they hedge legal responsibility through not making their claims overt. In this way the nurses' records as forms of writing are activities in themselves. They are representations of persons and events which act to define those persons in particular ways rather than others. This accords with Raffel's [1979] findings. Further, records are not complete representations, but as artefacts and as involving systems of distinction, they constitute a discursive practice, which help relay particular forms of signification and legitimation to enable the reproduction of everyday life.

Other records compiled and/or used by nurses are their charts recording their observations of patients, records of the patients admission, and of their property. These records are solely compiled by nursing staff, although other paramedical staff have access to them, as mentioned in Chapter Five, and medical staff use the nurses' records of observations. Added to this the nurses extensively use the accident and emergency

department "admission summary" and the doctors' prescription sheet's to indicate things about patients.

The issue arises how do the nurses know what to write in their records? How do the aspects of patients and their work which they record and report get made reportable, significant and legitimate. This is now examined in relation to the nursing handover.

Nurses' Handovers

Nursing handovers take place at each change of shift. The nurse handing over has the nursing 'kardex' in front of her, the metal folder containing all the nursing records, including the nurses' copy of the accident and emergency admission document (the "pink slip"). She goes through written records of each patient in sequence as they are situated around the ward.

The nurse handing over would either be handing over or reporting to the nurses on her own shift, as at the early handover, where she would have taken the report from the night nurse in charge or the night enrolled nurse. Or she would be handing over to the nurses on the next shift, as at the midday handover and the late to night staff handover. The handover nurse, as is the nurse in charge of the shift, is the most senior nurse on duty for that shift, except for the night shift where the staff nurse and the state enrolled nurse would take it in turns to handover to the day shift. The person handing over is always a qualified nurse. The nurse doing the handover sometimes reads from the "kardexes" or the "pink slip" and sometimes speaks without reading but looking directly at the nurses grouped in front of her. An aspect of the handover is the allocation of work. This worked on the early shift so that nurses are given 'bays' of patients to look after. The late shift nurses are given half the ward to look after. Usually, the bays are allocated to a pair of nurses. Sometimes specific patients are mentioned and allocated to a specific nurse. Where a patient is being nursed in a cubicle and is very ill this is called 'specialing' a patient, and usually this would be a nurse's only responsibility for a shift. Specific allocation might simply entail a nurse being given particular responsibility for a patient and asked to carry out a specific aspect of care; for example, when someone is very ill and is "for all two hourly care", or needs rehydrating and is "on two hourly fluids", or "on" observations which are more frequent than at the routine times, such as two hourly neurological observations.

The handover is routinised. The handover nurse gives particular details of the patient - name, age, diagnosis, relevant medical problems - then may go on to describe their current condition, give some account of what had happened during the shift in terms of

observations taken, any investigations undertaken, medications given or specific (as opposed to routine) nursing care. She may then give instructions as to any nursing care, observations, medications or investigations for the next shift. The extent of the handover material and length of time spent on a patient varies: time ranges from a few seconds to five minutes. The most time is spent on new patients, patients with apparently complicated problems or very ill patients. Long-term patients and patients close to discharge had short handover times: there was nothing much to say about these patients any more.

The late to night staff handover and the night staff to early shift lasts about ten to fifteen minutes in total. The early staff handover lasts about twenty minutes to half an hour. The midday handover lasts from half-an-hour to three-quarters of an hour.

Typically, nursing handovers are one-way communication channels for information and instruction to go down, along or up the hierarchy. The handover nurse is telling the others about patients, there is not usually any turn-taking. In this way the handovers are not usually forums for discussion about patients in terms either of what had been noticed about patients, what inferences can be drawn or what care patients might require in response to any particular problem identified. Similarly they are not, typically, spaces for speculation or explanation about conditions, aspects of nursing care, consequences of illness or patients' meanings, except in particular circumstances. Here is an example of a typical handover for a recent admission, Mr Blakely:

> **Handover Staff Nurse** - Then in Bay 3 you have Rob Blakely, a 76 year old man admitted this afternoon from A&E. He collapsed at home - he wasn't unconscious though. They're querying an MI [myocardial infarction] with him.
> **Staff Nurse** - I'm sorry - I didn't listen to a word you said. I was in a dream.
> **Handover Staff Nurse** - He's collapsed - query MI. He was quite bradycardic on admission. His pulse was 48 in A&E. We had him on a monitor - but they stopped that a couple of hours after he came in. His pulse is 60 at 6 , BP 120 over 80 and his temps fine. He's been on oxygen at 28 percent. And he's been comfortable since he came in. No pain or nausea at all. He's a sweety as well.
> 1 min 02 secs.

This handover is concerned to report on the patient in relation to his diagnosis, his current condition in relation to vital signs and any associated signs and symptoms. He's been bradycardic but he's fine and comfortable. The only specific instruction is about the oxygen. The nurse tags her assessment of Mr Blakely the man on to the end of her report - "He's a sweety". This was very usual in the handovers, for their to be an acknowledgment of the patient as a person at the end of the report. The nurse does not give a picture of the man but through connecting particular signs together conveys a picture of the patient - he is an acute admission, he has real affects from his chest pain - bradycardia - he's on oxygen

but is comfortable.

The handovers change over time. The handovers closest to the admission of the patient configure around making sense of patients as observed in relation to their possible medical condition, subsequently handovers configure more around mobilising patients. Sometimes there is detail at the beginning of a patient's stay in relation to the patient's home life and mental state where these are under observation or in question.

The handovers entail making aspects of the patient's behaviour or response significant, to be remarked upon and act to instruct nurses what to look out for. Instruction in the main is implicit not explicit: not only are the nurses giving an account of what they have noticed and done, they are passing on what others can attend to and do. For example, Staff Nurse above is relaying how she has done the observations of this patient to assess his condition (he's fine, comfortable, no chest pain etc) and is also indicating what the next set of nurses should observe (chest pain, nausea, bradycardia, etc). The handovers are like a relay.

Nurses reflect upon and discuss those aspects of "care" which are extraneous to ward routines: special drugs, observations, apparatus. Here is an example of how those aspects of a patient which are not routine get talked about:

> **Handover Staff Nurse** - Mrs Gardner 85 year old lady with an Inferior MI [myocardial infarction] and an Isoket infusion. This is set at 1 mille an hour. It should be through about ten. She's had no pain - she's fine - [Phone rings - S/N speaks for a few moments hurriedly]. - Uhm - So if it's through at ten take it down. Leave the venflon in - it may have to go back up again. Obviously if it's through at 9.30 wheek it out. [She turns page of kardex to next patient then goes back to Mrs Gardner's kardex] - er - She had it on the fourth - Keep her on bedrest - until the round anyway, she can be up for bedmaking.

This is the first handover to many of the nurses present on this patient. Some of them, but not all, were present at her admission the day before. The main focus of the handover is the issue of the isoket infusion and the 'venflon" (the intra-venous cannula, inserted to enable easy delivery of medicines in the event of severe chest pain or an emergency). Usually drugs are delivered uncomplicatedly through the routine drug round. But in the case of Mrs Gardner Staff Nurse details the one aspect of her drug regime which does not get carried in the ward routine: her isoket infusion. Further, this focus carries an emphasis: the patient has not only had a heart attack, she was ill enough to have an infusion for her chest pain, but is settled now, she is 'stabilising', can get up for bedmaking but is still to be kept on bedrest "until the ward round anyway". The warning comes with "Leave the venflon in - it [the

infusion] may have to go back up again". Mrs Gardner's status is being affirmed as someone who is 'sick', who may be changing her status, but for the moment is to be nursed as still at risk, as still sick. There is very little information about Mrs Gardner the person, she is constituted through a set of signs coded through the discourses of the setting, through medical and nursing discourse. She is also viewed in relation to time.

As can be seen from the above examples, references to 'care' are typically implicit, carried in the diagnosis and condition of the patient, or very brief, and consist mainly of brief references to such global terms as "bed rest", or "self-caring". These expressions appear to act metonymically in conjunction with the report on diagnosis, the patients' current signs and symptoms, and the known routines to signal care. Mrs Gardner had had a heart attack, but had not had chest pain and was fine, but was still capable of having chest pain: she is being constituted as someone who is still to be treated with care, she is still 'medically unstable' and to be watched.

It should be noted here how the nurses in the absence of overt instructions about nursing care on receiving the handover have interpretive work. They are left to translate the information given them at handover into both understandings of the patient's condition as relayed by the handover nurse, and also into specific nursing care. Where there are care plans, there is less onus on the nurse, but the care plans are often made up at the beginning of a patient's stay and do not get updated and lack detail as to basic nursing issues.

Handovers are more discursive where there are matters about the patient which can not be expressed routinely. These matters are constituted by nurses as those aspects of their assessment of a patient's condition which are difficult to explain given what is already known or where aspects of the patient's condition can potentially disrupt the usual flow, the patient's uneventful recovery and mobilisation.

These difficulties are constituted by anything untoward in either the area of observation of patients in relation to their medical diagnosis and their recovery from their medical diagnosis (e.g. persistent chest pain) or in relation to their potential or actual mobilisation (e.g the patient is lethargic and reluctant to be independent). Any of these issues might lead to more comment or to discussion between the qualified members of staff at the handover. An example of this type of handover is given in Appendix Nine.

Typically the handover is a one-woman performance, where the onus is on the performer as an 'authority'. It should be stressed at this point that the qualified nurses claimed that they found out about what is going on with patients mainly by "seeing for themselves", and through their supervision of juniors, but that "feedback" from down the

hierarchy is confined to specific aspects of patients' conditions or any "problems". However, what constituted "specific aspects" or "problems" are socially constructed in the setting through such features as the ward handovers.

The qualified nurses claimed that this way of working is mainly unproblematic: they said they found that the supervised nurses can usually be relied upon to report "problems" to them and where the supervised nurses are silent and do not report anything unusual they assume that the work has gone along and the patient is alright. While messages about patients went both ways, what emerges is how an aspect of doing nursing in the wards is knowing what can be said or written, where and when. So while nurses at the bedside might talk with patients and get 'information' about them, this does not necessarily get acted on. From my understanding of the setting, there was no forum for the supervised to tell the supervisors about what they felt or noticed about patients in a general way.

Apart from routinisation there are two other constraints on the handover nurse. The first constraint on the handover nurse is the problem of timing. The total handover time is important and in a sense drove the nurse on. There would be many interruptions - the telephone, doctors, patients requiring help. What is revealing here is that the time limit, acting as a constraint, reveals the nurses' *priorities*.

The second constraint on the handover nurse is that the person handing over is giving an account of herself as the manager of the ward. This is made explicit where the handover nurse is above some of those to whom she spoke and at the same time a junior to others or their peer. So, for example, a junior staff nurse might hand over to the late shift consisting of sister, a senior staff nurse, a learner and an auxiliary. This aspect affected the nature and content of handovers: while the nurse handing over might be in authority over some of those to whom she is speaking she is also in a sense accounting to others, in whose absence she had been acting in authority, but in public arena. The nurse handing over is having to simultaneously instruct and account for her actions and decisions about patients so that her knowledge of nursing and of medicine and her skill as a nurse in charge are, to a greater or lesser, extent at stake: if she missed things out or made mistakes it can amount to public loss of face.

Further, if she is handing over to someone supposedly senior to herself, how far should she be 'giving them instruction', how explicit should she be, how far does she need to go to preserve their face?

This aspect of handing over, the potential for losing face, is made explicit in several ways. For example, in one case a staff nurse handing over had not been in-charge of the

shift, but had been left to handover in the absence of the person who had been in charge of the shift. In this instance the staff nurse explained to those to whom she is about to handover that she did not really "know what is going on" because she had been "specialing and teaching the divinity students", that she had not "been on any ward rounds or anything and did not know the new admissions that well". The Staff Nurse preempts loss of face by giving her excuses before hand.

The following extract exemplifies several of the findings about handovers referred to above, as well as how, when a junior qualified nurse is handing over to a more senior nurse, it can become an occasion for a call to account and an explicit take over of the instructive aspect of the handover:

> **Handover Staff Nurse** (to the late shift) - Then you have Mrs Wendy Appleton, an 81 year old lady who came in on the 10th with chest pain. She's for exclusion of MI [myocardial infarction or heart attack] and treatment of a UTI [urinary tract infection]. She had a four day history of general malaise. But yesterday morning she just went out - she is in her bed -head slumped down. She had a strong regular pulse - and her B/P was OK. [phone rings Handover Staff Nurse answers it, call finishes after a few minutes] Uh..turns back to Kardex - She was unconscious for about three minutes - it resolved itself, she just gradually came round. An hour later the same thing happened again and it resolved itself. She's twitching all the time - when she holds your hand she sort of grabs it and can't let go. She's on a chart for recording these episodes - like this - if she's drowsy or unconscious or anything.
> **Senior Staff Nurse** - [to late shift nurses] - You had better check her obs [observations] as well at the time.
> **Handover Staff Nurse** - She was OK last night. Then this morning she felt a bit odd - she didn't tell us until afterwards - but she felt dizzy.
> **Senior Staff Nurse** - [has been looking over at the PATIENT who is lying in the bed next to the nurses' station with cot-sides up] Has she got a 24 hour tape on?
> **Handover Staff Nurse** - Yes.
> **Senior Staff Nurse** - She's in bed - Is she to be kept in bed?
> **Handover Staff Nurse** - Well, yes. When she sits up she .. it happened yesterday after she'd been sat up for her breakfast and after the doctor took her blood.
> **Senior Staff Nurse** - We'd better sit her up then - if she's got the 24 hour tape on. Did they say she isn't to sit up?
> **Handover Staff Nurse** - Er..no, I don't know. She is incontinent of urine yesterday -we didn't observe it but we think it may have been one of these episodes.
> **Senior Staff Nurse** - [to the late shift nurses] - Before you sit her up do her erect and supine blood pressure, then sit her up.

The handover staff nurse has been in charge on the morning shift. The Staff Nurse says what she has seen, but what she has seen does not yet add up, make medical sense, she relays how part of the work is to help make medical sense. As will be noted how the

patient is feeling, except in relation to dizziness is not reported. This it must be stressed is absolutely typical and usual of the handovers. This patient had two episodes of unconsciousness which did not apparently 'fit' with her diagnosis (a possible heart attack and a urine infection). The doctors were called and the patient was kept in bed, with cotsides in place and was put on a special observation regime. This illustrates how, where there is an ambiguity in the patient's symptoms given what is already known about the patient, there is extra talk and activity around the patient and a break in on the usual routine.

The consultant did a ward round the previous day and ordered an emergency twenty-four hour electrocardiograph (a twenty-four hour tape) in case the blackouts were due to cardiac arrythmias. This had been started in the morning. How the Senior Staff Nurse knows she has a twenty-four hour tape on is unclear, the special observation chart lying by the bed on the patient's locker may have signalled it to her, but she checks with the handover Staff Nurse if this is the case. During this test the patient is 'supposed' to do as much as she can 'normally', so that any abnormal heart activity during episodes of exertion or rest can be recorded. This is in contradiction with the usual care of a patient with suspected heart attack: usually, according to the ward protocol, a patient with a suspected heart attack would be up for only a half hour by Day Three. If the patient has any episodes of chest pain, dizziness or any other abnormal signs or symptom while the tape is on, the nurses are supposed to record this on an observation sheet.

The Senior Staff Nurse corrects the care of the patient and arranges for the patient to be got up and her observations to be recorded by the late shift during any "episodes". This turn in the patient's care began with the Senior Staff Nurse giving the late shift the instruction to do the patients "obs" if she has any "episodes" and then by calling the junior nurse to account for what she must count as an anomaly - the patient in bed with a twenty-four hour tape on - "Is she to be kept in bed?". There follows an exchange where the Handover Staff Nurse is clearly trying to think back (so to speak) to account for this state of affairs.

From this handover it is difficult to know what the nurses will have taken away about this patient. Much of the information about Mrs Appleton, is not really about the patient, the connection is tenuous and the instructions as to how she is to be nursed, apart from with regard to the twenty-four hour tape, are implicit in the handover and in the exchange between the two staff nurses. How the patient possibly feels is not gone into. What this handover does tell the nurses is that there are important protocols to be followed, but that these can be mediated to facilitate medical diagnosis (ie. gaze), and that the

important aspect about this patient is the observation of her "episodes". This handover raises another dimension as to how nurses organized their work.

The Senior Staff Nurse checks with the handover Staff Nurse in respect of whether the doctors have given an instruction for this patient to be kept in bed. This indicates that there are relationships of permission upon which the nurses rely to know how to go on. This is also implied in the handover of Mrs Gardner, quoted above.

The handovers help constitute systems of signification and legitimation, identity and difference. Through them as discursive practices, and in conjunction with other organizational features, what is observable - reportable (accountable) gets produced and reproduced. In this way the handovers help constitute nurses' practices, not in a functional way, but in terms of what activity is legitimate and what about patients is significant. This constitutive practice is further enhanced through the way in which the work is delegated and organized. These matters are now examined in relation to ward routines.

The Placing of Patients

The placing of patients is routinised and is interrelated to the construction of a hierarchy of needs, the naming of patients and the categorisation of nurses. This is confirmed in the qualified nurses accounts about how they place patients in the ward and their allocation of nurses.

The qualified nurses all stated that nurses are allocated to the Bays according to their level of skill and experience. Junior nurses are given Bays One, the Side Wards and Bay Four to look after with the auxiliaries and are supervised by a qualified nurse whenever possible. Bays Two and Three, especially three, are allocated to a qualified or senior student nurse or a qualified nurse with a junior student nurse.

Bays Two and Three are where the new admissions and the so-called "acute patients" are placed. Very sick patients who are " being treated" are also placed in these bays, while according to the Sisters and the Staff Nurses very sick patients who are "dying" and who are not being treated are placed in the cubicles. Bay Four is where the "long-term" patients are placed or patients awaiting discharge, convalescent patients or rehabilitation patients, and patients simply waiting to be placed elsewhere. Many of these patients are disabled, but are not constituted any longer as "medically" ill, that is, they are not called "medical" patients, but are constituted as other types of patients: "dependent", "geriatric", "social", "demented", "disabled". Staff in both wards talk about "our Bay Four" as being not "too bad" or "being heavy". In Ward One, nurses often referred to "the Bay Four ladies"

and one of the middle-grade doctors referred to Bay Four on the female ward, as the "cabbage patch". Patients for convalescence are placed in Bays One and the side ward, while rehabilitation patients are placed in Bays Two, Bays One and Bay Four. This includes some stroke patients.

These typologies are critical not just to how the ward was organized but in many other ways. For example, it is a cliche that the nearer the patient is to the ward door the nearer he is to getting out: patients were literally moved down the wards as they passed through the different categories towards their discharge or exit. From the nurses' accounts it appears that the justification for these arrangements is to do with facilities and surveillance. This was the same in both wards.

For example, I asked Sister 2 to talk about how she arranged the ward:

[Sister 2, interview]
JL - So when you're allocating nurses to patients in the morning how would you decide which nurses are going to work with which patients?
Sister 2 - It depends whether I've got trained nurses on or student nurses on. I tend to allocate, I take the patient priority of care so I allocate the most senior people to look after the sickest patients who need specific nursing care.
JL - The illest. And then you work your way down..
Sister 2 - I work my way down the off-duty [NB the off-duty goes down in terms of hierarchy, with Sister at the top].
JL - Right.
Sister 2 - I don't have, I don't like to allocate two junior students to work on a bay so I try to have a senior nurse and a junior nurse working together or a senior nurse and an auxiliary nurse working together so that they are supervised.

Sister 2 accounts for her allocation of nurses, her resources, to patients in terms of "patient priority of care": the most "senior people" "look after the sickest patients", those who need "specific nursing care". Junior nurses are allocated to look after less ill patients, but are "supervised". From the rest of this section of the interview it can be seen that she configures "sickest" around two concepts: the observation of patients and what she refers to as "high dependency" nursing.

JL - What is your plan there of the bays, how do you work out which people are going to go where, because you've got your nurses station in the middle? *[Sister in informal talk with me had already indicated that she liked the new admissions and the sick patients to be near the nurses' station - but I should not have led her here]*
Sister 2 - I have the illest patients in bay 2 and 3, high dependency nursing in bay 2 and 3.
JL - And why is that, what's you idea?
Sister 2 - Because they're near the station. I think they're near the centre of the

ward so they're near the station, you know there's always people around the station. And they can be observed, particularly overnight, that's an excellent place for them to be, so they can be observed from the nursing station.
JL - And what about the rest of them.
Sister 2 - Eh, the side wards are really just for the convalescing patients or for waiting list patients in for trial drugs or endoscopies, or that's what I use the four bedded room. The side cubicle I like to keep for terminally ill patients. Often they are very high dependency nursing as well, but it's a nice room to keep for the relatives and for the patient. Nice quiet room, other than that self-caring patients go into there.
JL - So you use it for the terminal care patients because..?
Sister 2 - Obviously we're not going to be actively resuscitating them.
JL - Right.
Sister 2 - And they don't have to be so closely observed for that. Although they are high dependency nursing.
JL - Right you mean they need a lot of?
Sister 2 - They need a lot of nursing care.
JL - Right, that's interesting. When you say high dependency what sort of things are you thinking of in their care? Although I know you're not observing them like....
Sister 2 - You're not observing them but you're caring for, full mouth care, eye care, turning, em, catheter care normally, perhaps care of an infusion pump. Really all nursing care.
JL - Right. And you also have the relatives.
Sister 2 - The relatives in. You've got all the communications with the relatives, and you must spend a long time with these relatives, supportive.
JL - You spend a lot of time with the relatives. Right. Okay and then you've got Bay 4, who do you tend to...
Sister 2 - Sorry I've got Bay 1 where I put convalescents, convalescent patients as well, patients who are getting better. Bay 4 normally is used for long term patients probably because there's no oxygen and suction down there, which is as good a reason as any. Em, although some of my long term patients if in good, long-term strokes I wouldn't nurse them down in Bay 4.
JL - Why is that?
Sister 2 - Because I would want them to have the stimulation of other, around the ward, of other patients, of seeing people coming in and out the ward, I would tend to nurse them in Bay 1, like Lenny.
JL - Like Lenny, yes. Because I remember when I first came you were just moving him.
Sister 2 - Moving him up, for the stimulation really. And he has come on you know, they do get stimulated up there.

To account for what she does Sister constructs patients according to types: "high dependency", elsewhere Sister also refers to "acute admissions", "convalescent", "rehabilitative", "waiting-list", "self-caring","terminal care", "long-term" , but "long-term" can be "good" so can become a category on their own - "strokes" who need "stimulation". And patients can move from one category to another - good strokes move from long-term to patients who get "moved up" for "stimulation" which helps them "come on". She configures

these typifications around needs - acute and high dependency patients need observing and may also need oxygen, suction, and other specific nursing care. Stroke patients need stimulation, to see people being busy, coming and going. Terminal patients need peace and quiet, their relatives close by, high dependency nursing, but observation is not, literally, vital (they are not for resuscitation), so they can be nursed in a cubicle, out of sight but not out of mind. Whereas long term patients are left at the back of the ward, out of sight, and with no specific nursing requirements, they can be looked after by junior nurses and auxiliaries, who are supervised. As Sister 2 remarks elsewhere, these are "heavy" patients.

Her talk contains metaphors which help signify the critical place of movement in her typologies: "up the ward", "coming along". The terminal and the long-term, have no movement, they can be out of sight. The long-term and strokes, are "heavy". A descriptive term, a metaphor, being heavy does not constitute them as "high dependency", it has a different meaning within these settings: they are heavy on the nurses, and often need two to move them about, they may be disabled and needing a lot of help, but they are not "really sick", but critically they stay on for a long time, they are long-term, they are weighing down the wards, difficult to move on.

The spatial arrangement of patients in the wards reflects the spatial organisation of the hospital. At a pragmatic level, in concert with the ward routines and discursive practices, the placing of patients acts to clarify or signify the type of patients with which nurses were dealing and from this they extrapolate the general forms of care the patient should be given.

So for example, on their arrival to the ward in the morning the nurses can take some of their cues as to how they treat a patient (e.g. get them up or sit them up in bed) from where they are in the ward. Nurses working to get the breakfasts out in Bay Three keep most patients in bed until after the nursing handover, as these are the patients who have recently been admitted. The places in which patients are situated helps remind and reinforce the types of care that they may require. Rarely mistakes were made: for example, Mrs Adamson, was very unwell on admission, she had been admitted the previous evening with a query heart attack but there were no spaces left in Bay Three and she had been put into Bay Two. This may have signified that she was not 'that' ill. The nurses sat her up for breakfast. Sister remarked at report that this was a mistake.

Nurses seem to look for particular types of work according to where the patient is in the ward - a very sick patient in the cubicle might indicate a visit at breakfast time, not to sit them up, but to turn them or give them mouth care or just to see how they are.

Placing, that is the spatial dimension, worked as an aspect of sign systems to be read and understood. In this way naming and the spatial arrangement of patients, like the overall organisation of the hospital, act to instruct and to enable the reproduction of the order of the setting. However, nurses' identities and the identities of patients are also constructed through place: patients with no "specific" nursing requirements are given to junior nurses and nursing auxiliaries to look after, while patients who need high dependency care and observation are given to more senior nurses to look after. The implication of these placements in conjunction with the reasons given is that some patients care *counts* more in the setting, is more important and difficult, it requires special skills and techniques. These patients have, for the nurses, more status as do the nurses who look after them. This is best exemplified referring to Sister 1's interview.

Sister 1 referred to how she allocated nurses to Bays in relation to the term "quality": her allocation depended on the quality of the patients and the quality of the nurses. Here she is talking about this aspect of her work:

> **Sister 1** - I do tend to leave the geriatric long term patients to really middle grade nurses with an auxiliary..... second years, or occasionally first years, depending on the quality of students we have.
> **JL** - Why, how do you make that sort of decision? What do you base that on?
> **Sister 1** - Well I tend to think that even most of the junior nurses know what basic nursing care is. They tend to know how to wash people, feed people, dress and just sit and listen to the older ladies. And they, I would suspect ,probably be a bit more frightened to look after somebody who's got central lines, IV's [intra-venous infusions] although they do get an opportunity to do that as well, with the staff nurse.

Sister 1 is accounting for her practice of allocation and through this account reproduces particular identities and values which were present in the setting: junior nurses can do basic nursing care (washing, feeding, dressing and talking with *older* patients) but may feel frightened by the technology associated with, and the expertise represented, by the sicker patients. Also it should be stressed how there is a relationship aspect to caring for older patients which is not associated with the sicker patients, this is constituted by Sister as more technical care. These expressed relationships instantiate hierarchies of identity and values: listening and personal care get down-graded to semi-skilled or non-technical work, while work with sicker patients is altogether of a higher quality.

This set of differences and identities relates back to the ward handovers where what is observable - reportable are those aspects of patients which signify their medical condition or problems with mobilisation. Immovable patients are constituted as heavy and not

particularly to be talked about: they just get cared for but not particularly *looked* after.

The placement of patients within the Bays carried with it a complex of signals to be read in concert with other signifying and legitimating practices within the setting. From the material so far, these are configured around two aspects of nurses' discursive practices: notions of sickness and dependency and notions of observation and surveillance.

How ward routines and materiality further enable nurses to know what to do for patients is now discussed.

Materiality and Ward Routine Signalling Care

"Ward routine" in the present study when critically examined, represents carefully constructed events which help nurses accomplish and recursively maintain the proper order of things in the site. Routines not only get facilities to patients, but help organize the setting and the people in it in many more complex ways. Through routines nurses and others both know what to do and can account for what they do. A lot of "care" is delivered through ward routine. The things that get included in routines are "basic patient care"; what gets accounted for, remarked upon, are those aspects of work which are extra to routines. They are made to count in a different way.

Ward routine (described in Appendix Five) consists of meals, nursing handovers, drugs, washes, ward rounds, staff breaks, observations, cleaning, toileting, bed-making. Not only do these events and encounters take place at particular times, but within themselves they are made routine: they are proceduralised and routinised.

It is within these routines that patients get particular forms of care rather than others: nurses would sit a patient up rather than give them their meal in bed, help them eat rather than leave them to eat themselves, give them food from the trolley rather than a diet. The arrangements to ensure these differences are attended to are complex and are now discussed.

Nurses may rely on their knowledge of patients from previous shifts and communicate these matters to each other as they pair up to do routine rounds. This is probably one of the single most crucial aspects to how nurses know what to do for patients. The off-duty works so that on any one shift some nurses will 'know' the patients. Nurses work together to help each other know what to do, to pass on what they know. This is not necessarily verbal communication, but can be carried through an action or an approach.

When in doubt about aspects of nursing care nurses occasionally refer to the kardex, but as already discussed, care plans are not consistently used, and instructions about care are not necessarily detailed explicitly. The daily record would sometimes indicate whether a

patient had been sat up the day before and this may have acted as a guide. The critical aspect is the 'status' or 'type' of patient. New 'acute' patients, those admitted after the previous morning shift, are routinely kept in bed for twenty-four hours. Occasionally mistakes are made, for example Mrs Adamson who had been admitted with a suspected heart attack was got up the morning after she came in from A&E.

Nurses know what food to give patients not simply through a menu system or directly asking them, but through complex arrangements focused on patients on special diets. Information about patients on special diets is written on a sheet and hung up next to the nurses' station. Some patients also have a sign hanging above their bed - 'diabetic', 'fasting', 'fluids only' - which indicated whether the patient is not on a normal oral intake. Ensuring these are in place is one of the jobs allocated to the nurse-in-charge of the night shift. All food sent up from the diet kitchen is labelled with the patient's name. Between these three mechanisms nurses would know who needed to have a special meal or restricted diet. Further, special diets are recorded in the patient profile and mentioned at handovers.

Basic observations of vital signs are routinised: most patients start off on four hourly observations, decreasing to once a day over time and as their condition settles. The night staff nurse orders the observations. There is an observations book and any patient for more than once a day observations is written in this book. Some patients are on more regular observations but this is specified for that patient and a separate observation chart placed at the end of the bed, on the bedtable, or on the locker. This gives it visibility. This extra observation helps signify the patient is special in some way.

According to the qualified nurses how the night nurse decided on which patients should be on what observations is a matter of how the patient is (their condition), whether the observations had previously been abnormal or not and for how long they had been normal, and the length of time they had been in under observation. These aspects are not necessarily made explicit in the nursing records or at nursing handovers. These arrangements mean that the nurse taking the observations or giving the diet does not necessarily have any explicit explanation for why their patient is on these particular observations or diet, they have to work it out, through reading the signs, making connections.

Charts and equipment help signify to nurses things to be done for patients. For example, on their way round the ward the nurses may notice that a patient is on special observations. I noticed that this would be a more senior student nurse or a staff nurse on the drug round. Acutely ill patients are usually in Bays 2 or 3 - the more senior students would

usually be looking after them - so they may be 'looking out' for these things. Also there may be intra-venous infusions or particularly ill patients with special needs who require some special nursing activity, for example, suction or a naso-gastric feed. The equipment around these patients, drips, tubes, machines and charts act to either indicate or remind that care may be required once the nurse knows how to read the signs. The records at the end of the bed of fluid balance, intra-venous infusions, suctioning, naso-gastric feeds etc, act to tell anyone who cares to check when the last nursing was done and even when the next activity may be due. In this way artefacts as materiality help to signal and remind nurses about care.

The combination of a material practice and routines help signal that a particular set of activities is about to occur and in which ways they are to occur. For example, trollies are in the current setting important to routines. Trollies are used in the organisation of meals, drugs, drinks, linen, library books, tidiness, electro-cardiographs, doctors' rounds, washes, pressure area care, things to buy. Even death is announced to the ward by a trolley and the drawing of screens. The arrival of the trolley announces the provision of the facility, whatever that may be. Trollies help staff to organize their work. Trollies are sign equipment which act together with other signs - like time. Sometimes I saw a nurse bring a bowl of water to a patient before any talk about a wash had arisen: the patient sits up and gets out their wash things. The bowl in combination with the time (after breakfast), the arrival of wash trollies and linen skips, all help signal that it is time for washes to commence.

As stressed, the day is marked out in time by routines. In these ways patients automatically get care and nurses automatically know what to do once they know the routines, and the way to carry them through. This was taken for granted in the setting. And according to some of the qualified nurses, getting through the routines took priority over and above everything, except emergencies. The individual, one nurse particularly felt, was sacrificed to ward routine.

The important issue is what aspects of "care" or "work" get routinised and what does this tell patients and nurses about the setting: critically how are routines used to move patients around? I shall now examine this in more detail in relation to the drug round.

The drug round is a routine. It entails using a drug trolley which is taken round from bed to bed. It is made to happen at particular times of the day, in a particular sequence, following particular procedures. It is the routine time for administering drugs. But the qualified nurses also claimed that it is a time to "look and see" how patients are, and more importantly to supplement their looking with talk to check up on how things are going

on "in there", in the patient, which most of the time they claimed they could know by "just looking". The qualified nurses do not do an official "assessment" or "ward round". The drug round represents a legitimate activity, visibly purposeful and legitimated by doing the 'medical'.

While the qualified nurses claimed they used this activity to "check up" on how patients are, they also use the round to help structure and control their encounters with patients: the pressure from the work (delivery of drugs) justifying, focusing and limiting the encounter; the pressure from the 'round' (the next patient waiting, needing drugs) limiting the encounters, as well as the physical barrier of the drug trolley (behind which the nurse can stay if she does not want to engage or drawing the nurse back as she lingers at the bedside) are all sign equipment used by nurses as a means of conveying messages about the limits, purpose, and nature of their activity: it is a performance.

Through transforming the drug round to do patient assessment the nurses remain in control of their encounters with patients and simultaneously convey messages about wider forms of organization to patients. I would like to suggest that in using the drug round to legitimate their gaze, they also recursively maintain hierarchies of power: that nurses do not have legitimate reason for simply doing an assessment round, using the drug round reinforces the requirement that nursing to be visibly purposeful has to be administering, doing the medical. Further, nurses use it to help bracket and restrain the encounter with patients: through the drug round they are announcing that the real business of their work is the delivery of drugs, it helps announce how they are busy doing something, this helps them control both the timing and the length of any interaction.

Discussion

Routinization has been theorised as giving a sense of order and security. For Giddens [1984, 1991] routines represent regularised and repetitive action which is essential to not just the reproduction of institutions but also to personal continuity. At an existential level Giddens argues that routines, through the predictability of repetitive acts, give a feeling that what is happening is 'under control'; this helps impart a sense of ontological security. Further, it has been suggested that routines represent an economy of effort [Berger and Luckmann, 1966]. Berger and Luckmann also suggest how through making particular practices unreflexive and habitual, they free up the attention and creative capacity to enable concentration on aspects which cannot be attended to through routines.

All this raises the issue of what exactly is getting routinised and what falls off

routines to get 'special' attention. In relation to accountability, routines allow action to be easily accounted for, their rationale is 'self-evident': this is being done because it is the routine. Whereas deviations from routines suggest that there has to be a reason for the deviation, there has to be an account. As Berg [1992] suggests, routines help constitute frames of reference so that deviations from the routine imply:

> deviation from the 'safety of the norm', psychologically necessitating an explicit legitimation for doing so. [p171]

This is now explicated further.

What I am suggesting is that routines are constituted through nurses' organisation to facilitate delivery of facilities to patients in particular ways rather than others. Routines represent not just the ways in which nurses manage both patients and nurses, in terms of resources, time and space, routines accomplish several aspects which help reproduce and maintain a particular order of things, a particular disciplined space.

First, although patients may now be given explanations as to the whys and wherefores of what is happening to them (are 'kept informed'), the essential ways in which the wards are organized means that delivery of care is organized largely as group activities. These are predecided. As Goffman [1961] points out, through these group activities, persons being delivered to can be reduced to blocks, a mass without particular identity, except in relation to small differences (digoxin rather than an anti-biotic, a special diet rather than the trolley meal, a help wash rather than a bedbath). Most care is delivered outwith the control of the patient and in relation to, as will be argued in the next chapter, typifications, as constructed by staff. Routines help nurses organize encounters with patients, not in collaboration with them: they are doing things for patients because these are the routines. Further, nurses can use the routines to excuse themselves from demands falling out of the routine.

For example, a patient in the study, Mrs Violet, wanted a wash and something to eat at nine o'clock at night having been in casualty for several hours and having missed lunch, tea and supper. Staff were busy, it was waiting night with several new admissions, and they were disgruntled by Mrs Violet's "demands": the Staff Nurse told her that she would have to wait, and indicated that there were routines which would take care of her wants, more or less.

In this way routines help facilitate monotony and uniformity: not just in staff but in patients as well. Routines help instruct patients as to what will be routinely provided and not to demand outside the routine. Bauman [1991] argues that organisations rely on

uniformity and monotony to maintain order and predictability. Bauman in his definition of modern social organisations, states that organisations achieve "precarious regularity" by "making irrelevant or otherwise down-playing" any "differentiating and thus potentially divisive features" of social behaviour. He claims that uniformity of behaviour is achieved by "suppressing" or "degrading" behaviours which are not uniform.

Bauman links autonomy with moral conduct, which in the predictable and monotonous world of modern social organisation is privatised. In this respect moral conduct is potentially subversive because of its unpredictability. Bauman takes Emmanual Levinas' definition of moral conduct as

> triggered off by the mere presence of the Other as a *face*, that is as an authority without force. [p142]

Routines help facilitate uniformity and predictability and help restrict the autonomy of patients: while nurses are in the presence of patients as a face they constrain the patient through the boundaries and brackets instituted through the routine. Patients are instructed through routines not to demand attention, to control themselves. But, as will be argued, some patients have more face than others through their constitution as special, as having high priority needs.

This aspect is reinforced by how routines contribute to the reduction of the patient to a body in its functional parts. Patients are being serviced according to their parts - a wash, toilet, food, drugs. The parts are administered to at times convenient to the institution (and sometimes there are awful clashes, like having your bloods taken while eating your breakfast). For example, being given a menu to select food preferred gives an illusion of choice. Choice is usually only permitted in relation to what are being referred to as 'hotel services'. Bauman [1991] suggests that the reduction of the other to their parts or their traits, so that they no longer constitute a self, is one of the arrangements in organizations to help render social actors practices a-moral and thereby organizeable.

Second, routines facilitate surveillance. At a glance the supervisor can see that the work that is going on fits with the time and the place, that both patients and nurses are doing what they are supposed to be doing, that they do not as Goffman [1961, p378] calls it "stand out" by stepping out of line by doing something different from the rest. This leads to the two other important metaphors arising from the site, and brought up by the qualified nurses in their interviews: "supervision" as "overseeing" and "knowing", by "looking" and "seeing".

From the gaze of the supervisor most aspects of what she surveys should not stand

out, when something does she knows there is disorder, something is amiss, something different is going on. Similarly those being surveyed work to *not* stand out, not standing out except when they cannot help it or when to stand out is positively remarkable, because it pleases: a patient has gone blue while up and about when they should be in bed, a nurse is walking a patient to the lavatory when he should be strictly immobilised, a pack of blood is hanging empty when it should be full. Charts and records are similarly routinized: their omission or a difference in their detail marks a moment for reflection or a check.

In this chapter how routine, place, space, and nurses' discursive practices constitute patients' identities and nurses' identities to imply care has been discussed. The next chapter is concerned with doctor-nurse-patient relations.

CHAPTER SEVEN

DOCTOR-NURSE-PATIENT: THE CONSTITUTING OF CLASSES

Introduction

Previous chapters have discussed how nurses are involved in prioritising particular aspects of their work and that this involves typifications. These typifications involve hierarchies of difference: these typifications carry *identity* and *status* not just of patients but of doctors and nurses. It follows that there will be some displacement in the setting first, of certain categories of patients and second, of the work nurses do for them, which does not have the same status as other work.

These matters imply a complex relationship between the conduct of doctors and nurses. While doctors' diagnoses of patients and plans for patients do at one level act to permit nurses to behave in particular ways, the relationship is not only one of domination. Certainly nurses and doctors act in ways which produce and reproduce a hierarchy of difference between them, but this emphasis obscures a further effect - a constituting of classes of patients in which both nurses and doctors are implicated.

Mills [1983] in her study of the care of dying patients in an acute hospital suggests a relationship between a consultant's interest in and involvement with a patient and the nurses' involvement with a patient: the less interested the consultant is in a patient "as a person", the more the nurses distanced themselves from them. In her study Mills found a situation where

> caring consultants worked most often with the qualified nurses who demonstrated professional autonomy and the consultants who indicated an interest primarily in the disease worked most often with the qualified nurses of similar inclination. [p256]

What Mills does not address is how these relations are effected. The discursive practices of nurses and doctors can be seen in the current study to be systems of signification and legitimation, which constitute and institute particular relations and practices. These relations are effected through language and action which help constitute systems of difference and hierarchies of value and identity, the identities of doctors, nurses and patients.

Further, while the discursive practices of nurses and doctors can be seen as exemplifying the epistemic frames in which meanings are constructed, particularly that of medical discourse, there are other discourses which interpenetrate with medical and nursing discourses.

This Chapter discusses the ways in which the discursive practices of nurses

interpenetrate with those of doctors to produce and reproduce a particular context in which patients become visible. This is now discussed in relation to doctor-nurse relations and the ward rounds.

Nurse-doctor relations: difficulties with the transfer of information

In Ward Two there was dissatisfaction with some doctors as communicators: the nurses felt some doctors were aloof and did not keep them informed. This was also experienced by some of the junior staff nurses in Ward 1. Sister 2 stated in her interview that she was going to arrange with the new resident doctors, as a condition of their practice in the wards, that they had 'to go through' their patients each morning with the nurse-in-charge. The focus of the nurses' dissatisfaction was not however, that their view of patients was disregarded by doctors, but that they, the nurses, were not kept informed.

As will be seen in Chapter Nine, access to the doctors' discourse about patients was conceived of as crucial by nurses in three ways: to enable their own nursing response, to enable their discharge planning, and to facilitate what they saw as an aspect of their job, helping to keep patients informed through explanation.

This access to doctors can be considered as available formally and informally. Certainly some of the qualified nurses had developed informal communicative relations with middle grade or lower grade doctors through which they got to know things about patients and through which they let the doctors know things about patients. These relations according to some of the qualified nurses relied heavily upon the personalities of the doctors concerned. My interpretation is that some doctors allowed nurses a more informal access to them. Such relations therefore are constituted as exceptions, not as regularised or routinised practices, and are instituted by individuals. For example, one Staff Nurse in Ward Two described how she went to the doctors room on a late shift and sat with the (then) resident and just "blethered about the patients". She felt this was helpful as they both could tell each other about patients and keep up to date. Another example is how one of the registrars, when he was acting medical registrar, always telephoned Sister 1 about any admissions from A&E or from the admissions ward himself. If a nurse then telephoned Sister 1 about these admissions she would tell them that she already knew about the patient.

Information about patients constitutes knowledge, and this helps effect power relations. Where the doctors control nurses' access to information it can be experienced as an exclusion and a way of displacing nurses. There can be an asymmetry in power relations if doctors are not keeping nurses informed and up to date; the onus is then on the

nurses to create access to information. For example, results and patients notes are delivered to and kept in the doctors' room, the doctors usually work in the doctors' room. Nurses rarely entered the doctors' room and rarely went to examine notes. For the nurses to have comfortably entered the doctors space would have assumed a particular kind of relationship between doctors and nurses, which did not appear to be the case in the current setting. The nurses told me that they simply did not have time to read notes.

The ward rounds help reproduce the dominant discursive practices of the setting: the examination and translation of patients in relation to medical discourse. However, this discourse does not involve just one way of viewing patients, but, as has been seen, several. The medical gaze is not constructed of a singular lens: it is pluralistic. A way of organizing these different views is explicated by Engestrom [1987, 1989].

Medicine as a practical discipline holds, according to Engestrom, five views of appropriate priorities to enable their work. These are all present in the current setting. First, in nurses' and doctors' discursive practices medicine was present in relation to the diagnosis and treatment of disease, a somatic view. Second, medicine was present as the new social medicine as instituted through a geriatric medical discourse, concerned with function and the social life of patients. Third, psychosomatic medicine was present, as instituted through psychiatric medical discourse, and which takes account of how personality and psychopathologies can affect health and recovery. Fourth, an administrative-economic perspective was present (the provision of health-care services) particularly in relation to the availability of beds. Finally, the patient as collaborator (a system-interactive approach) was not particularly present in any overt way, but there was a tacit expectation that patients would act to comply. These matters are *facets* of the medical gaze.

I would like to suggest, following Foucault [1973], these different aspects of medicine are not dissimilar in method, as described in Chapter Two, but have added on different subject matter. This is born out by Engestrom [1987, 1989] who, through analysis of videotapes of doctor-patient encounters, revealed discoordinations between doctors and patients: patients' complex problems were reduced by doctors through their restrictions to strictly biomedical conceptualisations and practices.

Further, I want to suggest that these facets interpenetrate with each other and are used to maintain interests and hierarchies of identity and value. That is they constitute elements of, not theories, but of discursive practices. In the current study all of these facets were present in the nurses' and doctors' discursive practices and were drawn on to move patients, to help dispose of patients, while preserving the visibility (and prestige) of a

primarily somatic approach to patient care.

Sister 1, however, was quite happy with her relations with the doctors and felt that these were on the whole very "nice". I would like to suggest that from my own reading of the two wards, the issue of information (and the problem of the Ward Two nurses feeling excluded from access to information) is not simply a question of poor communication practices or bad organizational arrangements between medical and nursing staff. Rather that experienced nurses and doctors relied upon implicit and tacit understandings carried in their language and conduct. Put simply, Sister Two and the Ward Two nurses did not (yet) always speak the same language as the doctors. It must be emphasised that Sister Two had only very recently joined the hospital staff.

Informal communication however, can take place in very formal situations. How implicit and tacit understandings are communicated can best be explicated through analysis of ward rounds and their relationship to nurses' practices, first the consultant ward rounds and then in relation to the "social rounds".

Ward Rounds

From the observation material, doctors' ward rounds are attended by the senior nurse on duty, the nurse in charge at the time of the round. Each consultant does a ward round once a week. If the consultant is "waiting", that is responsible for admissions, then they do a ward round on the admissions ward and on their 'own' unit the day after "waiting day". Some Consultants would also do another ward round the next day if this is over the weekend. The lecturers, senior lecturers, registrars and senior registrars, went round with the resident doctor most days. This ward round is not scheduled, and a nurse does not always attend it.

Typically consultant ward rounds are organized as follows: the consultant and their team or 'firm' (residents, attached medical students, lecturers, senior lecturers, medical registrar, any visiting doctors) would congregate and go round each patient under their care, sometimes talking to or examining the patient at the bedside, sometimes discussing the patient at the notes trolley some distance from the patient. For 'new admissions', the resident reads out to the Consultant, his "history" and the results of his examination of the patient, indicating any investigations already or about to be undertaken, and giving any results already obtained. This is done either at the bedside in the presence of, but not including, the patient or at the notes trolley.

The consultant then may examine the patient himself, usually concentrating on the

aspects of the patient 'in question' (e.g. listening to their chest and heart and feeling their pulse if they have been said to be admitted with chest pain) and talks with the patient. The Consultant then discusses the patient with the other doctors and they decide on the diagnosis and future 'management' (tests, investigations, treatments or discharge issues). In respect of elderly patients, the doctors are alert to viewing patients in relation to their 'functional' and social situation (their so-called support and how the patient usually manages at home and any possible difficulties such as urinary incontinence) in their history and examination, and these matters might enter their discussions.

In Ward One the nurses viewed the ward rounds as "the doctors' rounds", which they attended but did not participate in particularly except to report on what they had seen. They felt that they *got* information from ward rounds from which they could plan nursing care. Staff Nurse Four and some of the Ward Two nurses expressed how they felt that they *should* participate in the decision-making aspects of these rounds more directly. Staff Nurse Four also saw the round as the time for the nurse to help situate the patients discharge carefully in relation to their home support. This Staff Nurse had been working in a Geriatric Assessment unit for several years. In the field study, the nurses were not seen to participate in ward rounds as members who have different but equally valid expertise to that of doctors. This is now discussed further.

On consultant ward rounds, nurses rarely participate in discussion about patients. They act passively, positioning themselves discreetly, taking notes and occasionally responding to questions directed at obtaining their observations of patients or offering perfunctory agreement to plans instigated through the doctors' discussions. The nurse accompanying the ward round typically stands on the periphery of the round and very rarely speaks unless she is asked something specific by one of the doctors. Typically she does not initiate any discussion nor does she volunteer information.

In the following extract, a "waiting day" ward round, the extent to which Staff Nurse is asked to give an account of the patient is unusual but illustrates the aspects of nurses' work which nurses are asked to report upon at ward rounds:

> [Mrs Appleton, Day Two. The ward round is congregated at the end of Mrs Appleton's bed, Mrs Appleton is lying in bed. She has had two episodes of collapse this morning. Staff Nurse is on the ward round]
> **Consultant to Staff Nurse** - How is she now, dear?
> **Staff Nurse** - She's much better.
> **Consultant** - How often has it happened?
> **Staff Nurse** - Twice.
> **Consultant** - What time was that?

Staff Nurse - Between 8 and 9.
Consultant - And in between she's been quite alright?
Staff Nurse - She's been feeling faint and tired.

The Consultant is addressing the staff nurse as a witness - she is giving evidence and is cross-questioned to help establish the facts. He uses closed questions to elicit information. This specifies the focus of Staff Nurse's responses and delimits her participation to matters as directed by the Consultant. This example illustrates how nurses' act to extend the medical gaze. Their surveillance of patients is an aspect of their work which is legitimated by the medical: through it not only do patients become visible but their own activities have visibility. This extract also instantiates the nature of their participation in the ward round: this kind of discursive practice represents not a discussion between two different occupational groups with different views of the subject (the patient) but between occupational groups one of which (nursing) works to support the (other) medicine and which has the same viewing lens as medicine.

This type of arena or discursive practice contrasts with one described by Saferstein [1992] in his discourse analysis of sound effects spotting sessions and script meetings in the film and television industry. In Saferstein's study this type of meeting, between persons of differing occupational disciplines, is characterised by discussion. There are interruptions and turn-taking rather than questioning. A form of discursive practice emerges through which each member attempts to enable other members' understanding of how the script can be operationalised (to enable filming). This is done through visualising the script through their particular conceptual models to pinpoint and anticipate difficulties. This Saferstein characterises as "collective" cognition and is the basis of truly collaborative work. This is critical because film time is so expensive and wasting time on location or on the set is to be avoided. For example, the cameraman's visualisation of a scene may reveal problems with the script: as he visualises the script in relation to the positions of the actors and the possibilities of the camera's access to them he can see that as scripted the scene in question is not workable. This may then lead the script writer to change the script. The meeting enables each member of the film production team to have some insight into each others' perspectives (a "sharing of mental models"):

> Participants have organized their respective concerns about the scene into a shared model. [p77]

Saferstein argues how these meetings, as forms of discursive practice, are constitutive of forms of power relations which "refract hierarchical domination of the work processes" [p83] and institute more than economic efficiency: they give each member some control over the

overall production of the film. Through interactive cognition and communicative processes they institute a collaborative approach which produces a different form of organization.

In the current setting, in contrast, the ward rounds cannot be characterised as the meetings of professionals of more or less equal status who share their different views to enable the analysis and anticipation of problems for the management of patient care. The questions arising are, what then are the ward rounds accomplishing, what do they help institute and reproduce? These matters are now discussed referring back to the ward rounds.

The two areas of nurses' work about which they are asked to report on at ward rounds are their observation work and their work to get patients moving. Both these matters involve nurses in the surveillance of patients' 'behaviour' and their 'responses'. Patients' behaviours, as will be seen, are constituted through ward rounds and other discursive practices as either involuntary (somatic) while others are constituted as virtually voluntary responses (psychosomatic) or due to other matters (social, age).

An aspect then of nurses' work on ward rounds is to help themselves and doctors not only get a differential diagnosis (through mapping what are commonly called signs and symptoms), but also to differentiate between types of illness behaviour (straight somatic - acute or chronic, social/age and psychosomatic). As has been noted in Chapter Six, these are the same aspects of nurses' work which they talk about in detail at ward handovers and report on in writing in their written documents and which relate to their typifications of patients. These in turn relate to how they organize their work.

On ward rounds then, nurses appear to act passively, not just as observers, because they may occasionally contribute to discussion when requested to do so, but as someone giving their report and as getting their instructions. In this respect the nurse usually carried a note book, clip board or piece of paper and wrote things down.

Further, it should be noted that the nurses' behaviour in relation to the patient at these times did not support any notion that they were there as the patient's advocate or partner. If near enough, the nurse might assist in getting a patient ready for examination, by rearranging bedclothes or night garments or drawing the curtains around the bed, but frequently she is too far away, at the periphery of the group of people around the bed, so that a junior or middle grade doctor would assist in this respect. In this way the nurses do not place themselves alongside the patient on these occasions.

There has been criticism of how nurses constitute their role during consultant ward rounds [see for example, Busby and Gilchrist, 1991], but the implications from the present study are that nurses supported the ward round as it helped accomplish several aspects of the

order of the setting. Critical to this interpretation is the notion of performance as conceived by Goffman [1958]: each person on the ward round acts to present a self and, importantly, also acts to allow others their presentations of self. The ward round can therefore be constituted as a social encounter which is routinised in particular ways. Central to this interpretation is the notion that the ward round constitutes a discursive practice through which the patient is assigned an identity or their identity is reconstructed. The extent to which patients themselves are given presence at the ward round is crucial as to how their identity is constituted (either directly, through their own voice, or as mediated through the voices of others as they attempt to represent the patient).

From analysis of the observation material it appears that ward rounds have several dimensions:

First, they are functional - they are about reviewing and accumulating evidence to enable prompt diagnosis and decisions about treatment to keep things moving, to facilitate diagnosis and treatment issues, what Berg [1992] has termed "medical disposals". As the Professor of Geriatric Medicine put it in an informal interview, the ward round served as a time "for evaluation", "to keep exit always in mind", "to stop things drifting". The ward round at this level constitutes a form of inspection and audit, of both doctors' work and aspects of nurses' work.

Second, they are ceremonial - ward rounds are a ceremony. As a ceremony it is confirmative [Turner, 1967], and helps produce and reproduce the power relations of the hospital. So that both through the conduct of the ward rounds (the placing of the patient and the different members, the routinization of turn-taking) and through it as a discursive practice, identities are confirmed.

Third, the ward round is a ritual through which transformation [Turner, 1967] of a person into a patient of a particular type can be accomplished. This entails an ascription of patients to classes. Through coded behaviour and language patients are being ascribed to a class, which acts as permission or instruction to deal with patients in particular ways. These classes configure around constructing a patient's 'problems' as either somatic (acute or chronic), social (age is also constituted as an aspect of social), or psychosomatic. In turn, so classifying patients helps facilitate their disposal.

In the following extract a typical ward round is presented. In it all three dimensions of the ward round are demonstrated, the debate is whether this patient has enough social problems to warrant her being kept in for diagnosis and treatment of her 'somatic' problems:

[Mrs Marsh, Day 3]

Mrs Marsh is sitting by her bed in a chair in Bay 2. She is wearing her nightdress, dressing gown and slippers.
The Ward Round comes into Bay 2.

Present: Consultant, Lecturer, Senior House Officer, Resident x 2, Research fellows x 2, Medical Students x 2, Sister 1

They stand by the notes trolley in Bay 2.

Resident - [to Consultant] - Mrs Marsh [indicates Patient] - the pea lady.
Consultant - Is she new?
Resident - She came in the day before yesterday - [he reads from the notes and looks up at the Consultant as he speaks - he speaks quietly - confidentially - the others stand around] Essentially she swallowed a pea at lunchtime and became increasingly wheezy by the evening. By 8 o'clock she was very breathless and so 'phones her GP who sent her in here. She settled with nebulizers. She's been having daily physio. Her drug history - she's on warfarin - she's had a number of DVT's in the past - but no pulmonary emboli [the Consultant listens intently]. She's on Tamoxifen for a lump in her breast but I can't find it.
Consultant - Have you got the old notes to see what goes on there?
Resident - No.
Consultant - [looks at Lecturer] - Lets get hold of the old notes and check up on what's happening here [turns back to Res].
Resident - There's some old myocardial ischaemia, with some failure - she's fine - she lives alone. On systems enquiry she has some ankle swelling. She is apyrexial and she has a [..?.].
Consultant - [interrupts] So there is nothing of serious note on inquiry?
Resident - No.
****
Consultant moves off - goes over to Patient and bends right down to her - he gives her a big smile:
Consultant - Hello Mrs Marsh - I am Dr Fox. [shakes Mrs Marsh's hand]
Mrs Marsh - [looks up] Hello.
Consultant - How are you feeling?
Mrs Marsh - Well this hurts like mad - they gave me an injection [she shows him her arm all bruised] - it is terribly painful - I don't want any more of those.
Consultant - [looks at others who stand around] - What is that for?
Resident - Bloods.
Consultant - [laughs] [he's crouched down by her now] Well hopefully we won't have to do anymore of that now.
Mrs Marsh - Now I'll ask you the question everyone asks you - when can I get home? [laughs]
Consultant - [laughs] We'll see about that. Now, have you been coughing at all?
Mrs Marsh - No - wheezing.
Consultant - How long have you been wheezy?
Mrs Marsh - Just the once when it happened.
Consultant - And are you still wheezy?
Mrs Marsh - Yes - not as much - except with the machine - that makes me wheezy.
Consultant - Have you been coughing up any spit at all?
Mrs Marsh - No.

Consultant - And when you walk around do you get short of breath at all? [he's looking into her eyes and listens intently to her replies]
Mrs Marsh - I don't walk far - no not really.
Consultant - And at night - how many pillows do you use?
Mrs Marsh - One around here.
Consultant - Can you lie flat?
Mrs Marsh - No, but I don't have a lot of pillows.
Consultant - Do you stack them up?
Mrs Marsh - No.
Consultant - Do your feet swell up at all? [he looks at her feet and legs]
Mrs Marsh - I have had that for a long time - something went wrong with [..?].
Consultant - I've seen your x-rays and they are alright but they are not completely normal - there is a bit of infection there - Now we're wondering whether to do some more tests or not. Do you live alone?
Mrs Marsh - Yes.
Consultant - And do you manage on your own?
Mrs Marsh - No. I have a home help three times a week and friends and family help me.
Consultant - I see, I'll go and look at your notes and have a think what to do [he pats her hand and smiles].
***
Consultant - [Goes back to notes trolley and moves up the ward well away from Mrs Marsh. The others follow. To Lecturer] - What are we going to do - I don't want to take her off the tamoxifen - presumably she is on it for a good reason. If we could get her notes and check up on that. And it seems a pity to bronchoscope her. She is in mild heart failure?
Lecturer - She's had frusemide.
Consultant - How much?
Resident - 40.
Consultant - Well we'll increase that.
Resident - [nods].
Consultant - My feeling would be to let her go home and then bring her back in 10 days to outpatients where either you or Dick could see her. She could have another chest x-ray then. And you could decide if she needs bronchoscopy.
Lecturer - She's got no temperature.
Consultant - She's asymptomatic. She may have a touch of LVF [left ventricular failure] - with this nocturnal dyspnoea business. We could send her home on diuretics and you can see her in out-patients in 10 days time. If it's not all right then you can bronchoscope her. I should think a cooked pea would disintegrate - I should think it would be disintegrating and might just leave a shell. I'll let her out - sounds as if she would be happy to go home - [to Sister]
Sister - Oh fine - yes.
Consultant - We'll send her home on 80 of frusemide then? [to res] And is she on Anti-biotics ?
Resident - No.
Consultant - [to Lecturer] And the diagnosis - what would you say - dyspnoea of unknown cause with mild LVF?
Lecturer - [nods].
Consultant - [to Senior House Officer] - Are you happy with that Geoff?
Senior House Officer - I haven't had any thing to do with this lady.

Consultant - Oh - I'll just go.
***
Consultant - [he walks briskly back to the Mrs Marsh, stands close to her and bends down, hand on her arm] So we think you could get home - would you like to go today ?
Mrs Marsh - Oh not today - my family are at a convention - they won't be able to bring my clothes in until tomorrow - there is no way of contacting them.
Consultant - [looks at Sister 1] Alright?
Sister - That's fine.
Consultant - Good - Home tomorrow. We'll see you in outpatients and check the wheeziness has stopped, we'll give you some water tablets to take home with you. And you can go tomorrow, that'll give your family a chance to bring in some clothes for you. Alright?
Mrs Marsh - Thank you very much doctor.
[Consultant smiles pats her hand and goes]
[As he walks off]
Lecturer - What about the salbutamol?
Consultant - Well if it hasn't helped much stop that and give her a larger dose of diuretic and see her in outpatients. [to Sister] Are you happy with that Sister?
Sister - Yes - fine.
Time : 8 mins 48 secs.

At one level it is important to note that the Ward Round is accomplishing several things necessary to the construction and reproduction of ward reality. Each member is acting to construct a performance, the "star" is the Consultant.

The Consultant listens intently to what the Resident has to tell him but indicates his auditing and directive role by an explicit call to account and an instruction:

Consultant - Have you got the old notes to see what goes on there?
Resident - No.
Consultant - [looks at Lecturer] Lets get hold of the old notes and check up on what's happening here [turns back to Res].

The evidence is presented to him, but this does not include the nurses' views of the patient. He then looks at and talks to the patient himself. His examination is not extensive. This particular absence marks how he does not constitute the patient as very ill: usually with a very sick patient he himself would listen to the patient's chest and heart. The patient would not know this, she would see how he checks for himself to know through getting her to report on herself. He is demonstrating how thoroughly he checks the evidence and also emphasising his role as the 'expert' in authority. The evidence is amassed and displayed, the patient is made visible. This does not only include the medical evidence of any pathology, or the possibilities of pathology, but also the patient's 'social situation' - is she safe at home, how does she manage? This is very important because the patient's chest x-ray is not normal and they may want to do some tests. They could do it on an outpatient

basis but there is a slight risk involved, if she is not supported well in the community.

This patient is particularly plucky - she complains about her arm being painful and states she will not have any more injections. She also questions the Consultant on her own initiative:

> **Mrs Marsh** - Now I'll ask you the question everyone asks you - when can I get home? [laughs]
> **Consultant** - [laughs] We'll see about that.

On both occasions the Consultant, politely but firmly puts the patient in her place: he laughs and reminds her who is conducting the operation here with the authoritative *and*, if you are one of his co-ward rounders, inclusive "we" - "we" hopefully will not have to do any more injections, and "we" will see about when you can get home. He does not check that she really does want to get home, that this is not simply a presentation of herself as an independent and stoical, no-nonsense type of old person. Further on in the interaction she tells him that managing at home requires a network: she does not manage on her own, but relies on neighbours, home help, family and friends. Otherwise his treatment of the patient - he appears to engage her in the decisions about her, has his hand on her arm, looks into her eyes listening to her intently when she speaks - is demonstrating, to the patient and to the others on the ward round, how attentive he is and regarding of the patient herself. Later he makes use of her eagerness to get home to help tip the balance for her discharge despite the uncertainty or any risk involved.

In the next phase, when the Consultant moves to the notes trolley, he demonstrates how he weighs up all the relevant facts by 'thinking out loud' but also how he takes different aspects into account. He arrives at his conclusions, that the pea should disintegrate, that the patient can go home and be followed up in outpatients, but before finalising any decision he seeks consensus having already indicated the way forward: each member of the team who counts is asked if they are happy with his reading of the situation. If they are not happy they have to contradict him and indicate other possibilities in front of the others. He is keeping everyone happy while at the same time giving very little room for any other point of view. The last phase of the performance is to notify the patient that she can go home and get her agreement. She cannot get home until the following day as her family are tied up.

As can be seen the Consultant only refers to Sister 1 after his deliberations and once the patient's discharge is in sight, and even then it is an indirect referral, more for confirmation of his reading of the situation than anything else:

> **Consultant** - ...I'll let her out - sounds as if she would be happy to go home - [to Sister]

Sister - Oh fine - yes.

This is quite typical of this Consultant's ward rounds: as can be seen Sister 1 enters into the proceedings only at the mention of "home". Sister 1 is in the position to know what the bedstate is - when people are being discharged and whether beds are becoming available at the right time, so that the details about when and how a patient is to be discharged are frequently left in her hands. Further, the Consultant may tacitly be relying on Sister knowing about her mobility: any chance of her not being ready to go home could be raised here or I would suggest, would already have come to the doctors' attention through less formal channels or through the geriatrician's involvement with the patient. The Consultant gives Sister 1 the opportunity to add anything once they move away from the patient after the decisions have been made - "Are you happy with that Sister?".

The accomplishment is to display that there is hierarchical accountability involved here, as well as demonstrating how decisions about patients are rationally taken in an environment of consensus with regard for the patient. At a functional level, evidence of the patient's condition is reviewed in the light of aspects of her social situation, she is classified and her disposal agreed upon. Both the ceremonial and functional level act to recursively reproduce conditions of power.

However, the overall issue here is that during the ward round the patient is also transformed, from someone 'needing' to be in hospital, to someone who can go home, now. To do this she is reclassified. In the above case the patient is relegated to the class of someone not unwell enough to warrant in-patient investigation but potentially at risk. The risk comes from an abnormal chest x-ray, the patient's heart failure, the possibility that the inhaled pea could lead to a lung infection, some worry they have about the "tamoxifen", previous deep vein thromboses raising the question whether this current problem is in fact a pulmonary emboli (and therefore life-threatening) and her age. Although the element of risk in her discharge is tacitly present the Consultant makes his view clear: that he thinks the pea should disintegrate.

The interesting aspect is how any doubt and uncertainty about the case are dealt with in two ways. First, by getting the consensus of the team on the basis that the patient is "asymptomatic" . And second, by effectively constructing a safety net for the future (the out-patient appointment). No-one challenges this view, and the lecturer corroborates it with "She's got no temperature". The Consultant uses the others to confirm his view - that the patient can be discharged, taking the precaution of seeing her in outpatients in ten days time: he would "let her go" in these circumstances. However, to make his view he is drawing on

and confirming their view: after all the resident announced the patient as "the pea lady", who had nothing serious of note on examination.

Further, the patient herself has indicated that she is not seriously ill and wants to go home - patients do not usually complain about minor issues such as bruising from blood letting when there is enough at stake, like their life. The patient is ascribed to the class of someone not in need of the acute hospital services, she can go home. Mrs Marsh is now in limbo, since she cannot get home the same day because her support is not available.

It is only on closer analysis of the round that how the patient is ascribed to a class is revealed. At the ritual level there is a coded communication going on to facilitate the "medical disposal" of the patient [see Berg, 1992] through the ascription of the patient to a class. In various ways the doctors cast doubt on the patient's claims: that she choked on a pea and became increasingly breathless. For example, the admission document reads:

> Cough with wheeze since *inhalation* of a pea in a known asthmatic (though she vehemently denies being asthmatic). Multiple medical problems. [my emphasis]

The resident claims that the patient became breathless after "swallowing" a pea, not inhaling a pea. The distinction is critical in a medical discursive space: swallowing a pea cannot act to compromise a patient's breathing. He says she became breathless in the evening, calling her G.P. at eight o'clock: this is a long time after lunch; this indicates a different cause to the wheeziness. The Consultant sums up that there is nothing "serious of note on inquiry" and that she is "asymptomatic". And yet by the time the Consultant moves back to the trolley having spoken to the patient (an aspect of the exclusion of the patient, talked about at a distance by those who know), he is saying that there is this "nocturnal dyspnoea business", despite the patient telling him that she is not usually breathless and that she only uses one pillow at night. They move the 'evidence around' to suit a diagnosis which casts doubt on the authenticity of the patient's claims, that she choked on a pea:

> **Consultant** - [to Lecturer] And the diagnosis - what would you say - dyspnoea of unknown cause with mild LVF? [heart failure]
> **Lecturer** - [nods].

Asthmatics with mild heart failure do not need to be in hospital, but they do get wheezy, especially at night and do have swollen ankles. Mrs Marsh is transformed: from someone with an acute episode potentially at risk, to someone with chronic heart problems (due to old age), which she denies.

An interesting aspect is that the patient knew that she was not believed, but does not include the "big doctor". The following extract is from her interview with me carried out

later that day:

> **Patient** - Hmm. But I don't know why they think I, not the big doctor but the other ones, the wee ones, here doesn't think there is anything went down my wrong hole at all but there is! There is something that went down the wrong way, because that is why I kept coughing, trying to cough it up and that's why I went to my next door neighbour to see if she couldn't bang my back. I thought, you know, clapping my back would do it, and she battered and battered me but it never came up. She doesn't know, well she'll know now that I'm in the University.
> **JL** - And what's been happening to you since you came in?
> **Patient** - Oh I've had a lot of, what do you call it that thing, not breathless but wheezing, I've had a lot of wheezing, but they give me that mask I put that on, that takes it away.
> **JL** - Does that stop the wheezing?
> **Patient** - Yes. The doctor said that the three X-rays showed that there is a slight infection in my right lung and they don't know if it's the pea or not, but the young doctor don't believe I swallowed a pea and it happened, it did! As sure as there's a God above me that's what happened and I know exactly whatever I've swallowed the wrong way it is a pea, it went down the wrong hole.

Mrs Marsh insisted to me that she never usually got wheezy, but that the young doctor insisted that she is asthmatic. Mrs Marsh knows that she is not believed by the young doctor, but does not pick up that the Consultant himself is also moved to doubt her and that it is this element of doubt which tips the balance for her to be reconstituted as a discharge.

During the ward round Sister 1 does not appear to contribute anything directly to the analysis of the patient's problems or her future. The medical gaze appears to operate in a rational and reasonable manner. There may be an assumption that if Sister I was particularly worried by any aspect of this patient she would have already notified the resident or lecturer or would speak up. However, it would appear that while apparently taking her into account, acknowledging her presence and the need for her consensus, at no point is her opinion of the patient sought in open forum. As emphasised this is a typical example of how consultant ward rounds are conducted in the present unit.

The significant thing is that Sister 1 has already picked up on the patient as possibly ready for discharge before the ward round: the ward round may have simply confirmed her view of the patient. Sister 1 at the nursing handover on the day the patient is admitted, reported the patient's extensive medical history and her age. The Staff Nurse at the handover sighed deeply, Sister 1 turned to her and told her that the patient is "nay bad" - the patient is good for her age given all her ailments in Sister 1's assessment of her. Sister 1 expressed the view at the nursing handover the following morning that the patient could end up with a lung abscess if the pea is not extracted. But after a morning in which Sister 1 saw

the patient as mobile and self-caring she states at the midday handover that the patient "should be ready to go home soon". After the ward round the patient is ascribed to a class - through the medical construction of her as not an authentic patient for the ward she is movable. This suits Sister I as it is Waiting Day.

Subsequently the ward was short of beds, and Mrs Marsh was sent to another ward for the night and discharged from there the following day. She made her own discharge arrangements, including contacting her home help to restart. This might indicate that the nurses did not feel the need to ensure that discharge arrangements were suitably made. They no longer felt accountable for this patient, she did not need them, she was in under 'false' pretences. Here is the transfer letter sent with the patient when she was sent to a 'boarding' ward:

> Nursing care: Ambulant, baths in bathroom unaided. Pressure areas healthy, up for the lavatory without help, is mentally alert, is having medication.
> Details of Special Nursing Care: Is going home tomorrow. To continue with nebulisers until discharge.
> Other comments: Thank you for taking this pleasant lady.

The patient told me she could not bath in the bathroom unaided, that she had severe osteo-arthritis: she had a shower installed at home because she could not manage the bath, and that she had obtained an ejector chair at home because getting up from a chair is awkward.

I would like to suggest that the nurses enrol the doctors view to legitimize their own: that the patient is pretty well self-caring and has no medical problems which warrant her being kept as an in-patient. She is constituted as having had not a shock and an unpleasant and frightening experience, but as having mild heart failure, which in a woman of her age (84 years old) does not constitute anything unusual or acute. Mrs Marsh expressed to me how she did feel shocked, unwell and wearied by the whole episode of her admission, of her move to another ward and by the fact of being disbelieved. She said she had "lost her strength". And further, I would suggest that on the ward round Mrs Marsh is presenting herself as keen to get home to counteract the image of her she feels doctors have formulated.

The ritual of naming in the ward round in relation to the classification of patients is being affected with the nurses' view already read by the doctors. It would appear that the ward round enables the Consultant to make his interpretations of other staffs' comments, make his own reading of the patient and give permissions and instructions as to how to go on with any particular patient. While nurses take their instructions and manage their work to accommodate their surveillance role, they also enrol the doctors' views of patients to legitimate their own view of patients. This is achieved through a labyrinth of coded

language and talk. This is now explicated further.

Around Mrs Adamson's admission there is a slight potential for difference between the nurses' view and the doctors' view, this oscillates around whether the patient has psychosomatic problems or is really ill. Here is the first ward round concerning this patient.

> [Mrs Adamson, Day 2]
> Post waiting Day Ward Round
> Present on ward round: Sister 1, Consultant 1, two Medical Students, Resident, Senior House Officer.
>
> [The ward round comes into the Bay. Consultant goes straight to Mrs Adamson. He crouches down by the patient as she lies in bed and takes the patients hand. Smiles].
>
> **Consultant** - Hello Mrs Adamson - my name is Dr Brown. Just sit quiet while they tell me about you. [he looks up and the **Resident** comes and crouches next to him and speaks very quietly reading from the notes, gives a very brief resume of the patient's history and examination from the notes - I cannot really hear it].
> **Consultant** - [to Mrs Adamson] - Let me have a wee listen to your chest - just open that one button for me. [Patient - undoes button on nightdress] [Consultant puts on stethoscope and listens to chest - Sister 1 pulls the screens round - all the rest of the ward round stand at the end of the bed]
> **Consultant** - [stops listening and turns to look at the Senior House Officer] - I can't hear much in the way of crackles. [Turns back to Patient] - Well love, I think we'll do three things for you [he's taken her hand again]. First - you just relax - you're in the best place possible. Second, we'll give you a wee bit of oxygen - would you be more comfortable with a nasal tube rather than the mask? Does it make you claustrophobic? -[patient doesn't really answer] We have a kind of nasal spectacle - have you ever had nasal spectacles?
> **Mrs Adamson** - I wear spectacles - but I haven't got them with me.
> **Consultant** - No these are a different kind of spectacle - it's a tube that puts the oxygen up your nose. And we'll give you some medicine to help you get better. You rest quiet and look at the beautiful flowers in the sunshine [he points to the flowers on the windowsill - a lot of them are dead or dying].
> **Mrs Adamson** - Yes, it's a lovely day.
> **Consultant** - [he gets up to go - pats patient's hand] [to Sister] - Can we give a bit of that now? [points to O2 mask].
> **Sister** - Yes, of course.
> [**Consultant** walks off and Sister puts mask on pt. Whole ward round moves off].
> [Time with patient = 2 mins 25 secs]
> Senior House Officer - [to **Consultant** as they walk back to the notes trolley] - She's had attacks of breathlessness in the past - they couldn't find a cause and put them down to anxiety.

Sister 1 makes two contributions to the round: she draws screens around the bed, to enable

privacy while the Consultant examines the patient's chest, and she signals that she has received the Consultants direct instructions to give the patient oxygen straight away. However the claim here is that there is more being communicated to Sister 1 than is obvious: that there is coded instruction.

The Consultant places the patient in a passive non-participating position - she is lying in bed, she is patted and smiled at but told to be quiet, she is not asked anything except if she has had nasal spectacles before. The patient is told that three things are going to be done for her to make her better, (one of these she is supposed to do herself - relax), meanwhile she is to lie quiet, and "look at the beautiful flowers in the sunshine". The claim here is that the Consultant is giving his instructions, not overtly, but through his talk to the patient he is indicating his view of the situation and giving his instructions indirectly to the junior doctors and to Sister 1 as to how this patient is to be managed.

The Consultant is indicating that he knows she is an 'anxious' patient by emphasising how she needs to relax, and by his emphasis on the nasal cannulae in case she is "claustrophobic". But he is also confirming that she is ill and that she needs to be looked after carefully: she needs to be kept quiet and relaxed, she needs medicine and oxygen, now. His whole manner is demonstrably caring and concerned, but controlling and condescending at the same time. There is a coding going on around this patient, which amounts to her having a double identity for the ward staff. This is now explicated.

According to the G.P.'s letter she suffers with chronic anxiety, this is announced in the first sentence:

> G.P. letter: This 84 year old lady is well known to our practice with chronic anxiety and frequent calls.

This can be read to indicate that this patient's symptoms are usually due to her anxiety, she is considered neurotic, and is always bothering the G.P, but this time she is actually very ill: the G.P. stated "she is clearly unwell at present". On her arrival in A&E she is described in the admission document as "very distressed" and "cyanosed" with lungs full of fluid. Her chest x-ray and ECG confirmed that she has heart failure and a probable heart attack.

Sister 1 stands back as a virtual non-participant on the ward round, as is usual - she is not consulted, her view of the patient is not sought nor is it offered. Sister 1 has to decode the Consultant's behaviour and can take or leave what she has been informed of, the process relies on her attention, her ability to decode and her inclination, her self-discipline. The significant aspect here is that the Consultant does not directly discuss this patient's mental or emotional state with Sister 1, and that she does not raise it. There is no record of

the ward round in the nursing notes, and Sister 1 does not handover to the next shift. Nothing at first is made explicit as to how she is to be handled.

The nurses' talk about and behaviour toward this patient subsequently indicate that they do take her "seriously" while she is medically unstable, demonstrably ill. However, throughout her stay there is an ambivalence toward her, an uncertainty in the nurses' talk about her as to how much of her breathlessness and chest pain is due to anxiety and how much due to pathological changes in her heart muscle. They are very kind to her when she is distressed and having an attack of breathlessness and chest pain. This approach is maintained in direct relation to her expressed medical condition: it is as if the nurses could care for this woman's emotionally disturbed state as long as there is legitimation by the medical staff's attitude to her and that there is proof that she is really ill.

The ambivalence of the nurses' attitude became more overt as the patient's medical condition stabilised and is exemplified by Staff Nurse's handover to a late shift in the following extract:

> **Staff Nurse** - Mrs May Adamson, 85 year old Church of Scotland lady who came in on the 22nd with an MI, complicated by left ventricular failure and atrial fibrillation. She's having apex and radial pulse done. They think it's just a complication of the M.I. So she's just had stat doses of digoxin - she's not having it regularly. She's on frumeside regularly. She has pulmonary oedema. She has odd turns - there's no doubt she has chest pain but we're not sure if it's as bad as she says. She looks fine one minute - like just now, she's really perky - then she's terribly breathless and [mimics someone gasping for breath]. She can have GTN for chest pain. She needs a lot of reassurance, you know. She had to have cyclimorph this morning - five milligrams I.V. David Trent [the Lecturer] said we're not to hesitate to give her cyclimorph if she needs it as it's good for her L.V.F. apparently. I don't know how it works. This is her third day - so she's just been up to sit before lunch - for lunch in fact. But she had one of these episodes of breathlessness and chest tightness this morning, so she just got up to sit before lunch. [S/N looks at the Kardex again]. Her weight is coming down - which is good. And her apex and radial are synchronising this morning.

The Staff Nurse is not sure if she can believe that physical illness alone has caused this patients behaviour - that the patient's pain is as bad as the patient says it is or if her visual distress from breathlessness is 'real'. For Staff Nurse the interpretation of the visual signs and symptoms is made complex by the possibility of the patient using her behaviour as a form of language: if the visual manifestations of distress are being manipulated by the patient "to say" how she is (anxious), then in this particular case the usual visual signs cannot be trusted, cannot be relied upon, to tell what is going on and to know (that the patient has chest pain and breathlessness caused by angina). Staff Nurse believes that the

patient is getting better - the patient's weight is coming down, a sign that her pulmonary oedema should be resolving, and her apex and radial heart beat are synchronising, a sign that her heart is settling. But she cannot balance this with these "episodes of breathlessness and chest tightness". She uses the doctors' conduct to help her interpretation: David Trent [the lecturer] has said Mrs Adamson can have morphine if she needs - a sign that she is legitimately ill. But something does not quite add up for Staff Nurse - she cannot quite believe the patient's distress, her "odd turns", but she has to because 'illness' is being legitimated by the medical staffs' approach and care. But, through her different explanations and justification and expressions (her accounts), she is communicating her doubts to the other nurses.

The next day at another handover the nurses' doubts about the authenticity of Mrs Adamson is evident again. Here Staff Nurse on night duty is handing over to the nurse-in-charge on the early shift:

> **Night Staff Nurse** - May Adamson 85 year old lady who came in with chest pain. She's had an M.I. and is in left ventricular failure and atrial fibrillation. Her weight - her weight, what is her weight? [Looks at the observations book hanging up above the desk, reaches up and takes it down, looks at the book] It's gone down nought point two. Her apex and radial are almost synchronising - they synchronised last night. She's had a bit of this funny abdo pain [looks quizzically at Staff Nurse 1].
> **Staff Nurse 1** - I don't know, it's odd.
> **Night Staff Nurse** - Perhaps you could have a word with them about it.
> **Staff Nurse 1** - I did mention it to them yesterday. I said that she is having her bowels open regularly. David Trent seems amenable to the fact that she is having pain - she can have cyclimorph and everything and they're doing regular ECGs.
> **Night Staff Nurse** - Yes, yes. [Turns page to next patient] Mrs --..
> **Staff Nurse 1** - [Interrupts] And Bill [resident] spent alot of time with her yesterday morning, sitting with her, listening to her chest and doing her apex and radial with me and everything. They seem to be taking a great deal of care with her.
> **Night Staff Nurse** - Yes - she's lovely. But she's sort of faded overnight.
> 1 minute 41 seconds.

Here the Staff Nurse reports that the patient is complaining of abdominal pain which the Staff Nurse describes as "this funny abdo pain". The nurse signals she has checked the "funny" abdominal pain in relation to any possible bowel dysfunction, but the patient has been having her bowels open regularly. This either makes the abdominal pain unaccountable in terms of constipation or other obvious bowel dysfunction and in this particular patient casts doubt on the authenticity of the "abdo pain". Once again in this discussion the nurses are using the doctors' behaviour to indicate authenticity, to legitimate the patient's pain as illness to which they should attend, which they should take seriously.

As the tests began to come back as normal, Mrs Adamson's attacks are seen and described more and more as inauthentic - as something the patient is doing rather than as being caused by her illness, as psychosomatic. The nurses talk about "her hyperventilating", her "palpitations" and "panic attacks". These notions are used to describe the psychosomatic affects of anxiety and are not the language associated with somatic heart problems, this would be "breathlessness", "arrythmias" and "distress". In their direct behaviour toward the patient there is a marked change.

The nurses had spent a lot of time on reassuring and comforting Mrs Adamson while she is constituted through the doctors attention to her as "ill". But as she became constituted as not "ill", but as having psychosomatic problems, the nurses began to seem to question the time which reassuring her and nursing her took. Here is Sister 1 helping the patient out of bed six days after her admission. By this time with any 'ordinary' heart attack patient the patient would be mobile and independent if not actually discharged:

> 09.25 - [**Mrs Adamson** is behind the screens ?having been doing her morning wash. Sister 1 goes in to her and asks her if she has finished and pulls back the screens. She's in a big hurry].
> **Mrs Adamson** - Before you pull back the screens dear I think I'll need the..
> **Sister 1** - Loo? [Pulls curtains back round]
> **Mrs Adamson** - I'm sorry.
> **Sister 1** - That's alright. [Goes and fetches commode. Returns, takes it into patient. They're both behind the screens].
> **Mrs Adamson** - I'm sorry, dear.
> **Sister 1** - Take nice deep breaths - none of these silly little pants. [Sister 1's voice has a hard edge to it - authoritarian or irritated]. No! Slowly, slow down - right. [Her voice begins to soften]. That's better -good. [Soft now]. What's wrong?
> **Mrs Adamson** - That water tablet.
> [The nursing auxiliary goes in behind the screens and she and Sister 1 come out together and go off. Screen left half pulled round].
> 09.34 [Sister 1 returns and goes into patient, helps her off commode and into her chair, pulls back screens. **Mrs Adamson** is sitting in her chair with her head in her hands, puffing. Sister opens the windows on the other side of the patient's bed and goes].

In this episode Sister 1 is short with the patient, she has no time to spend on Mrs Adamson's "panic attacks" - "Take nice deep breaths - none of these silly little pants" and she opens a window. The attack is now not to be taken seriously. Throughout her stay at the ward handovers, Mrs Adamson has been described as someone who gets "very anxious" and who "needs" a lot of "reassurance". The cause of her anxiety - breathlessness on exertion and the pain in her chest - is not, once her results return to normal, taken as the cause of her panic attacks, nor, I would like to suggest, are they any longer constituted by

the nurses as putting the patient at risk (where anxiety can exacerbate heart disease).

Mrs Adamson, throughout her stay, made cracks about being for the mortuary and told me that she is terrified of what the pain and palpitations mean. While in hospital she had two complications from her heart attack - heart failure and atrial fibrillation - both of which would exacerbate any tendency to breathlessness and palpitation. Why Mrs Adamson reacted so badly to them is a question that was not raised, she was a known neurotic and was old, the concern was whether or not they were authentic or not, not what her experience of them meant to her. She told me that normally she could not manage stairs without getting a breathless attack and that because of them she had not been going out for two years. She claimed that any exertion threw her into a state of breathlessness or brought on the pain in her chest.

Shortly after the above episode between Sister 1 and Mrs Adamson, Sister 1 and the doctors on a ward round decide to send Mrs Adamson for convalescent care. She is discharged there only to return a few days later to have a cardiac arrest and die in the ward bathroom the day after her readmission.

By constructing Mrs Adamson as someone who needs reassurance, there is displacement of her fear and panic (if that is what it was) as something chronic and as not really serious in relation to the real work of the ward. The ward rounds and the doctors' behaviour can be seen to help locate the patient in the nurses' world, as authentic, that is as 'medical', rather than as inauthentic, that is psychosomatic.

The nurses' view and the doctors' view with few exceptions, were very similar in Ward One. In Ward Two there were typically only marginal differences. These are now discussed.

Ward Two nurses felt that sometimes one particular doctor was too hard on the elderly patients, wanting them to mobilise too quickly. However, it must be stressed that this did not affect the ways in which the nurses handled their relationships with doctors viz a viz patients. Ward Two nurses' dissatisfaction with some medical staff, expressed mainly as a "breakdown in communication", had not, at the time of the study, led to any differences in relation to ward rounds or any other forms of nurse-patient relations: the nurses had not begun to find ways to negotiate or simply confront the doctors with any different views of patients which they may have had. As already discussed, the main focus of their discontent was that the doctors did not keep them up to date. On Ward One the nurses were more happy with this aspect of their relations with doctors but there was still some feeling that the doctors could keep them better informed.

What did happen on Ward Two which was different from Ward One, was that some patients were left longer on bedrest in Ward Two, there was a slightly more *laissez-faire* attitude to mobilisation than in Ward One. One of the doctors complained to me about this. The Sister was new and had perhaps not yet been disciplined with regard to the ways of the organization of patient care. She had not, it seems, fully translated the pressure for throughput into pressure to mobilise early rather than late. Also, field work was undertaken in Ward Two after the worst of the winter was over, when there is less pressure on beds. Further, the patients were male, which also apparently constitutes less threat to throughput: less male patients end up blocking beds than female patients, statistically speaking and according to the medical staff. These matters of difference are discussed further in Chapter Twelve.

The nurses domain in relation to the doctors is in the dimension of observers: they watch to help doctors to know. But as has been shown this implicates them in the constituting of classes of patient. This constituting of classes can be seen in the meanings which nurses ascribe to the different categories of patients 'medical', 'social', 'geriatric'. These typifications do not just entail a valueless ascription of patients through classification, but in turn entail an authentication of patients: the question is always pertinent - is this patient appropriate to an acute medical ward? The nurses award patients with 'medical' status, this entails assessing their problems not just in relation to medical discourse but in relation to the ways in which the doctors represent, and act towards, patients. This is now further discussed specifically in relation to older patients and the Social Round.

The Social Round

The consultant geriatrician attached to the ward and/or his senior registrar visit the ward once a week to see all patients over the age of sixty-five. No nurse accompanied them. They rarely communicate with the nurses on these occasions but attend the "social round" on the following Thursday which is the 'multi-disciplinary' ward round where all patients over the age of sixty-five are discussed. This meeting takes place either in Sister 1's office or in the teaching room on Ward 2, it does not include visits to the patients concerned. "Social" and "old age" are inextricably linked.

The physiotherapists, speech therapists and occupational therapists, the dietician and social worker involved in the Wards attend this meeting, as well as a nurse from each ward - usually Sister or nurse-in-charge in her absence. All the members of the meeting sit, and tea or coffee and biscuits is provided by the nurses.

The nurses are frequently active participants in this meeting. Unlike the other Consultant ward rounds, they contribute more verbally to the meeting: they seem to have more to *say* in respect of social medicine rather than somatic medicine.

In the following extract Mrs Best is being discussed for the first time at a social round since her admission. The Consultant Geriatrician saw her and had done an "assessment" of her at the beginning of the week (this is also a part of his own research programme).

> [Attending the meeting are - consultant geriatrician and his senior registrar, sisters 1 and 2, physiotherapists 1 and 2, occupational therapists 1 and 2, residents 1 and 2, speech therapist, social worker, JL]
>
> **Consultant Geriatrician** - Ann Best?
> **Senior Registrar** - She's still here.
> **Resident 1** - Her Barium shows she's got a large benign ulcer. She's been put on gaviscon ...[etc]
> **Consultant Geriatrician** - Is it a gastric ulcer?
> **Resident 1** - I havn't seen the films yet and they didn't say over the phone.
> **Consultant Geriatrician** - From the social point of view - she lives with her daughter and gets out and about with her.
> **Sister 1** - Yes - I think she'll just get home.
> [Time: 37 seconds]

The Consultant Geriatrician leads the discussion of this patient with a question: the resident updates on the medical situation for this patient, she has a "large benign gastric ulcer". The Consultant Geriatrician checks if it is a gastric ulcer but the resident cannot qualify at this stage. The Consultant Geriatrician then sums up what he has assessed about this patient in terms of the "social point of view" : she "lives with her daughter and gets "out and about with her". Sister 1 agrees with this, and concludes the discussion with the notion that "she'll just get home". So here it is Sister 1 who concludes the disposal.

This meeting constitutes more of a discussion than the consultant ward rounds: while the Consultant Geriatrician leads the discussion he does not direct it in the same manner with closed or leading questions. However, this smooth discussion is full of signals: this patient has a medical condition for which there is no radical treatment (she is 80, the ulcer is benign, surgery is out of the question), and she has a daughter who looks after her in the community. On the ward she is termed "self-caring", is constituted by the nurses as mobile, able to wash and dress herself. From their assessment of this patient there is consensus: no further intervention is required, there should be no impediment to her discharge.

The impact of the current episode of illness on Mrs Best or her life is not raised, nor are the issues pertaining to her medical condition: she suffers with arthritis, so severe that

she has been dependent upon anti-inflammatory drugs for years. In the present situation, with an ulcer, she will no longer be able to take this medication. No one raises these matters at the meetings, nor do they get raised at any other time. So the question remains what were they assessing at these meetings, if it is not actually the patient's 'condition' in relation to her response to illness? From Sisters remark, what she is assessing is the patient's discharge potential: in her assessment there should be no problems to impede this patient's discharge.

How patients are constituted then in relation to their discharge can further be explored using another example. Here is a discussion about Mrs Appleton:

> [Present at the meeting are: consultant geriatrician, resident x 2 senior registrar, social worker, physiotherapists x 2, occupational therapists x 2, sisters 1 and 2]
>
> **Consultant Geriatrician** - Wendy Appleton?
> **Sister 1** - She's having another 24 hour tape done. She's alright.
> **Consultant Geriatrician** - I don't think she'll be a problem.
> **Resident** - No.
> **Sister 1** - She had a funny turn this morning - we recorded it all on the chart.
> **Resident** - Good, excellent.
> **Sister 1** - She was cold and sweaty, she went back to bed for a while.
> **Resident** - Good.
> **Sister 1** - So she's having that.
> 58 secs.

Here the consultant geriatrician states overtly that he does not think this patient will "be a problem", confirming Sister 1's statement that she is "alright", she is constituted by Sister 1 as somebody having medical investigations, as a medical problem, not as a geriatric problem. The basis for this is once again to be found in her social history and the staff's assessment that she is normally mobile and self-caring. The social history revealed that she lives with her daughter: as with Ann Best there should be no impediment with her discharge. Once again, note it is Sister 1 who initiates expression that there will be no impediment.

However, the cause of Mrs Appleton's "funny turns" or blackouts were never established. It was discovered that she had been having similar episodes for a number of years. How these were managed at home by the patient and her daughter was not raised. As with Mrs Best, the future ended with the patient's discharge: they were constituted as safe at home and able to cope.

Here is presentation of a patient who is constituted differently, that is as a potential "problem":

[Present at the meeting are: consultant geriatrician, staff nurses x 2 (Wards 1 and 2), physiotherapists x 2, social worker, medical student x 1, speech therapist, JL, residents x 2 come in after meeting has started]

Consultant Geriatrician - Bernard Gibbon is a 76 year old man who came in having collapsed with hypotension, he's got known arterial disease.[.?.]. He lives with his wife who attends the day hospital at Southmount. Home help five times a week, meals on wheels three days a week. So they're obviously a problem. [looks up at S/N]
Staff Nurse - His wife - she's not able to see, so I don't think she does much.
Consultant Geriatrician - Does he do anything for her?
Staff Nurse - I don't think so.
Consultant Geriatrician - So they just co-exist - with community support.
1 min 4 secs.

This time the patient is constructed as, in conjunction with his wife, "obviously a problem" by the geriatrician. The problem is signalled by a number of factors: the patient has long term disabling illness (arterial disease), his wife attends a day hospital which signifies she has physical/emotional disability, and they are already reliant on homehelp to maximum frequency as well as meals on wheels. It emerged during fieldwork that such matters as the presence and absence of relatives living at home, the frequency of visits by home help and other community workers acted as signs and could be read to indicate to ward staff how fragile the old person is at home. Where there is a high frequency of home visits indicates that the community support is already stretched to breaking point, without the added weight of any new, fresh illness and subsequent disability. These matters constitute aspects of the geriatric medical view and a new form of examination and history: where the patients' home life, their 'social situation' gets surveyed for signs.

In the present case of Mr Gibbon, the Consultant checks whether the patient does anything for his wife, Staff Nurse thinks not, they "just co-exist - with community support". At this point staff have not identified any particular impediments to discharge, and go no further.

The patient will not get going and this becomes an issue: he is described at handovers as always lying in bed, apparently reluctant to get up and wash and be independent. Here is an intermediate social round, the patient has been in for 10 days at this point:

[present at the meeting are: senior registrar for geriatrics, occupational therapist x 1, physiotherapist x 2, staff nurses x 2 (Ward 1 and 2), social worker, resident [Ward 2], medical student, JL]

Senior Registrar (geriatrics) - Bernard Gibbon an arteriopath. Collapsed

with horrendous hypotension.
Resident - He has paroxysmal AF [atrial fibrillation] on ECG [electrocardiogram] so he's started on digoxin. He feels very tired - I can't find any reason for it - his U's And E's are normal [urea and electrolytes], he's not constipated, no UTI[urinary tract infection], his spit is negative. I cannot think why he's so tired except that he's lying in bed all the time. We keep trying to get him up - the nurses keep trying to get him up but ?
Senor Registrar (geriatrics) - Is he depressed?
Resident - No! He's really cheerful - Whenever I speak to him it's 'Aye doctor, Yes doctor' [robustly] then.. [Resident throws his head back and snores loudly]!! [Everyone laughs - Senior Registrar smiles but does not laugh]
Social Worker - He's a bit like you then [The Resident has been asleep earlier in the meeting]! [Laughs - everyone laughs]
Resident - And I'm not constipated either. [Laughs]
Senior Registrar (geriatrics) - [he's stopped laughing] - Has anybody asked him about that? [serious]
Resident - No.
Senior Registrar (geriatrics) - I got the impression things are pretty hefty at home - with his wife and all.
Resident - She's in and out - she's psychotic I think.
Senior Registrar (geriatrics) - She goes to the day hospital doesn't she?
Resident - Yes - but there is some psychiatric history.
Senior Registrar (geriatrics) - She may be demented.
Resident - No - she's a very dependent personality - that's it. Also she's a cancer phobic.
Senior Registrar (geriatrics) - Right - ok - he's really a medical problem - the home help five days a week is more for his wife than for him.
2 mins.

The way the humour works here is interesting. Does it signify that the resident is actually embarrassed at some level? The geriatrician (the senior registrar) is calling the resident to account: he is pushing for the resident to confirm whether or not he has checked whether this patient is depressed. In geriatric medical discourse this is considered an important possibility for understanding different behavioural and physiological changes in old people: the patient maybe sluggish and difficult to mobilise because he is depressed. The resident claims that the patient is not depressed and accounts for this by a description of his behaviour. The geriatrician refuses to some extent the play acting and the jokes and asks if any one has talked to the patient about "that" (presumably the question of his mood). The resident says no, he has not. The geriatrician accounts for his pushing by reference to the patient's so-called social history - " I got the impression things are pretty hefty at home - with his wife and all". The resident then covers himself a little by revealing that he has gone into the question of the wife in some detail, he even knows she is a cancer phobic. This expression of knowledge about the facts of the patient's wife distracts from the revelation that he has not in fact talked to the patient about how he feels. Then there is an

odd turn: the geriatrician states that the home services are not really for the patient who is a "medical problem", and thus exonerates any further talk about Mr Gibbon's depression or of him at a meeting for geriatric consultation. But the alert has presumably been given: that the patient may not get going if he is depressed. It should be noted that the medical staff do not ask the Staff Nurse for her opinion, nor does she offer one.

A few days later the senior house officer interprets from a routine chest x-ray that the patient has had pneumonia for some time and there is some suspicion that he may have cancer. This accounts to the doctors why the patient is so tired, they appear not to be concerned to find out about how he feels and they tell Mr Gibbons they will send him home as soon as possible so that he can go on looking after his wife. The patient begins to recover himself when he is moved to the side ward.

In his interviews with me, both formal and informal, Mr Gibbon revealed his utter bleakness in relation to his future, his life for him was hell at home. His wife had been made partially blind by a stroke. She had to "feel her way " to get around. She did not do anything any more, he had to do everything in the house which the home help did not do. He said he could no longer get out of the house: could no longer walk any distance because his breath was so short. He said that he did not have any social life: they used to go to a club across the road several nights a week, but they no longer go because his wife cannot read the cards for Bingo.

Mr Gibbon - She doesn't go out so I don't go out either.
JL - So your social life now?
Mr Gibbon - Is finished. I've no social life at all.

But what really got him down was that his wife never stopped complaining and going on to him. He felt this was understandable and that she was terribly bitter about what had happened to her. Sometimes he had to go into another room "to stop something from happening" (I assumed he meant to stop himself from losing his temper or hitting her). He told me she would not let him watch television because she could not see it. Further, he could not sleep at night, he said he had been unable to sleep for months and months, but during the last few days of his stay he was able to sleep at night and felt less tired in the day. During his interview with me he broke down and cried when talking about going back home. This picture is a different one to the one representing him in the ward rounds. For him all his problems were inextricably linked together.

From the analysis, the purpose of the social round is to discuss fully each of the older patients in relation to their medical diagnosis and treatments, their rehabilitation and

their social situation but only in respect of how any of these may impede their discharge. As with other ward rounds actual nursing care is not discussed. The object of the round appeared to be aimed at bringing to light impediments to a patients discharge and to ensure that all possible care is taken to mobilise resources to enable as speedy and safe a discharge as possible, in whatever form this might take. The round is another form of audit to assess that staff are doing their work thoroughly and well in relation to getting patients through.

As can be seen through the analysis in this chapter, staff constitute patients as medical or other: as geriatric, psychosomatic, or as having social rather than medical problems. How this relates to patients' expressions of their problems is tenuous: there would appear to be some discoordinations.

Patients are ascribed to a class of patient through staff's constitution of their 'illness' in relation to the different aspects of medical discourse described above. Further, through their typifications staff reproduce not just the dominant discursive practices of the setting, but also hierarchies and identities: what is right and appropriate and has priority in the setting is the diagnosis and treatment of disease (somatic illness), the rest is executed to enable this centrally important work to continue through maintaining disposal and throughput work.

I am suggesting that doctors and nurses read each others' talk and conduct towards a patient to help indicate their identity, that is the status of the patient. This identity can be confirmed or transformed through the ceremony of the ward round to reconstitute the patient in relation to *medical* orders. So, for example Mrs Adamson, is turned around from a medical patient, who has chronic anxiety, into someone whose signs and symptoms are no longer the effect of their *medical* condition but are psychosomatic.

The next Chapter is concerned with a detailed analysis of the qualified nurses' accounts of how they work and how they understand what nursing patients need.

CHAPTER EIGHT

CONSTRUCTING THE VISIBLE

> ..if you're going to look after a whole person you need to know about the whole person. [*Sister 1, interview*]

Introduction

In the three previous Chapters some aspects of the scene in which nurses encounter patients have been presented and discussed. This has entailed showing how nurses and patients come together and how nurses organize their days. The ways in which nurses and others organize everyday ward life has been implicated in the ways in which nurses construct persons as patients and their encounters with patients as occasions for nursing. As has been shown the setting itself is 'set' by nurses through their organization of work and their encounters with others, and yet the setting is always in process of being accomplished through these encounters.

This chapter is concerned with examining the qualified nurses' accounts. The aim is to show *how* in the nurses' accounts persons are constituted by nurses as patients with "needs". This has two sides to it. First, how nurses conceptualise patients to focus their assessment of patients' nursing requirements. This includes such matters as 'medical condition', 'age', 'context', 'lifestyle' and 'social situation', 'capability' (past and present) and 'quality of life'. The second aspect concerns the ways in which the nurses characterise their methods for assessing patients.

The chapter is broken down into six sections. The order does not imply any serial hierarchy. Each section relates to each other section and has been developed out of analysis of the nurses' talk, rather than from any preconceived analytical framework.

The first section is concerned with the nurses' claims about how "diagnosis", "symptoms" ,"treatment" and "recovery" affect their judgements about patients. The second section is concerned with how the nurses attend to issues of a patient's past in relation to the future, and how this involves conceptions of "capability" and "support". The third section presents how "age" affects nurses' assessments of patients. The fourth section discusses on what occasions and in what ways nurses attend to "quality of life". The final sections, five and six, discuss the ways in which the nurses characterize their methods: first how "talk" is instituted by them and second how they claim they know "just by looking" what a patient

requires.

The analysis configures around the accounts by nurses in Ward 1. Where there were significant differences in the accounts of the nurses in Ward 2 these have been specified.

Naming: Diagnoses, Symptoms, Signs, Treatments

Knowing what is "wrong with patients" appears to be critical to knowing what patients need. Staff Nurse 3 described how she needed to know "what was wrong" with a patient or "have an idea" of what was wrong:

> **Staff Nurse 3**: So that you can plan their care appropriately, for example whether or not they're to mobilise, whether or not they can eat, just anything really.

Staff Nurse 3 introduces the notion that knowing what is wrong with a patient enables a nurse to know what their nursing treatment should be in terms of certain constraints or restrictions. In this respect "what was wrong" with a patient acts to locate choice of ways to proceed. The nurses talked about what was wrong with a patient in terms of knowing their diagnosis, what their signs and symptoms were and what treatments or investigations they were to have.

Staff Nurse 4 stated how diagnosis worked for her in knowing how to nurse a patient:

> **Staff Nurse 4** - ...provisional diagnosis would obviously send you off in one direction rather than another.

In this case provisional diagnosis acts as a signpost which points to a way of proceeding, limiting the choice, giving a direction. From the nurses' talk it would appear that these aspects can relate directly to nursing care requirements, that they act as specific *indicators* of ways to proceed, limiting possible choice.

In this way, from the nurses' talk, it would appear that diagnosis-symptoms-treatment aspects of a patient *focus* the nurses' views of patients. In a sense these aspects actually act to situate a patient in the nurses' world: ascribing a patient to some particular medical condition enables the nurses to place them. This relates back to the ways in which nurses and patients come together in Chapters Five and Six. The ascription of patients to a medical condition involves typifications and as such constitutes the second reduction of patients.

Although the nurses did not raise it in their interviews, the first reduction of patients in the setting is through constitution of the patient as a particular type of admission. These typifications emerged in Chapter Five to indicate differences in the appropriateness of

patients and nurses' identity as medical nurses. The second reduction locates patients through naming as a particular medical condition. Naming the patient as a medical condition helps nurses locate patients through their interpretations derived from medical discourse. Medical discourse allows translation. This is now discussed.

For example, patients named as having myocardial infarction through medical discourse implies a particular set of relations which are taken into account by nurses in the way they nurse patients. These will include such matters as how the heart muscle is damaged and vulnerable - to enable the heart muscle to cope and to heal, the nurses maintain the patient on bed-rest. Further, in expectation that the heart muscle may be compromised they take particular readings of blood pressure and pulse, and observe the patient for particular signs, like breathlessness and chest pain and an altered fluid balance. These matters are all ways in which nurses translate the patient through medical discourse into a particular set of nursing responses. For them, a diagnosis can stand for a set of nursing responses. It is in this way that diagnosis is metonymic for nurses.

Nurses implicated the medical discourse in their naming of patients to construct needs and revealed how this translation of patients into nursing discourse through medical discourse has become more or less routinised. For example, in the following extract Staff Nurse 1 is responding to the question of what she needs to know to decide what care a patient is going to have:

> **Staff Nurse 1** - Em, well first of all, what's actually wrong with her, her diagnosis if we have it. If we don't or even if we do, I want, I have to know the symptoms of her illness and then I treat the symptoms. Em or give nursing care for the symptoms and obviously nursing care for the treatment she is receiving, you know if she was on oxygen or if she was, then I would give her the care that people would expect on oxygen. If she was fasting then I would give that sort of care.

Staff Nurse 1 states that she nurses patients in relation to their symptoms and treatment. Staff Nurse 1 would respond to these aspects and give *the* nursing care "that people would expect" given the condition or treatment (fasting or oxygen), she gives "that sort of care". In this way, diagnosis-symptoms-signs-treatment, act to instruct: through interpretation of the medical issues surrounding a patient nurses allow a correspondence to certain normative aspects of patient care. In a sense nurses are not assessing the patient but the medical discourses about a patient.

From the nurses' talk about their response to patients in terms of these 'medical' aspects it would appear that this kind of system for nursing still constitutes a major aspect of how nurses' approach patients and how they decide what patients require of them. This is

confirmed by the observation material of the nurses' handovers and their care of patients. The nurses retain a normative view of how patients should be nursed given particular sets of medical issues and their responses become routinised. This has a particular affect on the ways in which nurses work with doctors.

Staff Nurse 1 pointed out that doctors do not normally need to instruct nurses directly as to what nursing care is required by a particular patient. This is confirmed in the following extract in which Sister 1 is talking about what was talked about on doctor's ward rounds:

> **Sister 1**: Just patient treatment, patient care, I mean they leave it very much up to us for nursing care, they don't kind of dictate how we should nurse patients. Though they change their medical care they tell us about it. There are generally strict policies about nursing say somebody with an MI, they're on bedrest for a couple of days, so they all know that. The medical staff know that as well.

The normative aspects of nursing help routinise nurses' responses to patients. This is sometimes articulated in protocols for nursing a patient with a particular condition, but more usually the routines relate to specific aspects of a patient's condition: for example if a patient has low blood pressure they are not mobilised, or if a patient is on oxygen they are given specific care for their mouth and are observed for specific affects on their breathing. These routinised responses rely on the nurses learning the relationships between diagnosis-symptoms-signs-treatments and the appropriate nursing responses.

This way of 'knowing what to do for patients' was very much borne out by the way the nurses structured their handovers as discussed in Chapter Six. They did not usually give too much detailed instruction as to the specifics of the nursing care to be given an individual patient, but gave information regarding the patient's medical condition, and any technical details relating to this, such as treatment or observational issues. Nursing care was frequently given in summary, or in global terms such as all two hourly care, or 'self-caring'. The indicators as to how to proceed are carried in the details of the patients ascription to a medical condition.

This routinised approach also obviates the requirement for doctors' orders (except in specific cases). However, it also relies on nurses' ability to read the medical discourse on patients to extract the relevant issues and further to know what contingencies necessitate or suggest a deviation and when permission should be sought. The implication is that nurses are disciplined in particular ways.

For example, for patients with myocardial infarction the nurses said there was a

particular protocol of mobilisation, which indicated how much a patient was to mobilise on a day to day basis. Staff Nurse 1 claimed that the protocol was "pliable depending on the patient". She gave the example of an elderly patient with a medical history of embolism and arthritis. Her interpretation of these matters indicates how the patient should be mobilised early. However, the permission to deviate from the usual routine would have to come from the doctors:

> **Staff Nurse 1** - So we have a sort of format, but we do bend it, it is pliable depending on the patient. That is usually decided by the doctors.
> **JL** - What, whether or not you get cracking or not?
> **Staff Nurse 1** - Yes, we would actually be reluctant to start somebody mobilising early without, and that would be decided on the doctors' rounds usually - 'we have to get this woman moving, start mobilising her'.

Diagnosis-symptoms-signs-treatment act as a formula to indicate a corresponding nursing response: these constitute the ways in which nurses routinise their responses. These routinised responses can be taken to constitute nurses' frames of reference for their practices [see also Berg, 1992]. Deviations from the routine imply special permission from the doctors which necessitates justification for the deviation.

This way of working further implicates a particular relationship with doctors. Nurses rely on being kept informed by doctors. Some of them indicated how they can use their own powers of observation to know how patients are in terms of their medical condition. For example, an aspect of the medical condition ascribed to a patient concerns how the nurses constitute progress or "recovery". Sister 1 particularly emphasised this aspect: she claimed that a patient's "treatment" and their "recovery" were the primary aspects which enabled her to know how to care for patients. From her talk it emerged that monitoring recovery was done by attending to the presence or absence of particular 'signs' or 'symptoms'. In respect of patients with myocardial infarction she indicated that unless there were "complications" she would proceed with mobilisation as per routine.

The explicitness of the normative aspects of the relationship between the medical condition to which the patient is ascribed and the nursing response varies. As stated above for patients' with possible heart attack (myocardial infarction) there was explicit protocol, this was pinned up on the wall at the nurses' station, but only referred to the mobilisation aspects of patients and the giving of an information booklet to patients close to their discharge. The nurses kept using this in their hypothetical examples throughout their interviews. However, in many respects there was a far less explicit relationship between aspects of a patient's condition and related nursing care.

In the absence of an explicit protocol of care the nurses' talk about how they need information about the patient in terms of their signs, symptoms and provisional diagnoses. So while the nurses present themselves as reliable and confident in their translation of medical issues into nursing care they in turn relied upon being kept informed by doctors about these medical issues. This puts them into a particular dependent relationship with doctors to which I have already referred in the previous Chapter.

At a discursive level, then, nurses interpret and translate the medical talk around patients into nursing care. Many of these are routinised responses, while some are instituted as protocols. The nurses do not usually require instructions from medical staff but 'know' these responses and routines. Problems arise where doctors do not keep nurses informed and up-to-date.

Deviations from the routines may require an explicit justification and permission from medical staff. The possibility for deviation is suggested in nurses' expressions about how they believed that other aspects of a patient's situation might act to mediate and, perhaps, at times transform their interpretation and translation of the medical talk about a patient.

Capability

Alongside the locating aspects associated for them with a patient's ascribed medical condition the nurses referred to needing to know how much patients could do for themselves, "usually" and in the present, in order to know what nurses need to do for them. Their reasons for and ways of judging this are complex.

Staff Nurse 3 claimed that knowing what a patient is capable of in the *present* is primary. She "based" her nursing care, after knowing what was wrong with a patient, on her assessment of what a patient "can and can't do". This assessment is enabled in some way by experience:

> **Staff Nurse 3** - Usually you can assess quite quickly, I think you, it's harder at first obviously, when you first start but I think you get to the stage that you can assess quickly what a patient can and can't do.

There is no sense here of how the present can be interpenetrated by the past to enable assessment. In the nurses' talk it emerges how there is a tacit sense in which a patient's history or background explicitly impacts the present in relation to how the nurses actually nurse, particularly in relation to possible signs of disability (the opposite of capability). This is now elaborated.

The nurses referred to how they need to know about a patient's "social situation". Other ways of referring to this area of concern were "home-life", "context" and "lifestyle". These matters were associated for the nurses with "mobility", "self-care" ability and "support". Taken together these matters for some of the nurses were wrapped in the concept "capability" and its opposite, "disability". The nurses claimed that it is important to know what a patient's "home" or "social" situation is like: this concept is evolved in their accounts in relation to notions of family support, usual 'self-care' ability, mobility, and about any social services involved. These act together in some way to indicate how *capable* a patient is *normally*.

Nurses stated that they need to know what a patient could do or not do for themselves normally or "usually". Normally was pre-admission, and was located in the past. Wanting to know how 'self-caring' or capable a patient is usually, in the past, is associated for some of the nurses with needing a measure or baseline by which to judge the present. Sister 1 claimed that knowing about a patient's normal mobility or self-care ability enables comparison with the present to know what is abnormal in the present situation:

> **JL** - Because I'm quite interested in what information you tend to use, you know?
> **Sister 1** - Any pieces of information that we actually have. We always get a history from a patient or from the relatives to see what they were like prior to admission. And if they were mobile prior to admission you think why aren't they mobile now?

In this extract Sister 1 associates the "admitting" process with getting a "history" of a patient. Getting a "history" has a specific purpose - to alert Sister 1 to discrepancies, particularly in mobility, and to "see" what a patient "was like" prior to admission. What Sister 1 looks for are 'signs', this is apparent in her response to a question asking when it was difficult to get information:

> **Sister 1** - Yes. We found, I find it difficult when an elderly lady has come in and confused having been found collapsed and not coping at home. Can't give us any kind of history as to what's wrong with her, and we find that she has never had any help whatsoever and she has no family. And it's very, very difficult. Very often they don't want to accept any social help that's the problem with them. So generally we have to send the OT [occupational therapist] off to their home, get involved with the social worker and then go off and look round the home to decide how suitable or unsuitable it is.

So normally a history enables Sister 1 to make an assessment of the patient in terms of their *social* situation and their capability. But here, no history from the patient acts in combination with something in the presenting problems to alert Sister 1 of the need to obtain

more information about a patient's home and their history.

In giving an example where apparent breakdown in an old person's life leads to having to send out into the community to "look" for further evidence of this person's life Sister is giving some indication as to how she normally tells or judges a person's so-called social situation. "Confused", "collapsed", "no help whatsoever", "no family", "found not coping at home" - these give evidence of traces for Sister 1 - from a history she gets information about a patient in terms of their mental state, their ability to cope at home, the support they have. Knowing how these things worked for the patient pre-admission acts in combination with other aspects to alert Sister 1: they act in combination to *signify* something about this person's life in relation to their ability to be at home. In the above extreme case she is alerted to a situation which is "very, very difficult".

In talking generally about what information she needs to know about patients, Sister 1 did not raise the issue of a patient's past or their home life except in relation to the elderly and the chronically disabled. These matters are only significant, that is in terms of their mobility and any support they require, where there is potential or actual disability. For example, in the above extract it would appear that in the case of an *elderly* person who is confused, home life has a special importance.

It would seem from Sister 1's talk that she differentiates between how much about a person you need to know given a particular set of conditions: their social situation and their past has significance in particular situations. In the following extract Sister 1 is responding to a prompt about whether it is important to know about an elderly patient's social situation and their family life:

> **Sister 1** - I think it's very important especially with a view to them going back. If they've come in having collapsed at home and are unable to cope at home you don't want to send them back into the same situation without any help, for them to bounce back into hospital within two or three days. You need to know whether they've got home helps, meals on wheels, district nurse, hospital club or day hospitals or social clubs that they go to. Usually if their relatives are staying with them, are their relative prepared to look after them for a little while after they come out of hospital or are the relatives prepared to put a bit more input into them when they are discharged? You need to know quite a lot about a patient, you need to know whether they live upstairs in a flat, you need to know whether they're on a ground floor or....

Sister 1 emphasises how it is important to know about a patient's social situation and their family life "with a view to them going back". There is no sense of how it can impact on the present, in relation to understanding a patient's nursing requirements, as they are in hospital,

with an acute illness. Sister 1 envisaged 'social situation' in terms of *support* to enable *'coping'* and related this to discharge arrangements and that these matters are particularly important in relation to older patients. The implication is that they were in hospital *because* of their situation: "you don't want to send them home into the same situation without any help, for them to bounce back into hospital". They are social not medical.

In this respect Sister 1's discourse and practices may be affected by geriatric medical discourse. From her talk it would appear that Sister 1 only regarded a patient's past as important where there is a potential or actual problem in a patient's "social situation" specifically in terms of a patient's 'capability', that is their mobility and their 'self-care' ability and how this is balanced against the support they need and can get. There were two groups of patients whose past she was interested in: the elderly and at another point she also mentions the chronically ill. In the case of younger patients she assumes them to be normally fit; the past, and their home life is 'absent' for her, it has no particular significance:

> **Sister 1** - You certainly wouldn't ask a nineteen year old who's come in having had a [?pneumonia] if they have a home-help or District Nurse or Health Visitor or, that's a different kind of, well, because you assume before they came in they were quite able to look after themselves. But the elderly on the other hand they do need a lot of social support.

So the past is absent because you "assume" that someone is able to look after themselves and most importantly they do not need any extra support in the future to enable them to get home. 'Capability' is connected for Sister with mobility which enables her to assess disposability. But there is also a degradation: a causal relationship is suggested between the past, home life and the admission rather, than the admission being due to ill health.

This has another dimension. Knowing what someone was like normally, some of the nurses claimed, gives something to aim for in their rehabilitation of patients. For Sister 1 this is an important aspect of knowing a patient's so-called history as it gives you a "goal". Similarly for Staff Nurse 3 an important aspect of knowing how someone is usually in terms of their 'capability' is that it gives you something *realistic* to aim for.

Staff Nurse 3 talks in terms of 'phases' of illness: once the acute phase of illness is over, mobilisation begins, and it is in relation to this aspect that knowing about the 'past' is important, because it enables you to judge the future: she says "we have a vague idea of how good they are anyway, so we know what to aim for, so we know what we're trying to get them to do". Patients' "mobility", their ability to cope normally and their 'goodness' are interrelated in some way: knowing what their "best" is gives something to aim for,

something to get back to.

Sister 1 also talked in terms of 'phases' of illness when talking about the elderly and associates the past with the future, making an 'acute illness' an interlude:

> **Sister 1** - It is certainly not ideal, although most of these ladies have come in with an acute condition and very soon after they've arrived their acute condition has resolved and they are back to their em best, which often is a chronic senile dementia. And once they're in hospital you really find out how unable to cope in the community they are so that you don't send them back out.

Here a persons' "best" is "got back to" after the acute phase of illness has resolved, in this case "best" is a chronic senile dementia, and the past was not "coping" in the community, which in turn acts as an impediment to sending "them back out". There is no sense of how the present illness impacts the future.

As can be seen the nurses mentioned the importance of knowing about the patient's 'past' in terms of specific concepts relating to a patient's ability to cope or self-care. What emerges is that this is particularly important in relation to a patient's future - their potential for discharge, their disposability.

Two of the nurses explicitly mentioned the importance of knowing a patient's 'medical history'. Once again the extent to which medical history had significance for the nurses seemed to be linked to 'alerts' for the future: in particular circumstances 'medical history' represents problems identified in the patient's pre-admission situation which can signify a potential difficulty to the patient's recovery and smooth exit from the hospital, because it affects the patient's 'capability'. This may lead the nurse to identify a need to make extra provision for a patient's discharge in terms of laying on more support or involving other agencies in the rehabilitation process, such as the physiotherapist or occupational therapist. It could also lead to the identification of a specific nursing strategy, such as earlier mobilisation than normal.

For example, Staff Nurse 1 claimed that a patient's past medical history - what had been wrong with someone in the past - and secondary diagnoses - conditions that were still present - could affect her decisions as to how she would nurse them. Here she is talking about how she would need to change a protocol to suit a particular patient, her example is hypothetical:

> **Staff Nurse 1** - Then having said that, it sometimes is changed, for example if it was an 85 year old lady who obviously needs to be kept mobile, if we are going, if we immobilise her too much as we would do initially for a post MI, [myocardial infarction] then that is going to be worse for her because she's going to become totally immobile, you know she needs to walk, she's

> got arthritis, she's got a history of D.V.T. [deep vein thrombosis] whatever, we need this woman walking so we might walk her quicker than we would somebody else.

In this extract Staff Nurse 1 expands her response to the question of what it is important to know about a patient to show how she is aware of how past medical history - "a history of DVT" - and present secondary diagnoses - "arthritis" - coupled with age - "85" - affect to modify what she is claiming would be her usual response to translating a diagnosis - M.I. - into nursing care - bedrest or restricted mobility. Her example is informative as it once again focuses on how older patients may require a different response instituting deviations from the usual routine responses to the primary medical condition. Once again it is in terms of mobility, getting them back on their feet, that the past is raised.

It is in this way that the patient's past and their capability can be regarded as an aspect of the contingencies which might lead the nurses to justify a deviation from their usual routinised practices, described above in the first section. Further, the relationship between the past and the future, has legitimised nurses taking account of a patient's history to alert them to possible problems with the patient's smooth recovery and discharge.

By association older patients are constituted as different from other patients. They may not be nursed strictly in accordance with the usual routinised responses in relation to their ascribed medical condition. Older people may be constituted in relation to other than strictly medical typifications. There is legitimation of these deviations through particular discourses: that older patients are not just at risk *from* prolonged immobility but that they are at risk *of* prolonged immobility, where immobility is constituted as movement through the beds. Disability and difficulties with home support may inhibit discharge. Further, this legitimates nurses' review of a patient's past and home-life for signs which may indicate impediments to the future potential for discharge.

There were some differences in the accounts of Staff Nurse 4 and some of the nurses on Ward 2. They talked about needing to know about a patient's pre-admission situation in terms of their "lifestyle", "history" or "background" to give "context" to the patient's current nursing requirements. These nurses had some of the humanistic discourse which is associated with the nursing process and which is strangely absent from the other nurses' talk about patients, although they were all using the nursing process. For example, it was only Sister 2 (who had recently come from a another hospital) who emphasised how she was attempting to introduce systems of nursing which would make nursing care individualised. The differences are now explicated using examples from Staff Nurse 4's interviews.

From Staff Nurse 4's examples of how she proceeds to get to know what a patient needs, it would appear that knowing what a patient is like normally can interpenetrate the way she sees a patient in terms of their current nursing requirements, but not simply as a project for the future. In the following extract Staff Nurse 4 is talking about a patient she had admitted the day before who had been described by A&E as a "total wreck" with a "knackered heart":

> **Staff Nurse 4** - ...so in that case we were able to see she was capable of quite a lot....so already we could assess that she was capable of doing a lot for herself. So I spoke to the patient, I spoke to her daughter, and, em, I got a clear picture in my mind and then wrote up the care plan according to what I thought her needs were from there.
> **JL** - .....So what sort of things did you get from them?
> **Staff Nurse 4** - Basically a history of what has happened over the past few days, for a start, leading up to the admission, so the recent history leading as to what led up to the admission. A history of what she was like before she took ill this time, so that at least for long term means you know how good you're trying to get the patient back to.
> **JL** - You got a base to..?
> **Staff Nurse 4** - You've got a baseline picture. Now I know that up until Sunday this woman was em, totally self caring, so if we were thinking now in the long term we're trying to get this patient back to that, to that level. So up until Sunday she was totally looking after herself.

Staff Nurse 4 here stresses how knowing about the patient in the past in terms of their capability acts as a "baseline picture". It is very important in terms of being able to aim for something: her metaphor, "baseline" and "level" implies that the past acts as an objective measurement by which to judge the patient's rehabilitation. This is similar to Staff Nurse 3's claim that the past gives you something realistic to aim for. However, there is also implication that Staff Nurse 4 is going to nurse the patient in the present in a different way because she knows that "up until Sunday this woman was, em, totally self-caring"; she was "totally looking after herself". Staff Nurse 4 stresses this aspect so that the implication is that she is going to nurse this woman in a way appropriate to someone who is normally totally self-caring, *rather than* nurse them as someone who has been totally dependent for the last x number of years.

Earlier in the interview Staff Nurse 4 made the claim that it was just by "looking" at this patient that she was able to see what she was capable of and that she was not the "total wreck" who had been described to her by someone in A&E. When she describes how getting a history - of the patient at home, of how she normally was, of events leading up to the admission - enabled her to get a clear picture in her mind of the patient, it would appear that tacitly the past *transformed* the present. There is a possibility that by listening to the

patient and to her daughter, by allowing the patient and their world, their account of their so-called history, to penetrate, Staff Nurse 4 also allowed for the transformation of her view of the patient. Staff Nurse 4 describes earlier how she changes her view of the patient: from the "total wreck" with a "knackered heart" that she was led to expect from A&E to someone who she could see was "capable of quite a lot" after she got a history from the patient. Hearing about the patient as she is normally - that she had been "totally self-caring" up until Sunday, just prior to the current illness event - and her experience of the patient in seeing, listening to her and her daughter, could have mediated Staff Nurse 4's perception of how the patient was in the present: that she was not a "total wreck" but "capable". In this respect allowing knowledge about a patient's usual state may indicate how situating the patient in their "history" is a legitimate way of giving entry to the notion of a patient's 'self', whereas the absence of a "history" could lead to judgments which are only narrowly informed. However, there remains in Staff Nurse 4's talk an underlying notion of *worth* or *value*, similar to Staff Nurse 3's notion of a patient's "best".

Both Staff Nurse 3 and Staff Nurse 4 talk in terms of "goodness" in relation to capability: through this realism there can be optimism (something to work for). Staff Nurse 4 talks explicitly about "levels", from total chaos up to something better, this is measured in terms of the patient's capability and this is related to "goodness". Being "capable" and being "knackered" or a "total wreck" are juxtaposed, and act as indicators of the good, or presumably its opposite, "chaos" which is associated with evil, or 'bad'. In some way knowing about a patient in terms of their previous, pre-admission state gives the nurse here a sense of their worth. I would like to suggest that nurses in the study were implicated in the constitution of patients not just as types, but that some types are more or less appropriate to the current setting, are more or less worthy of regard and care can be spoken of. An aspect of assessing patients, for nurses, is an estimation of them as a type. Further, I am suggesting here that this estimation reflects back to how nurses regard themselves: spending time on a patient who is usually incapable could be construed as a waste of time and not what they are here for.

However, there were other ways in which Staff Nurse 4 was different in her talk from the other nurses in Ward 1 (but not from some of the nurses in Ward 2) in how she talked about needing to know about an older patient's past. She claimed that she needed to have a "context" in which to understand an older patients nursing needs. Knowing about the patient in terms of how they are normally and in terms of how they were experiencing their current situation could be important to enable what she saw to be good decisions about

nursing care in the present. Staff Nurse 4 stated that she gets a history in order to get "a picture in my mind of what this patient is like in their own environment" and "gear myself to the overall picture". She gives an example of how background information can *inform* decisions about care by enabling understanding about a person's current experience:

> **Staff Nurse 4** - .. I was particularly frustrated in Mrs P--'s case, because we had quite a quiet evening shift that night and she was upset when we settled her down that night. Now I sat with her for about half an hour, just holding her hand and talking to her and asking her why she was crying and all the rest of it. And one of the students sat with her for half an hour and, em, we had actually said afterwards you know it's, she's ninety-five, she's never been away from home before, she's scared and I was trying to get across that sometimes in the elderly all this external stimulus, all the noise of the ward, the change in your team, everything can make them go as if they're really confused. That's what really annoyed me because just at the drop of a hat just because she was unsettled, they just give her drugs. And I sort of said to Betty [another staff nurse] -- because in actual fact a couple of students remarked on this, they said 'Oh, what has Mrs Pitt been given over the weekend you know because she just seems really changed from what she was last week'. And I had said to them at that point this is a classic example of bad management of a patient, who the background problems should have been looked at more thoroughly before they just used drugs as an alternative means out.

In this extract Staff Nurse 4 is showing how she believes background information about an older patient can enable better *understanding* of the present, so that judgements about requirements are situated in a more complete informational situation. In her example she claims that she allows knowledge gained about a patient in terms of their self to integrate with her knowledge about discourse on geriatric patients and into an experience of the patient as someone upset and crying and scared, someone who had never been way from home before, and someone who might be confused by the noise, the change of nurses etc. Also she refers to other nurses, what they noticed and how they as a group were trying to make sense of the patient's distress, not in terms of cause and effect, but in terms of understanding the meaning for the patient and how this should affect their response to the patient: to sit with her and talk with her rather than refer her to the medical staff as 'confused' and in need of medication to control her distress. It is not just the self in respect of the patient which is being allowed to inform Staff Nurse 4's view of the patient but she is creating an impression that her own emotions were in play here, her experience of the distressed person, her frustration.

The interesting issue here is that it was a confused old person - someone who no longer could 'go on' in the situation controlling their own behaviour, acting out normality,

concealing their distress - around whom Staff Nurse 4 introduces the issues of how knowing the person can help her nurse the person. By implication nurses do not need to know about the background and lifestyle of strictly 'medical' patients; it is added on information in the context of the older patient who is confused.

In contrast, Staff Nurse 5 claimed that probing into someone's past amounted to an imposition. She accounted for this through enroling the notion of how it might be constituted as an invasion of privacy and claimed that there had to be invitation. For Staff Nurse 5 a patient's social life is "private" whereas access to their body is taken for granted. In her talk she easily maintains a paradox: she says she has no hesitation in needing to know if someone is a 'drinker' because that can *cause* problems in the present - confusion and aggression (which are difficult to nurse) - but other 'social' aspects are not essential to know: she appears to regard them as separate from the body, which is her domain as a nurse. It is up to the patient to judge the relationship between them and her, and reveal as much as they feel they need to in order to get rid of their "desperation" to talk. By her acceptance of not necessarily knowing about a person's 'social situation', and its meaning for them, Staff Nurse 5 is pointing to its *insignificance* in terms of her decisions about how she is going to nurse someone. Her judgment of their nursing needs does not need to take into account any revelations about their "private" life. Staff Nurse 5 goes on to make the claim that she makes herself accessible to patients and that in this way she gives them room to tell her things if and when they want to. However, the whole issue of patients' access to nurses is made problematic by the study. This theme is pursued in Chapters Nine and Ten.

From most of the nurses' claims it would appear that a patient's "social situation" and their past life was important in a strategic relationship to managing the future: the disposal of patients. Further, the past history of a patient may indicate deviations from routinised responses to the medical condition ascribed to patients where working to the usual responses might act to impede recovery and mobilisation.

Staff Nurse 4 showed how a patient's past can inform the present in terms of her interpretation of a patient's nursing requirements and can even act to transform interpretation of a patient's 'condition'. This in turn has revealed how nurses estimate patients in relation to some notion of value.

What emerges from the nurses' talk is how older patients cannot be viewed simply in relation to their ascribed medical condition. The ways in which age figures in the nurses' accounts is now further discussed.

Age

All the nurses said they needed to know a patient's age in order to know how to nurse them. But age raised controversial and paradoxical issues for the nurses. This has already emerged in previous sections and is complex.

Some of the nurses revealed how they thought that knowing a patient's age would affect their nursing care because there are specific problems, potential or actual which older people are prone to and which require close monitoring or a nursing response. These include specific issues such as constipation, pressure sores, urinary tract infection, sensitivity to drugs, mental and functional vulnerability to illness and admission to hospital.

However, what arises with regard to elderly people as the nurses see them, is now the 'social' dimension is somehow important in relation to their nursing care, but that the social is not an appropriate dimension on an acute medical ward. As stated above most of the nurses had specific reasons for wanting to know about a person's past - to alert them to the future - apart from Staff Nurse 4, they did not conceptualise how a person's past and lifestyle can act as a context in which they view the patient in the present. This extends to their understanding of the elderly patient's requirements. All of them felt that nursing the elderly on the ward was problematic because they could not give the care that elderly people required.

For example, Staff Nurse 2 described the care of the elderly on the ward as a "shambles". She claimed that many of the nurses and doctors were very knowledgeable about old peoples' specific needs and that "most nursing is looking after the elderly so I mean we're all quite experienced at it". However she claimed that they were not giving the elderly what they needed. This she related to a social dimension. Staff Nurse 2 said that "we're hidebound by the routine" and indicated that this somehow got in the way of appreciating older patients as people, which is related to their identity in the past:

> **Staff Nurse 2** - ..because a lot of elderly people especially if they can remember, it's so much more important to them what happened to them in their youth than what's happening to them now. A lot of the time....And valuing, you know making others that you value. [...???...] today and its true to a certain extent, I mean not that you sort of say to them [...???...] but...
> **JL** - But valuing their experiences?
> **Staff Nurse 2** - Their experiences and that they've raised families and that you're only a slip of a girl as she says before she clobbers you round the ear with her wash bowl [laughs].

Staff Nurse 2 appears to be claiming that she believes that the present is not as important to older people as their past, that their past constitutes to a certain extent their self-identity in

the present. And that it is through talking with older people that you can value them as people in the present. This notion was echoed in the accounts of other nurses in both wards. They regretted that they could not do more for the older patients 'socially', they felt this dimension was missing in the ward as it was organized at present. This social dimension included talking, flicking through a magazine, stimulating them mentally, having relationships, taking them out. Once again it is present in nursing and medical discourse on the needs of long-term geriatric patients.

However, it indicates something critical and deeply embedded in the ways in which the nurses conceive of the differences between old people and other ill people, in what they conceive of as acute illness. Illness is constituted by them as something medical and as *detached* from the social. This extends to include how they conceptualise their nursing care: they constitute themselves as nurses who prioritise the medical and technical aspects but who do not really operate in a social dimension, except as a luxury. And further, as has been seen in the earlier sections, the social can act as a *drag* on the medical/technical, it gets in the way, to produce patients who are not medical but whose problems are 'caused' by their home life (the social), and who need social care.

This aspect of the nurses' talk confirms how they claimed that they actually went about judging patients' requirements. The strong impression is that the nurses felt that attending to the social dimension was not really appropriate in the present context: the social has little to do with getting acutely ill people well and home. By implication they seemed to be revealing how they needed to dispose of the social, to get on with the present. This is indicated in their talk about talking with patients and the ways in which they characterise their methods of assessment discussed at length at the end of this chapter.

Some of the nurses refute the idea that age affects their nursing care. For example, Sister 1 and Staff Nurse 5 believed that as they primarily nurse the condition rather than the patient, and that this constitutes a fair and rational way of going on, then it follows that any patient, no matter what their age, is treated by them in the same way.

However, they both gave the proviso that this depends upon whether the patient's medical condition is being actively treated. For example, Staff Nurse 5 was asked if she thought the needs of the elderly were different in any way from other patients. She stated that she thought that the elderly "are very much judged on their own merit" and "should have the care that they require" given their medical condition no matter what their age. She allows a difference if "they are not to be treated", if they are "not for resus [resuscitation]", in this case then their nursing care will be different from that which would normally be

given in the circumstances of a particular medical condition:

> **Staff Nurse 5** - You know, em, because if, perhaps if they have a massive M.I. and they weren't going to be treating them, perhaps more onto diamorphine or something to settle them and keep them more comfortable rather than saying "Right here's a wee book, read about your heart attack, take things slowly"; you know I think if both are being treated irrelevant of age you have to go through exactly the same for both, because it's going to affect their future life. I must say I don't think age should come into it, they're here to be treated, you give them the care they need no matter what their age.

From Staff Nurse 5's response it would appear that she interpreted needs in terms of medical condition and whether the person is to have a "future life". She is projecting an image of herself as someone fair and making rational decisions. Sister 1 responds in a similar way when asked about how she felt about nursing the acutely ill elderly patient in the present environment:

> **Sister 1** - Well if they [an elderly person] come in with an acute illness they are nursed as though they are, if they've an acute illness it doesn't matter how old they are. Frankly because you are always looking to get them well and home. And it doesn't matter whether you are nineteen or ninety, if you've the prospect ahead of you it doesn't matter how old you are, they come in, they're treated and they go home.

In Sister 1 's response there is the notion of being treated fairly, according to your medical condition, regardless of age, but with in some tacit way the future acting as a condition of possibility. There is the tacit understanding here that "if you've the prospect ahead of you" then you will be treated fairly and squarely, and the nurses adjust their care on that basis.

The prospect ahead of you and the notion of treatment seem to be interrelated with the assessment of the older patient's home situation and their usual capability, already discussed earlier in the chapter. The implication is that with age comes a difference in the treatment of patients which is dependent upon assessment of a patient's future prospects.

If the nurses are, as they seem to claim, mainly nursing in response to the patient's medical condition - their symptoms and their treatments - this raises the question as to what happens when these are no longer operational, when the doctors are not actively treating a patient. Sister 1 talks about this when she talks about the elderly in terms of those patients who are long term. Her response to how she feels about the elderly being nursed in her ward is to discuss the elderly who are unable to go home:

> **Sister 1** - I find it very difficult because I honestly don't think it's the right place for an elderly person to be if they're not ill. Because they're low priority in an acute hospital, em, they are not given the time they need. And we tend to, Bay 4 is Bay 4 [the Bay that the long term patients are put in].

> Rarely changes. It's very basic nursing care, and basic nursing care is all they get for most of the time. Because the priority are the, em, acutely ill, whether they're young or geriatric they need more nursing time than somebody who is 91 and waiting for a long term bed in a geriatric ward. It is certainly not ideal, although most of these ladies have come in with an acute condition and very soon after they've arrived their acute condition has resolved and they are back to their em best, which often is a chronic senile dementia. And once they're in hospital you really find out how unable to cope in the community they are so that you don't send them back out. And they're left to sit in an acute medical ward waiting for 18 months to 2 years for a geriatric bed.

What appears to be implicit here is that senile dementia and the other problems of old age which leave their traces in the present and leave a person unable to cope in the community do not constitute 'illness' in the present context. Sister 1 later explicates at my request her distinction between the acute patient and a geriatric patient:

> **Sister 1** - I think loosely the term geriatric is used by most people for a lot of people over the age of 65. But I find there are some geriatrics who are only forty.
> **JL** - What do you mean by that?
> **Sister 1** - Well it depends upon the person, there are some very young, mentally young 90 year olds who I would never describe as a geriatric, I would say they were elderly. Geriatric I would say are dependent people, elderly dependent people who need a certain amount of nursing care.
> **JL** - Physically?
> **Sister 1** - Physically dependent. Ladies who are confused...

For Sister 1 confusion and dependency are indicators of 'being geriatric'. The suggestion being made in the present study is that Sister 1 cannot dispose of these people easily so that they have a negative connotation for her. This in turn acts recursively on her approach to any older patient as potentially someone who is dependent or confused. This is partly why she pays attention to an old person's 'social situation' - she is checking for signs of problematic exit value. Her notions about older patients are paradoxical: as the organizer of the ward they have the potential to get in the way, to become bed-blockers. This relates back to the issue of value: how the past gives value to the present in terms of disposal. Patients whose ability to cope in the past gives an indication, despite the current episode of illness, of their being able to cope in the future (with or without support) have a positive value, they have a best which is worth aiming for, which is possible. What is interesting is how little the nurses mentioned the possibility that the current illness can cause the patient to have a negative value - to become unrehabilitable within the abilities of the current ward, whose nursing staff see their priority and raison d'être as the care of the acutely ill.

The following section is concerned with how the nurses talked about how "quality of

life" could affect decisions about patient care. This continues the discussion of how nurses constitute patients in relation to their medical treatment and the "prospect ahead" of them.

"Quality of life"

Staff Nurse 5 referred to how she needs to know how someone is in "their self" in order to decide how to proceed with their nursing care. The issue of knowing how someone is in their self is problematic.

When talking about "looking" and knowing how someone is (discussed at length below) the nurses were often talking about judging a patient as an experiencing self from the outside, from the visible. They refer to knowing whether someone is in pain, whether they are anxious or confused by what people had told them, just by looking at them. These aspects of a patient's situation are not seen as unimportant by the nurses interviewed, but their is a level at which they are seen as *separate* from the central focus of their activity, getting them "well and home", as Sister 1 put it. However, they are also constituted by nurses as having the potential to impede recovery and a satisfactory outcome: discharge, preferably home. The exceptions to this arose where some of the nurses were discussing decisions to treat patients or not: in these circumstances the notion "quality of life" was raised. Nurses were suggesting how they may inform their understandings about patients within a relationship of proximity, as opposed to only taking an *objective* view of patients.

In their interviews two of the Staff Nurses talked about a patient that the medical staff had decided not to treat. The nurses had been consulted for their 'opinion' as to how the patient should be managed. But both these nurses were against the decision not to treat because they felt that the medical staff had made their decision based upon their assessment of a patient's "quality of life", when the medical staff, they felt, were not in a position to judge this. They did feel that they were in a better position to judge a patient's quality of life. Here Staff Nurse 3 is talking about this patient, Mona:

> **Staff Nurse 3** - ..I can appreciate that it is a very difficult decision [not to treat the patient with anti-biotics] but, em, I don't feel that, the medical staff were saying that she had no quality of life etc, but I feel that I don't think it's up to them to decide, in her case, and I think that em, I feel that she should have been treated.
> **JL** - When you say quality of life with Mona, you think she's go.., her quality of life warrants her to continue to be treated. How do you know that?
> **Staff Nurse 3** - Well, for a start I think she was happy enough. She, I think she was quite content, maybe you or I or one of the doctors wouldn't be happy sitting in a chair in a ward all day and probably having to go into

> some sort of an institution for the rest of your life but I don't think, em, in her case, I don't think she would have minded that. And I feel that, I just feel that she should have been treated, I don't think the medical staff ever saw her as we did either, like em, one of them said yesterday, she was shouting out quite distressed yesterday and I sort of went in and asked for her to be written up for opiates, and he said 'Oh yes, that's the first time I've heard her even speak, she's just sat there mute for six months' and I said 'That's rubbish, she has not'; he says 'Oh she just used to sit there and stare into space the whole time'; I says 'Well, you don't know her very well then'.

From Staff Nurse 3's talk here she interprets "quality of life" as being associated with how a person feels about their life - "happy enough", "content" - and with what *their experience* is of their situation -"maybe you or I or one of the doctors wouldn't be happy...but I don't think she would have minded that". The question arises is how did Staff Nurse 3 *know* how Mona felt, or how did she think she knew? The implication is that she experienced the person 'Mona', that by being with and seeing her in a certain way, Staff Nurse 3 has constructed her identity in relation to something other than medical or nursing discourse. That she is informing her view of the patient with understandings derived from a relationship of proximity [Bauman, 1990] with Mona: Mona has a face, is an authority without force [Bauman, 1990, 1991].

Staff Nurse 3 mentions how the doctors have allowed their understanding that Mona's family could not take her home, to influence their decision, but how she would not allow it to influence her view -

> **Staff Nurse 3** - and I think what annoyed me more than anything else, was the fact that they said they were going to stop them [the anti-biotics] because she had poor home circumstances and her family couldn't take her home, and I don't think you should base your criteria on whether to treat somebody or not on what sort of home circumstances they have. The way they were saying was almost as if she had had a caring family that were willing to take her home then they would have carried on the anti-biotic treatment.

Staff Nurse 3 is claiming that the fact that the patient could not be disposed of affected the medical staff's decision not to treat her. It should be noted here that this patient was 54 years old, she was in the category termed 'young chronic sick', for whom there is very limited provision in the district concerned outside of placement in a long term geriatric ward or their own home. Staff Nurse 3 sees allowing this aspect of the patient's situation to inform any decision about treatment as wrong. Later Staff Nurse 3 claims how she is not "one of these people for treating everybody, you know I wouldn't, if she was riddled with cancer or something I would be the first to agree with just letting her go". So, for Staff Nurse 3, knowing how to care for someone includes judging a person's situation in some

way on its own merits, and this can only be done if you know how that person experiences their situation through being with her. This nurse said she was left feeling "sick" that there was not more she could do for this patient.

Staff Nurse 2 also talked about Mona. She was also very upset because Mona had not been treated. She felt that the decision had partly been made because Mona had nowhere to go, but would be on a waiting list for part four accommodation or long term care:

> **Staff Nurse 2** - Yes, because her quality of life was actually quite good. I mean I'm not one for treating people whose quality of life I feel is poor, you know, but I, em, I thought her quality of life was really. Maybe, what, six weeks ago she was very, she seemed happy within herself and although she was a blocked bed, which is what they're probably thinking about, her quality of life was good, and I don't think we had the right to turn round and say you know 'tough, you've got a chest infection, tough, you're only 54 we're going to let you linger and linger and linger'.

Staff Nurse 2 felt she knew what Mona felt like "within herself", that she was "happy". This is her criteria for judging that Mona's "quality of life was actually quite good". Staff Nurse 2 also believes or suspects that the medical staff are allowing the fact of disposal to inform their decision about Mona: "she is a blocked bed". Staff Nurse 2 is not as annoyed at this aspect as Staff Nurse 3, her own use of metonymy here indicates that she can understand how this would be taken into account: Mona is reducible to the status of her bed-state. But what Staff Nurse 2 sees as the problem here is one of communication with the doctors - that they did not *know* Mona as well as the nurses did, they had not experienced Mona the 'person', and that they did not take into account the view of people who did know, the nurses:

> **Staff Nurse 2** - Because we know Mona better. The way that they can assess quality of life from the end of the bed is different from the way that we can assess quality of life, when we see her at half ten at night sitting down in the day room having a really good chat and a joke, she's a very, very witty lady, you can enjoy her company.
> **JL** - I noticed this morning that you joked with her a lot. You mean she's a sociable person?
> **Staff Nurse 2** - And, eh, even with the [.?.] at the hospital she was, when she was more well, one of the more sociable patients on the ward, and the younger, you know when we had [.?.] we had a lot of young people in, you know, they really enjoyed her company.

Both nurses feel able to judge someone's quality of life because they feel that they know the patient as a person and that this is important. The difference arises through their proximity to the patient: doctors are attempting to assess quality of life "from the end of the bed",

while the nurses are closer to the patient, they have experience of her in a relationship of proximity. In this relationship she comes to matter as one who makes others laugh, and with whom one can have a conversation.

As stated in previous sections the nurses do not usually count their feelings about patients as persons as in any way relevant to their assessment of patients. On the contrary they pride themselves on not taking patients personally; the personal, as indicated in the handovers, only enters as a tag end to the main focus of nurses' assessment of patients medical condition and their capability ('he's a poor wee soul' or 'she's a nice lady'). The nurses are in their discursive practices on the whole uninterested in the individual person.

A critical aspect of their talk is that neither Staff Nurse mentions what, if anything *Mona* had said about her situation - there is a sense in which she has not participated in their assessment of her except as a person whom they have observed and experienced and about whom they have knowledge. They both talk about how they see her or feel or think about her, but they do not relate what she sees or feels or thinks about except as they see these aspects of her. Mona's self-identity is constructed through their appreciation of her, and through what they believe to be her feelings or experience of her life with them. Another critical aspect is how both the nurses condemn allowing the possibility of the patient's blocked exit from the hospital to inform judgements about how patients are treated and yet both claim that this was how the decision not to treat was really arrived at.

Staff 4 also raised the issue of "quality of life" in relation to information she required to enable her to care for elderly patients. She saw herself as in part protecting the elderly against unnecessary subjection to diagnostic techniques, where the medical staff had no intention of treating them:

> **Staff Nurse 4**: ..I feel very strongly about tests being performed on elderly patients if they're not going to act on the results...But I think a lot of that stems from where I worked in that it was a geriatric hospital were I worked and the approach to care was quality of life rather than maintaining life at all costs regardless of what I put the patient through.

In this extract, Staff Nurse 4 is advocating using "quality of life" as a measurement in some way, an approach to management of older patients, the implication being that "maintenance of life *at all costs*" is somehow what moves the approach to care in the present ward. Like the previous two Staff Nurses the issue is raised in connection with a difference in their way of seeing things from the medical staff's way of seeing things. The notion "quality of life" introduces both an ethical and *subjective* dimension to judging what older patients need which is contrasted to the 'rational' and 'fair' way of going on where all patients are treated

according to their diagnosis, regardless. This is of course very dangerous ethical ground.

In the following extract Staff Nurse 4 uses the same patient, Mona Barnes, to exemplify her point:

> **Staff Nurse 4** - You know because your general medical wards are, em, you know the age groups well over 65. Em but that is basically what is wrong. But I think the medical staff need some education as well on that line as to what are we here for, are we trying to maintain life at all costs or are we trying to maintain quality of life.
> **JL** - When you say quality of life what do you, how do you go about assessing for the quality of life?
> **Staff Nurse 4** - Em..
> **JL** - Again using an example if you ...
> **Staff Nurse 4** - Well for example Mona Barnes, now she's 54. Now you would look at your age and you would think 'we should save this woman at all costs' but you then say to yourself 'what are we saving her for?' She's literally, I mean, vegetating from all the medical problems that she's had. So we had to draw the line and there was obviously a decision made somewhere along the line as to stop sort of active management with her. Em, and the decision is made to keep that patient Mona Barnes comfortable. And to me that's a more sensible approach in her case because we're maintaining her quality of life, we're keeping her comfortable, at the end we're letting her die with dignity and in comfort, which is two of the most important things.

Staff Nurse 4 had only joined the ward four weeks prior to her interview and may not have known Mona when she was "happy", which was, according to Staff Nurse 2, about six weeks ago. Her view of the patient is completely different from the other nurses' - she sees her as "vegetating" and that the decision to stop "active management" was a correct one, morally, because it is a more "sensible approach" because "we're maintaining her quality of life". At this stage "quality of life" is constituted by "keeping her comfortable" and "letting her die with dignity and in comfort". The significant issue is that this nurse who had not been close to Mona when she was happy and communicative, has a completely different view of Mona from her colleagues. She *sees* Mona as vegetating from all her medical problems.

Staff Nurse 4 goes on to explicate further what she means by "quality of life":

> **JL** - Say before that, you know say maybe its not a matter of life or death.
> **Staff Nurse 4** - Well quality of life could be physical quality of life, good physical state, your health is important, em, you, a lot of people look on it if you haven't got the health you haven't got anything, so quality of life from the health point of view is em, I'm getting a bit muddled up with what I'm trying to say. If somebody presents with a problem you want to get to the root of the problem and obviously tests etc. have to be carried out to find what the original problem is, em then they come to a diagnosis of the patient. They come to a diagnosis that the patient can either be treated or

the patient can't be treated. Right, so can the patient be treated and still have a good life afterwards. I'm trying to think of what I'm trying to say, cos this quality of life keeps coming in to my mind and I'm trying define what I'm trying to say.
JL - I mean how would you go about deciding, you know. deciding on somebody's quality of life, you know, how do you judge that?
Staff Nurse 4 - Well its very difficult to judge an individual's quality of life because what might be a good life for one person might be unbearable for another.
JL - Right.
Staff Nurse 4 - For example somebody who's got everything to live for, you would possibly want to fight for them at all costs, whereas somebody living on their own who has nothing to look forward to, not that I'm saying that would be used as a judgement whether or not to treat somebody... em... Just somebody's overall lifestyle probably, if they've got family, you know if they've got friends, a good social life, em, I don't know, I'm not really making a very good job of what I'm describing, what I'm trying to say.
JL - No, I would think its an extremely difficult thing to pinpoint. I mean you've said just now that part of it is, for one person what's good might be for another... So really again you're saying again its the context for that...
Staff Nurse 4 - For the individual.
JL - Which you have to.... So how, I mean when one of the consultants is on the ward round, does he know, does he know the patient well enough to be able to make any sort of, how does he ...?
Staff Nurse 4 - See its very difficult to make a decision on seeing on, who makes the final decision as to whether or not to treat a patient or not to treat a patient. I think its a team decision because everybody has an input. Em, I suppose if I was asked an opinion and somebody said to me you know 'Do you think we should give this eighty five year old patient a right hemi-colectomy in the hope that she'll be improved from whatever. What do you think?' Then we have to weigh up well at the end of the day will this make the patient's life any better by going through major surgery. Em, and then you have to weigh up well, what's the patient's life like without the surgery? So its a very difficult decision to make about any patient. But certainly if I was asked the question those are the things I would take into consideration 'Is it going to make the patient's life any better?'
JL - Right. And how did you know that?
Staff Nurse 4 - Probably because I think its my responsibility to know about the patient before they came into hospital and what their lifestyle was like before. That's why I like to get an overall picture of their whole life before they came and before this most recent episode that brought them into hospital. And em, if I thought if it was going to be always major surgery, everything to go back into a situation that was worse than they came from, then I would say, you know, in my point of view that it wasn't the best form of treatment.

Staff Nurse 4 in attempting to pinpoint how she goes about judging someone's quality of life reveals what she means by that: it is what someone's life means to her in terms of what it might mean to them. Mona Barnes, the same patient discussed by Staff Nurse 2 and Staff

Nurse 3, according to this Staff Nurse is "vegetating from all her medical problems" and is 'not fit to live' so to speak. Being fit to live, having a social life (in the fullest sense of the expression), a family, people to care for and to care, is part of quality of life. She then says that you have to know what a life means to the person who is living it - what is bearable for one is "unbearable" for another. The essential aspect for her is to "get an overall picture of their whole life", particularly their past, in order to situate her judgments. You have to *know* what their life *was* like to be able to judge what the best form of treatment is for them, taking into account how it will impact on them in the future. And this can only be a team decision. Her thinking, as she admits earlier, is deeply interpenetrated by geriatric medical and nursing discourse: the patient remains the object of her gaze, they do not act, they do not, in her discourse, participate in any decision-making process. And in contrast to the other two Staff Nurses she does not take proximity to the person as critical to knowing a patient's quality of life. She describes a way of assessing a patient which is at a distance, but which constitutes a rational way of going on: the issues are weighed up, feelings do not enter into it.

Knowing what a person's life means to them and experiencing and having feelings about patients enters the nurses' discourses at the point where there is a question mark over whether their life is worth living or not. This question for Staff Nurse 4 is automatic where older patients are concerned, according to her account it is constantly used to offset decisions about treatment in the Geriatric Unit in which she worked.

The questions raised by the analysis of the nurses' accounts so far are how do nurses go about finding out about patients, how did they characterise their methods for making their assessments of patients in relation to the matters already discussed? These matters are now discussed in relation to talking and to looking.

Talking with Patients: Time, Disposal of Feelings and Persuasion

Some of the nurses talked about talking with patients in terms of checking how patients were, others talked about talking with patients as a luxury applying to aspects of patients that were not fundamental to survival or treatment issues. There are three aspects of interest here.

First, there were differences in how the nurses viewed the 'place' of talk in their work with patients. None of the nurses saw talk as implicated in fundamentally *understanding* how they might act towards a patient as a nurse, with the exception of the critical case of Mona and the two Staff Nurses. Some nurses saw talk as a method of supporting their

view of a patient, as a way of checking up that they had got it right, or they saw talk in terms of something separate from understanding how a patient was or what they needed, but related to what a patient needed to do, to what patient's wanted, how satisfied or unhappy they were.

Second, there was a tension for some of the nurses in that they knew that talking with patients was problematic, in terms of *time*. None of the nurses mentioned spacial arrangements as making talk difficult.

And third, talking with patients emerges in their accounts as a method of persuasion. This is connected to the relieving of patients feelings. These three issues are now addressed in turn.

The purpose of talk with patients was described variously. What is interesting is that the nurses rarely mentioned "listening" to patients in their interviews. Talk with patients was characterised in the following ways: as "chat" and as method. Talk as method was applied by different nurses to different situations: reassuring, crosschecking how a patient was, getting information about how a patient usually was and their 'history', explanation, socialising and valuing.

Talk with patients for some of the nurses was directed at getting the patient to support what they could see "just by looking" or what they had been 'told' about a patient by the medical staff or at the nursing handover. This is demonstrated by Staff 4, in her example of the patient whom she was told was a physical wreck but who she then saw was "capable of quite a lot". Staff Nurse 4 describes how in *talking* with the patient and her daughter she supported her own view of the patient which was in direct conflict with what she had been told by A&E staff about the patient (see the section on 'capability' above and on 'looking' below).

Staff Nurse 1 also described how she could see "just by looking" at a patient if they were in pain or anxious, but that she would ask the patient, "You know, how are you?", to check that what she saw was correct. In this sense the auditory is used to reinforce the visible: it is something the nurses say they do to make sure they have 'got it right'.

Within the confines of the ward routines some of the nurses described how they did make spaces to give time to talking to patients in relation to assessing patients: checking how patients were in relation to their medical condition and to their treatments or more generally to see how they were. An example given by some of the nurses was how they transformed the medication round into an assessment round. Staff Nurse 4, Staff Nurse 2 and Sister 1 and some of the Ward Two nurses mentioned using the drug round to 'talk' to

people. This is an interesting transformation of a routine activity which has already been discussed in Chapter Six: the giving of medication is transformed by them into a time to get information or to check up on how the patient is. Staff Nurse 4 described using the drug round in this way as follows:

> **Staff Nurse 4** - ...I find that's when I speak to patients the most... (is) because it's the only time you're sort of on a one to one interaction.

Sister 1 describes how she uses the drug round to check up on how patients are feeling about their treatment, the medicines which they are on. While Staff Nurse 2 claims it was the time she could do a "very, very crude assessment of patients":

> **Staff Nurse 2** - Speak to anybody, just check how everybody's been and everything, you know fairly quickly. You don't want to end up sitting down and taking great long, having a great long chat with most people, maybe try and get that in later on, but just check that everyone is broadly speaking okay, and I would already have discussed the observations so you don't really need to check up on the charts at all. But, em, just, you're supposed to do your first round of the patients in the morning when you do your drugs round, just to check that everyone's okay.

In this extract Staff Nurse 2 states that the drug round is "supposed" to be a time to do "your first round of the morning" and that the purpose of this is "just to check that everyone's okay". She also claims that she supervised the other nurses while doing the drug round, making sure they were getting on with their work as she wanted them to. She stresses the limitations of time and how this makes her talk with patients at this juncture limited to making sure they are "broadly speaking okay". What she describes is how she orientates herself to what she has to do for patients in terms of arranging for aspects of their care to be attended to, and prioritising these in terms of urgency. Later she expresses this aspect of her reasons for using the drug round as an assessment round:

> **Staff Nurse 2** - I put away the drugs trolley, sort out in my mind if there's anything I need to speak to the doctor about immediately for what I've noticed or anything like that, or em, any drugs I need up from Pharmacy make sure I've collected any relevant pieces of paper to make sure I can get those up from Pharmacy. Then collect the backing cards [prescription sheets], make sure I get them out and lay it ready and know it in my mind what it is and whether I'm going to get it immediately or later on, that sort of thing. As I'm just tidying up in my mind I think who I've got on and that are in to work that day and which patients I'd like them to look after.

For Staff Nurse 2 then the purpose of this type of "quick check" is to look for jobs she needs to do, like informing the doctor or getting medicines from pharmacy, and to enable her to decide which patients should be looked after by which nurses: it is to help her get herself organized, so that she can "tidy" up in her "mind". There is little sense of the

patients voice having penetrated, although she does claim to recognize how she may need to make time for a "long chat" later on in her shift.

Taking a patient's observations can be another event used for "checking" on how patients are according to Staff Nurse 4. In the following extract she is referring to the example of how she would take a very sick patient's observations herself:

> **Staff Nurse 4** - I would tend to check that patient's [a sick patient] observations anyway, because I maybe had a possible feeling that they weren't well. Not because, just for my own, probably my own peace of mind than anything else. Also it gives you the chance without worrying the patient too much, rather than going up and saying 'Oh you don't look very well' I'd rather say 'Look can I just check your observations' and that way get into have a chat with the patient, see how they really are.

Staff Nurse 4 is describing how she sometimes uses the event 'taking a patients observations' to check on what she feels and has seen, that they "don't look very well". Her "chat" is used to support what she is "seeing", to enable her to see how the patient "really is". Staff Nurse 4 claims she uses the event "taking of observations" to conceal her true purpose in order not to worry the patient. This places the patient in a 'non-participating' position. Further, in this way a quick chat can be used to get specific information and take a closer look without actually engaging with the patient.

Both events, the drug round or "taking a patient's observations", are transformed by the nurses into something more than their ostensible function. I would like to suggest that these events have a built-in focus and closure, both physically and in intention, which enables the nurse to engage in talk with patients but also to control that talk and focus it on the nurses' concerns rather than engage with the patient. As Staff Nurse 2 states, she does not get into long conversations with patients, "all the ins and outs of what they've been thinking about". The interactions are by admission purposeful, they enable speech but which is in support of some form of observation, some sort of "checking up" that all is going well or for the presence of specific problems. These methods control patients' *access* to nurses even though the nurse is proximate to the patient. These matters are elaborated further in Chapters Nine and Ten.

From the interview material, and from the observation of the nurses at work, 'going on' in the present ward for the nurses was partly constituted by the knowledgeability that getting through the routine was a priority. The nurses in talking about their priorities and their relationships with patients revealed that the 'routine', that is getting the hospital's facilities and some sort of nursing care delivered to patients, and talking with patients to identify what nursing care patients required were antithetically related. The problem here is

the extent to which the nurses, on being interviewed, were being *reminded* of holistic nursing discourse on patient care which advocates patient participation and 'knowing the person'. In giving their accounts of themselves they may be rationalising their work methods and felt the need to reveal that they knew that they should work differently but that they could not, or whether they genuinely believed that involvement with patients, hearing patients and knowing what nursing care patients needed was intimately related.

Some of the nurses characterised talking with patients, where this was identified as a patient's desire, as almost a luxury: given the important priorities of the acute ward, such as getting through the work, supervising junior nurses, administering drugs, attending to immediate safety aspects of patient care and doctors rounds, talk *for* patients was something they really could only afford if it was really necessary. Staff Nurse 2 talked explicitly about time and talking with the patients.

Staff Nurse 2 was able to give a picture of what her priorities were and how she had to act to fulfil these. This gives an indication of what constituted 'going on' [Giddens, 1984] as a staff nurse in charge of the ward. This is typical of the overall impression given by all the nurses as to what constituted 'going on' in the present context. In her representation of herself and how the ward was organized, she treads a fine line between ambivalence toward her role and exhibiting a kind of street wise attitude to nursing practice. Staff Nurse 2 believed that as a charge nurse in the present situation she has to prioritise the routine aspects of her work, as opposed to "doing what patients' want" or even "need".

> **Staff Nurse 2** - But it's difficult when you're in charge because you end up with, you can only talk to people you feel particularly need to be spoken to, and your assessment of that might not be quite right, you might not pick up on the people that do need to sit and chat to somebody who can answer their questions, and what have you. So it's something I try to do but it's sometimes difficult, especially it has been recently to find the time to - maybe we have false priorities, we think that everybody wants to be washed, maybe that's not the case, maybe some people don't want to be bothered about being washed. You know, we think we've got to do that!

Staff Nurse 2 claimed that patients are nursed to a great extent according to the routine. During the interview she revealed that she believed at one level that it was only through working with patients, getting to know them and talking with them that she could really understand their needs. However, as a staff nurse she could not always achieve this kind of contact, she stated that it was the students who had close relationships with patients. Ironically, the more junior the staff nurse the more often they were in charge without other trained nursing support and having to deal with all aspects of ward management, so that they

did not get much time to 'nurse' patients directly. And yet as already stressed in Chapter Six, there was no formal or systematic approach which ensured that the student nurses' views of patients could be heard.

Staff Nurse 2, as did most of the trained nurses, said that she relies on students to report any problems with their patients, such as a change or problematic observation to her. Otherwise she assumes that they have got through their work without any difficulties as instructed in the nursing report and as witnessed by her in her constant, if hasty, surveillance of their progress during the shift. There was no sense in her talk of finding out from students about what they thought about or felt about patients in a general way.

As Staff Nurse 2 stated above she thought the ward's priorities may be false, but that "we think we've got to do that". Staff Nurse 2 felt her priorities had gradually changed:

> **Staff Nurse 2** - ... you're either directly or indirectly responsible for what's going on, it's hard to say - when you start off you say 'well I would want to do what the patient would want me to do'. You know, if the patient wants me to sit and blether for half an hour well I would want to sit and blether with them and then you know, but in reality within the constraints of the ward, the ward routine and the set routine and what other people are expecting of you, need from you -
> **JL** - Other people being?
> **Staff Nurse 2** - Other patients, medical staff, other learners, and what have you - you tend to end up in a routine and you know, you get somebody up, you give somebody their breakfast, you make somebody's bed, and then you help them to wash, you know, whatever. Wash them whatever it is.

Staff Nurse 2 locates the change in her to her adaptation to what she called "reality". "Reality" was constituted by the "constraints of the ward", "the ward routine", and "what other people expect/need from you". "Reality" was not directly constituted by patients' needs. She saw her adaptation to "reality" as a part of her "socialisation".

> **Staff Nurse 2** - ..I think you gradually become socialised into the system and nursing. You know, nursing's a routine.

For this nurse prioritising the routine is related to what she believes to be the nature and purpose of the hospital. There is a fundamental expectation that the ward staff would ensure that beds were available when it was their turn, and to be in a state of readiness to deal with emergencies as they arose.

> **JL** - ...To get the routine through is your priority?
> **Staff Nurse 2** - It, to a certain extent it is, and sometimes I feel very guilty about that and I think 'that's ridiculous, that's terrible', and then at other times I think 'but we are, this is an acute hospital and you have got to be in a state of readiness, for an emergency, or for a turn of events'.

What this staff nurse knows is how she needs to behave to be 'nurse in charge', she has to

get through the routine. For her this was legitimated by what she believes to be the nature and purpose of her work in the acute hospital. She stated later in the interview that this frequently conflicted with what patients wanted and sometimes needed. She claimed that this left her with feelings of "guilt" and "frustration", although she is able to rationalise her actions to some extent by saying that the patients themselves need routine and quickly adapt to it.

Staff Nurse 2 may have been attempting, in some of her comments, to present a 'nurse' whom she thought would be more acceptable to me, the researcher, than the nurse I saw at work. I had been observing her at work for close on three months and her report of her self and her priorities was congruent with the impression I had of her as she went about her duties. Her beliefs about her activities and the rationalisations she made exemplify the 'image' she had of herself as someone both *acting on* the world (patients, students, the ward) and as someone being *acted upon* by the world ("socialised", the demands of others, the system), in the name of something larger than herself - the need to be ready to cope with the Acutely Ill, by having beds available, by being in a state of readiness.

It should be noted at this point that not talking with patients was not particularly verified by observation of the nurses at work: nurses did talk with patients while doing other things for or to them, such as a wash or walking to the toilet, but talk was mainly concerned with chat or focused by nurses on the job in hand. What I think the nurses were aware of was that their talk was not particularly meaningful, what they were not aware of or were not admitting is the extent to which they acted to avoid meaningful talk to control patients' access to them.

The question arises as to when do the nurses prioritise talk with patients: when does it become a necessity? It emerged that in the nurses' views a patient's need to talk can stem from their need for information or explanation or for their need for reassurance because they are worried or anxious. For example, in her interview Sister 1 said that she thought that the patients felt "neglected", because they usually do not get a chance to talk about what is worrying them until whatever it is long past.

> **Sister 1** - ... but generally we just don't talk to patients. We carry out our work procedures, you know, bathing, feeding, washing, dressing, and that's basically all they get, when there are five or six people on. It's nice when there are more staff on, then the patients don't feel so neglected.
> **JL** - Do you think they actually feel neglected?
> **Sister 1** - I'm sure they do. I'm sure they, the ladies there, constantly they say 'Nurse, nurse, Sister can you come and speak to me?' and you say 'I'll be there in a minute'. Now when you do that to a patient you do try and get

> back within five or ten minutes but very often you don't and very often it's towards the end of a shift you think 'my God, Mrs So and So wanted to speak to me I better go and see her' and by that time she's gotten over whatever crisis she was going through and she didn't really need you then. But when there are enough staff on, I find I can go and quite happily chat to anybody.

Here Sister 1 is revealing her priorities and her image of talking with patients. Her image of talking with patients is of something separate from her ongoing activities, which take priority over talking. She does not count all the activity around a patient as a kind of language of care. Nor does she mention talking with patients at active times - when giving a bedbath, for example. She constitutes talking with patients as something separate from the mainstream of caring for patients.

Sister 1 is characterizing talk as something the patient needs to do rather than as something she needs to do to help her know about what patients need: talk is associated with a 'crisis' or 'worry', as the patient's need for reassurance or information, and as extraneous to any assessment of the central nursing issues. Here Sister 1 is articulating something which was present in all the nurses' accounts, on both wards, and which was present in their encounters with patients and in their talk about patients at handovers.

Further, the revealing aspect is Sister 1 is suggesting that typically the patient can sort it out for themselves anyway: "and she didn't really need you then". The implication is that 'neglect' here is not professional neglect, that 'not talking' with patients does not constitute any grave impediment to delivering the goods - nursing care - but that it is something patients 'feel' the need of, which is not really of any momentous importance, because they get over it by the end of a shift.

When asked to give examples of when she had lately talked to a patient, Sister 1 gave two examples of patients expressing their fears and worries about their situation. Here are the two examples Sister 1 gives:

> **Sister 1** - Like Dolly Mullen she vomited up her naso-gastric tube last night and she was feeling very depressed this morning so I had a long chat with her and she feels, she's a very inadequate young woman, and she feels, who feels that, I don't really know, she thinks that she ought to be doing better and can't understand why she's not getting well. She's got very low self esteem for some reason...I asked her how she was feeling and she said she was feeling absolutely dreadful. So I just sat there with a sympathetic look on my face and she just poured out her heart, told me everything that happened that night and that she was waiting for the doctor to come, so I reassured her that Bob Richards [the doctor] would come up and pass a tube and we would try and start again. And she seemed reasonably content with that, but even though she says a lot, speaks a lot, she doesn't actually say a

great deal. But she's very worried - that comes across.

****

Sister 1 - Mrs Garvald who's very concerned about, em, her ill health and her ischaemic heart disease. Quite concerned about what's going to happen to her young son if she should die. So we sat the other day and discussed that. A lot of people when they're in hospital their past comes back to haunt them for some reason, they sit and think, they've got nothing else to do but think about but themselves and become introspective and think about - Mrs Garvald is a case in point, she started telling me the other day about her husband used to beat her up. And that he'd left her, and then she couldn't understand why she was telling me about it because he left her maybe fifteen years ago and hadn't spoken to anybody about it for a while but felt that she had to get it off her chest [laughs]..So she was worrying about her past life when at the time she was actually having a myo-cardial infarction. Not worried particularly that she might die there and then, but she had been thinking about it and it had been worrying her more than anything else, or so it seemed to be.

From these examples it would appear that talking with patients was for Sister 1 a patient need and was intimately bound up with them *disposing* of their negative feelings. While Sister 1 expresses how she understands that both patients were very worried and upset she is in a sense non-plussed by both of them: Dolly Mullen is judged as a "very inadequate young woman" with "low self-esteem" and Mrs Garvald is named as "introspective" with a past which she allows to haunt her at a time when she should be worried by the present. Both are anomaly for Sister 1, they exist like they do "for some reason" which she cannot comprehend. It is as if it is only in relating these stories that she begins to make sense of them: when people are in hospital they have "nothing else to do but think about themselves and become introspective". Worrying about the "self" happens when a person has nothing else to "do", when they have time on their hands: the self does not bare reflection until the 'taken-for grantedness' of a life, doing, is interrupted by illness, something extraneous to the self. Sister 1 does not appear to have taken account of Mrs Garvald's concerns for her son, who would be left alone if she died, which Sister 1 seems to have believed was a definite possibility. Sister 1 sees Mrs Garvald in relation to the risk to her life in her not attending to the present.

At some level Sister 1 takes the talk at face value and translates it into manageable terms, those of her 'role', here as the giver of reassurance. She does not appear to see what the patients are talking to her about as creditable in terms of influencing or informing her ongoing relation to them in terms of the nursing care they require. Reading between the lines Sister 1 is using talk as a method: she has implicit knowledge that there is a danger

that emotion may get in the way of smooth recovery or compliance with treatment. Dolly Mullen may be fed up with the naso-gastric tube and refuse reinsertion. While Mrs Garvald may upset herself so much that she exacerbates her heart condition.

While these examples of talk are like interludes or interruptions to Sister 1's everyday work, there is also a level at which it would appear that letting the patients talk helps prevent difficulties: refusal to comply with treatment being a potential problem or being so worried or upset that the condition is exacerbated.

These people require Sister 1's valuable time because they need something extra: time spent on reassurance. For Sister 1 "pouring out her heart" and "getting it off her chest" are ends in themselves. She is expressing a belief that this enables the patient to dispose of their worries and bad feelings, which gives her the permission to dispose of the episodes as revelations of bad feelings, to be got rid of, so the business of getting them well and home, by having smoothed the way for the doctor to pass a tube or the avoidance of undue strain on the heart, can be achieved.

Apart from these aspects Sister 1 does not appear to be able to account for how she can allow, or to know how to allow a patient's experience or feelings to situate her judgement about a patient in terms of their nursing care requirements. There is no doubt that what she has heard will affect her judgments of patients and her behaviour towards them in the future, but not necessarily reflexively. The point is here that talk is used by Sister 1 to dispose of bad feelings to make way for the treatment or recovery process to continue. As mentioned in Chapter Six patients' past life, their fears and worries, were rarely discussed at nursing handovers nor written up in nurses' reports - they were not usually accountable topics.

As can be seen from Sister 1's statement above, talking with patients took lower priority than what the nurses took to be more pressing work. Only on occasion does talk take its own priority as the supplement to self-discipline to gain control. In Chapter Six it has been suggested that nurses use routines to instruct patients to restrict themselves and not articulate their wants except in exceptional circumstances. In later chapters how nurses control patients' access to them and instruct patients through their talk and activities to discipline patients is discussed at length. It is in this respect that I would like to suggest that in the nurses' accounts there is also indication that the nurses use talk to control patients through 'persuasion'.

An aspect of talk was related for some of the nurses to what patients wanted and to compliance. It emerged that for some of the nurses talk helps persuade patients. In the

following extract Staff Nurse 5 was talking about how she makes decisions about care:

> **Staff Nurse** 5 - I tend to rely quite a lot on the patients and how they feel.....Obviously I listen to what's the matter with them at report - em - but I go over to them and see how they're feeling in themselves, what they're feeling able to do, than having a sort of report saying 'and she's mobilising up and down the ward'. Well I go over and say 'and how do you find the mobilising, do you find it's too much?'. I will go over it with them and just see how they're feeling in their self and what they're able to do, particularly if they have been on bedrest for a while and it's their first day up walking. So I rely a lot..when that's possible I rely on the patients to tell me a lot, and then I take it from there and use my own judgement. Obviously with the medical staff, if they've got an M.I. [myocardial infarction] or something, we've got the guidelines to go by, and if they're particularly tired and they can mobilise I'm not going to say, 'right you're still mobilising up to the toilet', you know, I'll wheel them up, although they can mobilise, I don't see the point of forcing any one. Whereas some people say 'Oh but you know you can mobilise'. I don't see the point. I will ask the patients.

Feelings here refer to wishes and wants and what the patient feels capable of doing. Staff Nurse 5 presents a self-image here of someone who finally decides what a patient needs at the bedside taking the patient's view into account: "I rely on the patients to tell me a lot, and then I take it from there and use my own judgement". Staff Nurse 5 "relies" on the patients to "tell her", it is up to the patient to give her the information she needs to get it right, having "asked" the patient directed questions. While Staff Nurse 5 is claiming that the *course* of care is predetermined according to particular guidelines, how this is implemented can be modified by how a patient is feeling "in their self", what they feel capable of at the time, provided they tell her about that. This is persuasive, it convinces the patient that their feelings are being considered while maintaining the implementation of a plan of care, it helps ensure compliance.

From the nurses' talk the basis upon which people are nursed is some kind of correspondence between diagnosis, recovery and nursing care, provided there is patient compliance. Patients do not participate in the *design* of their care but their feelings and wishes are taken into account at the implementation of care, at the bedside, so that "within reason you just let them do what they want to do" (Sister 1). In this way, according to both Staff Nurse 5 and Sister 1, patients' feelings about their "capability" and their willingness to comply might modify any treatment or nursing care planned for them. This position presumes a particular relationship between nurses and patients, that nurses are accessible.

Staff Nurse 5 and Sister 1 are not really talking about patient participation, in the sense of the patients' experience or knowledge informing nursing care, but about compliance and wishes. The question of compliance in decisions about nursing care is an interesting

one as it contrasts directly with patient participation: the notion of compliance presupposes a normative, pre-determined plan of management for a patient to which they agree and comply or the opposite. Both Sister 1 and Staff Nurse 5 discuss how they decide on their idea of what a patient's nursing needs are according to her diagnoses, symptoms and general state and that the patient either complies with this or does not, and that this is usually un-problematic for patients, they both say they would not "force" a patient to do anything against their will. Sister 1 points out, that most people are only too happy to conform, so their "will" is in harmony with the will of the nursing staff anyway. But talk can come as the supplement to ensure this overlap of wills: talk can be used to persuade.

This aspect of how talking to patients is associated for some nurses with notions of compliance is emphasised by an example given by Staff Nurse 5 of a patient who she claims "would not comply". When Staff Nurse 5 gives examples of talking to patients, she talks about Mrs Keppie:

> **Staff Nurse** 5 - When I took her admission, I think she was admitted on the late shift - em - an M.I. [myocardial infarction] lady who wouldn't stay in her bed, was up and down and up and down. Eh - that night she was up talking with us saying that her husband had died in C.C.U. [Cardiac Care Unit], actually I hadn't appreciated he had died in C.C.U., I thought he had died at home but he had spent a lot of time in C.C.U. And she was concerned that she was going to end up a cripple like him before his death and that she was on her own as well. But she was a difficult -- *because she was not complying with our way that we wanted to treat her and we couldn't get it through to her* that we wanted her to stay in her bed because of her chest pain and because we didn't know what it was. But whether she was trying to prove to herself that 'no this isn't going to happen to me, it can't be what my husband had' - it was more denial she was going through, I don't know, she seemed to think after that she would be able to wangle me round her little finger but she unfortunately found that was not possible. She was not impressed, she refused to speak to me the following night because I wouldn't let her have a bath. [my emphasis]

Staff Nurse 5 is describing how an "M.I. lady", a patient with myocardial infarction, would not stay in bed as required by the protocol for nursing patients with heart attack. What is interesting here is not so much that Staff Nurse 5 is contradicting her earlier claim that she does not force patients to do things that they do not want to do. The interesting aspect is how she uses talk on a patient to attempt to achieve the patient's 'compliance'.

Staff Nurse 5 expresses some interest in understanding this patient in terms of her "motives" for behaving as she did - that it "was more denial she was going through". But there is no evidence of whether, or if so, how she translated her understanding of Mrs Keppie into her nursing care of Mrs Keppie. She describes how a relationship was set up

which amounted to a battle of wills: Mrs Keppie was not going to "wangle me round her little finger" and be able to have a bath. Later, after the extract above, Staff Nurse 5 goes on to emphasise this aspect of the relationship. It is as if she sees the episode as a challenge to *her*, that Mrs Keppie's behaviour was challenging something fundamental. Mrs Keppie was "not complying", her behaviour was "difficult", her life was under threat. Staff Nurse 5 expresses how she believed it was safer for Mrs Keppie to comply with the protocol for a patient with heart attack, because she had "chest pain" and "we didn't know what it was". Staff Nurse 5 said that in fact Mrs Keppie did have a cardiac arrest and was transferred to the cardiac care unit from where she took her own discharge.

The nurses did not generally give a sense of doubting that what they were doing for patients was 'right', even if it was limited by lack of time due to shortages of staff. Staff Nurse 2 said she felt "guilty" and "frustrated" by the way she had to work but she also gave the impression that she was getting her priorities right, that what she did was necessary and 'rational'. The sense was that to deal with the survival aspects of patients was right and proper, and that the possibilities of recovery should always be taken into account. However, experiential issues did not really relate to this central focus for the nurses: the patient was very much to be judged from the outside looking in, in terms of how they responded to treatment, how they were recovering, what they were capable of. If anything, the nurses saw the social, emotional and the experiential as a 'drag' on the technical.

In a sense the nurses acted to 'watch over' a patient's progress from illness to optimum wellness, while at the same time supporting this process with their care and attention to the body's needs. There was really only hasty and snatched interludes for talk and for noticing how the patient was in his/herself, and this aspect really only counted in so much as feelings or 'mental state' could impede a patient's progress. 'Talk' with patients or their relatives was on the whole useful in order to supplement observation, to confirm what was visible to them.

This observation work was primary in the nurses' accounts of how they assessed patients and is now discussed.

"Just by looking"

The nurses talked about getting to know about patients in terms of what was *visible*. "Looking" at patients should be understood as having both a literal and virtual meaning for the nurses. There was in their talk constant reference to knowing aspects of patients' requirements in terms of "seeing", "looking", "getting a picture". While it is recognised here

that in everyday language 'seeing' and 'looking' are used as dead metaphors, in the present context "looking" as method for the nurses had a deeper significance.

Some of the nurses talked about getting to know about patients in terms of a metaphor of visibility, getting a mental picture of the patient over time, as well as literally being able to see what patients needed " just by looking" at them. Sister 1 used the expression "looking after" to denote something akin to knowing by seeing, and that she delegated this aspect of patient care to others: she gives patients to nurses to be "looked after" because they cannot "look after" themselves.

An aspect of the nurses "look" is appraisal of the patient: summing up how they are. In the following extract, Staff Nurse 3 is talking about how she knows what people need from her:

> **Staff Nurse 3** - Well I think a lot of people you can just assess very quickly when they come in, just by the way they act. Usually it's easy to spot if someone's really anxious when they do first come in, em, I think if someone comes in and they're confused or, em, very clapped out or something, you would need to ask the relatives or somebody else with them what they're usually like, but I don't think you can get a full picture straight away, it sort of builds up.

Staff Nurse 3 is making the claim that she can assess "a lot of people" quickly when they come in "just by the way they act". For example, knowing that a patient is anxious can be seen by the way they act, it is easy to "spot". For this nurse knowing whether or not a patient is anxious is important because she believes that some people can get into "such a state that they can actually exacerbate their illness". She says that when a patient has chest pain and is really anxious you would then need to "keep a special eye on them". And, to refer back to the previous section, perhaps use talk to help them get through it.

Staff Nurse 3 does not discuss anxiety in terms of talk and a patient's voice resonance, but in terms of a way of seeing, which is in some way informed and judgmental, in the sense of making a judgement. The expression <act> here may refer to the observable manifestations of anxiety in a patient's behaviour, such as the arrangement of their face and hands, their eye movements, what is called 'body language'. The expression <act> may also include the speech dimension, so-called speech-acts. But Staff Nurse 3 is describing her method of knowing only in terms of seeing, "spot", in terms of what is visible.

Staff Nurse 3 contrasts this immediate way of knowing about patients by "spotting" with a situation where a patient is in some way not themselves, not able to act themselves, that is when they are "confused" or "clapped out". In this instance, Staff Nurse 3 claims, "you" ask someone else who knows the patient, what they are "usually like". Staff Nurse 3

is saying that it is important to know how a patient is "usually" but that certain conditions disenable the patient from "act"-ing as they "usually" are. In this situation she cannot 'see' them 'act' how they are. In this situation she claims that she gets to know about how they "usually" are through talk. But talk in her mind is converted or translated into an image, into the visible: she uses talk to help build up a picture of someone over time. Although this phrase is resonant with the phrase <the mind's eye>, it implies translating what becomes known, through talking with relatives, into thinking as if it has been observed, thinking talk as visible. So, for Staff Nurse 3, even what goes on on the inside of a person - their feelings and experience of the present - is somehow observable, knowable by seeing.

In talking about her priorities when she is 'nurse-in-charge', Staff Nurse 1 talks in terms of "seeing" that patients get their "proper treatments", both nursing and medical. Here she is implicating "seeing" with overseeing, with supervision and surveillance: an aspect of the visible is checking up that what is going on on the ward is what is "proper". Monitoring patients' progress, supervision, feedback and *surveillance* were intimately bound up in the nurses' talk.

Staff Nurse 1 says that her initial way of finding out about how a patient is would be to "look at her". She claimed that she could tell "just by looking at them if they're in pain", but that she would then crosscheck by asking - " You know, how are you?". She also claimed that on doctors' ward rounds, she could "tell just by looking at the patient if they're confused by what they've [the doctors] said, if they're anxious or whatever", so that she would know to return to the patient afterwards and help elucidate what the doctors have said. This nurse, like the previous nurse, is claiming that she can understand some of the patients' requirements, some of what is going on on the inside, by reading their behaviour through looking. She is prepared to cross-check her reading of the situation through talk with the patient, but the emphasis for her was on seeing for herself and reading what she sees as the visible signs of the patient's experience, in her examples "pain" and "confusion" are manifest in behaviour.

Staff Nurse 2 talks about "looking" for herself when she was worried about a particular aspect of a patients condition she wanted to be "observed", such as pressure areas. Seeing for herself here is related to 'knowing for sure'. This nurse felt that only by seeing for herself could she be sure of something. She also discussed how "looking" on the morning drug round enabled her to do a crude assessment of how patients were:

> **Staff Nurse 2** - Oh well it's just a general, I mean anybody who say is looking very breathless or is looking as though they are in pain, or is

> looking, it's just basic crude observations you know, that you've a person with a left ventricular and you've just been told their weight's up and you notice they're sitting gasping for breath, you think 'I'll get something done about this, see about you later'. Just very crude, not all the ins and outs of how, what they've been thinking about overnight, just a crude assessment.

Staff Nurse 2 is inverting "looking": she gives "looking" (like something) to the patient, so that she can "observe" their problem. She announces that this is "just basic crude observations", and contrasts it with what presumably she thinks of as less crude assessment: "all the ins and outs, what they've been thinking about overnight".

For this Staff Nurse there are aspects of assessment which are visible and relate to signs which correspond to certain problems the patient can have, like pain or breathlessness, aspects which she can "get something done about" or "see about [you] later". From what she says later in the interview she is referring here to informing the doctor about the patient. She implies that previous information given to her, relating to the patient's diagnosis and their current 'condition' ("left ventricular failure" and "their weight is up"), directs or gives meaning to what she is seeing, transforming into the technical, her "observation". Medical discourse makes visible what she is looking at: a patient "gasping for breath" contains both *auditory* ("gasping" as sound of <laboured intake of breath>) and *visual* ("gasping" as <mouth gaping open with chest heaving up and down>) information about a patient but for Staff Nurse 3 she transforms both into visible evidence, "observations", which supports what she has been told in terms of the so-called facts about the patient, that the patient has heart failure and that their weight is up. (Staff Nurse 5 explains how they observe fluid intake and output and weigh all patients on diuretics, which usually signifies some sort of heart failure, daily so that they can 'see' if the patient is "actually passing urine").

Staff Nurse 2 takes the evidence as meaning that she needs to do something about it, "later". She does not give any indication of how she translates what she sees into how the patient is feeling about their situation or into some kind of nursing discourse about how she can act directly toward the patient: find out how they are feeling, making sure they are sitting up, well supported, checking if her mouth is dry, giving her a sip of water, comforting her if she is afraid. These 'bedside nursing' aspects do not enter her picture of how she sees herself at work in this situation. Either they are so 'taken-for-granted' that she cannot raise them in reflection, they do not 'enter her head'. Or she simply does not address these aspects, in this context these are the aspects of patient care that get done, ad hoc, by chance, if you're lucky, as a reflex, in the routines.

Knowing for sure by seeing for yourself was also important for Staff Nurse 4. Staff

Nurse 4 claimed that she never really felt that she knew about a patient unless she herself "assessed" the patient from the beginning, because "it's never the same getting a second-hand report". She explicated what she meant by this:

> **Staff Nurse 4** - Even in the case when I am not actually there to admit the patient, which often happens, it's a student that takes the first, you know all the details and things anyway. At some point in the shift I would certainly make a point of going in just to give the patient the once-over, no matter how harassed I was. Em, just looking at their overall state to be sure that they weren't, because I suppose experience you can tell if a patient is looking distressed, or if they're in pain or if they're really breathless, just really by looking at a patient you can tell how they are really. But again that's experience, that you know just by over the years you get used to looking at patients.

Staff Nurse 4 differentiates between "admitting" a patient in terms of getting "all the details" and "assessing" a patient. She talks about "telling" how a patient is by giving "the patient the once-over" and "just looking at their overall state". The "once-over" has the sense of a quick appraisal, a look which takes in the patient from head to toe: in conjunction with the notion of 'looking' the sense is of the patient as the object of the nurses experienced gaze, from which she can read the signs, understand the "tell", the signs which serve as an indication of something, the disclosure of the body's secrets, as Staff Nurse 4 says "just really by looking at a patient you can tell how they really are". The more experienced you are the easier this becomes.

It should be noted that all four nurses figure they can tell by looking the same things - whether someone is in pain, is breathless, is anxious, is distressed. Pain and breathlessness are a part of the 'symptoms and signs', the medical discourse, to be looked for in the case of someone having a heart attack. 'Distress' is the word doctors use to indicate how a patient is coping when they first come in, it is laced with meaning. Doctors specify at the beginning of their history and examination of a patient admitted as an acute admission whether or not a patient is 'distressed': this refers to the extent to which a patient is *visibly* compromised by what is happening to them. It may be accompanied by a notion of whether the patient is anxious or not, this indicates that the distress is not so much caused by the 'physical' but the 'mental' - the patient is causing his own distress as distinct from his having been compromised by his 'illness'.

Returning to the analysis of nurses' talk, Staff Nurse 4 states she uses "looking" when talking about nursing a patient whose diagnosis is unclear or where there is no set protocol. Staff Nurse 4 states that she "would just look at the patient on an overall basis" but qualifies her statement by making it a patient who is unable to communicate, which

marks an absence: she has no choice but to look and to "assess their needs from there". But she immediately qualifies her "just looking" further by revealing how in the "giving of total care" you can also "see" something - what the patient is "capable of". So for this nurse by giving care you can also "see" the patient, in terms of what they are "capable of": capability is *visible* in activity. Later, in working through an example of an admission of a new patient, Staff Nurse 4 reveals how "looking" works for her, and how it relates to the visibility of capability:

> **Staff Nurse 4** - Right when I got the phone call from A&E, the description I got was somebody who was a total wreck. Literally.
> **JL** - That was what they said?
> **Staff Nurse** - That was what they said. They said, em, obese, non-insulin dependent diabetic, eh, with chronic obstructive airways disease and a knackered heart...And, em, possibly with a chest infection [...]. So I said to the girls 'Right we're getting this patient', and I was expecting a physical wreck so we got the oxygen and everything, made sure that we had everything round the bed because I didn't know what we were expecting, made sure that we had everything we would need for the patient's [pause]. So, however when she did come into the ward by looking at her I knew she wasn't as they said. She was sitting up on the trolley fully supporting herself looking quite well profused, and really not as sick as we first thought. So then we've moved up, up my scale from total chaos. Em, so we got her into bed, she got herself off the trolley, into bed, we sat her upright because we knew she was short of breath, sat her upright and assessed her from there. And she was able to give us a full history so in that case we were able to see she was capable of quite a lot. And her main pro..so already we could assess that she was capable of doing a lot for herself. So I spoke to the patient, spoke to her daughter, and, em, got a clear picture in my mind and then wrote up the care plan according to what I thought her needs were from there.

Staff Nurse 4 says that "just by looking" she could see that the patient was not what she was reported to be. She had been alerted to expect a "total wreck" by the information she had been given: a patient with chronic illness - diabetes and chronic obstructive airways disease - both of which can indicate that a patient may be very 'dependent', someone further 'compromised' by a "knackered heart" and a "chest infection" on top. But by looking she saw something different, she changed her view, she disposed of what she had been told. "Looking" here seems to involve a very complex process of noticing, reading signs, inferencing, having knowledge, making connections.

What Staff Nurse 4 describes is an informed way of seeing which takes as its central focus the patient's activity in relation to medical discourse: the patient was able to support herself i.e. she was not 'collapsed', the colour of her skin indicated her breathing and circulation were able to suffuse her body adequately (in the staff nurse's view), she was able

to get off the trolley onto the bed unaided, she was able to "give a history" presumably, in Staff Nurse 4's opinion, by answering questions lucidly without compromising her breathing, giving further evidence of adequate circulation, especially to the brain. So "we were able to see she was capable of quite a lot". Here capability is made *visible* through translation of signs of activity by the cipher of medical discourse.

The translation is made possible by an understanding of the meaning of the signs in the ordered world of the medical discourse on the body's circulation. "So then we've moved up, up my scale from total chaos": Staff Nurse 4's metaphor would indicate that she believes at some level her ability to 'see' a patient's capability is analogous to a measuring instrument. A "clear picture in my mind" came after talk, with the patient and with her daughter, the auditory gave clarity to what she had seen, which was in conflict to what she had been told. From this Staff Nurse claims that she was able to construct a care plan, that is, make decisions about the patient's nursing care requirements.

I would like to suggest that in this instance Staff Nurse 4 describes herself as being put on the alert which leads her to be extra careful in her checking how the patient is: she was told she was to receive a very ill patient, a "physical wreck", she is relayed an image which *worries* her, so she pulled out all the stops, got everything ready, and when the patient arrived she made sure she was there to receive her and immediately assess her or give her a thorough "once-over" as she likes to call it. Her own observation and assessment of the patient were in conflict with what she had been told so she used talk to further supplement her, rather than A&E's, representation of this patient as someone "capable of quite a lot" rather than someone who was "wrecked". Here talk, the auditory, is used to supplement and confirm the visible. It should be emphasised how 'clinical' the nurse's assessment is: she presents herself as a cognitive subject (she does not mention feelings or intuition), she speaks about herself as having a gaze, as looking according to a grid of perception and noting according to a code, and as deciding for herself. But as has already been indicated, the central point of reference is not how the patient is feeling, her comfort and the relief of her suffering, but how capable the patient is. The gaze is searching to estimate the patient's value in relation to the good of getting her mobile again, as opposed to the evil of someone who is immovable: "So then we've moved up, up my scale from total chaos".

Assessment of patients and 'seeing' are linked by Staff Nurse 5 in the sense of an appraisal of how the patient is doing: her talk reinforces the notion that nurses believe they are able to objectively *measure* how a patient is by "looking" with the instrument of their

experienced gaze.

Sister 1's ways of knowing relate more directly to being told about patients by others who are more directly concerned with "looking after" patients.

> **Sister 1** - Eh, well I have to take report, find out what's been going on, assess priorities, eh do the nurses' [allocation]..

These others included nurses, doctors, physiotherapists and occupational therapists. It was from their "looking after" that she got her information about how patients were or what patients needed. This fitted very well with her report of herself as someone who should be "organising" and "facilitating" in her world. She expressed quite categorically that she only gets directly involved in patient care by default, because frequently there are not enough staff to do the nursing. She claimed that she decides what a patient's nursing needs are by "how the patient's treatment and, is em, really their recovery" . She stated that she knows about their "recovery" from the nurses' reports to her of the patients they have been looking after and from what she "sees".

Nurses express their own assessment of patients in terms of the observable: they think "visible". They claimed they like to "look" and "see" for themselves how a patient is. This seems to indicate that they imag-ine themselves as taking into account in their assessment of patients not only what they are given in terms of a patient's diagnosis-symptoms-signs-treatment but also what they see for themselves, what they believe they establish as the visible manifestations of a patient's situation. This relates not only to the facts of disease, the traces of illness throughout the body, the so-called signs and symptoms of illness, but also to feelings, emotion, thought and capability: they are claiming that all aspects are on display if a nurse just knows how to look and translate what they see.

What emerges from the nurses' talk is that their articulations about how they go on, their discursive consciousness, is not just deeply penetrated by medical discourse, but that they have constructed a *nursing gaze*. Patients' meanings become traces of experience which the nurse converts into the visible, the auditory is relegated to supplementing the visible or even gets transformed into the visible in the mind's eye.

This instantiation of a nursing gaze was the same on Ward 2. But in the Ward 2 nurses' accounts there was more mention of how the profile of the patient and other forms of information interact with the nurses' gaze. Their claims implied clearer relations between the ways in which nurses look and the nursing process. For example, Staff Nurse 7 reported how she notices patients as she comes on the ward at night and how this translates into an alert as she sits listening to the report on the patient:

Staff Nurse 7 - Mr Smith, a very frail old guy, he *looked* frail this chap, so the decision was quite easy really, he was a star in my little book, a definite star [this is staff nurse's private notebook in which she codes patients for different forms of care as she listens to the nursing handover - a red star indicates pressure area care].
JL - Pressure areas, so you knew...
Staff Nurse 7 - Nobody at report said his areas were red, but he did look thin.
JL - Right, so you had a look at him.
Staff Nurse 7 - Yes, I recognised him, well I saw him when I came up the ward. I thought 'Oh he doesn't look so well', he had oxygen on and he was quite breathless.
JL - Right, so primarily you looked for yourself.
Staff Nurse 7 - Yes, he stuck out. [my emphasis]

As she listens to the report the Staff Nurse claims that she "recognised" the patient as the person she particularly "noticed": as the "frail old guy", the "thin" man who "doesn't look so well" , "with oxygen on and quite breathless". This illustrates how in her account Staff Nurse can relate all the signs and crosschecks she has made to know how to nurse the patient. He "stuck out" and was noticed, through her particular gaze - frail, cyanosed, thin, unwell old people are at risk from pressure sores. But she does not say whether, and if so, how what she heard confirmed her view. Like Staff Nurse 4 the nurses in Ward 2 were discursively very competent, and could talk easily about how they decided as individuals what patients needed. There was a harmony to their accounts.

Discussion

Nurses may have developed their talk about knowing what patients need in relation to the visible in the present setting because they can then fight the visible with the visible: what is given status as observable evidence in the rational world of 'science' can become transactable knowledge. This relates back to the conditions of possibility in which nurses are working discussed in Chapter One and in Chapter Three. They can attend to a patient's experience, their feelings and emotions, only in as far as they can make them observable behaviours, give them factual status, make them legitimate objects for concern.

As discussed in Chapter Six, nurses are instructed through report and the ways in which the wards are organized to be alert to and report only certain issues: only specific things are to be considered problems which need to be brought to the attention of qualified nurses. Sister 1 helps maintain a field in which 'problems' are those aspects of how patients are which may affect the flow of patients through the beds. These include such things as capability, complications, anxiety, non-compliance, dissatisfaction, age. The Staff Nurses are

disciplined to know these things just by looking, supplementing what they see with talk or other information.

I would like to suggest that Sister 1 helps maintain a field of visibility in which nurses and patients are self-disciplined to see and reveal these particular problems to her: she helps ensure the accountability of certain problems. Patients are disciplined to communicate to nurses only the things which count (this aspect is pursued in Chapter Nine). This helps institute a particular "gaze" : it reinforces how the nurses look and see certain things, rather than other things, and report those matters which are significant in relation to the recovery and discharge of the patient, their disposal. This usually excludes matters relating to how the patient is feeling or his experience. But there are exceptions: when feelings and emotion can get in the way of recovery through exacerbating illness or through non-compliance. This situation, to refer back to the discussion of Foucault's work in Chapters Two and Three, can be taken as constituting a governmentality effect: the effects of constructing and communicating a particular field of visibility is to promote nurses' and patients' self-discipline.

It is at the point where disposal may get interrupted by exceptions ('problems') that Sister 1 attends, she then may either see for herself or use talk to help reduce any risk of blockage from dissatisfaction, anxiety, non-compliance:

> **Sister 1** - I like to find out how they're feeling and if they think their treatment is working. You know, if I'm doing a drug round or, I'll sit down and chat to them on the way round and see, if they moan about their tablets, why are they upset because they're taking so many or are they, it very much depends on how the patient's feeling that day. If they're sitting looking glum I go and speak to them and find out why. But I must say I don't have a lot of opportunity to do that. I tend to be very choosy in who I talk to. It depends on the pressure I am under from workload, if someone who really needs my attention I would go and speak to them.

From three months observation of both Sisters at work, talking with patients intimately, whether on the drug round or at other times, was certainly not as far as could be seen one of their priorities. They controlled their actions when in the vicinity of patients to avoid engagement. When they did talk with patients, in the research material, they controlled the focus and extent of talk rigidly.

I would like to suggest how the Sisters are the centres of calculation [Latour, 1987]. In the case of Sister 1, getting patients "well and home" is at the centre of her view of her work. She sees patients in relation to this view and more importantly she helps maintain a field of visibility in which problems which may affect this movement will come to her

attention. She *calculates* the possibility of disruption to the flow through the beds.

As has already been discussed the nurses use the doctors' views of patients not only to situate the patient in their world (give direction, indicate nursing care) but also to help place the patient in a hierarchy of need. I have suggested that nurses ascribe patients to classes. Both their gaze, and the field of visibility which it constructs (in which nurses and patients work) are partly defined through the constituting of classes of patients. This emerges in the nurses' talk in relation to particular kinds of old or disabled people: the future of these people is problematised by nurses because of their difficult disposal, they are a drag on the flow through the beds.

The nurses' have constructed a gaze which not only makes patients visible in relation to medical and nursing discourse, but which also makes visible those patients who may constitute a drag on the flow: they are social or psychosomatic, not medical. There is also suggestion that this latter aspect can transform the former: that patients can be viewed differently because they are constituted as a drag on the flow through the beds; their 'problems' are due to age or the social, not to illness and the medical.

The question to be addressed is 'what does this emphasis on knowing by looking displace'? This forms the central issue in Chapter Nine where analysis of nurse-patient interactions is presented and discussed.

CHAPTER NINE

NURSE-PATIENT ENCOUNTERS: THE SEQUESTRATION OF PATIENTS' EXPERIENCES

> There seems little doubt that nurses do not generally communicate with their patients. [Faulkner and Maguire, 1984]

Introduction

The present chapter is concerned with the ways in which nurses conduct themselves in their encounters with patients and the ways in which these encounters are developed as occasions for nursing. The chapter centres on research material pertaining to the period at, and immediately after, patients' arrivals to the wards, and on research material concerned with how patients were nursed subsequent to their admission. This material is analyzed to ascertain what nurses accomplish through their encounters with patients in relation to the nursing assessment.

At a visible level, the nurses in the study can be described as following the usual sequence advocated in most nursing process models, which emphasise the collection of a data base of information about patients as soon after their admission to hospital as possible. Many examples come from my analysis of Ward One. The research material from Ward Two was used finally as a crosscheck on my analysis and sometimes particularly pertinent examples from this material are used to illustrate my points. There was very little difference in the quality of nurse-patient interactions in the two wards.

The first part of the chapter concerns how nurses organise the admission of patients. The second part presents the analysis of these encounters in relation to the form of the admission, the conduct of nurses and the constitution of meanings. The third part of the chapter addresses the question of what nurses accomplish through their communicative practices at the time of the patient's admission to hospital: this is discussed in relation to the institution of a disciplined nurse-patient relationship. Finally there is a brief discussion.

Doing Admission

As discussed in Chapter Five, persons coming to the hospital are named and constituted as types of "admissions", this gives them access to space and the facilities on offer in the hospital. In the discourse of the hospital persons are constructed as patients

categorised as particular types of admission: "acute", "medical", "surgical", "chronic", "geriatric", "emergency", "social". In the in-patient clinical notes the doctors' history and examination of a patient begins with detailing what type of admission a patient is: for example, "E/A via A&E" - an emergency admission via accident and emergency department. In this way, patients come to the ward named as a category of admission: this constitutes the first reduction of persons to patients.

The second reduction, described by the nurses in their accounts, is constituted through naming patients in relation to a diagnosis. In a medical ward, as has been seen in the discussion of the medical and social ward rounds in Chapter Eight, these aspects, the type of admission and the diagnosis ascribed to a patient, are not necessarily self-evident and can be changed over time. In effect the nurses' work of observation and evaluation contribute to the ascription of typifications ('medical', 'social', 'geriatric', 'psychosomatic', 'acute', 'chronic') and of diagnosis.

The term "admission" is present in the everyday language of the nurses in the study and in the formal procedure relating to the gathering of information about patients on their arrival to the ward. The expression 'admission' is metonymic, and indexical, and stands for a process. The expression is also an institutional metaphor. It stands as an aspect of members' methods for accounting for the activities which they undertake at this time. The expression "admission" also instructs nurses, and patients, as to the *nature* of the activities which take place during the first few hours around someone's arrival to the wards.

The admission period is the time allotted to the deliberate or procedural collection and documentation of information about a patient. Nurses refer to their activity around a patient during this time as "doing an admission" or "admitting a patient". In this respect a nurse is asked to "admit" a patient and new nurses are shown how to "do an admission". At one level, nurses construct the admission of a patient around the completion of the patient profile or "nursing record". Photocopies of the "nursing record" and the formal document outlining the procedure for the admission of a patient to hospital are given in Appendices Six and Seven and have already been discussed in Chapter Six.

How the ward nurses complete the formal admission process varies according to where the patient has been transferred from, how ill the patient is and his apparent ability to communicate.

The main points of the admission process are the completion of a patient profile, including baseline observations such as temperature, pulse and blood pressure; checking any property through the property book and putting it away in the locker allocated, or arranging

with a relative for its removal; filling in and applying a wristlet nameband, and filling in and placing a namecard above the patient's bed. The admission is also "put through the admissions book", this is the ward record of all patients who are admitted to the ward with some basic details, such as name, address, age and diagnosis.

If a patient is admitted via another ward the nurses do not do a full admission: they do baseline observations, check and record property but omit the interview with the patient. Nursing records are transferred with patients from other wards, and even where this nursing record is incomplete, the nurses do not go through this part of the procedure with the patient. In the study it was noted that for patients transferred from the admission ward the profile was hardly completed at all.

I asked on the admission ward why this was: Sister there explained that as patients are admitted during the night and are frequently very unwell, the nurse's only obtain minimal information from patients and their relatives. She accounted for this in relation to how there were only limited staff on duty during the night and that, because of the acuteness of the care, nurses did not have time to instigate a full assessment of patients. She stated that this should be done by the receiving ward. However, the ward nurses do not complete the profile either, so that in such cases only a minimal record of a so-called data base is ever established.

Typically, one nurse is given responsibility for admitting a patient. Sometimes she is helped by another nurse over a specific aspect of the admission like taking a patient's observations, or putting away a patient's belongings. There does not appear to be any direct matching of the level of nurse allocated to admit a patient and the severity of illness or the potential trickiness of the admission. The nurse is usually admitting the patient because she has been geographically allocated to the part of the ward where the patient is placed. The student nurses are very rarely helped directly by the qualified nurses, unless it is their 'first time'.

Nurses allocated to admit patients use several 'sources' of information to fill in the profile. They consult the admission document, referred to as the "pink slip": typically they transfer information, such as reason for admission, medical history, past medical history and provisional diagnosis directly onto the nursing records. Nurses do not usually consult any previous hospital notes, which are taken to the doctors room, off the main ward area, at or shortly after a patient's arrival. The resident doctor takes a patient history after the nurses have done their admission of the patient so that the doctor's "in-patient" clinical notes are also not available at the time that the nurses admit the patient.

When a patient has been transferred directly from A&E, the admitting nurse does a type of interview with the patient. Occasionally a nurse interviews a patient's family or relatives, as well as, or instead of the patient. Relatives are interviewed by nurses, away from the patient's bedside, usually outside in the corridor leading to the main ward area, where they are left on the patient's arrival to the ward. This occurred in the case of four of the elderly patients in the study. It transpired that the nurses' perceived each of these patients as possibly "confused".

The 'interviews' with patients take place with the patient in bed and the nurse either sitting on the bed with the forms on her lap, standing at the bedside with the forms on the locker, or sitting in a chair at the bedside. Admitting nurses do not introduce themselves by name to the patient prior to the interview. The admitting nurse usually checks the patient's demographic details, fills in the details on the profile and fills in the wristlet nameband and places this on the patient's wrist. Thus the patient is labelled. The nurses never make a formal, systematic physical examination of the patient at the time of admission but do make what they call "baseline observations": the patient's temperature, pulse and blood pressure. The nurses do not weigh or measure the height of patients on admission.

The admission of patients is now discussed in greater detail, first in terms of how admissions are organised by nurses and then in relation to how interviews with patients and their families are conducted.

The ways in which nurses organize admissions can be seen as a series of moves which contribute to the induction of the patient into the day-to-day world of the nurses. The ways in which the nurses use the patient profile to gather information is only one part of that induction. The induction helps patients pass through into a world of work where meanings are located outside their own experience and knowledge. I would like to suggest that the admission process acts on patients and has a liminal quality: the conduct of admissions is ritualistic and helps persons pass across a threshold, through which they are transformed into patients.

'Admitting a patient' commences prior to patients' arrival on the ward. In A&E the patient is undressed, their clothes and their other belongings put in a large plastic bag, and usually, a hospital gown put on them. Paperwork has already accumulated and is transferred with a patient to the ward. Paperwork consists of an admission document, any old medical notes from previous admissions, and any letter from their own G.P.

Where family accompany a patient, they are told to wait outside the ward on the patient's arrival (this is also an aspect of the procedural rules as defined in the manual, see

Appendix Seven, point 8). Thereafter, family's access to the patient thereafter is restricted by nurses and by the rules of the hospital: visiting times are restricted to an hour in the afternoon and an hour and a half in the evening. Exceptions and privileges are sometimes granted by nursing staff. For example, the family of patients who have just been admitted might be allowed access for a time after the patient has been examined by the doctors. Here, for example, is an extract from Mrs Menzies' admission:

> [Mrs Menzies, day 1]
> [visitors bell rings]
> **Student Nurse** - That's for the end of visiting time.
> **Mrs Menzies** - Oh, is it?
> **Student Nurse** - Yes - visiting time is between three and four in the afternoons. Is that your daughter outside?
> **Mrs Menzies** - Yes .[.?.].
> **Student Nurse** - I'll let her come in when we've finished - she can stay on, you're privileged today. [Smiles]

The admitting nurse tells Mrs Menzies that she is "privileged" because her daughter can come into see her, the nurse will "let" her in: the nurse is indicating how special permission is required for family to have access to patients outside the prescribed times. For patients who are no longer being 'treated' by medical staff, the dying and the long-term, family might be allowed to visit patients at any time, but this, of course, relies upon these patients being constructed as 'dying' or 'long-term' for this to happen: these matters are not, as has been discussed in earlier chapters, self-evident.

Many of the usual accoutrements of 'being' a particular person, that social actors do not actually take for granted but which they use as sign-equipment in their presentation of themselves in their day-to-day lives, are removed on their arrival. Clothes, jewellery, etc are designated "property", listed and put away or taken away by family. In this sense patients are denuded, sometimes literally, as in the case of Mrs Violet whose pants were left down. Patients admitted through A&E have been 'rushed' into hospital, and may not have their things with them. For example, here is Mrs Adamson:

> [Mrs Adamson, Day 2]
> **Mrs Adamson** - [to me] - They've taken my watch away, they took away my glasses - I've got nothing - they took them away in the house before I came in the ambulance, I think.

This patient had been, by her account and that of the GP, suffering from severe chest pain and had been very unwell at home. In this extract, from observation material taken the day after her admission, she states that her watch and spectacles were "taken away" at home before she was sent in. "They" are her GP and the ambulancemen.

Where patients do have these things, their access to them is controlled by nursing staff - their belongings once checked through the property book are either packed away in the locker or sent home with a relative. I would like to suggest that both belongings and family help constitute the self, but the nurses control patient's access to both.

Typically, patients are not asked during the admission period if there is anything they want to keep with them, if there is anything or anybody they thought they might want or need before their things or their family are packed away or sent off. These 'decisions' are made on their behalf by the nurses. To counteract them would require work or protest by patients.

This seems ironic at a functional level where in geriatric medical and nursing 'theory' helping older people to orientate themselves is critical to helping prevent disorientation and subsequent confusional state resulting from admission to hospital: a watch, spectacles, own possessions, presence of family, can all help support the older patient at this distressing time.

For example, here is an extract from Mrs Appleton's admission. It is just after eight o'clock in the evening, Mrs Appleton having arrived about ten minutes before, is in bed being interviewed by the student nurse:

> **Student Nurse** - Did any body come in with you?
> **Mrs Appleton** - Yes my daughter - she's waiting outside.
> **Student Nurse** - Will she take your clothes home for you?
> **Mrs Appleton** - Yes.
> **Daughter** - [comes in at this point and stands just inside curtains, picks up plastic bag of property] - I'll just pop home with these, shall I, and bring in your night things?
> **Mrs Appleton** - Oh, yes.
> **Student Nurse** - Oh, you don't need to come back - are you coming in tomorrow?
> **Daughter** - Yes - in the afternoon.
> **Student Nurse** - Well, it'll wait until then - we can lend her a nightie for the moment and we've got little packs with soap and things in.
> **Daughter** - Oh alright then. I'll just go now shall I? You don't need me, to know anything ?
> **Student Nurse** - No, we're all right [smiles].
> **Mrs Appleton** - Yes - don't trouble yourself. Behave yourself [smiles].
> **Daughter** - Right - [hesitates at curtain] - Bye - [Student Nurse is writing on forms - I say goodbye] - **Daughter** goes.

Mrs Appleton and her daughter live together. It can be seen in this extract that the student nurse takes over from Mrs Appleton and her daughter in deciding what Mrs Appleton needs: she can wait until tomorrow to have her things brought in and they do not need the daughter. The Student Nurse has only just met Mrs Appleton and may have little idea of the

sort of things she may need or of the kind of person she is; whether, for example, Mrs Appleton wears spectacles or would appreciate her daughter coming back as a comfort at a stressful time. The daughter hesitates, and checks if the student nurse needs her to know anything, but the student nurse says no, "we" will be alright. This exclusion of the daughter may have been an attempt to include the patient; if "we" denotes herself and the patient, then the student nurse is now constituting them as aligned in some way. But, at this point, she has a limited relationship with Mrs Appleton, they have only just met. Further, the "we" is ambiguous, it may also be an institutional "we": we, the doctors and nurses, do not need you to know anything. In this case this is a direct exclusion of both patient and daughter.

Mrs Appleton's daughter telephones the ward from home some time later to let the nurses know that her mother gets "agitated", a nurse comes over to Mrs Appleton at about ten pm to tell her about the call:

> **Enrolled Nurse** - Mrs Appleton - your daughter 'phoned to see how you're settling in. She said she would phone again in the morning. She said that you get a bit agitated.
> **Patient** - Yes, I do.
> **Enrolled Nurse** - You're safe here with us - you're right by us at the station - so there is no need to worry - we'll look after you [all this said very sweetly].
> **Patient** - I get agitated then I get angina.
> **Enrolled Nurse** - Well, you get a good sleep and we'll be just here - we'll look after you.

The night nurse tells Mrs Appleton that her daughter has said that she gets agitated, but does not attempt to discuss this with her, she does not listen to Mrs Appleton telling her about how she feels. The nurse disposes of the problem by reassuring the patient. She may presume a relationship of trust, that the patient will feel better if she is made to feel safe, by knowing that the nurses are close. Like the student nurse above, this nurse and the patient have only just met. In doing this the nurse avoids engaging with Mrs Appleton through not allowing Mrs Appleton the space to express herself.

According to the night nurses, Mrs Appleton became very distressed in the early part of the night:

> **Night Staff Nurse** (to the early shift Staff Nurse) - She was very upset and agitated for the first part of last night.

The night nurse explains Mrs Appleton's behaviour as possibly due to the fact that she sometimes takes a sleeping pill and may have had 'withdrawal'. Her vulnerability from anxiety is not passed on as an aspect of her 'profile', to be treated as a part of her 'nursing care'.

Other patients, like Mrs Appleton, appeared disconcerted by a loss of control at these times. For example, Mrs Gardner and Mrs Violet both questioned the location of their property, they appeared not to trust the people involved to look after their things for them and ensure their safe delivery. In the case of Mrs Violet, her daughter returned with a bag of things for her while she was being examined by the doctor, but the nurses did not let her know and let the daughter go. Mrs Violet expressed chagrin at this. Where family could be useful in providing information they were then 'included' for a time and questioned by staff. This happened in the cases where there was some doubt about the patient's state of mind.

This exclusion of family and control over their access to patients is a systematic and regular feature of how the nurses dealt with family. It helps constitute a displacement: it is one of the ways in which the nurses help to constitute a separation of the patient from their social selves. This, I am suggesting, helps disempower patients. Further, I am proposing that the control instituted through nurses' conduct, over patients' own artefacts and their family is symbolic rather than instantiation of incompetence or ignorance: it helps, in concert with other effects, to reduce patients' potency. These other effects are now discussed.

As stated, patients arrive on the ward already denuded of many of their social attributes, their sign equipment, including their families. However, the signs may have been replaced with those of the institution. For example, how patients arrive on the ward seems to act in concert with other aspects of a patient as a signal to ward nurses. From observation of nurses' behaviour at these times a correlation emerges between how ill they perceive a patient to be and how a patient is transferred and received. Patients who are not constructed as particularly 'ill' arrive either sitting up on a trolley or in a wheelchair, and are accompanied by a porter alone, and no nurse. These patients are not being presented as particularly ill. Ill patients are on a trolley, often lying down or semi-prone, perhaps with oxygen on or some other technical equipment, such as an intra-venous infusion or a cardiac monitor attached to them, and are accompanied by a nurse and a porter.

I would like to suggest how these artefacts act as signals, so that a patient arrives as a *visibly* 'acutely ill' patient (signalled perhaps by an oxygen mask, an intra-venous infusion, lying down, an accompanying staff nurse). In this instance more than one student and the qualified nurses gather around the new patient at or soon after their arrival and 'take a look' at them. For example, here is the arrival of Mr Dean:

> [Mr Dean, Day 1]
> 10.20 - Staff Nurse tells me she has heard from the admissions ward - there is one admission - "An 83 year old man called Mr Wally Dean, with LVF [left ventricular failure - heart failure] and they think he may have had an

MI [myocardial infarction]. He'll be along soon."
10.55 - The bed is made up with clean linen - the backrest is out with two pillows.
11.49 - A patient arrives on a trolley - he is lying virtually flat with an oxygen mask on. A porter and a staff nurse accompany him. They come into Bay 3 - Staff Nurse and Student Nurse 1 walk to meet them -
Student Nurse 1 [to side of Patient] - Hello Sir. We're just going to get you into bed.
[Porter and the transferring Staff Nurse push the trolley parallel to the bed and up close to it. Then Student Nurse 1 and transferring Staff Nurse go round to the other side of the bed - Student Nurse 1 pumps the bed up high - and then they both climb onto it, stretching out their arms and help Patient to move across onto the bed]
Staff Nurse 1 - [next to patient] - OK, Mr Dean, can you move across to the bed to make it easy?
[He moves across, the other nurses get down off the bed and the porter removes the trolley]
Student Nurse 1 - There we are Sir. [She covers him up] We'll get your oxygen mask for you.

This patient arrives lying flat, with an oxygen mask on, accompanied by both a porter and a staff nurse from the admission unit. The Staff Nurse in charge of the ward and the student nurse allocated to the Bay in which the patient is to be placed, both receive the patient and help with his transfer into bed, although they do not actually lift him in: the patient is asked to climb across to "make it easy". The Staff Nurse has been given the information over the telephone that the patient has had a possible heart attack, and that he is in heart failure. She can also see that he is being sent with a staff nurse and that he is lying down and has oxygen on. Quite simply he looks as if he is 'ill'.

In contrast the following patient, Mrs Violet arrives with a similar diagnosis, possible heart attack, straight from A&E, but with no nurse just a porter, also the ward nurses have not apparently been told about this admission, she is unexpected.

[Mrs Violet, Day 1]
19.32 [A Patient arrives with a porter on a trolley - she is sitting up looking alert and flushed. Two junior student nurses on the ward - Sister 1 is in her office with another student checking a large amount of money which a patient has brought in with her. This patient is unexpected. There is no bed ready - a patient who is going to be boarded has not gone yet. The porter waits in the middle of Bay 2 with the trolley - no-one helps him, the students look confused, eventually one of them attends to the presence of the trolley - she goes to the porter and asks the patient's name, he gives her the notes from the bottom of the trolley. She takes these and goes to Sister 1's room. Sister 1 comes out of her office and looks at the scene from a distance, she tells the student nurses to move the beds around - she has no contact with the Patient on the trolley, the only contact with the patient so far is a cursory hello from the one of the student nurses. They move the

beds. Sister 1 goes and sits at the desk in Bay three.]
[Porter speaks to the Patient on the trolley - he tells her the ward is very busy.]
19.41 - [The nurses have moved the beds, the vacant bed is now in Bay Two; Nurse 1 pumps it up, pulls out the back rest and rearranges the pillows.]
19.43 - [The student nurses and the porter move the trolley across to be parallel with the bed - Student Nurse 1 goes to the other side of the bed and asks the patient to climb across. This the patient does - when they take the blanket back from her you can see her knickers are half way down her thighs. No screens round. She has a right sided facial weakness which affects her mouth and eye - this is half closed. Also her speech is very slightly affected.]

This second patient arrives unexpectedly, and has to wait for attention. When Sister 1 finds out the patient is there she does not go to her, but looks at her from a distance. She may or may not have read the notes which came with the patient from A&E. My expectation is that she read the medical registrar's admission summary in the office. The interesting aspect is why did Sister not approach or visit this patient, have a close look at her, or, out of courtesy, make up for the muddle and delay at her arrival. The porter gives the patient an account - the nurses are very busy.

Like the man in the first extract Mrs Violet has been admitted with prolonged chest pain and breathlessness. The point is how is Sister 1 constructing her, that she can, from a distance, assess that she is safely left, in the first instance, to the student nurses (who were very junior) to sort out. There are a number of possible influences on Sister 1. These are now discussed.

The patient looked 'well' (unlike Mr Dean who was white and lying down] - she was sitting up, had a high colour (indeed, she was quite flushed), she had no intra-venous infusions or oxygen, and, significantly, no nurse accompanying her. She also looked as if she had had a stroke at some time - she had a marked, one-sided facial weakness. Mrs Violet did not look like someone compromised by a circulatory problem or as if she were suffering.

This 'looking like something' is supplemented by other signs: signs that Mrs Violet has not been constituted by the doctors in A&E as someone who, however she may feel now, is seriously ill, as someone who has had a heart attack. The signs indicate that the doctors' in A&E had not assessed her situation as grave enough to warrant sending a nurse with the patient, setting up a drip or giving her oxygen (she had been on oxygen but this was stopped prior to her arrival on the ward). This impression is confirmed by the admission summary which Sister 1 may have read in her office:

Impression: Unstable Angina.

Sister 1 reads the signs and may count the patient as not very serious. This is borne out in her own handover of the patient, which, like the doctors', admission summary, indicates that the patient has been admitted with her "usual angina". But Sister 1 does not cross-check her readings with her own independent assessment of the patient: she does not talk with the patient or take a close look at her and allow the patient's responses themselves to move her assessment of her. She does not allow the patient to tell her about what had happened to her or how she felt: she does not give Mrs Violet *access* to her.

At the late to night shift handover Sister tells the nurses that Mrs Violet:

> was admitted from A/E tonight er...following two episodes of pain in her left arm plus her usual angina. Her obs are -- on admission. She's only in for observation - she'll probably only be in overnight.

Subsequently the night nurses were quite impatient with Mrs Violet and the night Staff Nurse told Sister 1 the following morning that Mrs Violet is demanding. Although Sister 1 does tell the Night Sister that Mrs Violet is for "exclusion of MI (heart attack)" she does not communicate this in the above handover or in subsequent handovers to her day staff. Her conduct with regard to this patient, communicates that Mrs Violet is not seriously ill: her problems are chronic and her admission may be a mistake at a busy time. Further, Sister 1 does not particularly follow the usual protocol for mobilising the patient with possible heart attack. I would like to suggest that the nursing staff did not view Mrs Violet as acutely ill. Yet it eventually emerged that Mrs Violet had had a heart attack, and that the first patient, Mr Dean had apparently not had one.

In these ways the patient can be read by nursing staff as 'written', not necessarily by the illness process itself, but by medical staff: the patient becomes something the medical staff have produced which then can be read as text by the nurses. I would like to suggest that nurses are to a certain extent substituting the artefacts attached to patients, and the signs in the written texts about patients, to know how a patient is and what their status is. This writing does not necessarily include the signs produced by the patient themselves. These signs construct the visibility of the patient and help nurses to constitute the patient in relation to their 'class' (acute, chronic, medical, social, psychosomatic or geriatric).

This substitution, I am suggesting, acts in concert with other sign systems carried in the work place, both to tell nurses about patients and also to instruct the patient about the place. It helps achieve the transformation of persons into patients, and helps nurses to construct their identity and their identifiability. What is left to the patient, is his voice and

his ability to project a self through his voice and through gesture. This, however, relies on access to the nurses. This access is complicated by the affects of the disease itself making it difficult to express the self (because of pain or other affects), and by the ways in which nurses conduct themselves in their encounters with patients. These matters are now unfolded further through discussion of the nurses' conduct during the admission period.

Nurses' Conduct: Creating Social Distance

There were methods through which nurses communicate that patients are now in the hands of those around them and that for the time being, the person as a social self is subordinate to the needs of the body as constructed and defined by nurses and doctors. I am suggesting that there is a concerted activity to communicate to, and act on the patient to achieve their subjection. This is achieved in several ways.

Nurses help accomplish this (as discussed above) through stripping patients of their sign-equipment and their family as they enter the ward. Further, the sequencing of the admission itself and the ways in which nurses receive patients can be taken to signify the relationships which patients can expect. These matters are now discussed as aspects of the conduct of the admission.

Although patients are the centre of activity they are positioned through the activity of others. For example, the receiving nurse and the porter or transferring nurse take the decision about how to get the patient into the bed, they rarely ask the patient themselves. Here, for example, is an extract from Miss Hepburn's admission:

> **Staff Nurse** - Hello Mrs (sic) Hepburn [to patient at side of trolley and then goes over to indicate bed. They are in Bay Three - the bed is the one right by the nurses' station. Staff Nurse addressing the porter or Staff Nurse from Accident and Emergency] -
> **Staff Nurse** - Can she climb over or do we need to lift her?
> **Staff Nurse [A&E]** - Yes - she should be able to.
> [Porter manoeuvres trolley in by bed]

At other times, no-one was asked: the nurse read the patient from the signs, like Mr Dean above, and dealt with the situation. On other occasions the nurses ask the porter, not the patient who she or he is, as in the case of Mrs Violet above. These strategies help position the patient and to displace them as socially potent.

Nurses rarely introduce patients to the place or to those present; they rarely introduce themselves, by name or rank. Not knowing who people are puts the patient at a further disadvantage, leaving the patient to work to know who people are. Knowing who people are gives some indication of their power to help you: not knowing who they are can

help to exclude. For example, Mr MacGregor, a retired squadron leader and used as he told me to "being in charge", was aware of this. At the end of his admission interview he asked the admitting nurse and myself our names. During his stay he asked me to tell him who all the different people were - what their uniforms signified:

> [Mr MacGregor, Day 6]
> As we're walking down the ward together, having met by chance, Mr MacGregor asks me - as we walk back to his bed - what the different uniforms mean - he says he has no idea to whom he is speaking - "whether it is someone with the power to help you - the authority - or not". He says that "none of them [the nurses] really have any power to get things done"

A further aspect of nurses' conduct which helps indicate that persons are now subjects with reduced social potency, is the way in which patients are swept along by the flow of the nurses' agenda. As already stated, they are typically not asked what *they* need or want. For example, on their arrival on the ward patients are routinely put to bed. However, in the case of two patients transferred from the admissions ward the morning following their admission, the patients are sat up in a chair shortly after their arrival. In both cases the patients had been admitted during the previous night, were in their eighties, and had hardly slept at all. However, Sister 1 gives the patients no real choice in the matter, but got them up to sit in a chair.

Here is an extract from Mrs Best's admission period. Mrs Best had arrived from the admissions ward in a wheelchair about an hour and twenty minutes previously:

> [The Ward Round is in Bay three, around another patient. Mrs Best is sitting in bed. The Lecturer, Sister and the resident doctor are standing back from the ward round, talking together, they are looking at Mrs Best while they talk.]
> 12.30 - [The Housekeeper and a Student Nurse come into the bay with the soup trolley. After an exchange, the Student Nurse gives the patient some fruit juice from the trolley. Someone else goes to fetch her a bedtable.]
> 12.32 - [A chair is brought to end of patients bed. The ward round is still in the Bay. Sister breaks from the ward round and suddenly comes over to the patient.]
> **Sister 1** - Would you like to get up for lunch Mrs Best? [Pulling back bedclothes as she speaks]
> **Mrs Best** - Oh yes. [mumbles something - starts getting out bed. A radiography student who is doing a day of nursing for her training comes to other side of bed and tries to help]
> **Mrs Best** - [to student] I can manage.
> **Sister 1** - [puts Mrs Best's slippers on as patient sits at edge of bed. All happening very quickly. Mrs Best stands up]
> **Sister 1** - Right. [Student has dressing gown and helps patient on with it and patient sits down in chair]
> **Mrs Best** - Oooh! [Student goes]

Sister 1 - A bit low for you isn't it? We'll get you a better one later on, one that is a bit higher, so that you can get in and out of it.
[Puts table in front of the patient and dinner tray].
[Sister 1 goes]
2 mins.

A chair is brought and placed by the bed, Sister 1 comes over and as she pulls the bedclothes back she simultaneously asks if the patient would like to get up. This makes it difficult for the patient to say no, she would prefer to stay in bed. She is being told to get up through Sister 1's gestures. The patient also produces signs: she lets the Student know she does not need help, and when she sits down she lets out an exclamation. Sister 1 reads this as indicating the chair is too low and claims she will change it later, for one that is a bit higher so you can "get in and out". The patient is being instructed that she is expected to move around. I presume Sister 1 had got permission to 'mobilise' Mrs Best after her consultation with the doctors on the ward round.

Mrs Best was admitted in the night with blood in her stools, and with "48 hour history of nausea with vomiting", "epigastric tightness" and "light-headedness". Neither Sister 1 nor any other nurses have asked the patient how she feels at this point in the admission, but they have read the pink slip and the nursing notes transferred with the patient. Most of the profile is incomplete. She is being investigated for a "? gastro-intestinal bleed", but it is clear from the above extract that she is to be mobilised. She is eighty years old and 'keeping her moving' seems to be what is on Sister 1's agenda. The irony is that Mrs Best is being got up for lunch and is subsequently offered a full meal: the nurses have not checked how she feels in relation to food given her so-called presenting history of nausea and vomiting and blood in her stools.

That patients are routinely put to bed may be a reflex: if someone is ill then they need to rest their body. But there is also discourse which indicates that prolonged immobility is bad for the body especially for older patients. Putting the patient to bed and immobilising them at the beginning of their stay enables access by the doctors for their examination of the patient immediately after admission. Mrs Best had already been examined and her future decided upon (to investigate for gastric ulcer), so she could be got up, and mobilised, thus preventing complications due to prolonged immobility. However, as can be seen, her own feelings in the matter are not accounted for. This is quite typical, not just of nursing at the time of admission, but as a pattern throughout the patients' stay. Patients, like Mrs Best, usually complied willingly with the nurses' implicit instructions. At this juncture, the point to be emphasised is that the signs produced by a patient could not

alone legitimate nurses' activities. This is now further discussed.

Legitimating Care

During the admission period the nurses seemed to postpone attention to patients' immediate requirements unless these were legitimated. Adherence to procedural aspects at the time of the admission appeared to take priority over response to immediate issues arising out of the patient's experienced condition (for example thirst, or a wash, going to the lavatory or something to eat).

Typically, nurses attend to issues which can be established as 'needs'. Nurses do not prioritise any immediate requirements that come up during the admission period only through their proximity to, or their talk with, patients.

In the following example, Miss Hepburn has just been admitted from A&E having collapsed at home. As yet there is no diagnosis, but she may have been lying on the floor all night. Miss Hepburn is on the trolley:

> [Porter manoeuvres trolley in by bed]
> **Staff Nurse** - [pulls back blanket - A&E Staff Nurse pulls screens round. Student Nurse is inside with them as well]. [to Student Nurse] - Oh dear - go and get a fresh gown and a couple of pads. [Student Nurse goes]. [to Porter] - Could you excuse us a second [he goes]. [Student Nurse comes back with nightdress and pads, gives these to Staff Nurse - she goes].
> **Staff Nurse** - [to patient] - I'll just change your nightie you're a wee bit damp - then you'll be nice and dry.
> **Miss Hepburn** - Aye.
> **Staff Nurse** - Then I'll give you a wash a wee bit later on. [She takes gown off Miss Hepburn and helps her on with the nightie. She then puts incontinence pads over the draw sheet on the bed].
> **A&E Staff Nurse** - [is standing on far side of bed - the trolley is parallel with the bed - Staff Nurse helps patient move across to the bed - A&E Staff Nurse leans across bed to receive her - Staff Nurse virtually lifts Miss Hepburn across].
> **Staff Nurse** - There, lift your bottom across [as she is doing it - leans down - she is standing on patient's right] Is there anyone with you? [She and other staff nurse cover patient up with bed clothes].
> **Miss Hepburn** - Yes, my niece. [Speaks in very quiet hoarse voice - her mouth looks very dry and her lips are cracked. When she got off the trolley the blanket underneath her was wet and there was a small amount of faeces on the blanket].
> **A&E Staff Nurse** - Her niece came with her - she's sitting outside.
> [Both Staff Nurses go.]

Miss Hepburn is not desperately ill, but is very pale, dishevelled and frail-looking. Staff Nurse, as she draws back the blankets to enable the transfer of the patient into bed, sees Miss Hepburn has been incontinent of faeces and urine. Her nightie is changed and

incontinence pads are placed over the bedclothes. Both actions can be seen as ways of protecting the bedclothes and only minimally directed at making the patient more comfortable or protecting the patient from excoriation of her pressure areas and groin. Any further 'care' is postponed until 'later' and was not witnessed within the two hour observation period.

Further, it should be noted that the Staff Nurse attempts to minimise the issue of incontinence with Miss Hepburn herself. Staff Nurse tells Miss Hepburn that she is "a wee bit damp" and that is why she is going to change her nightie. In this way the Staff Nurse, to some extent conceals, or does not admit what has happened to the patient. She may have been trying to 'spare' Miss Hepburn embarrassment or thought the patient incapable of participation at this point. But I would like to emphasise that the Staff Nurse's approach is typical and instantiates one of the ways in which even in situations of co-presence [Goffman, 1958; Giddens, 1984], nurses restrict their access to patients and patient's access to them. Here, Staff Nurse does not allow the patient any *awareness* of her incontinence, she does not raise the issue with Miss Hepburn directly and avoids admitting Miss Hepburn into her view of matters: she avoids engaging with Miss Hepburn. It is the student nurse who goes on to interview the patient. This nurse also does not take the opportunity to discuss the occurrence of the incontinence with Miss Hepburn.

In contrast, the Staff Nurse comes back after the above episode and checks if the patient has any pain and if she is thirsty. Miss Hepburn says she is thirsty but does not want tea - some water is brought and the student nurse gives Miss Hepburn a drink. On the admission summary from A&E the patient is described as having had some back pain and as looking dehydrated. Pain and thirst have been identified and legitimated in this case by the doctors' view of the patient, and the nurses are permitted to attend to them. These matters hardly interrupt their procedural goals, whereas offering the patient the toilet, helping her to wash off the faeces and urine and discussing the problem directly would postpone the achievement of 'admitting' the patient.

In the present case, attending to the patient's physical state at the time of her admission in terms of helping her have a wash and observing her so-called mental and functional ability might have 'told' the nurses involved much more about Miss Hepburn in terms of her physical condition, her mental and her functional status than the interview itself. In this respect, the nurses were not only denying the patient's experience and the patient as a source of knowledge, but also their own potential experience of the patient, their powers of observation where they were engaged with the patient.

One explanation for deferring 'nursing care' during the admission period is that it is a tradition to leave the patient in their 'presenting' physical state for the doctor to examine: that it is necessary for him to see with his own eyes, the patient as admitted. As discussed in Chapter Two, drawing on Foucault's archaeology of medical methodology, central to its credibility is the notion that, in its purest form, the medical gaze relies upon the doctor seeing 'what is actually there'. The doctor sees the patient as 'written upon' by disease and pathology, but the marks, the signs and symptoms upon the body, are interconnected. To disturb the writing on the body would be to distort the picture. This is not as farfetched in the current setting as it sounds. The nurses were engaged in making the body ready for examination, they did, by their own account, as discussed in Chapter Eight, act primarily in relation to medical discourse. That they did not do any nursing work on the patient's body until the patient had been seen by the doctor fits with this picture. To illustrate this argument, here is an extract from another patient's fieldnotes.

Mr Wallace has just been transferred into bed. The screens are pulled round. He is going in and out of sleep and the resident doctor and admitting student nurse are both together at his bedside making their observations of him and various other jobs:

> [Resident listens to chest at the front again. Then pulls back bedcovers. Admitting Student Nurse comes back and takes down drip and caps off venflon. Resident is examining Mr Wallace's abdomen, then his arms. Another Student Nurse comes in and goes again]
> **Resident** [to Admitting Student Nurse] - Has he been washed and so forth since he came in?
> **Admitting Student Nurse** - He just came in.
> **Resident** - He's been well looked after.

Here the resident checks with the Student Nurse that he is reading the correct signs: that this is the patient's 'admission state'. In this particular example his inference is that the patient has "been well looked after", this is also a sign where, added on to the medical gaze, as demonstrated in Chapters Six and Seven, there are questions of future disposal: Mr Wallace's condition and medical management can be debated in the light of how well looked after he has been at home. So the nurses may privilege giving access to the medical gaze and defer attention to a patient's comfort, except where it is already legitimated by the doctors' or the nurses' view of the patient, as in the case of thirst and pain ascribed to Miss Hepburn or the pressing 'need' for Mrs Best to mobilise given her age.

I would like to suggest that the nurses are indeed accomplishing more than simply privileging the doctors gaze. Another demand upon the nurses in their ordering of the admission period to defer patients wants or 'nursing care' is that they also have an agenda to

fulfil: the completion of the nursing profile or assessment instrument which they do before the doctors examine the patient. How this document is completed will now be discussed in relation to the constitution of meaning.

Form-alities: Method and the Constitution of Meanings

The nurses structured their admission of patients around completion of the nursing profile (described in Chapter Six). This included an interview-type encounter with patients and/or their relatives. It would appear from the analysis of the research material that nurses constituted the purpose of the admission procedure to be the collection of information or the construction of a "history" of the patient. This is now discussed in relation to how the nursing profile was completed in practice.

The term 'assessing a patient' was not heard to be applied in the day-to-day of the nurses' talk in relation to the completion of the nursing profile. In their interviews some of the qualified nurses referred to the patient profile as a "history" and to their own review of a patient's condition on or shortly after their arrival on the ward as "assessing".

As discussed in Chapter Eight, it appears that the actual collection of information about patients, often undertaken by student nurses, was constituted by qualified nurses as an aspect of some greater whole, or some process which occurred inside their own heads as "assessing". What the 'admitting nurse' did was not constituted as 'assessment', although it may or may not contribute to the qualified nurses ability to do their assessing of patients. For example, as discussed in Chapter Eight, Sister 1 referred to the "history" taken on admission as useful in relation to background information about patients. The implication is that there can be 'collection of data' about patients which is separate from 'decisions' about patient's problems and their nursing care.

The wording of the procedure manual [Appendix Seven] implicitly directs nurses to the type of approach they are to take:

> any information required is obtained from relatives
> collect and document necessary information required

The wording here implies an approach: the nurse is directed to "obtain information" which is "required" or "necessary" from the patient and from their family. Information is "collected" from them. The metaphors are revealing: they support the notion that the admitting nurse, the patient and their family do not participate in the constitution of what is "required" or "necessary", but are sources from which information can be obtained or the instruments through whose agency data can be collected.

This framing of the admission interview is reflected in the ways in which the nurses announce it to patients. Only on one occasion was a nurse seen to introduce herself, it was her first admission, [Miss Hepburn, Day 1]. Nurses sometimes gave no explanation of what they were going to do and just started to ask the patient questions, but with the forms prominently to hand, which they filled in as they went, and which may have announced that their questions were part of some administrative or at least authenticated procedure.

Sometimes nurses gave patients an explanation of what they were going to do. On one occasion a patient was told by the nurse that she was going to "check some details" [Mrs Mitchell, Day 1]; in two instances patients were told that the nurses were going to "admit" them [Mrs Best, Day 1, and Mrs Menzies, Day 1]; and on another occasion that the nurse was going to "ask some questions" [Miss Hepburn, Day 1].

In these ways nurses announce to patients that filling in the form is what is on their agenda. They do not give any indication that they are uncovering details that might affect the way they are going to nurse the patient. The interview is constructed as a procedure to be completed with patients' assistance. The encounter, it is never referred to as an interview, is not offered to the patient as a conversational arena in which the nurse and the patient can talk about the patients health to ascertain what nursing the patient requires. The nurses conduct the interview very much as if the patient profile is a structured questionnaire. They usually lead the interview: turn-taking is set at a question and answer format. During the admission interview the nurses do not seek patients' narratives: they typically refuse anecdotal forms.

Fairclough [1992] describes this as a discursive genre that indicates a methodological approach which constitutes both the interviewer and interviewee in particular ways: it is an aspect of a process, carried out on the patient, not as an exploration or as a form of discovery to be undertaken *between* patients and nurses.

In the procedure manual the nurse is instructed to obtain from patients and their relatives, "information" as "necessary" or "required". These terms are not completely ambiguous but support the underlying epistemology of the setting: that within the context of the setting there will be specific types of information that it is necessary to know, but that the status of the information is not arrived at in conjunction with the patient. This contrasts with models for nursing assessment which advocate that the patient is expert, as discussed in Chapter Three.

Constituting such entities as 'necessary' or 'required' 'information' supports the notion of a normative and imperative hierarchy of knowledge as facts whose decoding by

those 'in the know' is necessary to knowing what care patients' need. Constructing information as needed supports the basis for action as the response to a hierarchy of needs. It is an integral aspect of accountability, of that which is "observable-reportable" [Garfinkel, 1967].

So, the nursing profile form itself is left to be interpreted by nurses within the setting, drawing on - what? As already indicated in Chapter Six, nurses were involved, not simply in recording a description of the patient, but in some kind of evaluation of aspects of the patient, to ascertain whether or not they had problems (for example, with mobility, bladder, bowel, etc).

I would like to suggest that the ways in which the nurses operationalise the nursing profile reflect and help reproduce the epistemological underpinnings of the setting. This is now discussed through analysis of the ways in which nurses conduct these interviews.

In their questioning of the patient, nurses avoid speculative investigation of patients' experience and understandings. They make patients 'stick to the facts'. In this respect the nurses' get the patient to assist in the completion of aspects of the profile which constitute 'reality': the nurses' reality in relation to their routinisation that is, not the patients'.

The nurses ask patients closed or leading questions about their 'bowels', 'bladder', 'diet', 'sleep', etc. In this way the questions relate to aspects of a patient's so-called 'needs' which correlate with things the nurses are responsible for providing and might have to arrange for the patient. These are facilities which the nurses provided as part of the daily reproduction of their reality and which, as has been discussed in Chapter Six, nurses routinise. They are matters which require daily and repetitive acts, but which may entail marginal differences according to the type of patient.

In this respect, it is unsurprising that at the admission interview what nurses establish is whether there are any aspects of how the patient 'is' which affects the nurses daily arrangements. They establish if there are any specific differences to which they need to attend. They do not probe for particular details of problems from the patient's point of view. The moves made to establish these 'facts' about patients are now described.

Firstly, the nurses act to control the direction and the areas covered in the patients interview. It is structured, like a questionnaire and follows the sequence given on the profile. A complete transcription of a (typical) interview is given in the last section of this chapter (p242) and this sequencing and movement can be seen there.

Second, aspects of the patients 'living', like what they eat and drink and how they eat and drink, are reduced to a medicalised version of this, that is 'diet'. For example,

patients are not asked about their appetite, how they took their meals, how they cook, what kinds of food or drink they consume, or how their weight has been. They are typically asked if they are on any 'special diet'. For example,

> **Staff Nurse**: Are you on any special diet or anything. Low sugar, vegetarian or anything?
> **Mrs Mitchell** - No.

It is part of the nurses' job to order special diets from the kitchens and to give the patients their meals, ensuring that the patients on special diets receive theirs. As can be seen from this exchange the nurse excludes possible meanings food and drink may have for the patient. She may, in her estimation of the patients appearance have decided she looked nutritionally healthy enough but this approach, which was typical, did not really tell the nurse anything about the patient's dietary habits or the lived experience of food and drink.

Similarly, patients are asked what medication they are taking. Nurses are responsible for giving the patients their medication, knowing what medication a patient is taking may act as a crosscheck on the doctor's prescription (e.g. Had he included all the patient's usual drugs and at the same doses? If not, why not?) to ensure correct delivery of drugs. It may also act as a check on what was wrong with the patient. But nurses do not ask the patient how taking the medication affects them.

The third move made to position and control patients' responses is through the use of metonymy. This is where one aspect of a process is substituted for the whole process. When applied in the present context it is reductionist because it fragments and dehumanises [cf Osterwalder, 1978]. In this way, the life processes of eating, drinking, growing, moving, eliminating, keeping warm, loving, being, are reduced by metonymy to 'diet', 'bowel', 'bladder', 'weight', 'height', 'skin', 'family support', 'mobility', 'social activities'. The problem here is that, while it might be useful for nurses to *record* aspects of patients under these categories or to use them to crosscheck already identified areas of difficulty, it is controlling and limiting to use them when asking the patient about themselves. It is an effective way of positioning the patient to be concerned with the nurses reality and need to get facts, and to leave their own reality out of the matter in hand.

The fourth way that nurses position patients is through focusing on 'problems'. This is where they announce to the patient that they only want to know if the patient has a problem with the issues concerned. They are in effect asking the patient to make their own assessment of matters. They did this through the use of leading questions. For example, patients are asked if they have a problem with their bladder or their bowel:

Student Nurse - Do you have any bladder problems?
Mrs Violet - Only during the night. As I said, I get up every two hours - but during the day I'm alright.
Student Nurse - Any bowel problems?
Mrs Violet - No - I'm a good girl - I take All Bran every day for breakfast.

Here the student nurse restricts Mrs Violet's replies to any problems the patient may have. Although Mrs Violet gives the nurse details about how her bladder disturbs her during the night and how she takes All Bran for her bowels (implying some potential difficulties), the nurse does not explore these issues further.

Sometimes patients are positioned by being told that they do not have a problem:

Staff Nurse - You get out and about, you're fully mobile, you don't need a stick or anything?
Mrs Mitchell - Oh, no.

Here Staff Nurse gives the patient no chance to tell the nurse about how she 'moves' about. Staff Nurse has made an assessment and tells the patient that she does not have a problem with getting around. She makes several moves: in the first she translates the dimension of "getting around and about" into a medicalised version - "being fully mobile". She then uses metonymy to reduce the issue further so that the process 'getting around' is substituted and limited to, the matter of using or not using a stick. (This sequence was frequently used - see the interview with Mr MacGregor, p242). The patient had already told the Staff Nurse that she has a home help once a week, but otherwise manages herself. Staff Nurse also 'knows' the patient was out at the shop that morning, where she collapsed. She had also been informed by the patient that a previous stroke affected the patient's left foot. However, what Staff Nurse does not establish is whether the patient has fallen before, or whether she experiences any difficulty in getting around. Staff Nurse makes the move that "using a stick" is representative of "not being fully mobile". All that can be said after this line of questioning is that the patient does get out and about and that she does not use a stick. Staff Nurse has not seen the patient walking at this point. I did observe that the patient was in fact very 'nimble' when she did get out of bed and walk around. She did, however, limp.

Sometimes nurses lead the patients reply by qualifying their question, as with the special diet illustration above. It is very rare for nurses to use completely open, undirecting questions. When they do they often 'take it away' again by qualifying it with another one:

Student Nurse - How's your skin? Do you get ecxema, dry patches or any thing like that?
Mrs Appleton - No. Just old and wrinkled.

This approach to questioning patients about themselves and their health is displacing:

patient's meanings get excluded from any picture nurses make of the patient. The following example illustrates how the nurse, using this approach, ends up excluding the patient's meanings but constructing an image of the patient:

> **Student Nurse**: Are you on any kind of diet at all - for diabetes or anything like that?
> **Mrs Violet** - No.
> **Student Nurse** - Are you allergic to any food or anything?
> **Mrs Violet** - No, not that I know of.
> **Student Nurse** - And is there any foods you particularly don't like?
> **Mrs Violet** - Only sausages - and beans - I'm not very partial to those.
> **Student Nurse** - Do you have any bladder problems?

In this exchange Mrs Violet is willingly complying with answering the nurses' questions about food. The questions relate to three aspects of food - any medical diet that the patient may be on, any allergies the patient may have, and any food the patient does not really like. All three aspects may have implications for the nurse in terms of arranging the patient's meals in hospital, but they do not tell the nurse anything about the patient in terms of her so-called 'nutrition'. The interesting issue here is that the patient had already indicated that she had what she clearly perceived as a difficulty with intake of food, constituted by her as her weight:

> **Student Nurse** - What is your height?
> **Mrs Violet** - Five feet six inches.
> **Student Nurse** - And your weight?
> **Mrs Violet** - [laughs] Well, I'm eleven stone four but I would much rather be a bit less than that.
> **Student Nurse** - Are you on any kind of diet at all - for diabetes or anything like that?

In the sequence on the form the category 'diet' comes just after the category 'weight'. The nurse is not asking the patient to elaborate on the diet issue in terms of the 'weight issue', as is firmly indicated by her qualifying her question with "for diabetes or anything like that?". 'Weight' in this respect for the nurse is unconnected to diet. The nurse does not report in the patient profile about the 'weight' issue. She wrote on the patient profile:

> weight: 11 stone 4
> Diet: Normal diet.

The interesting aspect of this disregard for what the patient perceives to be an issue about her weight is that the patient had just been admitted with a 'heart problem'. Diet, in nursing and medical discourse, is usually of concern in those patients with heart disease. But no connection is made by the nurse (Mrs Violet was certainly not particularly visibly fat), and the patient's attitude to her diet is not investigated further. The nurse does not pursue the

issue of diet and ask what sort of diet she would like to maintain while in hospital, for example, if she would like the nurses to provide her with a reducing diet. Mrs Violet was just given the usual diet, there was no special instruction over quantities of food she was given.

Questions about sleep are also directed at checking off aspects of a patient's needs which have bearing on the nurses reality. This particular patient, Mrs Violet, was very good at giving leads. When asked about her 'sleep' she tells the nurse about her sleep despite the nurse's directive that she only wants to know if the patient takes a tablet to help her sleep:

> **Student Nurse** - Do you sleep O.K? Or do you have to take any medicines?
> **Mrs Violet** - Oh no, as I said, I was up every two hours - it's just a reaction since my husband died. I wouldn't take anything - I don't like sleeping pills or anything like that - I don't believe in them.
> **Student Nurse** - Do you smoke or drink at all?
> **Mrs Violet** - No, neither.
> **Student Nurse** - You don't suffer from depression at all or anything like that?
> **Mrs Violet** - Oh no, I've learnt to live.

The patient had previously told the nurse about the water tablets she was on and that she had to get up every two hours at night to go to the lavatory. She had repeated her statement that she got up to go to the lavatory at night when asked "do you have any bladder problems?". In the sequence of her questions here the nurse, as was usual, is following the sequence on the patient profile form, which she filled in as follows:

> Sleep: wakes every two hours to go to the loo
> Occupation : retired
> Social activities: doesn't smoke or drink
> Emotional status: good

There is some ambiguity as to why the patient is waking up at night. In her account there is a suggestion that Mrs Violet associates it with her bereavement but also with a problem caused by the water tablets she is on. There may even have been some connection between the two: Mrs Violet is giving an account which suggests that her heart problems may have arisen since the death of her husband which led to her taking diuretic therapy. However, the nurse makes it clear that she is not going to enter into any exploration of this apparent ambiguity. Her question "you don't suffer from depression at all or anything like that?" is closed and announces that she is not probing, even indirectly, about the possibility of disturbed emotional or mental state in this patient. Once again, the interesting aspect is that this is a patient with a heart condition so that uncovering any emotional disturbance may (or may not) be helpful in nursing her back to health.

Mrs Violet, in her interview with me, said that her husband had died of a heart condition in the ward below the one she was admitted to: this was not as far as I know ever revealed by the nurses. When telling me about her husband the patient wept and impressed me with how distressed she was while having maintained enormous control over herself during her stay in the ward. In my dealings with her I learnt that her emotional status was a complex achievement on her behalf. She had indeed "learnt to live".

There are several features of this particular aspect of the interviews which are of interest. First, as can be seen the sequence of the profile is used to move patients on and away from discussion. Secondly, in the nurses' approach there is separation of one category from another, whereas for patients there are connections. 'Weight' is connected to diet, 'sleep' is connected to 'bladder' to emotion, etc. Thirdly, the terms used by the nurses are not everyday terms but more or less 'medicalised', and in talking with patients they frequently maintained the medical translation. In these ways there is not only a separation of different aspects which in everyday life may be considered connected, there is a translation of these aspects which fragments and reduces. For example, 'bladder', 'diet' and 'bowel' are not aspects of life processes, eating and drinking and going to the lavatory, but are treated as separate entities translated into a specialist discursive space. This sets up discoordinations between nurses and patients and can be controlling as it acts to restrict patients' responses.

The most marked instance of the medicalisation of terms to control patients' responses can be seen in the nurses approach to the patients' 'past' health, the category on the profile called 'relevant medical history'.

Usually patients were directed to give specific details as to their past health history which had been 'treated'. In the following example the Staff Nurse commences her investigation of Mrs Mitchell's past medical history by asking if the patient had ever been in hospital before:

> **Staff Nurse** - Have you ever been in hospital before?
> **Mrs Mitchell** - I had a small stroke in August. I was in the Queens Hospital.
> **Staff Nurse** - Does it effect you at all?
> **Mrs Mitchell** - Just my left foot was weak. It was very slight though. I was only in a week.
> **Staff Nurse** - Just your left foot [looks down and writes on form].

By her opening question Staff Nurse defines the limits of interest in the patient's past ill-health to hospital admissions. In this way the constraint is applied so that even subsequent discussion about health remains limited to the medicalised world of health.

The categories 'reason for admission' and medical diagnosis [see Appendix Six] are completed using the admission summary. This is the doctors' version of the patient compiled in A&E. Nurses read the admission summary as soon as the patient has been put into bed. On occasion the nurse in charge reads it as the patient is being put to bed. The admitting nurse reads it and usually has it with her when interviewing the patient. Sometimes the admitting nurse transfers information directly from the admission summary onto the patient profile before visiting the patient. Typically, when the admitting nurse is not using it, the admission summary sits on the locker or at the end of the bed, on the bedtable and other ward nurses come up and read it. Patients do not read it. Once the part of the admission which takes place at the bedside is complete, the admission summary is kept in the nursing documentation in the nursing "kardex". It is frequently referred to during nursing handovers.

A comparison of the wording used in the admission summary and the wording used by nurses in their own records and at subsequent handovers reveals little or no difference in the ways in which what has happened to patients and what is wrong with patients is represented. The story recorded by the medical staff on the admission summary about why the patient has come to hospital and their possible diagnosis is subsequently used by nursing staff. It appears to form the basis of their view of what had happened to the patient and of what was wrong with the patient. As discussed in Chapter Eight in relation to the qualified nurses' accounts, the doctors' views of the patient help locate the patient in the nurses' world. But this has its problems.

Typically, nursing staff do not check in any depth *with* the patient the reason why the patient has come to hospital. In the research material any inquiry as to why a patient has come to hospital appears perfunctory, almost a matter of courtesy rather than as a part of an investigation.

In the following example Staff Nurse is admitting a patient, Mrs Mitchell, having already copied information from the admission summary onto the patient profile prior to seeing the patient. What follows is the only reference initiated by Staff Nurse during the admission interview as to what had happened to the patient:

> **Staff Nurse** - So what happened to you today?
> **Mrs Mitchell** - I was getting my paper this morning and I just collapsed in the shop.
> **Staff Nurse** - Uhm. I just want to check some details [goes on to check name and address etc].

The Staff Nurse does not ask Mrs Mitchell to explicate further about what had happened or

how she felt at the time of collapsing. As can be seen she moves on to the next part of her agenda, thus announcing she has finished with this topic. The admission summary reads :

> sudden onset of dizziness in Newsagents this morning....Doesn't remember much about it. Thinks there was a brief L.O.C [loss of consciousness]
>
> The medical Registrar reported (in the admission summary): Probable mid-brain CVA [cerebro-vascular accident or stroke]

The patient profile, written by Staff Nurse, reads :

> reason for admission - Sudden onset of dizziness
> medical diagnosis - probable mid-brain CVA

The progress notes, where nurses write a brief synopsis of the admission history, is compiled of extracts from what is written on the admission summary:

> Admitted via A&E after sudden onset of dizziness in a shop. Doesn't remember much. Thinks she could have blacked out.

As can be seen Staff Nurse used the information about the patient's admission as recorded on the admission summary to describe why the patient had come into hospital. Staff Nurse made one change, which was to state that the patient "thinks she could have blacked out", rather than using the terms on the admission summary - "Thinks there was a brief L.O.C. [loss of consciousness]". Staff Nurse asks the patient "what happened" but does not probe any further so that her query appears to be a matter of courtesy or a confirmatory check of what she has read on the admission report. In contrast, she goes on to make a detailed check of the demographic information required, much of which is written in the admission summary prior to writing it on the patient profile form.

At the handovers following the patient's admission, the patient was presented as Mrs Molly Mitchell, 84, having come in with "sudden onset of dizziness", and "possible mid-brain CVA". During the patient's stay the nurses use the notion of "dizziness" as a yardstick of wellness or progress, so that they record in their progress notes and report at handovers whether or not the patient was dizzy and how dizzy the patient was, if she was dizzy.

During the admission interview Mrs Mitchell attempts to initiate further discussion about what had happened to her.

> **[Mrs Mitchell, Day 1]**
> **Staff Nurse** - ...Have you had any problems with raised blood pressure?
> **Mrs Mitchell** - It's been very good. I went to the doctor last week. She said it was fine. I have had no problems with it since I started taking those tablets.
> **Staff Nurse** - Uh-uh [smiles]. Have you any money with you?
> [A little later in the interview]:

Staff Nurse - Do you have any problems with your heart or chest at all?
Mrs Mitchell - I occasionally get a wee pain in my heart. I take a wee tablet under my tongue and that deals with it. It is nothing though really. My heart's fine. So what's wrong with me this time?
Staff Nurse - When you came in your blood pressure was up so that's probably what made you collapse. We'll keep an eye on you for a few days to check that it's alright.
Mrs Mitchell - The doctor said it was fine only last week? [A query in her voice].
Staff Nurse - [Smiles]. Do you wear spectacles?
[A few minutes later]:
[Staff Nurse takes the patient's blood pressure]
Staff Nurse - It seems fine.
Mrs Mitchell - I don't see how it can be the raised blood pressure that caused it.
Staff Nurse - That's what the doctor seems to think at the moment. [Takes temperature and pulse].

In these extracts Mrs Mitchell seems to want to discuss 'what was going on' - it is as if she wants to make sense of what has happened to her. Staff Nurse uses various techniques to return the patient to the matter in hand - filling in the profile and taking observations. She smiles and asks the next question once the patient has told her what she wants to know about blood pressure: in this way Staff Nurse indicates that that is the end of that topic. When the patient asks the direct question "So what's wrong with me this time?" the Staff Nurse tells the patient that high blood pressure probably caused the patient to collapse. Staff Nurse is concealing information from the patient, that she may have had a stroke (a mid-brain cerebro-vascular accident).

Mrs Mitchell, however, appears sceptical of Staff Nurse's explanation, that high blood pressure caused her to collapse, because her own G.P. had told her so recently that her blood pressure was fine. Staff Nurse's account does not make sense to her. Staff Nurse indicates that she is not prepared to enter into any debate about this by again blocking the patient - she smiles and asks the next question "Do you wear spectacles?".

When Staff Nurse has taken her blood pressure and tells her that "It seems fine", Mrs Mitchell again reveals her apparent scepticism at Staff Nurse's explanation that high blood pressure caused her to collapse. But the message given back to the patient by Staff Nurse is categorical - the doctor, not she herself, thinks that is what happened. Staff Nurse accounts for her account by reminding the patient that there are hierarchies involved here.

Staff Nurse may have been trying to exonerate herself from any potential mistake, to devolve responsibility for the diagnosis onto the medical staff or simply to withhold the diagnosis to protect the patient. But she cites the "doctor" as an authority and puts the

patient in the position of having to doubt herself and her own G.P. or the hospital doctors [the so-called experts].

There are several interesting aspects about how Staff Nurse handles this admission. She is effectively announcing to the patient that making sense of what has happened to the patient is something that she is not prepared to investigate *with* the patient. Staff Nurse acts to avoid engaging with the patient in this matter.

It does not seem to occur to Staff Nurse that the patient may have already been told that there is a possibility of her having had a stroke by someone in the A&E department. Also, she did not take into account the fact that the patient had already had a stroke in the past, so that the patient may have recognized the signs if she had had another one. Staff Nurse does not allow the possibility that Mrs Mitchell is clearly unable to account for the story being constructed around her admission (that she had high blood pressure and that caused her to collapse) to have significance. Further, Staff Nurse does not allow the possibility that Mrs Mitchell may have had more to tell and may have been helpful in establishing what had happened to her: that discussing these matters together may have helped Staff Nurse construct her story about Mrs Mitchell which was informed by Mrs Mitchell's own account of herself and what had happened to her.

The following day on the ward round, one of the doctors asks the patient in some detail about what had happened prior to the patient going to the shop where she had collapsed. The patient revealed that she had taken an angina tablet just prior to going out for a "little pain in her heart". The rest of the ward round members give knowing nods and smiles at this information. The lecturer continues to cross-examine the patient, leading her on, to show that what she has done is go out too soon after taking the angina tablet, but he does not tell the patient that. Mrs Mitchell is told by the lecturer that she has had a "simple faint". In the doctors' notes a diagnosis of " probable GTN [glycerin trinitrate] induced syncope" was recorded. Sister 1 attended the ward round. The change in the medical diagnosis from mid-brain CVA to GTN syncope was recorded on the front of the patient profile. The fact that the patient was for discharge the following day was the other outcome of the ward round recorded in the nursing progress report.

Just prior to her discharge I interviewed Mrs Mitchell: she claimed that no one had discussed further with her why she had collapsed. She said that "they don't seem to know - it was just a simple faint". The issue as to how she should take her heart tablets was not gone into with the patient.

Nurses did discuss what had brought a patient to hospital, their usual health nor their

so-called diagnosis with them in any detail at any time during the six-month research period. In this respect there may be some relationship between why nurses make only cursory inquiry as to what had brought the patient to hospital and the 'danger' of discussing what is wrong with the patient: causal relationships such as reason for admission and diagnosis are matters for those with expert knowledge and sight. As already indicated in Chapters Six and Seven qualified nurses are quite happy to discuss these matters between themselves.

It must be stressed that it is not simply junior or student nurses who would not or do not discuss these matters with patients. The senior nurses also avoid these types of discussion: it is virtually a taboo. So, while the nurse in charge at the time of the patient's admission usually comes to see the patient some time soon after they had arrived on the ward, any inquiry as to what had brought the patient to hospital or how they are actually feeling *now* appears perfunctory or simply as a crosscheck on some already known or identified issue. This is now illustrated.

In the following extract, Sister 1 has taken the handover from the staff nurse who accompanied the patient, Mrs Mary West, on her transfer from the admissions ward. Sister 1 had no contact with Mrs West at the time of her arrival, but stood at the end of her bed to take the transfer. The transfer centred on the admission document and on the technical equipment attached to Mrs West to enable observation of her vital signs. These included a central venous line (CVP) and a urinary catheter attached to a urometer. Sister 1 then came over to see Mrs West about 40 minutes later. Sister 1 looked at the urometer with the student nurse assigned to look after the patient, Mrs West was on hourly measurements of urine. Sister 1 then moves next to the patient to speak with her:

> [Mrs West, Day 1]
> **Sister 1** - [moves over to patient and leans down] How are you feeling? Is your shoulder sore?
> **Mrs West** - ..?. my leg.
> **Sister 1** - You got a bad knock yesterday - can you remember what happened?
> **Mrs West** - I was at the island and crossing the road when the car came and hit me...[inaudible].. I am usually so careful. I didn't see him.
> **Sister 1** - Ach, well, don't worry. [takes patient's hand].
> **Mrs West** - [goes on speaking - I cannot quite hear. The doctors arrive at the bed].
> **Sister 1** - [turns away from the patient as the doctors arrive at the bed; the patient goes on speaking, turning to me].
> **Mrs West** - ....a policeman came over on the other ward but I - [Sister and the Doctors walk off].

Sister 1 asks how the patient is feeling but immediately qualifies her question to focus and limit the patient's response to whether or not her shoulder is sore. Sister 1 may have been

asking the patient what happened because she wants to check whether the patient is suffering from any loss of memory and to get an idea of her general state. In other words she may have been concealing her intentions, a technique described and discussed in Chapter Eight.

At the arrival of the doctors, Sister 1 turns from the patient in preference to them. Her turning away from the patient as the patient is speaking indicates she is not particularly interested in what the patient is telling her, her own version of what had happened. Sister 1 leaves the patient without any parting as the patient is in mid-sentence.

A little later Sister 1 accompanies the lecturer on his examination of the patient. She spends quite some time on this and from this consultation she takes away 'information' about how the patient is to be 'managed' according to the doctor: the patient can drink and is to remain on hourly measurements of urine and central venous pressure. As can be seen Sister 1 does not appear to see the patient herself as an important 'source of information'.

Both these extracts are typical in the wards of how nurses avoid engaging with patients and disregard patients as informant with respect to how they came to hospital or what is wrong with them. It confirms the ways in which the qualified nurses talked about how they assess patients: that signification does not come through the patient as a source of knowledge or as an experiencing self. This can best be explicated further in tracing the story of Mrs West on from her admission.

At the handover following the patient's admission, Sister 1 reads from the records that the patient "was knocked down yesterday by a car". She does not embellish this statement with any of the apparent meaning this had for the patient or even with what the event may have symbolised in terms of the patients frailty and potential dependency. From the extract quoted above, it appears that the patient is not only shocked by the violence of what had happened to her - the car "came and hit me" - but is also worried by her own mistake - "I am usually so careful. I didn't see him". Mrs West was eighty-eight, living alone, very frail and by her own account only just managing to still get out and about. Sister 1 does not say anything directly about these matters at the post-admission handover. Sister 1 reports that:

> She's fine. She can be up to sit.

A Staff Nurse then points out that 'they' are now mobilising patients with the particular kind of fracture which the patient may have suffered (there remains some uncertainty of diagnosis here). Sister 1's response is as follows:

> Yes get her going, get the physios to see her. She's 88 - we ought to get her going.

In her assessment of the patient, that she was fine, and in her directive to "get her going" Sister 1 appears to be attending to some other, invisible discourse, which makes aspects of Mrs West's situation significant and which legitimates her directives, a discourse which decrees that eighty-eight year olds must be mobilised as soon as possible.

However, from the observation data of the patient in the two hours prior to this handover the patient was not seen to be 'fine'. She exclaimed, moaned with pain and resisted when the nurses, including Sister 1, wanted to move her to carry out some procedure, such as taking a CVP reading or for the doctor to examine her chest. She quite clearly told the nurses and the doctor that any movement was "very sore".

Further, Mrs West was evidently concerned and shocked by what had happened to her, as can be seen in the exchange above with Sister 1 about being hit by the car. However, Sister 1 does not mention the patient's feelings about her accident and while she takes the 'pain' into account it is in an oblique, disembodied way: she does not describe the patient's pain but only discusses the analgesia, in terms of her own assessment of the patient's pain:

> Sister: She's for all care, turns two hourly. And for paracetamol. Analgesia.. she's written up for cylclimorph but I think that's a bit fierce really - ask them to write her up for something less powerful - DF118 maybe.....She's fine [pause]. She can be up to sit.

From Sister 1's point of view, perhaps, the patient is not medically critically ill at this point, although she did have the artefacts associating her with critical illness - a CVP line and an hourly urometer. Sister 1 had at the beginning of this handover described the patient to the assembled nurses as

> A new patient. Mary West, 88, who I do not think is a medical problem at all but an orthopaedic one. She is an RTA [road traffic accident].

I would like to suggest that Sister successfully blocks out the experiential level of the patient's 'unwellness', this is insignificant and unable to legitimate nurses action. Sister 1 reduces the patient to a metonymic - "she is an RTA"; to an organizational problem - "an orthopaedic problem"; to an age - "88" and to the recipient of an analgesic. Further, this patient apparently having been unwell enough to have hourly recordings of her urine output and a central venous pressure line is to be mobilised, because she is "88".

Is there mediation of Sister 1's view of Mrs West's medical problems (that these are not serious enough to keep her in bed) because she is constituting Mrs West in relation to a particular class of patient: old, a risk, potentially able to block the bed, to be difficult to keep moving? Not listening to the patient's story helps not only sequestrate the patient's

feelings and experiences but helps maintain an emotional distance for the nurse, it helps avoid engagement to enable a particular view.

Mrs West became restless and confused in the night. She was apparently given morphine to "settle her", and subsequently became very delirious and "disruptive", shouting and screaming. She was then given a major tranquillizer (chlorpromazine), this had no immediate effect, and she was given a further dose. By the morning she was drugged and quiet. The nurses washed her and tried to get her up: she was clearly distressed and unable to make out what was happening to her. After she had been sat out in a chair she collapsed, she was said to be hypotensive. After two weeks she was only just beginning to get around and the geriatricians took over her care, and she was transferred to an orthopaedic rehabilitation unit.

The example of Mrs West helps illustrate how the non-medical aspects of a patient may actually mediate nurses' views of a patient's so-called medical condition. Mrs West is constituted as a risk because of her age (?and the look of her - frail, dishevelled, bashed about, agitated) and possibly her so-called history (she had home helps everyday etc). These matters alert Sister 1, who then does not rate her as a medical patient and who got her mobilising early despite the apparent gravity of her medical condition (the CVP line, the urometer). The suggestion is that with respect to particular classes of patient (the very old, the very dependent, the demented) nurses have tacit permission to get on and mobilise a patient *despite* his or her medical condition. The context allows certain aspects of the patient to take priority, to have visibility, while others recede. For example, Sister 1 does not mention when handing over that the reason Mrs West has a CVP line and a urometer is that she went into shock and had bled from her stomach while in A&E: a gastric haemorrhage, in the parlance of the hospital constitutes a 'medical problem', while Mrs West's fractures constitute an 'orthopaedic one'.

It is in this way that the moral underpinnings of the setting - expressed as the saving of life - can be manipulated by constituting classes of patient which are exempt from this as a moral obligation. This is suggested by Bauman [1991] in his discussion of the social manipulation of morality. Bauman suggests that there is social manipulation of morality through the institutional ascription of persons to classes, some of which are exempt, so that they no longer have a face or authority to trigger moral conduct: Bauman describes this as "effacing the face". Bauman states that these exempt classes can range from the exemption of a

> ...declared enemy from moral protection, through the classifying of selected

> groups among the resources of action which can be evaluated solely in terms of their technical, instrumental value, all the way to removal of the stranger from the routine human encounter in which his face might become visible and glare as a moral demand. In each case the limiting impact of moral responsibility for the Other is suspended. [1991, p145]

The face as a moral authority has a "limiting impact " on conduct. Where the other is constituted as a class of actor who is exempt from moral protection, there is effacing of the face, and the limiting impact is suspended. I am suggesting that in the case of particular patients *seen* in particular ways by nurses there can be a suspension of or a reconstruction of their moral responsibility to the individual. This is accounted for by nurses in various ways: that quality of life must be considered in some circumstances to determine treatment, that the ward is for acute patients and beds must be available. These matters have already been suggested in my analysis of the nurses accounts in Chapter Eight and of the ward rounds in Chapter Seven. There is further discussion of this aspect of nurses' assessment in Chapter Twelve.

Typically then, patients' current condition as experienced by them, their explanation of what had happened to them and the meanings this has for them, are not really taken as significant enough to be accounted for by the nursing staff. It is only those issues which can be read by nursing staff in relation to some predefined legitimating discourse which have visibility/accountability. But it must be stressed that, as can be seen in the case of Mrs West, these matters are not fixed, but, *critically* can be manipulated according to the particular situation at hand.

Further, it would appear that nurses actually avoid engaging with patients to explore their experience and the meanings matters have for them. A patient's 'condition' gets represented through other voices than their own.

From the analysis this does not just happen in relation to the immediate issue of diagnosing patients but in relation to their usual health and to any specific issues which could be constituted as their response to their current illness: the nurses systematically and consistently block patients' participation in the constitution of the story about them. This constitutes a particular methodological approach: it simulates a form of history and examination based upon a positivistic science. It reduces the patient to traits and parts and affects a non-participative relationship both in the constitution of meanings and the production of signs.

I would like to suggest that these methods and tactics represent accomplishments: nurses, in their encounters with patients, are through their conduct achieving sequestration of

patients' experiences and concerns. Patients experiences and concerns are not only not given significance, they cannot alone legitimate action. They are not 'important enough' on their own to support action or have accountability. They are not observable/reportable matters.

The effect is to exclude the patient from participation in the interpretations about their condition/status. One effect of this, as has been demonstrated in this chapter, is that nurses' records and their talk about patients do not represent them in the light of how patient's see or account for themselves (e.g. Mrs Violet above). The patient's voice is excluded from helping to constitute the context in which they are viewed and in which they become visible. There is an attempt to silence patients.

So the question which arises from the analysis of the nurses and patients encounters is: 'what are nurses accomplishing in these encounters'? This question is now addressed.

Disciplining Patients, Disciplining Nurses

I would like to suggest that what is being communicated through nurses' conduct are forms of order: what has priority in this place and what does not have priority in this place, what gets counted and what does not get counted, what has visibility and what does not have visibility.

Through nurses' conduct forms of order are established through a displacement and sequestration of patients feelings, concerns and experiences. It is only where feelings can be translated into what are commonly called signs and symptoms that they have significance. As Bauman [1991] has discussed, what is effected is a social manipulation of morality: nurses, with medical and paramedical staff, are effecting the reduction of patients and an effacement of patients as a "face" (with a moral demand to be counted as an authority without force) [Bauman, 1991].

The practices through which nurses help achieve this reduction and effacement are displacing: they exclude patients from membership. This exclusion is accomplished through nurses and others *communicative practices.* Nurses act to exclude patients from participation in the production of significances and the constitution of meanings: that is from participation in a constituting discourse through which they are written and read in the setting. They are systematically excluded from participation in authorship of the accounts constructed around them. This effectively denies patients' membership (however temporary) in the setting where membership is constituted through participation in a language. As Garfinkel and Sacks [1969] express it:

The notion of member is the heart of the matter. We do not use the term

'member' to refer to a person. It refers instead to mastery of natural language. [p163]

The accounts of the setting are composed through drawing on a variety of discourses, these constitute the natural languages of nurses and doctors, they are not constituted in participation with patients. An effect of this exclusion from membership, it is proposed, is that patients cannot legitimate the actions of others on their own account.

What is also suggested by the qualified nurses accounts and appears to be confirmed through examination of nurse-patient encounters, is how nurses achieve this displacement of patients as an authority through locating their understandings outside their proximity to patients. Through looking at patients according to particular grids of perception, and interpreting what they have supposedly seen through particular codes [Foucault, 1973], nurses are constructing an expert or professional gaze and create forms of social distance between themselves and patients. So while they are in situations of co-presence, are proximate to patients [see Bauman, 1990], they restrict patients access to them: they successfully act to avoid engagement in the patients' accounts and their life-world.

The qualified nurses stated that their main method, after their interpretation of the doctors' representations of patients, is their looking: their looking is a looking for, they are looking to see the patient as written in particular ways, translating what they apparently see through particular codes.

Nurses are assessing patients in relation to an order of things which displaces patients, but which the patient, fractured into traits and parts, can be seen to re-present: the patient is in the present context an artifact, not a co-producer of signs, and nurses, along with others, consume them as significant in particular ways, rather than others. The patients self-identity is annulled to reveal what is identifiable to the expert eye. The patient is written. I am suggesting that this also displaces the nurses' own socially embedded and interpretative engagement with patients as both an other (and 'one of us').

What has not been addressed so far is how nurses' conduct acted on patients: 'how does nurses' conduct help nurses and patients make occasions for nursing'? I would like to suggest that through placement and displacement a particular type of disciplined nurse-patient relationship is being instituted through which patients' are being instructed to discipline themselves. This matter is now explored using the admission of Mr Macgregor.

[Mr MacGregor, Day 1]
[Student Nurse goes to side of the Patient with forms. She leans on the locker to write and turns to the Patient when she speaks to him - she is standing above him - not close].

Mr MacGregor - If you could - I am not sure if I have any money - but if you could phone my wife?
Student Nurse - Right, what is the number?
Mr MacGregor - What?
Student Nurse - What is the phone number?
Mr MacGregor - Oh yes. It's [says phone number]. Tell her they've made a decision to keep me in, this hospital, ward 10.
Student Nurse - Right - can I ask you a few questions first?
Mr MacGregor - Yes - certainly.
[Patients' mouth is terribly dry - he looks quite sallow and unwell]
Student Nurse - What's your address, please.
Mr MacGregor - [gives address].
Student Nurse - And what's your date of birth, please?
Mr MacGregor - It's [gives date of birth].
Student Nurse - And your religion?
Mr MacGregor - C of E, well you know, episcopal. And my wife is C of E. We share things out [laughs].
Student Nurse - [laughs]. What's the name of your doctor?
Mr MacGregor - Dr Peters.
Student Nurse - And his address?
Mr MacGregor - It's..[gives address]
Student Nurse - OK, right.
Mr MacGregor - It was him that sent me here.
Student Nurse - Right, do you know why you were admitted?
Mr MacGregor - I'm not quite sure - I had these pains, and shaking yesterday, I thought [.?.].
Student Nurse - If you need to ..?..telephone [.?..] own number. Do you take any medicines at all?
Mr MacGregor - They're all in there [points to plastic shopping bag on bedtable. Student Nurse fetches bag and gives it to him. He takes out the tablets and reads off the labels to her].
Mr MacGregor - Lanoxin - one a day.
Student Nurse - Right [takes bottle and comes to me and asks about the dosage - I says it is 0.0625 mgs. She goes back and stands by the Patient]
Mr MacGregor - Zyloric .[.?.].Slow K three a day.
Student Nurse - [writes].
Mr MacGregor - Frusemide, one a day.
Student Nurse - Frusemide.
Mr MacGregor - I think that's all. [Looks in the bag] Oh good grief. Oh!
Student Nurse - How many of these do you take a day? [holding up zyloric pack]
Mr MacGregor - One. You've probably only got 100's. Is that six pills?
Student Nurse - No four. Three bottles and a box.
Mr MacGregor - Frusemide?
Student Nurse - Frusemide, Zyloric, Slow K, and Lanoxin.
Mr MacGregor - I'm trying to think what the others were.
Student Nurse - That's OK - we can get the others later. How are you on your feet - any problems?
Mr MacGregor - Not really - OK - I get around.
Student Nurse - Do you use a stick at all?
Mr MacGregor - Oh yes.

Student Nurse - How tall are you?
Mr MacGregor - About five foot five and half.
Student Nurse - And what weight are you?
Mr MacGregor - About 9 stone.
Student Nurse - Do you have any problems with your bladder?
Mr MacGregor - I'm always on the run.[smiles]
Student Nurse - But that's because of your frusemide isn't it [not a question]. How about your bowels?
Mr MacGregor - I was a bit - so I took two pills night before last.
Student Nurse - Were you constipated?
Mr MacGregor - I think so.
Student Nurse - Is your diet quite good?
Mr MacGregor - Everything.
Student Nurse - Do you suffer with dry skin at all?
Mr MacGregor - Not particularly.
Student Nurse - Are you allergic to anything?
Mr MacGregor - Not that I am aware of.
Student Nurse - Do you smoke?
Mr MacGregor - I used to - I gave it up.
Student Nurse - Very good.
Mr MacGregor - I went to a party and came home and when I got up in the morning I smelt my clothes, it was revolting, I thought how awful for other people to smell me like that.
Student Nurse - Very good. Do you ever wear glasses?
Mr MacGregor - Yes.
Student Nurse - Are you a good sleeper?
Mr MacGregor - We go to bed at half past ten - I mean we turn out the light then. Then I wake at 12 - I take a sleeping pill then - normally I sleep until 7.30 but if I wake up again at about 4 or 5 I take another pill.
Student Nurse - Do you have any activities - what hobbies have you got?
Mr MacGregor - None now. I used to do a great deal of walking - up into the Moorlands and up North - can't do it now.
Student Nurse - Do you have any social workers or home helps?
Mr MacGregor - No, we employ.
Student Nurse - How often?
Mr MacGregor - Monday and today - she came in to do the ironing. Because my wife's like me - heart trouble.
Student Nurse - [writes].
Student Nurse - If we need to get in touch with your wife - I'm going to give her a ring just now - but if we needed her in the night is that the right..? [pointing to the number he has already given to her]
Mr MacGregor - Yes.
Student Nurse - I'll just do your blood pressure and pulse.
Mr MacGregor - I would like a drink of some kind.
Student Nurse - I'm sorry?
Mr MacGregor - I would like a drink of some kind. I'm very dry.
Student Nurse - Right. [Continues to write. She turns to patient holding nameband] I need to put this band on to tell who you are, and your date of birth. And I'll check with the doctor if it's alright for you to have something to drink. [puts nameband on]

Mr MacGregor - Oh yes.
Student Nurse - I'll just cut that off. [takes scissors and trims the end].
Mr MacGregor - Thank you. [Student Nurse turns to go]
Mr MacGregor - What are your names?
Student Nurse - My name is Carry.
JL - Joanna.
Mr MacGregor - Right.
Student Nurse goes and I follow.
14 mins 53 secs.

[N.B. Approximately one and half hours later the patient is given a drink and is told by both the doctor and the Staff Nurse that he must drink as much as possible - they suspect he has a urinary tract infection].

This interview with Mr MacGregor was typical in the setting, across student nurses, qualified nurses and two different wards. Held up against models for so-called nursing assessment the interview fails. However, as stated earlier in the chapter these encounters with patients do represent competencies: they are examples of how nurses with patients organise themselves to make occasions for nursing. They represent accomplishments. The question to be addressed is what does this encounter accomplish?

First, the facticity of the nursing assessment form allows the nurse to act directly on the patient. It creates an access through which the nurse can instruct the patient. The nurse is instructing the patient in the order of things in this particular setting. She is *disciplining* the patient. For example, the patient, used to giving orders [he was a professional officer in the airforce] and being in authority, as he told me later, asserts himself at the beginning of the encounter. He asks the nurse to telephone his wife, and gives precise instructions as to what she is to be told. The nurse takes the instruction, but defers it until later, she asserts her work of asking questions is to come first.

From then on the interview can be seen as a series of moves to let Mr MacGregor know that his meanings, his life-world and his experiences of illness are subordinate to or are set apart as extraneous to the main work of the setting. For example, he states that while he is unsure as to why he has been admitted what brought him to the hospital were "pains and shaking", these as aspects of 'how he was' are not developed by the nurse to know how 'he is now'; he says he "just" gets around with a stick and cannot go walking like he used to, why this is or how this affects his life is not developed by the nurse; further, he and his wife have heart trouble, how this affects him and his life is not pursued. Unlike in an ordinary conversation, the nurse does not pursue many of the patient's leads. The implication is that in some mysterious way these facts are telling her (or someone else) something about the patient.

But the purpose of the nurse's questions remain hidden from Mr MacGregor (and quite possibly from the nurse). She does not allow him to participate in the production of significances or in any interpretation: she does not let him help translate these aspects of himself or his identity into understandings about him and his care. She treats these aspects of his life and of his self as separate from each other and as matters of fact, and conducts the interview as if she is revealing the facts of the matter. She makes him do work in revealing the matters of fact, like reading off the drugs for her. The key to the significance of these matters of his self and his identity is held elsewhere: they simply become signs which the nurse is collecting, to be consumed by others. She is reading off the writing on the wall.

Towards the end of the interview Mr MacGregor breaks in again, and asks for a drink. In an echo of the beginning of the interview the nurse indicates she did not hear, so Mr MacGregor repeats his request and this time gives an account of his request. Whereas at the beginning of the encounter he did not account for his request for his wife to be informed of his admission, his justification for wanting a drink, that he is very dry, indicates how he is ready now to explain himself: it indicates that he has been disciplined, he knows now that to break in on the nurse's routine, on the nurse's time, he 'needs' to justify himself, to give a reason. The nurse once again defers Mr MacGregor's request for a drink, first to put the name band on, and then she, in her account, establishes a new aspect of the order of things - Mr MacGregor, like her, 'needs' permission from the medical staff before he can have a drink. This hierarchy helps her and Mr MacGregor to rank his wants and to relay how Mr MacGregor may require permissions from the nurse. It helps to establish the relations of power and the hierarchies in the setting. Mr MacGregor's thirst has no legitimacy, a drink requires authorization from someone else, an authority.

Mr MacGregor was not given a drink for about an hour and a half. A jug was placed upon his locker sometime before this but he did not notice it. He repeats his request for a drink, to Staff Nurse, who expostulates that the drink is there, already supplied, and tells him he must drink plenty. Shortly after this the resident also tells him he must drink plenty. So he is disciplined once more: the staff will supply the drinks because they want him to drink, it is in their interests and in his interests for him to be supplied with drinks, it is now a legitimated issue, to help his condition, but it is up to him to follow the orders. His thirst and dryness, take on significance as they are translated through the discourses of the setting: he has a urine disorder, he must drink.

Mr MacGregor's concern for his wife appears to have a short lived significance for

the nurse. She telephones his wife and tells Mr MacGregor she has done so and that his wife is having tea with the warden of their flats. She indicates that the warden has told her that his wife has recently been ill. Mr MacGregor confirms this, but the nurse does not pursue the matter. For Mr MacGregor his concern for his wife was of enormous significance to him throughout his stay in hospital: she was dependent upon him, or so he said. This concern of his was not made significant in the setting for some reason. He was quite willing to express this concern, he did so to me on a number of occasions and to one of the doctors. However, it did not as far as I know get reported as a matter of any significance, neither in the nurses' discussions about Mr MacGregor or in the nurses' records. In their representations of him he was simply married and his wife was simply unwell: something which he claimed was central to his life-world had no place in their representations of him.

I am suggesting that the form-filling accomplished something apart from acting to instruct the patient. That it acts on the nurse: that it acts to reveal and to effect her disciplined behaviour. It makes something about her visible to others and creates a context in which she can view the patient. Through her treating Mr MacGregor as fractured, as rendered to parts and traits, and in treating the admission as revealing matters of fact, a discursive space is created in which she can think of him as fractured and herself as ordering the world in particular ways.

Further, any interpretative dimension to her own understandings of Mr MacGregor is displaced. She is being disciplined to think of patients in particular ways, she is being instructed to think of patients not as persons, knowing and understanding, experiencing and whole, but as fractured: as diet, mobility, allergies etc. This fracturing helps discipline the nurse to think of patient's as a series of wants and of him as a self as somehow extraneous to knowing how to nurse him in the immediate present, so that understanding how to nurse Mr MacGregor in the immediate present is dislocated from Mr MacGregor himself and displaces the possibility of her own interpretations of his wants.

The care plan for Mr MacGregor read that he had three identified "Existing/Potential" problems:

1 Chest Pain

2 Immobility

3 Hygiene

None of these so-called problems appear to have arisen from the interview. The immobility and the hygiene are derived from his being confined to bed by the nursing staff. "Chest

pain" was not discussed during the interview and on his nursing assessment form the nurse wrote "cardio-respiratory function: non-smoker". His shivering, his thirst, his wife, his constipation - none of these are on his care plan.

The second accomplishment of this encounter, which acts on the patient, is that Mr MacGregor is fractured into aspects of himself: his life-world is surveyed and rendered into parts. He is reduced to traits and parts: diet, mobility, allergies etc, etc. Bauman [1991] discusses how this form of reduction helps in the social manipulation of morality in modern organisations: the reduction of the other to their parts or their traits helps deconstitute the self.

The nurse's conduct relays to Mr MacGregor through disciplining him the order of things and accomplishes the institution of a particular form of relationship between him and the nursing staff. He is disciplined enough to take the instruction and 'do' [Garfinkel, 1967] patient, to be patient: he goes along with her performance. Mr MacGregor is predisposed to reveal and to be instructed. Thus the critical moment is how Mr MacGregor is turned from taking it for granted that his wants and his concerns, expressed plainly by him, will be 'taken on trust'. By the end of the encounter he feels compelled to give an account of himself, to justify his breaking in on the nurse's agenda, the nurse's time: "I would like something to drink. I am very dry." He can no longer take it for granted that he will be taken on trust or that he as a self (his self at this time being tied up with concerns for his wife who was herself ill and dependent upon him and his thirst) will be taken into account, he has to account for himself. He recognises his lack of authority and is thrown back on himself to rethink his identity and, perhaps, that of the nurses.

In this particular case Mr MacGregor expressed his impatience with the workings of the ward and was left in a quandary as to what precisely it was all for. But he was at a disadvantage: once he was fairly recovered the doctors investigated him for something much more sinister than a urine infection, he had a 'cyst' on his kidney, with an abnormal blood picture and the doctors wanted to check it was not 'a growth'. This prolonged his stay and made his situation even more tense with regard to his wife, but he hung in there in case it was something grave.

Discussion

In this Chapter I have explored the nurse-patient encounters mainly at the time of patients' admission to hospital. I have suggested that through these encounters a particular form of nurse-patient relationship is instituted. Nurses and patients are disciplined to

reproduce relationships in which the patient and nurse displace the patient as a producer of signs and a source of knowledge. Through this displacement patients are effaced, their face cannot legitimate action. Further, the nurses' accounts about patients displace the interpretive nature of understandings through dislocating them from patients' life-world.

This relationship is instituted through nurses *disciplined* conduct. The induction of the patient at the time of admission and subsequent nurse-patient encounters institutes occasions for nursing which are constituted through discourses and orders located outside nurses' proximity to patients. I have suggested how aspects of patients to be attended to through nursing activities, are constituted through nurses location of patients through the doctors accounts of patients and through their view of patients in relation to their moveability. These relationships are now further discussed in the next Chapter.

CHAPTER TEN

DOING PATIENT, BEING PATIENT

> They must keep quiet because they know people are so busy; they must be really lonely, very lonely. *[Staff Nurse 7, interview]*
>
> What do old people want? But I never can hear what old people want because of the uproar made by people telling me what old people want. Most old people take what they can get because they have no choice about it. It is we who make the moulds and pour old people into them. [Isaacs, 1976]

Introduction

It has been demonstrated in the previous Chapter how nurses' conduct acts to restrain patients' responses and to control discussion pertaining to how the patient had come to hospital and how they were feeling. It has been suggested how nurses' actions and words together, and sustained in particular ways, act as communicative practices to instruct patients. These communicative practices relay background expectations for patients' conduct and help patients produce and reproduce the order of things. However, these communicative practices instantiate forms of distanciation between patients and nurses and help institute a particular type of disciplined nurse-patient relationship.

In the previous Chapter it has been suggested that nurses move patients and themselves around through their encounters with patients. This state of affairs assumes that both nurses and patients are themselves doing something to be moved. To return to the extract from Garfinkel and Sacks cited in Chapter Four, something more has to be said about the patients to reveal how the encounters of nurses by patients can be constituted as occasions for nursing.

This Chapter discusses the work patients' do to "do" patient [Garfinkel, 1967]. This expression has been chosen as it conveys several features about the conduct of patients: first, it suggests how patients act or work to accomplish an identity through presentation of self; second, it suggests how patients read the socially embedded background expectancies to help accomplish an impression which will be visible and acceptable in the setting; and, third, it suggests how patients act to allow the performances of others in the setting. Further, there is discussion in this Chapter of how these matters are achieved through how patients and nurses *together* develop ways in which to go on in the setting to achieve presence and

construct self-identity.

In the first section there is discussion of how patients may be predisposed to do patient, drawing on the work of social theorists such as Giddens [1991] and Goffman [1955, 1958]. In the second section, there is a concern to show how patients and nurses together do work to maintain face and repair identity, and how, drawing on the work of Bauman [1991], this work is constituted as private. There is then some discussion as to how this work helps constitute membership and the production and reproduction of everyday life. In the following section there is discussion of the grounds for the sequestration of patients' feelings and experiences and that through social forms of sequestration particular features of modernity are upheld and reproduced. The effects of sequestration on patients are then discussed at the end of this section and then again in the next section in relation to the risks involved in the constituting of classes.

Patients as Predisposed to Work

This section is concerned with discussion about how patients allow themselves to be acted upon in the ways I have described in previous Chapters. Patients are not in the apparatus long enough to be socialised, they are not members of the organization and, as has been suggested, are not given membership status within the organization. However, they do act to go along with staff and get along as best they can by doing patient and being patient.

The conditions of possibility in which this apparent acquiescence occurs are now presented. They are conditions which have been suggested through my interpretations of the research material as well as from social theories drawn upon in previous chapters.

Patients like all social actors do tact work to allow others their performances [Goffman, 1958]. Further, social actors will, as Garfinkel [1967] has suggested, work to understand and reproduce the background expectancies in any setting to maintain the moral order.

Through Garfinkel's [1967] experiments with trust, the relationship between the reproduction of ordered day-to-day conduct and members "common sense" knowledge of the features of settings is demonstrated. The link for Garfinkel is some form of commitment to the reproduction of ordered life as a moral commitment:

> Common sense knowledge of the facts of social life for the members of the society is institutionalised knowledge of the real world. Not only does common sense knowledge portray a real society for members, but in the manner of a self-fulfilling prophecy the features of the real society are produced by persons' motivated compliance with these background

expectancies. [p53]

Garfinkel both takes and reveals the ordered nature of human interaction as an accomplishment of actors as members within particular settings because they work to grasp "What Anyone Like Us Necessarily Knows" [Garfinkel, 1967, p54]. But as Garfinkel argues this usually presupposes a commitment, a "motivated compliance".

I would like to suggest that there are complex relations which mobilise *some* patients' commitment in the setting and that these patients work for some kind of membership status, despite the displacements and exclusions.

While patients are reading the conduct of others to know what to expect and how to conduct themselves, I would like to suggest that they do have a commitment to allowing these performances, even where they themselves are being moved around or displaced. This commitment, it is suggested through analysis of the patients' transcripts and through readings of their interactions with nurses, comes through forms of (self)-discipline and in particular a common belief in the risks of being identified as a particular *type* of old person: dependent, mad, unattractive, demanding, old. It is argued here that the patients' commitment comes through being predisposed to an ethos or culture which holds that self-discipline and autonomy are positive features of self-identity [see also Giddens, 1991].

From the interview material (and at this point I would like to remind the reader that these were very loosely structured) it became very clear that many of the patients interviewed in the study were concerned by what many of them termed "dependency". In the accounts of many of them what emerges is a fear of becoming dependent or more dependent than they were. This was not only because they dread becoming a burden on others, but importantly, as some of them expressed it, because having to rely on others is somehow deeply problematic.

Old people are written in particular ways rather than others: their accounts are constituted and disciplined by cultural, historical and social forms. Through their conduct old people give an account of themselves, to constitute and reproduce forms of identity, which are interpenetrated with systems of belief and thought.

Here for example is an extract from Mrs Best's interview. She has been saying that she gets a bit low sometimes and has a weep and a "grumble" to herself. Mrs Best lives with her daughter; she has arthritis and a colostomy, which her daughter attends to because Mrs Best cannot manage the colostomy bags with her arthritic fingers. But she does not tell her daughter that she sometimes feels low:

JL - So why didn't you tell your daughter?
Mrs Best - I didn't want to worry her, you know what I mean. I didn't want to worry her. Just, but still. I don't want to say too much about that. (Starts to cry)
JL - You'll cry. [Pause]. Do you miss your husband sometimes quite a lot? (She had been talking about her husband just before the present extract)
Mrs Best - Oh yes, but ... [pause]
JL - But it's not that?
Mrs Best - Oh no, it's not that. [Pause]
JL - You just feel low?
Mrs Best - You just feel alone, that you've got to depend on other people.
JL - Yes. [pause]
Mrs Best - See, I cannot do it for myself, I've got to depend, but there's nothing I can do about it, I've just got to grin and bear it.

Mrs Best gets low for deeply felt reasons: she cannot do for herself, she is dependent, she has to be grateful and grin and bare it, make the most of it, but this makes her feel *alone.*

Through analysis of research material it emerges that many of the patients are concerned to be self-disciplined and to be autonomous. And, most importantly, they are concerned to be seen by others as such. They are concerned *not* to be perceived as malingering, dependent, uninterested and uninteresting, 'old'. This was particularly evident in the patients' interviews and their expressions of their concerns to be as independent and as active (socially, mentally, emotionally and physically) as possible. At best, to be productive is to be socially acceptable; at worst, is to be both unproductive *and* dependent. Being old has a very dodgy identity status in modern *ageist* Western societies and old people know this just as well as anyone else. As Sister 1 put it, it is easy for inexperienced nurses to mistake all old people as "geriatric confused crumblies". Her statement reveals how she, as do many people, consider some old people to be geriatric, confused crumblies. Around the concept 'old', are clustered many negative qualities. However, old people, are just as interested to maintain face as anybody else while they can.

While patients are made dependent by an acute episode of illness they may be acquiescent, they may have lost some of their potency, because they have to take what they can get. But they are even when very unwell, concerned also to preserve face and are committed to a return to optimum independence as soon as possible. Quite simply, they want to be identifiable as active, minimalising their dependency, not as old, dependent and unproductive. Here for example is an extract from Mr Donald's interview, I have just asked him how he feels about the future:

Mr Donald - In fact the future as far as I'm concerned for over a year, I should be dead, ready laid, right, no regrets, dead! I want to die, I want to die, I want to die!

JL - Is that how you're feeling?
Mr Donald - That's how I've felt for over a year, I want to die. Because I've nothing to live for. I'm a man who's never owed other people and I'm having to depend on other people to look after me and I don't want that, I'd rather be dead. See?
JL - Really.
Mr Donald - But as far as I'm concerned now when I get to have my (..?recovery/?discharge..), I make the best of it and go home and see how things goes. So far, but oh, I would just love something to happen that I could just slip away and be finished with it all.

Mr Donald like Mrs Best will make the best of it, but he suffers from his condition of dependency (now increased through having had a stroke): he would rather be dead and wishes he might just slip away.

Mr Donald complains about the ward; he told me that he found there are "rules", and that the nursing is "regimented". For example changing pyjamas everyday when they are not dirty did not make any sense to him. I asked him whether there is anything that could help the nurses to understand a bit more what it is like from his point of view:

Mr Donald - Well, the only thing I would notice was the like of me being in here, I would rather have a quieter more peaceful day, instead of being rushed into this and rushed into the next, I'd rather they gave you a more quiet lazy time should I say.
JL - Right, more relaxing sort of time.
Mr Donald - Yes, I find that they keep you on the move all the time and just sometimes, I just seem to be tired all the time with the doing all the working with me.
JL - Right. What about, do you find you talk with the nurses much or they talk with you much?
Mr Donald - No I don't talk much with any of them.
JL - No.
Mr Donald - I never was happy to tell them much to any of them.
JL - Why was that?
Mr Donald - Well it was just that I'm what I'm interested in is not what other people are interested in, you see. When I get amongst (..?..) and chaps like that and we can talk about things, then we know where we are, but to talk to a nurse about something what nursing or that, that's no use.

Mr Donald in this extract is in difficulties: he has to rely on the nurses to help him but as can be seen he is not happy with their way of doing things. They always keep him on the move. Yet from this extract he makes it clear that he could not talk with the nurses: he did not want to talk with them about nursing. This is not insignificant. He is aware that nursing is something discontinuous with his life-world and is constituted as separate from his usual identity: he and nurses do not have anything to talk about. And yet for this man, what troubled him is that his usual way of living is not taken into account in the present setting.

He does not usually wear pyjamas at home and likes to lie down at odd times throughout the day. He is not allowed to do this in hospital. He has to live as the nurses want him to live. Mr Donald knows that his identity does not count for much in the current setting; nursing is something that is done separate from his identity. And yet he lets them do what they do to him. The proposition here is that he lets them do it because he fears being dependent; he hopes that he will get out, become less dependent, by letting them discipline him, even if that partially erases his identity.

Many of the patients, like Mr Donald, said they did not talk deeply with the nurses. Some said that they had a laugh and a chat, that the nurses were very friendly. They accounted for how they did not have meaningful talks with nurses by saying that the nurses were very busy.

From my analysis of the research material it emerges how some patients work to project a self who is not visibly old and dependent - they readily get up, do things for themselves, make it quite clear that they do not lie around waiting for others to look after them unless there is a very good reason. Some patients do this even when they are still very unwell and make themselves more ill than they are already, like Mr MacGregor.

Some patients are concerned not just to be active and independent but to look active: looking active means not looking old. How they look is a part of the patients' way of controlling how they are perceived. I am not suggesting that all patients could articulate this, but that, following Goffman's work [1955, 1958], it is present in most of us. Here is one patient talking whose facial nerves had been severed during an ear operation:

> **Mrs Violet** - Oh, it made it very much more difficult, especially like a woman feeling like without two eyes being opened, one eye shut and the other feeling as you were, you just didn't feel attractive at all. Nor could I smile, I didn't want to smile and if I saw a photograph of myself I felt I didn't want anybody to take a photo. I just felt so miserable. My looks you know were changed, to my mind. But that was two years ago nearly, two years just now, but everyone said there was a great improvement because my mouth you know at first the saliva would come out. I couldn't eat properly without an awful lot of napkins I needed, very awkward, but gradually that improved, thank goodness for that, because it's very nasty to be in company and find that you're having stains on your clothes and if you've been a tidy person that's not a thing you want is it?
> **JL** - No. No, I mean, I've noticed that you obviously do like to keep your appearance. It's important to you.
> **Mrs Violet** - Very important. And that was the first thing, reaction I had after the operation, when they came and asked me I was very distressed about it. And, eh, I said well, you know, you want to keep your looks, after all I am still a lady, I want to be that, you know you don't want to be just like an old woman, you want to keep yourself fresh and intelligent and just

> pleasant to look at. It was very distressing, but I don't think people realise how distressed I've been with this thing that's happened to me. Everybody's encouraged me but I have been very distressed. And I hate looking at myself in the mirror.

Mrs Violet is expressing what most of us know: that we are in the eyes of others what we are perceived to be. In the present context it has been suggested in Chapter Nine patients' self-identity is annulled to a certain extent during their induction to the ward. Further, they are disciplined through their talk with nurses to know not to tell about themselves in relation to the wider discourses about them. To some extent they are abstracted as a self and their social potency is reduced by this process. It has been suggested that through this stripping away the patient becomes visible as an artifact: through the gaze they are written upon by disease (signs and symptoms) and then again by those in the setting (the ways in which their body is positioned, the technical apparatus applied as treatments or investigation, the ways in which they are moved around bodily by others, the spaces in which they are placed to be nursed).

The suggestion being made here is that some patients, through this sequestration of them as a self and as potent, are *thrown back* on themselves. They are called upon to work to reconstruct an identity to give a positive impression in the setting. They are an artifact upon which are written the signs to be read by the nurses, but they also work to make themselves visible in particular ways, to give an account of themselves as some particular one.

For example, some patients presented a self in the setting to imply that they were being as active and independent as they could in the circumstances. In being restrained from telling about themselves and constructing an identity through telling, they show themselves in other ways.

Here for example is Mrs Best shortly after her admission. (NB Mrs Best had been in hospital for very long periods on several occasions: she was an experienced patient and used to being disabled). She has been got up by Sister 1 and has been given tacit permission to be mobile. She demonstrates here how she is able and keen to get up and moving:

> 13.07 Mrs Best is sitting in her chair having just had her lunch. She pushes the table away, and moves in the chair and stands up using the bed as a prop. She walks around her bed, holding on to the bed and gets her walking stick which is hanging from the head of the bed, she then heads off up the ward, she asks me where the toilets are, I say I don't know, she asks another patient, and goes off up towards the lavatories. All the nurses on late shift are sitting at report at the nurses station, right next to Mrs Best's bed. Staff

Nurse is handing over. An early shift student nurse meets Mrs Best in Bay Four and escorts her to the lavatory. They go in together, and the nurse shows her the toilet.
Student Nurse - Use this one here.
Mrs Best - [goes in to the toilet].
Student Nurse - [goes in] - Do you manage on your own?
Mrs Best - Oh yes - I'm a wee bit shaky though.
Student Nurse - Do you want me to stay or?
Mrs Best - Oh no.
Student Nurse - Well, there is a bell there if you need anyone.
[Goes].
1 minute

Mrs Best throughout her stay was concerned to demonstrate her independence and willingness to accommodate the nurses. In this extract she is presenting herself as someone who just gets on with it. She gets up, holds on to the furniture to get around her bed to get her stick and goes off to find the lavatory (patients were not shown round or 'oriented' to the environment). She tells the student nurse in response to her question, "will she manage?", that she is "a wee bit shaky", but picks up the student nurses cue - "Do you want me to stay or ... ?" and gives the nurse permission to go and get on with what ever she was doing - "Oh no".

Willingness and unwillingness to mobilise was an important aspect of the ways in which nurses in the setting represented patients in their handovers and in their written reports. In this extract Mrs Best is demonstrating her pluck and gets on with finding her own way and does not disturb the nurses at the nurses' station in the middle of their report. In her interview Mrs Best describes herself as follows:

> **Mrs Best** - but I don't sit back and expect other people to do everything for me. I like to try and do it myself, from the time I ever knew I had the arthritis I felt I wanted to do for myself. But, eh, I've always been active and that.

Her projection of her self-identity did work on the nurses. She was always cheerful, always smiling, and despite being riddled with arthritis, half-blinded by a stroke, with a colostomy and a massive gastric ulcer, she was undemanding and as independent as she possibly could be. Here Staff Nurse describes her at the nurses first nursing handover after her admission:

> **Staff Nurse** - Then you have a lady called Mrs Best. And she's 80. She looks wonderful for her age.

How you seemed to others was as important to patients as to anyone else. As has been suggested it was critical to how you were moved around. You were called upon in the present setting, just as in any setting, to make your identity visible in particular ways.

Where patients could not project a self through their own activity they had other

methods and strategies for making an impression. Apologies and moments of humour were ways in which patients let staff know that they were not performing as themselves. Here, for example, is an excerpt where Mrs Gardner, who has been very unwell the day before so that her mobilisation has been set back, has been having a wash by her bed with Sister 1 helping:

Sister 1 - Are you feeling alright? What's wrong? [concerned]
Mrs Gardner - (..?..) I have that pain across there (..?..)
Sister 1 - Are you alright - are you sure? ....Did you sleep well last night?
Mrs Gardner - (..?..) I'm such a nuisance.
Sister 1 - Not at all (..?..)
Mrs Gardner -(..?..)
Sister 1 - You just let people help you for a change.

In her interview, Mrs Gardner, like Mrs Best, revealed a self-identity which was rooted in a self-image of someone who was usually active and independent. In the extract she wants to do some repair work on her identity. She has not been given any opportunity to let the nurses know what she is really like. She lets Sister 1 know that there is a difference; she is "such a nuisance". Sister 1 helps her do the repair work and picks up her meaning about how she usually is - that she usually likes to help others - "You just let people help you for a change". On another occasion Sister 1 had told the patient that she would just "have to get used to it [being helped]".

I would like to suggest at this point that the patients in the study were pre-selected, not by me, but by the admission process, described in Chapter Five. Through doctors' vigilance as the gatekeepers of the acute services even at the time of the study they had managed to 'improve' the system to prevent the admission of 'geriatrics' to acute hospitals. Further, some very disabled old people do not, of course, come to the attention of the health services at all until they are already dead. While others are constituted as 'not suitable' for admission to an acute hospital, and may be kept at home by their GP's, with augmented home care, sent home from casualty, or simply have been identified as at risk prior to an acute event and have already been admitted elsewhere. In this way, I am suggesting, that some of the patients in my study may be pre-selected and that their accounts may reflect this: that some of them are the older patients who are allowed in by the gatekeepers because they are 'worth' treating, in the words of one of the Staff Nurses, they have the 'prospect' ahead of them.

Obviously there are mistakes as it is in the nature of 'acute' medicine for the exact circumstances of someone's 'acute' episode to be unclear, as has been stressed an important aspect of the ward work is investigation and diagnosis. As discussed in Chapter Eight, in

reference to Sister 1's accounts, sometimes the acute episode resolves and what is left is someone with a senile dementia and social problems.

This leads to the second condition of possibility through which the patients' commitment to the setting is mobilised and which is rooted in cultural/epistemic forms which were discussed at length in Chapter Two, in relation to Foucault's work. That is that patients act to help reproduce an acceptance that there are those who have authority as those who know and can see what others cannot.

Some of the patient's talk was dotted with references that indicate that they are used to thinking in terms of "taking orders" from doctors: there is a suggestion that they are schooled to believe that doctors should know best, that doctors should be rational and have their best interests at heart and that they have a sight which sees what they cannot see. I am suggesting that this permission extends to the nurses to some extent, particularly where what nurses are doing can be seen by patients as in support of the medical. This is not to say that the old people as a group did not readily question any one *individual's* competence, but that they are deeply susceptible to medical authority, especially in the circumstances, where they are brushing with death, suffering or confront a possible future of dependency.

Here for example is Mr Banks talking about how the doctors have told him to stay off a pill (atenolol) that another consultant prescribed him:

> **Mr Banks** - Atenolols, I always forget what it is. I can never remember that word, the Mrs goes mad. Well this is the second time a hospital doctor says to me: "You shouldn't be having these". See the first one did, now the second one does. So you think to yourself, well they both can't be wrong and not having a lot of faith in the consultant in the first place.
> **JL** - That was the one up [North]?
> **Mr Banks** - I know it's easy to say, were he's a foreigner, but he didn't seem to show a lot of interest and he put me off right from the start.
> **JL** - He put you off him?
> **Mr Banks** - Yes. He didn't seem to have any trouble at all, I mean to say he didn't want any trouble, all he wanted was the date of birth, I could see that. And me own doctor is a cheery old general doctor, he'd go the easy way as well. They all do, all the general practitioners do, I know one that doesn't, but the majority do. They just take the easy way out: go to the hospital or use a pill. That's the two things they do. Well, it's fair enough if you're satisfied with that sort of thing.

In effect, old people have no real alternative but to rely on and turn to hospital care when they are dangerously sick. Alternatives are expensive, and at some level, as discussed in Chapter Two, doctors (and to some extent nurses) have constituted themselves as expert and on the whole most people are disciplined to help produce and reproduce the conditions of their expertise.

The third condition of possibility affecting the ways in which patients act to help reproduce the order of the setting relates to gratitude for times and moments where they were cared for and their self reaffirmed. This is now discussed in detail.

Making a Space for the Self

Nurses in their "administration of the body" [May, 1992] repair some of the displacement work done elsewhere. Even where their administering to the body is misplaced, many patients are grateful for nurses' attention and allow them their good intentions.

While some of the male patients complained about the nursing care they had been given, most of the patients praised the nurses and the care they had been given. Many of the patients mentioned how busy the nurses were, particularly in relation to how the nurses were friendly and chatty but did not have time to really talk with them.

However, there is a suggestion in some patients' talk that they may 'excuse' nurses' conduct, not simply because they saw that the nurses were so busy, but also because they are disciplined to believe that nurses have no real authority in the current setting. That nurses do not have power. Mr MacGregor as already mentioned in Chapter Nine points to this aspect of how patients see nurses: not just as busy, but as powerless.

When asked to detail what the nurses did for them, patients exemplified this by reference to how the nurses give them their medicines and help them wash, shave and do their hair. Some patients found it difficult to say what the nurses did for them; while others said the nurses were very kind, would always just notice that they needed something, were always attentive and ready to help.

Some of the patients emphasised how much the nurses helped them at the beginning of their stay while they were in bed. They remembered this with a great deal of gratitude. For some this work can help restore the identity of the person, by helping them be presentable in very many ways, particularly where this has been difficult for some time prior to their admission to hospital. The work that nurses do for patients while they are in bed, helps patients through helping them maintain face, an identity. Nurses know themselves that they are not, in doing a bedbath, just doing hygiene work, although it is what they will put on a care plan. To illustrate this point here is an extract taken from Mrs Appleton's second morning in the ward. In the following extract the patient has been confined to bed having had a blackout which the nurses and doctors cannot explain. She has had cotsides put on her bed and is being observed. A student nurse has just been allocated to care for her for

the morning. Although it has not been mentioned at the handover, the patient is very anxious and nervous at being in hospital and expressed this to the night staff.

> 08.54 - Mrs Appleton, in bed next to the nurses' station, is trying to sit up without much success - she looks over to the nurses as they are getting up as they finish the nursing handover and catches the eye of the student nurse who is caring for her that morning. Student Nurse goes over to side of bed and smiles. Bends down to patient a little.
> **Student Nurse** - Just try and lie back and relax - [takes hand and smiles at Mrs Appleton - they talk a moment but I can't hear]. Don't worry about anything.
> **Mrs Appleton** - I get awfully upset.
> **Student Nurse** - We'll give you a wee wash later. Just try and relax and we'll get you back on your feet again. [Mrs Appleton visibly relaxes and smiles at nurse. Nurse smiles and goes].
> 1 min 29 secs.
> [Mrs Appleton lies back and closes eyes. She's very fidgety still].
> [Student Nurse comes to end of bed with the back trolley. Pulls screens round and takes trolley in. Other Student Nurse 2 has a quick word with her then goes].
> [Student Nurse goes too].
> 44 secs.
> 09.03 [Student Nurse goes into patient and pulls screens round completely. I cannot hear as Sister and Staff Nurse are talking by me]....
> **Student Nurse** - There now you can have a good wash and feel better. You lie there - put your legs down - and I'll do all the work.
> **Mrs Appleton** - I'm sore down there.
> **Student Nurse** - Are you sore down below?
> **Mrs Appleton** - Uh-uh.
> **Student Nurse** - So what time did you come in last night?
> **Mrs Appleton** - About six, and then up here about 9 o'clock.
> **Student Nurse** - Give me your arm [she says all this kindly in soft but confident tones]. Do you live at home by yourself?
> **Mrs Appleton** - No, I live with my daughter.
> **Student Nurse** - With your daughter.

The student nurse gives the patient reassurance not through telling her "not to worry" but through letting her know that she recognises that Mrs Appleton gets awfully worried and that at this moment this is understandable. Giving patients a bedbath, with full back trolley etc, is a sign: it tells the patient or an onlooker that the patient is so ill that they cannot or must not do anything for themselves. The nurse 'takes over' the patient: she does not ask why the patient is trying to get up or has caught her eye, but tells her "to lie back and relax". The nurse does the bedbath not because she has been told to, she has been told the patient is to have a wash and that she is to remain on bedrest. Frequently in this situation patients were given a bowl to wash themselves with minimal help. The nurse is translating the instructions into something more than a 'wash in bed'. She is giving the patient a full bedbath. Through giving the patient a bedbath she is effecting a mode of restoration and

repair. She is helping the patient to maintain face: Mrs Appleton can lie back and be relaxed because the nurse is taking her anxiety seriously. The patient has told the nurse that she "gets very worried" and the nurse attempts to help her relax and feel comfortable by affirming that she is very ill and should relax and let her "do the work."

However, when the patient tells the nurse she is "sore down below" the nurse does not pursue this but goes on to ask the patient about who she lives with. The nurse does not allow the patient any authority but she does affirm her identity as someone 'very ill' and 'very worried'.

Some patients, made vulnerable and laid low by illness, rely on the tact of the nurses in some of the most intimate moments. How these moments are handled are memorable, patients are grateful. For example, in the following extract Mrs Adamson is behind the screens and has just stood up from the commode. It is the day after her admission:

> [Student Nurse goes back in to the screens, Mrs Adamson is standing by the commode - Oxygen mask is off]
> **Mrs Adamson** - I'm sorry - I forgot to pull my pants down [she's trying to take them off - panicky] I'm sorry.
> **Student Nurse** - Don't worry [soothing tone] [helping Mrs Adamson to sit on bed and remove pants] I'll give them a wee wash for you.
> **Mrs Adamson** - I'm sorry - they'll be soiled.
> **Student Nurse** - That's alright - these things happen to all of us.
> **Mrs Adamson** - I'm blooming useless.
> **Student Nurse** - Don't worry.

The body and the self are not experienced as separate: the self is embodied and socially embedded. This has been discussed earlier in Chapter Four, drawing on Goffman's [1955] work on the face and in reference to Bauman's [1991] work on effacing the face. Nurses as they work with the body are working with the Other (as one of us) and their selves. In this extract Mrs Adamson has not pulled her pants down when going to the lavatory (commode). The nurse helps restore her face with "These things happen to all of us". Her tone is soothing and her actions restore the patient to some sense of herself, she was always putting herself down: "I'm blooming useless", "Don't worry".

I am suggesting that through being thrown back on their selves patients are grateful for what they can get from others to reaffirm some identity. There are clear moments in the fieldwork in which patients' gratitude for the attention that they receive can be seen; some patients make the most of these moments.

It is suggested here that in these moments of caring patients find moments of intersubjectivity, where nurses were engaged in doing things for patients and in chatting with patients. While these were usually private and constituted through encounters with nurses as

the nurse is doing something for the patient, like washing them, or simply in an acknowledgment of how the patient is as a person with a face to preserve or present, these moments are personal and intimate. This level of informal repair work was often constituted through patients' relationships with nursing auxiliaries and student nurses. Patients appeared to be able to translate nurses' activity as a language of care, and were grateful for this care.

Through these relationships patients' self-identity could be affirmed through nurses and patients joining together to reaffirm the proper order of things, but in doing so reproduce systems of difference. For example, in the following extract Mrs Adamson, has been having a breathless attack and has been put back to bed very agitated. The ward has been disturbed by another patient who has been screaming and attacking the nurses. The nursing auxiliary, an older woman and permanent member of the ward, is tidying up the ward. She comes over to Mrs Adamson's bed, in which Mrs Adamson is lying, and rehangs a part of Mrs Adamson's bed curtain. As she does this she is talking to the woman in the bed space next to Mrs Adamson:

> 10.53 [Nursing Auxiliary tells the patient next to Mrs Adamson about the confused patient and how "terrible it is". She steps down off the bed].
> **Mrs Adamson** - I'm sorry.
> **Nursing Auxiliary** - Ach you didn't think I meant you, pet! Of all people! [She hugs Mrs Adamson]. God Almighty. Are you needing sitting up a bit?
>
> [A student nurse comes over and helps the Nursing Auxiliary sit Mrs Adamson up in bed].

In this extract the nursing auxiliary interprets Mrs Adamson's expression -"I'm sorry" - as indicating that she has misinterpreted her words as referring to her. The nursing auxiliary 'knows' Mrs Adamson and how could she "of all people" mistake what she was saying. She hugs her and then as if to confirm that Mrs Adamson is seriously ill and a proper person for the setting she notices that Mrs Adamson needs sitting up and helps to sit her up. In this small act of nursing care the nursing auxiliary reaffirms Mrs Adamson as a sick woman who needs care, and as some 'one' to whom she attends. She also reproduces the order of things: she is marking a difference between what constitutes the proper patient (really sick) and the improper (demented). In doing this she reaffirms her own identity as a nurse caring for the acutely sick and the patients' identity as properly ill and worthy of care.

May [1991, 1992] in his study of nurses accounts of their relationships conceptualises nurses work into two aspects: work administering to the body and work directed at revealing and normalising the experiencing subject, or pastoral work. In writing nursing in this way May maintains the split between the work nurses do to administer to the

body and the work they do around the care of the experiencing subject. This split is present in nurses' discourse and in the new medical sociology literature.

Against this, there is suggestion in the present analysis how action and language act together on patients, that the experiencing self is embodied and that it is a central misunderstanding in medical and nursing discourse to separate the body from the self. As suggested by both Goffman's [1955, 1958] and Foucault's [1975] work, discussed in Chapters Two and Four, it is through acting on the body that there is a possibility of moving the self around: the body and the self are separated through discourse and social mores. As nurses and doctors act on and around patients' bodies they are acting on and around their selves: sometimes displacing the self and sometimes, as in these examples, acting to reaffirm some self-identity. Patients strike up friendly relations with some of the nurses. Humour plays a large part in this. On a day to day basis, patients chat about their lives and ask nurses about their lives. Through these informal relations nurses get to know about aspects of patients but how much of this is translated into the nurses' formal accounts about patients remains questionable and tacit. Nurses' feelings about and impressions of patients are not generally discussed and as a consequence it appears that this more everyday experience simply remains private. But for patients it existed and had happened and was a part of their experience of hospital.

Another way in which some patients develop a space in which to construct a self-identity is through their relationships with other patients. This is significant in the study: some patients set up a social life through their engagement with other patients. This is particularly marked in the female ward. I will now briefly discuss this 'repair' work more generally in relation to social theory.

In the present setting one of the effects of nurses' conduct is to help exclude patients from membership, from belonging, at the level of accountability: they are excluded from co-authorship in the accounts constructed about them and cannot legitimate action on their own account.

But social actors are usually committed to belonging, to being members, and usually this is constituted through grasp of natural language [Garfinkel and Sacks, 1969]. Through being able to give an account of themselves as social actors, their belonging is constituted through grasp of and contribution to natural language, to what is accountable. I have suggested how social actors can exclude others from belonging, from membership, through positioning them and controlling their access as collaborators in and contributors to the natural language of settings, to the production of meanings. But neither Garfinkel [1967]

nor Garfinkel and Sacks [1969] fully realise how there may be, in one organization, different communities and different levels of membership, which are always provisional [Munro, forthcoming(a)].

For example, in a hospital, persons have different, provisional membership status - student nurses and medical students may have only provisional and partial membership, and the extent to which they have a voice may exemplify this. While patients may have no membership in relation to the dominant discourses of the setting, but may relate to those others who also have only partial membership (but who are also hoping to achieve fuller membership status). I would like to suggest how those with only partial membership may commune together and form their own sub-communities: this includes student nurses, auxiliaries, porters, domestic cleaners. All of these people may be flexible and go in and out of the dominant membership community (of doctors and qualified nurses) but the hierarchies involved, limit and restrict their membership status within this community. The most important thing is not to negatively stand out in this wider hierarchical community, but to maintain private and discreet relations with others in the sub-communities. But as can be seen these private and discreet relations, although they may have no accountability, that is they are not worth reporting, they are interpenetrated with and help reproduce the dominant discourses of the setting. For example, Mrs Adamson and the auxiliary are confirming the order of things: that sick patients are authentic and belong, while the demented are not.

I would suggest that this resonates with Bauman's [1991] analysis of conduct in modern organizations. Bauman argues that organizations rely on uniformity and monotony to maintain order and predictability. He states that actors are defined as social actors by virtue of their ability to account within the terms of the organization:

> ..actors are challenged to justify their conduct by reason as defined either by the goal or by the rules of behaviour. Only actions thought of and argued in such a way, or fit to be narrated in such a way, are admitted into the class of genuinely social action, that is *rational* action, that is an action that serves as the defining property of actors as *social actors*. By the same token, actions that fail to meet the criteria of goal-pursuit or procedural discipline are declared non-social, irrational - and *private*. [p144]

So although some actions are not worth talking or writing about, are not accountable, within the organization, they may still occur as private occasions. However, I would like to suggest that they are still visibly purposeful, that is they cannot be constituted as completely spontaneous moments of co-presence. As they occur and how they occur is at moments which appear to be congruent with doing the routines or doing the prescribed care: there is still discipline. Just as in the case above, where Mrs Appleton and the nurse are doing what

they should, but within these activities they are making contact. The student nurse did not of course report that she was doing reassuring and repair work through a bedbath; this has no accountability; it does not make sense or is taken for granted.

Further, I would like to suggest that through self-discipline, those with partial membership act to visibly maintain and control their relations in accordance with the wider community and that this constitutes a governmentality effect: nurses' and patients' relations are on the whole self-disciplined, with the possibility of the supervisory gaze ever present. Moreover, that the apparatus actually *relies* on these private and discreet relationships for its suppleness [Foucault, 1980a]. These relations help keep patients and nurses 'happy' while allowing the wider community its own projects and access: a belief in compassion and care can be maintained, but is on the whole constituted at a private and discreet level.

In the next section I discuss further the possibilities for patients' conduct in relation to the sequestration of experience.

Sequestration and the Contours of Modernity

In Chapter Nine how nurses assist in the sequestration of patients' feelings, understandings and experiences has been presented. I would like to suggest that, not only was this a systematic effect of nurses' communicative practices, but that it exemplifies a trajectory of 'modernity'.

It has been argued that it is a feature of modernity to achieve subordination of the world by human domination [Giddens, 1991] and to do so in the name of autonomy and self-discipline. As discussed in Chapter Three, 'nurses' have been concerned with autonomy and self-discipline in their quest to professionalise. One aspect of this has been to introduce the notion of the 'nursing process', which involves the nurses in their own autonomous and disciplined assessment of the patient.

Giddens [1991] argues how one of the ways in which we accomplish domination of the world is by the sequestration of certain types of experience which appear to us as likely to disrupt our ability to maintain control. Giddens defines the sequestration of experience as:

> the separation of day to day life from contact with experiences which raise disturbing existential questions. [Giddens, 1991, p244]

Contact with sickness and death are experiences which are particularly disturbing. Giddens states that

> ..like prisons and asylums, the hospital is also a place where those who are

> disqualified from participating in orthodox social activities are sequestered, and it has similar consequences in terms of the concealment from the general view of certain crucial life experiences - sickness and death. [1991, p161]

In his reference to hospital patients as constituting those who are "disqualified from participating in orthodox social activities" Giddens appears to be drawing in part on Parsons' [1951] notion of the sick role as a form of deviance. Parsons represents the sick role as a result of conflict in a person's life and therefore as having a psycho-social component. Illness is in this sense "motivated" as it gives social actors permission to withdraw from their usual responsibilities: illness legitimates deviant behaviour (not working, not coping etc). I would like to suggest that both Giddens' and Parsons' representations of sickness and death are actually integral to the medical ethos but that the findings in the present study suggest that relations are more complex than even they have suggested.

As discussed in the introduction to the study, there has been an inversion: hospitals are no longer places in which to conceal the deviant or sequestrate sickness and death, hospitals are under examination and being called upon to display their effectiveness and efficiency, their contribution to the saving of life, the overcoming of sickness and death. They 'need' patients who are going to help display the technical prowess of acute medicine and nursing. While within the organization there are notions that *some* illness is a form of deviance (it is self-inflicted, psychosomatic or simply 'social' rather than medical) there are no longer the resources available to maintain hospitals for the sequestration of the deviant. It is, I am suggesting, those patients who do not help produce and reproduce the spectacle of medicine and health care, who are constituted as inappropriate, and who are now to be kept at home: the trend is to keep the dying, the dependent, the disabled, the old and the very old, at home, not admit them to hospital.

Once in hospital these patients may still to some extent remain 'hidden', as instantiated in the current setting, where the dying are put in cubicles and the dependent are warehoused at the back of the ward. But there is a movement also to display death, for example in the hospice movement: those who are dying well are displayed [Mazer, 1993]. Death has become a new project, constituted through technologies of the self: the project is to make death positive through pastoral care [May, 1991].

However, I would like to suggest that within these forms of display and spectacle, new forms of sequestration have developed: these are constituted, as has been shown in the current study, through forms of *social* distance. Sequestration of sickness and death is achieved through sequestration of the expressions of a patient's *experience* of sickness and

death: expressions of these experiences are made unaccountable and unsayable. Moreover, patients are instructed, through the conduct of nurses to maintain control of their expressions of their experience of sickness and death. This is now discussed further in relation to the current setting.

Patients are admitted to hospital by virtue of their closeness to sickness and possibly death. In the present study nurses organize their everyday life in ways which, while in proximity to patients, mainly 'distance' them from contact with the patients' experience of sickness and death. At one level, therefore, sickness and death are made absent.

I would like to suggest that this sequestration helps support the spectacle: that nurses and doctors through their technical prowess help patients. To perform they do not need to know how patients feel, except as has been shown in Chapter Eight, through analysis of the nurses' accounts, where a patient's feelings are constituted as capable of interrupting the flow through the beds. Then feelings take their own priority. Otherwise, as has been shown in the current setting patient's feelings and experiences are constituted as extraneous to the main work of the setting: the diagnosis and treatment of disease to enable timely disposal.

This is an aspect of doing nurse: to say that she knows by looking, and interpreting the signs; not through engagement with patients, by getting involved. This is left to the vicissitudes of the private and discreet moments between nurses and patients at the bedside.

I would like to suggest that patients are instructed to deal with their experience of being close to sickness and death. There is evidence in the current study that patients act to go along with the nurses' conduct to normalise their relationships with nurses and to submerge their own fears and anxieties, to privatise them. Some patients are in a position, as they get better, to spare the nurses their emotion. But some patients also attempt to reveal themselves to nurses throughout their stay in hospital: they may simply want to let people know how they feel, perhaps to make sense of how they feel, or even to get help with how they feel.

Once again it must be emphasised here by 'feeling', all the different forms of feeling are meant, not just what is usually referred to as "emotion". Feeling includes the ways in which we are experiencing ourselves and our being in the world. For example one patient, Mrs Menzies, who was dying, was asked by a doctor on a ward round how she felt. In response she told him that she was feeling "exhausted". The doctor and the staff nurse turned from the patient straight away, to discuss together how the patient was in relation to her signs and symptoms. They did not pursue her response, they did not go forward on how she was feeling.

Mrs Menzies was one of the patients who attempted to express her emotion. She was admitted for investigation and diagnosis of a breast tumour, which she had concealed for eight years, she also had ascites and heart failure. Getting a diagnosis was difficult and took two weeks. She had not consulted a doctor for over forty years. On her arrival Mrs Menzies kept breaking down and weeping. But over time she began to control herself, to express herself as friendly and appreciative of the nurses' daily acts: she told me how frightened she was but took the cues from staff and only on one occasion engaged with a member of staff (a student nurse) to express her fears and worries that she had cancer.

Eventually she was told she had cancer and was to go home. At this point she 'broke'; she was no longer able to discipline herself. She became paranoid, expressing a fear that her children were going to take her money and her house. The nurses reported this to each other but did not talk with her or her family about it. They believed that her mind was affected by her cancer, that she may have had secondaries and was "confused". She was discharged home and died three weeks later.

Many patients in their contacts with me expressed deep fear and worry and on occasions became very emotional. Several patients cried for prolonged periods in their interviews with me. I am aware that my presence changed their experience of hospital and, for some, may very well have improved it. Perhaps I made up for what was not present in the setting: someone that listened and who was engaged in their presence. This reading of my possible affect on patients' experience was suggested by things the patients said themselves.

Through my closeness to some patients I became aware that often the nurses' re-presentation of patients at handovers was very different from my experience of the same person. Where they perceived a patient as happy or content, I was aware of deep ambivalence in their state of being. This was particularly the case with regard to patients who were very vulnerable for very many reasons, like Mrs Menzies and Miss Hepburn.

The 'failures' of nurses' work to understand patients in relation to patient's feelings and understandings may have repercussions in relation to their care. This aspect is discussed by Strauss *et al* [1982] in their report of a study of "sentimental work" in a "technologised hospital". The authors show how there is differentiation between the 'real work' of the hospital, that is medical work, and sentimental work. They reveal how the dominant focus of staff was "acute illness and the medical interventions which it entails". The authors recognize that, while sentimental work was intertwined with other work:

Many patients prefer to do their own sentimental work (perhaps especially

> identity work) silently, invisibly, for it is their lives that must be reworked, their biographical stakes that are being gambled by even the best-intentioned of medical interventionists. [p274]

This statement suggests that patients, like others, are concerned with the project of the self as an individual. I would agree that for some patients this is true: they do not engage with nurses to do their identity work, particularly where they are 'put off' by the nurses' conduct.

However, Strauss *et al* also emphasise that sentimental work is "an ingredient of any kind of work where the object being worked on is alive, sentient and reacting" [p254] and that failure to do sentimental work can do patients harm, and lead to non-sentimental work not being done or proving difficult to do. This matter relates back to the issue of the embodied self which emerged in the previous section and will be raised again in the discussion in Chapter Eleven.

I am suggesting how an aspect of the current setting, an acute medical unit in a major teaching hospital is to show how it can overcome sickness and death through "positive" [Foucault, 1973] knowledge. In this respect, there are patients who risk being constituted as less than worthy, who detract from the spectacle: the old who are disabled, dependent and demented. Old age has become a form of social deviance. How this may affect staff's assessment of patients is now further illustrated.

Fear and Trembling

In addition to fear, physical weakness, emotional and mental vulnerability, staffs' displacement of patients further reduces social potency to make it difficult for patients to get themselves across, to account for themselves and move others around. For some patients this position is prolonged, particularly were there is disruption in their connection with the present social reality.

Throughout the thesis asymetries in power relations between doctors and nurses, nurses and nurses, and nurses and patients have been revealed. But it is where patients are rendered very ill or are losing a grip on reality that dramatic asymetries in power relations can be effected. Here patients as potent selves are affected and where there is effacement of their self then there is risk.

It is being suggested in the current thesis that there is an effacement of patients and a constituting of classes of patients which are constructed through the discourses of the setting. These discourses are not just medical but have been radically impacted by managerial interests. Where there is a particular set of conditions pertaining to the

constituting of classes of patients in an environment in which patients as experiencing selves are displaced, there is the possibility of an abuse of power. Brink [1991a, 1991b] has also emphasised the potential for nurses to abuse their power. I will now explicate further these dangers.

Where patients are old and their so-called mental state is disordered in some way, but where they are recoverable (i.e. not actually in process of dying) they can be constituted by staff as a threat to the ebb and flow of the setting. Further, where a patient is at risk of dying but is constituted as a class of patient for whom there is no social future, then dying can be constructed as a viable alternative or, as Berg [1992] refers to it, as an acceptable medical disposal. This set of circumstances is represented by the case of Mr Wallace, who was admitted in a semi-conscious state. His wife who cared for him did not come to the ward with him. Here is his admission:

> I come onto the ward at 10.20 - Sister 2 says there is an admission for me - "a 90 year old with pneumonia and who is demented". I say that if he is severely demented then he is inappropriate to the study - she says that she doesn't really know how bad he is - he may not be too bad - but that he does sound like a "lovely one". She is "dreading him".
>
> I decide to observe the admission and see how it progresses.
>
> 10.29 - Mr Wallace arrives - he is lying down on a trolley with oxygen on accompanied by a porter and Student Nurse from A&E. Sister passes them and says: "Bay Four, please". She looks at Mr Wallace as she passes. They take him up to Bay 4 and Sister goes in the opposite direction.
> They get to Bay 4 and Student Nurse 1 joins them
> **Student Nurse 1** - This one here [indicates bed].
> **Mr Wallace** - [looks very ill - white, breathless, eyes closed, semi-prone. He has oxygen on and an intra-venous infusion running].
> Silence.
> [Sister comes with drip stand. Clinical Teacher has also joined the group].
> **Sister** - [to Mr Wallace - She stands at the side of the trolley and looks down at him - quite close] - Hello [smiles] - how are yer?
> **Mr Wallace** - Not too bad. How's yourself?
> **Sister** - [laughs] Not too bad either - none of us is very bad. [Sister lowers the side of the trolley and takes the oxygen mask off].
> **Sister** - There you are - that's it, OK? - [to the student nurse from A/E] - How much oxygen?
> **Student Nurse from A&E** - Sorry?
> **Sister** - How much oxygen?
> **Student Nurse from A&E** - 2 litres.
> **Sister** - 2 litres.
> [Sister and Porter push the trolley to the side of the bed - Sister goes round and climbs on the bed, Student Nurse 1 has pumped it right up - two pillows - backrest out].

Sister - We'll just lift you over onto this mattress [She and the Porter and Student Nurse 1 help lift/drag Mr Wallace onto the bed using a canvas from a stretcher which has been left under Mr Wallace - it all looks a bit precarious -screens pulled only down one side].
[Porter moves the trolley out the way and Student Nurse 1, Clinical Teacher, Student Nurse from A&E and Sister get the stretcher cover from under Mr Wallace by rolling him from side to side - the bedscreens are not drawn - Mr Wallace is covered with a blanket].
Sister - [rolling Mr Wallace from side to side] We'll just roll you off.
Mr Wallace - groans.
Clinical Teacher - [hangs up drip on drip stand].
Sister - Shall we sit you up the bed, love? [Sister, Student Nurse 1, Student Nurse from A&E and Clinical Teacher all sit Mr Wallace up the bed].
[Clinical teacher, Sister and Student Nurse 1 all tuck blankets in].
Sister - [to Student Nurse 1] - We'll need to put him in Bay 2.
Student Nurse 1 - Oh, alright.
[Clinical Teacher goes up to Bay 2].
[Porter goes].
Student Nurse from A&E - [to Sister - both are looking at A/E slip] - Mr Wallace, 90 year old man, his blood pressure was low down in A and E so we've got normal saline up, he's on oxygen 2 litres. His daughter is waiting out there.
Sister - Thanks very much indeed.
[Student Nurse from A/E goes].
[Clinical Teacher comes with empty bed. They all move Mr Wallace in his bed up to Bay 2. Clinical Teacher puts charts and things on the bed on top of Mr Wallace as they go. I work out that they've moved Mr Wallace to Bay 2 as there were no oxygen points in Bay 4].
Student Nurse 1 to Sister - [she is connecting up the Oxygen] Is it 2 litres?
Sister - 2 litres.
[Sister hangs up drip, Clinical Teacher brings other pillow - no cover on it and leaves it on the bedtable at side of Mr Wallace - Student connects up Oxygen and Sister goes].

Sister and the Clinical Teacher get involved in this admission. The signs are that the man is visibly very sick, he has been written on: he arrives with a porter, a nurse, an intra-venous infusion and oxygen; he looks very ill. Each member of the ward who gets involved gets busy doing jobs to settle Mr Wallace in. Simultaneously they are making their assessment of him as they go. Sister is originally going to put him in Bay Four, where she puts convalescent patients and the older patients for rehabilitation or who are just waiting to go somewhere else. She does not put patients there who are for observation or high dependency nursing. But after seeing him she changes her mind and they move him. However she still does not put him in a bed where she usually puts the high dependency patients who are also for observation, she puts him at the front of the ward, well away from the nurses' station. Mr Wallace responds to Sister and asks her how she is when she asks

him how he is.

Shortly after the above extract the resident doctor comes and examines Mr Wallace and takes his blood pressure. When he introduces himself and takes the patient's hand (his manner is kindly and quiet) Mr Wallace opens his eyes, smiles and says "morning" but then has his eyes shut most of the time. After a brief examination (time = approximately four minutes) of the patient, including taking the patient's blood pressure and reading the admission summary, the resident asks the student nurse to take down the intra-venous infusion:

> **Resident to Student Nurse 1** - Could you take the drip down and cap off the venflon.
> **Mr Wallace** - [Eyes shut - lying propped up, white gown on].
> **Student Nurse 1** - Right.
> [Goes]
> [Res listens to chest at the front again. Then pulls back bedcovers].
> [Student Nurse 1 comes back and takes down drip and caps off venflon].
> [Resident is examining the patient's abdomen, and then his arms].
> [Student Nurse 2 comes in and goes again].
> **Resident to Student Nurse 1** - Has he been washed and so forth since he came in?
> **Student Nurse 1** - He just came in.
> **Resident** - He's been well looked after.
> **Resident** - [draws back bedcovers even more and examines legs and feet, reflexes, tone etc].
> [Student Nurse goes with drip stand].
> 1 min 31 secs.
> [Resident covers Mr Wallace up - examines nails and eyes again].
> [Goes].
> Total time with Mr Wallace = 6 mins 47 secs.
> [As he goes I ask the Resident why he had the drip taken down - he says - "It's not necessary - it's one of those things that once it's up no one will take it down - best to take it down - he doesn't need it". I ask why was it put up - he says because Mr Wallace was in Casualty and very ill].

The nurse unquestioningly removes the drip at the doctor's request. The doctor invests the taking down of the drip with symbolic meaning: "it's one of those things that once it's up no-one will take it down - he doesn't need it". The information passed on from A&E is that Mr Wallace is ninety, he has, according to medical staff, pneumonia, is normally demented and dependent, with long-standing Parkinson's Disease. The Resident speaks with the relatives. They tell me that he told them that "he [the doctor] doesn't hold out much hope" for the patient; in the notes the resident writes "I have told her [the daughter] that I do not think he will survive". After he speaks with them they cry.

The nurses read the symbolism and the signs. They extrapolate or have been

informed that the doctors have decided not to "treat him" (in the doctors notes it says that he is for "nursing care"), that they will, as one of the doctors put it of another patient, "let nature run its course".

The staff quickly reconstitute the patient, from being very sick and perhaps treatable, to dying. The Clinical Teacher and Sister 2 both read the situation so that they go into a different mode - care of the dying patient. They talk about him together with the student nurses who all come to look at him. They do not spend time with him. An interesting aspect of this scenario is that the nurses construct Mr Wallace as dying but do not enter into his experience. In the two hours I sat by him he was very restless at times, fidgeting with his legs and trying to keep his eyes open as if trying to focus on things. But the nurses did not appear to 'see' this. For example:

> Student Nurse looks at Mr Wallace who is very restless. Mr Wallace looks to me as if he is trying to turn or sit up - he keeps drawing his legs up. I can see that he is actually lying on the iron bars of the backrest and only partially on the pillows. The Student goes. No contact with Patient.

At one point a student nurse comes over to Mr Wallace and Mr Wallace is trying to tell him something, but the student responds by trying to get him to cough. The nurses noticed and were concerned by the noise his breathing made:

> [Clinical Teacher and Voluntary Helper walk past - VH takes the pillow that was on the chair]
> **Clinical Teacher** [to me] - I think that we will ask the doctor to write him up for hyoscine [a drug to dry up secretions, used in terminal care to prevent the death rattle].
> **JL** - Oh right.
> **Clinical Teacher** - I think we should move him to a side ward, don't you?
> **JL** - Why?
> **Clinical Teacher** - Just because of the noise.
> **JL** - Oh, I see.
> [Clinical Teacher looks at Mr Wallace - his knees are drawn up but he's just this minute gone quite still].
> **Clinical Teacher** [to me] - Poor old thing [she pulls a sympathetic face].

The Clinical Teacher asks the resident to prescribe an injection of a drug which will dry up the patient's secretions. Mr Wallace is then given an injection of this drug. Otherwise he does not have any further direct care during the admission period.

A student nurse interviewed the patient's sister to fill in the nursing profile. She came to look at Mr Wallace shortly afterwards:

> [Mr Wallace 186, Day 1 - Notes immediately after the conversation].
> I ask the student nurse to tell me what the relatives have told her about the Patient.
> **Student Nurse** - He is senile. His wife, who is 85, looks after him - she

washes him from head to toe every day - she creams his back and legs every day as well for the itchy areas there. They have a home help 3 days a week. They live in sheltered housing. His mobility is very poor, apparently. He is very shaky -he walks with a zimmer very slowly. He is normally incontinent of urine - [she doesn't know why]. He is slightly deaf. But he can see OK. They realise what the state of play is. [I ask what she means]
Student Nurse - He is dying. The daughter talked about wanting to have the mother come and live with them. They're going to bring the mother in later. He gets confused about things - he repeats things over and over. They said that the wife has the patience of a saint. She has to repeat things over and over to him until he understands.
[I ask her what her plan is].
Student Nurse - We'll treat the medical things - chest infection - sit him in an upright position - all the usual things. There is his dementia - he requires a stable environment. I've been reading up about dementia and this is very important. They require the same people and the same routine every day - this helps stabilise things for them. There is his itchy skin - it is important that he continues to have the cream applied while he is in hospital. He will need mouth care - It's very dry and then there is the oxygen therapy as well. He'll need lots of mouth care. There is his incontinence - they will probably catheterize him - [I ask why] - then we will be able to keep an eye on his fluid balance.

Here is Sister's report on Mr Wallace at the nursing handover a little later:

Sister 2 - Robert Wallace, a 90 year old gentleman sent in from A&E with an MI (heart attack), pneumonia, and probable mild LVF (left ventricular failure). He's got a history of chronic bronchitis and pneumonia since 1985 and Parkinson's Disease. He had a convulsion [she's reading from the nursing notes] and vomited then ..?..[noisy - can't hear]. [Then she reads from the A&E slip] He was admitted from A&E at 10..with pneumonia and LVF. He had a previous fit. He was unresponsive with recurrent vomiting. A past history of Parkinson's Disease and chronic bronchitis. He came in with an intra-venous infusion - that's been discontinued. His observations on admission were [she reads these from the nursing notes]. He is more or less unresponsive. He's on 2 litres of oxygen. He's very bubbly - he's been charted for hyoscine intra-muscularly. He's not for active treatment. His relatives have been spoken to - they know he's very poor.
Staff Nurse - Do you want him in a cubicle?
Sister - Yes. I suppose so - now that we know he's for terminal care. He's got a wife at home - she's 85 - and a daughter [she's reading from the nursing notes again] - a Mrs Bell - that's her number there [she points to a space in the nursing notes]. He's a poor soul.
[2 mins 18 secs].

As revealed in earlier Chapters the qualified nurses are active in the constituting of classes. Further, as analyzed in their accounts in Chapter Eight, this constituting of classes becomes evident in relation to how they identify patients and their own self-identity. This man has become a "poor soul" for terminal care, to be moved to the cubicle. From Sister 2's report of him there is evidence of a transformation: from a patient being actively treated (with an

intra-venous infusion) into a patient for terminal care. In Sister 2's representations of him he is "virtually unresponsive". Moreover, he is "bubbly". However, there is no mention of his attempts to communicate or his restlessness.

There is no mention of Mr Wallace as some one with a future: in the student nurses' report of him to me she conceives of him still as someone who experiences and as someone who has a future. In Sister 2's report of him the basis for constituting him as 'for death' comes from an assessment of him as written: his history as senile, chronically ill and dependent, constructs the context in which to view his present illness. It changes the meaning of the present. No one mentions, for example, how Mr Wallace or his wife feel about their life together. No one mentions how Mr Wallace is feeling now. These matters are absent. Through the constituting of classes Mr Wallace is denied presence.

Some of the nurses talked about how they regarded quality of life and how they assessed quality of life. However, what has emerged through the analysis of nurse-patient encounters as occasions as for nursing is that patients' feelings, their knowledge and experiences are sequestrated. Nurses are looking at patients in particular ways and in relation to a particular order of things. So the question arises, how do they judge patients as worthy where the patient is unable to do work to get themselves across?

Patients are being looked at by nurses according to a particular grid of perceptions. This grid is disciplined by notions which help them assess patients in relation to notions of their medical condition and in relation to throughput and movability. In this context old patients, with minimal potency who cannot insist on their presence, are at great risk.

In this Chapter some of the conditions of possibility for patients' conduct have been discussed. These suggestions arise from readings of patients' conduct as observed in the setting as well as from talk with me. It is by no means intended as an exhaustive review of all the different motives and explanations for how patients and nurses as individuals behave together, but it is an attempt to suggest ways of understanding how patients constitute themselves in their relations with nurses.

The next Chapter summarises the previous chapters and discusses how the study has developed understandings of nursing assessment as an aspect of nurses' conduct.

PART THREE

CHAPTER ELEVEN

SUMMARY AND DISCUSSION

> We're like those natives in New Zealand who just went on fishing because they *couldn't see* Captain Cook's ship - there it was in the bay, but they couldn't conceptualise it. [Iris Murdoch, 1988, p562]

Introduction

The research project set out to examine nursing assessment as an aspect of nurses' conduct. Placing nursing assessment within the broader context of nurses' conduct has included a wide-ranging examination and discussion.

The study has also adopted a critical perspective. I have suggested how in order to care for patients nurses read many different things. How much this 'care' is reflexive, or planned, or indeed reportable, is made problematic in the present study. In the study, for example, nurses often worked together on routine 'back rounds' and in the routine delivery of facilities, such as food: at these times activities around patients may have passed on information about how to care for a particular patient without explicit instruction or record.

Within the routine and mundane occasions for nursing the nurse may 'see' that the patient 'needs' to be repositioned, the nurse lifts a patient in a certain way rather than another, or may call for help to lift a patient in a particular way or might get the patient 'up to sit' in a chair or 'enable' a patient to sit up in a chair themselves. Nurses are doing these forms of care rather than other tasks; they are doing caring in particular ways, rather than in other ways. The current study has attempted to reveal *how* the particular ways in which nurses care occur. The project is not a normative one. I am *not* setting out to suggest certain skills should be applied. It is *how* nurses apply their skills and *when* they apply them and *what* skills they apply in preference to other possibilities, that are the issues here.

I am suggesting that nurses recognize certain matters, while they do not recognize other matters. This lack of recognition is not because they simply have not been taught or have not experienced and therefore lack a 'cognitive' model. Instead I am suggesting that what has visibility is socially constructed. Further, like the New Zealanders above, nurses may refuse to see/recognize some things rather than others for very many diverse reasons.

In examining nurses' practices, what is at stake is to what extent nurses authorise their activities and to what extent patients mediate that authorization.

In attempting to analyze how occasions for nursing occur it emerges that no single instruction or set of signs can indicate forms of nursing: it is in this respect that the present study has revealed three things. First, the complex, situated and semiotic nature of nurses' understandings. Second, the disciplined space in which nurses work and which they help accomplish. Third, the work that patients do to do patient and be patient.

What has emerged in doing the study and which will be discussed in this chapter, is how these three things are recursive and inseparable. Some readers may find the present study critical of nurses' practices. This has not been the intention. The interpretations of the findings argued in this present chapter are aimed rather at revealing just how socially and organizationally *competent* the nurses in the present study actually were. The findings are now presented and discussed.

Organising a Disciplined Space

Within the field studied, nursing assessment as an aspect of nurses' conduct has been shown to be constituted through a complex and heterogenous arrangement of nurses practices and an interplay with nursing and other discourses. However, what has emerged and been presented in the current thesis are patterns of activity and communication which are sustained over time. Drawing on numerous examples, nursing assessment has been shown in the present study to be a socially embedded, semiotic activity. This activity is not separate from or independent of the organising of nurses and care. Nursing assessment is constituted by and helps constitute particular forms of organization: an order of things.

Through the examples in Chapters Six and Seven, 'what' constitutes nursing care has been shown to be transmitted through a number of sign systems working together, rather than just through instructions given in work sheets, handovers or care plans. These sign systems include ward routines, the placing of patients, the posting of signs (e.g. nil by mouth or diabetic diet), the artefacts surrounding patients (such as intra-venous infusions, observation charts, or other equipment) in conjunction with the form and content of accounts of patients (nursing handovers, records and care plans). It is in these diverse ways that the work-place can be understood to speak [Munro, 1991].

These chapters were concerned to evoke a sense of the setting and the ways in which it is organized as aspects of how nurses know how to conduct themselves in relation to patients, what to do for/to patients. The ways in which members have organized the

hospital in relation to the admission of people is reflected in members methods [Garfinkel, 1967] for organising the wards. What has emerged is how members move patients through the hospital through a constituting of classes of patient. Members in their interactions together, such as during ward rounds and social rounds, ascribe patients to types and turn patients around: they transform how a patient is seen and understood, is constructed, in relation to their 'needs'.

Staff ascribe persons to typologies of admission: acute, social, geriatric, medical. This constitutes a way of pointing to the 'out there' [Deetz, 1992]: these typifications carry with them certain identities and values. They carry with them ideas about 'needs', which are put in an order, and which to some extent indicate care. Within the illustrations drawn from the study nurses have been seen and heard to move patients through the different categories: from types of admissions through to a discharge, transfer, death or a blocked bed. As patients are moved through these typifications they are moved through space. As shown in Chapter Six, space, which is never only geographical, gives place and meaning.

The ward work is organized to some extent around these typifications: geriatric patients and patients with social problems are placed in particular areas which in turn are looked after by particular grades of nurse and given particular forms of care, usually delivered through ward routines. Medical patients and acute patients are placed for observation and high dependency care, with qualified nurses or student nurses with some experience assigned to look after them. While geriatric and rehabilitation patients are placed so that nursing auxiliaries and junior student nurses look after them under the supervision of more senior, experienced nurses. The hierarchy of nurses and their work is reflected in the ascription of patients to types and the hierarchy of needs.

Members use the construction of typifications to identify patients and communicate forms of care. However, they also use these same typifications to organize and to account for their organization and to maintain their own identities. For example, in the social round an aspect of this nominalism involved "definitional labour" [Goffman, 1958]: through the organization of definitional labour staff were seen to construct or reconstruct patient identities and, by reflection, their own.

Nursing handovers, as the formal accounts of nursing and patient care, while having some overt instructive content, effectively help instruct nurses in implicit ways. Wolf [1988] emphasises how the "change-of-shift report" is an event through which meanings are relayed, and asserts:

As an occupational ritual, change-of-shift report was a stage where nurses

> learned what it meant to be a nurse. Here the goals and values of nursing were taught and reemphasized. [Wolf, 1988, p290]

Here, Wolf is reproducing the notion that there are "goals" and "values" which are somehow occupationally 'set' or 'fixed', to be learnt and applied. In contrast, in the current study the nursing handovers were the principle occasions through which 'permissions' could be transmitted. This is not to suggest that handovers conveyed rules and norms to be learnt, but that the burden is on the nurse to interpret, to know, and to understand. Handovers convey, through legitimation and signification practices, what the 'room for manoeuvre' is in this particular place. This can be understood as a form of organization, which enables flexibility, but which simultaneously disciplines: handovers help define the space in which nurses act and which they help produce and reproduce.

In the present study what constitutes the proper focus of 'nursing' and how to 'do nurse' is relayed through these ward handovers and records of care, together with the other methods for ordering the setting (routines, spatial arrangements of patients, the conduct of senior staff with patients, with nurses and with doctors). The accounts of nurses constitute as Giddens [1984] would argue it, communicative events. As discussed in Chapter Four, nurses' accounts and communicative events relay meaning, moral order and relays of power.

Handovers, as communicative events, can be read as helping to imply what has significance in this place and what is importantly legitimate in this place. They help define accountability, and in this way handovers are one of the ways in which the order of the setting is recursively maintained. Giddens [1976] asserts that:

> The organization of 'accountability'...is the fundamental condition of social life; the production of 'sense' in communicative acts is, like the production of society which it underpins, a skilled accomplishment of actors - an accomplishment that is taken for granted, yet is only achieved because it is never wholly taken for granted. [p20]

Handovers are structured and timed in ways which convey that observation work and administration of medicine (or intra-venous fluids) work are given priority. These aspects are talked about in detail in particular situations: where these aspects are not covered by ward routines or where a patient is new, their condition is still 'unstable', or potentially unstable, or where there is still some ambiguity as to why they are there or whether they will get out. For these patients, there may be more specific instruction about how they are to be nursed. Other nursing work was referred to in general terms (e.g. self-caring, up to sit, mobilise, two hourly care). Care plans appeared to be seldom used and where they did exist they cannot be taken to represent the work which went on around patients.

Further, as demonstrated in Chapter Nine, patient's expressions did not appear to inform the nurses accounts about them. Patients' feelings and experiences were not discussed at handovers or reported on in nursing records to any significant extent. Patients are identified through their diagnoses and associated signs and symptoms. They are frequently talked about metonymically: their diagnosis or some other feature is used to express or imply a whole 'process' or set of nursing issues (eg. 'she's had an MI, she's day two' or 'she's an RTA, she's 88, get her up').

Where patients are talked about in any detail in relation to how they are 'behaving', a pattern emerges to reveal that on these occasions what is being constructed is how the patient is an anomaly either in relation to their apparent diagnosis (as with the case of Mrs Adamson), or that their behaviour may represent some impediment to their smooth recovery and discharge (as with the case of Mrs Menzies and Miss Hepburn).

Through both the structural emphasis of the handovers, and the means by which patients were identified, patients are reduced to their traits and parts as translated through particular discourse. Patients do not have the authority to inform about themselves in relation to their medical condition. Their feelings, reflections and experiences *alone* are insignificant, and cannot legitimate nurses' practices. That is, formally and officially patients cannot be *seen* to do so. Patient's feelings and experiences, the meaning events had for them are not generally referred to at handovers or in nursing records. As has been stressed in Chapter Ten, occasions where patients are able to affirm or reform some self-constructed identity with staff, instantiated private and personal moments of involvement.

The very structure of the handovers relays messages to nurses about how to conduct themselves. Except on occasions between qualified staff handovers are essentially non-discursive and non-collaborative. Handovers are not constituted as forums for discussion about nurses' feelings, experiences, observations and reflections about patients generally. This, in conjunction with the observation that there is no forum, either formal or informal, for such discussion, indicates something more about the setting.

Taken together with the material content of the handovers, the implication is that talking about patients entails a specialist language. This is confirmed by Wolf's finding [1988]:

> As nurses exchanged information and interacted during report, they communicated in a hospital-bound, nursing-specific language. The language kept the meaning of report somewhat secret and was intelligible only to those who were initiated into hospital nursing life. [Wolf, 1988, p232]

In the present study, in contrast to Wolf's study, the authority to speak and to authorise was

limited to a few. Knowing about patients and how to nurse them involves special knowledge, learnt over time, expressible in particular ways. Seeing, knowing and the authority to speak go together. This is reflected in the qualified nurses' interviews, presented in chapter Eight, where they claim that they just knew by looking and that this came with experience.

The form or structure of handovers helps maintain a hierarchical ward administration. Whoever is in charge 'knows/has special sight' and while they get feedback from those under them, this feedback itself is preset by indicators laid down in the setting: feedback configures around problems predefined to a certain extent by the focus of ward handovers and records. These set precedents and indicate the proper focus of nurses talk and behaviour. So, for example, nurses would tell about things like chest pain, or whether someone had not helped to wash themselves when they were supposed to be mobilising. "Vague" and undirected feedback was most unusual. As has been shown in Chapter Six these aspects of communication in the setting are reproduced in the written nursing records of the "patients' progress".

Further, they instantiate forms of distanciation which Bauman [1991] argues is one way in which organizations maintain control. Bauman defines distanciation as the removal of the consequences of action from the knowledge of actors or even the ability to recognise the consequences of one's actions if gazing at them. This may be a partial removal enabling only partial connections. The junior nurses in the current study collect specimens, information and observations about patients and give care. They record and report these matters, but they do not get involved in the interpretation and translation of these matters: they are excluded from the consequential 'decisions' about patient care. Their views of patients are only taken into account in a very limited and restricted way until they can begin to speak the discourses, showing by saying that they can see what others cannot see.

I would like to suggest that in this respect there is some parallel between the position of patients and the position of junior nurses: like the junior nurses, patients 'give' (both voluntarily and involuntarily) information about themselves but are not involved in the constitution of meanings and therefore in the consequential decisions about their care: they may comply but they do not, typically, participate.

In these ways handovers are disciplining: they help relay, in conjunction with other aspects of the ways in which the setting is organized, messages to nurses about how they are to conduct themselves in the setting, and reproduce the conditions of possibility in which nurses constitute their conduct. According to Hacking [1986], Foucault

> ..held that the class of sentences that can be uttered in a specified time and place is not determined by the conscious wishes of the speakers. The possibility of being true-or-false does not reside in a person's desire to communicate. Hence the author himself is irrelevant to the analysis of such 'conditions of possibility'. [p32]

The handovers and written records of patients are texts, which help, recursively, constitute a disciplined space, a space in which (some) nurses can talk about and think about patients in particular ways rather than others. This space helps constitute the ways in which nurses see patients *and* themselves: it helps constitute what is seen by conveying what can be said. The text helps give permissions through defining accountability.

Nurses' accounts of patients get constructed and written in the setting through texts from the authorship of which the patient has been excluded, except where their expressions can be translated through discourse. For example, "I have a terrible pain in my chest" becomes a measure of recovery "has Mrs Smith had chest pain today?". Further, these texts are constructed in particular ways which exclude the everyday experiences and understandings of the junior nurses as they go about their work. It is almost as if authority to speak depends upon establishing distance. Until sufficient distance is constructed the nurse has no authority to speak. Without the gaze the nurse cannot see, she cannot see because she is too close.

In the light of the findings in the present study, the emphasis on nurses developing their own language takes on a new and sinister meaning: its exclusiveness is an exclusion of patients' meanings and the everyday understandings which can inform nurse's understandings about patients. In the work of Benner and her co-authors critiqued in Appendix One, it is the very emphasis on the fluency of the experts' language which reveals a wedge, a form of distance constructed between nurses and the patients about whom they speak. As argued by Foucault [1973] and discussed in Chapter Two, it is through the development of a specialist language that experts constitute themselves as those who have special sight/knowledge and the possibility for exclusions and displacements occurs. It further displaces the interactive nature of understandings and puts the onus and the reward of knowing at the door of the individual.

In Chapter Eight, nurses talked about how they knew what to do for patients. From their talk it appears that the nurses have developed a gaze, through which they read the patient for signs, and which can be interpreted according to a code, but which displaces the patient from participation in the production of signs and the construction of meanings. The burden of knowledge is on the individual nurse. Nurses claim ways of seeing patients which

enable them to identify the patients as such a 'one' with particular needs. In the nurses' accounts this seeing is divorced from nurses' own 'experiencing' of the patient, except in particular ways: the nurses' experience the patient as seen and thought, not as felt. This seeing is also divorced from the patient as an experiencing, knowing self, and further, it diminishes the extent to which nurses' interpretations are affected through their *interactions* with patients and other nurses. The patient as an experiencing self is displaced: there is assumption that the will of the patient and the will of the nurse overlap. Only in exceptional circumstances does the experiencing subject come to matter. Primarily this occurs where there is a likelihood of disruption to the flow, to a patient's smooth passage through the bed and home.

Talk among nurses as indicated in Chapter Eight is used to check on what is seen or noticed as potential blockages to the flow. Talk with patients helps relieve the pressure and the potential blockage caused by things like anxiety and worry, or any aspect which may lead to non-compliance, like lack of information or understanding about medicines or investigations. Talk with patients and being with patients is not conceptualised by nurses as method to inform their understandings of how to proceed. The patient as subject is non-participant in directives for care.

Nurses in the study know they prioritise ward routines and the "acutely ill". They assess patients in relation to their vital status, and the care a patient "should" have given this vital status. And they know that they assess patients in relation to patients' exit potential. Those patients who have neither immediate threat to their vital status nor any exit potential are degraded to a class of patient which is neglected. The nurses' accounts reveal how their gaze is disciplined through their work to get patients moving, up and through the beds, and how they are on the look out for any potential impediments to this work.

Old people represent potential impediments to this work. As most of the nurses claimed, their greatest satisfaction is to see someone get better and get home. Concomitantly, their source of dissatisfaction was in not getting people through. In the reflection of their accounts, their worries were located around how the long-term elderly and disabled patients do not get the care they need within this setting, that there is no time for attention to the social life of these long-term and elderly patients. Nevertheless, the social and the real work of the setting remain detached in the nurses' accounts.

The nurses have very little conception of how their conduct affects others: they have no explicit regard for how each of their acts constructs the social and is socially constructed, that the very ways in which they are conducting a bedbath may speak a language. And yet

they know these things implicitly. They underestimate and devalue these aspects of their work. These aspects have no accountability for them, they are the invisibles. As can be seen in the analysis of the nurses' encounters with patients, in Chapter Nine, they do know at some subliminal level how the social works, how they institute forms of relationship and move patients around through their conduct.

Drawing on Foucault's work, as discussed in Chapter Two, a discursive formation draws boundaries and while giving order to things and giving them place, it displaces other things. Further, the discursive formations, as forms of representation, (of patients) constructs what has visibility. What is seen (noticed or read) does not necessarily correspond with the object which is then represented in language. There will be exclusions and displacement of things.

Displacement

How nurses conduct themselves in their encounters with patients to make occasions for nursing was explored in Chapter Nine. Nurses in the study were heard to refer consistently to the activity around patients at the time of their arrival and shortly afterwards as "doing an admission". Chapter Nine examined how nurses accomplish "doing an admission" and what they achieve by this.

Chapter Nine concentrated on research material taken from the time around nurses' admissions of each patient, but was crosschecked with material taken from throughout the patient's stay. The methods and strategies nurses employed have been presented, including their operationalisation of the "admission" documents, that is the "nursing profile" or "nursing record" or "kardex", and the formal procedure for "doing an admission" as defined in the procedure manual, which were analyzed in Chapter Six.

The functional or pragmatic object of the 'formal' aspects of the admission appears to have been to uncover and to *exclude* problems which might require special attention and to get what some of the qualified nurses referred to as "background" or "history", to know how a patient is "usually". This is connected to the pragmatism of the setting described in Chapter Six, which relies on delivery of care being partly constituted through routines, action in a block and the easy facilitation of surveillance, of both junior staff and of patients themselves.

Analysis of the 'admission' presented in Chapter Nine, revealed that nurses constitute a formal admission as involving the collection of information, obtained from patients, families and other written sources. The collection of information was treated as if

it did not entail a process of interpretation, as if there were matters of fact to be collected and recorded rather than signs to be produced and read. This helps displace both the admitting nurse and the patient as integral not just to the interpretation of signs, but to the production of signs and meanings.

Through this displacement it can be anticipated that nurses are accomplishing other things through the admission procedure than the collection of information. It is suggested that the admission procedure can be conceptualised as the induction of the patient. Through their communicative practices which act on patients, nurses displace patients as experiencing selves, sequestrating their feelings and concerns. This both produces and reproduces a nurse-patient dynamic which locates legitimation and signification *outside* the nurse-patient relationship.

The displacement and sequestration of patients' feelings and experiences is achieved through nurses systematic control of the form and content of their talk with patients and their activities around patients. In discussion with the patient (or their relatives) they control talk about why the patient has come to hospital or how they are feeling at the time of their arrival on the ward or about how their 'signs' and 'symptoms' affect them. Additionally, nurses use the version of a patient's 'admission history', that they find recorded on the admission document, as a basis for their identification of a patient's immediate problems. In these respects the patient's own testimony is unsought and virtually discounted and the patient himself is not given space to be actively participant in any investigation of his illness. Patients are not fully participant in either the *production* of signs or in the constitution of meanings. This requires further comment.

Following Eco (1976, 1984) it is how signs get produced in the current setting that is problematic. The production of signs is preset by the gaze, this is suggested by Foucault's work discussed in Chapter Two. The displacement occurs seriously at the point of sign production: because the patient's own accounts and commentary are excluded they are not participant in sign production. So for example, the nurses ask patients about their weight, how much it is, but they do not engage in the patient's account about their weight *unless* it has significance according to their discursive map. The translation occurs before the apprehension of the sign and fixes what is seen, what has visibility. This of course helps constitute expertise: it is only those with special sight who can see the signs.

This exclusion of patients would appear to be a failure on the part of the nurses to do nursing assessment as per nursing process. However, it is being suggested in the current study, as discussed in Chapter Nine that through these interactions with patients the nurses

are accomplishing forms of distanciation. Nurses' conduct is in effect disciplining patients, aiding their induction into the ways of the ward and maintaining the order of things in the setting. Once isolated patients' feelings and experiences lack significance. On their own they are insufficient to legitimate action. Like student nurses, the patients lack a voice, effectively they are silenced.

Through close examination of the conduct of these encounters, the effect of nurses' moves can be understood. By ordering their encounters with patients in particular ways they institute a particular type of relationship with patients. Patients are positioned to lose the potency of the self. This displacement, I have suggested, accomplishes something equivalent to what Bauman [1991] refers to as the effacement of the face: nurses do not respond to patients as an Other, as a face with authority (to know, to feel, to tell), their knowledge and authority as a self is displaced. Nurses constitute patients as other (than us). Once the system of signs carried by a patient is detached by nurses from their feeling, experiencing selves, patients alone cannot authorise meaning or action. This detachment is accomplished through nurses' discursive practices.

The Patient as Writing

Through my interpretations of research material I am suggesting not just that patients are read, but that they are written through the codes of nursing and medical disciplines. This is not new - professional socialization, it is claimed, leads to "an assumption of superiority of knowledge and a lessening of weight given to client opinion" [Munns, 1980, p97]. Further, there have been numerous studies to reveal the discoordinations between client and professional perceptions of wants and needs [see, for example, Buckley and Runciman, 1985; Gray, 1977; Johnson, 1972; Poulton, 1981]. But in relation to the rhetoric of nursing, the claims of nursing discourse, this situation is problematic.

In Chapter Eight it emerges that nurses in the study are not claiming that they are listening to patients but that they are "looking" at patients, looking for signs, particular signs, to know. They may use talk as supplement to what they see. In Foucault's [1973] terms they are saying that they are able to see to know, but their seeing is disciplined: they are "looking according to a grid of perceptions and noting according to a code". They did not for example look and see that Mr Wallace was restless, attempting to communicate and lying on the bars of his backrest. Only particular aspects of patients come into view at any particular time, others can be refused as they do not count, do not have visibility. This visibility of aspects of patients is constructed through context: as stated in the Introduction,

context is the perspective within which objects become viewed.

Nurses read the patient in relation to how they are written by the medical staff: an aspect of their assessment is assessment of the medical version of the patient, the medical story as written by the doctors. This forms the basis of their way of viewing patients, it creates a context in which aspects of the patient become visible. But nurses do not just assess how the medical staff write the patient and talk about the patient, but also, as has been shown in Chapter Seven, in relation to how the medical staff conduct themselves in relation to a particular patient.

Nurses enrol the medical staff's accounts about patients and doctors' conduct around patients, to help situate patients in their world and help in their constitution of classes of patients. The conduct of doctors, as well as their accounts, carry implicit and tacit meanings for nurses, through which they evaluate patients and assign them to a particular class.

The nurses' gaze is constructed to identify marks on the patient: nurses see the patient as written. First, through disease the patient is written on, there are marks and signs which the nurses read to know (blue lips in relation to a diagnosis of heart attack indicate circulation may be compromised). There are particular observations which can measure the body's vitality in relation to the disease process proposed by a diagnosis or set of symptoms: nurses use these to know and to confirm what they see.

Second, as already indicated, nurses read the patient as written by medical staff: the ways in which a patient is being constituted by doctors is read by nurses. So, for example, the artefacts attached to a patient or the absence of these and the ways in which a patient is being treated, or the absence of treatment, help indicate a patient's status (acute, medical, social, terminal, rehabilitative), and the care that 'should' be given.

Third, nurses read marks and signs in a patient's 'behaviour' to know how he feels or what he is thinking and to evaluate his commitment to getting well and through. For example, 'pain' can be seen, or the patient's ability to move in particular ways is seen to indicate capability and/or willingness.

And finally, nurses are reading the patient in relation to his so-called social history or lifestyle. This is where aspects of a patient's social situation are taken by nurses as representing signs through which they attempt to predict the future and decide on the present course of action. The patient is prewritten through the doctor's account, but also through nurses' disciplined gaze, the patient is re-written.

Nurses can tell by seeing, and what is more, they can by saying show that they have seen what they know. However, this writing does not just come through a rational

discourse: this writing comes through the nurses' experiences in the setting in which they work. This in turn interpenetrates with their own identity. In writing patients and nursing, nurses write themselves.

Wilson-Barnett [1988] emphasises how nursing knowledge can highlight human difference [p793], and proposes how this can be achieved through the individualisation of nursing care:

> Although the disease and its consequence determine some of the patients needs and problems, the nurse's proper interest is the person and their response to potential or experienced sickness. ...Hopefully in the 20th century, nurses can firmly rest with understanding the individual. ..It needs to be reincarnated through the careful understanding and introduction of the nursing process, that is problem-oriented care based on assessment of need. [p793]

Here Wilson-Barnett links the nursing process to the individual as an experiencing subject. This stress on the individual as central to care, contrasts vividly with the findings in the present study.

Nurses, in the present study, through their conduct, displace patients' potential for co-authorship by sequestrating their feelings and experiences. In maintaining the patient as written through nursing and medical discourse and the discourses of the setting, nurses act to restrict patients' participation in the production of signs and the constitution of meanings about them. Nurses are denying patients' authority, their authorship of themselves or at least some participation in the authorship of how they are written. Nurses are effecting control not just through regulation of the body [Turner, 1992] but through separating the body from the self.

Nurses, in excluding patients' self-expression, displace their self-identity and their participation in the constitution of meanings about them and their illness. Discourses about patients are managed at a distance from the patient themselves, as expressed by the qualified nurses in Chapter Eight and in the forms of organization and discourses of the setting described in Chapters Five and Six.

In Chapter Nine it was suggested that nurses work on patients to move them around, however, this relies on patients to work to know and to learn how to go on: they read the signs in the setting, particularly in the conduct of nurses, to know how to do patient. In this respect in Chapter Ten there was discussion of the patients' accounts of themselves. This is now further discussed.

Repairing Identities

Some conditions of possibility for patients' conduct have been discussed in Chapter Nine. These suggestions arise from readings of patients' conduct as observed in the setting as well as from talk with me. It is by no means intended as an exhaustive review of all the different motives and explanations for how patients and nurses as individuals behave together, but it is an attempt to suggest ways of understanding the patients in the study constituted themselves in their relations with nurses.

In the discussion so far it has been suggested that through nurses' conduct what gets relayed or communicated are forms of order: what has priority in this place and what does not have priority in this place; what gets counted and what does not get counted. Through nurses' conduct forms of order are established through displacement and sequestration of patients' feelings, concerns and experience. Nurses with others are effecting the effacement of patients as a face with a moral demand to be counted as an authority without force [Bauman, 1991].

One form of displacement, it is suggested, is through exclusion of patients from membership. This exclusion is accomplished through nurses' and others' communicative practices. Nurses act to exclude patients from participation in the production of signs and the constitution of meanings: that is from participation in constituting a discourse through which they are written and read in the setting. Patients are systematically excluded from participation in authorship of the discourses constructed around them. An effect of this exclusion from authorship is that patients cannot legitimate the actions of others on their own account.

What has also been demonstrated in previous Chapters is how qualified nurses achieve the displacement of patients as an authority. Nurses accomplish this displacement through locating their understandings outside their presence with patients. Through looking at patients according to particular grids of perception, and interpreting what they have supposedly seen through particular codes, nurses are constructing an expert or professional gaze and creating forms of *social* distance between themselves and patients. Their looking is a looking for, they are looking to see the patient as written in particular ways, translating what they apparently see through particular codes.

These codes are detached from patients' interpretations, and there is little interpenetration with patients' feelings and understandings. Nurses are assessing patients in relation to an order of things which displaces patients, and in which the patient, fractured into traits and parts, can be re-presented as having been 'seen'. In this way the patient is in

the present context (of nursing assessment) an artefact, not a co-producer of signs. Nurses, along with others, consume patients as significant in particular ways, rather than others. The patient's self-identity is partially annulled to reveal what is identifiable to the expert eye.

The patient is pre-written and the patient is written on. These are the ways in which the social is reconstituted in the setting: it is impossible for nurses to reveal, to account for a socially embedded and interpretative engagement with the patient as an Other. The ways in which the nursing admission is constructed denies the nurse's involvement in the interpretative and interactive dimension to any nursing assessment. This denial particularly affects junior nurses, the neophyte most likely to 'fall back' on the life-world of the patient. They are disciplined through being constituted as the collectors of information, of facts to be revealed. Both patients and junior nurses do not have the special sight to speak and to authorise action. Within the discursive space of everyday nursing conduct, they are low-status persons.

How patients and unqualified nurses interact, in spite of, or as an affect of, the displacement of their experience and feelings, has been discussed in Chapter Ten. I have suggested that some of these interactions help patients and nurses do identity work and help repair same of the displacement work done elsewhere. However, I have suggested that while these interactions typically remain private and discreet, they are still constituted to maintain a disciplined space. They do not constitute forms of resistance, but help produce and reproduce the order of things in the settings. As Garfinkel's [1967] work suggests, social actors are compelled to construct community.

As already indicated, student nurses and patients are constituted as those who can not say, who can not yet (not) see (or only have partial sight in the case of more senior student nurses), so both patients and student nurses have no authority, they have 'low status'. This aspect has also been suggested by Ward [1988].

Two matters emerge from this reading. First, that there is a sequestration of feelings and experience of both nurses and patients and that this is disciplining in particular ways. There is a risk, an epistemological problem, that this sequestration effects too limited an authorisation of information: the problem with sign production discussed earlier implicates the validity of information. This in turn implicates the *legitimacy* of nurses activities. Putting it simply: what nurses are in fact nursing, has become questionable in the current thesis.

Second, it risks causing pain:

Having one's feelings ignored or termed as irrational is the analogue of

> having one's perceptions invalidated ... Both are likely to be experienced by lower status persons and to be inflicted by those in power. The invalidation of one's feelings, however, may be more threatening than the invalidation of perceptions, since feelings as a form of information are experienced as the deeply authentic, existential ground of who we are. In general the threats to ontological security are greater for those in dependent, subordinate positions. The lack of resources to protect oneself or to legitimate oneself further contributes to the status-related insecurity. Less powerful people face a structurally built handicap in managing social and emotional information and this handicap may contribute to existential fear and anxiety. [Freund, 1990, p466-467].

In the current study it is being suggested that patients develop strategies and methods to reform an identity within the hospital setting and that there are spaces in which nurses and patients come together to do repair work on their identities and to help defend against anxiety. They use the only resources they have: their social relationships with others.

The social relationships of low-status workers as a resource in the management of identities and definitions of work is suggested by Ghidina [1992] in her study of low-status workers. In her study Ghidina shows how lower-status workers need others to positively affirm their definition of their work and their self-identity. She reveals how they accomplish this maintenance and management of their identities and definitions of their work through their social relationships with others. Ghidina's study suggests that a possible way of interpreting relations between nurses and patients in the present study is that caring social relationships constitute methods and strategies of lower-status workers.

If so, this suggests that auxiliary nurses and junior student nurses do not necessarily have the same skills in constituting patients as strangers [Bauman, 1990], as completely other (than us), that they lack an objectifying gaze. They have not yet acquired the 'gaze' which acts to socially distance the nurse from the patient: there is still sufficient presence to allow the 'face' to act as a moral demand without force. And recursively, the status of both auxiliaries, junior student nurses *and* patients is constituted through this lack of (or only novice) gaze. This in turn excludes them, as discussed in Chapter Ten, from full membership, because they cannot say that they see in particular ways.

In this Chapter how nurses *operate* in a disciplined space has been discussed to suggest that nurses are also *operating* that disciplined space through their discursive practices. Nurses' narratives about patients are constructed to indicate what constitutes (accountable) nursing in this particular setting. The accountability (that which can be talked about and legitimately acted upon) configures around two foci: the extension of the medical gaze (look and see) and the 'rehabilitation' of patients (keeping them moving). These two aspects of nurses' work are now discussed in the final Chapter in relation to the construction of nurses' discursive practices.

CHAPTER TWELVE

CONCLUDING DISCUSSION

> Curiosity is a vice that has been stigmatised in turn by Christianity, by philosophy, and even by a certain conception of science. Curiosity is seen as futility. However, I like the word; it suggests something quite different to me. It "evokes" care; it is the care one takes of what exists and what might exist; a sharpened sense of reality, but one that is never immobilised before it; a readiness to find what surrounds us strange and odd; a certain determination to throw off familiar ways of thought and to look at the same things in a different way; a passion for seizing what is happening now and what is disappearing; a lack of respect for the traditional hierarchies of what is important and fundamental. [Foucault, 1980b, p328]

Introduction: Medical Nursing Expertise Extending the Medical Gaze

The preceding analysis of the nurses' narratives about patients and nursing, (constructed from their accounts in the setting, both written and verbal, observation of their activities and their interviews) appears to confirm other writers' picture of nursing as one of medical dominance. Nurses claim they prioritise their support of the medical: they are concerned to act to extend the medical gaze, to act as the doctors' eyes in their absence. They observe patients according to particular medical criteria, for particular effects defined by medical discourse, and they translate what they see into discourses about patients. They look at the patient for how they are written through medical discourse. For nurses, how they see (say) themselves as 'medical nurses' is a central aspect of their identity.

How nurses look at patients is recursively constituted through their identity work. That nurses see themselves and act to be seen as medical nurses, impacts on how they organize their work and the placing of patients. It was particularly demonstrated in the ward rounds (where they were asked to give accounts of what they had seen), in the ways in which they ordered the ward (placing patients in particular areas to facilitate observation of patients), in their records about patients which repeatedly recorded information about observation of patients, and in their talk about patients at handovers, which frequently focused on their 'observations' of patients.

Other aspects of their work which they said took priority, were the administration of drugs and intra-venous fluids. Monitoring the effects of these, constitutes a further aspect of their medical observations of patients. Managing or facilitating this observation work and

drug work was the work which, by the qualified nurses' own accounts, was given priority and constitutes a focus for their interactions with patients.

Patients who were constituted in the setting as 'needing' observation work were also prioritised: they were the acutely ill and they were authentic and appropriate patients in the place. They were constructed as those who need the expertise and facilities on offer. It was further noted in Chapter Six, that these patients were routinely immobilised and, therefore, made virtually dependent on the nursing staff while they were 'acutely ill', that is during the period at the beginning of their stay when they were under investigation, under observation. Patients were then mobilised and practices were instituted to ensure that they became less dependent on the nurses.

One way of understanding this is certainly to see patients as being given an initial period of rest. An additional possibility, however, is that it facilitates the medical gaze. Certainly conditions of stability (bedrest and restricted movement) might be thought appropriate for taking medical observations. The so-called dangers of immobility were not expressed explicitly in ward reports. However, the mobilisation of patients constituted an unwritten priority, but occurred only when the nurses constituted the patient as 'medically stable'.

However, elderly patients were sometimes constituted as different: they could constitute exception to this unwritten rule, especially in the first ward, where they might be mobilised (that is got up) *despite* an 'unstable' condition. This mobilisation was not directed simply at the safe delivery of health to patients through the so-called prevention of complications due to prolonged bedrest. Rather, it shows how the management concerns (of nurses and doctors) can override usual 'medical orders'.

The proactive aspect of movement and rehabilitation as constituting justification for early mobilisation, can readily be legitimated by recourse to the nursing literature. Proactive rehabilitation was developed in medical discourse and has been addressed at length in the nursing literature, particularly in relation to the mobilisation of elderly people in an acute medical environment [see for example, Hulter Asberg, 1986]. Attention to mobilisation and proactive rehabilitation is consistently stressed in models for geriatric nursing [see for example, Eliopoulous, 1979]. There has been suggestion that dependency in the elderly may be iatrogenic and related to enforced immobilisation leading to increased dependency [see for example, Armstrong-Esther, 1986; Miller, 1984, 1985a, 1985b]. In these ways rehabilitation, proactive care to prevent dependency, and immobilisation and the elderly are inextricably associated in the nursing literature. But there is also suggestion they are

associated with the issues of cost and time, as raised in the Introduction to the study: proactive rehabilitation is associated with difficulties with older patients' tendency to stay longer in the acute services and to, sometimes, block beds.

Legitimations for getting patients mobilised early were not explicitly stated in the discourses of the setting and may have been taken for granted. On the contrary, there was very little discourse generally, in either ward, in relation to proactive aspects of nursing care. For example, there were very few overt instructions as to how to manage a patient when they were confined to bed. Nurses did not talk about, or write about, passive limb exercises, deep breathing or the positioning of body and limbs, and only occasionally mentioned pressure area care, which all constitute so-called preventative nursing actions. (NB: Mr Donald, whose care plan and progress report is included in Appendix Eight, constituted an exceptional case: he had friction burns down one side of his body where he had lain on the floor all night, following a stroke).

As already indicated, the focus of instructions configured around observation of patients, delivery of treatments, and subsequently around evaluation of how patients were mobilising or doing self-care. The pull on the nurses appears to have been a conceptualisation of 'rehabilitation' to get people moving, to get elderly people *through*, rather than any enrolment of notions of proactive rehabilitation.

The proactive aspects of rehabilitative nursing work is presented in models for nursing. For example, the much quoted definition of nursing by Henderson [1966], states that a nurse's activities should be done in "such as way as to help him [the patient] gain independence as rapidly as possible" [p15]. Kitson [1986], drawing on Orem's [1980] model, emphasises this aspect as the primary function of good quality geriatric nursing, and as helping to constitute a care model, rather than a treatment model, for nursing practice. More recently, the so-called rehabilitative component of nursing has been reemphasised in government discourse as one of the proper and appropriate distinguishing focuses for *professional* nursing activity [Scottish Office Home and Health Department, 1992]. This emphasis on rehabilitative nursing will be returned to below.

Nurses' observation work and their administration of drugs is easily 'visible'. The visibility is achieved either through the activities concerned, (taking recordings of temperature and pulse, paying attention to intra-venous infusions) or through accounts (the saying and writing involved, on charts, in the nursing notes, at ward handovers). These aspects of nurses' work are "observable-reportable" [Garfinkel, 1967, p1]. As discussed in the Prologue drawing on Goffman's [1958] work, visibility is important for nurses to convey

the purposefulness of their work.

It should be noted that these two aspects of nurses work were also the only aspects of their work which were inspected by others from outside the ward: doctors examination of patients entailed an examination of the nurses' observation records, (sometimes) a questioning of the nurses themselves about what they had seen, and their administration of drug records. On several occasions the nurses were seen to be called to account by a doctor for what they had done or had omitted to do. Unlike the medical staff, the nurses in the study have no direct, regularised inspection and examination of their clinical work with patients. Nor did the nursing administration, at the time of the study, have methods for auditing the ward nurses' work with patients (there was at this time no nursing audit). They did not, for example, inspect the nursing records. In view of the earlier discussion in Chapter Two on surveillance, and how the possibility of inspection and examination help discipline, this is an important point.

I would like to suggest that the doctors' direct inspection of nurses' work helps discipline nurses in particular ways: the aspects of their work in which doctors have an interest will be of importance to them. In the present case, these aspects configure around nurses' observation work and their drug administration work. Through the possibility of inspection and examination the nurses can be called to account for these aspects of their work: their conduct in these respects not only *has* visibility, but through the possibility of inspection and examination of the patient, and nurses' work to observe and give drugs to the patient, a state of visibility is induced in the nurses. There is always potential for these particular aspects of their work to come into view. I would like to suggest that this helps to define what takes priority in the setting, and in this respect, helps produce and reproduce the order of things.

In contrast, there is a marked absence of an inspection and examination of nurses' *clinical* work by nursing administration. There is, it would appear, a much greater reliance on nurses' *self-discipline*. However, there are informal messages relayed to nurses down the hierarchy to indicate what has importance: there is emphasis through the communicative practices of senior nurses on the importance of the bedstate. This emphasis helps produce and reproduce the emphasis on the movement of patients through the beds. These matters were stressed in Chapter Five. The senior nurses presumably have implicit signs systems by which they judge how the ward is being managed. So, for example, the senior nurse in the present setting expressed an opinion that Sister 1 was a good and an efficient ward sister, while she expressed more reserve over the competence of sister in Ward 2. I would like to

suggest that this assessment may have been partly based upon how patients were slower to move through the beds in Ward Two than in Ward One, this was the view expressed by some of the medical staff, and that over time Sister in Ward Two would be disciplined to speed up the process.

It would appear that there was an "indulgency pattern" [Gouldner, 1955, p56] in effect in the hospital: ward sisters were not *overtly* and *directly* interfered with as to the ways in which they nurse patients. They were not directly called to account for these matters. This approach to management enables the indulgency pattern, which Gouldner suggests can be understood as:

> a connected set of concrete judgements and underlying sentiments disposing workers to react to the company favourably, and to trust their supervisors. It is an important, though not the only, source of job satisfaction experienced by the workers, motivating them to fill the roles for which they were employed, expressing commitment to a set of beliefs as to how the plant should be run, generating loyalties to the plant and Company, and expressing preferences for certain patterns of social relationships than others.[Gouldner, 1955, p56]

Sisters in the present hospital are not told how to run their wards but I am suggesting there were implicit and tacit expectations as to the end product of their management of their wards. As has been shown throughout the thesis, the nurses' conduct is disciplined in particular ways rather than others: nurses' conduct is both an effect of and helps effect the production and reproduction of ward life. Ward life includes the routinization of day-to-day life in conjuction with communicative practices and the complex relations between doctors and nurses. Nursing staff are disciplined and help discipline through the social to know how to *specifically* 'go on'.

Prioritising 'medico-technical' work produces and reproduces the ideology which supports the order of the setting: to ensure life and to save life is the purpose of the institution. It was present in the nurses' accounts of themselves. What these accounts instantiate is that the purposes and goals of the institution can be achieved *primarily* through diagnosis and medical treatment. Observation work and administration of drugs is the work nurses' can do to make, and *to show*, their contribution to this achievement.

Making observation work and drug work a priority, gives nurses' activities visible rationality and meaning. As has been discussed, it is wrapped up in the nurses' identity (as expert medical nurses who have special sight and skills), and in the ways in which they can glorify what otherwise may appear to be, *and* feel, mundane or dirty work [Ghidina, 1992]. This point relates to the professionalisation of nursing and is emphasised in Melia's [1981]

study of student nurses, and in Dingwall *et al's* [1988] social history of nursing: nurses to be seen as and to feel professional, must show that they are different from nursing auxiliaries or domestic cleaners.

The relationship between the socially constructed and performative nature of 'work', and its relationship to the self, is emphasised by Ghidina [1992] following Goffman [1958]. As discussed in Chapter Eleven, Ghidina in her study of low-status workers establishes the connection between work, self-identity and meaning. She reveals how low-status workers "individually create and maintain definitions of work and self" [p84]. Through negotiations with others, these others legitimate these definitions of work and self. It is in this respect that social relationships with others (clients/patients) are critical in low-status work, as it is only in the presence of others that the work and the self can be affirmed. Ghidina states that the difference for people with professional status is that they do not have to do this individual work:

> One way of viewing professional status, then, is that an occupational ideology or definition of work has been collectively made by the workers and accepted by others. In this light,"professional" workers need not individually manage the aspects of their work in order to create and maintain a positive definition of work. [p84]

Although she does not draw it out, the difficulty arising for professional workers then may be that the social relationships with others (clients/patients) do not count as much because they are not necessary to the maintenance of a positive definition of work and of self-identity. The relationship between client and professional reconstitutes the social as something less important and interactive than it really is.

One of the essential aspects of the construction of the self in modernity, is how time and space affect the project of the self. Giddens [1991], for example, holds that social actors see their present involvement in terms of a 'project', a future outcome. Featherstone's [1992] work suggests how these projects are constituted through how social actors, in their accounts, are compelled to give events a narrative form: there is a beginning, a middle and an end which the social actor(s), in their accounts, have *engineered.* In this respect, their medico-technical work helps nurses to associate nursing work with the whole project of curing, of 'getting someone well', the series of acts which fictionally *result* in the saving of a life.

Foucault [1984] describes modernity as an "attitude", a "mode of relating to contemporary reality" [p39]. This attitude is not simply struck because of the consciousness of the discontinuity of time - the "break with tradition, a feeling of novelty" [p39] - but is

also constituted by the mode of the relationship of the actor with himself. This attitude is contrasted by Foucault with the image of "la flaneur" [p30] - the disengaged, urbane actor, looking on - the modern actor is concerned with creating himself: by heroizing the passing moment in relation to some historical project, the modern actor constitutes himself as an autonomous subject.

Getting someone well cannot only be seen, in the remit of the heroizing attitude, to be achieved through bed-baths and the administration of hot broth, through little discontinuous acts of comfort and repair. Rather, success, happy endings, are accomplished through the technical and insightful prowess of individual and autonomous actors. The glamour and heroism of nursing work is partly constituted through its association with the technical and insightful, with the medical gaze, and through constituting itself in relation to a 'narrative', saving lives.

This association between the narrative form of accounts and medico-technical work is exemplified in some of Benner's (and her co-authors) writing, which acts indirectly to perpetuate this focus of nurses' work by giving many exemplars which configure around the medico-technical aspects of nursing. In these exemplars [Benner, 1984; Benner and Wrubel, 1989; Benner, 1991; Benner *et al*, 1992] the emphasis is on how a nurse could 'see' how critically ill a patient was, while others were blind, and how she knew how to act either to confirm her sight or to deal with the situation. Benner [1991] herself refers to how nurses' work is often concerned with "heroic saving of life" [p1]. Benner's work as a whole is constituted to reveal how this heroism is accomplished through the autonomous nurse subject who has special sight, and who (expertly) engineers events to accomplish a specific outcome. There is a story (a beginning, a middle and an end) of which the nurse is the author and through which her expertise is revealed.

This aspect of how nurses' work is wrapped up with medico-technical work to constitute meaning through imparting a sense of narrative and order, is also emphasised by Wolf [1988]. Wolf notes that nurses have developed rituals, and that this is an important aspect to understanding how nurses organize their work, like the change-of-shift handover which accomplished more than the passing on of information:

> Order was imposed on uncertainty as the nurses informed each other of patients' progress in relation to the signs and symptoms of disease. [p231]

Order is established through the nurses' interpretations and construction of patients in relation to their medical condition: this reveals their progress, it gives the nurses' work a narrative line and pushes back the margins of uncertainty. Implicit in Wolf's analysis is a

performative dimension: nurses recursively maintain the easy accountability of medico-technical work as primary in the ideology and symbolic of health care to present the narrative, the order they construct.

The heroizing inherent in the rhetoric of health care is discussed by Schrock [1987]. Schrock notes how professional disciplines achieve their power and influence in the social world through constructing ideology and symbols to underpin their "contract with society". She refers to

> ...the 'life-and-death' symbolic which is especially nurtured in the health care professions.. [p17]

She claims that this symbolic does not represent the "humdrum reality" [p17] of health service work but exemplifies how professionals convince and persuade their public.

Narrative and heroizing may represent one of the ways that nurses deal with the existential problems inherent in their close proximity to sickness, death and suffering, raised in Menzies Lyth's [1960] study and discussed in Chapter Three. It is an easy way to display to self, and others, some control over (and an effective sequestration of) what are otherwise deeply disturbing issues: another feature of modernity [Giddens 1991].

However, I would like to emphasise how the privileging of medico-technical work constitutes an aspect of nurses conduct which represents a further denial and disassociation of nurses, and nursing, from the everyday and mundane. Featherstone [1992] develops a notion of a 'hero ethic', which is associated with the masculine, the doing of deeds away from the home, and is concerned with the "elevation" and the "preservation" of the self [p174], in contrast with

> an ethic of sociability....which is less elevated, and more open to an egalitarian exploration of playfulness and pleasure with the other, to the immersion and loss of the self. [p174]

Observation work and the administration of drug work is *persuasive* work: it helps to reveal and confirm nurses' expertise, not just to others, but also to themselves. It also elevates the nurse in ways which remove the nurse even though she is in close proximity with the patient. Through this work, the patient is associated with or becomes an artefact to be read as written upon. This helps sustain forms of social distance: the nurse does not centre the patient to assess them but is concerned to assess their progress along the ways in which they have been already written. Further, the nurse can maintain her (always provisional) membership to the setting, through her practices around these as aspects of discursive practices (mainly medical), while simultaneously excluding patients from membership. This in turn, enables preservation of the self, (as member, as medical nurse) and helps to defer a

relationship which may risk immersion of the self in an exploration with the other.

The behaviours of some of the nurses as explained by them would confirm this aspect. For example, noticing that a patient looks ill, the nurse 'sees' to them under the mask of doing routine observations. This enables the nurse to motor past the patient as one who is emotionally engaged and engaging. Through avoiding any confrontation of the real reason for her proximity, the nurse defers expressions of emotion which may invite the patient to participate in making sense of what is going on.

One way, then, of understanding why nurses' prioritise, organize themselves around and can talk explicitly, and formally, about the aspects of their work concerned with observation and drug treatment, is wrapped in the notion of visibility. Not only do these aspects have credibility and a cultural significance, but they help confirm and maintain nurses' identities as persons having expertise, special 'sight', (they know "just by looking"), they persuade and convince not just the public, but also themselves, and the managers. It is, after all, cheaper to employ nurses rather than doctors to watch over patients and, so far, there are no machines that can do the job as well.

Nurses, therefore, may be seen as managing their performances to maintain an association with medical discourse and ideology to legitimate their work as it constitutes a ready made rational and *scientific* discourse, one of the conditions of the setting noted in Chapter One. Observation work and drug work are, in short, commodifiable. Medico-technical work has accountability, not just because of nurses' deep security in the effectiveness of medicine, but, to refer back to Chapter Two, because it contains the possibilities of a discourse which has already convinced: the nurses can say that they see. This helps them define their work as importantly legitimate and based on special knowledge, they can see themselves as acquiring or having expertise and, further, it helps associate them with the heroic project of the saving of life.

In Melia's [1981] study, from the student nurses' accounts, it appeared that as they went up the hierarchy, they took on more medico-technical work. While they expressed contentment at the prospect of enhancing their status and of doing less mundane and dirty work, they claimed regret at the prospect of losing, what they perceived to be, closer relationships with patients. Doing nursing work in support of the medical is easily visible and easily convinces: it is acceptable as work. But how does it leave nurses' status, and how does it affect their identity and their relationships with patients? This is now discussed.

There is irony in how nurses' prioritise medico-technical work. In making medico-technical work central to their identities and to revealing the legitimacy of their expertise,

nurses would be reproducing the ethos of the setting, and recursively maintaining what has accountability in the setting. As many have suggested, they are reproducing, rather than resisting, the medical ethos and the domination of medicine.

Further, the very work of nurses which helps display their expertise (observation work and drug work) has been shown in the study to constitute a form of distanciation: there is in the day to day running of the ward, (as opposed to in critical situations or 'emergencies'), separation between the activity of observing, the interpretation of observations, and the actions instituted as a consequence of the observation work. Bauman [1991] claims that one of the ways in which control in organizations is maintained is through this separation of actions from their consequences as a form of distanciation: what he calls keeping "moral responsibility afloat" [p145]. Where there is a "hierarchy of command and execution", the "effects of action are removed beyond the reach of moral limits" [p145]. Once people are placed in what he calls an "agentic state" they:

> ...are separated from both the intention-conscious sources and the ultimate effects of action by a chain of mediators, the actors seldom face the moment of choice and gaze at the consequences of their deeds; more importantly, they hardly ever apprehend what they gaze at as the consequences of their deeds. [p145]

Nurses watch patients, collect specimens, take and record vital signs. This creates a space in which the medical gaze can access the patient but it also creates a distance between nurses and the consequences of their work (the decisions about treatment etc). As has been seen in Chapter Seven, nurses do not really participate in these decisions. Nurses are acting as the agents of the medical staff, albeit through their own self-discipline, which is different from on their own authority. However, this disciplined medico-technical work entails few direct instructions from doctors to nurses and is different from the old image of nurses acting as the handmaidens of medical staff [see also Dingwall *et al*, 1988]. Nurses have the appearance of being more autonomous: there is great reliance on their self-discipline to know what to do for patients in relation to the medico-technical work, which, in the present study, mainly constituted observation work (there was very little 'high-tech' medicine actually going on in the ward), and the administration of drugs.

In contrast, I would like to suggest that what has emerged in the study, is that while nurses are doing some of their observation work on behalf of others, which constitutes an agentic state, they are doing this in conjunction with other surveillance work, which is not constituted as an extension of the medical gaze, as it is usually understood. They are developing discourses and practices which constitute different forms of expertise from those

traditionally associated with so-called medical nursing expertise. They are developing a gaze which is centred on 'rehabilitating' patients and maintaining the flow. This work does not constitute the heroic work done in support of the saving of life (although these aspects may be implicit), but is emerging as importantly legitimate work, and helps constitute a different sort of narrative with which nurses can maintain their work as a project and which disciplines their gaze to locate it in the future.

The Nurses' Gaze

What has emerged in the study is that nurses have instituted practices and have developed discourses with which they reveal forms of expertise which are different from their association with the medical discussed above, although this association may help legitimate these new practices and discourses.

It would appear from the nurses talk in Chapter Eight, that while the nurses relied on their interpretations of the medical criteria about patients to indicate particular methods and strategies for nursing patients, there were other aspects to their assessment of patients. They spoke of a way of seeing which indicates that they can see things which others cannot see, that they know how to look in a special way.

This supports the methods for discussing and reporting upon patients described in Chapter Eleven: it is not simply that non-nurses and junior student nurses do not know how to translate what they see, they do not yet know how (not) to see, they have not yet got special sight, a disciplined gaze, they are in process of learning and being disciplined to see in particular ways rather than others. One of the differences between the wards was that informal talk between the qualified and unqualified staff in the second ward was about making special sight more explicit.

That nurses' interpretations of the medical issues directs nursing care, was confirmed by the qualified nurses in their interviews. However, the construction of patient diagnoses, observation and treatment issues, involves identifications which are not strictly medical. The research material concerned with the qualified nurses' accounts of their work in conjunction with analysis of observational material, reveals that the typifications inherent in the setting are neither neutral nor purely medical, but involve an *evaluation* of patients against other than so-called medical criteria. This resonates with Engestrom's [1987, 1989] work, discussed in Chapter Eight.

From the observation material and from the nurses' talk, it would appear that practices have been developed by nurses which involve a form of examining [Hoskin,

forthcoming] patients in relation to potential impediments to recovery and discharge. This form of examination has been, according to the nurses, particularly instituted for older patients. This is to be understood as contrasting with the notion of nurses having 'attitudes' to particular patients [see for example, Armstrong-Esther *et al*, 1989; Fielding, 1979; Fielding, 1982; Ingham and Fielding, 1985; Snape, 1986].

The nurses have developed ways of talking about how they examine older patients. This examination according to their accounts involves surveillance of patients in relation to their so-called 'social situation' or 'history', and to their capability and mental criteria. Like the health visitors in Bloor and McIntosh's [1990] study, the nurses are developing a gaze, a set of criteria against which patients' behaviour can be measured, and against which they can be evaluated.

In the current study this surveillance works to help the nurses identify the patients' future potential, as well as their present status, as medical, rather than as 'other than' medical (e.g. social or geriatric). They do this through a combination of effects. Critical to these effects is how the nurses construct patients' identities in relation to time: 'are these problems chronic or acute, are they medical or due to old age?' They enrol [Callon and Law, 1982] aspects of time to make their case.

The nurses also look at patients and work with patients to know their capability (their functional state). This, in conjunction with their perceived mental state, is measured against a patient's past history of the extent of support and usual capability prior to admission. These aspects are taken by the qualified nurses to help them construct the patient's identity: as someone who is medical or other (social or geriatric). Someone who is medical needs to be rested and watched, whereas someone who is other may need to be got moving.

What emerges through the analysis of the nurses' talk and their practices is that they enrol the medical activity around (the active treatment of patients), and the doctors' expressed views of patients, to legitimate a patient's presence in the ward. However, the nurses have constructed their own gaze to calculate the patient's care in relation to their passage through the ward. In this sense, they establish a place for the patient in the ward (with the associated care which patients in that position usually receive). While they enrol the medical fictions to legitimate these categories of patient, their typological spacing and placing of patients goes beyond the medical.

Nurses are sensitive to potential impediments to a patient's passage and look out for the presence of such impediments. Sister in ward One was particularly acute in this way:

she also had her eye on the possibility for getting older patients moving.

The nurses' gaze extends to include such things as anxiety and worry or a combination of effects, such as old age taken in conjunction with perceived functional state. Time is essential to how these aspects of patients are perceived. The research material indicates that nurses construct patient's needs in relation to their past and their future. For example, a chronically dependent patient may be seen differently from someone who has only recently been rendered incapable: although both patients may have had a heart attack they may be seen differently according to how they are written by the medical staff, their past and the possibilities for their future. Their normal or usual capability constitutes their 'best'. The nurses read this, their usual or normal capability, to affect their care in the present, *because* the future may be implicated.

As already discussed above, this way of assessing older patients, can be explained by recourse to the nursing literature and to a notion of proactive rehabilitative care: there is a risk in immobilising an old or a chronically disabled patient, which nurses may weigh up as counteracting the risk of mobilising a heart patient earlier than is usual. The critical issue is that the patient is taken first as disabled and second as a heart patient, and may be mobilised earlier than they usually would be. What was seen in practice, particularly in Ward One, was that elderly patients were mobilised early because they constitute a potential risk ("Yes, get her going, she is 88").

However, the risk, I would like to suggest, is not just to the patient but also to the nurses' identities. Nurses are concerned with the project of the heroic saving of life, which can be witnessed by getting people better, and home; their performance is also to some extent assessed by their ability to make beds available. Patients who do not get going are visibly impeding these as goals for nursing. Old people may constitute a risk to both these goals.

In Chapter Seven it was shown how the doctors have developed their own examination of patients in relation to these other non-medical criteria. At ward rounds the medical examination of patients is reviewed and the status of the patient is affirmed: the patient has got medical problems or is ready for discharge. However, the patient is also reviewed in relation to a broader examination for identification of "problems" and for early identification of impediments to discharge. This identification is constituted in the light of criteria other than medical criteria. That is, in order to transform the patient's "problem" into a "solvable problem" [Berg, 1992, p168], it is the identification of the patient's problem which can be seen to be moved around. I would like to suggest that the issue of disposal is

driving forms of care.

This underlying movement was overtly and explicitly revealed in the nurses' accounts of how quality of life affects decisions about care. For example, in their talk about Mona, a patient whom two of the nurses claimed was seen by the medical staff as 'blocking a bed', because she had no where to go, was not 'treated' with antibiotics as a result of this. However, the research material suggests that both nurses and doctors act to constitute patients in terms of classes in very many discreet ways, and this affects the ways in which they 'see' patients.

In the ward rounds, including the social round, there is a shifting around of information about patients, and a communication about patients in relation to something other than either a purely medical gaze, or a person-centred caring ethos. This can be seen particularly in relation to the ward round concerning Mrs Marsh, and in the social rounds, discussed in Chapter Seven. It would appear that medical disposal is not constituted through a 'purely' medical examination nor through a person-centred assessment. Practices have developed to involve other criteria which inform and which can transform, not just interpretation of medical criteria, but the medical criteria themselves.

These other criteria involve configurations of the future possibility for the patient in relation to their mental state, their physical function and their support in the so-called community. Any or all of these can, in certain circumstances, create blockages to the flow of patients through the beds.

My interpretation is in keeping with the findings suggested by Berg's [1992] ethnographic study of medical diagnosis and treatment decision-making, which he terms "medical disposals". Berg, himself a practising doctor, drawing on the work of Latour [1987], examines ward rounds, not simply in relation to the social conduct of doctors, but in relation to their conduct as supposedly *scientific practices*. He reveals how:

> Historical and examination data as well as medical criteria and disposal options are not 'givens' which undirectionally lead the physician towards a disposal. [p167-168]

There are an "array of heterogenous elements which constitute her [the physician's] micro-environment" [p168], and which effect the medical disposal. According to Berg these elements include the following: "the patient", "finances", "medical criteria", "historical information", "organization", "disposal options", "time", and "examination results" [p168].

While Berg reveals how a routine for examination and assessment of patients is central to medical disposal, this acts only as a point of reference. He demonstrates how

there "are not sources of data which the physician only needs to reveal" [p162] through examination and historical information. He demonstrates the relationship between the possibilities for the transformation of the patient's problem into a solvable problem and the data: data are not simply revealed, but are "(re)constructed to fit a certain transformation" [p162]. What Berg is suggesting is that so-called scientific practice is thoroughly interpenetrated with the social: medical diagnosis and treatment decisions are wrapped up in, and are constituted by other phenomena. Berg's findings parallel the findings in the present study about how nurses assess elderly patients: there are heterogenous elements related to the nurses' environment and which they draw on to construct their assessment of patients and subsequent delivery of care. In the context of the present study, Berg's findings can be restated as underlining the impossibility of detaching scientific and technological practice from the social.

What Berg does not draw out is how this relates with the impact of managerialism in the health services (his study was conducted in Holland), nor to the affects of the methods in relation to the patient. Apart from the myth that medicine is conducted as a science, Berg gives no reading of how the practices and discourses, in Foucault's terms, and as discussed in Chapter Two, displace, exclude or silence. What Berg's study suggests, and what the present study also suggests, is that the "good" of the patient can no longer be taken as the bottom line for understanding the practices of nurses and doctors and their 'decisions' about patients. There is a new pragmatism which does not accord with either the self-projected image of medicine as scientific, nor with the rhetoric of nursing discourse which promotes a patient-centred, caring heart to nursing. Nurses are doing more than nursing in a "hostile environment" [Pyne, 1993], they are at work constituting aspects of hospital care that can be seen as hostile to the person who cannot do patient and be patient.

The new pragmatism to be found in the present study reveals how there is not simply a domination of nurses by the medical, nor how nurses work is constituted by the medical. The critical finding in the study is a demonstration of how nurses have constructed a gaze which surveys patients to (re)construct their so-called medical condition in relation to the possibilities for their exit *from* the hospital. In the setting studied, there are particular sets of conditions now taken into consideration by nurses in their assessment of patients which allow them to reconstruct someone as "not medical" but as "social" or "geriatric". That is, that nurses constitute patients in relation to classes of persons.

The opportunity for misrepresentation of a patient comes where patients are excluded from sign production: how they are seen and read is partly constituted through the nurses'

and doctors' gaze. Patients are seen and read in relation to particular grids of perception. This has been discussed in detail in previous chapters in relation to the constituting of classes. The logical difficulty is, therefore, that where there is misrepresentation there may be mistreatment: a patient who is constituted as having 'no prospects' is not necessarily *actively* treated, but how this coordinates with the patient's view remains hidden, through staff's systematic exclusion of them from participation in the accounts about them.

What compels the nurses to construct such a gaze is not a holistic or humanistic discourse on the so-called proper focus of nursing, but economically-based criteria made to count in the setting through very many complex, socially organized and organizing features. These economically-based criteria are present in the nursing process itself, and were instrumental to its initial *American* conception, and to its introduction into British nursing.

The nursing process was introduced into American nursing practice at a time when the Diagnostic Related Group Payment System [DRG's] was being introduced. And further, it is used in American nursing to audit nurses work. I would like to suggest that the nursing process was introduced into British Hospitals at the same time as measures to increase throughput. The emphasis on increasing throughput can be constituted as a 'strategic value' [Munro, 1991]: a management strategy to help institute particular practices by refocussing staff. It helps effect a managerialist ethos in health care which is driven by cost reduction, and value for money [Broadbent *et al*, 1991; Read, 1989].

The nursing process was introduced at the time when explicit accountability was being demanded through examination of the health services, and the handing over of power within the health services to managers and accountants. The nursing process, and in particular nursing assessment, helps focus nurses' attention to the future, (the outcomes of care) and on the patient's past, their social situation is read for the possibilities of support for the future. It also appears to push accountability out into the open as a matter of the individual and for the individual. As a record it adds weight: as a legalisation of the relationship between patients and nurses, it constitutes a form of contract which can be used as evidence (these things were identified and this was the plan, these were the actions taken to fulfil that projected/desired outcome). This helps to keep nurses to their promise, to only write down a plan which they can deliver.

The nursing process and the forms in which it is written (problem, objective, action, progress, outcome) helps nurses maintain, and make visible, a sense of narrative, of their instigation of, and contribution to, the project of cure and care, which has a beginning, a middle and an end, and which they have collectively helped to engineer. The process of

writing nursing in these ways, I would like to suggest, helps enhance the indulgency pattern suggested above: by increasing a sense of satisfaction through engagement in a project, a narrative, which has outcomes.

I would also like to propose how, in the presence of other social features, the nursing process as a form of representation - a way of *writing patients, writing nursing* - may help discipline nurses to see/think patients in relation to economically based criteria. The nursing process has "put into play a way of paying attention to the 'out there'" [Deetz, 1992, p29]. Patients are no longer viewed simply in relation to the 'medical', or the impact of the illness upon them (their so-called response), but in relation to other criteria: their home life and the way they live are reviewed in terms of how they cope, and enables assessment of how they will cope in the future. "Social situation" and "functional state" have come to matter, are legitimate objects, in terms of how they may represent possible impediments to the delivery of, and efficiency of treatment, and to discharge: of disposal.

Although emotional state did not particularly come up in the nurses' talk with regard to older patients specifically, in relation to patients generally, emotional state mattered to nurses when it was seen as potentially getting in the way of a patient's recovery (the nurses' project). This is to say, the examination by nurses of patients' so-called psycho-social traits and parts, have not been taken up in practice in the current setting for nurses to know their patients better, to see them holistically, to enable better individual care. All aspects of the rhetoric of nursing [see for example, Couchman, 1987; Wilson-Barnett, 1988]. The current study reveals how the nurses construct patients' identities through their surveillance of these so-called psycho-social aspects of patients to reveal possible breaks in on the flow through the beds (she's not a medical problem, she's a social problem, her problems are psychosomatic).

In Chapter Eight, through the qualified nurses' accounts of how they work, it would appear, that as well as extending the medical gaze, their work is concerned to assess not patients, but patients' features and parts in relation to the maintenance of mobility and movement through the hospital. They think in terms of the nursing process, in that they break the patient down into particular features: medical situation, emotional traits, social situation, capability, age, the past and the future. Like the nursing process, the nurses in the present study maintain a detachment of the social and emotional from the functional and the medical.

As discussed in Chapter Ten in relation to May's [1991,1992] study of nurses interpersonal relationships with dying patients, I have suggested how this detachment

constitutes an *epistemologically* problematic area in relation to the constitution of meanings. The nursing process effects and helps maintain a particular gaze when constructed in the presence of other social features, those conditions of possibility described in Chapter One. Emotional status, social situation and mental state are all features of the patient which can be surveyed for potential or actual impediments to, or breaks in on, the smooth transformation of an admission to a discharge. In this way, the nurses have transformed the nursing process to construct a gaze which focuses on the individual patient, not to enable 'care', but to enable effective treatment and throughput; disposal.

The new pragmatism which helps constitute, and which is constituted by nurses conduct, has several difficulties. The first concerns what gets displaced, excluded and silenced, the second concerns the disciplining of patients, and the third concerns both the above: that the basis, the criteria upon which nurses are founding their understandings of patients implicates a particular discursive space.

This thesis is suggesting that the nurses are operating in, and on, a discursive space which detaches patients from their life-world. This is contrary to much of the rhetoric of care. Further, the nurses' discursive practices, while helping to reconstitute the social so that more is taken into account in the review of patients for treatment (disposal), also helps produce and reproduce a particular order of things. Care, then is to have a place in the order of things; but it is a care that is to be prespecified in terms of its application. It is a care that moves hand-in-hand with a minimalistic curiosity.

The Limits of the Study

The study took place across two wards, a so-called single unit, in one 'acute' hospital. Delimiting the research in this way raises questions as to the generalizability of the findings.

At its limit, the study claims only to show the specificity of practice as nurses practice with others within this location. In commenting here on the generalizability of findings, it is important to stress that the methodology prohibits universalizing claims, as it sets aside any imputations of causality. In particular, the study avoids (and indeed disputes) assumptions of a hegemonic order. Therefore, the research findings cannot be used to claim either that such a hegemonic order exists, or is desirable, or that nurses conduct as described in the present study instantiates such an order, or deviations from such an order. As Law [1993] explicates the matter:

Sociology tells stories about the social world. Some of these, perhaps most,

> are stories of order. They claim to tell what 'the social order' or some close analogue thereof really is. And they explain away their limits by telling of deviance, or inadequate socialisation, or false consciousness. This is the sociological equivalent of the hideous purity of Year Zero: a hegemonic order, and distractions from that order. It is a sociological form of classical modernity.[p9]

The study cannot be used to tell about how nurses should behave, but don't. However, I want to discuss some ways in which the findings over nurses' conduct can suggest wider issues.

Viewed as a 'qualitative' study from another particular epistemology/ontology, the study has some obvious limitations. The position in the study, that the site of practice is always *specific*, precludes any reader from extrapolating the findings to define universal rules or laws about how nurses do (or should) conduct themselves or 'know' (or should know) their patients. It is in this respect that I would like to caution any reader in their interpretations of the study, as taking the study to constitute 'a (small) sample' contradicts the methodological approach.

Rather, the study can be read as limited to a kind of "modest sociology" [Law, 1993]. As Law [1993] goes on to say after the passage cited above:

> ...sociology has sometimes managed to do better. And when it has done better, this has often been because it has concerned itself with the description of social processes. Such descriptions simplify, for to tell a story about anything is already to simplify it. But they are less prone to heroic reductionisms than some, for they also tell, or at any rate they assume, that they are incomplete. And they tell that they are incomplete not because they haven't quite finished the business of sorting out the order of things, but rather because they know that it is **necessarily** that way: they will **always** be incomplete. Such sociologies are relatively modest...[p9]

From a particular point of view it might be argued that any findings could only be 'generalizable', and therefore of more use, if the study had extended across several different locations: different wards in the same hospital, different hospitals, different regions. However, to accomplish a detail of research material comparable to that collected in the present study, these studies would either have to be undertaken by several researchers, or be conducted by one participant observer over a very long time. Such extensions would clearly require resources which stretch well beyond those available to a graduate student. There are, however, other more serious problems.

Using several different researchers across different locations immediately undercuts any claim to have conducted an ethnographic approach. As Van Maanen [1988] argues, there may be alternative fieldwork methods but these are not necessarily done in the spirit of ethnography:

> ..fieldwork is not of an ethnographic sort when it is pursued by a team of

> social researchers as a sort of expedition or Foucault-like panoptican observation-and-interview project. Fieldwork of an ethnographic kind is authentic to the degree it approximates the stranger stepping into a culturally alien community to become, for a time and in an unpredictable way, an active part of the face-to-face relationships in that community.[footnote, p9]

The alternative, extending one participant observer across many locations at the level of detail attended to in the present study, would entail a saturation of material and experiences which would be impossible to cope with without recourse to a level of abstraction which might obviate detailed description. This is important, as it is exactly this care for detail which Latour [1991] argues helps the ethnographer transform description into explanation.

For more quantitively oriented readers further difficulties might arise from viewing the research in terms of the size and type of sample. Is the 'sample', for example, to be considered, the nurses across two wards (n=24 + 4 auxiliaries), or the doctors [n=?15], or the patients around whose inpatient career the study focused (n=20 persons aged 75 and over admitted as emergencies)? Or do the wards (n=2, acute medical wards) stand as the sample, or perhaps the hospital (n=1, a regional teaching hospital)?

Considered this way, the study certainly appears to have grave limitations and this raises difficult questions as to how the study can be read. Were the practices described specific only to these wards, to these old people, to this hospital or this/these group(s) of nurses and doctors? In this respect some readers might feel happier if I suggest that the study be replicated, but with different and bigger samples, and/or with more or different locations: with, for example, fifty old people and perhaps fifty children to provide a 'comparative' study. Of course the arguments here quickly reduce to absurdity. Why not use a hundred booked or planned admissions, in seventy-five different wards scattered across the British Isles (or why not extend further and take in the USA, France, Japan)? But would not these numbers be preferable, more sure, give more certainty that what I have spoken of are general truths about how nurses with others act?

As possible, and indeed desirable, approaches for specific circumstances, or areas, it is important to clarify they would be more than extensions. Changing the scale of the study would give different studies. But would the findings be more generalizable? This is a difficult point. From a particular view discussed above, the answer would be 'yes: if different people could be shown to be doing the same sorts of things in many different places then, both the researcher and the reader, accustomed to a diffusion model, can feel more comfortable when saying that the findings represent 'universal' social processes. Further, any setting which does not 'fit' the pattern can be depicted as 'deviant'. Rather

than question the universality of the initial findings, further research can be called for to study the causes of such deviations.

It is critical to understanding the present study that any attempts which I have made to generalize are not conflated with attempts to abstract a universalistic model. The present study cannot be used to make universalistic claims, and is therefore limited in what it can say, how it should be read and what arguments it is used to support.

Ethnography is accomplished through the ethnographer entering into particular social relations. Such relations include meeting with the subjects of study within their own everyday settings, and include the ethnographer writing a text constructing her interpretations of how actors within the setting accomplish culture and social organisation. To take in more than one site may mean gaining research material about different locations and could of course be of great interest, especially where the locations dramatise difference, as in the case of Sudnow's [1967] ethnography of death within a county hospital and a private hospital. Again, however, the care for detail would be different from my own study. To achieve the care for detail the ways in which I replicate myself would have to be variant to each specific site. This of course would defeat the ethnographer's purpose. It is precisely germane to ethnography that the researcher is sensitive to a site in ways that permit one to understand (as a native) what 'the devil they're up to'.

Comparative ethnography is the subject of Strathern's book [1991]. Strathern clarifies how changing the scale has effects but goes on to debate whether these are preferable or not: more information may mean different results but not necessarily better results. Within the terms of comparing different locations, what are the variables and how can you possibly 'control' for them? Which do you include and which do you exclude? In line with Strathern's reasoning, the present study took for granted the possibility that the sites for practice are so specific that to find two locations which one could name 'comparable' may very well be impossible: where human activity and creativity are concerned the variables are surely infinite! As Strathern [1991] emphasises, in changing the scale we move from complexity and heterogeneity to complexity and heterogeneity.

The attraction of an ethnographic approach is that you do not lose care for detail through too many exclusions, from making too many categorisations before the case, from 'prefiguring the space' [Strathern, 1992a]. Or at least it is possible (reflexively) to use any categorisations as devices, as in my case: I drew an initial boundary to define a setting (an acute medical ward) and a group of actors (doctors and nurses assessing old people), not just to help define a physical space but to help raise a site (or sites).

I avoided prior theorising in favour of noticing the iteration of social actors' moves.

It is only through the ethnographer's presence in the setting that such research material can be gained. In order to both see and experience how social actors move each other about in a setting, the researcher has to 'be there'. And the study approach is limited to this. The study cannot be used to imply that there is anything *determined* about each move (repeated or not), and equally cannot be used to indicate that an absence of similar moves in other settings or locations can be considered as deviations from 'the norm'. In this sense, the findings in the present study cannot be used to generalize about the conduct of nurses as they interact and do their ordering work.

Within the present methodology, the site of *practice* then is always by necessity specific. But this emphasis is not to suggest that the site is to be understood as an isolated whole. Each setting is also plural, indeed, each social actor can be considered as several different sites. Any notional location or the setting also consists of many different sites [John Law, personal communication and 1993], a never-ending and unquantifiable number of sites, in fact, of which any study will only uncover a few. Such an approach stands therefore against a universalizing sociology. This does not entail, however, adopting a position of solipsism. While features of sites are expected to vary, other features will remain prominent, and those social actors involved in other locations (either as patients, nurses, doctors, researchers or managers) can be expected to recognize in my ethnography some features. In particular, I would expect from the material discussed that certain effects from increasing throughput will be easily recognized. Further, some of the effects on work practices of increasing throughput can be expected to be recognized not just by people within the health services, but by lawyers, teachers, academics, civil servants and business people alike.

As I have discussed in Chapter One, I chose to focus the study around the care of old people as I believed that the care of old people within the so-called "acute sector" of the health services to have been made problematic in ways which would help throw light upon very specific issues about how nurses with others 'assess' patients. These issues are connected to how matters of interest and identity are managed through the deployment of systems of distinction. In particular, the health and welfare of elderly people brings into play in the discourses of managers, civil servants, doctors, nurses and other allied groups distinctions between the medical, the technical and the social. The present study has been concerned with exploring not just what effects get constituted as medical or social, but how social actors accomplish and deploy these distinctions, and what are the products and effects of these accomplishments and deployments.

I have recently returned to the setting for the study and met with a number of

doctors and nurses working there. A senior nurse manager said she does not know what care goes on at the bedside, that she's 'lost touch'; a clinical nurse manager said that there is no time to care any more, 'it's all about throughput'; a Professor, now a medical director, said 'It's all disintegrating, falling apart, I don't know who anybody is'; a Sister said 'It's all changed, there's been a reorganization of the hospital, but do you know, nothing's changed, it's just as difficult to nurse, that's all'.

With hindsight, more recent agendas for managing the health and welfare services have made some of the issues raised in the present study more explicit. Indeed, some of the issues seem now to relate not just to the elderly but to other 'groups' of patients. Dare I suggest that no group of patients has 'sanctity': people within the health and welfare 'market' are working for outcomes that suggest their effectiveness, they are cost conscious, looking to move patients along. In the national press there are reports to this effect, such as the patient with leukaemia who was turned away from a trust hospital: there was no curative prospect ahead of them. Here indeed is a constituting of classes, although it is perhaps one more associated with 'bureaucracy' than with clinical judgement. Presumably there is no 'cost benefit' to be had from caring for the patient, so the patient was designated 'palliative' or 'social', with support supposedly coming from within the 'community'.

In contrast to this example, I have also heard of a hospital, a real-life 'St Elsewhere', in which the doctors and nurses work to keep people 'in' while simultaneously keeping the 'records straight' and the accountants happy: they 'beat' the diagnostic related group system, by discharging and then readmitting any patient who they feel needs more care, but who has gone over the prescribed length of stay for the diagnosis they have [Ronnie Frankenberg, personal communication].

None of these effects requires a 'conspiracy theory', blaming the government or, indeed, other institutional agencies. This is the importance of my study: by looking at how people working within the health and welfare services accomplish systems of distinctions, I have shown how they help produce such effects. In this way, the current study helps throw some light upon critical issues for nurses and anyone else concerned with health and welfare. And there are, I am certain, many different tales still to be told.

APPENDIX ONE

Problematising Context: an extended example

Advocates of the so-called interpretive or narrative approach [Benner, 1984; Benner and Wrubel, 1989; Benner, 1991; Benner *et al*, 1992] claim to reveal how nurses *in practice* make 'clinical decisions'. Their methods involve incurrence and examination of the narrative accounts of practising nurses.

Underpinning this approach is the concept of clinical decision-making which involves diagnostic reasoning [Tanner *et al*, 1987] but which takes account of a 'context' of practice and a trajectory of experience [Benner, 1984; Benner *et al*, 1991]. This interpretive approach to clinical decision-making claims to be phenomenological, that is taking practice as the lived experience of nurses, and inductive, a bottom up approach, taking nurses' accounts and nursing practice as the ground from which nursing knowledge and nursing practice can be understood and theories refined or constructed.

Underpinning Benner's [1984] methodology is a radical shift from the normative, top down approach to reforming clinical practice represented by models for nursing. In Benner's approach the assertion is, that by listening to nurses talk about their work in their 'own' language, the embedded nature of nursing knowledge and clinical decision-making can be accessed. Benner [1984], while allowing nursing process and, in particular, assessment models their place as tools for learning in the first instance, critiques models for nursing assessment as adequate representation of practice:

> It is possible to describe expert practice [Kuhn, 1979, p192], but it is not possible to recapture from the experts in explicit formal steps, the mental processes or all the elements that go into their expert recognitional capacity to make rapid patient assessments...Attempts may be made to model or make explicit all the elements that go into a nursing decision, but experts do not actually make decisions in this elemental, procedural way [p43].

Benner is pointing to what she describes as the complex, holistic and context-specific nature of expert clinical decision-making as undetachable from their assessment of patients. However, she does allow a problem-solving, information processing type function to practical nursing decision-making but that it can only be understood in relation to "content, context and function" [p42]. She disposes of notions of formalised, programmatic approaches to planned nursing care as not adequately representing *expert* practice.

Benner [1984] draws a distinction between practical, everyday knowledge and formal theories, between "know-how" and "knowing that". Her aim is to demonstrate the complexity and multi-dimensionality of knowledge embedded in clinical practice and it s relationship with theory or more formal knowledge. She suggests how for expert nurses clinical decision-making is not normative, "rule governed", systematic and processual but involves discretionary judgement and experience, mobilising conceptions of "saliency" and "contingency". Her agenda is to show how "risky, situation-specific decisions" taken daily by nurses can be "understood as orderly, reasonable behaviour that responds to the demands of a given situation rather than rigid principles and rules" [pxx].

Benner does not discount theory. While she describes the relationship between theory and practitioners as a "dialogue" [p36], whereby theory has its place in informing practice by guiding practitioners "to ask the right questions", "making explicit and formalised" what can be made explicit and formalised [p36]. But theory cannot represent practice:

> clinical practice is always more complex and presents many more realities than can be captured by theory alone [p36].

Underpinning Benner's position is a notion that nurses' theoretical knowledge is enriched, enhanced and sometimes transformed through experience, through practising nursing. Benner [1984] maintains that her theoretical position is concerned with issues of the self and the notion of experience, so that her concern appears to be to recenter the experiencing, knowing nurse-subject as opposed to a subject who simply internalizes rules and norms.

Experience is defined by Benner as

> the refinement of pre-conceived notions and theory through encounters with many actual practical situations that add nuance or shades of difference to theory [p36].

In Benner's exposition, then, theory still 'comes first', is prior to experience. This movement:

theory -> experience - > expert know-how and knowledge

underpins the structural approach that Benner takes to clinical excellence in nursing practice. It underpins her graduated model of nursing excellence, based on Dreyfus and Dreyfus's [1985] skills acquisition model. She asserts that, and claims to demonstrate in her 'exemplars' that nurses learn theories of nursing ("rules" and "systems") and then proceed to practice and to getting or going through experience:

novice -> advanced beginner -> competent -> proficient -> expert

This parallels the track of and transformation of knowledge through experience from "knowing just 'that'" to "know-how" and expertise. Benner claims that "know-how" (for example, the qualitative difference in pulse or the meaning of numbers) gained through experience and acting in the world, transforms "knowing that". The difficulty here is that Benner's claims to draw on Heiddeger [1962] and Gadamer [1976] are questionable since not only is 'sequence' problematised by them but the very division between theory/knowledge and experience is abandoned by them.

In later work [Benner and Tanner, 1987; ; Benner and Wrubel, 1989; Benner, 1991; Benner *et al* 1992; Magnan and Benner, 1989] notions of intuition, caring, ethical comportment, agency, community and emotion are introduced as also informing and interpenetrating with how nurses go on to do work with patients: they are integrated with nurses' clinical decisions about patients. The nurses' narrative accounts which are used to provide the researchers with their material for their formulations, illustrate how these notions inform and interpenetrate with how nurses assess patients and help form the basis upon which nurses intervene (or not).

There are methodological difficulties with Benner's (and her co-researchers') approach as forms of *representing* nurses' practices. These difficulties concern how the methods are used to make claims about the bases upon which nurses give patients nursing care (their so called clinical decisions). Benner states that the narrative accounts are able to show the context-specific nature of nurses' clinical decisions and how nurses mobilise notions of "contingency" and "saliency" in their clinical decision-making and patient assessment. These aspects of clinical decision-making are conceptualised as "situated judgement".

Benner's method [1984] entails eliciting narrative accounts from nurses of differing levels of experience (length of practice). These narrative accounts are elicited through asking the nurses in individual interviews or in groups to tell stories about something which was really important to them or something which changed their practice. An aspect of the analysis appears to be to compare the content of the narratives to reveal differences between the different levels of nurse (experts, advanced beginners etc). The researcher makes claims about how experts practice, and how this differs from other levels of nurse.

The narrative method as used by Benner and others takes nurses' accounts as 'true' representations of reality, not as discursive accounts. The narratives are retrospective and are taken out of their social and organizational context: there is no fieldwork to cross check the accounts against other representations of events (e.g. records, a researcher's record of events, other participants views of events). They cannot be checked against what usually and systematically occurs. This constitutes the first way in which Benner constructs nurses' practices as separate from their social and cultural context.

The nurses' accounts are interpretations of events which are already interpreted (preinterpreted) by them. They are stories which as they are told help make sense of events, give them a narrative line, and may present the nurse in a particular way, but which may falsify how the events occurred at the time. As stated above the patient's views of events were not included nor are there any records of the interactions as they occurred. Where this approach is taken to represent not just nurses' practice, but excellence and expert practice it constitutes a "methodological romanticism" [Silverman, 1989a, 1989b]. It is underpinned by a notion that the narratives are true representations of reality and more importantly that narratives articulate experience as it occurred at the time. It is suggested that this confuses how there is a difference between doing and saying. As Giddens [1984] notes, there is a difference between what is "characteristically simply done" (practical consciousness) and what can be said (discursive consciousness) [p7].

The nurses' accounts cannot be taken to represent how best practice is practised. Benner [1984] states the criteria for selection of 'experts' is their recognition as such by their peers and superiors and a recognizable mastery of language. Benner asserts that these "recognised experts" have a fluency of language to their accounts. She takes the fluency of their accounts as a hallmark of their expertise [p19], their stories are "accomplished" and there is a genuine narrative flow to them which places the "listener deep into the situation ... The expert is at home with the language" [p19]. This constitutes a circular logic.

Referring back to the work of Foucault discussed in Chapter Two 'experts' may be expert at presenting themselves in particular ways: they constitute themselves through language. It is those who can say that they see what others do not see who are revered as having expertise. Experts constitute their expertise through their mastery of language. The

narratives are accounts.

The nurse's accounts are reflexive forms which can be taken as deeply involved in "the recursive ordering of human practices" [Giddens, 1984, p3]. Giddens states that

> To be a human being is to be a purposive agent, who both has reasons for his or her activities and is able, if asked, to elaborate discursively upon those reasons (including lying about them). [p3]

Giddens here is stating that to be an agent is to have purpose, and to be able to tell at a *discursive level* his reasons for his actions, including *lie about them.* Eco [1976] also asserts that a sign is any entity which can be used to tell a lie. Accounts may not be true representations of acts but help present how what was done was purposive, and in doing this they help define what has accountability and present the self to impress in a particular way [Goffman, 1958].

Because they are accounts (stories, tells, discourse) the nurses' accounts in Benner's study are interpenetrated by organizational ethos and sedimentations of discourse. But Benner does not use them in this way, but uses them to show the excellence and power of practising nurses'. They are used to re-present nursing, to make it visible as expert practice. Mastery of language may reveal the nurses' socialisation into and their successful membership of settings and institutions ('Nursing' and 'the medical world') where membership is constituted through a "mastery of natural language" [Garfinkel and Sacks, 1969].

Following Garfinkel [1967] accounts can be taken to tell the researcher about ethos, rules, beliefs, values, nursing discourse and the construction of reality, but may not be taken to tell very much about how best practice is practised, because frequently what we do, and the reflexive recall of what we did are different. The accounts are mediations [Wegar, 1992]. It is how they work as mediations which is of interest. Lived experience is mediated though accountability, through language and discursive formations: in this way the narrative form, which suggests an autonomous subject who acted to change, as one who knew how to act in the world, loses the sense of how meaning is socially constructed.

Who knows when or how we first noticed something; or how and when we first intended to do something; or why we intended to do it; what readings we were actually making at the time, in the setting, for all practical purposes; what knowledge we drew upon, and how we came by that knowledge? The nurses can tell about their experience, and give their view on events, but extrapolating claims from these accounts about best practice is problematic. It has been suggested that narrative accounts constituted through the research interview cannot be taken to represent reality [Wegar, 1992]. The narratives are "discourses about meanings" [Wuthnow, in Wegar, 1992, p91]. They can be taken "to reflect and express broader cultural frameworks of meaning" [Mishler, in Wegar, 1992] because

> Rather than being expressions of pure experience, the articulation and communication of experiences is always socially motivated [Wegar 1992, p90].

In her analysis of the narratives, Benner does not, as the researcher, take the accounts as mediated forms, to expose how they are socially constructed. This constitutes

the second way in which Benner constructs the accounts in a context which is separated from other culture and organizational issues.

This leads to further methodological problems with Benner's [1984] work: the problem of context in relation to the constitution of meaning. Benner argues that meanings, in this case of the nurses' accounts, have to be understood as "dependent upon a shared world of meaning" [p40]. She asserts that this is achieved in an interpretive approach because "the intentions and understandings of the participants are taken into consideration" [p40] and the context of action is considered "holistically".

Benner [1984] asserts that knowing the specific context of the situation "inherently limits the possible meanings of behaviour into manageable and relevant wholes" [p40]. She gives as an example how knowing the context (a patient's health status) can change the meaning of a (nursing) behaviour: giving a bed bath (a nursing behaviour) early on in a patient's illness (the 'context') may be "an essential comfort measure" (first meaning) while with increasing recovery (the changing context) "this same bed bath may mean the excessive fostering of dependence" (second meaning) [p39-40]. These notions of the meaning of a bed bath as an activity are prescribed by nursing discourse: it is very difficult to see either where holistic settings, that is entailing patients or others as participant in the production of meanings or in what ways the goals and objectives of the organization come in to the picture and how they impact meaning.

While there is emphasis on the interpretive method which takes into account a so-called context [Benner, 1984], the context referred to is an individualistic one:

> ..the interpretative approach always relies on the particular context of the situation - that is, the timing, meanings, intentions of the particular situation. [p40]

As already stated there is no possibility of crosschecking the "timings, meanings, and intentions of the situation" with the patients involved (or other nurses, doctors, researchers observations, managers, etc). In being given accounts of practice, the reader only has the nurse's word that the events had the same meanings for the patients as the nurses claim they did, or that they did what they say they did as far as everyone else in the situation is concerned. Further, the researcher does not analyze the narratives in relation to social and organizational issues.

The justification for this methodological difficulty is to be found in a later work [Benner and Wrubel, 1989]:

> Because personal concerns determine what is at stake for the person in any situation, the challenge for the health care provider is to interpret those concerns that influence the person's understanding of his or her own illness. Just as with background meaning, because we share a culture, we have shared meanings. Even when those meanings are not personally held by the interpreter, they are understandable as possible ways of being in the world because of shared culture. Caring for a patient enables the expert nurse to be a participant in the sub-culture of being a patient. In this way, the expert nurse can have access to a patient's meanings and concerns without directly having the illness experience. [p88]

This interpretation of a phenomenological approach involves the notion that "the individual is the author of his own life-world, definer of his own reality." [Oiler, 1982, p178]. As discussed in the Introduction and in Chapter Four, the unproblematic contextuality of meaning has now been questioned by a critical approach to language [Deetz, 1992]. The argument advanced in the current thesis is that shared meanings are problematic: through becoming a nurse one takes on and bears a subculture which is very different from that of patients and that to move into patients' sub-culture is problematic, because of the purposive nature of human action. Further, discourse involves translation, in which something is always lost and something is always gained. It is difficult to claim that the nurses' accounts are accounts of the ways in which they made decisions in practice if the reader is relying on the notion that they, by definition of their expertise, can share patients' meanings. A critical approach, as explicated in the introduction to the study, questions whether meanings are negotiated and shared.

In a later work [Benner *et al*, 1992] there is an assertion that novice nurses and experienced nurses occupy different "lived realities". Referring back to Foucault's work, it is suggested here that what Benner *et al* do not draw out is, how the lived realities of these nurses are constituted through language, they only represent different discursive spaces. Benner *et al*, [1992] claim that nurses of differing levels of experience live in different semiotic worlds from each other, they both notice and interpret things in the world differently. How much more true then of nurses and patients. Benner and her co-authors are unable to demonstrate that in relation to the patients' lived experience of events or their accounts of events, the nurses were able to access patients meanings. This approach is sociologically naive which is exemplified by other nursing research which takes account of the patients' perspective, for example that of Bloor and McIntosh's [1990] study (discussed in Chapter Two), or the words of Ward [1988], Price [1987] and Tilley [1990]. The work of Ward [1988] and of Tilley [1990] is now used to exemplify the problem of accessing patients' meanings.

Ward [1988] is setting out his position between two research projects. The first project evaluated implementation of the nursing process in a psychiatric unit for elderly patients. This revealed that there were, unexpectedly for the researcher, deficits in nurse-patient communication which prevented client participation in clinical decisions. The second project was an interview-based research project aimed at revealing that nurses and their clients are "talking differently to each other without realising it" [p23].

Ward [1988] asserts:

> ..language cannot be separated from the social context in which people find themselves. [p21]

Ward is setting out to examine how language affects clinical relationships, particularly those between nurses and their clients, so that clients are not involved in the "clinical decisions" about them, despite the introduction of the nursing process. Ward states that there is a sociological sequence:

> ..which depends upon nurses maintaining their power base through unconscious use of an inappropriate linguistic code. The exclusion of the patient is not a conscious act, but the simple maintenance of power differentials. [p22]

Ward argues that there are linguistic codes present which interfere with nurse-patient communication and make it problematic and that these codes are somehow embedded in the context of practice. His work suggests that these codes help constitute power relations: patients as 'lower class' because they do not 'know', and nurses as 'middle class' because they are 'experts'.

Ward's position is in complete contrast to that taken by Benner and Wrubel [1989], cited above. Benner and Wrubel were claiming to demonstrate that expert nurses can share unproblematically not only background meanings but also patients' meanings because "caring" facilitates entry into patients' sub-culture. Both Ward's and Benner and Wrubel's positions raise issues about the possibility for shared meanings and what constitutes the 'context' of nurses' practices. This is further suggested by Benner *et al* (1992) as they indicate there are different "lived realities" of nurses with different experiences.

The two issues being raised in this discussion and which are central to the difficulties of researching nurses' practices (communication practices or otherwise) are, therefore, first, what constitutes '*context*'? And second, what is the relationship between context and how nurses conduct themselves in their relations with patients to constitute meanings (and can this be 'unconscious')?

Tilley [1990], whose field study took place in two psychiatric units, has shown how there is a particular relationship between knowledge and power in nurses' conduct in relation to patients. He shows that nurses move patients meanings around through their enrolment of particular discourses. His argument is based not on direct observation of interactions between patients and nurses, but on accounts of interactions given to the researcher by nurses and patients about "conversations" they have had together. Tilley suggests how the discourses which nurses employ are developed in the settings in which the nurses work and are interpenetrated with particular discourses which they 'carry' with them (derived from, for example, psychiatry and psychology).

Tilley develops a thesis to suggest how nurses act on patients, through surveillance and conversation, to rework and sometimes simply exclude patients' meanings: how nurses develop meanings about patients which are commensurate with the discourses of the setting. These in turn relate to the perceived purposes of the setting. Nurses act on patients to accomplish a particular order.

It is through their interpretations as expressions of knowledge that nurses effect power and maintain a moral order. Tilley claims that what counted as 'illness' may constitute a negotiated or disputed order in nurse-patient talk. Through face-to-face interactions

> the objectivity of patients' subjective reality had to be negotiated [p165]

So for example, a patient might complain "its the pills" while the nurse would state "no its you". Tilley's study illustrates how patients' experiences of their illness and their knowledge of their illness is taken into account by nurses only when it can be interpreted through the nurses' frames of meanings.

However, Tilley's thesis does not give a view of how nurses and patients act together or with others to make this possible. In omitting this aspect of the field of study he

does not give a view of the wider social context of nurses' conduct: how their conduct is constituted by and how their conduct helps constitute particular forms of social organization.

This relationship is suggested, but not pursued by Benner and Wrubel [1989] through their presentation of a story a nurse told about her experience of a patient:

> ...I felt that I was teaching him a lot, but actually he taught me. One day he said to me (probably after I had 'delivered' some well-meaning technical information about his leukopenia), "You are doing an OK job Mary, but I can tell that every time you walk in that door you are walking out".
>
> He was right. He had developed so much meaning in his illness and life that I was not relating to. This man had really expanded the context of his life into areas where I could have been effective, had I had some understanding. He gave me that understanding. [Benner and Wrubel, 1989, p14]

Benner and Wrubel use this example to illustrate how *'being present'* with patients is an aspect of the expert nurses way of understanding. But what they do not explore is how being there with patients is so problematic in the settings in which nurses work: their agendas and understandings of what it is to be a nurse in any given situation are so complex, how there are so many contingent claims. The implication in the extract above is that these claims cannot only prevent nurses from attending to patients but actually can be used by nurses to "walk out", to create distance. The authors do not comment on how it is only the work of the patient which gets him noticed. Benner and Wrubel's research method does not enable the researchers to access how nurses manage themselves to order the contingent claims upon them, how they give some priority rather than others, and in what ways this relates to the organization in which they work and to wider cultural issues.

In Benner's [1984, 1991] narrative method the researcher rarely analyses the accounts in relation to wider organizational issues: for example how nurses' decisions about patients may be contingent upon the type of hospital or economic status of the patients. It is suggested by Strathern [1991] that employing a wider analytic frame allows for the meaning of what is said and of action to be crosschecked against other issues which may be 'contingent' upon how social actors conduct themselves. This is exemplified in Sudnow's [1967] ethnography of death in two different types of hospital (a county hospital and a private hospital): the study suggested how staff's decisions about care could be wrapped up in how staff perceived the moral status of the patient which in turn was interpenetrated with the economic status of the patient.

In Benner's work the nurses' narratives are used to construct a particular discourse which constitutes economic, cultural and political context purified in some way. Through in attendance to the possible wider significance of nurses' accounts the author constructs her interpretations in not a value free, neutral world but in a world disconnected from issues of social organization: a world constructed by the nurses and the researcher as unproblematically *there* for the *good* of the patient. As Schrock [1990] has argued that 'knowing how', 'knowing that' and 'knowing what ought' are inseparable for nursing practice, but that knowing what ought can never be only a matter of *individual* conscience. I would like to assert it is Benner's method which constitutes nursing expertise and nurses as experts.

It is suggested in the present study that the ordering of conduct is an ongoing affair recursively constituted by actors in their day-to-day dealings. In organizations such as the health service, a hierarchical organization, there are "structural asymetries of domination" "expressed by the existence of normative sanctions" [p30]. However, as Giddens [1984] states, these normative elements can only enter relations because of complex arrangements of social interactions, the productions of social actors:

> the normative elements of social systems are contingent claims which have to be 'made to count' through the effective mobilisation of sanctions in the context of actual encounters. [p30]

There are many different claims on nurses, many different pressures, those which are more legitimate or more important, are made to be so by the mobilisations of sanctions and meanings in the context of actual interactions.

Benner does not ignore the complex question of how legitimation and signification are constructed in social settings [Giddens, 1984] but sets out to construct nurses' practices in particular ways which exclude the possibility of *crosschecking* on the nurses accounts. Her work implies that the autonomous subject knows what is right, albeit through gaining practical experience and know-how, there is no critical sense of the organizational/cultural backdrop against which the subject understands and lives in the present and whose conduct helps constitute that present. The expert nurses' accounts suggest that objects or situations "saliency" are self-evident [Benner, 1984, p42; Benner *et al*, 1992], but Benner does not suggest how what has saliency, how when something appears to be self-evident, is in fact a complex, socially constructed phenomenon [Douglas, 1975].

The methods chosen by Benner and her followers to analyze nurses' narratives do not take critical account of the social or organizational context to inform interpretation (what gets routinised and prioritised and made to count). This creates an absence: an implicit displacement of the social and frequently unreflective nature of experience [Heidegger, 1962] and understanding. The nurses' accounts reveal a discursive competence but through the absence of crosschecks, the reader has no way of knowing how these competencies relate to action and the reproduction of everyday life. The patient is not centred to inform relevancy, only the nurses' view is given: she, not the patient, becomes the centred subject.

Benner's work while advertising itself as concerned with representing the complexity of nurses' decision-making as a practical activity, denigrates the everyday and how we know how to go on in the everyday. While she justifies her method:

> The goal was not to describe the typical day or hour but rather the highlights, the growing edges of clinical knowledge [p.xxi].

She makes the assertion that

> the nurse-patient relationship is not a uniform professionalised blue-print but rather a kaleidoscope of intimacy and distance in some of the most dramatic, poignant, and mundane moments of life [p.xxii].

If the purpose is to "uncover the knowledge embedded in clinical practice" [p1] a displacement of the everyday to focus on what is special seems contrary to current notions

of how we know how to go on in the everyday [see Berger and Luckmann, 1967; Garfinkel, 1967; Giddens, 1976 and 1984]. Benner represents an idealised notion of nursing practice. For example, it is not clear how she substantiates the notion that the "highlights" of practice incorporate the "growing edges of clinical knowledge". And further, for whom were the events described, dramatic, poignant or mundane? The hypothesis here is that what Benner describes reflects cultural preoccupations with individualisation. Her agenda clearly stated [1984] is to reveal the power and excellence effected through expert nursing practice: she is making through a constituting language, nursing visible as expertise. But patients do not authorise her text: their voices remain silent.

APPENDIX TWO

The Structure and Conduct of the Study

There were *three* parts to methods for the collection of research material and a variety of tools and methods were used, to enable crosschecks and a broad base for analysis. The three parts of the study ran concurrently, first on Ward One, then on Ward Two. The first part, involved observation and patient interviews.

This part of the study was designed to give focus to the central issue of nursing assessment. I selected twenty patients (ten in each ward) aged 75 and over around whose stay in hospital I focused my attention. The aim was to develop a rich base in order to identify and describe the dimensions of nursing assessment and to explore the relationship between assessment and other organizational features.

I included patients over the age of 75 admitted to the wards to this part of the study, subject to the following *exclusions*. Specifically, the patient was:

not completely unconscious on admission
not suffering from moderate to severe senile dementia
not completely deaf or unable to speak

These exclusions were instituted because a critical aspect of the study was to include the feelings and perspectives and understandings of patients to enable comparison with how they were not only viewed by nurses and doctors, but how they interacted with nurses and doctors: a severe degree of communicative impairment would impede this aspect of the study. In addition, I had to be present at the patient's admission.

The last two criteria were initially assessed by me as an experienced medical nurse and ward sister, through reading the patient's history and listening to staff talk about them, through observing the patients and talking with them or their family directly myself. Later crosschecks were made on my own assessment through obtaining the Geriatricians', nurses' and paramedical staffs' impressions of the patient's so-called mental state and ability to communicate, and later still 'measuring' this using the Clifton Assessment Procedure for the Elderly [Pattie and Gilleard, 1979]. If it turned out that the patient did not fulfil these criteria they were dropped out of the study. This happened in the case of a very severely 'disturbed' woman who, once admitted to the hospital, no longer spoke in English but had reverted to speaking entirely in Hungarian, this made it impossible for me to assess her although we did communicate. She seemed to me to be beside herself with grief and unable or unwilling to conform to being in hospital.

Usually I 'followed' one patient closely for the first week of their stay and then reduced the amount of formal observation. At this point I would take the next person over seventy-five admitted to the ward who fitted the criteria for inclusion into the study. However, I continued to 'follow up' each of the twenty patients until their discharge or death, or for a period of 31 days.

I employed four strategies to collect research material in Part 1 of the study. These

were as follows:

1. **Observation**

Observation was structured in two ways:

(a) I observed the twenty patients for two hour periods at their admission and at selected times during their hospital stay. Average formal observation time for each patient was 10 hours. During these observation periods I wrote down in a note book, using a form of shorthand which I had developed for myself, the nature, content and timing of all patient interaction and patient activity. This included writing down word for word all verbal interaction and notes of non-verbal communications.

(b) I observed specific formal *events* relating to the 20 patients. This included doctors' ward rounds, nurses' handovers, social rounds. I wrote down all verbal interaction relating to the patient and timed it.

2. **Talk with staff and patients**

I gathered supplementary material to the observational material in discussion with patients and staff on a daily, ad hoc basis. I made notes of these conversations immediately after their occurrence. For example, after a ward round, I might ask the patient what the patient felt about the ward round or what they had been told. I might then ask the nurse what had been said on the ward round. I could then compare these with notes I had made during the ward round and subsequently with what was written in the nursing records and what was said at the nursing handover (or what was not written or said). Subsequently I could extend the view I was getting, of social relations and the concerns of the nurses in relation to the patients, to what was done or not done in terms of 'nursing' the patient.

I would visit patients in the study every morning or when I came into the unit. I would frequently sit and talk with them about how they were feeling and what had been happening to them. I would make notes afterwards as to this talk and as to how I saw them, how the patient felt to me. Through these conversations I became involved and close to some patients: they told me many intimate things about themselves and their feelings.

3. **Tape Recorded Interviews with Patients**

Toward the end of their hospital stay (or 31 days) I invited each of the twenty patients (where possible) to participate in a semi-structured, tape-recorded interview in which their feelings about and their perceptions of their health, their daily lives, their hospital stay and their future were explored. The interview was exploratory and did not always take the same form. The interviews lasted about an hour. There was a basic schedule which is included in Appendix Three. One patient died before an interview was possible, one patient declined the interview altogether, one patient declined to have the interview taped but agreed to my taking notes by hand, during the interview with another patient notes were taken by hand as the tape recorder 'broke down'.

These interviews took place after I had spent a lot of time listening and being with these patients. Typically patients were very ready to tell me about how they felt and about their lives. As one fellow researcher put it, I was as interested in and as involved with the patients as I was with the nurses. I treated the interviews as

informal occasions. My object was to get an overview of their life and their concerns and interests. Through the interview I could get on tape the language they used and how they presented themselves and what had happened to them, before coming into hospital and since their arrival.

The interview took place once the patient's discharge had been settled, usually in a little room off the main ward. In the case of two patients, their stay on the ward was prolonged because alternative arrangements were being made to discharge them to long-term care, so their interviews with me took place after they had been in hospital for four weeks. Their interviews were very disjointed and fragmented: I took this to be significant, not of my interview technique, but of their ontology, by this time they had withdrawn into themselves and their pasts.

4. **Transcription of all nursing and medical records**
I transcribed all nursing and medical documentation relating to these 20 patients (for the current admission). Sources included G.P.s' letters of referral, accident and emergency patient summaries, in-patient clinical notes, nursing notes, any discharge summaries/letters, observation and medication charts.

The second part of the study involved more general fieldwork and was directed at uncovering the ways in which administrative and other organisational features impacted nurses' views of patients. These methods included the following:

1. **Talk with and observation of staff**
The strategies and methods used by staff to organize ward life were identified (e.g. specific admission procedures, liaison with para-medical staff, staffing levels, nurse allocation, etc). This included the ways in which space and time were organized. The physical environment and the arrangements of space were taken as organizational forms, representing allocation and use of resources, and as such noted as important aspects of the site. Procedures, lists, written forms, equipment were all taken as artefacts and technologies present in the setting. I discussed these aspects with ward staff as seemed appropriate and made notes.

3. **Interviews with nursing staff**
Toward the end of field work I invited all qualified nursing staff [**n = 12**] to participate in a tape-recorded interview where their perceptions of their work, their approaches to the management of patient care, and of the care of the elderly in particular, were explored. The interview was loosely structured, and a copy of the schedule can be found in Appendix Three. As with the patients, by the time I interviewed staff, I was well known to them in an everyday sense. However, I arranged to spend the shift prior to the interview with them as their shadow, so that they could use examples of their work to illustrate their talk. It was during the interviews that I questioned them about how they thought they knew what nursing patients needed and what they felt about nursing elderly people in the ward. I have used all the interviews, both the patients and the nurses as first person accounts [Blauner, 1987]. That is not to claim them as truer versions of reality than observations of action, but as a dimension of accountability.

An original aim of the study was to identify and describe any health-related problems specific to patients aged 75 and over admitted to acute medical wards. I developed and employed two instruments for this part of the study, to enable comparison of elderly people with other people admitted to the wards, and to give detailed so-called objective assessment of the physical and mental function of elderly people admitted during the research period. These instruments included a questionnaire designed by me [the "dossier" - see Appendix Four] and "The Clifton Assessment Procedure for the Elderly" [CAPE] developed by Pattie and Gilleard [1979].

The questionnaire was concerned with information about possible health-related needs, social situation, nursing and medical care given, as well as biographic material. The dossier was compiled for all patients aged 75 and over [**n = 67**] and every other patient aged 74 and under [**n = 124**] admitted during the study period. Each dossier was completed by me using patient documentation and in informal interviews with nursing and medical staff.

The CAPE was employed to crosscheck my assessment and staff's assessment of the physical and mental function of elderly people aged 75 and over admitted to the unit during fieldwork [n=44]. Only those patients who were able and willing to participate were entered into this part of the study.

In conducting the study I became increasingly aware of the constructed and interpretive status of so-called 'information'. This led to realisation of the limited ability of either of these instruments to reflect or represent patients and their requirements. But the use of these instruments helped my understanding of the setting in far more general ways.

In doing the Capes I came into contact with a wide range of patients. They almost invariably told me how they were feeling and what they thought about the setting in general and how they had come to be in the hospital. Further, the collection of information around the dossiers allowed me an in-depth view of what had significance for staff and how staff ascertained things about patients, and what they recorded and what they did not record.

For example, after completing about twenty dossiers on Ward Two for patients of all ages I checked with Sister 2 about how she knew who did the housework and the shopping at home. She said that she could tell by looking at the wife and the husband what sort of arrangements they had at home, what sort of people they were, and whether or not the husband would help in the home. On another occasion, in Ward One, I undertook to assess one patient using the CAPE. From my speaking with her and from her result it became clear that she was unable to remember anything of what had recently transpired. She did not really know who she was or where she was. She was very affable and easy to talk to but was, according to the CAPE, severely demented. I had been following her progress through the ward handovers and in the nursing records: there was no mention of her 'mental state'. When I asked Sister about her she told me that "Oh yes, she's away with the fairies". The nurses had never recorded this information nor did it come up in the handovers about this patient. Much knowledge about patients is implicit and tacit for nurses, it comes up in discreet ways, not necessarily in their records and reports, it does not get officially accounted for. Records and reports as Raffel [1979] has debated cannot be taken as records of the events they refer to nor representations of facts which have been observed or amassed, but constitute activities in themselves.

These are just a few of the examples that led me to discount the notion that any one

source of information is reliably representing the facts: it did in fact help me to abandon the whole issue of expecting to get facts, to develop an interpretive perspective on the socially constructed nature of information! I therefore abandoned analysis of this material as "hard data" although both the experience of collecting the information and the nature of the information collected have informed and constituted crosschecks on my readings of the setting.

Access to the setting is a complicated matter. A protocol outlining the objectives of the study and the study design was submitted to the Ethics of Medical Research Sub-Committee for Medicine and Clinical Oncology, and ethical consent obtained. This was a condition of my entry into the setting according to the traditions of doing research in the particular place I was at the time. However, I constitute 'access' not simply as a means by which the research proposed could be vetted for its relevance and the extent of its intrusive nature on the setting but as enlisting support and permission to be included in the setting.

I gained 'access' to the setting initially by approaching the heads of Nursing and Medicine of the unit concerned. I approached the nurses who were in administrative charge of the unit where I wanted to conduct field-work (the then Director and Assistant Director of Nursing Services). They read my research proposal and after talking with me, agreed for me to carry out the project, as long as I got ethical consent and consent from the Professor and Consultants involved in the unit. I had very little to do with the senior nurses after this apart from an informal interview with one of them subsequent to fieldwork. This interview was aimed at establishing how the nursing process had been developed and introduced in the hospital five years before the current study.

They handed me on to the senior nurse (who was acting senior nurse for the unit while the senior nurse for the unit was on a course). She took me to the unit and introduced me to the Sisters. She was not given the research proposal to read, as I decided, with both the Director of Nursing's and the Assistant Director of Nursing's agreement, to conceal the central object of the study - nursing assessment - from the nurses in the unit. This is discussed below.

I gave my research proposal to the Professor of Medicine, the Professor of Geriatric Medicine, and the Consultant Geriatrician attached to the medical unit concerned. I had several meetings with each of these doctors. They did not attempt in any way to change the proposed methods for conducting the research. Subsequently I wrote to and met with each of the other three consultants with beds in the unit, outlining the project as an interest in the nursing care of old people admitted to an acute medical unit and the needs of elderly people in this setting. All acknowledged that this constituted a problematic and significant area for them. Each consultant had a medical specialty.

I knew it was important to get the physicians involved, and get their permission in a real way, as I was going to be acting to 'survey' them and their juniors, attending their ward rounds, reading their notes, sitting in on their talk. I wanted them to feel that I was doing something they could relate to and felt was important. I think I was personally vetted *with suspicion* but that once vetted the physicians regarded me as someone who knew about their work, and who fitted in. I was acutely aware of needing to remain politically neutral and of how in a strange way I was 'claimed' by each set of physicians, the medical physicians on the one hand, and the geriatricians on the other. There was a sense of collusion, and ostensible equality. I am grateful for the respect they showed me. All were very supportive

and keen for this research to be done. Both the Professor of Medicine and the Geriatrician were concerned to make their unit efficient and effective in care of elderly patients, as well as increase throughput.

During field work, the consultants and Professors public acceptance and *inclusion* of me, just through gestures and casual talk, for example explaining some aspect of their work on a ward round, helped signify I was a part of the setting. As will be seen in later chapters, the senior doctors were used to being watched and observed, they were used to giving a performance. In this respect I did not trouble them too much by my presence. Their inclusion of me gave me access in a way which helped me become a part of the setting to all intents and purposes.

This was the same with the Sisters and the nurses on the wards. I was included in and therefore became a part of their everyday lives. Through chatting and being with them and listening to them I became accepted and included. This was what I take to constitute access - inclusion in commonplace, everyday ward life, despite being subject to everyday, commonplace suspicion and scrutiny. Sudnow [1967] describes an aspect of access as "getting to know" members of staff through chatting so that he managed to:

> gain access to some of that settings hidden features [p7]

Consent was obtained from doctors, patients and nurses invited to participate in all aspects of the study. Before approaching a patient I ensured that it was appropriate to do so and took steps to ensure that I did not detrimentally encroach upon the patients privacy, care regime, rest periods, meals or visiting time. Even after I had obtained consent from participants I might feel that I could not enter behind the screens, to watch what was taking place. (In the analysis I sometimes took these feelings as a gauge: how was I reading the patient to indicate that they may find my presence an intrusion at these times, and why did I feel that something was particularly private. What was I reading or how was I constituting the situation, what was my, or their embedded view of things at these times?).

In this situation I would record all talk and the action I could make sense of standing outside the screens: this is where my own experience as a nurse came in very useful. For example, if a patient was being washed and their bed changed behind screens, I might be able to add to my reading of the situation through signs like the colour of bag the nurses used to put the linen into: the colour of the bag might indicate that the linen was soiled, that the patient had been incontinent. However, I would not necessarily rely on this reading alone, I could then check this observation later with what had been written or said about the patient in the nurses' reports and records or with what the patient told me about what had been happening to them.

I sought permissions from both the nurse-in-charge and the available doctor responsible for the patient before approaching a patient for interview. All nurses and patients invited to participate in the study were told that they could withdraw at any time they wished to do so. Further, I explained to nurses and patients who participated in the research that any information given to me would not be passed on to anyone else or be used for any other purpose than the study in hand. Confidentiality was assured.

I practised some of the methods in a Geriatric Assessment Unit, within a larger Geriatric Unit, in another hospital. Subsequently, I spent a further two week period in the unit prior to

patients being entered into the study. This allowed me to practice and refine my observation and recording techniques, and to get impressions of how the wards and the work was organized. This initial period of fieldwork enabled me to get to know the context in a general way and also gave everyone on the wards a chance to meet me and get used to my presence. The impressions gained at this time are very vivid, later research material, collected systematically, was used to crosscheck on these impressions.

Ethnography and the Conduct of the Researcher

> the social scientist of necessity draws upon the same sorts of skills as those whose conduct he seeks to analyze in order to describe it; generating descriptions of social conduct depends upon the hermeneutic task of penetrating the frames of meaning which lay actors themselves draw upon in constituting and reconstituting the social world. [Giddens, 1976, p155]

The ethnographic approach entails placing oneself so that one can be in the same 'place' as those whose conduct one seeks to analyze. How this was achieved is partly accounted for in my discussion about my access to the setting, discussed above. But my conduct is now explicated further.

I introduced myself to all the staff as an experienced practising nurse, as an ex-ward sister, doing a study for myself about the needs of elderly people in acute medical wards. I tried to resist participation in ward work as such (although I made staff tea or coffee sometimes and on one occasion drew a Staff Nurses attention to an emergency situation). I have used the word resist because the nurses and patients alike tried to get me involved in the work of the ward. Further, I had until recently been a practising nurse: I found not helping, contributing *and* showing off my knowledge and skill almost irresistible at times! If I was called upon to help with some physical task or asked for my opinion I would tactfully refuse to get involved in what I saw as direct patient care. I did this because I wanted to minimise any change in peoples' responses to patients caused by my presence, and because I did not want to be constituted by patients as a nurse working in the ward.

There has been some debate as to participant/non-participant roles in social research [see for example, Hammersley and Atkinson, 1983; Pearsall, 1965]. One author has described it as a continuum [Connors, 1988]. I would accept the view that by one's presence the researcher is participating in the setting, but that one is controlling the form of that participation to a greater or lesser extent and in particular ways. Hammersley and Atkinson [1983], give an account of how these different ways can be constructed: from actually taking a job in the setting and going 'undercover', to structuring the collection of research material to exclude normal conversation in the setting. The possibility of normal conversation as a fieldworker is problematic: one is a consumer, always looking for notes to take home. The fieldworker, in this respect, has been likened to a tourist [Strathern, 1991].

I participated in the setting as already suggested in a controlled way. I communicated an interest in all aspects of ward life through talk and being present. Towards the end of the study in Ward Two, I became a party to general conversations about how the nurses felt about the doctors. The nurses voiced some criticism of the medical staff. I took this to be a sign in this ward of a different consciousness about who they as nurses were. I explored this as a possible lead in the analysis, and checked their talk and

dissatisfaction against how they worked with patients and how they constituted patients. This material has informed my interpretations.

As I have stated having been a practitioner proved very valuable to understanding many aspects of ward life. Some difficulties arose, of course, in that I already felt I was a native: I had to turn researcher by learning to willingly suspend disbelief or any value judgments and by ensuring that all aspects of observation could be crosschecked. I wanted to *not* be looking according to a grid or noting according to a code, but to be open to and be able to capture the codes in the setting. I developed a technique whereby when a nurse was telling me about something I pleaded ignorance and encouraged her to go on and explain what she meant, as if what she was telling me had either never occurred to me or that I had no knowledge or experience of it. I was surprised at how well this worked.

I was aware that everything I did and said, particularly the way that people responded to me, would be being read by and interpreted by on-lookers and other participants. Tilley [1990] describes how he was both subjecting others and being subjected to gaze. I would dispute this use of the term gaze - I was attempting to rid myself of a gaze, and I felt that I was being scrutinized and came under suspicion in a very commonplace, everyday sort of way, not examined according to a grid of perception. For example, a physiotherapist in the pilot study called me the spy sent from the Health Board. This tipped me off to work in the main study to ensure that the staff realised that I had not been *sent* by anybody. Despite my efforts I was aware that Sister 1 in her interview with me was giving nursing administration messages about how short staffed she was and how she lacked time to do her work properly.

I knew that it was important for patients to trust me, to want to tell me things, and for nurses to feel the same way, and for all concerned to go on as they would whether I was there or not. With some exceptions (some people are more suspicious than others and more private) I feel I achieved this acceptance and the confidence of most of the actors in the setting. Most people acted out in front of me regardless, and many wanted to tell me about what they were doing, including me in their world, explaining it to me, showing me who they were and what they were achieving or feeling. For example, I attended a discussion between two doctors and some nurses where the nurses agreed to order extra medical supplies for the doctors to take on a safari trip with them.

The intention was for me to have a dual identity: to patients I was seen as accepted by staff but not as a member of the ward staff but by staff I wanted to be seen as an unthreatening colleague, to have some membership.

Challenging staff may have destroyed this trust, in the manner described by Garfinkel [1967] in his experiments with trust and pointed out by Melia [1981]. It is for these reasons that I decided not to always ask directly what people were doing or why they were doing what they were doing, as I thought it could constitute a challenge, and upset the *duree* of activity and thought. I acted on the basis that the meaning of action, its significance would come out in talk between nurses and others or between themselves, in records or in subsequent action. Social actors are compelled to give accounts, I regarded this as a source for enabling interpretation of action. It was only toward the end of fieldwork on each ward that I felt accepted enough to be able to occasionally ask questions about what people were up to.

The way I conducted the research meant that I would literally sit around in amongst patients for hours on end. Feeling what it was like to be there as a patient and being amongst them. A few minutes later I might be up, integrated in a ward round, listening and writing down what people said, or sitting with the nurses, listening and being told about what worried them or hearing them tell each other about the patients. The objective was to be accepted by the people within the setting but to minimally influence the setting so as to maintain the integrity of its reality. Further, I wanted to be moved around by the presence and actions of others, I wanted to be acted on to know and understand their codes and meanings.

In this respect I concealed the main focus of my study - the nursing assessment of a target group of patients. The ethical status of such a decision is problematic. The account I give of my decision relates to my intention to keep the nurses and others as unself-conscious as possible about what they did. I did not want them to talk to me through their activity, to tell me through their performances what they thought I wanted to hear or know, any more than they would normally. I did not want them to attend to what they thought I represented, to me and my discourses but to their own. This is not an entirely achievable situation, but I believe that concealing the purpose of the research was one of the means by which I helped to maintain the integrity of the setting. Using multiple methods to collect research material enables aspects of the setting to be crosschecked from one sign system or medium from another: this also helped at the analytical stage to highlight the differences between nurses and others talking to me, presenting a self to me, incorporating what they thought I wanted to see, hear or know, and their construction of performances which were sited in the setting.

APPENDIX THREE

Interview Schedules

1 Interview Schedule - Nursing Staff

How often are you in charge of the ward?

What does being in charge mean to you?

Tell me about what you do when you are in charge of the ward - say on an early [night] shift on your own?

What sort of things do you worry about happening when you are in charge?

What do you find most rewarding about being in charge of the ward?

How do you find out what has been happening to patients during the shift?

What are your priorities when you are in charge of the ward?

Can you think of examples when it has been difficult to maintain these?

Do your priorities ever change?

Tell me about how you know how to nurse patients.

How does the age of a patient affect the ways in which you nurse them?

How do you feel about nursing elderly patients in this ward?

2 Interview Schedule - Patients

How are you feeling?

Tell me about what happened to bring you to hospital.

Tell me about what has been happening to you since you came into hospital.

Tell me about a typical day for you at home.

How do you feel about the future?

Patient No: | 0 | | |

APPENDIX 4

DOSSIER

Data collection schedule for research purposes

Joanna Latimer

SHHD Nursing Research Training Fellow

Nursing Research Unit

Department of Nursing Studies

University of Edinburgh

Source: mn=medical notes, nn=nursing notes, n=nurse, d=doctor

Source

DOSSIER

1. Patient number: 0

2. Age: 61 yrs

3. Sex: (a) male (b) female

4. Marital status: S W D M/cohab Sep

5. Date of admission: ________ ________

6. Date of discharge: ________ ________

7. Length of stay: (a) 7 days.

(b) no discharge at one month.

8. Admitted from: (a) home

(b) other ward

(c) other hospital

(d) longterm care

(e) other (specify)

(f) don't know

9. Was the patient admitted originally via:

NN (a) A&E (b) outpatient clinic

(c) waiting list (d) other

10. Who is/are the patients' next of kin: (relationship to patient)

Husband.

Medical/physical profile

NN 11. Medical diagnoses: (in order of significance)

(1) DVT Ⓡ leg.

(2) COAD

(3) ? Ca lung.

(4)

(5)

11b Past medical history:

NN Coad.
TB
Thyroidectomy

(discharged from Black hospital 4/7 ago)

Source

12. Reason for admission: For heparinization.

13. General condition on admission: Fresh, slightly cyanosed. pyrexial

14. During the patient's stay did their treatment involve any of the following?:

(a) Intra-venous infusion

(b) Central venous infusion

(c) Cardiac monitoring

(d) Urimeter

(e) Intra-venous medication

(f) Oxygen therapy

(g) Suction

(h) other (technical equipment)

15. Was the patient given any of the following nursing care?:

(a) Dressing

(b) 2-3 hourly pressure area care

(c) Catheter care

(d) 2-3 hourly mouth care

(e) 2-3 hourly walks

16. Was the patient monitored in any of the following ways?:

(a) qid TPR or more often (Crosby)

(b) qid B/P or more often

(c) Stools for occult blood

(d) Peak flows

(e) Blood sugars (BM stix)

(f) fluid balance record

(g) daily weight

(h) others

Source

Functional profile

17. Was the patient on bedrest at all during their stay?

(a) no

(b) yes

18. Did the patient require assistance with any of the following while in the ward?

(a) washing/bathing

(b) eating/drinking

(c) walking

(d) getting in/out of bed/chair

(e) getting to/from toilet/commode

(f) getting dressed (clothes/night clothes)

19. If the patient did require assistance with any of these activities, how often did they require it?

	always	most times	occasionally
(a) washing/bathing		✓	
(b) eating/drinking			
(c) walking			✓
(d) getting in/out bed/chair			✓
(e) getting to/from toilet/commode			
(f) dressing (clothes/ night clothes)			✓

20. Did the patient require assistance with any of these activities prior to the present illness?

(a) yes

(b) no

(c) do not know

If 'yes' please give details if known:

Source

21. If the patient required assistance with these activities who provided that assistance?
(relationship to patient)

22. When discharged did the patient still require assistance with any of these activities?

(a) yes

S/N - ✓(b) no

If the answer is 'yes' give details:

23. Bowel/Bladder control: was the patient continent while in hospital?

S/N ✓(a) yes

(b) no

If 'no' please give details of how often the patient was incontinent:

24. Do you know if the patient was continent prior to coming into hospital?

(a) yes

✓(b) no

M.N. (c) don't know Mild stress incontinence

25. Was the patient continent on discharge?

S/N ✓(a) yes

(b) no

26. Was the patient catheterised while in hospital?

(a) yes

S/N ✓(b) no

Source

27. Was the patient catheterised on discharge?

(a) yes

S/N (b) no

28. Is the patient's hearing adequate?

MN (a) yes

(b) no

(c) don't know

If 'no' please give details (e.g., they can hear if you speak loudly or they're completely deaf):

29. Is the patient's sight adequate (with/without glasses)?

(a) yes

S/N (b) no

(c) don't know

If 'no' please give details:

30. Does the patient give and receive information without difficulty?

(a) yes

- S/N (b) no

If 'no' give details:

Psychosocial profile

31. Is the patient?

(a) employed

(b) unemployed

MN (c) retired

(d) other

(e) not known

Source

32. What was or is the patient's pre-dominant occupation?

MW Shop assistant

33. Does the patient have any children?

MW (a) yes

(b) no

(c) not known

34. Prior to admission was the patient living:

(a) alone

MW (b) with others

(c) not known

35. If the patient was living with others, were they living with:

MW. (a) a spouse

(b) a child/children

(c) A close relative or friend

(d) other (give details)

(e) not known

36. If the patient was living with any of the above is this person or are these people in good health?

(a) yes

(b) no

S/N. (c) don't know

If 'no' please give details, if known:

37. Prior to admission did the patient require assistance with any of the following:

(a) cooking

(b) cleaning

(c) shopping

S/N (d) don't know

(e) none required

Source

38. If any, who provided the assistance required in question 37, if known?

(relationship to patient)

39. Do you know of any life events experienced by the patient in the last year (apart from illness)?

(a) bereavement

(b) change of house

(c) change of partner

(d) change of financial status

(e) other (give details)

S/N. ✓(f) not known

(g) none

40. What is the patient's mental state? Is the patient:

(a) often confused

(b) sometimes confused

S/N. ✓(c) never confused

(d) semi- or unconscious

(e) very withdrawn

41. Is this different from before admission?

(a) yes

S/N ✓(b) don't know

(c) no

If 'yes' please give details, if known:

42. What is the patient's present emotional state?

(a) good

(b) worried but seems to cope

(c) anxious

S/N · ✓(d) depressed

Source

43. Did the patient use any of the following community services prior to their admission to hospital?

(a) home help + how often

(b) community nursing service + how often

(c) health visitor

(d) day hospital

(e) social worker

(f) voluntary organisation

(g) community occupational therapist

MN (h) nil

(i) day centre

(j) meals on wheels

Discharge arrangements

44. Where was the patient discharged to?

Dany (a) their own home

(b) a friend/relative

(c) a convalescant hospital

(d) another ward/hospital for further treatment

(e) a rehabilitation unit

(f) a long-term care hospital/home

(g) a part-4 home

(h) other

(i) sheltered housing

(j) not discharged at one month

(k) died

Source

45. What support arrangements were made?

(a) none

(b) home help

(c) day hospital

S/N (d) family/friends

(e) meals on wheels

(f) community nurse

(g) other (give details)

(h) not applicable

46. If patient unable to be discharged at one month reason given by:

(a) charge nurse:

(i) still requires treatment

(ii) still requires nursing care

(iii) requires medical/nursing care but could be given at home if facilities available

(iv) waiting for alternative accommodation but no bed available

(v) other + details

(b) consultant or deputy:

(i) still requires treatment

(ii) still requires nursing care

(iii) requires medical/nursing care but could be given at home if facilities available

(iv) waiting for alternative accommodation but no bed available

(v) other + details

Source

Miscellaneous items of information

47. Was the patient boarded out to another ward during their stay?

NN.

(a) no

(b) yes + details of how long and how often

48. Was the patient referred to any of the following while in hospital?

Physio

(a) physiotherapist

(b) social worker

(c) occupational therapist

(d) geriatrician or psychogeriatrician

(e) none

(f) other + details

49. Was an o.t. home assessment done?

(a) yes

NN

(b) no

(C P ? (a) yes (b) no)

APPENDIX FIVE

Routines

Ward Life

Nurses organize the delivery of many of the wards' facilities to patients through ward routines.

The early nurses day begins at seven-thirty, "giving out" (they do not use the word 'serving') breakfasts, sitting some patients up, making beds, putting out the wash trollies and the linen trollies and "skips" for the dirty linen. The nurses divide themselves into pairs for these activities - two sitting patients up and two giving out breakfasts.

Patients are either sat up in bed and their bedtable moved into position or sat up in an armchair by their bed for meals, there is no 'dining area' on either ward. The nurses bring chairs and tables from the dayroom where they are stored at night. Nurses ask patients what they would like for breakfast as they go round or give them food provided by the diet kitchen.

In Ward One the nurse-in-charge takes the night report at seven-thirty. "Handovers" or reports usually take place at the nurses' station. If there is another qualified nurse on duty, she does the morning drug round. In Ward 2 they are experimenting with having all qualified nurses *and* senior student nurses attend the night report. The senior student nurses then either have no further handover or are given brief instructions as to their patients' care.

When a qualified nurse is on her own then she takes the night staffs' handover, the drug round and the handover to the early shift. Because of the way in which the off-duty devolves the qualified nurses most likely to be on their own in the morning are the most junior staff nurses. If the ward is 'short of staff' in the view of whoever is 'in-charge' for the shift, then the medication round is done by a qualified nurse on her own with no checker. On Ward 2, two of the staff nurses liked the nurse responsible for the patient whose drugs they are administering to be checker. They would use this time to handover the patient to the nurse as they went round their bay.

After breakfasts are "given out", some nurses help patients to eat while others start to make beds until the early shift nursing handover. In Ward 1 all the nurses sat down for this handover. In Ward 2 the qualified nurses handover patients specific to the nurses to whom they had been allocated. During the rest of the morning patients are washed and some dressed. There is another drug round before lunch, which takes place at midday. The nurses give out the lunches, the nurse-in-charge serves them from a dinner wagon standing at the head of or in the middle of the main ward.

The morning is spent mainly on washes, shaves, teeth cleaning, getting patients up and changed, toileting, bed-making, observations and tidying up. Observations of temperature, pulse and blood pressure are routinised for most patients. Observations are done at routines times : ten, two, six, ten, two etc.

Some patients also go for investigations during the morning. There may be special preparation for these investigations which the nurses would undertake before the investigation was due. There are also doctors' ward rounds in the morning. After lunches, there is a toileting time and then a rest time until visiting time at three o'clock. Then the early staff write up their nursing reports, going off duty at three forty-five.

The late staff come on at one o'clock. The early charge nurse hands over to them all at the nurses' station. After this report they take over from the early staff in toileting and getting patients back to bed while the early staff go to lunch. The nurses are not officially told to handover their patients at this point to the nurses taking over, although sometimes the student nurses were heard to have a quick word with each other to indicate where they were 'up' to (e.g. "I've just put her on the commode, she's been up all morning").

The nurses (both early and late) then do the two o'clock observations. Some dressings are scheduled for the afternoon. This might also be a time for teaching or for talking to the long-term patients. Teas are given out between two-thirty and three o'clock, the nurses sit patients up again for this, do pressure area care, ready for visiting time. The late nurses go for their break at three. On their return they might get more patients up, walk patients and do any special nursing procedures. There is another drug round at five o'clock, and the nurses sit patients up, do toileting and pressure areas, ready for supper and do the six o'clock observations at about this time. Once again they often split into pairs to do these things. Supper is at about five-thirty. Evening visiting is between six and seven-thirty. During this time the nurses take their own supper breaks and start to get some of the 'long term' patients, who have less frequent visitors, ready for bed. After visiting, the nurses get the rest of the patients ready for bed, and put them back to bed. The charge nurse writes up the nursing records, handing over to the night staff at eight forty-five when they come on duty. The late shift go off duty at nine o'clock.

The Division of Labour

The nurses day is divided into shifts - early, late and night shifts. There is some overlap between shifts to allow for nursing handovers and breaks. The nurses are divided into three groups - qualified nurses, student nurses and auxiliary nurses.

The work undertaken by each group varies considerably: what evolves is that there are in effect two types of nurse, the supervisors and the supervised. The supervisors talk about patients, 'make decisions' and give instructions. This group consists of the qualified nurses. The second group are the supervised. This group consists of the student nurses and the auxiliary nurses up to a certain point. The lines are not completely fixed: for example, a junior staff nurse might still require some supervision, while a nursing auxiliary or a senior student might be left to more or less 'get on with it'.

Supervisors also participate in the bedside care and the ward routines, such as washes, bed-making or meal-giving. This is an important part of the culture of the setting: qualified nurses are all involved in the delivery of care. They explained that when they are "in charge" this is a necessity - they stated that with the numbers allocated that they can not remain supernumary.

However, some of them also claimed how it is only through being with the patient themselves that they really got to know patients. Further, in doing the bedside nursing the qualified nurses, including the Sisters, are carrying on a tradition, acting out a discourse: that nursing is about doing practical jobs, nursing patients. This is egalitarian in a sense, that even the most senior ward based nurses get involved in the basic care and the "dirt", and it reinforces the conception that real work in nursing is still rooted in bedside care: they still legitimate themselves through being seen to do nursing practically.

However, in practice being in charge acts as a constraint on their relations with patients. The qualified nurses in charge are always very busy, when they care for patients it is in a rushed and hurried way, they are always being pulled back by matters of organization: the telephone, other nurses, doctors, continuously interrupt their work at the bedside.

The supervisors told the supervised what they should do in respect of individual patients at handovers and supervised them throughout the shift, sometimes letting them know about changes in care. The supervised contribute to the assessment of patients, and to the making and giving of instructions about care, in restricted ways. They carry out the work, and give informal verbal reports or formal written reports of aspects of what they did or what they believe is worth reporting. The supervised are, according to the qualified nurses, as part of their supervision, asked about specific aspects of the patients as they worked. They are, according to the qualified nurses, expected to report any problems or anything unusual to the supervisors.

APPENDIX SIX

Nursing Records

NURSING RECORD

WARD ADMITTING NURSE

Surname First Names	Next of Kin Relationship
Address	Address
	Tel No
Tel. No.	Immediate Contact
Date of Birth Age Sex	Address
Marital Status M. S. W. D. Sep. Rel.	Tel. No.
Date of Admission Time	Day/Night Call
Source W/L A/E OPD TR. GP REF.	G.P.
Reason for Admission	Address
Medical Diagnosis	

RELEVANT MEDICAL HISTORY	CURRENT MEDICATIONS	PERSONAL BELONGINGS
		Clothing
		Money
		Valuables

3/5

PHYSICAL ASSESSMENT		SOCIAL AND PSYCHOLOGICAL ASSESSMENT
Gen. Condition	Skin Condition	Occupation
		Social Activities
Ability to Communicate	Allergies	
		Emotional Status
Mobility	Cardio/Resp. Function	
HT. WT.		Family Support
Diet	B.P. T. P. R.	Health Services H.V. Dist. Nurse
Bladder	Sight/Hearing	Physio. O.T. Other
Bowel		Social & Vol. Services Home Help Soc. Worker
Hygiene	Sleep	Meals on Wheels Other

Discharge Date		Home	Convalescence	Transferred	Died
Arrangements.	Amb.	O.P. Appt.	Dist. Nurse	Soc. Worker	Other
Personal Belongings.	Clothing	Valuables	Money	Transfer Slip	Nurse Sig

INVESTIGATIONS, OPERATIONS, SPECIAL PROCEDURES

Date Ordered	Procedure	Date Completed	Nurse Signature	Date	Miscellaneous Information

M120

PROGRESS NOTES

Date	Prob. No.	Nursing Action Taken	Progress/Evaluation	Signature

SURNAME **FIRST NAMES** **CONSULTANT**

AME:
21

NURSING CARE PLAN

PAGE No.:

)ate		Existing/Potential Problems	Short/Long Term Aims	Planned Nursing Action	Evaluate Date/Time	Date Discontinued	Nurse Init.

APPENDIX SEVEN

The Admission Procedure

ADMISSION TO HOSPITAL

The patient and relatives are welcomed by Nursing Staff or Ward Clerkess. The patient may be seated or prepared for bed, depending on medical condition.

Relatives or friends are asked to wait until it is ascertained whether the nurse in charge or doctor wish to see them. Details about visiting are given to relatives and any information required is obtained from relatives depending on condition of patient.

DOCUMENTATION AND COMMUNICATION

1. Collect and document necessary information required, making sure that it is written legibly and accurately.

2. Make out charts eg. temperature charts.

3. Record temperature, pulse, respiration. Record weight and height if required. Specimen of urine is obtained and tested as soon as possible.

4. Identity band with patients particulars (name, d.o.b., Unit No., Ward No., Hospital) is placed on patients wrist.

5. Consent for operation is required if patient is for surgery or other therapeutic procedure. This is responsibility of doctor.

6. Patient is asked to undress, and outdoor clothes are given to relatives or stored in appropriate cupboard.

7. Clothes and valuables are documented in the appropriate way.

8. Relatives may see patient before leaving, also nurse in charge or doctor if requested or necessary.

9. Orientate patient to ward and introduce to fellow patients.

10. Care plan and patient profile are compiled.

11. Bath patient if required and if patient appears in a neglected condition hair must be inspected and brushed if necessary.

12. Any medication brought into hospital should be given to nurse in charge.

13. Reassurance for both patient and relatives is very important.

APPENDIX EIGHT

Nursing Records: examples

NAME: Mr DONALD

NURSING CARE PLAN

PAGE No.:

Date		Existing/Potential Problems	Short/Long Term Aims	Planned Nursing Action	Evaluate Date/Time	Date Discontinued	Nurse Init.
4/4/87	①	OBESITY i SKIN	To REDUCE TO MAINTAIN	i. Commence on reducing diet to be seen by dietician ii. Monitor for pressure sores iii. Clean bd - monitor existing abrasions			
	②	DIABETES	TO MAINTAIN BLOOD SUGAR LEVELS	Monitor blood levels BM stix bd			
	③	IMMOBILITY	TO PREVENT COMPLICATIONS OF	i. Mobilise as able ii. Use of all aids			
	④	CONSTIPATION	TO ALLEVIATE/PREVENT	i. Administer suppositories/enemas as prescribed ii. Monitor bowel movements			
	⑤	HYGIENE	TO MAINTAIN	i. Thorough bedbath ii. Basin at bedside as able iii. Big bath as able			
6/4/87	⑥	INFECTED (R) ARM	TO HEAL	Irrigate with hydrogen peroxide Clean with normal saline Apply Sherisorb and Lyofoam held on with hypafix.			

MR DONALD

PROGRESS NOTES

Page No.

Date	Prob. No.	Nursing Action Taken	Progress/Evaluation	Signature
4/4/87		Mr Donald was admitted at 14^{30} to ward 2 via A&E. He collapsed this am at his home and lay for 4 hours. His hygiene is poor and he has many abrasions and bruising on (R) side where he lay. He smokes 60/day, lives on his own, though has home help. Does not drink. He is a non-insulin dependent diabetic and takes metformin 1G tid.		
5/4/87	(night)	20 turns from back to (L) side Incontinent x1 of urine	Washed in bed, settled since admission (R) side painful from falls at home, unable to find bottle in time.	Staff Nurse Staff Nurse
	(3)	Up to sit for afternoon	required two nurses to transfer please encourage patient to help himself	
	(5)	Washed in bed BM stix at 6pm Oral hypoglycaemic given Lactulose prescribed 6pm observations	All care given 17 mmol Complaining of constipation P120 T 37^{7}	Staff Nurse
6/4/87	(night)	Turned regularly from back to (L) side	Incontinent x1 of urine, appears disoriented at times. T 37^{2} P120 BM 17 at 06^{00}	Staff Nurse
		Bedbathed fully	Not attempting to help much has limited use of (R) side but	
		Possibly for further investigations	when transferring with two nurses tends to lean to (L) side	Staff Nurse
		Slightly pyrexial	10am – 37^{3}, Temp 37^{4} @ 14^{00}	Sister

SURNAME DONALD FIRST NAMES CONSULTANT

M120

PROGRESS NOTES

Page No.

Date	Prob. No.	Nursing Action Taken	Progress/Evaluation	Signature

SURNAME **FIRST NAMES** **CONSULTANT**

APPENDIX NINE

Nursing Handover: example

Early to Late Shift Handover for Miss Hepburn - Day Five

Handover Staff Nurse - Then you have Lucy Hepburn an 87 [interrupted for a few moments]. Lucy Hepburn, an 87 year old who collapsed at home. She's doing great. She's had a basin to wash this morning with minimal assistance required. She wanted her feet washed - she has bunyons - so I gave them a good soak. She's mobilising very well under supervision this morning. But she can go on her own now. The angel was down this morning and took the pain out of the corns - the sun was high and shining and he took the pain away. He doesn't take the corns away, you understand, just the pain.
Late Shift Staff Nurse - Do you think she's demented?
Handover Staff Nurse - I don't know if she's eccentric or what but it obviously means alot to her. I can feel myself wanting to smile when she's talking like this and I have to stop myself [holds hand over her mouth as if she is trying to prevent a smile].
Nursing Auxiliary - Maybe she is a spiritualist.
Handover Staff Nurse - She's an "I am what I am" - it's American or something. So - she was seen by the physio and I've asked the OT's [occupational therapist] to assess her to see if we can get her home again. Having said that, I'm impressed - I thought she was borderline - well she is borderline.
Late Shift Staff Nurse - She's fine.
Handover Staff Nurse - If she could have meals on wheels when she's sent home, I don't think that would do any harm.
Late Shift Staff Nurse - Some visitors were in to see her last night and they were saying "how's she doing", and I said "fine". They said if only we could stop her climbing on chairs. [laughs].
Handover Staff Nurse - What is it when you look up and back and it effects your neck [she demonstarates and looks at me]? [No one replies - **Staff Nurse** looks at me again].
JL - Basilar artery insufficiency?
Handover Staff Nurse - That's what they think she has. So if she does go home can we arrange meals on wheels, considerng she's already had one admisssion for malnutrition - it won't do any harm.

2 mins 56 secs.

[NB The handover staff nurse had worked in continuing care of the elderly for a number of years].

APPENDIX TEN

Admission Interviews: supplementary examples

During the interviews patients sometimes persisted in telling the nurse what had happened. It was in these cases that the control exerted by the nurses over what was discussable can be seen. For example, in the following extract a student nurse is admitting Mrs Appleton:

> [patient 047, p2]
> **Student Nurse** - ... How are you normally?
> **Mrs Appleton** - Yes - I can do everything myself normally - until this week - my legs are just so weak. I just dropped..[inaudible].
> **Student Nurse** - Are you on a special diet?
> **Mrs Appleton** - No - I eat anything.
> **Student Nurse** - Not diabetic?
> **Mrs Appleton** - No.
> **Student Nurse** - Do you have any problems with your bladder?
> **Mrs Appleton** - Just this week - then I took this pain in the heart. And the doctor said I had to go to the hospital. [Sounding more anxious].
> **Mrs Appleton** - I think you're better off in here - where we can find out what's going on. [She leans over to the patient a bit to say this then leans back]. Are your bowels alright? Do you get constipated or anything?

Here the Student Nurse returns the patient to the agenda in hand by asking the next question when the patient tells her about how her "legs are just so weak" and that she just "dropped". The Student Nurse does not check if the patient is still feeling weak or probe the patient further as to her meaning about having "just dropped". In her profile of the patient the Student Nurse reports:

> physical assessment: blank
> general condition: good
> mobility: normal

There is no record of the patient having weak legs or having "dropped". Again when the patient digresses from saying that she has had problems with her bladder this week to taking a pain in her heart, the student pursues neither of these issues with the patient but tells her that finding out "what was going on" was something that would happen "in here", in some way divorced from the patient as an active participant. It is something "we do", presumably the nurses and the doctors, for or to you 'the patient'. In the profile of the patient the student nurse records:

> bladder: nocturia
> cardio-respiratory function: angina, breathless

The nurses' interest in the patient's urinary problems is divorced from the patient's claim that she had problems with her bladder: the nurses subsequently focus their attention on the collection of a urine specimen. Mrs Appleton's urinary problem had already been

established by the medical staff (they asked for an urgent urine specimen to be collected), the nurses make no further investigation of their own as to the meaning the problem has for the patient. For example, was she incontinent, did she need the toilet quickly and how often, was it painful when she passed water, was she able to drink plenty of extra fluids? Similarly, Appleton's claims that she had "dropped" and had "taken a pain in her heart" were also not investigated further by the nurses with the patient, as far as I know.

The morning after her admission the patient passed out in bed while eating her breakfast - she appeared to be on the verge of a cardiac arrest. This happened several times over the next few days. Eventually it comes to light that this had been happening at home - she had been dropping regularly for a couple of years. Despite thorough medical investigation no diagnosis was made apart from urinary tract infection, although the microbiological report on the urine specimen came back negative, and angina, the cause of her blackouts could not be found. The patient was discharged with no solutions to this problem or management plan as to how she and her daughter should deal with the blackouts at home.

In the following example, a 'relative' approaches the admitting nurse to give information on behalf of her mother-in-law, Mrs Menzies. The admitting nurse has already spoken with this woman in the completion of the nursing profile, outside the ward, at the house keepers desk.

> The patients 'daughter' [the nurses have not yet identified her as the patients daughter-in-law] approaches the Student Nurse at the desk while she is writing up the profile.
> 'Daughter' tells the Student that the patient wants to wear pants. The Student Nurse says that's fine. The 'daughter' says that the patient is worrying about wetting the bed. The Student Nurse says that they can give her plastic pants and a pad to wear if she is worried. The daughter says the patient is worried about how she will get to the toilet. Student nurse says that they will make sure she gets the toilet when she needs it. The Student Nurse asks the Daughter if there are any stairs in the flat at home. A little later the Student Nurse goes over to the patient and tells her that she is to call for a nurse if she needs the toilet or anything.

The Student nurse did not make any further investigation of the patient's apparent difficulties with elimination with the patient. In the patient profile she noted under 'bowels' that the patient had diarrhoea, and under 'bladder' she wrote "?cystitis, dribbling, nocturia". Presumably these details emerged as a result of the student nurse's conversation with the patient's 'daughter'. There was no note made in the patient profile of the patient expressing her difficulties over soiling the bed, or wearing pads, or needing the lavatory in a hurry. At the morning handover the following day there was no mention of the patient's elimination difficulties at all. Sister 1 gave the patient a wash the following morning, took plastic pants and a pad into the patient.

> [Mrs Menzies is behind the screens, sitting up in a chair having a wash by her bed with Sister 1 helping her. It is the morning after her admission. Sister 1 has been off to fetch something. Later Sister 1 disposes of the bedlinen in a special plastic bag for soiled linen and I assumed that the patient had soiled the bed].

Sister 1 comes back immediately carrying disposable knickers and a pad. Takes them into the patient.
Sister 1 - I'll give you this pair of pants to put on and a pad.
Mrs Menzies - ..?..[inaudible]
Sister 1 - Stand yourself up. There, they'll give you a wee bit more security. That's it - feel comfortable?
Mrs Menzies - Yes, very comfortable.

Sister 1 tells the other nurses at the midday handover following this episode that the patient has had two episodes of diarrhoea, but she does not mention whether the patient had soiled herself or give any instruction about the patient wearing pants and pads. In this way the nurses did not surface the patient's actual functional problems with elimination or her feelings about this aspect of her physical state. What is interesting is that there is mention in the admission summary and in the doctors' in-patient records of possible incontinence. What is essentially a major nursing issue - that of 'elimination' - was never investigated by the nurses, they simply were seen to respond to it on a day to day basis.

Two points are of interest here. First, that the patient was being given large doses of diuretics for her congestive cardiac failure and for her ascites, so if she was having trouble with urinary incontinence it could be made much worse for her by the drug therapy. Secondly, on the nursing care plan (constructed on the third day after the patient's admission) there was no mention of any urinary difficulties. Her diarrhoea was mentioned, not in terms of incontinence or management but in terms of evidence of something, but not of what. The doctors had showed some interest in the patient's bowels on ward rounds, which would legitimate the nurses taking notice of the problem of the diarrhoea - they had put the patient on a 'stool' chart, this prescribes that the patient's bowel motions are examined for form and consistency and tested for blood. At handovers the nurses referred to the motions as being 'not positive' to blood and recorded this information in the kardex. However, the nurses did not seem to realise the object of the doctors' interest - the doctors were concerned that the patient's breast cancer had metastasised in her gut causing a partial bowel obstruction, this might be building up to a complete bowel obstruction and result in the patient becoming a surgical emergency, an untenable situation given that she also had severe heart failure. In the care plan the nurse had written:

Problem: Diarrhoea.
Aims: To monitor.
Planned nursing action: Keep stool chart and report findings.

As can be seen the experiential level of the diarrhoea, that is what it meant for the patient and how they could help her, was not accounted for.

On discharge, the staff nurse interviewed to help complete the dossier of the patient told me that Mrs Menzies had "dribbling incontinence" and that she had worn pads and pants while in hospital. On one occasion the patient was being washed after her morning wash had been completed. The nurse involved told a Staff Nurse that the patient had wet the bed: she said that "she normally dribbles a bit but this time she soaked the bed". The fact of her incontinence was noted at the handover following this episode and in the nursing progress notes. There was no further mention of it and the patient was discharged to her sister's home with no management plan as far as I could identify from the nurses talk together and from speaking with both the patient and her relatives. According to the patient

her son had bought a new commode and was taking that to her sister's, where she was going to stay after her discharge.

BIBLIOGRAPHY

Alderson M. 1986. An Ageing Population - some demographic and health trends. Public Health, 100:263-277.

Allen D. 1987. Critical Social Theory as a model for analyzing ethical issues in family and community health. Family and Community Health, 10(1): 63-72.

Armstrong-Esther CA and Browne KD. 1986. The influence of elderly patients' mental impairment on nurse-patient interaction. Journal of Advanced Nursing, 11: 379-387.

Armstrong-Esther CA, Sandilands ML and Miller D. 1989. Attitudes and behaviours of nurses towards the elderly in an acute care setting. Journal of Advanced Nursing, 14:34-41.

Bachman S, Collard A, Greenberg J, Fountain E, Huebner T, Kimbal B and Melendy K. 1987. An Innovative Approach to Geriatric Acute Care Delivery: the Choate-Symmes Experience. Hospital and Health Services Administration, 32 (4):509-520.

Bachman S and Collard A. undated. An Innovative Method of Providing Acute Care to the Elderly. Final report. The Health Policy Center: Brandels University.

Bantz CR. 1990. Organizing and Enactment: Karl Weick and the Production of News. In: Corman SR, Banks SP, Bantz CR and Mayer ME. Foundations of Organizational Communication. New York: Longman.

Barker WH, Williams TF, Zimmer JG, Van Buren C, Vincent SJ and Pickrel SG. 1985. Geriatric Consultation Teams in Acute Hospitals: Impact on Back-up of Elderly Patients. Journal of the American Geriatrics Society, 33:422-428.

Bauman Z. 1990. Effacing the Face. On the Social Management of Moral Proximity. Theory, Culture and Society, 7 (1):5-38.

Bauman Z. 1991. The Social Manipulation of Morality: Moralizing Actors, Adiaphorising Action. Theory, Culture and Society, 8(1): 137-151.

Benner P. 1984. From Novice to Expert. Excellence and Power in Clinical Nursing Practice. California: Addison-Wesley.

Benner P and Tanner C. 1987. How Expert Nurses Use Intuition. American Journal of Nursing, 87: 23-31.

Benner P and Wrubel J. 1989. The Primacy of Caring. Stress and Coping in Health and Illness. California: Addison-Wesley.

Benner P. 1991. The role of experience, narrative, and community in skilled ethical comportment. Advances in Nursing Science, 14(2):1-21.

Benner P, Tanner C and Chesla C. 1992. From Beginner to Expert: Gaining a differentiated clinical world in critical care nursing. Advances in Nursing Science, Vol. 14 (3), p.13-28.

Berg M. 1992. The construction of medical disposals. Medical sociology and medical problem-solving in clinical practice. Sociology of Health and Illness, 14(2), p151-180.

Berger P and Luckmann T. 1966 [1991]. The Social Construction of Reality. A Treatise in the Sociology of Knowledge. Harmondsworth, England: Penguin Books.

Bishop AH and Scudder JR. 1987. Nursing Ethics in an Age of Controversy. Advances in Nursing Science, 9 (3): 34-43.

Blauner B. 1987. Problems of Editing "First Person" Sociology. Qualitative Sociology, 10(1): 46-64.

Bloor M and McIntosh J. 1990. Surveillance and Concealment: A Comparison of Techniques of Client Resistance in Therapeutic Communities and Health Visiting. In: Cunningham-Burley S. and McKeganey NP. Readings in Medical Sociology. London: Tavistock/Routledge.

Bond J and Bond S. 1986. Sociology and Health Care. Edinburgh: Churchill Livingstone.

Bouchier I and Williamson J. 1982. The Elderly Patient in the Acute Hospital Sector. Health Bulletin, 40(4).p179-182.

Brink PJ. 1991a. Editorial. Western Journal of Nursing Research, 13 (2): 162-164.

Brink PJ. 1991b. Editorial. Western Journal of Nursing Research, 13 (5): 566-7.

Broadbent J, Laughlin R and Read S. 1991. Recent Financial and Administrative Changes in the NHS: A Critical Theory Analysis. Critical Perspectives on Accounting. 2(1): 1-30.

Brocklehurst JC. 1978. The Evolution of Geriatric Medicine. Journal of the American Geriatrics Society, 26: 433-439.

Brocklehurst JC. 1982. Health Visiting and the Elderly: a Geriatricians' View. Health Visitor, 55: 356-357.

Buckley EG and Runciman PJ. 1985. Health Assessment of the Elderly at Home. A study supported by Help the Aged. University of Edinburgh.

Burkitt I. 1991. Social Selves. Theories of the Social Formation of Personality. Sage Publications Inc.: London.

Burley LE, Currie CT, Smith RG and Willliamson J. 1979. Contributions of Geriatric Medicine Within Acute Medical Wards. British Medical Journal, 2: 90-92.

Busby A and Gilchrist B. 1991. The role of the nurse in the medical ward round. Journal of Advanced Nursing, 17:339-346.

Callon M and Law J. 1982. On interests and their transformation: enrolment and counter-enrolment. Social Studies of Science, 12(4):615-26.

Capra F. 1982. The Turning Point: Science, Society and the Rising Culture. London: Fontana Paperbacks.

Carnevali D. 1983. Nursing Care Planning: Diagnosis and Management. Philadelphia: J.B.Lipincott Company.

Coid J and Crome P. 1986. Bed Blocking in Bromley. British Medical Journal, 292: 1253-1256.

Connors DD. 1988. A continuum of researcher-participant relationships: An analysis and critique. Advances in Nursing Science, 10(4),32-42.

Cormack D. 1985. The Geriatric Nursing Process. In: Cormack D [ed]. Geriatric Nursing. A Conceptual Approach. Oxford: Blackwell.

Coser LA. 1975. Two Methods in Search of Substance. In: Bulmer M [ed]. 1984 (3rd edition). Sociological Research Methods. Hampshire: MacMillan.

Craig J. 1983. The growth of the elderly population. Population Trends. 32: 28-33.

Couchman, W. 1987. Getting to Know You. Nursing Times, 83(28): 57-58.

Currie CT, Smith RG and Williamson J. 1979. Medical and nursing needs of elderly patients admitted to acute medical beds. Age And Ageing, 8: 149-151.

Czarniawska-Joerges B. Forthcoming. Narrating The Organization: Dramas of Institutional Identity. Unpublished draft.

Deetz S. 1992. Disciplinary Power in the Modern Corporation. In: Alvesson M and Willmott H [eds]. Critical Management Studies. London: Sage.

De La Cuesta C. 1983. The nursing process: from development to implementation. Journal of Advanced Nursing, 18:365-371.

Denzin N. 1978. The Logic of Naturalistic Inquiry. in Denzin N. [ed]. Sociological Methods: A Sourcebook. New York: McGraw-Hill Co.

DHSS. 1981. The Respective Roles of the General Acute and the Geriatric Sectors in Care of the Elderly Hospital Patient. Report of a study. ISBN 0-902650-34-3.

Dickson S. 1982. The Nursing Process and the professional status of nursing. Nursing Times, 78 [16]: 61-64.

Dingwall R, Rafferty AM and Webster C. 1988. An Introduction to The Social History of Nursing. London: Routledge.

Douglas M. 1975. Implicit Meanings: essays in anthropology. London: Routledge and Kegan Paul.

Donaldson LJ. 1983. Care of the elderly in hospitals and homes: foci of discontent. Journal

of Rehabilitaion and Social Health, 5: 181-185.

Dreyfus HL and Dreyfus SE. 1985. Mind Over Machine. New York: Free Association Press.

Eco U. 1976. A Theory of Semiotics. Bloomington: Indiana University Press.

Eco U. 1984. Semiotics and the Philosophy of Language. Hampshire: Macmillan.

Eliopoulos C. 1979. Geriatric Nursing. Lipincott Nursing Series. London: Harper and Row.

Engestrom Y. 1987. Learning by Expanding: An Activity Theoretical Approach to Developmental Research. Helsinki: Orienta-Konsultit Oy.

Engestrom. 1989. Developing Thinking at the Workplace: Towards a Redefinition of Expertise. San Diego: University of California Center for Human Information Processing.

Evers H. 1982. Key issues in Nursing Practice: Ward Management - 1. Nursing Times, February: 21-24.

Fairclough N. 1992. Discourse and text: linguistic and intertextual analysis within discourse analysis. Discourse and Society, 3 (2), p193-217.

Fairclough N. 1993. Critical discourse analysis and the marketization of public discourse. Discourse and Society, 4(2):133-168

Faulkner A and Maguire P. 1984. Teaching Nursing Assessment. In: Faulkner A [ed]. Communication. Recent Advances in Nursing. Edinburgh: Churchill Livingston.

Featherstone M. 1992. The Heroic Life and Everyday Life. Theory, Culture and Society, 9 (1):159-182.

Fernandez JW. 1986. Persuasions and Performances. The Play of Tropes in Culture. Bloomington: Indiana University Press.

Fielding P. 1979. An exploratory investigation of self-concept in the institutionalised elderly, and a comparison with nurses' conceptions and attitudes. International Journal of Nursing Studies, 16: 345-354.

Fielding P. 1982. An Investigation of Student Nurses' Attitudes Towards Old People in Hospital. Unpublished Ph D Thesis, University of Southampton.

Fisher S. 1991. A discourse of the social: medical talk/power talk/ oppositional talk? Discourse and Society, 2(2):157-182.

Foucault M. 1968. Politics and the Study of Discourse. In: Burchell, Gordon and Miller [eds]. 1991. The Foucault Effect. Studies in Governmentalility. London: Harvester Wheatsheaf.

Foucault M. 1970. The Order of Things. London: Tavistock Publications.

Foucault M. 1973 [1976]. The Birth of the Clinic. London: Tavistock Publications.

Foucault M. 1975. Discipline and Punish. The Birth of the Prison. Harmondsworth, England: Penguin Books Ltd.

Foucault M. 1977. The Eye of Power. in: Gordon C [ed]. 1980. Michel Foucault: Power/Knowledge. New York: Harvester Wheatsheaf.

Foucault M. 1978. Governmentality. In: Burchell, Gordon and Miller [eds]. 1991. The Foucault Effect. Studies in Governmentalility. London: Harvester Wheatsheaf.

Foucault M. 1980a. Questions of Method. In: Burchell, Gordon and Miller [eds]. 1991. The Foucault Effect. Studies in Governmentalility. London: Harvester Wheatsheaf.

Foucault M. 1980b. The Masked Philosopher. In: Kritzman LD. 1988. Michel Foucault : Politics, Philosophy and Culture. Interviews and Other Writings 1977-1984. New York : Routledge.

Foucault M. 1981. The Political Technology of Individuals. In: Martin, Gutman and Hutton [eds]. The Technologies of the Self. London: Tavistock Publications.

Foucault M. 1984. What is Enlightenment? In: Rabinow P [ed]. 1991. The Foucault Reader. Harmondsworth, England: Penguin.

Fox NJ. 1993. Discourse, organization and the surgical ward round. Sociology of Health and Illness, 15(1): 16-42.

Frank AW. 1990. Bringing Bodies Back In: A Decade Review. Theory, Culture and Society, 7 (1): 131-162.

Freidson E. 1975. Profession of Medicine. A study of the sociology of applied knowledge. New York: Dodd, Mead and Co.

Freund P. 1990. The expressive body: a common ground for the sociology of emotions and health and illness. Sociology of Health and Illness, 12 (4): p452-477.

Gadamer H-G. 1976 [1977]. Philosophical Hermeneutics. Berkeley: University of California Press.

Game A. 1991. Undoing the Social. Towards a deconstructive sociology. Milton Keynes: Open University Press.

Garfinkel H. 1967. Studies in Ethnomethodology. Englewood Cliffs, New Jersey: Prentice-Hall Inc.

Garfinkel H. 1974. Introduction. In Turner, Roy [ed]. 1974. Ethnomethodology. Penguin Books: Middlesex, England.

Garfinkel H. 1986. Introduction. In: Garfinkel H [ed.]. 1986. Ethnomethodological Studies of Work. London: Routledge and Kegan Paul.

Garfinkel H and Sacks H. 1969. On formal Structures of Practical Actions. In: Garfinkel H [ed]. 1986. Ethnomethodological Studies of Work. Routledge and Kegan Paul: London.

Geertz C. 1983. Local Knowledge. New York: Basic Books.

Ghidina MJ. 1992. Social Relations and the Definition of Work: Identity Management in a Low-Status Occupation. Qualitative Sociology, 15 (1):73-85.

Giddens A. 1976. New Rules of Sociological Method. London: Hutchinson.

Giddens A. 1984 [1989]. The Constitution of Society. Outline of Structuration Theory. Cambridge: Polity Press.

Giddens A. 1991. Modernity and Self-Identity. Cambridge: Polity Press.

Gillick MR, Sewell NA and Gillick LS. 1982. Adverse consequences of hospitalization in the elderly. Social Science and Medicine, 16: 1033-1038.

Goffman E. 1955. On Face-Work : An Analysis of Ritual Elements in Social Interaction. In: Laver J and Hutcheson S. 1972. Communication in Face to Face Interaction. Harmondsworth, England: Penguin Books Ltd.

Goffman E. 1958. The Presentation of Self in Everyday Life. University of Edinburgh, Social Sciences Research Centre, Monograph No.2.

Goffman E. 1961. On the Characteristics of Total Institutions. In: Worsley P [ed]. 1978. Modern Sociology. Harmondsworth, England: Penguin Books Ltd.

Gordon C. 1980. Afterword. In: Gordon C [ed]. Michel Foucault. Power/Knowledge. New York: Harvester Wheatsheaf.

Gordon M and Sweeney MA. 1979. Methodological Problems and Issues in Identifying and Standardizing Nursing Diagnoses. Advances in Nursing Science, 2(1): 1-15.

Gouldner AW. 1955. Patterns of Industrial Bureaucracy. London: Routledge and Kegan Paul.

Gray, G. 1977. Assessment of the Nursing Needs of the Dying Patient. Unpublished MSc. Thesis. The Victoria University of Manchester.

Green JA. 1979. Science, Nursing and Nursing Science: A Conceptual Analysis. Advances in Nursing Science, 2(1):57-64.

Grimley-Evans J. 1983. Integration of geriatric with general medical services in Newcastle. Lancet. 1: 1430-1433.

Hacking I. 1986. The Archaeology of Foucault. In Couzens Hoy (ed). 1986. Foucault : A Critical Reader. Basil Blackwell: Oxford.

Hamdy RC. 1984. Geriatric Medicine. A problem-orientated approach. London:Balliere Tindall.

Hammersley M and Atkinson P. 1983. Ethnography: Principles and Practice. London: Tavistock Publications.

Hammersley M. 1990. Reading Ethnographic Research. A critical guide. London: Longman.

Heidegger M. 1962 [1985]. Being and Time. Oxford: Basil Blackwell.

Henderson V. 1966. The Nature of Nursing. New York: Macmillan.

Hiraki A. 1992. Tradition, rationality and power in introductory nursing textbooks: A critical hermeneutics study. Advances in Nursing Science, 14(3):1-12.

Holmes CA. 1992. The drama of nursing. Journal of Advanced Nursing, 17:941-950.

Holter IM. 1988. Critical theory: a foundation for the development of nursing theories. Scholarly Inquiry for Nursing Practice, 2(3):223-232.

Hochschild AR. 1983. The Managed Heart. Commercialization of Human Feeling. Berkeley: University of California Press.

Hoskin K. Forthcoming. Boxing Clever: For, Against and Beyond Foucault in the Battle for Accounting Theory. Critical Perspectives on Accounting.

Hulter Asberg KH. 1986. Elderly Patients in Acute Medical Wards and Home Care. Functional assessment, prediction of outcome, and a trial of early activation. PhD Thesis. Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine, 25. University of Uppsala, Sweden.

Hurst K. 1983. The Quiet Revolution. Nursing Mirror, October:36-40.

Hurst K and Dean A. 1987. An Investigation into Nurses' Perceptions of Problem-Solving in Clinical Practice. Proceedings of Nursing Research Congress: Cinical Excellence in Nursing. International Networking.

Hurst K, Dean A and Trickey S. 1991. The recognition and non-recognition of problem-solving stages in nursing practice. Journal of Advanced Nursing, 16: 1444-1455.

Hutton PH. 1988. Foucault, Freud, and the Technologies of the Self. In: Martin, Luther and Hutton (eds). Technologies of the Self. A seminar with Michel Foucault. London: Tavistock Publications.

Hymes D. 1964. Toward Ethnographies of Communication: The Analysis of Communicative Events. In: Giglioli P. 1972. Language and Social Context. Harmondsworth, England: Pelican Books.

Ingham R and Fielding P. 1985. A review of the nursing literature on attitudes toward old people. International Journal of Nursing Studies, 22(3): 171-181.

Isaacs B. 1976. We make moulds and pour old people into them. Occupational Therapy, July, p171.

Jay M. 1986. In the Empire of the Gaze: Foucault and the Denigration of Vision in Twentieth-Century French Thought. In: Couzens Hoy D (ed). 1986. Foucault. A Critical Reader. Oxford: Basil Blackwell.

Joel LA. 1984. Geriatric Imperative: the Acutely Ill Elderly. The Journal of the Medical Society of New Jersey, 81(8): 655-657.

Johnson ML. 1972. Self-Perception of Need Amongst the Elderly: An Analysis of Illness Behaviour. Sociological Review, 20: 521-531.

Jolley D.J. 1987. The Aetiology of Confusion. Presentation given at the British Journal of Hospital Medicine Conference: The Care of the Elderly Patient in the Acute Medical Unit, Edinburgh.

King's Fund. 1982. The Respective Roles of the General Acute and Geriatric Sectors in the Care of the Elderly Hospitalised Patient. Report of a Study Day held on 4th June 1982. KFC 82/213.

Kitson A. 1986. Indicators of quality in nursing care - an alternative approach. Journal of Advanced Nursing, 11 (2): 133-144.

Kratz CR. 1981. The Nursing Process. London: Balliere Tindall.

Lanceley, Ann. 1985. Use of controlling language in rehabilitation of the elderly. Journal of Advanced Nursing, 10: 125-135.

Latour B. 1987. Science in Action. Milton Keynes: Open University Press.

Lentz E. 1954. A Comparison of Medical and Surgical Floors. Mimeograph: New York State School of Industrial and Labour Relations, Cornell University.

Lindeman C. 1981. The effects of three methods of collecting information during the nurse-patient admission interview. in Kramptz S and Pavlovich N [eds]. Readings for Nursing Research. St Louis: C.V. Mosby Co Ltd.

Lorenson M. 1988. Response to "Critical Theory: a foundation for development of nursing theories". Scholarly Inquiry in Nursing Practice, 2(3), 233-236.

Lyth I M. 1960. Social Systems as a Defense Against Anxiety. An Empirical Study of the Nursing Service of a General Hospital. In: Trist E and Murray H [eds]. 1990. The Social Engagement of Social Science. Volume 1. The Socio-psychological Perspective. London: Free Association Books.

Machad. Undated. In: May J. 1984. Changing People, Changing Laws. Mambo occasional papers - Socio-Economic Series, No22. Gweru, Zimbabwe: Mambo Press.

Mackay L. 1989. Nursing a Problem. Milton Keynes: Open University Press.

MacLennan WJ. 1987. Ageing. Presentation at the British Journal of Hospital Medicine Conference: The Care of the Elderly Patient in the Acute Medical Unit, Edinburgh.

Macleod Clark J. 1984. Verbal Communication in Nursing. In: Faulkner A. [ed]. Communication. Recent Advances in Nursing. Edinburgh: Churchill Livingston.

McArdle C, Wylie JC and Alexander WD. 1975. Geriatric patients in an acute medical ward. British Medical Journal, 4:568-569.

McLain BR. 1988. Collaborative Practice: A critical theory perspective. Research in Nursing and Health, 11, 391-398.

Magnan M and Benner P. 1989. Listening With Care. American Journal of Nursing, 89: 219-221.

Maguire GP, Julier DL, Hawton KE, Bancroft JHL. 1974. Psychiatric morbidity and referral on two general medical wards. British Medical Journal, 1: 268-270.

Maguire PA, Taylor IC and Stout RW. 1986. Elderly patients in acute medical wards: factors predicting length of stay. British Medical Journal, 292:1251-1253.

Mathieson A. 1988. Rating Needs. Nursing Times, 84(35):38-41.

May C. 1991. Getting to Know Them: An exploratory study of nurses' relationships and work with terminally ill patients in acute medical and surgical wards. Unpublished PhD Thesis: University of Edinburgh.

May C. 1992. Individual Care? Power and Subjectivity in Therapeutic Relationships. Sociology, 26(4):589-602.

Mazer T. 1993. Death and dying in a hospice: an ethnographic study. Unpublished PhD Thesis: University of Edinburgh.

Meleis A. 1985. Theoretical Nursing. Development and Progress. Philadelphia: Lippincott.

Melia K. 1979. A sociological approach to the analysis of nursing work. Journal of Advanced Nursing, 4:57-67.

Melia K. 1981. Student Nurses' Accounts of their Work and Training: a Qualitative Analysis. Unpublished PhD Thesis: University of Edinburgh.

Miller A. 1984. Nurse/patient dependency - a review of different approaches with particular reference to studies of the dependency of elderly patients. Journal of Advanced Nursing, 9:479 - 486.

Miller A. 1985a. A Study of the Dependency of Elderly Patients in Wards Using Different Methods of Nursing Care. Age and Ageing, 14:132-138.

Miller A. 1985b. Nurse/patient dependency - is it iatrogenic? Journal of Advanced Nursing, 10(1):63-69.

Mills WD. 1983. Problems associated with the nursing care of the dying patient in hospital. Unpublished M.Litt. Thesis: University of Glasgow.

Morrison E G. 1989. Nursing Assessment: What do Nurses Want to Know? Western Journal of Nursing Research, 11(4):469-476.

Mumby DK and Stohl C. 1991. Power and discourse in organization studies: absence and the dialectic of control. Discourse and Society, 2(3): 313-332.

Munns B. 1980. Problems and Satisfactions of the Elderly at Home. A study of the elderly person's perceptions of their main life concerns with comparison in certain areas between these perceptions and those of nurse interviewers. Unpublished MSc Thesis. University of Surrey.

Munro R. 1991. Enabling Participative Change: the impact of a strategic value. International Studies in Management and Organization, 21(4): 52-65.

Munro R. Forthcoming/a. Just When you Thought it Safe to Enter the Water: Accountability, language games and multiple control technologies. Accounting, Management and Information Technology.

Munro R. Forthcoming/b. Disposal of the Gap. Advances in Public Interest Accounting.

Murdoch I. 1987 [1988]. The Book and the Brotherhood. Harmondsworth, England: Penguin Books Ltd.

Newby H. 1992. Times Higher Education Supplement. January 17.

Newell A, Simon HA and Shaw JC. 1958. Elements of a Theory of Human Problem Solving. In: Anderson R and Ansubel D [eds]. 1965. Readings in the Psychology of Cognition. New York: Holt, Rinehart and Winston Inc.

Nightingale F. 1859 [1970]. Notes On Nursing. London: Duckworth.

North NT and Hall DJ. 1984. The First Inner City Community Hospital: An Appraisal of the First Year of Operation. Unpublished internal document. Paddington and North Kensington Area Health Authority: London.

Ochs E and Taylor C. 1992. Family narratives as political activity. Discourse and Society, 3 (3):301-340.

Oiler C. 1982. The Phenomenological Approach to Nursing Research. Nursing Research, 31(3):178-181.

Orem D. 1980. Nursing - Concepts of Practice. (second edition). New York: McGraw-Hill.

Osterwalder H. 1978. T.S. Eliot: Between Metaphor and Metonomy. A Study of His Essays and Plays in Terms of Roman Jakobson's Typology. Bern: Francke Verlag.

Pattie AH and Gilleard CJ. 1979. Manual of the Clifton Assessment Procedures for the Elderly [CAPE]. Sevenoaks: Hodder and Stoughton.

Panicucci, C.L. 1983. Functional Assessment of the Older Adult in the Acute Care Setting. Nursing Clinics of North America, 18(2):355-363.

Parse R R. 1981. Man-Living-Health. A theory of nursing. New York: John Wiley.

Parsons T. 1951 (1983). Illness and the Role of the Physician: A Sociological Perspective. In: Hamilton P. (ed.) Readings from Talcott Parsons. Milton Keynes: Open University Press.

Pearsall M. 1965. Participant Observation as Role and Method in Behavioral Research. Nursing Research, 14(1):37-42.

Pearson A and Vaughn B. 1986. Nursing Models for Practice. London: Heinemann Nursing.

Pembrey S. 1980. The Ward Sister - Key to Nursing. London: Royal College of Nursing.

Popper K. 1969. Conjectures and Refutations. London: Routledge and Kegan Paul.

Porter S. 1993. Nursing research conventions: objectivity or obfuscation? Journal of Advanced Nursing, 18:137-143.

Poulton K. 1981. Perceptions of wants and needs by nurses and their patients. Unpublished PhD Thesis: University of Surrey.

Price Bob. 1987. First impressions: paradigms for patient assessment. Journal of Advanced Nursing, 12:699-705.

Purkis ME. 1993. Bringing 'Practice' To The Clinic: An excavation of the effects of health promotion discourse on nursing practice in a community health clinic. Unpublished Thesis submitted for PhD. University of Edinburgh.

Pyne R. 1993. Ethics and Nursing: Management in the changing NHS. The Nursing Studies Association of the University of Edinburgh, 27th Annual Study Day. Proceedings, forthcoming.

Raffel S. 1979. Matters Of Fact. London: Routledge and Kegan Paul.

Ragucci AT. 1972. The Ethnographic Approach and Nursing Research. Nursing Research, 21 (6):485-490.

Read SM. 1989. Management Changes In The National Health Services: Nursing and organizational theory in relation to the development of a new unit of health care. Unpublished PhD Thesis. University of Sheffield.

Roberts J. 1991. The Possibilities of Accountability. Accounting, Organization and Society, 16 (4): 355-368.

Roper N, Logan W and Tierney A. 1980. The Elements of Nursing. Edinburgh: Churchill Livingstone.

Roper N, Logan W and Tierney A. 1981. Learning to Use the Nursing Process. Edinburgh: Churchill Livingstone.

Roper N, Logan W and Tierney A. 1983. Is there a danger of processing patients? Nursing

Mirror. June:32-33.

Rose N and Miller P. 1992. Political power beyond the state: problematics of government. British Journal of Sociology, 43(2):173-205.

Rubenstein LZ. 1984. Geriatric Imperative: Geriatric Assessment Programmes. Journal of the Medical Society of New Jersey, 81(8): 651-654.

Rubin SG and Davies GH. 1975. Bed blocking by elderly patients in general hospital wards. Age and Ageing, 4:142-147.

Saferstein B. 1992. Collective cognition and collaborative work: the effects of cognitive and communicative processes on the organization of television production. Discourse and Society, 3(1): 61-86.

Schatzman L and Strauss A. 1973. Field Research. Strategies for a Natural Sociology. New Jersey: Prentice-Hall.

Schrock R. 1987. Professionalism - a critical examination. Recent Advances in Nursing, 18, p12-24.

Schrock R. 1990. Conscience and courage - a critical examination of professional conduct. Nurse Education Today, 10: 3-9.

Schutz A. 1967. The phenomenology of the social world. Evanston, Illinois: Northwestern University Press.

Scottish Hospital In-patient Statistics. Supplied by the Information and Statistics Division of the Common Services Agency of Scottish Health Services.

Scottish Office Home and Health Department. 1992. The Role and Function of the Professional Nurse. Edinburgh: HMSO.

Seymour DG and Pringle R. 1982. Elderly patients in general surgical units: do they block beds? British Medical Journal. 284: 1921-1923.

Silverman D. 1989a. Six rules of qualitative research: A post romantic argument. Symbolic Interaction, 12: 215-230.

Silverman D. 1989b. The impossible dreams of reformism and romanticism. In: Silverman D and Gubrium J (eds). The politics of field research: Sociology beyond enlightenment. London: Sage.

Smith G. and Cantley C. 1985. Policy Evaluation: The Use of Varied Data in a Study of A Psychogeriatric Service. In: Walker R [ed]. Applied Qualitative research. Hampshire: Gower.

Snape J. 1986. Nurses' attitudes to care of the elderly. Journal of Advanced Nursing, 11: 569-572.

Stevens W. 1947 [1951]. Transport to Summer. New York: AA Kopf.

Strathern M. 1991. Partial Connections. Maryland, USA: Rowman and Littlefield Publishers Inc.

Strathern M. 1992. Writing societies, writing persons. History of Human Sciences, 5(1): 5-16.

Strathern M. 1992a. After Nature. English kinship in the late twentieth century. Cambridge: Cambridge University Press.

Strathern M. 1993. Society in Drag. Times Higher Educational Supplement, April 2nd:19.

Strauss A, Fagerhaugh S, Suszek B and Wiener C. 1982. Sentimental work in the technologised hospital. Sociology of Health and Illness, 4(3): 254-278.

Sudnow D. 1967. Passing On. The Social Organisation of Dying. Englewood Cliffs, New Jersey: Prentice-Hall Inc.

Tanner C, Padrick K, Westfall U and Putzier D. 1987. Diagnostic Reasoning Strategies of Nurses and Nursing Students. Nursing Research, 36 [6]: 358-363.

Thiele JE, Holloway J, Murphy D, Pendarvis J and Stucky M. 1991. Perceived and Actual Decision Making by Novice Baccalaureate Students. Western Journal of Nursing Research, 13 (5): 616-626.

Thomas J. 1993. Doing Critical Ethnography. Qualitative Research Methods Series, 26. Newbury Park: Sage.

Thompson J. 1987. Critical Scholarship: the critique of domination in nursing. Advances in Nursing Science, 10(1): 27-38.

Tierney AJ. 1984. A Response to Professor Mitchell's "simple guide to the nursing process". British Medical Journal, 288: 835-838.

Tilley SC. 1990. Negotiating Realities: making sense of interaction between patients diagnosed as neurotic and nurses in two psychiatric admission wards. Unpublished PhD Thesis, University of Edinburgh.

Turner BS. 1992. Regulating Bodies. Essays in Medical Sociology. Routledge: London.

Turner V. 1967. The Forest Of Symbols: Aspects of Ndembu Ritual. Ithaca, New York: Cornell University Press.

Tyler SA. 1986. Post-Modern Ethnography: From Document of the Occult to Occult Document. In: Clifford J and Marcus G (eds). Writing Culture: The Poetics and Politics of Ethnography. Berkeley and Los Angeles: California University Press.

Van Dijk TA. 1993. Principals of Critical Discourse. Discourse and Society, 4 (2):249-283

Victor C and Vetter NJ. 1984. DN's and the elderly after hospital discharge. Nursing Times. 80(15). p.61-62.

Victor C and Vetter NJ. 1985. A one year follow-up of patients discharged from geriatric and general medical units in Wales. Archives of Gerontology and Geriatrics, 4:117-124.

Ward M. 1988. Sociolinguistics and the nursing process. Senior Nurse, 8(11): 21-23.

Webb C. 1985. Sexuality, Nursing and Health. Chichester: John Wiley.

Weber M. 1949. The Methodology of the Social Sciences. Glencoe: Free Press.

Wega K. 1992. The Sociological Significance of Ambivalence: An Example from Adoption research. Qualitative Sociology, 15(1):87-103.

Wells T. 1980. Problems in Geriatric Nursing Care. Edinburgh: Churchill Livingstone.

Wieck KE. 1979. The Social Psychology of Organization. New York: Random House.

Wilkinson I and Zissler LM. 1984. Standardized assessments for the elderly: clinical applications. Nursing Times, 80 (1):36-37.

Wilson-Barnett J. 1988. Nursing values: exploring the cliches. Journal of Advanced Nursing, vol. 13, p790-796.

Wolf ZR. 1988. Nurses' Work, the Sacred and The Profane. Philadelphia: University of Pennsylvania Press.

Addendum bibliography

Bloomfield B, Coombs R, Cooper DJ, and Rea D. 1992. Machines and Manoeuvres: Responsibility Accounting and the Construction of Hospital Information. Accounting, Management and Information Technologies, 2(4), 197-219.

Callon M and Latour B. 1981. Unscrewing the big Leviathan: How actors macro-structure reality and how sociologists help them do so. In Knorr-Cetain KD and Cicourel A (eds), Advances in Social Theory and Methodology: Toward an Integration of Micro and Macro-Sociologies, London: Routledge.

HMSO. 1989. Working for Patients. London: HMSO.

Latour B. 1991. Technology is society made durable. In Law J. (ed), A Sociology of Monsters, Sociological Review Monograph 38.

Law J. 1993. Organizing Modernity. Oxford: Blackwell.

Loveridge R and Starkey K. 1992. Introduction: Innovation and Interest in the Organization of Health Care Delivery. In Loveridge and Starkey (eds). Continuity and Crisis in the NHS, Buckingham: Open University Press.

Van Maanen J. 1988. Tales of the Field. Chicago: The University of Chicago Press.

Walton I. 1986. The Nursing Process in Perspective. A Literature Review. York: Department of Social Policy and Social Work, University of York.