NURSES, PATIENTS AND FAMILIES

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THE NEGOTIATION OF ORDER ON
ACUTE CARE WARDS

BY

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A Thesis

Submitted to the School of Graduate Studies

in Partial Fulfillment of the Requirements

for the Degree

Master of Arts

McMaster University

August 1977

MASTER OF ARTS (1977) McMASTER UNIVERSITY
(Sociology) Hamilton, Ontario

TITLE: Nurses, Patients and Families
The Negotiation of Order on Acute Care Wards

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SUPERVISOR: Professor Victor W. Marshall

NUMBER OF PAGES: xi, 237

ABSTRACT

In this thesis, the symbolic interactionist, control and negotiated order perspectives provide the theoretical framework within which to analyse how workers seek and maintain control over their conditions of work.

The thesis is a secondary analysis of participant observation data from a primary study conducted on four wards of an acute care teaching hospital. The nurse-client relationship is the focus of investigation, with the patient viewed as the primary client and the patient's family conceptualized as a secondary client.

The nurse-patient relationship is investigated, examining situations in which patients come to be perceived as behaviour problems by nurses and the ways in which nurses react to regain control over these problem patients. A group of 102 problem patients is analysed, and several distinct problem categories are discovered. Patients in each category are analysed according to age, sex and diagnosis. Sex is found to be a significant determinant of being perceived as a problem, with female patients comprising a large proportion of the problem group. Unlike other studies, age is not a determinant of being perceived as a problem in these data. Nurses' techniques of control are investigated. Implications of these techniques with respect to institutional goals of total patient care and psychosocial care are discussed. It is see that patients who are perceived as behaviour problems are

very likely to be defined as having social and emotional problems and to be seen by a psychiatrist or social worker.

The relationship between nurses and patients' families is examined. It is argued that problems of control over families are heightened in the study hospital as a result of institutional policies of open visiting and family participation in patient care. Analysis of 46 problem families reveals the use of altercasting as a technique of interpersonal control. Nurses cast families into three roles -- visitor, worker and patient. Nurses prefer the visitor role but when this breaks down they cast the relative in a combined patient/worker role, with the patient role the preferred one. This contrasts with other studies which indicate nurses more commonly cast relatives in worker roles. It is argued that the emphasis in the study hospital on psychosocial care encourages the imputing of the patient role to the problem relative and provides the possibility of increased social control over clients.

Information control is analysed and found to be pervasive and taken for granted in this setting. Difficulties created for nurses by information control are given particular attention.

Patient satisfaction with nursing care and information is examined. High levels of satisfaction are found, placing in perspective the focus on problems which is taken in the thesis and raising questions with respect to policies of information-giving that would be most beneficial to patients.

ACKNOWLEDGEMENTS

I wish to express my deep appreciation to my Supervisor, Dr. Vic Marshall. His encouragement, perceptive criticisms, readiness to listen and discuss, and his guidance have been invaluable. I also wish to thank the members of my committee, Dr. Peta Sheriff and Dr. Bill Shaffir, for their helpful questions and suggestions.

I am grateful to Dr. Marshall for inviting me to join the research project on which this thesis is based, and wish to thank the other investigators of the primary study, Dr. A.S. Macpherson and Susan French, for welcoming me into the research group and allowing me to use their data.

I am indebted to the research assistant on the primary study, Zoe Fortuna. Her lively interest in other people and her intelligence are constantly reflected in the quality of the participant observation notes which she collected and upon which my secondary analysis is based. My numerous discussions with her about the project in general and my developing analysis proved immensely helpful.

To my parents, I am deeply grateful for their unwavering confidence in me and for their encouragement over the years to pursue my academic interests.

Special thanks go to my three children, Gary, Ken and Julie, who know that not all mothers are graduate students but have come to accept as wholly natural the fact that their mother is. Their adjustment to a very non-routine household and their sharing of responsibilities have been truly helpful. I am grateful to them and proud of them.

My profoundest appreciation goes to my husband, Donny, for without his unique combination of flexibility, humour, patience, and unfailing emotional support, I would never have undertaken graduate work. His help and encouragement in countless ways enabled me to meet the pressures and demands of writing this thesis, and to find the enterprise a rewarding one.

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION

In this thesis, I am interested in studying a particular situation to see how a group of health professionals seek to gain control over their conditions of work.

This concern has a long history in sociology. Studies in the area have focussed on such concerns as the worker's need to be able to make decisions, be independent and self-actualizing, as well as the identification of the worker's ability to control conditions of work with worker satisfaction (for examples of work in this area, see Argyris, 1959, 1960; Brown, 1962; Goldthorpe et al., 1969; Katz, 1968; Kohn and Schooler, 1969; Lawrence and Lorsch, 1967; Lewin et al., 1939; Maslow, 1954; Mason, 1960; Pearlin, 1962; Roy, 1952. For reviews of work done in the area, see Singer, 1974, and Argyris, 1972).

I General theoretical perspective: symbolic interactionism, control, and the negotiation of order

In this study, I begin with the assumption that individual human beings act in such a way as to strive to control their relationships and situations. There is order in the social world, but it is a precarious order, negotiated as actors interact in social situations.

This thesis is based, above all, on the methods and theories of the symbolic interactionist school of sociological thought. In describing this perspective, I will discuss three interrelated aspects: symbolic interactionism, control, and the negotiation of order. Human beings are seen as interpreting, linking their lines of action, and creating and re-creating their social world. Blumer enunciates the basic premises of the tradition as follows:

> ...human group life consists of the fitting to each other of the lines of action of the participants; such aligning of actions takes place predominantly by the participants indicating to one another what to do and in turn interpreting such indications made by the others; out of such interaction people form the objects that constitute their worlds; people are prepared to act toward these objects on the basis of the meaning these objects have for them; human beings face their world as organisms with selves, thus allowing each to make indications to himself; human action is constructed by the actor on the basis of what he notes, interprets, and assesses; and the interlinking of such ongoing action constitutes organizations, institutions, and vast complexes of interdependent relations (Blumer, 1969:49).

Blumer emphasizes meaning and the voluntaristic nature of individual action. The methodological stance of symbolic interactionism is direct observation of the empirical social world, the study of interaction between individuals over time and in natural situations.

> ...the empirical social world consists of ongoing group life and one has to get close to this life to know what is going on in it (Blumer, 1969:38).

The control perspective, implicit in the symbolic interactionist approach, is made explicit by Dawe. He takes the central problem of sociology to be the problem of control. Philosophically, the sociology of control has its roots in the Enlightenment philosophes' concern with "how human beings could regain control over essentially man-made institutions and historical situations" (Dawe, 1970:547). Basic to this perspective is the postulate that each actor has a "central meaning" system by means of which he organizes his experiences. The actor is...

> ...conceptualized as integrating his different situations and biographical episodes in terms of an overall life-meaning from which he derives his situationally specific goals and definitions (Dawe, 1970:548-9).

To control an interaction situation is to impose one's definition of the situation upon the other actors in the situation.

Dawe differentiates between control and conflict.

> There is no postulate of consensus or...co-operation, conflict or constraint. The extent to which a concrete interaction situation turns on any or all of these becomes the empirical question it really is (Dawe, 1970:549).

The capacity for control is differentially distributed. The factors involved include...

> ...the nature and scope of situational definitions... the relationship, in terms of projected outcomes, between the consequent courses of action...and... differential access to facilities and subjection to limiting conditions (Dawe, 1970:549).

The dual concepts of central meaning and control produce a distinctive view of the nature of society.

> Social systems are conceptualized as the outcome of a continuous process of interaction, which turns on the "projects" and differential capacities for control of the participants (Dawe, 1970:549).

This perspective conceptualizes roles and institutions...

> ...at two emergent levels. At the level of the social actor, they are linked by their relationship to a central meaning and by the attempt to activate that meaning across the institutional board. At the social-system level, they are linked by relationships of control and by the purposes which emerge as the result of interaction (Dawe, 1970:550).

Combining the symbolic interactionist and control perspectives, it is clear that...

> ...social interaction is a process that forms human conduct instead of being merely a means or a setting for the expression or release of human conduct (Blumer, 1969:8).

Human action is emergent in nature and is characterized by individuals striving to achieve their goals. Because individuals do not act in a vacuum but interact with other purposive individuals, the outcome or order may be different than what any of the acting parties intended. Order is, in this sense, negotiated. This view of behaviour is...

> ...one not so much of overt, continuous, and visible conflict, or of relatively harmonious integration, but of moves and countermoves, of claims for and denials of legitimacy, of concealment and discovery, of overt and covert bargaining, of concern and indifference; in short, of negotiation (Morgan, 1975).

The negotiated order perspective received its major statement in the work of Strauss and his colleagues (Strauss et al, 1963). They focus on "negotiation - the process of give-and-take, of diplomacy, of bargaining - which characterizes organizational life" (Strauss et al, 1963:148). While their study investigated the negotiation of order among hospital staff members, in this thesis I will examine how order is negotiated between staff, specifically nurses, and patients and their families. As Strauss et al outline, negotiation consists of making claims and counterdemands, games of give-and-take, the use of variety of devices and strategies such as withholding information, bargaining, and displaying varying degrees of co-operativeness.

Hewitt describes the negotiative process as follows:

> ...if we examine any joint action, we are more likely to see coordination and order as the results of people's self-conscious efforts to produce them than as the spontaneous, unconscious products of their activities. Everywhere in social life we see bargaining, negotiation, deliberation, agreements, temporary arrangements, deliberate suspensions of the rules, and a variety of other procedures in which the accomplishment of social order and coordinated activity is a deliberate undertaking (Hewitt, 1976:171).

In this view, then, "order is actively maintained and at the same time continually open to question" (Morgan, 1975:224). Control over conditions of work is an ongoing, negotiated process rather than an established order.

Several recent works in sociology have employed the theoretical perspective described above. Roth's study of tuberculosis patients, Davis' study of polio victims and their families, Freidson's study of the views of patients, Glaser and Strauss' work on dying patients, Goffman's research on inmates of mental hospitals, Lorber's investigation of hospital patients, and Millman's research on surgeons' mistakes fall clearly within this perspective as it applies in medical settings (Roth, 1963a, 1963b; Davis, 1960, 1963; Freidson, 1961; Goffman, 1961; Glaser and Strauss, 1965; Lorber, 1975; Millman, 1977). Such works as Gold's study of the janitor and his clients (Gold, 1964) and Wilfred Martin's study of the negotiated order of the school (Martin, 1976) illustrate the fruitfulness of applying the perspective to the wider area of organizations and clients.

The application of the perspective described above to the nurse-patient, nurse-family, or nurse-physician relationships involves a view of these relationships at variance with the traditional view which stresses roles, complementarity, co-operation and reciprocity. These relationships are viewed, in this thesis, as problematic. Professional and layperson are from two different worlds, and bring to the hospital setting

different definitions of the situation, different needs and different goals. Nurses, like other workers, may be expected to seek to control their conditions of work. They must control patients in order to do their job. At the same time, patients and their families may be expected to try to control the conditions of their hospital experience. The ensuing process of negotiation takes place under circumstances of unequal power. The structural features of modern medicine create an asymmetrical relationship between the health professional and the patient or family member. This asymmetry is intensified when the patient is in hospital. Access to information, degree of uncertainty, competence gap -- all of these place the nurse in a more powerful position relative to patients and families. However, as will be seen in this thesis, patients and families manage to exercise considerable influence despite unequal power. Furthermore, structural conditions also have an unfavourable aspect for nurses. While nurses must accomplish much of the routine care of patients, and must bear the brunt of the patient's struggle for control, they are constrained by their subordinate position to physicians. Thus, the nurse's struggle for control must be considered not only in terms of interaction with patients and families, but

with the other health team members as well, particularly the doctors to whom the nurse is subordinate.

These relationships are enacted in the hospital, a special kind of organization and one which is thought to influence the human interaction within its sphere. It will be useful to look now at this particular area of organizations and clients; although only some of the points made will be directly relevant to the thesis, the discussion will form a general background within which to view the discussion in the following chapters.

II Theoretical background: hospitals and clients

The hospital is a complex organization which provides a service to clients and employs a high proportion of professionals. These characteristics are thought to have implications for the nature of the organization (Freidson and Rhea, 1965; Hall, 1972; Scott, 1965). Whether or not a hospital is properly characterized as "bureaucratic" or "professional" is a question which has received much attention in sociology. The term "professional bureaucracy" is sometimes used to describe a hospital (Litwak and Meyer, 1966). Goss (1963) calls a hospital "semi-bureaucratic" since there is usually a dual control system, with an administrative arm overseeing most functions and a medical arm which consists of physicians overseeing medical staff. Decisions on administrative matters are

made and enforced by the authority of office, but matters involving professional judgment are left to individual physicians' professional authority, or perhaps to the professional authority of other health professionals.

Freidson says the term "professional" is commonly used to denote a flexible and egalitarian way of organizing work, while "bureaucratic" denotes a rigid, mechanical and authoritarian approach. As Freidson points out, there is an assumption that professional authority is "neutrally functional" and gains compliance because it is"in some way naturally compelling" (Freidson, 1970c: 73). In reality, Freidson suggests, many of the problems in health services thought to stem from bureaucratic aspects of the system may in fact be traced to its professional organization; this is the root of authoritarianism and rigidity, not bureaucracy. Freidson contends that in the hospital the expertise of the professional is institutionalized into something similar to bureaucratic office. The medical profession is dominant and there exists a hierarchy, not of office but of expertise.

> ...the dominance of client services by the principle of expertise which is embodied in a professionally ordered division of labor is, analytically and practically, fully as problematic as is dominance by the principles of rational-legal bureaucracy. Expertise institutionalized into a profession is not...an automatically self-correcting, purely task-oriented substitute for "arbitrary" bureaucracy...both the ideology and the technology combine to produce bureaucracy-like consequences for (the client) (Freidson, 1970c:90).

Freidson discerns two patterns of hospital care, one traditional and one more contemporary, within which to view staff-client interaction.

The traditional pattern of hospital care is termed the "classical hospital care model" by Wessen (1966) and the "medical-intervention pattern" by Freidson (1970a). The physician is dominant and the staff's work is organized by the physician's orders. The patient is considered incapable of judging what is needed and expected to submit passively to the judgment and treatment of the staff. The staff serve mainly as the physician's agents in dealing with the patient.

> Interaction between patient and staff thus takes on an impersonal quality, and interaction among various members becomes ordered by a professional chain of command...(Freidson, 1970a: 133).

Over the past few decades, this model has been undergoing change.

> The phrase "comprehensive care" has risen to serve as a label of the view that ailments should not be managed discretely, separately from each other by individual specialists. These developments...while still more programmatic than actually realized, have come to make ambiguous the character of the classical intervention patterns, particularly in the university-affiliated hospitals where they flourish (Freidson, 1970a:134).

This contemporary pattern, the one subscribed to by the hospital in the present study, tends to include the

patient taking an active, motivated role in his treatment. The physician's position is somewhat more ambiguous. He is first among equals. While he is still in charge of the patient, and bears ultimate responsibility, all members of the health team are held to have valuable contributions to make with regard to planning treatment. The patient himself/herself may be, on occasion, included as part of the team. However, even where this model prevails...

> ...the absolute character of the authority of expertise makes itself felt (Freidson, 1970a: 134).

As a description of hospital organization, Freidson's analysis seems to me to be highly suggestive. However, no matter which view of the hospital one accepts, certain common features seem apparent. In the hospital, professional service is provided in a bureaucratic setting, and the experiences of nurses, patients and families will be subject to bureaucratic strains. Nurses are subject to bureaucratic control and perform many routine functions. Patients' and families' complaints about hospitals -- depersonalization, feelings of helplessness, loss of dignity as individuals -- have much in common with clients' complaints about other types of bureaucratic organizations (for studies documenting negative effects for clients

of bureaucratization, see Ferguson, 1958; Freidson, 1961 and 1963; Stanton and Schwartz, 1954; Levinson and Gallagher, 1964; Mitchell, 1966; Rubington, 1965; Bidwell, 1965).[1]

I turn now to a more detailed discussion of the staff-client relationship. In this thesis, the term denotes either a patient or a family member, following a definition of client as "an individual who has contact with a bureaucratic organization in connection with his own personal interests and obligations" (Katz and Danet, 1973:668). "Staff" denotes an employee of the hospital, usually a professional. The nurse-client relationship will be of central interest.

Both the bureaucratic model described by Weber (1947) and the professional role described by Parsons (1951) prescribe universalism, achievement orientation, specificity with regard to task orientation, and emotional neutrality. Deviations from these norms, whether in the client's favour or not, are considered illegitimate. In addition to the above characteristics, the professional role adds a "collectivity orientation" rather than the self-interest which is a legitimate component of other roles such as the businessman. Professionals are further characterized by autonomy, expertise, a service ideal, special training and internalization of a set of professional norms and values.

The relationship between health professional and client in the hospital setting is asymmetrical in that the professional has greater competence, more information and less uncertainty than the client, and is performing a full-time occupational role with commitment to a career and long-term participation in this role; for the client, commitment and participation are more limited, both in scope and time.

While some analysts (Fox, 1957, 1959 and 1970; Waitzkin and Stoeckle, 1972; Waitzkin and Waterman, 1974; Davis, 1963; Freidson, 1970b; Roth, 1963a) focus on the professionals' manipulation of their advantages to maintain positions of power and control with respect to clients, Parsons (1969) stresses the bridging of the "competence gap" through the patient's trust in the professional's judgment, knowledge and action.

Critics of Parsons have suggested that the factors stressed by him as typifying the professional-client relationship, namely functional specificity, affective neutrality, universalism rather than particularism, achievement-orientation and collectivity-orientation, create distance between professional and client.

> Parsons' analysis of the doctor-patient relationship leans in the direction of formality and distance between doctor and patient, rather than toward closeness and trust (Waitzkin and Waterman, 1974:19).

Waitzkin and Waterman (1974) point out that in the health professional-client relationship there is an inherent tension between the professional's social control function -- regulating access to the sick role -- on the one hand, and the expectation that the client will display trust and confidence in the professional on the other. There is a resultant ambiguity in the relationship; the patient may not believe that his/her doctor or nurse has only his/her best interests at heart. The tension for nurses and doctors between the healing role and the gatekeeper role will be evident in Chapters Two and Three.

The tension between the service and social control functions is an example of conflict resulting from mixed goals of an organization. Another common conflict is between service and procedure. These conflicts have implications for how the organization treats clients and how clients perceive their experiences. For example, Catrice-Lorey (1966) showed that while officials were concerned with administrative procedures, clients expected officials to be accessible and to treat them as individual cases.

Social characteristics of clients and staff such as friendship, kinship, race, age, sex, class, ethnicity and religion are termed "latent" or "role-

irrelevant" by Katz and Danet (1973:690) and are not supposed to influence the behaviour of staff or clients toward one another. That they do, in fact, impinge on the official-client relationship and may exert pressure on the official to deviate from organizational norms has been demonstrated in several studies (Sudnow, 1967, and Katz and Eisenstadt, 1960, for example). In this study, it will be shown that the sex of patients impinges significantly on the professional-client relationship.

Social class has been found to be a significant factor in professional-client relationships, with the lower class client at a decided disadvantage. Health professionals are usually middle class. Since lower class clients are accustomed to interpersonal relationships which emphasize the concrete and the personal, they experience more difficulties and greater feelings of powerlessness and confusion in bureaucratic settings than do middle class clients (Miller, 1964). A number of studies investigate the effects of social class on attitudes and knowledge about health, illness, diagnosis and treatment (Blau, 1960; Rosenblatt and Suchman, 1964a and 1964b; Freidson, 1961; Feldman, 1966; Waitzkin and Stoeckle, 1972). Lower class individuals know less

about illness, have different definitions of illness, are slower to accept the sick role and are more dependent once defined as sick than are middle class patients. Lower class patients are hampered linguistically and by feelings of awe and greater social distance. Lower class patients are less critical than middle class patients toward health services.

For all patients, hospitalization brings the probability of some degree of alienation in the sense of powerlessness. They lose control over their bodies, over many or all of the ordinary routines of life, and they lose their role as independent adults.

> The roots of patient alienation lie in this surrender of the body...(Waitzkin and Waterman, 1974:76).

The widespread practice of withholding information exacerbates alienation.

> ...alienation becomes most severe when physicians withhold information about illness and therapy (Waitzkin and Waterman, 1974:76).

The efforts of staff to control information and of the clients to obtain it have been extensively documented in hospital studies (Quint, 1965; Davis, 1963; 1960; Roth, 1963a, 1963b; McIntosh, 1974, 1977; Kelly, 1950; Waitzkin and Stoeckle, 1972; Glaser and Strauss, 1965). Freidson views information control as the key to the unhappy experiences of clients in hospitals. He sees

practices of information control as stemming directly from the dominance of the medical profession in the organization of hospital care and the physician's conception of his relation to his client. The medical profession, by withholding information and insisting the client have faith rather than facts, protects its position of institutionalized authority. Information control will be discussed extensively in Chapter Five.

Of the areas covered in the above section, some will be highly relevant to the thesis while others are intended simply as background. The professional-bureaucratic debate, at the organizational level, is largely outside the immediate interests of the thesis. While social class is not used as a variable in the analysis of this thesis, I consider it another interesting and important dimension of the professional-client relationship and discuss it above for that reason. Patient alienation is not discussed directly in the thesis, but as it is a common aspect of patient experience it seemed important to acknowledge it above.

Other aspects of the preceding discussion are more pertinent to the thesis. The position of nurses in the authority structure of the hospital creates problems for them, as will be seen in Chapter Three. The comprehensive care model of patient care is, as mentioned above, the model subscribed to in the hospital in this study. Some of the ambiguities in this model will be evident in the

examples from the field notes which appear in the following chapters.. Patients and families may be annoyed when they feel they are not part of the health care team. Nurses perceive doctors as exercising quite arbitrary authority, despite attempts at a somewhat less hierarchical team structure than in traditional settings. Patients are not treated as total persons despite philosophical slogans to the contrary. As noted above, Chapters Two and Three discuss the conflict between the gatekeeper and health care functions of medical professionals. Role irrelevant characteristics will be seen to play a part in the professional-client relationship; this is discussed at length in Chapter Two. As stated previously, information is discussed in Chapter Five.

III Methodology

a) Primary study

This thesis is a secondary analysis of data originally gathered as part of a project called "The Evaluation of a Psychosocial Programme."[2]

i) Research site

The study was conducted in Hamilton, Ontario, a city of approximately 300,000 people. Hamilton is a heavily industrial city, being the centre of Canada's steel industry and many of its related enterprises.

The hospital under study is McMaster University Medical Centre, a 470-bed teaching hospital adjacent to McMaster University and located in the western periphery of Hamilton, a non-industrial, mainly residential, middle-class area.

McMaster University Medical Centre (MUMC) opened in 1972[3] and houses educational, research and patient care activities and facilities.

MUMC has had high public visibility from its inception. It was conceived and constructed amidst disagreement concerning its necessity and its location in the city. Remnants of this controversy persist to the present time. The building's controversial architecture also received much public attention; the innovative design drew reactions ranging from highly enthusiastic to severely critical. Innovation is also a keynote of the medical school housed in MUMC and of the Centre's complex organizational structure of matrix management which cuts across traditional interdisciplinary, interinstitutional and interdepartmental boundaries (Campbell, 1972: Evans, 1970). The hospital is committed to the health team approach and to the total patient concept which includes personalized patient care and the development of adequate psychosocial assessment, management and follow-up of patients' social

and emotional conditions (Bihldorff, 1975).

The amount of public attention drawn by MUMC, as well as its commitment to the more innovative aspects of patient care, professional relationships, and medical education, are reflected in a sense of the Centre's uniqueness on the part of many staff members. This may be positive or negative in nature, as will be seen later in the thesis. At the policy or institutional level, there is a similar sense of being unique; this is reflected in the areas described above as well as in the commitment to being a community hospital, responsive to community needs. High sensitivity to the environment is a feature of hospital policy and organizational members.

ii) Objectives of the primary study

The primary study was conducted over an 18-month period in four wards of the teaching hospital described above. This was a quasi-experimental study to examine the effects of systems consultation (described below) on psychosocial care to patients and on team function in the four wards under study. For an extensive description of the psychosocial programme whose operation was being evaluated, the reader is referred to Cleghorn, 1974; a brief description will serve here. The programme had, as its broad aims, improved patient care and improved functioning of health teams through a major change in consultative styles. This entailed transforming the

traditional "consultee-oriented approach" in which...

> ...the referring physician's motives for requesting a consultation and his related difficulties and expectations are the center of the consultant's enquiry and advice...

to a"situation-oriented approach" in which...

> ...interpersonal transactions of all the members of the clinical team involved in the care of the patient for whom consultation has been requested are taken into account to understand the patient's behaviour and the consultee's concern about it (Macpherson et al, 1974: 1: 7).

This latter approach is referred to in the primary study and in this thesis as "systems consultation," the term given it by Lipowski (1967a).

iii) Design and methodology of the primary study

The study was conducted in four wards. Comparability measures relating to medical-surgical complexion of the wards, patient load, staff competence and patient characteristics were undertaken to ensure that the wards under study could indeed be compared.

Consultee-oriented consultation was carried out on two (control) wards, while an intensified version of situation-oriented or systems consultation was instituted on the other two (experimental) wards. This intensified version is described by the investigators of the primary study as follows:

> Contributing to the development of multidisciplinary teams; facilitating the excellent functioning of the teams; setting specific goals in psychosocial care for teams; helping clinical teams to utilise social workers, clinical specialists in psychiatric nursing and psychiatric consultants appropriately;[4] encouraging the development of

> adequate psychosocial assessment and integrating it with medical assessment (Macpherson et al., 1974: 1:7).

The primary study employed a quasi-experimental design (for a full description of the design, see Macpherson et al., 1974: chapter 6). In each of the four wards studied, two study populations were identified, the health professionals working on the wards and the patients on each ward.

Both these populations were interviewed in three survey periods. The health professionals were given a Team Function Interview Schedule, a 29-page, 153-item questionnaire, consisting of Likert-type scale responses as well as open-ended, less structured questions, and measuring such dimensions as authority structure, communications flow, role-task allocation and organizational goals. This questionnaire was administered three times at six-month intervals in 1974-75 to the health professionals on each study ward: physicians, residents, interns, patient care co-ordinators (head nurses), team leaders (supervisory nurses), registered nurses, registered nursing assistants, social workers, nutritionists, occupational therapists, physiotherapists, chaplains, and psychosocial consultants. A total of 540 interviews were conducted to measure team function. The resulting data allowed comparison between wards at any of the three study times as well as longitudinal investigation of change over time.

To evaluate patient outcomes, a Patient Follow-Up Interview Schedule was administered to all patients admitted to the study wards during the 20-day periods paralleling the administration of the Team Function Interview Schedules. A total of 388 patients were interviewed about one month after discharge. The questionnaire consisted of 249 items measuring patient satisfaction and physical, social and emotional function.

Participant observation encompassed the entire study period and constitutes the study's third major data base, and the main source of data in this thesis. Recorded observations, resulting in almost 670 pages of single-spaced, typed field notes, were conducted on the four study wards for approximately eight hours per week for a period of 18 months, from September, 1974 to February, 1976. The observations were initiated about three months prior to the first administration of the Team Function Interview Schedule and concluded three months after the third and final Schedule was given.

b) Developing a secondary analysis

Developing a secondary analysis requires, first of all, that the analyst have confidence in the reliability and validity of the primary study data. Secondly, a thorough familiarity with the data is necessary, in order that one may come to see the world through the eyes

of the participants almost as if one had done the data collection oneself. Thirdly, since a secondary analysis examines a topic which was not the main focus of primary data collection, it must be determined that the data are rich enough for analysis of the particular topic chosen for secondary analysis.

i) Reliability and validity

Turning to the first issue, that of reliability and validity, the author has the deepest respect for the competence with which the primary investigators conducted the study. Furthermore, the use of triangulation in methodology greatly enhances confidence in the data. Not only are data enriched by multiple methodological approaches, but data obtained with one approach often offer a reliability check on data obtained by another method. For example, the investigators of the primary study conducted a check of this sort and reported:

> The field notes provide an external validity check on the participation in decision-making scores (survey instruments). Observation, as well as formal administrative organization indicate that most decisions regarding patient management are formed at team meetings. Therefore, occupations obtaining high index scores (on survey instruments) can be expected to show high meeting attendance and participation (in participant observation notes). The field notes contain systematic documentation of meeting attendance and discussion, and contact and participation of occupation members in decision-making structures can be extracted. Such measures provide a behavioural comparison to the self-report index scores.

> Meeting attendance was counted by occupation and a count of quoted and paraphrased statements was made. Any statement that was a response to a direct question was excluded. An approximation of average participation per attendance can be formed by dividing an occupation's total number of recorded statements by total attendance.
>
> We find that rankings of occupations by average participation and average index scores are identical and would produce correlations of 1.00 on most rank-order statistics. Moreover, corresponding intervals in the two rankings are almost proportional. If we assume the data to be an interval level of measurement, the two measures show a correlation of r = .994. The self report and behavioural measures form an almost exact linear function (Marshall et al.,1975).

A further check was provided on several occasions when two participant observers attended the same meetings. The correspondence in their recordings increases confidence in the reliability of the data (Browne,1977:25).

Yet another reliability check is available by comparing this thesis study with another secondary analysis, that done by Browne. As will be discussed in Chapter Three, he investigated a group of high-decision and low-decision meetings and analyzed the significance of the presence of representatives of the various categories of health professionals (Browne,1977:55). In Chapter Three of this thesis, I analyze the significance of the presence of various occupational groups for decisions regarding the management of problem patients; the findings are completely consistent with Browne's, despite the facts that a different sample of meetings was examined and

that the decision-making concerned problem patients rather than patients in general. Such congruence not only increases confidence in the original data but lends additional support to this thesis' findings and conclusions.

ii) Familiarity with the data

My familiarity with the primary study data rests, first of all, upon my involvement with the study. I joined the research team as soon as I was accepted into graduate school in May, 1975. I attended the weekly meetings of the research team from May, 1975 to February, 1976, that is, throughout the latter half of the period of data collection. After data collection was completed, I attended a number of other meetings with the research team members as their analysis proceeded.

I did 10 hours of participant observation in the study wards during the fall of 1975, along with the full-time observer. I thus acquired some first-hand familiarity with the people and the kinds of situations described in the field notes.

I have worked closely with the research team, particularly with Zoe Fortuna who did most of the participant observation. We have had innumerable conversations about the various wards. I have interviewed her, asked her questions, probed for more details, clarifications, confirmations, and opinions on or reactions to ideas that I formulated based on my readings of the data. Her help has been invaluable, as I have noted

elsewhere; however, in addition to inspiring my appreciation, her assistance has also, I believe, helped to ensure that this secondary analysis remains firmly grounded in an accurate interpretation of the primary data.

Although this thesis is based primarily on the participant observation data, I have familiarized myself with the survey data on patients and health team personnel.

To develop familiarity with the data, I began by dealing intensively with a six-month segment, approximately one-third of the field notes. My initial study of the data resulted in three papers. One concerned patterns of authority among health professionals; two wards were compared and extensive use was made of survey data as well as the field notes. A second paper was a case study of one ward and closely examined nurses' perceptions of patients, relating these to the implementation of the psychosocial programme. A third paper looked at the relationship between nurses and patients' families (Rosenthal et al, 1976). Along with growing familiarity with the data, came an increasing interest in the nurse/patient/family relationships and the certainty that the control perspective characterized the social world in question and thus would provide an appropriate and illuminating analytical tool. Both the overall topic of this thesis and the theoretical perspective arose from the data and became focussed in my mind after many readings of the field notes. This is the methodology

proposed by Glaser and Strauss (1967).

Reading through the data, I realized that nurses talked about control. When this became significant to me, I read through the notes again, alerting myself to references to control. It became clear that such references included a sense of loss of control attributed to the hospital, its policies and philosophy, a loss of control attributed to the patient who might be described as manipulative, for example, or as wanting to control treatment, or attributed to the family particularly if a family member was involved in the patient's care. There seemed to be a great deal of discussion among nurses about control, or, more accurately, about lack of control. The basic question which arose in my mind was precisely which patient or family situations were perceived by nurses as presenting problems of control and how did nurses respond to these problems? I was equally interested in the patient's perception and response to the same sorts of control problems.

Here, however, secondary analysis carried its own limitation. Most of the participant observation was done in health team meetings; some was conducted in the ward, but even here the patients were not well represented. What the field notes provide is a great deal of information about nurses' perceptions of patients and their treatment of and responses to patients. However,

nurse-patient interaction is rarely observed directly. Using the field notes, information on what patients actually do or feel must be inferred from what health professionals say about them. The patient interviews provide data which help fill in this information about the patient's perspective, and use is made of these data in Chapters Two and Five.

iii) Managing the data

A system of managing and coding participant observation data is essential; nothing is quite so frustrating as searching through hundreds of pages of field notes for a particular example which one remembers but cannot locate.

The system I developed for organizing and retrieving data involved recording items of interest from the field notes on 4" x 6" index cards. On each card I noted the page number and ward for the particular item. At the top right hand corner, the category (or categories) into which the item fell was noted. On the main body of the card, a brief description of the data item was noted, complete enough so that the item could be sufficiently brought to mind without having to consult the original field notes each time the item had to be examined.

In all, I developed a set of 230 cards, with one incident per card. The incident frequently suggested more than one category, and many cards had several categories.

noted at the top. This proved to be somewhat cumbersome; if I were to use this method again, I would cross-index cards in order that I might have a complete set of cards instantly available for each category instead of having to sort through them each time I wanted to look at another category.

Initially, I looked through the data for items concerning problem patients, information, and the family. The coding on problem patients was later refined to include the categories used in Chapter Two. Some examples were collected but not used, for example, patients who upset the nurses' composure and patients who lacked motivation to get well. Other categories for which data was collected but not used included dying patients and nurses' reactions, aged patients, nurses' feelings of inadequacy, and patients perceived by nurses as good patients. Coding was also done for examples of the institution being perceived as a constraint, conflict with doctors, the use of typologies and the patients' views of things.

As I began to write each data chapter, I transferred all relevant data onto a large master chart on which all the analytical dimensions were noted. This provided easy access to the data and aided the search for patterns.

IV Overview and conclusions of the thesis

In Chapter One, I have established the theoretical perspective used in the thesis, and have reviewed some of the relevant literature on hospitals and clients, especially professional-client relationships. The primary study from which this thesis' data is drawn was described, and the development of the secondary analysis was discussed. The system of data management was also described.

The following four chapters of the thesis are "data" chapters.

Chapter Two looks in detail at the nurse-patient relationship, investigating when the patient becomes a problem for nurses. First, nursing as an occupation and nurses' expectations and definitions of their jobs and patients' roles are discussed. The main thrust of the chapter is an exploration of the kinds of patients nurses perceive as problems. A total of 102 examples of problem patients were extracted from the participant observation data. These patients are analyzed by problem type, age, sex and diagnosis. Eight types of problem patients are identified: manipulative patients; demanding and complaining patients; patients who are violent, aggressive, confused or irrational; patients who complain more than the nurses feel is appropriate about pain; career patients, patients who are no longer ill

but are still in the hospital, and patients who were inappropriately admitted to the particular ward; patients who are not complying with treatment; patients who are unpleasant as people, and patients who are perceived as trying to control staff or treatment.

Sex appears to be a significant determinant of being perceived as a problem patient. Two and one-half times as many females as males are problems, whereas in the total patient population the sexes are equally represented. Females are especially predominant in the manipulative, demanding and complaining, and pain categories, while males predominate only in the violent and aggressive group. It is concluded that hospital patients manifest culturally-approved sex role behaviours and that staff respond to and reinforce these stereotypes.

Analysis of the age of problem patients leads to the conclusion that age is not a predictor of problem patients in these data. This is a noteworthy finding in that it differs from other studies which found younger patients more likely to be perceived as problems.

Type of illness appears to be a determinant of being perceived as a problem; three-quarters of the problem patients had what the staff defined as non-acute illnesses.

The final section of Chapter Two draws on the field notes and especially on the patient interview schedules

to determine the patient's view of the staff. The field notes suggest patients may want more information than they get and that lack of such information leads to anger, fear, unhappiness or apprehension. Patients may want more involvement in planning their own care. They may be unhappy if the nurses avoid them, a common tactic used by nurses with problem patients.

However, the patient questionnaire data place the above discussion in perspective. On the whole, patients were satisfied with their hospital experiences. More than three-quarters of the patients responded positively to open-ended questions probing satisfaction with nursing care. An index of patient satisfaction was constructed, and on a scale of two to 12, the scores ranged from 8.8 to 9.6, indicating high levels of patient satisfaction with nursing care.

Chapter Three examines in detail how nurses control patients and seek to regain control over problem patients. Dilemmas in authority are discussed; while nurses have considerable power and authority over patients, they themselves are subject to the authority of doctors, feel constrained by the institution in which they work, and are constrained by patients and families.

Techniques of control are discussed. These include loyalty to the team, a defensive measure which is

threatened when patients cause friction among nurses. Another technique is depersonalizing the patients by discussing and labelling them. Ironically, this use of patient typologies tends to neutralize organizational efforts to implement the "total patient" philosophy. The team acts as a support system for nurses, for example in instances where nurses' composure is threatened, but above all in practices of information control. Another control device is forming a management plan and "rehearsing" its aspects in team meetings.

Nurses' reactions to the problem patients identified in Chapter Two are analyzed for such responses as avoidance, anger, annoyance, discussion, complaining, forming a management plan and prescribing a psychosocial consultation.

The most common reaction to problem patients is to arrange for a psychosocial consultation. Almost twice as many problem patients received psychosocial consultations as patients in the total patient population; furthermore, as noted in Chapter Three, the number of patients receiving psychosocial consultations is probably under-reported in this thesis, and the actual number more than twice as many. It is clear that being perceived as a problem patient is very likely to lead to a psychosocial consultation for the patient.

In one-third of the problem patient cases, a management plan is formulated. In certain categories, the proportion is much higher than one-third. The management plan is viewed as a major control strategy.

A significant finding is that management plans are only formulated when a doctor or psychosocial consultant is in attendance at the meeting. When neither is present, nurses appear to respond to problem patients by complaining to each other. Complaining is a common reaction and occurred in half the problem patient discussions.

Most problem patients are discussed in psychosocial terms; this occurred 70% of the time. One may conclude that a problem patient is very likely to be the focus of psychosocial discussion by staff.

The patients' control strategies are discussed near the end of Chapter Three, utilizing data extracted from the field notes. Despite the unequal distribution of power, patients do appear to have a number of strategies at their disposal. They refuse treatment, impose their demands on staff, use their illnesses as "levers" to get what they want, enlist the help of their relatives, and communicate with and supply information to each other. Interestingly, staff appear to be aware of patients' potential legal power over them, although no actual instance of legal action was recorded throughout the entire study period.

Chapter Four examines the relationship between

nurses and families: does it present control problems for nurses, and, if it does, when and why? Categories of problems involving the family are established and nurses' strategies for maintaining and regaining control over family members are discussed, as are the relatives' counter-strategies.

The members of a patient's family pose a potential threat to nurses' control over their conditions of work, a threat which is heightened in the study hospital as a consequence of a policy of open visiting and an institutional commitment to family involvement in patient care. Analysis of 46 problem families discloses that nurses cast families into three roles -- visitor, worker and patient. Altercasting is seen as a basic technique of interpersonal control. The visitor role is the most common for the family, and probably the one preferred by nurses. When the relative begins to step out of the visitor role, a move which is often closely related to the amount of time a relative spends in the hospital setting, the nurses may cast the relative in a new role, that of worker. The worker role appears usually in conjunction with a secondary patient role. When the worker role begins to break down, the incipient patient role is imputed openly, endowing the problem relative with the status of problem patient. The staff then work out a management plan to control the relative, much as they do with problem patients. In this study, nurses appear to

prefer casting the relative in the patient rather than the worker role. The latter is only imputed to relatives who initiate a problem situation and even then the worker role has strong patient role overtones.

Chapter Five of the thesis focusses on a pivotal control issue: information, its control by staff, and its seeking by clients. Theoretical issues and previous research are described. Participant observation data are then utilized to determine the staff's view of and actions concerning information in this hospital. Areas investigated include nurses' perceptions of information withholding, nurses' conflict with physicians on this subject, nurses' roles in the information struggle, their perceptions of problems in controlling information, decision-making concerning information control, the role of the family in the information struggle, professional rationales in information control, and patients' views on information. For the last topic, data from the patient interviews are utilized.

Information withholding is a profound control strategy and one which this study indicates is taken for granted by the health professionals in this hospital. It is as commonly practiced here as elsewhere. The rules governing information are informal and vary from physician to physician. Generally, physicians use a rationale of uncertainty to justify the control over the amount and nature of information given to patients and families.

Much team effort goes into keeping "stories" to families and patients "straight" and into keeping each other informed about what the patient or family knows. Even with the team structure in this hospital, physicians retain the decision-making prerogative over information. Nurses may disagree with doctors' decisions, but they are expected to carry out these decisions regarding information, and they appear to do so. Although they complain in private about information-withholding practices, nurses do not confront physicians with these criticisms. The explanatory principle offered in this thesis is that nurses' negative feelings regarding withholding information stem from the fact that such practices interfere with nurses' ability to do their jobs. Their behaviour around patients becomes subject to increased strain as they conceal information and guard against slips. At the same time, the anxiety and uncertainty of a patient who can only guess at the truth places an additional strain on the nurse. Thus, the practice of withholding information interferes with the nurses' work and is considered a problem by them. A further finding is that the family appears to have a higher level of information than the patient, a finding that is in accord with other studies.

The patient survey data indicate a surprisingly high degree of patient satisfaction with information received. On a scale of 1 to 9, scores ranged from .97 (highest satisfaction) to 3.4 (lowest satisfaction). These scores indicate that patients are quite satisfied with the information received.

As outlined above, the field notes indicate widespread and taken-for-granted withholding of information from patients. In this context, the high patient satisfaction is surprising. One possible explanation is that patients are socialized to expect little information and are satisfied with what little they get. It is also possible that patients who seek information actively may have less difficulty getting it than in traditional hospitals; patients on the programme wards improved over time in satisfaction with information while patients on control wards did not, indicating that the psychosocial programme liberalized information practices to some extent. The field notes do not provide an answer to this seeming contradiction of staff control over information and patient satisfaction with the situation. Perhaps there is no simple answer. As McIntosh suggests in discussing his research on information given to cancer patients (McIntosh, 1977:191-203), the issuesof how much information to give and who wants it and how badly are complex; the best solution he is able to offer is that patients who appear

to want to know the truth should be told, but that full information should not be given routinely to all patients. He also points out that patients' satisfaction with information may be perceived differently after discharge. That is, the patients in this study may have expressed higher satisfaction post-discharge, with the anxiety of hospitalization safely behind them. Both McIntosh's work and the present study indicate that, while a great deal has been written about practices of information control, much remains to be learned about the patient's views and reactions to these practices.

Following Chapter Five, a brief discussion of some of the overall implications of the thesis will be given.

The thesis emphasizes problems and struggle, and herein lies a danger that the picture may be overdrawn and the reader may come to perceive staff as unfeeling wielders of power over helpless patients. Certainly, one cannot help but sympathize with the hospital patient who must cope not only with relative helplessness but pain, anxiety, fear and uncertainty. At the same time, one has to sympathize with the nurse who faces a succession of patients with different needs, some creating bizarre and difficult problems, others threatentng to upset the nurse's delicate hold on his/her professional detachment. Duties must be carried out within an organizational and authority structure which limits nurses' autonomy and

professional mobility. Being a nurse is not easy, nor is being a patient. The real wonder is not that problems arise in the relationship, but in the great majority of cases the relationship is relatively unproblematic. To a great extent, each party must be reasonably satisfied with the negotiated order they create and must feel in reasonable control of his/her conditions. Analysis of problem situations reveals much about how order is successfully negotiated in non-problematic situations.

I turn now to the body of the thesis.

FOOTNOTES

1 These studies are cited here with the intention of being suggestive more than decisive, for the question remains as to whether bureaucratization must inevitably have this effect on client orientation. Individuals can and do adapt very differently, and therefore negative reactions need not necessarily always occur.

2 The project was funded by Ontario Ministry of Health Grants no. DM196 and PR402. The primary study investigators, all of McMaster University, were A.S. Macpherson, principal investigator, Susan E. French and Victor W. Marshall, co-principal investigators. Tom Garrison was the research associate and Zoe Fortuna the research assistant. Ms. Fortuna did the vast majority of the participant observation while Mr. Garrison compiled the survey data.

3 Some departments in the building opened in 1971. The building's official opening, however, was in May, 1972. It was at about this time that patients began to be admitted to the hospital facilities.

4 Throughout this thesis, I refer to the "psychosocial consultant." This term implies a person who is either a psychiatric nurse or a psychiatric consultant. The latter may be either a psychiatrist or a psychiatric resident, that is, a doctor currently taking specialist training in psychiatry.

CHAPTER TWO

THE PATIENT AS A PROBLEM FOR NURSES

This chapter deals with ways in which patients are problems for nurses. The theoretical background against which the nurse-patient relationship should be viewed was presented in Chapter One, especially in the section containing an overview of professional-client relationships in hospitals.

Patients are not solely problems for nurses; they are an important focus of the nurse's job and the object of the nurse's hopes and efforts, as well as frustrations. Part I of this chapter investigates what nurses expect from patients and from themselves. A brief description is given of nursing as a job, including socialization in the training and work settings and the different role conceptions.

In section II, I examine the types of patients who were perceived as management problems in this study and consider the role played by age, sex and type of illness.

Part III is concerned with the patient's view of the staff and of the hospitalization experience.

I Nurses and patients: the nurse's view

In Chapter One, I described the nurse-patient relationship in terms of its tensions, problems and the struggle for control. While I believe the control perspective accurately describes the day-to-day reality of human interaction in the hospital, there is another layer of reality,

an understanding and recognition of which must be kept in mind if the discussion is to accurately reflect the relationship between nurses and patients.

First and foremost, nurses deal with sick people; regardless of the intricate paths into which discussion and analysis might lead, one must not lose sight of the fact that nurses personally want to alleviate suffering and participate in the process of caring for or curing the sick. Furthermore, nurses' training and philosophy urge them to treat each patient as an individual rather than a "case."

The literature of medical sociology concentrates on such subjects as the social structure of the hospital, the sick role, institutionalization and identity, and the like; these are legitimate areas of sociological study. Pain and suffering are not the prime interest of the sociologist. However, many medical sociology studies read as if pain and suffering were irrelevant or even nonexistent. One is often left without any sense of the human suffering that hospital patients undergo and that health personnel strive to alleviate. Underlying the patterns of behaviour with which patients and staff cope with their situations, and which are a proper area of sociological interest, is this bedrock reality of the most basic problems of pain, suffering, death and grief. Waitzkin and Waterman (1974:30-31) make this criticism with reference to Freidson's work, arguing that he neglects the emotional and experiential quality of illness

for both patients and medical personnel. Similarly, viewing illness as social deviance is illuminating in many ways, but must not be allowed to obscure the fundamental fact that illness is not only deviance, not simply a social category. Waitzkin and Waterman point out the need for the researcher to grasp the potential, in the illness situation, for "suffering, conflict, helplessness and potential exploitation" (Waitzkin and Waterman,1974:31).

I wish to establish this dramatic, rather than detached, framework as a general backdrop against which to view the nursing profession and the nurse's day-to-day job. I have stated that nurses want to care for patients and to treat them as people. While these goals are quite straightforward, their realization is not. How these goals are to be achieved, what the priorities should be, and what is the nurse's proper role are issues of conflict and ambiguity within nursing itself. In order to better understand nurses' responses to patients, it is necessary to gain some insight into how nurses define their roles with regard to patients. What are their expectations and conflicts?

All occupations are in a state of change; nursing, however, seems rather extreme in this regard. There is a drive for professionalization within nursing; this is particularly evident in university-based schools which emphasize the professional role of the nurse. The hospital

work setting is thought to have a more bureaucratic orientation than the university-trained nursing student is led to expect, creating conflict and confusion for the nurse (Kramer,1974). Whereas in school the student learns that the patient is the primary focus of nursing work, job experience leads to a view that the main goal of the nurse is to foster the work of the organization. Talking and listening to patients and giving them emotional support is given high priority in professional training but low priority in the job setting (For discussions of the varying and conflicting conceptions of the nurse's role, see also Corwin, 1965:345; Corwin and Taves, 1963:190; Coser, 1962; Johnson and Martin, 1965; Skipper, 1965a).

Another major orientation or framework for action is the humanitarian or service conception of nursing. Since most nurses hold definitions of nursing which combine elements of all three conceptions -- professional, bureaucratic and humanitarian -- and since these conceptions may involve conflicting demands, it follows that nurses may hold unclear or incompatible expectations of their jobs as nurses and their roles vis-a-vis patients.

One ambiguous area in nursing is the appropriate extent of emotional involvement for nurses with patients and families. This ambiguity is found in nursing school as well as in job settings; students are taught to be cheerful,

to reassure the patient, and to care for the whole patient, but at the same time they develop a definition of professional behaviour which includes dignity, defence, and distance (Mauksch,1965).

Nurses hold the philosophy that each patient should be treated as a person and not an object. Recently, nursing schools have stressed the importance of viewing the patient as a whole person involved in and dependent upon a network of emotional and social support systems. What happens to this total patient philosophy in practice? The nurses in Coser's study emphasized the training-school idea of the "patient as a person, not just a disease" (Coser, 1962). However, Coser concluded that this ideal was more a slogan than a norm and tended to give way to the more pressing business of maintaining order in the ward. The "total patient" was a symbol but the individual patient appeared to the nurse more as an object to be disciplined, a case to be managed.

Quint made similar findings.

> ...generalized sets of actions for all patients are commonly observed in spite of the frequently repeated remark, "Every patient must be treated as an individual" (Quint,1965).

The hospital in this study has an institutional commitment to the total patient concept (Bihldorff,1975; Cleghorn, 1974; Rosenthal et al.,1976). Therefore, the fate of the

total patient concept for nurses in this study will be especially interesting.

From the literature on nursing, one may conclude that nurses do hold a service ideal. They wish to give supportive physical and emotional care to their patients and to treat these patients as individuals and whole persons. However, it is also apparent that because of the ambiguous definition of the nurse's role, and the incompatible expectations contained within this definition, these initial goals of the nurse may be frustrated or diverted.

II a) The patient as a problem for nurses

Ideally, from the nurse's perspective, all patients should be sick when they enter the hospital, should follow eagerly and exactly the therapeutic program set up by staff, should be pleasant, uncomplaining, fit into the hospital routine, and should leave the hospital "cured. handle their illnesses well, are co-operative, as cheerful as possible, comply with treatment, provide the staff with all the relevant information, follow the rules, do not disrupt the ward, demand special privileges or excessive attention. Staff do not want patients to be so undemanding or uncomplaining that they do harm to themselves, nor do they want patients to suffer unnecessary pain; complaints in this are are viewed as legitimate and not as problems.

In a study of problem patients in one hospital (Lorber, 1975), the staff labelled "good" patients those who caused no trouble for staff and who did not interrupt the smoothness of medical routines. "Average" patients were those whose complaints were seen as medically warranted and who did not take more time than staff would expect in such cases. Problem patients were of two kinds, "forgivable" and "willful." Patients of the first type needed a lot of time and reassurance from staff, were anxious and complained a great deal. These were seriously ill patients and their problems were viewed as not their fault. They received the attention they demanded, especially if they were grateful to staff. Patients of the willful type were not seriously ill from the staff's point of view, but acted as if they were. They complained, were emotional and unco-operative, and were considered willfully troublesome.

Few, if any patients approach the simplistic ideal described at the beginning of this section. Patients do, in fact, pose many problems for nurses. While some patients who deviate from the ideal are non-problematic in the nurse's view, others are perceived as problems. I will turn now to a consideration of this phenomenon.

In order to examine the types of patients nurses perceive as problems, I have extracted from the participant observation data 102 examples of "problem patients" who were discussed at team meetings (see Table 2:1). These are

TABLE 2:1
PROBLEM PATIENTS BY AGE, SEX AND DIAGNOSIS

Patient type	n	Sex m	Sex f	Typical age	Diagnosis	Nurses' reactions
Manipulative	12	1	11	All under 60. No aged.	Only one had serious illness (cancer). Others had less severe problems (foot ulcer, arthritis) or non-physical (social or emotional) reasons for being in hospital.	Annoyance, anger, avoidance of patient.
Demanding, complaining	9	1	8	Half over 60; one-third over 65.	Half had serious illness.	Avoidance.
Violent, aggressive	13	4	1	Almost half over 65; one-third over 70.	(not codable)	Frustration, anger, avoidance, treat like child.
Confused, irrational		4	4			
Pain	17	2	15	Three-quarters under 60; one-quarter over 65.	(not codable)	Avoidance, psychiatric consult, send to pain clinic. Medication, even though pain non-organic in origin.
Career	21	4	17	True career patients are relatively young - 50s and under.	Diabetes, asthma, pain with no organic cause.	Anger, feel "had" by patient, avoidance. Justify avoidance by suggesting these patients encouraged by receiving attention.
Not compliant	11	4	7	Middle aged to old.	Eight had chronic illness.	(not codable)
Unpleasant	10	4	6	(not codable)	Half had chronic illness.	Callous. Use typologies to label.
Try to control staff or treatment	9	4	5	No aged. One patient 66, others under 65.	Half had chronic illness.	Avoidance common. Make management plan. Psychosocial consult.
TOTAL	102	28	74			

patients whose behaviour or actions are viewed as non-legitimate in some way. They belong in Lorber's "willful" category. I do not include here patients who are considered medical problems in that they are not getting well or responding physically to treatment as well as staff would hope, or whose unpleasant behaviour, moods or reactions may be viewed as legitimate. For example, a patient may be understandably annoyed because a meal never arrived. I do refer to patients who display what the staff feel are non-legitimate behaviours. Such patients create "management" problems for the nursing staff and are perceived by them as difficult or as problems.

I wish to stress once again that the following discussion should not be construed as being totally a matter of the nurses' interpretation or construction of reality. Some kinds of management problems are firmly rooted in physical or concrete reality; a patient who punches a nurse in the stomach is this type of problem. In other cases, however, the definition of a particular kind of behaviour as a problem is more linked to the particular demands of the nurse's job.

What kind of patients do nurses perceive as problems? Some patients are described as manipulative; others are said to be demanding or to complain excessively. Some patients are physically abusive, aggressive or violent, while others

behave in a way that, while not dangerous to staff, is considered bizarre. Some patients do not comply with the treatment program. Nurses react to patients as people and describe some of their patients as being generally unpleasant. Another problem category relates to pain, pain management and medication. Finally, in many cases, the fact of hospitalization itself is considered non-legitimate, either because patients are thought to be "career patients" who seek out hospitalization for its own sake, patients who enjoy hospitalization, patients who are not really sick or patients who have fully recovered and therefore have no reason to be in the hospital. Some patients are problems because they are considered to be inappropriate patients for the particular ward to which they were admitted. For example, psychiatric patients -- or patients the nurses consider to be psychiatric patients -- are not always admitted to the psychiatric ward but may become patients on a medical ward.

i) Manipulative patients

The term "manipulative" is used twelve times in the field notes during discussions of patients. The word covers a range of meanings -- causing friction among staff members by turning them against one another or playing one against the other, trying to control the situation, being a disruptive or difficult patient, using pain as a device to

make others give in and being in the hospital when not really sick.

> A 30-year old female patient is described by a nurse as "very manipulative...a disruptive force on the ward (213).*

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> A female patient with multiple sclerosis is described by a supervisory nurse as a social problem. The social worker asks, "You mean she has a social problem?" The nurse replies, "No is a social problem. She's manipulative" (375).

\- - -

> A nurse, referring to a patient who is frequently admitted to hospital complaining of nausea and vomiting, says, "There's nothing the matter with her...people like that are manipulating us, they use us and use us..." (31).

\- - -

> A nurse describes a patient who has had a severe spinal problem all her life and is in hospital because of new difficulty with walking as "spoiled, demanding and manipulative." The patient is said to always look "depressed and unhappy" (47).

\- - -

> During a discussion of a female patient who suffers from pain for which doctors can find no organic cause and who is viewed as a career patient, a nurse says, "We're being taken by some of these patients -- all they're doing is manipulating us...some of them come in for a clean bed and food, they are in for a while, you let them out and they're back again " (31).

\- - -

Patients who manipulate staff by causing friction between team members are perceived as threats and problems.

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* The numbers in parentheses indicate page references in field notes. Quotation marks indicate verbatim quotations from staff.

One ward was having a problem with nurses' morale. Discussing this, a supervisory nurse offered the following opinion:

> "...we are undermining each other and it's bad for morale. A nurse who has had a patient for a long while...will tell another nurse she isn't doing something right...we let it happen because we let the patients manipulate us...we just blossom all over them when they tell us how good we are" (245).

In another example...

> The resident suggests the family doctor be informed of the management plan the team has decided upon to prevent the patient's daughter from "manipulating the situation and playing one against the other" (93).

The word "manipulative" appears to be used by staff to cover several different types of problems which are troublesome to them. It encompasses several meanings and is an inexact or imprecise term of description. It is significant that the word, despite its psychological ring, is never used by psychosocial consultants or social workers, suggesting that it is a term in a non-professional vocabulary.

ii) Demanding and complaining patients

When patients make more demands than the staff perceive as reasonable or acceptable, they may be labelled "demanding."

> One patient was described by the supervisory nurse as yelling and swearing at the nurses, calling them names, and being "very demanding." The patient had insisted on being transferred to a private room and demanded a private nurse (301).

- - -

> Another patient, whose son is a chiropractor, is in hospital with back pain. A supervisory nurse says, "She is driving the staff nuts with her demands" (42).
>
> - - -
>
> A patient is described as being difficult, demanding and complaining, and one who complains constantly about her illness and pains (37).
>
> - - -
>
> A male patient is described by the nurse as "demanding, complaining and unco-operative...he doesn't like us, period." This patient threatened to go to the nurses' supervisor and to write letters to the administration (62).

Of the nine patients called demanding, four had connections with the medical world. Two were former nurses, one a medical student, and one the mother of a chiropractor. Two other former nurses were problem patients, one complaining of pain and one a career patient.

iii) Violent, aggressive, confused and irrational patients

The patients in this category have been grouped together for analysis as they share either an abusive or irrational quality. These two qualities are often, although not always, combined. If the patient is rational, he/she has abandoned all pretence of civility toward the nurse. It is this complete departure from everyday rules of civility that characterizes the different patient types in this category. In this section, however, the different types will be discussed separately in order that their other characteristics be clearly conveyed.

Confused and irrational patients

Irrationality and confusion are fairly common in hospitalized patients, and create management problems for nurses. Nurses often complain that patients seem to understand everything they are told and yet the next day they don't remember a thing. The head nurse of one ward commented to the observer that the regular weekly meeting she held with patients was cancelled for that week because she only had three patients on the ward at the moment who were rational (262). Many hospitalized patients are elderly and with these patients senility may produce bizarre behaviour, creating management problems for nurses.

> An 83-year old female is described by a nurse: "She gets up in the middle of the night, walks around nude and gets into other peoples' beds" (87).

Another patient is described as being "out of it" and is said to have drunk his own urine (87).

Aggressive and violent patients

Another type of management problem is the patient who is physically aggressive or violent. The following examples dramatically illustrate the problems for the nurse, and portray a side of the nurse's job far removed from the images of the crisp professional or the ministering angel.

> In trying to "manage" a 21-year old epileptic, the nurse told the patient, "Stop that now, you're acting like a child." In response, the patient became violent, hit the nurse across the face, and punched her in the stomach (214).

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> The head nurse refers to an elderly patient as a "difficult management problem...the nurses who have worked with him find him to be abrasive, nasty and impossible to look after...I believe he's very depressed, he's not taking his drugs and he won't eat." One of the nurses involved, when asked by the psychosocial consultant whether anyone had tried an "empathic" approach with the patient, said, "I did, I asked him why he was angry and he just yelled at me, and that's when he threw a full urinal at me..." (394).

As the above example suggests, patients may also be verbally aggressive and abusive toward nurses.

iv) Patients who complain of pain

Since pain is a feature of most patients' experiences, it is not surprising that the second largest category of patient management problems should refer to pain. Since the presence of pain is such a common experience for both nurse and patient, it is not often perceived as a problem. A certain amount of pain is expected and considered normal. Medications are prescribed to make the patient as comfortable as possible. However, there are times when, despite medication, the staff cannot provide comfort for the patient and pain comes to be viewed as a problem. Patients are, furthermore, expected to be able to bear a certain amount of pain without complaining. Patients who complain beyond what is considered appropriate are considered problems. The patients who create great problems for nurses are those who complain of pain for which no organic cause can be determined. Running through the field notes is a theme related to pain management: there is an operative norm

that medication should not be prescribed unnecessarily and that patients should be on the smallest workable dose of medication. In other words, there seems to be a general inclination, on the part of physicians at any rate, toward questioning whether medication is necessary and toward weaning patients off medication where it is thought to be of purely psychological or dependency value.

> A female patient with renal disease has been complaining of constant right flank pain. The doctor says he thinks the patient will have the pain permanently. The patient has been receiving medication, but the doctor says to the head nurse, "We must get her off that. She strikes me as a really dependent person and I don't want to have her on that unless it's really necessary" (80).

Some patients complain of pain for which no organic cause can be found. These patients are discussed frequently at team meetings because dealing with them presents special problems for staff. One problem concerns what to tell the patient about the pain. The accepted solution or "official line" seems to be to tell the patient that the doctors have not been able to find a physical cause for the pain but that they will give medication to relieve it. Discussions among staff usually extend well beyond this, however, and may include the implication that the patient "needs" the pain for some reason. Of the 17 problem patients in the pain category, 13 cases concerned patients whose pain could not be explained organically and who were

in hospital solely for pain management.

> About one such patient, a supervisory nurse says, "I think she overdramatizes her pain" (104).
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> - - -
>
> Another patient is discussed by the resident: "It's hard to tell if her pain is organic...She's well known about the city. She's been to many psychiatrists and hasn't been satisfied with them" (83).

In 10 of the examples, patients are said to be complaining about pain in the sense that doctors have not been able to medicate the patient to a point of relative comfort. In seven cases, there is speculation that the patient likes the medication more than is acceptable.

> A nurse says about a male patient's attitude toward his medication, "He loves it, he drinks it three times a day" (96).

Many of the references to pain per se are made by physicians. It is the nurses, however, who must develop strategies for handling these patients. Such strategies will be discussed in Chapter Three.

v) Career patients, patients who do not belong in hospital and inappropriate admissions

The largest category of patients perceived as problems is "career" patients, patients who do not properly belong in hospital either because they are not really sick or because they have recovered but for one reason or another have not been discharged, and patients whose chief complaint signifies that they do not belong on the ward to which they

have been admitted. Of the 21 examples in this category, 10 were true career patients in that they were considered to be people who made a career of being sick and seeking hospitalization. Five patients were thought not to belong in hospital, and six were inappropriate admissions, usually because of psychiatric problems.

This is, of course, a legitimate area of concern for nurses and health professionals. They are expected by others and by themselves to perform a gatekeeper function, regulating access to the sick role and the patient role. Physicians are responsible for "certifying" illness, and the health team concept allows and encourages other team members to provide information to assist in this certification. Furthermore, the primary study on which this thesis is based took place over a period of time during which there was much public and government discussion of the spiralling cost of health care services and during which the average length of stay in the study hospital was reduced from 16 days to 10.9 days (Marshall et al.,1976). Nurses often mention the cost of providing services to patients who do not really need them, thus legitimating their annoyance with these patients.

> Regarding one patient, a nurse says that the patient and her husband are "a middle-aged couple who relish being sick. The less attention given her the better" (119).

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> Another female, an asthma patient, is a frequent admission. This patient, according to the recommendation of the psychiatrist and social worker, was to be treated on an outpatient basis only, but the patient got herself readmitted. The social worker says, "The only time she gets attention and recognition from her husband is when she's admitted to hospital... she's playing her game again." (221)

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> Referring to a patient who had just been discharged, a nurse says to the team, "Have you bought your lottery ticket yet?" When asked what she meant, the nurse replied, "Well, you name the correct time and date for his (the patient's) return and you win all the money in the pot." (312)

Some patients are said to enjoy being in the hospital and to try to stay there.

> The supervisory nurse says about a patient, This guy is a fake..." and that when it's time for the patient to go home "He develops all kinds of illnesses."(221)

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> An elderly female patient has been in hospital a long time. One problem is that the family can't care for her at home, yet feel guilty about having her placed in a nursing home. As for the patient herself, a nurse says, "She's playing games with us. She doesn't want to leave." Another nurse adds, "She loves it here."(133)

The family may be viewed as the reason a patient is in hospital unecessarily.

> A nurse asks, at a meeting, why a particular patient is in hospital, and says, "Didn't her husband go on a trip and he dropped her here before he left?" No one had any more information on the patient. (209)

Nurses sometimes explain why a patient is admitted to hospital or kept longer than necessary in terms of the admitting doctor being pressured by a referring physician,

family member or the patient, or having a propensity for keeping patients in hospital for an unduly long time.

Some patients have psychiatric components to their illness and were described above as management problems because of their violent or bizarre behaviour. For other patients, the psychiatric complaint is the only reason the patient is in hospital. Such patients are considered by nurses to be inappropriately admitted to medical wards.

vi) Patients who are not compliant with staff or treatment

Patients who do not comply with treatment present problems for nurses whose job it is to see that the physicians' orders are carried out.

> A female diabetic patient was on a water deprivation test. It was suspected that the patient was not following orders and was sneaking out of her room to get drinks of water. The doctor instructed the nurse in charge to tape the patient's door shut so they would know for sure whether or not she was leaving her room. The nurse said, "I was really embarrassed having to do something like that to a patient, but I guess she didn't leave us any choice." This action resulted in the patient complaining to the head nurse and to the physician who was in charge of the unit. (430).

As the above example suggests, diabetics appear frequently in this category. One diabetic is said to lie about what she eats (279-2) and another is described as not taking care of himself well (70). A nurse says about another diabetic that he is not taking his drugs and won't

eat (394).

Non-compliance becomes a problem in chronic disease patients such as diabetics when patients must assume responsibility for some of their own care. Ignoring prescribed medication and diet regulations are common. Another kind of non-compliance is refusing tests the staff wants the patient to have.

> A nurse says that a patient's daughter told the patient that "she did not have to have her legs scanned so she is not going to have it done." (160)

Seriously ill patients may refuse treatment.

> Doctors have discovered that a patient who has had cancer of the lung for four years now has cancer of the vocal cords. The doctor says, "He is refusing to have anything done about it." (170)

vii) Patients who are unpleasant as people

Many patients are unpleasant as people, and nurses react to this. Such patients are referred to by nurses as being "abrasive," "nasty," "mean," "childish," "bitchy," "obnoxious," "sulking," "weird," "antagonistic," "nuts," and "a pain in the neck." Psychiatric terms such as "schizo" or "paranoid" are also loosely employed.

viii) Patients who try to control staff or treatment

Staff do not approve of patients who are perceived as trying to control their treatment or the staff.

> The head nurse says about a female patient, "Whenever she's geared for discharge she has an attack. It's as if she's controlling us and that makes me angry." (94)

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> Another patient is said by the doctor to be a person who abuses analgesics. A nurse asks, "Isn't he the type of person who likes to dictate his own treatment?" (275)
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>
> Another patient had been demanding her medication before the scheduled hour. When the nurse refused, the patient was verbally abusive and screamed at her. The supervisory nurse said about the patient, "She is used to controlling things." (356)
>
> - - -
>
> A patient admitted to hospital with intractable pain is said to be "controlling her treatments." The occupational therapist says, "All of us are feeding into this." (308)

b) Correlates of problem patient type

As Table 2:1 indicates, the characteristics associated with these problem patient categories are not random but assume a pattern on analysis. The role played by sex, age, and type of illness will now be examined.

i) Sex

Of the 102 patients perceived as problems, 74 are female and 28 are male; that is, about two and one-half times as many females as males are problems for nurses. Females in the patient study population as a whole comprised only 52%, compared with 72.5% of the problem patient group. It is clear that females are far more likely than males to be perceived as problem patients.

Looking at sex differences in the individual problem categories, no significant differences appear in the

categories of non-physical aggression or trying to control staff or treatment. In the non-compliant and unpleasant categories females predominate slightly. Differences are quite startling, however, in the other categories. Of the patients called manipulative, 11 out of 12 are female. Eight of the nine patients considered demanding and complaining are female. Females are far more likely than males to be problems in the pain category; 15 out of 17 patients in this group are female. Of the 10 true career patients, nine are female. Only in one category, the violent and physically aggressive group, do males outnumber females. It would appear, according to these data, that hospital patients manifest culturally-approved sex role behaviours, and that staff respond to and reinforce these stereotypes.

ii) Age

Data on age are available for 62 patients of the 102 in the study sample of problem patients (see Table 2:2). Of these, 18 or 29% are over 65. The over 65 group is slightly over-represented in the problem patient group since only 21.5% of the total patient study population is over 65. The mean age of the patient study population ranged from 43 to 54 years, depending on the time period; for the problem patient group, the mean age was 54.5 and the median age 55. Age does not appear to be a significant determinant of problem patients when all categories are taken together. Looking at the categories individually, older patients are slightly over-represented in the

TABLE 2:2
PROBLEM PATIENTS BY AGE

Patient type	Man.	D.&C.	Agg.	Pain	Car.	Non-comp.	Unpl.	*Control	Tot-als
Mean	43	51.7	52	54	60	61	-	50	54.5
Median	55	59	61	54	54	59	-	51.5	55
Typical age	50s	50s 60s	50s to 80s	50s	40s, early 50s	older,* late 50s, 70s, 80s		50s, 60s	
n in category	7	8	12	9	11	7	2	6	62

*No statements made on ages of this group due to insufficient data.

demanding and complaining, aggressive and non-compliant groups, and younger patients slightly over-represented in the group of patients who try to control treatment or staff. However, these differences are very small; from these data, one is led to conclude that age is not a predictor of problem patients. The finding in this study that age does not seem to be significant is unlike Lorber's findings that younger and better educated patients were more likely to cause trouble (Lorber, 1975), and also different from Skipper's research which found age to be a predictor of patients' attitudes, with those over 45 more likely to see themselves as having obligations toward doctors and nurses (Skipper, 1964).

iii) Type of illness

In these data, most problem patients are not seriously or critically ill from the staff's point of view. Of the 88 patients for whom diagnoses are included in the field notes, 62 have non-acute illnesses or conditions. Physical illnesses tend to be of the chronic type (arthritis, diabetes), uncertain origin and therefore suspected of having psychological components (asthma), or having no physical cause whatsoever. These patients cause trouble and take time and attention which the staff does not perceive as medically warranted. Lorber, too, found this type of patient perceived as a problem by staff.

> Patients who are not seriously ill in the staff's eyes, but who nevertheless act as if they are by complaining, crying, and refusing to co-operate with medical routines, are the most soundly condemned by staff (Lorber, 1975:224).

With three-quarters of the problem patients having non-acute conditions, the conclusion may clearly be drawn that type of illness is a determinant of being a problem patient.

What are the consequences of being perceived by staff as a problem patient? A significant set of correlates are listed in the "Nurses' Reactions" column of Table 2:1. Nurses feel angry and annoyed with such patients, and try to limit their interaction with these patients to the simple completion of tasks. This subject is of great importance and will be explored more fully in Chapter Three.

Before moving on to the next chapter, however, I wish to consider ways in which the staff is perceived as a problem by patients.

III The patient's view: the staff as a problem for patients

The field notes provide one source of information on how staff present problems for patients. Since most of the field notes record the proceedings of health team meetings, most of the examples consist of what staff say about how patients are feeling.

Patients may feel staff is not providing enough information.

> A patient is described as unhappy because he was not told what was going on. (27)
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> - - -
>
> Another patient is said to be afraid she has cancer and to feel the staff is concealing this from her. (80)
>
> - - -
>
> A nurse says a patient is"apprehensive because the doctors aren't telling him what's happening to him. He doesn't know what's going on." (99)

On the other hand, a patient may have been given information that leads him/her to perceive the nurses as unsympathetic.

> A nurse reports that a particular female patient had been told by a resident that she "needed her pain because if she didn't have that she'd have nothing because her life was empty without it... now she's very hostile to us." (283-2)

A patient may feel that he/she has been left out of the management planning for his/her case.

> A male patient is said to be upset because he wasn't asked to participate in a conference regarding his case. (41)

As has been pointed out above, nurses often employ avoidance tactics with difficult patients. Patients may interpret such tactics as evidence of lack of nurses' concern for them. Ironically, in the following example, the avoidance was actually part of the patient management plan.

> The nurses have been avoiding conversation with a female patient who complained all the time about her pain. One nurse said, "I was feeling guilty because I wasn't talking to (the patient) whenever I went into her room. We were told not to discuss her pain with her, but there was nothing else to say to her. One day, I went into her room and asked her how she was...(the patient) told me that I was the first person who asked how she was. She went on to say that none of the doctors or nurses really cared about her." (31)

On the other hand, nurses may be overly enthusiastic about talking to a patient.

> On one ward, nurses were very conscientious about trying to help a dying patient talk openly about her oncoming death. The social worker said that a lot of the nursing staff were going in and talking to the patient to get her to talk about her feelings and that this proved to be very trying for the patient. (188)

The patient follow-up questionnaire provides further data on how patients perceive staff.

The responses to several open-ended questions asked of patients post-discharge suggest a high degree of patient satisfaction with nursing care. Patients were asked, for example, "How would you describe the way they (the nurses) looked after you?" and "Were there any times when you felt the nurses could have done more for you?" Over the three survey periods, only 20, 12 and 11 per cent of patients replied affirmatively (that is, indicating negative feelings) to the latter question. Their replies ranged from specifically medical complaints to highly general responses. Examples of medical complaints include:

> I had to wait for pain pill; I didn't know I had to ask for pills; not much bedside care; I requested additional support for my back but never got it; they took too many blood samples; they didn't change my dressing; they did a lousy job of bandaging; wouldn't bandage my eye: wouldn't treat cuts on my feet; wouldn't call a doctor when I needed blood transfusion.

Some of the general responses include:

> A nurse should be a woman, not mean, snobbish, and snooty; could have brought things when I asked; could have treated me more courteously; could take more interest; could have been nicer when I asked for a bedpan.

These complaints, however, comprised a small portion of the total responses. Patients were quite generous in their praise of nurses, with more than three-quarters of patients in any study period making comments such as:

> Nurses were first-rate; nurses did anything you needed for you; nurses were there when you wanted them; nurses showed concern.

Taking all the questions which tapped patient satisfaction with nursing care together, both closed-ended and open-ended, the negative responses comprise from 4.8% to 13.9% of the total responses, depending on the particular question.

Based on responses to four closed-ended questions, an index of patient satisfaction with nursing care was compiled. The scores here were high. On a scale of two to 12, with the higher scores indicating greater satisfaction, 8.8 was the lowest and 9.6 the highest score. All the scores were in the upper range, indicating high patient satisfaction with nursing care.

In summary, there are ways in which staff presents problems for patients which are indicated in the field notes in the reports by staff to other team members. It seems reasonable to assume that direct observation of patient-staff interaction would reveal many additional examples.

However, this must be viewed in an overall context of high levels of general patient satisfaction with nursing care as perceived by the patients in the primary study.

Having described the ways in which nurses and patients may perceive each other as problems, I turn now to a consideration of the ways in which each seeks to maintain control over the other.

CHAPTER THREE

CONTROLLING PATIENTS: MAINTAINING THE SICK ROLE

I Introduction

The preceding chapter outlined the kinds of patients who were considered "problems" by nurses. This chapter will discuss questions such as: How do nurses establish control over patients? How do nurses establish control over problem patients? How is the authority of nurses over patients realized? How do nurses enforce the sick role? In general, how do nurses deal with the various problems outlined in Chapter Two? Nurses are subordinate to doctors in the hospital hierarchy; how does this affect the ability of nurses to deal with problem patients and what strategies are employed to accommodate this discrepancy in authority? How do patients, for their part, attempt to assert control over their treatment and hospital routines?

As these questions suggest, the efforts of nurses and clients to gain or retain control will, for the most part, be viewed as separate sets of actions. In practice, however, these actions do not occur separately but are played out in interaction between the various parties; order is, in this way, negotiated.

> Control actions are not carefully thought out and preplanned...Rather, the control actions typically arise in situational negotiations. Each party to the negotiation reacts to the behavior of the other in a way that he believes will tend to keep the choice or initiative in his hands...(Roth, 1972)

Goffman outlines five different perspectives from which an organization may be viewed -- the technical, political, structural, cultural and dramaturgical (Goffman,1959:240-1). Each perspective selects and orders data in a distinctive way. The political perspective, for example, is concerned with power and the kinds of punishments, rewards, and social controls which accompany its exercise; the political perspective is useful in the present discussion, as power and authority are distinct, though often combined, phenomena. The structural perspective, focusing on status divisions, is too static for broad application to the present discussion , but it is an important component in viewing the authority structure and the social relations between various groups and individuals within this structure. The cultural perspective is used when I refer to the influence of nurses' ideals and professional goals on their daily activities; guilt resulting from avoiding a difficult patient would fall into this category. Goffman emphasizes the fifth perspective, the dramaturgical, as the most useful in highlighting

> ...the capacities of one individual to direct the activity of another...(Goffman,1959:241).

The strategies employed by an individual to direct others' activities include keeping strategic secrets from them, example, enlightenment, persuasion,exchange, manipulation, authority, threat, punishment, and coercion.

In the following section, the constraints on nurses emanating from their position in the authority structure will be discussed. This discussion should be viewed as a backdrop against which the nurse-patient drama is played. Authority in the hospital is discussed primarily in structural and political terms.

The third section of the chapter views the nurse-patient relationship from the dramaturgical perspective, and examines ways in which control over patients is maintained by nurses.

Section IV examines the ways in which nurses attempt to regain control over problem patients; the analysis in Chapter Two is extended here.

Section V looks briefly at the ways in which patients attempt to control their conditions and treatment.

The chapter is summarized in Section VI.

II Dilemmas in authority

Nurses have considerable power and authority over patients, but are themselves subject to the power and authority of others, and of doctors in particular. They feel further constrained, in this hospital, by a distinctive hospital philosophy. Finally, they are constrained to varying degrees by their clients, the patients, as well as by their patients' families.

a) The nature of authority in the hospital

The operation of authority in the hospital setting may be interpreted or conceptualized in two ways, the authority of expertise, expert authority, and the authority of office or position, bureaucratic authority (French and Raven, 1959). Professional authority, particularly in the case of physicians, is usually characterized as belonging to the former category. However, when professionals work in a large organization, the two types of authority become mixed. Freidson (1970a) points out that physicians exercise a hybrid form of authority. The physician has a sociolegal responsibility for patients and can legitimately give orders to others. He can, in other words, solve some of the problems of authority by formal, institutional means. This is a more pervasive authority than simply "expert power" (Davies, 1972).

Freidson says the medical profession has...

> ...organized autonomy, the authority to direct and evaluate the work of others without being subject to formal direction and evaluation by them. Its autonomy is sustained by the dominance of its expertise in the division of labor. Some of the occupations it dominates claim to be professions, but although they claim the name they do not possess the status...the dominant profession stands in an entirely different structural relationship to the division of labor than do the subordinate...in essence, the difference reflects the existence of a hierarchy of institutional expertise (Freidson, 1970a:71-92).

The position of physicians in the authority structure of the hospital is quite awesome since they have a double justification for the exercise of their authority. This has implications for the other health care workers, all of whom are subject to the authority of physicians.

No group feels more keenly the effects of physicians' superordinate status than do nurses, for while the work of other groups cannot be initiated without the agreement of the physician, the nurses' work emanates directly from the physician. It is both subordinate to and dependent upon the physician and his orders. Indeed, one traditional aspect of the definition of the nurse's role emphasizes the performance of functions specifically delegated to the nurse by the physician (Devereux and Weiner, 1950: 628-630). The drive for "professionalization" in nursing has been accompanied by a garnering of new tasks. It appears, however, that while the task structure has changed, the authority structure has not. While many duties formerly performed by physicians are now carried out by nurses, it is significant that the decision-making power concerning the transference of such tasks rests with doctors, not nurses. The nurse's job may, perhaps, have higher prestige now than in the past, but in terms of authority the nurse remains firmly under the physician.

> The primary experience of the nurse in the health field is one of legally defined marginality, blocked upward mobility in the health hierarchy, and institutionalized second-class citizenry (Krause, 1971: 122).

Freidson discusses this issue at some length (Freidson, 1970a: 56-76, 117). He attributes the nursing profession's lack of autonomy in part to the fact that most nursing takes place inside the hospital where the medical profession dominates. He traces the definition of nursing work to Florence Nightingale who refused to allow any nurse to give service based on her own initiative. Rather...

> ...what the nurse did for the patient was a function of what the doctor felt was required for the care of the patient. Even such unskilled tasks as feeding a patient were thus defined as part of the medical regimen. All nursing work flowed from the doctor's orders, and thus nursing became a formal part of the doctor's work... Nursing was thus defined as a subordinate part of the technical division of labor surrounding medicine (Freidson, 1970a:61).

Nursing as an occupation is dependent...

> ...upon the doctor's orders and requirements to delineate which tasks belong to nursing and which not. And the demanding patient can still make her (the nurse) feel like a servant. This is symptomatic of the secondary or assistant role she plays in the medical division of labor (Freidson, 1970a:64).

The ward nurse, Freidson points out, is subject to two lines of authority, administrative and medical.

> ...while the floor nurse is subject to the orders of her supervisor, who is her official superior in the hospital hierarchy, she is also subject to the orders of the physician involved in the care of her patients (Freidson, 1970a:71).

These hierarchical relationships are not eliminated by the health team concept as used in the hospital in this study. The authority structure of any particular health team may be more or less hierarchical; in this hospital, one does not find a situation where health team members are fully equal, nor is such a structure anywhere stated or envisioned as a goal. Hospital policy, as implemented through the psychosocial programme,[1] strives for a team situation in which authority is less hierarchical and therefore in which nurses are less subordinate to doctors than in more conventional settings. To the extent that this goal is achieved, nurses are somewhat less subordinate to doctors than in other hospitals, but subordinate they remain. As one supervisory nurse put it...

> "...you can't get around the fact that the man who writes the orders (that is, patient care orders) runs things." (246)

The nurses' position of being subject to doctors' authority yet responsible for managing the ward and its patients results in frustrations and problems for nurses.

They may not normally initiate aspects of medical care, yet they are not always adequately informed by doctors as to current programs or future plans. It is difficult for nurses to make decisions about patient management without proper information from doctors.

> An 81-year old patient had been transferred from another ward. The supervisory nurse had not been told that the patient had a brain tumour and suffered from fits. She says that had she known, she would have assigned the patient to a private room, instead of having the patient in a room where the other occupants as well as nearby patients could be upset by the fits. (29-3)

When nurses or the team do make decisions, such as how to manage problem patients' behaviour, doctors may contravene these decisions and plans, often without bothering to inform the nursing staff.

> For one problem patient, the team had decided on a plan which included limiting the patient's medication. Now the doctor had ordered increased medication for the patient without even telling the nurses first. One of the nurses says, "The analgesics have been increased...and the nurses have been upset by this." (263)

Doctors decide who is admitted to the ward; when admissions are inappropriate, such as with psychiatrically disturbed patients, it is nurses who must cope with the resulting problems.

> Complaining about all the psychiatric problems on the ward, one nurse offers this information: "We had a patient we tried to admit to (the psychiatric ward) recently and...the chief psychiatry resident refused to admit the patient because it would, as he put it, 'be too disturbing to the patient to admit him to a psychiatric ward.' Do you believe that? Psychiatry is the only place that can look after a patient like that." (322)

Nurses get very frustrated having to deal with disturbed patients. In the following example, nurses resolve to change this situation. (In fact, the field notes reveal that nothing changed in the following months).

> The supervisory nurse says, "The nurses have reached a point where we are going to stand on our feet. We're not going to put up with patients who display behaviour problems. I've been walking on eggs for two years because I've been afraid of what doctors would say. Doctors, I found, are concerned about developing clientele." (218)

Nurses are also concerned about chronic patients and, as noted later in this chapter, often blame the doctor for not discharging the patient.

The following example sums up the nurses' problems and frustrations resulting from their lack of authority.

> A 20-year old problem patient is being discussed. The patient is violent and nurses don't know how to handle him. One nurse says, "We discussed this before and decided that the psychosocial team should be involved but the resident said that he...didn't need a psychosocial consultation... we can make all these decisions...but a doctor has to order the consult." The supervisory nurse sums up the discussion later by saying, "...all of us function as a team but the doctors don't support us...(they) make their own decisions." (179)

The team structure in this hospital slightly modifies the traditional authority relationships found in most hospitals. Control over patients may be increased, particularly as a result of the extensive sharing of information which occurs at team meetings. Control over conditions of work should, in principle, be increased since team meetings are supposed to provide a forum for discussion of problems and a setting where each team member may contribute to possible solutions. The ability

to influence one's conditions of work through interaction with one's immediate superiors is thought to reduce feelings of powerlessness and alienation (Argyris, 1964; Barrett, 1970:12-14; Bowers and Seashore, 1966; Katz and Kahn, 1966; Likert, 1961; McGregor, 1960; Pearlin, 1962). The survey data from the primary study support this assertion. When a number of variables measuring dimensions of health care teams were regressed on alienation from work, the two most important predictors of low alienation from work were low inter-role conflict and high peer supportiveness for achievement.[2]

This increase in reciprocity, while carrying the above-mentioned positive effects, also carries an increase in visibility. Nurses and their work become more visible, through discussion, to other team members. They are less able to simply do their job as they see fit.

The psychosocial programme, operating through team meetings, increases "accountability" of health professionals. Nurses and doctors have traditionally been accountable for the technical aspects of their work with patients but rarely for their behaviour with patients; behaviour in areas other than physical care is outside the province of professional standards. This nonaccountable area of patient care has been lucidly discussed by Glaser, Strauss

and Quint with respect to the care of terminal patients (Glaser and Strauss, 1965:4,5; Strauss, Glaser and Quint, 1964). The concept may, I feel, be usefully extended to cover aspects of care for non-terminal patients as well. Hospital regulations stress which procedures should be done, rather than the way in which they are to be carried out. Within a framework of regulations and institutionalized responsibilities, professionals are given considerable freedom as to how actions are performed.

> ...the assumption of professional competence leads to far less scrutiny of how procedures are carried out than that they are carried out. How procedures are carried out includes not only technical skill but also whether social and psychological sensitivity was employed (Strauss, Glaser and Quint, 1964).[3]

Many of the nurses' and physicians' nonaccountable actions are not observed by other personnel and not reported. These actions may be considered "invisible."

In this study, both the team structure and the psychosocial programme operate to increase accountability and visibility through discussion and expanded responsibilities. In this sense, they represent a certain loss of control over conditions of work for the individuals involved.

b) The institution as a constraint

Another dilemma in authority is reflected in a feeling by nurses that the hospital in this study, its policies, philosophy and community position, exercise a constraint on their professional behaviour. While social scientists may argue whether or not an organization has a reality sui generis, it is apparent that the nurses in this study perceive the organization as "real." As described in Chapter One, this hospital has a strong commitment to community involvement; implicit in this is a recognition that the hospital is accountable to the community. This organizational philosophy constrains nurses, as the following excerpt from the field notes illustrates.

> A psychosocial consultant asks if the nurses ever tell the patients they feel hurt by the patients' criticism. A supervisory nurse says, "No, because the patient is always right." Another supervisory nurse says, "I think it's the philosophy of this place that prevents us from doing something like that...this is a community hospital...so we bend over backwards to make sure that the patient is comfortable and does not become upset." The first nurse who spoke responds wryly, "It's a McMaster syndrome." (84)

Nurses feel this philosophy is unusually emphasized in this institution.

> One of the nurses says at a meeting, "I lost a patient here one night some time ago and I nearly went crazy. I kept thinking of all the television cameras and the press and the publicity this place would get if we couldn't find that patient. I've lost patients at other hospitals before and I haven't worried about it one bit, but here it's really different." (141)

Nurses feel caught in the middle, between several sources of authority and power; their own sense of powerlessness is expressed in the following excerpt as a lack of control.

> A nurse says, "I don't know what it is, but ever since I started working here, it seems I have no control over anybody or even my own job...Patients tell us what to do, we have to answer to administration, we have to answer to the relatives, we have to answer to the doctors, it seems like it's never ending." The suggestion is made that this is characteristic of teaching hospitals, to which a supervisory nurse replies, "We've all worked in teaching hospitals and we haven't lost that power to control." (141)

c) Patients and families as constraints

Finally, the nurse must deal with the actions and wishes of the patient and the patient's family. The family is discussed at length in Chapter Four, the patient near the end of this chapter. As mentioned in Chapter One, the patient may make life difficult for the nurse. While the patient does not have legitimate authority in the medical hierarchy, the patient's co-operation is needed in order for the health personnel to perform their tasks adequately and get the patient well. A patient may frustrate normal procedures, disrupt the ward, threaten to sue the hospital, sign himself/herself out of the hospital, convince a relative to transfer him/her to another hospital, complain to the doctor or the head nurse, or cause friction among the staff. Nurses will

try to keep patients happy, in order to forestall such inconvenient and threatening turns of events.

Authority, then, is subject to the dilemmas and constraints outlined above. Subject to these constraints, the nurse must manage the patient, carry out the doctor's orders, and keep life on the ward running smoothly.

III Maintaining control: staff and patients as performers and audiences

a) The performance metaphor

Nurse-patient interaction may be usefully viewed as a performance, in Goffman's terms.[4] Non-problematic nurse-patient relationships are those in which the performance is more or less successfully staged, and control is maintained. The participants in these relationships do not necessarily believe in the perfection of performer or audience; what has been achieved is an adequately managed performance which the audience (patient) has supported. The patient has not openly expressed lack of confidence in the nurse or the hospital, has not made a "scene," and has made appropriate responses. The nurse has maintained a suitably professional bearing and has not incurred any manifest disturbances in the patient.

Problem patients may be viewed as failing to play their appropriate audience roles, creating what Goffman calls "performance disruptions." The "polite appearance of consensus that characterizes the performer-audience/nurse-patient relationship in non-problematic situations is threatened or destroyed. Sometimes this occurs because the patient himself/herself creates a scene, no longer caring about maintaining the appearance of consensus. It may occur because the united front of the team is broken, for example when a team member is induced by a patient to criticize another teammate. This provides the patient with a "backstage" view, a glimpse through the break in the ranks.

b) Defensive measures

Goffman points out that performers employ "defensive measures" to "save their own show." Normally the audience assists them by employing devices to help save the show. Performers' devices include dramaturgical loyalty to the team, which entails not disagreeing with teammates in the performance area, developing high in-group solidarity within the team, and providing a sense of community and social support for each team member. Discipline is very important as a device. Claims of expertise or professionalism may be another device employed. Control over information is a major strategy for performance maintenance. Rehearsing the agenda in the backstage area facilitates the subsequent maintenance of the performance. Examples of the use of these devices will be given in the discussion later in this chapter.

Goffman notes that "most of these defensive techniques of impression management have a counterpart in the tactful tendency of the audience and outsiders to act in a protective way in order to help the performers save their own show" (Goffman,1959:229). Audiences employ such techniques as tactful inattention, the giving of a proper amount of attention and interest, holding one's own performance in check so as to avoid contradictions, interruptions or demands for attention, and the desire to avoid a scene. When the performer "makes a slip" the audience may tactfully pretend not to have seen it or may accept the excuse offered. There is a "tacit collusion" between audience and performers. Underlying this is the basic assumption of Goffman's that a disclosed discrepancy between reality and the impression being fostered is uncomfortable for the audience as well as the performer and the avoidance of this discomfort motivates all parties to the interaction. But audiences may also be motivated to act tactfully because they identify and sympathize with the performers, or because they want to ingratiate themselves with the performers for purposes of subsequent exploitation.

The major devices will now be examined in more detail.

i) Loyalty to the team versus involvement with the patient

Dramaturgical loyalty to the team includes the obligation to present a unified front, not to criticize teammates to the audience, and not to disagree openly with teammates in the performance region. One potential problem here is that

a performer might become attached to the audience and betray the team as a consequence. One way the team can counteract this danger is to change audiences periodically, a technique used by the health team in the form of having rotating nurses assigned to different patients. Nurses rotate both in terms of shifts and of groups of patients on a particular ward. Rotation schedules are set up according to the dictates of circumstances rather than patient preferences for particular nurses or the wishes of nurses to work with certain patients. Within this system, there is some continuity in patient assignments and some patients, especially if they are in the hospital for any length of time, do establish more personal relationships with nurses with whom they become familiar. The problem of nurses becoming involved with or attached to particular patients, while attenuated somewhat by the practice of rotation, cannot be avoided completely since nurses do repeat on their patient assignments. Furthermore, nurses recognize, perhaps because of the emphasis in this hospital on the psychosocial aspects of health care, that a changing parade of nurses may be detrimental to the patient's social and emotional state. Also, if the staff changes continually, no one can really have the opportunity to get to know and understand the patient, making proper psychosocial care impossible.

> Discussing this problem at a meeting, the suggestion is made that "it's important that someone, maybe one or two individuals, have to know the total patient," and that perhaps only two or three nurses should be responsible for the patient's primary care. The supervisory nurse says that there is no reason why arrangements could not be made so that nurses who got

> along with certain patients, and who enjoyed caring for them, could be assigned to care for these patients on a regular basis. This would establish continuity of care for the patient. (84)

In the above example, the nurse recognizes that such an innovation would benefit the patient. Such an arrangement would also lessen nurses' frustration and increase their control, for they would get to know the patient more fully. Of course, such an arrangement would also include the potential for nurses' over-involvement with patients. Earlier in the discussion from which the above quote was taken, another problem was mentioned, that of patients becoming attached to some nurses and creating divisions among the staff.

> "...the patients become dependent on those nurses who have been continually involved with them and they begin telling those nurses negative things about their colleagues" (84).

It is apparent from the field notes that patients, at least in the nurses' perceptions of the situation, have a fair degree of success in creating conflict among staff.

> "...we are undermining each other and it's bad for morale. A nurse who has had a patient for a long while ... will tell another nurse she isn't doing something right...we let it happen because we let the patients manipulate us...we just blossom all over them when they tell us how good we are" (245).

In another example, following a long discussion at a problem patient meeting, the supervisory nurse closes the meeting by saying,

> "I think...we should...be supportive of one another and not...have either the patients or the patients' relatives make us fight with one another, okay?"(141)

ii) Depersonalizing the patient: discussing and labelling

Another defense against team disloyalty is

> ...to develop high in-group solidarity within the team, while creating a backstage image of the audience which makes the audience sufficiently inhuman to allow the performers to cozen them with emotional and moral immunity (Goffman, 1959:214).

Goffman's statement may be somewhat extreme as a characterization of what occurs in the health team situation. However, to a degree, the backstage team meetings do provide for and in some ways contribute to a depersonalization of patients which enables nurses to manage their needs for detachment and thus strengthen solidarity. For example, when a patient is dying and nurses discuss their own personal feelings, their reactions are, while not neutralized, diminished to more manageable proportions. Emotional reactions are diluted by talking about them. It is paradoxical that while discussion of patients is intended, at least by the organizers of the programme of psychosocial care in this hospital, to enhance viewing patients as individuals, there is ample evidence in the field notes that patients, when discussed, are typed or classed. This relates to the discussion in Chapter Two on the emphasis in nursing education and in this hospital on treating the patient as a total person and not simply as an object or disease.

The professional ideal in nursing prescribes a "professional" attitude toward patients. This includes maintaining a professional detachment toward each patient, focussing on each patient's unique problems and displaying the appropriate reaction toward the individual patient. This professional role conception has been shown to become strained in bureaucratic settings (Mauksch, 1963; Corwin, 1961). For example, as noted in Chapter Two, both Coser and Quint found the "total patient" philosophy broke down in daily nursing practice (Coser, 1962; Quint, 1965).

In the present study, the conflict between viewing the patient as individual or object, a feature of hospital life that is always at least latent, becomes manifest and creates a contradictory situation for nurses. They are committed at least superficially to the total patient concept because of hospital policy and professional training. At the same time, they wish to maintain control and thus ensure an orderly ward within which to carry out their nursing work.[5] One method of coping with this stress and conflict in the nurse-client relationship, and the worker-client relationship in service occupations in general, is the use of client typologies by workers (Pennerick, 1974). The client forms similar

typologies of the workers. By employing "social types," workers and clients "fill in the gap between merely knowing the other's formal status and being acquainted intimately with him" (Mennerick, 1974). In this study's setting, the use of social types enables nurses to identify specific types of patients and then to orient their behaviour according to these classifications. Mennerick, in reviewing some of these works (Becker, 1952; Davis, 1959; Cicourel and Kitsuse, 1968), identifies five major dimensions underlying the use and importance of client typologies -- facilitation of work, control, gain, danger, and moral acceptability (Mennerick, 1974). The general principle, one which Lorber found to be highly applicable to hospital patients (Lorber, 1975), is that "good" clients are those who facilitate or contribute to workers' efficiency and "bad" clients are those who hinder or cause problems for the workers. Control implies a situation in which the "client allows the worker to perform his service at the time and in the manner thought appropriate by the worker" (Mennerick, 1974). The dimension of gain or profit implies that the worker may gain something, for example satisfaction or experience, from dealing with a particular client. In this context, patients who are in the hospital because of placement delays cost time and effort but provide little "payoff" to nurses.

Dangerous clients pose a physical threat to nurses. The final dimension, moral acceptability, has been found to form a basis for typologies among medical students (Becker, 1961:323-4). In the present study, career patients or patients who are feigning illness are typed by nurses along this dimension.

Patients may be classed by nurses into categories which have professional-medical labels or into lay categories. The latter usually violate the professional ideal, shared by many nurses, of treating each patient as an individual (Kramer, 1974: 42) without allowing personal feelings to interfere.

The following examples illustrate the use of non-professional labels.

> Speaking of a problem patient who is being discussed, a nurse says, "He's a mean old cuss." She goes on to say, "Personally, I don't like him, but that doesn't mean I can't care for him... that's my job. I can look after him without getting my feelings involved...he behaves like a child and sometimes you have to treat him like that." (394)

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> In another instance, a supervisory nurse says she doesn't know too much about a particular patient except "She's a pain in the neck...She goes out of her way to antagonize everybody...I don't feel sorry for her one bit." (282-2)

Other examples include referring to a patient as a "big baby" (p.71), "weird" (p.199), "basically bitchy" (p.133), a "real pain" (p.375), a "dirty character"

(p.158), a "nut" (p.98), and an "obnoxious person" (p.93).

Sometimes the labels used have a more medical or professional character.

> Commenting on a 27-year old female who has just had a craniotomy and delivered a baby by Caesarian section, the nurse says, "She has a low threshhold to pain and is very childish." (322)

Without further elaboration on what particular problems the above patient was experiencing or presenting, the patient has been labelled as childish, presumably for not being able to tolerate what the nurse considers a tolerable amount of discomfort. "Childish," a lay term, is linked to the inability to bear discomfort stoically.

Nurses sometimes use psychiatric terminology and concepts when typing patients. While it is possible that such labels may sometimes increase understanding of patients, it may also serve to lump them in pseudo-psychological categories. This esoteric vocabulary is typical of professionals.

> Vocabularies of certain organizational participants can be pretentious and filled with esoteric referents and jargon. Professionals and quasi-professionals often develop vocabularies which have the trappings that convey to the uncritical observer a deep sophisticated understanding of complex individual problems, but which on closer examination and inquiry reveal little more than a facade of ignorance, or a professional ideology which is not based on knowledge but assumptions (Bogdan, 1972:34).

Drawing on research on teachers and pupils (especially Cicourel and Kitsuse, 1963: chapter 4), Bogdan continues...

> ...in schools an elaborate pseudo-psychological vocabulary is often used among personnel in describing pupils' behavior and academic potential. This vocabulary is selectively applied to pupils on the basis of social class and other such variables, and to the researcher they reveal more about how the users see the pupils, themselves, and the function of the school than they do about the pupils" (Bogdan, 1972:34).

In the present study, an example of the use of a psychiatric label occurred in connection with a patient who had been presenting staff with management problems. The nurse describes the patient as "really paranoid." Another staff member says, "I'm glad I'm not the only one she's picking on" (376). While the description of paranoid was not inappropriate for the incident under discussion -- the patient had accused the staff of trying to poison her -- the label will likely have the effect of discrediting any other complaints this patient might make.

In another example, a male patient is called a "schizo" by a nurse (70). This shows how psychiatric labels may be used in a sense close to slang.

The numerous examples discussed in Chapter Two of the use of the term "manipulative" to describe various patients are furthers illustrations of this use of labels.

Labelling, then, lumps patients -- problem patients --

into categories. Individuals thus come to be perceived as "types" rather than as unique persons. In this sense, patients are depersonalized in the team meetings and discussions. The audience is made less human in order to give staff a measure of what Goffman calls "emotional and moral immunity," or decreased involvement. At the same time, in-group solidarity among team members is strengthened by discussing a problem patient and formulating a common perspective.

iii) The team as a support system

Another defense against disloyalty is to provide for teammates a "social community which offers each performer a place and a source of moral support" which enables performers to "protect themselves from doubt and guilt and practice any kind of deception" (Goffman, 1959:215).

Teammates function as a source of support for nurses, and nurses themselves recognize this.

> At one meeting, the psychosocial consultant asked the group, "Who do you go to when you are feeling down about a patient who is dying?" A nurse responded, "We talk with each other. We get a lot of support from that. We've got a pretty good group here." (251)

The support function of the team is apparent, above all, in connection with practices of information control; while this will be explored in depth in Chapter Five, a few examples here will illustrate how the team may achieve this communal support which acts as a bulwark

against guilt.

> A nurse complains that she doesn't know how to act with dying patients because she doesn't know how much information they have been given by the doctors. "I find that I can't behave naturally with some patients who have a terminal illness, because I don't know whether the doctors have told them their prognosis, and I've found this to be very frustrating. I'm finding that I have to be cautious of what I say for fear of letting the cat out of the bag." (250)

The nurse in the above example not only vents her frustration at having to function in a situation where her own information is incomplete, but goes on to express disapproval over the practice of withholding prognosis information.

> "Doctors are always quick to say, 'How can I tell a patient how much time he has left? He might have six weeks or he might have six months. Who am I to say?' So they end up saying nothing. That's their big rationalization. I think it's a cop out." (250).

Nurses are protected from feeling too much personal guilt since it is the doctor's responsibility to decide what and how much to tell the patient. This is seen in the following cases.

> A young patient is going to be permanently blind but has not yet been told by the doctor of this prognosis. A nurse says, "I think it's ridiculous not to tell a patient something like that...he can't even get any help from the resources available to him if they don't tell him that he'll be blind." (99)

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> The social worker says, "I think the patient should be told what's happening to him. I don't know about the doctors who are working on him..." The supervisory nurse says to her, "It's not your responsibility or mine to tell the patients." (259)

Thus, although nurses often complain about having to keep information from patients, they are assisted in maintaining this difficult performance by being able to air frustrations to each other in team meetings, and by reminding each other that information is the doctor's responsibility.

Meetings also provide a forum in which plans concern-information are carefully worked out and up-dated.

> Concerning a young patient who has just had an iliostomy operation, a nurse says, "He doesn't know what's going to be happening to him at all. The resident replies, "(the doctor) told him about it and he's pretty assured that (the patient) understands what's going on." The resident goes on to say, "I haven't seen his family...I wonder if they know about the operation." At this point the physician in charge comes into the room in which the meeting is taking place. Having overheard the end of the above discussion, he confirms the resident's statement that the patient does understand what's happening to him. (148)

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> The doctor says of a cancer patient, "She has metasteses of the liver...We will tell her that we didn't get all the metasteses, but we're not going to make any predictions." (148)

The following example illustrates clearly how plans are made.

> The resident tells the team that a patient was operated on and a tumour was found in the pancreas. He says, "We decided not to do a biopsy. If it turns out to be C.A. (cancer) it's inoperable." A nurse asks, "How will you know what he has if you don't biopsy?" The resident replies, "If he has cancer he will die." Another nurse adds this information to the discussion. "(another resident) talked to his wife already." The first resident asks her, "What did he say to her? Do you know?" The nurse says, "No." The resident then says, "I better talk to him first before I see (the patient) so we can have our stories straight." (98)

As will be elaborated upon in Chapter Five, the staff's control over information, while not absolute, is profound. This provides a major control strategy for maintaining a performance. The performance must be adjusted to the patient's current information level. If a dying patient does not yet know his/her prognosis, the nurse must not "give away" the truth, either by verbal or non-verbal cues. The performance must, furthermore, be managed in a way that discourages patients' demands for more information than can be given at the present time. Demands, if made, must be mollified without giving more information than decreed permissible by the physician.

iv) Rehearsing the management agenda

The performance is aided by the team practice of rehearsing or deciding on an agenda of management with a patient. This allows performers to consider possible contingencies and to formulate plans of action in advance. Above all, it creates a "united front." Not only does the staff have more information than the patient concerning diagnosis and prognosis, but they also have more information about how the patient is going to be treated, including how the staff will act toward the patient. The patient must guess at these plans. The team tries to assess patients' behaviour. Often, team members try, in a sense, to outwit or out-manoeuvre the patient.

> In one example, the team is anxious to get a patient to do more for her own care. The doctor says, "I don't know how we can change her attitude." One of the nurses says that the patient "can play weak. You've got to watch out for her." (56)

If, in fact, the patient in the above example was using weakness as a device, it may well prove less effective from now on.

This planning extends to families as well as patients.

> A difficult family member whose wife is dying has been critical of the staff. The team has a long discussion about the various psychosocial aspects of the case and then decides that the husband "should be told every step along the way of his wife's condition" but that they "should interpret the nursing care of his wife to his advantage rather than his disadvantage." They also decide to "try to find out what's happening to him in terms of his fears...to talk to him...to be understanding." (17-3)
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> An elderly male patient is not eating enough and the problem is aggravated by his daughter who insists on making out his menu for him. The nurse says, "It's a constant battle between (the daughter) and us." The nutritionist says, "I'd like to know how I can handle this." The doctor says he will make out the menu from now on in ink so the daughter can't change it. The resident says, "Okay, this is our plan of action. Let's change his diet from 1200 cc's to a diet as tolerated." Another resident says, "Also, I think we should call (an absent resident) to let him know what's going on, to prevent her (the daughter) from... playing one against the other." The first resident says, "That's a good idea, and let's see what happens from there." (93) *

v) Maintaining the expressive status quo

To maintain the performance requires discipline. The performer must be able to suppress spontaneous

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*This example has appeared before (see page 54). From time to time I repeat examples in different analytical contexts.

personal feelings and maintain the "expressive status quo," that is, the affect agreed upon by the team and prescribed by the professional role. Goffman points out, with pertinence for the discussion here, that a "display of proscribed affect may not only lead to improper disclosures and offense to the working consensus but may also implicitly extend to the audience the status of team member (Goffman, 1959:217). This difficulty becomes complicated in this hospital by the notion that the patient should be a member of the team. To health professionals, this means participation by patients in their own care, but under the direction of and at the discretion of the health professionals. There is an inherent ambiguity in this situation, and if a patient takes the philosophy at face value, it may create problems for the staff.

> A 62year old male patient is said by the supervisory nurse to be mad because he wasn't involved in a conference of his care. The nurse suggested that they should have a conference before he was discharged. (36)

IV Problem patients: the threat to control

In the preceding discussion, I have viewed the nurse-patient relationship in terms of a performance metaphor. Not only the individual actor, but the entire cast or team is involved in some way in most interactions.

By means of various devices, staff maintain control over patients; patients are socialized or induced to play their roles -- the sick role -- properly.

One may assume that patients whose behaviour (as opposed to medical conditions) does not come up for discussion in the field notes are playing their roles as staff would have them. They are not presenting management problems. Control has been successfully established by staff. The patients, for their part, are either satisfied with the flow of events or are complying with staff routines despite inner, unexpressed dissatisfaction. One may infer that control has been exerted and maintained by such devices and strategies as those discussed above.

When a patient's behaviour passes beyond what nurses consider reasonable under the circumstances, the patient is almost certain to come up for discussion at a team meeting. It is common for a particularly difficult patient to be the sole topic of a problem patient meeting, occupying the staff's attention for as long as an hour or more. Once this occurs, the patient is quite certain to be discussed at least once more as a follow-up. Unusually difficult patients are often discussed several times in the course of their stay in the hospital.

a) Reactions to specific types of problem patients

How do nurses regain control over problem patients and restore control over their work routines and the material -- patients -- on which they perform their work?

Chapter Two delineated several categories of problem patients: manipulative; demanding and complaining; aggressive, violent, confused or irrational; career patients, patients who do not belong in hospital, and inappropriate admissions; non-compliant patients; patients who are unpleasant as people, and patients who try to control staff or treatment (see Chapter Two, Table 2:1). These categories were then analyzed to determine the roles played by age, sex and diagnosis. In Chapter Two, I briefly indicated some of the consequences, in terms of staff reactions, to being perceived as a problem patient. This issue will now be explored more fully.

Table 3:1 summarizes nurses' reactions to the problem patients discussed in Chapter Two.

With manipulative patients, the common staff reactions are annoyance, anger and avoidance. Avoidance is often justified with the assertion that manipulative patients are better off if they receive less attention. However, the fact that avoidance was only a clear reaction in one-fourth of the cases suggests that these patients are fairly successful in their efforts to control staff.

TABLE 3:1
NURSES' REACTIONS TO PROBLEM PATIENTS

Patient type	Total cases	Modal sex	Typical age	Diagnosis	Annoy-ance, anger	Avoid-ance	Disc-uss-ion	Agree on plan	Blame doc-tors	Psycho-social con-sult	Total reac-tions n	Total reac-tions $\bar{X}$
Manip-ulat-ive	12	F	all under 60	Only one had ser-ious illness; others had less severe problems or were in hospital for social or emotional reasons.	4	3	8	4	1	5	25	2.08
Demand-ing, compl-aining	9	F	half over 60, 1/3 over 65	Over half had serious illness.		7		5		6	18	2.0
Violent, aggress-ive, etc.	13	M	older, half over 60, 1/3 over 65	not codable	2			8	1	4	15	1.5
Pain	17	F	most in 50s, 3/4 under 60	not codable	3	4	4	8	1	9	29	1.70
Career	21	F	50s and under	Chronic illness (diabetes, asthma).	4	3	5	3	6	7	28	1.33
Non-comp-liant	11	F	mid-aged to old	3/4 had chronic illness, esp. diabetes	1	1	8	3	1	4	18	1.64
Un-pleas-ant	10	poss-ibly F	not codable	Half had chronic illness, half acute	4		7	2		3	16	1.6
Control staff, treat-ment	9	no diff.	no aged-all under 66	Half chronic, half acute	2	4	8	4	2	9	29	3.2
TOTALS	102				20	22	40	37	12	47	178	1.74

These were the patients who caused friction and divisiveness among staff. A management plan was agreed on in one-third of these cases, and usually included a staff resolve not to let the patients cause fights among the staff.

Patients who are demanding or complaining are controlled through avoidance, the staff reaction in seven of the nine cases. This appears to differ from Roth's findings. He noted that...

> Although the staff will usually not give in to a patient's...demands in an immediate and overt fashion, pressures from the clients do have an effect...A patient received his medication right away when he insisted on it...A nurse made additional attempts to get a physician right away when a patient complained about a long wait (Roth, 1972).

Roth's findings and those of my analysis may be reconciled by suggesting that although these patients are avoided, when they do make demands to the nurses, these demands may be met. A further qualification in comparing Roth's findings with mine is that his patients were observed in an emergency room situation where avoidance was far more difficult for staff to carry off.

The prevalence of avoidance as a reaction to these patients is also striking in view of the fact that over half of these patients had serious illnesses. Avoidance

appeared with equal frequency regardless of the degree of seriousness of illness.

A management plan was formulated for half the patients in this groups.

The common reaction to violent patients is to use physical force in the form of restraints, even though nurses find this procedure distasteful. These patients are often viewed and treated as children.

When verbally or physically abused by patients, nurses are highly displeased.

> One such patient was being nasty to a nurse. She reports, "I asked him why he was angry and he just yelled at me...that's when he threw a full urinal at me...I'm furious, I could kill him." Another nurse calls the patient a "mean old cuss" and says, "He behaves like a child and sometimes you have to treat him like that." (394)

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> Discussing a patient, a supervisory nurse says, "I was ready to strangle him. He was using extremely foul language." (158)

These violent patients are often not held responsible for their actions. Therefore, while nurses are angered by the actions of these patients, it is a different sort of anger than that displayed toward, for example, manipulative patients.

Patients who complain excessively about pain may invite anger, annoyance or avoidance from nurses, especially if the pain cannot be related to an organic cause.

In almost half the cases in this group, the patients were either given increased medication or sent to the pain clinic, a facility provided by this hospital.

While anger, annoyance and avoidance are possible reactions to career patients, these reactions are apparent in only one-third of the cases. Rather than react to the patient, the nurses hold the doctors responsible for what is perceived as the unnecessary hospitalization of many of these patients.

Non-compliant patients, on the whole, are those who do not comply with medical treatment. For example, not taking prescribed medication is common in this category. As Chapter Two described, most of these patients are not acutely ill; three-quarters had chronic illnesses.

Nurses do not appear to react emotionally to these patients. Anger and annoyance are less common in this category than in any other, and avoidance is similarly uncommon.

The consequences of non-compliance are more serious for the patient, whose condition may worsen, than for the nurses. The nurse may be somewhat frustrated in his/her desire to care for the patient, but rarely does non-compliance lead to an acutely worsening condition. The major problem non-compliant patients present seems to be related to the authority structure; the

doctor depends on the nurse to see that orders are carried out. Since this type of problem is the most closely related to the work of the doctor, it is not surprising to find that it is the type most frequently discussed with doctors (see Table 3:2).

TABLE 3:2
PRESENCE OF DOCTORS AT MEETINGS
WHERE PROBLEM PATIENTS DISCUSSED

Patient Category	Total number of patients in category	Times doctors present at discussions
Manipulative	12	4
Demanding, complaining	9	3
Violent, aggressive, etc.	13	7
Pain	17	10
Career	21	4
Non-compliant	11	8
Unpleasant	10	3
Tries to control staff, treatment	9	4
Total	105	43

While doctors are present at only 41% (43 of 105) of the total problem patient discussions, they are present at 73% (8 of 11) of the discussions concerning non-

compliant patients.

While this type of patient does present problems for nurses, it does not appear to irritate them in the way some of the other types do.

Patients who are unpleasant inspire anger and annoyance in nurses. The common reaction to these patients is to label or type them. This occurred in four-fifths of the cases. A certain callousness or lack of sympathy on the part of nurses toward these patients is evident, suggesting that nurses react very much as other lay persons in a situation where they are treated rudely. Patients who are notably rude are not wholly in the patient role; nurses do not really expect rudeness from patients and do not have appropriate responses in their professional repertoire.

> Discussing one unpleasant patient, a nurse says, "We're not used to having people talk back to us. Patients are usually very polite and we don't know what to do when they are sarcastic or snarky." Another nurse adds, "When people treat us this way, we just want to avoid them." (47-2)

The patients who are perceived as trying to control staff or treatment have the second highest rate of avoidance by nurses. The seriousness with which such patients are viewed by staff is evidenced by the fact that this group of patients had the highest rate of discussion and psychosocial consultations.

b) Nurses' complaining as a reaction

TABLE 3:3
COMPLAINING BY NURSES

Total instances of complaining by nurses			45
Complain about general features	30	51	
doctors	21		
overlap	6		
total complaining		45	
Complain in presence of doctors, psychosocial consultant present			5*
Complain in presence of doctors, no psychosocial consultant present			0
Complain in presence of psychosocial consultant			37
Complain in presence of neither of above			8

*See negative case discussion below

Table 3:3 shows that complaining by nurses is a reaction to problem patients in 45 of the 102 cases, or almost half the time. The table notes that five of these instances of complaining took place when doctors were present. It is important to note that in all five instances, the doctors present were residents and not staff doctors. While residents are of higher formal status than nurses, they have far less status than staff doctors. Their presence would be less likely, therefore, to intimidate nurses. Furthermore, of these five negative

cases, only two involved blaming or complaining about the doctor; in both these instances, complaints were made about a staff doctor in the presence of a resident, not the staff doctor in question. These data, then, show that while nurses complain about problem patients almost 50% of the time, they are much less likely to do so in the presence of a doctor. This occurred only 5% of the time in these data. Moreover, nurses are highly unlikely to complain about doctors when other doctors are present, although this did occur in two of the 45 cases . As noted, in these two cases, the complaints were made in the presence of residents. At no time did nurses complain in front of staff physicians.

It should also be noted that complaints of any sort were never made in the presence of doctors unless a psychosocial consultant was present, suggesting that nurses feel supported by these consultants. It may also be that the psychosocial consultants introduce the sort of discussion and leading statements, comments or questions into the general patient discussions which make it easier for nurses to voice complaints.

Sections a) and b) above have outlined a variety of reactions by nurses to problem patients. Sometimes they blame the doctors for the particular problems. Sometimes they feel annoyed or angry with the patient. More often, they avoid the patient and/or discuss the

patient at meetings. As the column totals for Table 3:1 indicate, the most common reactions are formulating a management plan for problem patients and/or arranging for problem patients to receive psychosocial consultations; these reactions may be viewed as strategies for maintaining the sick role and regaining control over problem patients.

c) Strategies for dealing with problem patients

i) Psychosocial consultation

The most prevalent reaction to being viewed as a problem patient, and one which is common to all categories of problems, is to receive a psychosocial consultation -- to be seen and assessed by either a social worker or a psychiatrist.

This strategy was most commonly used with patients who try to control staff or treatment. Virtually all such patients received a psychosocial consultation.

Two-thirds of the demanding and complaining patients, about half the manipulative and pain patients, and one-third of the unpleasant, non-compliant and aggressive patients received psychosocial consultations.[6]

Fewer than half the career cases received a psychosocial consultation, but close inspection shows over half the "true career" patients received psychosocial consultations. There were eight true career patients in this category, that is, eight patients for whom no medically

valid reason for hospitalization could be offered. Included here were patients who had what were perceived as psychosomatic symptoms such as nausea or vomiting with no cause, and patients who claimed a return of illness when discharge was imminent. These were the "true career" patients. In addition, two patients were perceived as liking to be in hospital and were included in the overall category. Five patients were felt to be in the hospital long past the time when their physical condition would have justified hospitalization. Finally, closely related to the preceding group, six patients were felt to be in the hospital only because the doctors were afraid to refuse admission.

Table 3:4 shows the distribution of psychosocial consultations for these various patients in the career category. It can be seen that seven out of ten patients (first two categories) who are perceived as career patients received psychosocial consultations. Of the eleven patients in the two latter categories, none seems to have been seen by a psychosocial consultant. No doubt this is because the problem is perceived to be the physician's fault, rather than the patient's.

TABLE 3:4
CAREER PATIENTS RECEIVING
PSYCHOSOCIAL CONSULTATIONS

Patient category	Number in category	Number receiving psychosocial consultation
True career patients	8	5
Patients who like hospital	2	2
Patients who should no longer be in hospital	5	0
Patients in hospital with no reason -- doctors afraid to refuse admission	6	0
Total	21	7

For the total group of problem patients, a psychosocial consultation was one of the consequences of being perceived as a problem in 47 out of 102 cases, or 46% of the cases. The proportion of all patients in the total study population receiving psychosocial consultations was only 24% (Marshall et al.,1976).[7] It is clear from these data that, in this hospital, being identified as a management or behaviour problem creates a distinct likelihood of being labelled a psychosocial problem as well.

Other reactions, such as anger or avoidance, while typical, occur less frequently.

The psychosocial consultation is, of course, intended to benefit the patient and in many cases it may achieve

this objective. The less altruistic side of this strategy consists of extending social control over the patient by expanding the medical role to include responsibility for and expertise concerning the patient's social and emotional condition.

ii) Formulating a plan

When problem patients are discussed at meetings, a plan of action or management is sometimes formulated and agreed upon. As Table 3:1 shows, this occurred in 37 of the 102 examples in this study, or 36% of the cases.

For the demanding and complaining, aggressive, pain and control categories, management plans were agreed upon in approximately 50% of the cases.

The group of patients who were violent, confused, aggressive or irrational had the highest rate of plan formation, with plans being agreed upon in eight out of 13 cases. This category is notable for its lack of other types of reactions. In only two cases were anger or annoyance expressed, and these were instances of physical or verbal abuse. This anger was tempered by recognition that the patient was not fully responsible for his/her actions. The apparent lack of avoidance of these patients by nurses must be viewed with two qualifications. Nurses may avoid these patients, but fail to perceive avoidance as problematic since these patients may be considered unlikely to benefit from psychosocial

attention; if nurses do not perceive avoidance as problematic, the comments about avoidance would not appear in the field notes, even if avoidance was occurring. The second qualification is that many of these patients, by the very nature of their actions, render avoidance impossible. A screaming patient must be calmed, as must a violent patient, not solely for their own benefit or safety but for the comfort of other patients as well. One reason that a plan of action is so often agreed upon, then, is that the actions of these patients often demand resolution of some sort. Another factor is that solutions are often obvious and available, even though they may be unappealing to nurses. A common solution with violent patients is the use of "restraints." Another frequent approach is to treat the patient like a child and use straightforward reward and punishment techniques.

> An irrational patient often refuses to eat. The supervisory nurse suggests,"Why don't we find out what she likes. Then if she won't eat, we'll deny it." She then gives a ten-minute summary statement of how the patient is to be managed, beginning with, "Then this is what we'll do." (13-3)

The demanding and complaining patients have the second highest rate of plan formation. When these patients are discussed, a plan is often arrived at. It is interesting that this group also has the highest avoidance rate in the study; avoidance implies focussing on tasks to do with physical care, but otherwise staying

away from the patient as much as possible.

> The supervisory nurse says a patient was very difficult and demanding, and complained constantly about her illness and pains. The nurse says that the nurses who were responsible for the patient didn't feel much like talking to her. They just went into her room, did what had to be done, and left. (37)

The nurse in the above example notes later on that this avoidance made the nurses feel guilty; it is perhaps guilt that contributes to the fact that in half the cases a plan is formulated. This frequency may also indicate that, in fact, demanding and complaining bring results, if not popularity, for the patient.

Plans are frequently agreed upon for patients in the pain category. In part, this is due to the fact that two types of solutions are readily available, medicating the patient or sending the patient to the hospital's pain clinic. The patients in this group may also inspire anger, annoyance and avoidance.

Plans are agreed upon for one-third of the manipulative patients. Interestingly, this category ranks highest in having annoyance and anger as nurses' reactions, often accompanied by avoidance. Extensive psychosocial discussion rather than agreement on a plan of action seems to be characteristic in dealing with this group of problem patients.

> The patient is an 18-year old female, discussion of whom occupied an entire problem patient meeting and goes on for three, single-spaced, typed pages of field notes. The patient is said by one nurse to be "spoiled, demanding and manipulative." Another nurse says, "The patient is very depressed. She looks unhappy all the time." Another says, "None of the nurses can relate to her. She's spoiled." One nurse relates an incident in which the patient was suspected of stealing the nurse's ring. The nurse says, "I never wanted to get too involved with her after that." But this nurse objects to simply calling the patient spoiled, and says, "She struck me as the sort of person who has had a rough life," and adds that she has never seen any family members visiting the patient. The psychosocial consultant says she thinks "the patient has been through a lot" and the group should try "to understand her demands and her hostility and sarcasm as a front... She is probably really a scared, lonely girl..." Despite all this discussion, the observer notes, "I didn't feel anything was really resolved this afternoon..." (47-3)

The unpleasant patients rarely became the foci of management plans. Here, as with the patients who try to control staff or treatment, typologies occur commonly, perhaps sanctioning nurses' subsequent unsympathetic dealings with the patient. This is speculation, however, since such observations are not part of the participant observation data.

Management plans were only arrived at for one-quarter of the non-compliant patients; this is surprisingly low, unless one assumes that these patients are not causing overt trouble for staff or interfering with routines, and for whom, therefore, a plan is less urgent.

The category of problem patients for which a plan was least often arrived at was the career group. This was especially true for the patients for whom there was no longer any reason for continued hospitalization or whose hospitalization is seen as a result of the doctor's weakness or inability to refuse the patient's or family's wishes. Here, instead of making a plan, nurses complain and blame the doctors.

> The patient under discussion is asthmatic. The head nurse says that in her opinion, "There is no longer any reason for her to be on the ward." She adds that the patient and her family "are perfectly content to have her stay here." A nurse mutters, "It's typical of (the doctor in charge)...this practice of having patients staying indefinitely." She goes on to say that this particular doctor's patients know more than the nurses do "in terms of their care." (41)

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> An elderly female patient, 182 days post-operative, is discussed. One nurse asks, "Are we ever going to get her out of here or is she just going to become part of the institution?" The supervisory nurse says that the doctor doesn't want to discharge her because the daughters can't care for their mother themselves yet will only allow her to go to a certain nursing home which has a long waiting list. The supervisory nurse continues, "There is no maximum limitation on OHIP (the government health insurance plan) and since the bills are being paid there is no pressure on anyone to discharge her." Later on, she adds, "If the powers-that-be wanted her out of here they could do it." The physiotherapist becomes increasingly agitated and says, "This is getting silly. How can they keep her here? I think we ought to bring this up at the...meeting." The nurses say things like, "I wish I had a dollar for every time...." "How many times have we discussed this?" (207)

In the following example, frustration with one patient leads to a general outburst of frustration.

> A nurse says about a female patient, "She writes letters to administration and (the doctor in charge) is afraid of her. (The doctor) told me that that's why he won't discharge her, because he's afraid that it might get back to administration and he'll lose his license...I'm sick and tired of being manipulated by these patients. There is even one patient whose slip came back from the suggestion box that said, 'Just like the Holiday Inn but cheaper.' Can you believe that?" (154)

In the next example, anger is clearly directed toward the doctor.

> A nurse complains that a long-time patient has been readmitted. The social worker says that when the patient's family doctor refers the patient to the specialist at this hospital, the specialist "is not able to refuse because he thinks too highly of (the family doctor)...I've raised hell before but it doesn't do any good." The physiotherapist becomes quite upset and wants to take the matter to the specialist. The supervisory nurse says, "Maybe you' l get through where we've failed." The social worker says, "I can't tell (the specialist) to get her out of here. We don't have the right to do that." The physiotherapist persists, saying he is going to talk to the specialist. The nurse says in a cynical tone, "You can report to me. I'd like to see how far you get." (273)

As Table 3:5 shows, a management plan was formulated only when a psychosocial consultant, physician or both were in attendance. This supports Browne's findings on high and low decision meetings (Browne, 1977:59). Browne's dissertation is an analysis of the same participant observation data on which this thesis is based. In his study, a decision was considered made when a change was indicated in the patient care plan (Browne, 1977:38). A meeting was viewed as a decision situation. To examine

TABLE 3:5
PRESENCE OF PHYSICIAN AND PSYCHOSOCIAL CONSULTANT WHEN MANAGEMENT PLAN IS MADE

		Physician present		
		Yes	No	
Psychosocial consultant present	Yes	13	19	32
	No	5	0	5
		18	19	37

the impact of the physician on decision-making, he selected five meetings at which the patient's physician was present, five with the head nurse present but not the physician, and five at which neither was present. He found that physicians were represented at over half of the high decision meetings in his study and at only one of the low meetings. In general, he found that the highest proportion of decisions were made at meetings where the patient's physician was present. Browne did not investigate the role of the psychosocial consultant on decision-making, but the data here suggest the psychosocial consultant plays an important part in decisions concerning non-medical management, probably because

he/she often purposely guides the group to analyze its own behaviour and seek a solution. This is a specific aim of the consultant's role.

TABLE 3:6
PRESENCE OF PHYSICIAN AND PSYCHOSOCIAL CONSULTANT AT MEETINGS AND PERCENTAGE OF TIMES PLAN MADE

Present at meeting		Times plan made	Percent
Physician	43	19	44
Psychosocial consultant	78	32	41

Table 3:6 illustrates that a plan is formed slightly more frequently in the presence of a doctor than of a psychosocial consultant. Although a plan is formed in 41% of the cases when a psychosocial consultant is present, it is formed in 44% of the cases when a doctor is present.

Earlier in this chapter, I discussed complaining by nurses as one reaction to problem patients. What is the relationship between complaining and plan formation? When problem patients were discussed in the presence of doctors, a plan was formulated 44% of the time, and nurses complaints were voiced only 5% of the

time.

The data reveal 45 instances of nurses' complaining as a reaction to problem patients. In these instances, a plan is formulated in 18 cases. In 27 cases, nurses complain but no plan of management is formulated. Table 3:7 examines who is present when nurses complain and no plan is made.

TABLE 3:7
WHO IS PRESENT WHEN
NURSES COMPLAIN AND NO PLAN IS FORMULATED?

		Physician present		
		Yes	No	
Psychosocial consultant present	Yes	4	15	19
	No	0	8	8
		4	23	27

Table 3:8 shows that there were 13 instances in which problem patients were discussed and which were not attended by either a doctor or a psychosocial consultant. Table 3:7 shows that in eight of these instances, almost two-thirds of the time, nurses responded by complaining and failing to formulate any management plan.

TABLE 3:8
PRESENCE OF PHYSICIAN AND/OR PSYCHOSOCIAL CONSULTANT AT PROBLEM PATIENT DISCUSSIONS

		Physician present		
		Yes	No	
Psychosocial consultant present	Yes	31	47	78
	No	11	13	24
		42	60	102

When problem patients are discussed, the team often engages in psychosocial discussion of the patient (see Table 3:1, column 8). The next question to be considered is what is the relationship between psychosocial discussion and the formulating of patient management plans. Table 3:9 summarizes the data on the frequency with which psychosocial discussion of problem patients occurs when a plan is and is not formulated. In 70% of the problem patient discussions (71 out of 102 cases), psychosocial discussion took place. This is not surprising in view of the fact that psychosocial consultants were present at 76% of the problem patient discussions (78 out of 102). Overall, psychosocial consultants were present at 83% (59 out of 71) of the total psychosocial discussions.

One may conclude that, in this study, problem patients are very likely to be discussed in psychosocial terms.

TABLE 3:9
PSYCHOSOCIAL DISCUSSION OF PATIENTS

		PSYCHOSOCIAL DISCUSSION				
		Yes		No		
		Psych-osoc. conl. present	Psych. cons. not pres.	Psych. cons. pres.	Psych. cons. not pres.	
PLAN	Yes	30	2	2	3	37
MADE	No	29	10	17	9	65
		59	12	19	12	

Table 3:9 also shows that psychosocial discussion is almost certain to accompany the formulation of a management plan for a problem patient; this occurred in 87% (32 out of 37) of the cases.

In the 13 instances where nurses talked about problem patients in the absence of either a doctor or psychosocial consultant, psychosocial discussion occurred in only five cases.

In this chapter, I have described and analyzed ways in which nurses try to control patients. What has been ignored up to this point is the patient's simultaneous efforts to control the nurses. I turn now to a discussion of patients' control strategies.

V Patients' control strategies

Since most of the data arise from team meetings, far more data are available on how nurses control patients than how patients control nurses. However, by inference and occasionally by direct observation, some statements on how patients attempt to control their hospital situations may be made.

The most obvious inference is that behaviour which is perceived by staff as problematic is often a direct effort by the patient to gain control over the staff. Often these efforts prove successful. Thus, patients who complain or make demands may not be popular, but their demands may be met. Patients who are perceived as manipulative may be quite successful in enlisting the sympathy and support of particular nurses. Patients who are suspected of faking illness to avoid discharge often manage to have their hospital stay extended.

Patients may simply refuse to be treated.

> A patient who has had cancer for four years has been admitted to the ward. The cancer has spread to his vocal cords. The doctor says, "He is refusing to have anything done about it." (170)

The above example suggests that patients have more power than they know. The following example illustrates this further. The patient in question refused to be seen by anyone but her admitting doctor.

> A retired nurse, considered a very demanding patient, was highly critical of the nurses. This patient had refused to have anyone but the staff doctor look at her. (36)

As the preceding example suggests, patients who are "experienced" either through former hospitalizations or familiarity with hospitals through occupation know what demands they can make, which demands will be met, and how to time their demands to advantage. (see Roth, 1972).

The next example shows how staff take into account the patient's projected reaction to a psychosocial consultation.

> The occupational therapist asks if the social worker should see the patient under discussion. The resident says, "Yes, I can see the need for a social worker, but I think at the moment it's premature. She might be hostile if a social worker approached her at the present time" (104).

The patient's hostility, real or imagined, has warded off a psychosocial visit. In this sense, the patient has controlled her treatment.

The suggestion above that patients wield more power over staff than they may suspect is apparent whenever a staff member expresses the fear of being sued or losing his/her license. Roth's findings are pertinent here.

> ...patients and their agents rarely use legal threat to try to control the way in which they are treated. The possibility of lawsuit seems to be a bugaboo of the staff which is not reflected in the clientele's conception of its own arsenal of weaponry (Roth,1972).

In this study, there are no instances recorded where the hospital is actually involved in legal action. There are, however, numerous times where staff express general concern over the threat of legal action by patients.

> During a meeting a nurse suddenly realizes that the nurses had forgotten to get a patient to sign a consent form before she went for a test. The nurse says, "It's just like her to sue too...we better be careful about things like that in the future" (285).

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> A female patient is said to be suicidal. The supervisory nurse says, "I don't know what she's doing here in the first place. We are responsible if she happens to kill herself...if she kills herself we're all going to be in court" (56-3).

Patients may enlist the efforts of a family member in dealing with staff.

> One problem patient has a sister who, the nurse says, "comes in daily at noonhour and if the patient brings up anything in the way of complaints about the staff or the food, she harps on it and makes things worse"(62).

Roth noted that patients defined by staff as uncontrollable actually had an advantage. Since staff did not expect reasoning to be effective with these patients, they often gave the patients faster treatment just to get rid of them (Roth,1972). This finding is mirrored in the finding discussed earlier in this chapter that management plans were frequently formulated for the patients who exhibited violent and irrational behaviour. Whether or not such is their intention, these patients do manage to force staff to deal with them.

Patients may seek what they want by dramatizing their symptoms or maximizing their incapacities.

> One patient who was a severe management problem for nurses tried to control the staff by using her incapacities to get them to do things for her. First she would yell and swear at nurses. If this failed to bring results, she would cry and say how lonely and depressed she was. On one occasion, when neither tactic worked, the patient invoked the sick role and screamed at the nurse,"I'm the sickest person on this ward" (356).

Nurses are well organized in their efforts to control patients, while patients, especially in an acute care hospital such as this, have little opportunity to communicate or organize to pursue their common interests. Nonetheless, patients do communicate with each other to some extent. Two examples recorded by the observer while sitting in the patient lounge illustrate this communication.

> Two patients are conversing in the lounge area. One patient says that she was having "just an awful time...I kept vomiting all night." The other patient suggests she might be allergic to some of the drugs she is being given. (51)

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> One patient says that she is supposed to go home the next day but doesn't think she will be able to because her mother can't get to the hospital before 11 o'clock to get her. The patient to whom she is talking says she doesn't have to go by 11 but if she goes later she will be billed for an extra day. The first patient says she was told that patients had to be discharged before 11. The second patient says that she thinks sometimes that isn't possible because "almost three-quarters of the patients here are from out of town and are not able to get out before 11." (52)

As the above example suggests, patients manage to "learn the ropes" from one another. This kind of situational learning is common to...

> ...the newcomer in any social situation -- his attempts to master where things and people are, the niceties of rank and privilege, who expects him to do what, at what time, for how long; what the rules are -- which ones can or must be broken, which followed to the letter (Geer et al, 1968:209).

The following excerpt further illustrates how patients learn the ropes concerning...

> ...facts about persons, places, and things... relevant to mastering his situation (Geer et al, 1968:228).

Again, the setting is the patient lounge.

> One patient says to another, "I can't tell the nurses from the rest of them." Another patient says, "They're all nurses." A third patient says, "Well, some are registered nursing assistants and some are registered nurses." The first patient says that he hasn't seen one yet (referring to RNA). The patient who had said that some are RNAs says, "You can tell the nurses apart by the shape of their pins. Some wear square pins and other ones wear round ones." (59)*

It can be clearly seen, as the above discussion shows, that patients, although infrequently observed directly in this study, make serious efforts and use identifiable strategies in seeking to control nurses and the conditions surrounding their hospitalization.

* In actual fact, the shape of the pins does not differentiate RNs and RNAs, but identifies the particular school from which the nurse graduated.

VI Summary and conclusion

The position of the nurse in the hospital's authority structure holds many frustrations for nurses. Doctors may arbitrarily make decisions concerning patient management, despite previous team decisions. The results of this situation appear in the finding that nurses, when a doctor or psychosocial consultant is not present, do not formulate management plans at all. Since lack of a plan decreases nurses' control, such a reaction may be interpreted as alienation in the sense of feelings of powerlessness.

Institutional policies and philosophies were shown to exercise constraint over nurses. The health team exercised a further constraint over nurses, but probably increases their control over patients.

In maintaining control over patients, loyalty to the team is vital. In practice, this loyalty often conflicts with involvement with the patient. With the emphasis on psychosocial care in this hospital, nurses recognize that some nurses must get to know the patient well, yet this increases the potential for over-involvement with the patient, leading to a situation where loyalty to the patient may take precedence over loyalty to the team. Not only does this situation threaten nurses' control over patients, it also often leads to conflict among the nurses themselves.

One method of fighting the threat of over-involvement is to depersonalize the patient. In this study, this was achieved through labelling and typing patients, as well as

through extensive discussion of patients.

The team aids control and defends itself against disloyalty by providing its members with psychological support and a sense of community. This is particularly evident in matters relating to information control.

When control is threatened by problem patients, nurses seek to regain control. Reactions vary according to the category or type of problem patient. Patients who were perceived as trying to control staff or treatment were discussed the most, followed by manipulative patients probably because of the friction they created among staff. Avoidance is a common reaction, especially in the case of demanding and complaining patients. Avoidance does not seem to be related to diagnosis, appearing even when patients are seriously ill. With career patients, nurses' anger is directed toward doctors who are seen as responsible, rather than toward the particular patients.

A psychosocial consultation is the most consistent and frequent reaction to problem patients, being documented in 46% of the cases in this study (compared with 24% for the total patient population), and no doubt occurring in many more cases than were noted in the field data. One may conclude that, in this hospital, being identified as a behaviour or management problem creates a distinct possibility of being labelled a psychosocial problem as

well. The use of the psychosocial consultation, while no doubt benefiting the patient in some instances, may also be viewed as an extension of control by staff over patients where staff assume responsibility for and expertise in the patient's social and emotional, as well as physical, condition.

A management plan was formed for 36% of the problem patients discussed. Plans were formed most often for violent and aggressive patients, appearing in over half the cases. For patients in the pain, demanding and complaining, and control categories, plans were formed about half the time. Manipulative patients had plans formed only one-third of the time. Unpleasant and manipulative patients incurred the most frequent rates of anger and annoyance from nurses. Unpleasant and non-compliant had low rates of plan formation, and career patients had the lowest in the study. Many patients were discussed at great length by nurses and were often avoided.

Management plans were never formed when nurses only, without either a psychosocial consultant or physician, were present at meetings. Plans were only formulated when a doctor or psychosocial consultant was present. The presence of a doctor may be the more significant factor; plans were formed 44% of the time when a doctor was present and 41% when a psychosocial consultant was present.

A frequent reaction to problem patients by nurses is to complain; this occurred in over half the cases, although it is much less likely to occur if a doctor is present.

Psychosocial discussion occurs in 70% of the problem patient cases. Obviously, in this hospital, a problem patient is very likely to be discussed in psychosocial terms. Psychosocial discussion was seen to accompany the forming of a management plan in 87% of the cases.

The management plan is a major control strategy and yet nurses do not, in these data, formulate such plans on their own. The number of cases where nurses only are present is very small and generalizations must be made cautiously. On the other hand, the pattern is apparent and is consistent with Browne's analysis of team decision-making (Browne,1977), allowing a degree of confidence that further research would strengthen this finding. Furthermore, if the team concept is realized, with doctors and/or psychosocial consultants attending all or most team meetings, management plans are more likely to be formed and nurses' control over patients will thus be enhanced.

It was seen in this chapter that patients, too, seek control over their situations with some degree of success. Non-compliance, for example refusing to be treated, seems quite effective; staff appear to accept such refusal and other forms of non-compliance and rarely formulate management plans for these patients. There is also evidence that patients who make demands have their demands met although such patients are not liked by nurses. The frequent references to possible legal action indicate a general awareness by staff of the patients' power. Patients were seen to enlist the help of their relatives in their efforts to control their conditions of hospitalization. Patients were also seen to "use" their illnesses as levers to get staff to grant their wishes. Patients also communicate with each other, supplying each other with pieces of information they need in order to be more effective in their control efforts. In sum, patients use many means in their struggle for control, and despite their unequal position compared to the nurse, they have a variety of means at hand. It is quite logical, from the patient's point of view, to "use" helplessness or to make demands. What seems logical from the patient's point of view often seems a behaviour problem from the nurse's perspective. The asymmetrical relationship between patient and nurse, the often conflicting goals of each, and the different means available to each in seeking control give rise to the dramas enacted in so

many of the examples seen throughout this chapter.

The most alarming implication of the findings of this chapter is that in contemporary hospital practice, non-conformity is labelled and dealt with as a psychological or social problem. While the non-conformity may be extreme, as with violent patients, it may also be a perfectly rational form of action if viewed from the patient's perspective.

I turn in the next chapter to a consideration of the relationship between nurses and the relatives of their patients, investigating the ways in which each party seeks control over the other and the kinds of problems that arise.

FOOTNOTES

1 For a description of the psychosocial programme, see Chapter One, page 20.

2 Unpublished study data show the following results of a multiple regression analysis based on all nursing service respondents for all three survey periods:

ALIENATION FROM WORK,
BY SELECTED MEASURES OF TEAM FUNCTION

Dependent variable	Beta	p	Independent variables	
Low alienation from work =	.278	.000	Low inter-role conflict	+
	.176	.021	High peer supportiveness re achievement	+
	.096	.006	Low rule observation	+
	.121	.048	High goal integration	+
	.123	.056	Low role ambiguity	+
	.047	.054	High participation in decision making	+
	.089	.145	Low job codification	

Multiple correlation coefficient (R) = .648,
p = .000

Significance levels (p) should be interpreted only as ranking the variables in order of importance.

The alienation from work and rule observation measures are adapted from Hage and Aiken (1967a, 1967b, 1969, 1970, 1971). The measures of inter-role conflict and role ambiguity are adapted from Kahn et al (1964). The measure of goal integration is taken from Barrett (1970:3).

3 Strauss, Glaser and Quint suggest that psychological aspects of care are not stressed in professional schools and are not associated with technical skill but with common sense. Professional staff are, they say, assumed to have such qualities "in them." To

some extent, this situation has changed. There has been, in nursing education at any rate, an increasing emphasis on social and psychological aspects of care, although the job setting has often frustrated the new graduate's desire to attend to these aspects of patient care (Kramer, 1974:149).

4 The following discussion categorizes nurses as performers and patients as audiences. This is appropriate in the sense that nurses and other staff perform tasks on and around the patient. It is, furthermore, a useful metaphor when looking at the interaction from the nurse's point of view. In another sense, of course, the patient could be considered the performer and the nurse the audience.

5 As discussed in Chapter One, "control" is a more dynamic concept than "order." The nurses seek to maintain order as they define it; to accomplish this they need control over patients.

6 It is likely that the actual number of problem patients receiving psychosocial consultations is higher than this. My figure is based on information clearly indicated in the field notes, and this information may well be incomplete.

7 This figure of 24% is based on information obtained from administration data. It is, thus, an accurate figure and not subject to the qualifications discussed in footnote 6 concerning the number of psychosocial consultations received by problem patients.

CHAPTER FOUR

NURSES AND PATIENTS' FAMILIES

I Nurses and families: partners or opponents?

In this chapter, I turn to an examination of the relationship between nurses and patients' families. Like patients, families represent different social worlds than do nurses. Furthermore,

> ...the two do not share the same phenomenological meanings, assumptions or concepts. Illness never means the same thing to the client and to the professional (Freidson and Lorber, 1972:202).

While subject to many of the same stresses and strains as the nurse/patient relationship, the nurse/family relationship is more difficult to define. The position of the family as client is somewhat vague to nurses themselves and is subject to a shifting definition.

While both patient and family may be properly considered clients, the patient is usually the primary client with the family occupying a secondary position. This situation parallels that of the teacher/student/parent relationship. The family of a patient, like the parent of a student, is located outside the institution and its routines of work. This has implications for those who work in the institution. Becker (1953) says that one of the preoccupations of those who work in a service organization is the "...maintenance of their authority definitions over those of clients, in order to assure a stable and confenial work setting." He arrives at the following proposition:

> ...the relations of institutional functionaries to one another are relations of mutual influence and control and...outsiders are systematically prevented from exerting any authority over the institution's operations because they are not involved in this web of control and would literally be uncontrollable, and destructive of the institutional organization as the functionaries desire it to be preserved, if they were allowed such authority.

Patients' families are "outsiders" in the sense implied above. They are less subject to control than sick patients, and therefore represent a potential threat to nurses. The ways in which authority and control are challenged by families and how such challenge is met and managed by nurses comprise the subject matter of this chapter.

The family and nurse usually share the same overall goal of getting the patient well. However, the means required to attain this goal are viewed differently by professional and client. Furthermore, the specific interests and goals of nurse and family are often very different. The family wants to know the nature, course and treatment of the patient's illness; professional practice often tends toward the withholding of just such information from patients and families. The position of the nurse as buffer between doctor and family aggravates this as a problem area for nurses. The family may want more information than it is getting, or may demand special privileges, different treatment or more attention. The nurse, who wants a co-operative and compliant patient (see Chapter Two), also wants a co-operative and compliant family. The nurse wants a smoothly-functioning ward, without disruptive scenes, emotionally exhausting situations, unnecessary work

or loss of time. The nurse, in other words, wants a situation where nursing work may be satisfactorily performed according to definitions stemming from training and socialization. To this end, the nurse seeks to control the work setting and the position of the family in this setting.

II Institutional setting contributes to problems of control

While the family always poses a potential source of problems for nurses, this situation is intensified in the hospital in this study as a result of two distinctive features: a policy of open visiting and a strong institutional commitment to family participation in patient care.

The open visiting policy means there are no specific visiting hours and no institutionalized limitations on the duration of visits. Friends and family members may visit whenever and for however long they wish. This means that nurses' conventional strategies of maintaining control over families by minimizing, avoiding or channeling their interaction with family members (Glaser and Strauss, 1965: 59; Quint, 1965 and 1966) are far more difficult to employ. Since nursing tasks can no longer be confined to non-visiting hours, nursing work becomes far more visible to family members. Nurses themselves become more available to family members to question, make demands, or complaints.

That the uncontrolled and unscheduled presence of the family is perceived by nurses as a problem is evident in the participant observation data. For example, during a discussion of problems the team was having with family

members, one nurse said:

> "It's the McMaster philosophy. Some of them (the family) are here all day." (141)

In another example, a nurse comments:

> "He spends a lot of time on the wards... he's on the ward all day." (17)

The institutional commitment to family participation in patient care (Bihldorff, 1975) is a further constraint on nurses. The policy of family participation should be viewed within the larger institutional context. This hospital is a community-oriented institution. It was conceived as a community hospital. The community was consulted and involved during the development stage, and is represented on such administrative bodies as the patient care committee and the board of governors.[1] There is community representation and involvement in the admissions process to the medical school which is part of this hospital complex. The policy of involving the family in patient care falls naturally within this larger perspective. It is the philosophical style of this hospital to draw members of the wider community into the orbit of the hospital, rather than to systematically exclude them. Family involvement, in itself, is consistent with contemporary nursing philosophy which emphasizes the importance of the patient's support systems, including the family, in total patient care. However, family involvement, especially in this institution which emphasizes

responsiveness to the community and in combination with the open visiting policy, heightens the potential threat to nurses' authority and autonomy, while at the same time limiting the options open to them. Nurses' perception of lack of control is evident in the following example:

> A nurse says to the supervisory nurse, "I don't know what it is, but ever since I started working here it seems I have no control over anybody or even my own job...Patients tell us what to do, we have to answer to administration, we have to answer to the relatives, we have to answer to the doctors, it seems like it's never ending." One of the nurses suggests that perhaps this is characteristic of teaching hospitals, to which the supervisory nurse replies, "We've all worked in teaching hospitals and we haven't lost that power of control." (141)

III <u>The family as a problem for nurses</u>

In this section I first set the broad context within which families become involved as problems for nurses. This context includes the fact that some families never do become problems. It also includes the families of some patients who are placement problems. Against this general background, stand out several types of family problems which are very important for the ways in which nurses try to control their conditions of work. Based on the examples of family problems in the field notes, a typology of such problems will be developed.

a) Background

The following discussion and analysis is based upon examples of problems with families as discussed by nurses and other staff and recorded by the observer. A total of 46 examples were extracted from the field notes. The nature of the data is such that no claims may be made as to whether this represents a relatively high or low number of problems. There are certainly many instances in which the family poses no problem whatsoever for nurses. By not discussing these, I by no means wish to write them out of existence. However, it is from the situations which become problematic to nurses that insight may be gained into both types of nurse/family relationships, the ones which are thrown into relief as "problems" and the others which conform to routine expectations of nurses and remain undiscussed and part of the ordinary routines of work. The major question which will be pursued here is: what are the factors involved when some families come to be identified as problems by nurses?

b) Placement

Families are often discussed in connection with placement, that is, the placing of a patient after discharge from the acute care hospital into a nursing or convalescent facility. As was discussed in Chapter Two, placement was a factor in nurses' discussions and perceptions of problem

patients. In discussions of patients' families, placement was a feature in twelve incidents in the participant observation data.

Placement is always a feature of hospital life and the nurses' orbit of work; unless a patient dies in hospital, discharge is an inevitable occurrence, and a patient must have somewhere to go when discharged. Concern with placement issues was no doubt heightened during this study as a result of hospital and government pressure, exerted during the study period, to lower health care costs by not keeping patients in hospital longer than necessary. The impact of this pressure is apparent in the reduction of the average length of stay, as noted in Chapter Two, from 16 days to 10.9 days, as measured at the beginning and end of the study period (Marshall et al., 1976).

While placement concerns were perhaps accentuated during the study, placement-related problems are routine facts of life for nurses and as such are not my major interest in this chapter. However, I hope that a brief survey of these problems will serve to highlight by contrast problems which are not considered routine. These will be discussed later in this chapter.

Upon discharge, the most expeditious arrangement is for the patient to return home; this is a "no problem"

situation. For example, in the case of a female patient who has just been diagnosed as having cancer, the resident says:

> "She goes home Friday if all goes well. Her son is a doctor and her husband is really good with her. She also has two daughters so I don't think we should have any trouble in that area." (102)

In another example, a 70-year-old female is being discussed.

> The nurse says, "If she doesn't improve, she'll be a placement problem. We have to look after her completely and she's gotten worse and probably will get worse." The resident replies, "I think her husband will look after her. They have a good relationship." (87)

Relatives may contribute to placement problems by insisting on a specific facility or type of facility which may not be immediately available. Despite the organizational and governmental pressure to discharge patients as soon as medically advisable, the field notes reveal that the family wields enough power over physicians with regard to placement to counteract such pressure. The face-to-face power of the family over the physician is greater than the impersonal power of the hospital and certainly more than the remote influence of the government.

Illustrating the above, the following discussion centers around an elderly female who has been in the hospital six months. A nurse asks:

> "Are we ever going to get her out of here or is she just going to become part of the institution?" Another nurse answers that the doctor doesn't want to discharge her because her daughters can't cope with her at home and the only nursing home the family will approve has a very long waiting list. The patient has been placed on this list. (206)

The family may be unable to make a firm decision about placement, although the patient is ready for discharge.

> A nurse says about a patient's family, "They don't have the proper set-up for her at home, yet they feel guilty about placing her in a nursing home." Another nurse says, "The family wants her and then they don't want her." (133)

The family may be happy to have the patient remain in hospital. In the following example, a patient with asthma is ready for discharge but is afraid to go home because she fears she won't be able to manage. The supervisory nurse says:

> "There is no longer any reason for her to be on the ward...(the patient) and her family are perfectly content to have her stay here." A nurse mutters, "It's typical of (the doctor in charge)." The supervisory nurse says it was "allright for this sort of practice to go on in the beginning when the ward had a lot of empty hospital beds but this practice of having patients staying indefinitely is being continued by (the doctor) and his team." She adds that patients of this particular doctor"know more than the nurses do in terms of their care." (41)

While the family in the preceding example will probably take the patient back, the family in the excerpt below is clearly through with the patient, an 88-year-old man who is waiting for placement.

> The supervisory nurse says that the patient's family have apparently wiped their hands of him. They expected him to die in intensive care and her impression is that they seemed annoyed when he didn't. (36)

In cases where the family is not ambivalent or vacillating about placement, placement may still be viewed as mildly problematic. Nursing home and chronic care facilities are crowded and patients usually have to wait at least a short time before being admitted. During this time they remain in the acute care hospital. While the task of arranging the transfer to the new facility falls to the social worker, the staff must continue to provide care until the patient leaves. Thus, the family who does not plan to take the patient home but wishes to seek placement instead may create extra work and perhaps extra problems for the staff. This is particularly true when a problem patient is involved.

> Regarding a 73-year-old male patient, the resident says, "I think we're going to be placing him. His wife can't handle him at home....he slugged (a nurse) last night." (93)

In another case a female patient is discussed.

> The supervisory nurse says, "She's always asking for her husband. She thinks her husband is running around with other women." The occupational therapist says the husband "is finding it difficult to cope with that...the patient told me that she is not going home...she is going to wait for placement."(125)

Placement, then, does involve problems, but these are somewhat peripheral to the major focus of this chapter. I turn now to a discussion of the types of problems staff have with families.

c) A typology of family problems

I have categorized family problems in three groups: staff-initiated definition; family-initiated definition: routine; and family-initiated definition: crisis. If the first group is pictured as "sitting quietly," and the second as "raising their hands," the third receives attention by standing up and speaking out. To pursue the classroom metaphor, the third group alone is breaking the rules, or getting out of line. The first group does not threaten staff control. The second group poses a potential threat. The third group, however, poses a direct challenge to nurses' authority and control.

TABLE 4:1
TYPES OF FAMILY PROBLEMS

	Problem category	Patient is primary focus	Family is primary focus
least severe	1. Staff-initiated definition: routine - family doesn't interfere	15	4
to	2. Family-initiated definition: routine - family interferes	4	6
most severe	3. Family-initiated definition: crisis - family interferes	6	11

In Table 4:1, the 46 instances of problems involving families are divided into three categories and along two dimensions. The first category contains the mildest problems. The definition of the family as a problem is initiated by the staff. The family has not actively invited this definition, nor has it interfered with the staff's work. The essential criterion for inclusion in this category is that families do not create problems for staff directly. They do not demand information, interfere with treatment, disrupt the routine or upset the staff. The problems in this category are considered routine or part of the job. Usually the patient remains the primary focus of attention, and the relatives are discussed as an extension of concern for patients. For example, a patient's problems may be discussed as relating to or stemming from poor family relations or specific problems involving a relative. The psychosocial attention given the patient is extended to include his family situation.

> A 17-year-old male patient is said by the nurse to cry if he doesn't get his needle. The nurse says that the parents have really babied him. (153)

Sometimes the focus of attention is transferred to the family member.

> A patient's family is reported to be "concerned and anxious about his condition." (102)

When the definition of the family as problem is initiated by staff, whether the patient or family is the primary focus, the relatives are seen as having problems rather than being problems.

In the second category, the problems are more serious. The family here is active, not passive. It actively draws the staff's attention to itself, resulting in the definition of the family as a problem. Some kind of interference with the routine flow of events occurs, and control is threatened. Despite this interference and potential loss of control, these problems are accepted within the framework of the job nurses are educated and socialized to expect to do. They are considered "all in a day's work" and as such are still routine problems.

Some of the relatives in the second category cause problems by directing emotional reactions toward staff. They may cause problems related to nurses'emotional composure or performance of tasks. A family may be perceived as not being properly concerned about the patient or posing some kind of threat to the patient's welfare. These relatives may complain or make demands but to a limited extent. Such relatives are more of a nuisance than a serious, disruptive problem. The following family situation belongs in this category.

> Regarding a female patient with renal disease who has pain the doctors cannot alleviate, the nurse says that the sister isn't pleased with the way the staff is handling the patient. The physician says, "Tell her to see me about that." (80)

The third category contains what staff consider severe problems. The family interferes with aspects of the work routine in such a way as to create what is perceived as a crisis situation. They may come into open conflict with the staff, upset the patient, create friction and disunity among the staff, criticize or complain excessively, or interfere with treatment. Families may create composure problems for nurses: for example, in the case of young, dying patients, nurses seem vulnerable to becoming over-involved with a family member. The problems in this category represent crisis situations which call for action to restore order. This sense of crisis can be seen in the following example.

> A woman whose husband was a patient was involved in the husband's care. The wife was asked not to get involved with his care by one of the nurses on duty over a weekend. The wife became very upset and wanted to take her husband out of the hospital. (140)

Classifications such as those in Table 4:1 are, of course, somewhat artificial. They represent ongoing human interactions frozen at one moment in time. In reality, a crisis situation on one day may become more routine by the next day. Similarly, a non-problematic family may become more difficult and staff-initiated

discussion of such a family may represent awareness of this and an effort to forestall such a development.

Looking at Table 4:1, a pattern emerges. In instances where the definition of problem families is initiated by staff, the problem is most likely to be viewed with the patient as the focus. In the second category, where the problem definition is family-initiated, the patient is about as likely as the family to be the focus of concern. In the third category, however, it can be seen that the focus of concern is more likely to be the relative.

Table 4:1 summarized all the incidents in the field notes in which the family was discussed as a problem. Analysis was begun by grouping these incidents according to whether the definition of the problem was initiated by staff or family, whether patient- or family-centered, and whether perceived as part of the routine or as a crisis situation. To further analyze these problem incidents, they have been broken down within each category according to whether or not nurses initiate the definition by being the team member to describe the incident. Table 4:2 summarizes this information.

TABLE 4:2
INITIATION OF DEFINITION OF PROBLEMS WITH THE FAMILY: PROPORTION OF INITIATIONS MADE BY NURSES*

Severity type	Focus of problem: Patient	Focus of problem: Family
Staff-initiated definition: routine	7/15	0/4
Family-initiated definition: routine	4/4	3/6
Family-initiated definition: crisis	6/6	10/11

*Incidents were coded by which occupational group was recorded as voicing the problem.

Table 4:2 reveals an interesting pattern. In both patient-centered and family-centered problems, nurses are more likely to voice the problems as the problems themselves become more severe. In the crisis category of problems, nurses almost completely monopolize this function. The more a problem poses a threat to order and interferes with conditions of work, the more it is likely to be a nurse who brings the problem to the discussion stage. Put another way, in these crisis problem situations, the nurses are the professionals who most keenly suffer the effects.

These three categories of problems with the family will now be examined in more detail.

i) Staff-initiated definition: routine

Staff-initiated definition as a category implies that the family does not actively bring itself to the staff's attention. Figuratively speaking, the staff, as it surveys the medical situation of the patient, pauses to consider the family. In most of the examples in this category, 15 out of 19 cases, consideration remained patient-centered.

> A resident says about a female patient, "She seems to have a lot of problems with her family...I think she likes to take all the family's problems onto her shoulders." (101)

Relatives may be viewed as contributing to a patient's physical or emotional problems.

> An 82-year-old male patient is unable to get around by himself, although doctors do not know why. The resident says, "I think we should involve his wife and daughter...they don't give him much encouragement to get around on his own." (87)

The family in the preceding case is going to be involved in order to help the patient; concern is patient-centered.

In the next example, the role of the family in contributing to the patient's problems is not as explicitly stated. Psychosocial information on the family is offered to provide a broader framework in which to understand the patient's behaviour.

> A male patient is presenting a variety of problems for staff. He is suspected of smoking marijuana in the hospital and possibly using other drugs, is not complying with treatment, and is threatening to sue the hospital. The social worker asks the staff to tell her some more about the case. The occupational therapist says, "The mother was in last night. She's neurotic and hypertensive. The husband is European and has no control over the children. The wife has taken control over the children." (147)

In other cases, the psychosocial discussion focusses more strongly on the family, but remains essentially an extension of concern for the patient.

> Discussing a female patient, the psychiatric resident says the patient's sons don't really care about their mother, and that they only show her "superficial affection." (26)
>
> - - -
>
> The resident says about a 44-year-old male, suffering from chest pain and obesity, that there is "a lack of communication between the patient and his wife. They hide their problems from each other rather than discussing them openly." (29)
>
> - - -
>
> A 44-year-old woman is dying of cancer. The social worker says they "decided to discuss with (the patient) and the kids together what her death means to them. They had never been close...the kids , whenever they visit the mother, seem to be really flippant. They haven't really come to grips with discussing her death at all." (199)
>
> - - -
>
> A 36-year-old female patient is discussed. The resident says, "Family counselling is underway. She wants help about her private life which is a real mess." A nurse says, "I don't know whether you've ever noticed this, but there is absolutely no conversation between her husband and her when he visits. They just stare at one another." (119)

Sometimes attention is centered on the relative's psychosocial state, and the patient is no longer the primary focus of concern.

> In the case of an elderly diabetic, the resident says, "His daughter is upset about his degeneration." (101)
>
> - - -
>
> The resident asks the social worker to see how the wife of a gastrectomy patient "is taking it... she seemed to be under a lot of stress." The social

> worker sees the wife and says he found her to be "pretty stoic." The resident agrees and says she kept her emotions pretty much in check. (83,87)

A family may be perceived as a problem in that they do not have the patient's best interests at heart, or do not care about the patient. One such case involved a family who did not come to visit a dying patient.

> The nurse says, "The conference that (the physician) had with (the patient's daughter) didn't seem to go very well. The family still comes in only on weekends. I've heard that they're waiting for her to die so they can get her money." (104)

ii) Family-initiated definition: routine

Family members may, by some direct action, bring themselves to the staff's attention. They may complain or express emotion to the staff, or interfere with treatment or hospital routine. However, such occurrences are perceived as being more or less routine, that is, a less-than-pleasant but still to-be-expected part of the job. The ten examples in this category were split according to focus: four were patient-centered and six family-centered.

The relative in the following example has complained to the staff.

> A patient's daughter has spoken to the physician claiming the hospitalization has made her father worse. The doctor and clinical clerk have spoken to the daughter and tried to explain things to her. (9/21/74)

Another family expresses anger and dissatisfaction with the amount of information they have received.

> A patient's family is said by the social worker to be very angry because they felt the doctors didn't tell them fully about their mother's operation... they "feel they haven't been informed enough by the medical staff regarding the amputation of her leg." (189, 198)

Relatives may make treatment of patients more difficult by interfering in some way. In the following example, an unco-operative patient is encouraged by her daughter not to comply with treatment.

> A nurse says that the daughter told the patient, an elderly female, that she "did not have to have her legs scanned so she is not going to have it done." A second nurse adds that the daughter "doesn't want her mother to go to the bath," to which the first nurse replies, "That's tough." (160)

Although there is the potential for confrontation and disruption in the above case, it suggests that as long as the relative's influence is directed toward the patient rather than the staff, the staff can deal with it by ignoring, cajoling, etc. It is easier to impose one's will on a patient than on a relative.

A family may engage in deviant behaviour while visiting. While this necessitates action by staff, it may be considered non-problematic in that the course of action is clear-cut and relatively non-debatable. For example, in the case of a male patient admitted with severe head pain and suspected of being an alcoholic:

> The nurse says that the patient's family had to be kicked out of the room because they had all been drinking. Apparently someone had sent in a basket of fruit with a bottle of wine and some whiskey hidden in the basket. (24)

Relatives may be seen as posing some kind of threat to the patient in addition to not acting in the patient's best interests. For example, in the case of the previously mentioned elderly female who had had a foot amputated, a nurse says,

> "It says on her record that the family did not want the amputation because they wanted her to die in dignity." A second nurse responds, "Well, maybe her family might want her to die in dignity but she doesn't want to die and perceives us as the ones who are trying to help her." (187)

In another example, the parents are perceived as unwittingly creating problems for the patient, a 16-year-old male who has had his leg amputated.

> The nurse says that when his parents came to visit him they appeared to be distraught over the amputation and instead of them trying to cheer him up, he was telling them that he was fine and putting up a big front." (118)

Family members may create potential composure problems for nurses.

> The team learns that the wife of a former patient has committed suicide. The consensus of the people at the meeting was that they had not prior knowledge of what was in her mind. Some felt she had felt guilty about placing her husband in a nursing home. Others felt that she was trying to get back at her husband for leaving her by going into a nursing home. One nurse talks about how they had not had a close, loving relationship. (203)

The nurses and other staff need to reassure each other that they need not feel responsible and guilty, since they didn't know the wife was thinking of suicide.[2]

A family may be considered a moderate problem for staff when there is some need for the nurse to guard against giving more information than the physician has authorized. For example, the case of an 81-year-old male is discussed and the resident says about the wife:

> "I think someone on this ward is giving his wife the message that he shouldn't be going home. The wife was very careful when I saw her at home today." He goes on to say that the wife shouldn't be told anything by anyone until they were certain about her discharge plans and management. (87)

iii) Family-initiated definition: crisis

Whereas the first category of family problems involved no threat to staff control, and the second category involved a potential threat, the third category issues a direct challenge to staff authority and control. There are seventeen instances of such non-routine or crisis situations involving the family. Of these, eleven are family-centered, while only six retain the patient as the primary focus of attention. This is not a surprising finding, for once the relative is perceived as being out of control, the reassertion of authority and regaining of control become matters of urgent and immediate concern.

Of the seventeen "crisis" incidents, eight are explicitly related to open visiting and eight are directly related to family participation in patient care. In many cases, this distinction is artificial

since participation in patient care may be frequently viewed as a consequence of open visiting: a relative who is present for long periods of time may be given the role of patient or worker and thus integrated with the staff's routine. Glaser and Strauss (1965:164) found this was the case with relatives of dying patients for whom visiting rules were relaxed. Many of their findings are duplicated in the hospital under study, since visiting rules in this hospital were relaxed universally, not just in the case of dying patients. The open visiting policy leads to a situation where the presence of family members cannot be confined to a narrow and predictable time segment. This creates strain for nurses in several ways. The nurse may no longer be guaranteed of carrying out nursing tasks on and around the patient in private; these may have to be done in the relative's presence, or the nurse must request that the relative leave the room, thus risking conflict. The unlimited presence of the family makes it difficult for nurses to employ tactics which in other settings and situations serve to maintain distance between relative and nurse, prevent extensive questioning and interference, and thus maintain control. Other studies have noted these verbal and non-verbal tactics -- appearing busy, maintaining a cheerful, brisk, detached manner, popping in and out of the room, answering

questions with evasive, non-specific replies or simply saying, "You'll have to ask the doctor" (Glaser and Strauss, 1965; Quint, 1965 and 1966). A logical consequence of open visiting is that the family, with free access to the patient, may be constantly around to observe and judge the patient's care. Relatives may criticize or make demands for more care. Indeed, this was often the case with families in the "crisis" category. Such criticism may be quite unwarranted, and simply a form of scapegoating by a distraught relative. Even when nurses understand this process, as they frequently do, it is nonetheless highly frustrating for them.

The constant presence of relatives heightens the possibility of nurses becoming over-involved emotionally with them. The nurse, unable to employ avoidance tactics described above, cannot help but get to know the relative. This becomes particularly threatening to the nurse's composure when the patient is dying, and even more so when the patient is fairly young.

d) Problems stemming from open visiting

Glaser and Strauss note that the "influx of family members creates many management problems for the staff... the patient's domestic problems may follow him..." (1965:165). This suggests the hypothesis that the more time the relative spends visiting the patient, the more likely the patient's

domestic problems are to impinge on the patient's hospital situation.

> The sister of a problem patient is viewed as contributing to the patient's problems as well as creating problems for staff. The supervisory nurse says, "The sister comes in daily at noonhour and if the patient brings anything up in the way of complaints about the staff, or the food, she harps on it and makes things worse." Another nurse says, "The patient appears more dependent when his sister is there. When he is alone, he seems to be doing more things for himself." (62)

In the above example, the relative not only creates problems for staff by complaining and encouraging the patient to complain, but also is viewed as discouraging the patient from achieving what is deemed a suitable level of initiative and self-sufficiency.

In another example, conflict between a dying patient's wife, father and mother is creating problems for staff.

> A nurse says, "...the father doesn't want the son sedated, he wants him alert so that he can talk to him but (the wife) wants him sedated and comfortable." The social worker suggests, "Well, maybe we can limit the visiting hours on the father." The nurse says, "No, you can't do that around here. Parents have just as much rights as the spouse around here." (198)

In another case, nurses feel they cannot come to grips with a problem patient who is described as "cold and resentful of the nursing staff" because of the presence of the patient's boyfriend who is said to "come in the morning around ten o'clock and stay all day."[3]

> The psychiatric resident asks the group, "What can you do when she's (referring to the patient) hostile?" A nurse replies, "It's really difficult to do much because the boyfriend is always there." The nurses feel that this is part of the reason they have avoided going into the patient's room. One nurse adds, "I felt like I was intruding." (47)

In another case, the husband of a dying woman is creating a variety of problems for staff and the nurses feel they have lost control over the patient and the husband. The resident comments:

> "It's not normal behaviour for him to be hanging around the wards all day and to be doting over her. It's just not normal, it's not rational." (69)

As noted earlier, a family member may resort to criticizing staff as an outlet for his/her own grief or frustration at not being able to help the patient. Nurses understand this, especially when a dying patient is involved, but their sympathy and understanding do not prevent them from getting caught in the tangle of emotional outbursts and criticisms of themselves and their colleagues.

Leading a discussion about this problem, a supervisory nurse says:

> "The patient is getting excellent care, but his family is frustrated and as a reaction to his illness takes out the frustration on the nursing staff...they (the relatives) explode because of minor incidents that occur and this has the nurses upset because they feel they are giving excellent care." (84)

During a discussion of the case referred to earlier, that of a woman dying of a brain tumour, it is clear that the nurses understand the problems the husband is having in coming to accept his wife's condition.

> A nurse says the husband "complains that things aren't done on time" and that he is "looking for anything but the tumour to be the answer to his wife's state of confusion." Another nurse adds, "There is definitely a conflict between what the nurses feel is right for (the patient) and what her husband feels is right for her." He criticizes the way they are looking after her and this is all very "frustrating" for the nurses. (17)

e) Family participation in patient care

Family participation in patient care is a general policy of this hospital. Involving the family is usually viewed favourably by nurses, not only because of hospital policy but also because of their training. However, the process of the family becoming involved is neither smooth nor universal. The field notes are filled with examples that show this area to be one of struggle, conflict and confusion between health professionals themselves as well as between nurses and families.

> At a team meeting, a specific problem concerning a patient and his wife[4] gave rise to a general discussion about relatives getting involved with the treatment of patients. A nurse said, "I can see the relatives being involved but tell them they have certain limits and outline these from the outset." Someone asked what some limits might be. A nurse said she would ask the wife (that is, the problem relative they had been discussing) to leave "while we were administering physical care functions and things we have to do that aren't nice to look at." Another nurse said, about the wife, "That's the way she is...she wants to get involved. I don't think we should stop her if that's what she wants to do." (140)

In response to the strain of having a family member constantly present, nurses may view with favour getting him/her involved. Section IV examines this process.

IV Nurses' strategies for controlling the family

When a family member begins to slip out of the visitor role, he/she is given a role as either a patient or a worker which integrates him/her with the staff's routine (Glaser and Strauss, 1965:164). This study reveals that the two roles may be combined -- the family member is given both roles simultaneously. While the role of relative is external to the hospital routine and often interferes with it, the role of worker or patient transforms the relative into someone who becomes part of the work context and therefore more controllable by nurses. I will look first at the relative as worker, and then at the relative as patient.

a) The relative as worker

The relative who is occupied in doing some of the nursing tasks may be less likely to complain that the nurse is giving insufficient or improper care, because helping makes him feel less anxious and helpless. By assuming responsibility for some of the patient's care, the family member becomes part of the health team;

loyalties to the team may thus be engendered, placing the family member under normative control. This was most apparent when such normative control broke down.

In the case of a patient whose dying was of prolonged duration, the wife was a constant source of irritation to nursing staff, who responded by allowing her and the children to take an active part feeding and bathing the husband. Nurses in fact were split as to the desirability of this involvement. When, however, the husband became more severely ill in the terminal stages, some of the nurses sought to resume these duties. On one weekend, there were no nurses on duty who favoured the wife's involvement. One nurse requested that the wife leave the patient's room. The wife reacted to this with anger, tears, and complaints which eventually led to a reinstatement of her participation. Later, at a team meeting, a nurse said:

> "I wasn't here for the big bust up. What happened?" Another nurse replied, "The wife thought that she wasn't a part of the nursing care plan anymore." (121)

A few days later, the nurses continued their discussion of this case. It is apparent that there has been some friction among the staff.

> A nurse says, "I think the problem with this particular case was that there was no definite plan of approach. Another nurse suggests, "The problem lay in not supporting one another...we shouldn't have listened to her stories about the other nurses." The psychiatric resident asks, "What was she criticizing?" The nurse replies, "Basically, she was criticizing the care, but the care was the same and I told her that. We just all have different ways of doing it." The nurse who spoke first said, "With some people she was involved, and with others she wasn't." (140)

It is obvious that despite team meetings and discussions, staff disagree among themselves on the desirability and proper extent of family participation, and fail to present a "united front" to the relative. This represents a source of power for the relative, and one on which the above-mentioned relative was able to capitalize.

While nurses are split, social workers may be particularly enthusiastic about family involvement, since this falls into their area of recognized expertise and may represent an opportunity to expand their professional domain within the hospital. Nurses gain in the sense that they are stuck with the family member in any case, and conferring the worker role avoids the chaos of having a role-less participant in their health care setting. It provides a focal point for nurse-family interaction.

Generally, this strategy may prove mutually satisfying to family and nurses; that there are often problems, however, is evident in the following example:

> At a Problem Patient Meeting, nurses said they had lost control over the management of a patient, and that they had allowed the patient's husband to gain almost complete control over her care. The resident wants the nurses to resume feeding the patient. The social worker interrupted: "Forgive me if I disagree with Dr.____. What's the harm in him feeding her? I thought before that we had decided that it was all right for him to help feed her." A nurse spoke up here. Her face was flushed and she seemed quite upset. She said in a faltering voice, "He's doing her harm, he's not helping her. This morning he was forcing her to eat; he was forcing the food into her throat and she almost choked on it." The observer noted that at this point she could notice tears in the nurse's eyes. The nurse put her hand to her face to wipe away the tears. She was extremely upset. (69)

If family involvement comes to be perceived as a loss of control, a struggle may ensue whereby nurses try to regain control of the situation by reducing the role of families; this may involve, as seen in the case of the dying patient discussed earlier, taking back tasks which had been delegated to the family.

By and large, nurses do go along with family participation and some actively endorse it. If nurses try to control their conditions of work, and if family participation represents an actual or potential loss of control, a key question is: why do nurses allow family members to become involved? Nurses allow families to become involved in health care work on the ward as an extension of their training to consider and use the family for support, because hospital policy encourages

family participation, and because this participation relieves them of time-consuming work.[5] It is not just time saved, but the type of work which a family health care worker might contribute, that is important. It is often noted that the nurse tends to be rewarded for performance of bureaucratic rather than professional functions (Corwin, 1961; Kramer, 1974). This research literature suggests an ambivalence about the professional nature of direct patient care, or "bedside care." While turning over patient care to the family may represent a possible or real loss of control, this ambivalence[6] toward such functions may make the family assumption of such duties an appealing proposition to the nurse, freeing her to devote more time to the putatively more "professional" tasks of an administrator.

Involving family members as workers may help the health care staff deal with patients who evoke deep emotional involvement. Nurses are particularly vulnerable to becoming emotionally involved with patients because of the amount of time they spend with them. This is particularly problematic with dying patients (Glaser and Strauss, 1965). Quint (1965) argues that a fatal diagnosis has a doubly painful meaning to staff, who as individuals are reminded of their own mortality, and as professionals are faced with failure in that they have been unable

to save the patient's life. Avoidance of the patient may be seen as an outcome of these painful feelings. The delegation of direct care functions to family members allows nurses to cope with their own discomfort by reducing their involvement, restoring some physical and emotional distance between themselves and the patient and cushioning themselves against the oncoming death.

With terminal patients, the goal of nursing shifts from curing the patient to providing as much comfort as possible. The nurse who fails to perform these comfort functions, or who delegates them to the family, may experience feelings of guilt.

The nurses in this study are not unaware of these issues. Problems of managing the family and managing their own emotions are frequently discussed by nurses.

> A nurse says, "I think that when we get to know the family because of a patient's serious illness, we tend to lose control of the patient." Another nurse says, "Speaking of losing control, I think that when we release some of the nursing care over to the patient's family, such as feeding, making the bed, etc., our coping mechanisms are taken away from us. We know that we can't do any more for the patient and by making the bed, doing feedings, things like that, it helps to prevent us from getting too depressed." Another nurse agrees, saying, "That's right, if I don't have that sort of thing to do I'd go nuts." (84)

Thus, encouragement of family involvement varies with prognosis. When they can, nurses prefer to "cure." When cure is not possible, they wish to reserve "care" for themselves, but find the caring process difficult.

In summary, the situation is one of tension between the need for control versus the need for composure; or, to put it another way, there is tension between the need for control over the patient and family versus the need for control over one's self.

Involving the family member as a worker keeps the member under normative control by providing a role, and engenders loyalty to the health team. For the nurse, involving the family member as a worker conforms with prior socialization and hospital policy, and facilitates the maintenance of composure by limiting emotional involvement with patients. On the other hand, the ambiguities of the nursing role (Kramer, 1974) render this strategy problematic, for it involves the abandonment of some accustomed instrumental tasks. The nurses may be left with nothing to do. A preferred strategy for maintaining control over the families of patients is, therefore, to cast them into the more traditional role of patient.

b) <u>The relative as patient</u>

The emphasis on family involvement in the hospital under study encourages a strategy of viewing the relative as patient. The family member becomes a legitimate object of the health professional's attention and skills.

Relatives may have needs for sedation, comfort, counselling, consolation and help, particularly in facing a patient's death (Glaser and Strauss, 1965; Carpenter and

Stewart, 1962), and the nurse comes to see meeting these needs as the chief tasks. This strategy is not limited to relatives of dying patients. A family member may simply be added to the patient list, figuratively speaking:

> In a discussion of one patient, a nurse said, "The husband is coming across as anxious and angry. We told him that it was allright to get angry and that we understand completely." A supervisory nurse said, "Part of the problem here is guilt." A social worker added, "He had had a bad marriage." The doctor suggested that the social worker and another team member discuss the case with the family. (56)

In the case of a dying female patient, the health team became concerned early in the patient's hospitalization with the husband's failure to recognize the seriousness of his wife's illness. A nurse said she thought one of the husband's problems was that...

> ...he hasn't really been able to identify with any of the staff members. There hasn't been any one nurse that he can turn to or talk to when he feels desperate. (17)

The discussion above clearly deals with continuity of care not for the patient, but for the family member. At the same time, however, this encompassing of the family member into patient care is seen as posing problems, for another nurse interjected that she didn't mind giving the husband support, but she felt she should not become "too involved with his problems" and that she should "maintain her objectivity" as a nurse.

As with the conferring of the worker role, there are, then, dilemmas associated with conferring the patient role; dilemmas which, perhaps, reflect the ambivalences

and uncertainties of the nursing profession today. The nurse wishes to be "objective" and "professionally detached." Her role, however, involves both "caring" and "curing." "Caring," the fundamental or traditional aspect of the nursing role, is now being endowed with new importance as a professional function. To the ambiguity of this changing situation is added the further development that "caring" is to be devoted not only to the patient, but to the family of the patient.

c) Discussion

As the preceding discussion has illustrated, nurses cast families into three roles -- visitor, worker and patient. The questions of why and when nurses impute these roles to families has been touched upon in the preceding pages. The concept of altercasting (Weinstein and Deutschberger, 1963) provides a theoretical framework for further understanding these processes. Altercasting is the casting of Alter by Ego into a particular identity or role type. Each participant in the interaction is assumed to have his/her own goals or purposes; thus, roles are seen as purposive as well as normative. Ego's actions are examined "on the basis of the identity they create for Alter." Weinstein and Deutschberger contend that altercasting is a basic technique of interpersonal control. By "creating an identity for the other congruent with one's goals," Ego controls or attempts to control Alter.

Hewitt (1976:135) points out that "altercasting operates by placing limits on the capacity of others to make roles they choose." Alter is constrained to act in a certain role because he/she is being treated as if he/she were a certain kind of person.

> The phenomenon of altercasting entails a key aspect of all social interaction: the imputation of roles to individuals, and action toward them on the basis of such imputation, places powerful constraints on their conduct (Hewitt, 1976:137).

The concept of altercasting captures the negotiated quality of interaction. Alter tends to accept the role imputed by Ego, perhaps because of a norm of reciprocity as Hewitt suggests. However, such acceptance may be long-term or short-lived. Interaction is, in this sense, precarious, and negotiation is more or less continuous.

The most common role for relatives is the visitor role. This is probably the role preferred by nurses, since it is the most familiar and, when properly acted, the least threat to control. The set of norms surrounding the role of hospital visitor is similar in many respects to the role of visitor in the wider culture. A visitor should not overstay his/her welcome, should not tire or upset the host and should be polite. A visitor need not be helpful, but should observe good manners. With increasing familiarity, the proprieties may be relaxed, and the visitor may take more liberties. In terms of

control, then, casting a relative in the role of visitor renders the nurse in control of the situation since the relative is bound by the role to behave in a certain way. However, as the relative becomes more familiar with the setting and the staff, he/she may begin to step out of the visitor role. Familiarity is significantly related to the amount of time a relative spends visiting the patient. When the relative spends long periods of time around the hospital, the techniques by which the visitor role is maintained, techniques which were discussed earlier in this chapter, are no longer as easily employed. As control begins to slip, the nurse searches for a new role in which to cast the relative. The data suggest that the role of worker is imputed in the case of relatives who are spending extensive periods of time at the hospital, who are slipping out of the visitor role, and who are interested in being involved in the patient's care. The assumption of duties such as feeding and bathing keeps the relative occupied, frees the nurse for other tasks, and places the relative in a position of authority subordinate to the nurse. The relative has been brought into the authority system and placed in a subordinate position. Emotional distance between relative and nurse is decreased, but again Alter is in a subordinate position to Ego since Alter must look to Ego for supervisory instruction and evaluation of performance. While the relative may look

to the nurse for praise, the reciprocal of this is that Alter may perceive himself/herself as "helping out" and expect an expression of gratitude from the nurse. Interdependence increases, since both nurse and relative are now actively involved in the care of the patient, rather than simply sharing concern for the patient. To sum up, while the relative has been brought under the nurse's authority, there is also an increase in intimacy and interaction; control is gained for the moment at the price of greater potential for conflict and threat to control in the future.

When the worker role is imputed, it seems to be combined with a patient role, although the patient role may be less prominent. When the worker role begins to break down, either because the relative is beginning to overstep the bounds of the role or because the nurse wishes to resume tasks which the relative has taken over, the patient role may be more strongly imputed to the family. This sequence seems to occur when the family has become a crisis problem. At this point, the patient role endows the relative with the status of problem patient, a patient who must be "managed." Since the relative has, by now, been in the hospital setting for a significant amount of time, the nurses may have become over-involved with him/her; the imputation of the patient role provides a means to deal

with over-involvement by placing the relative in a position in which the nurse may "do something to help," and by placing this relationship in a professional context. Critically ill or dying patients are likely to have relatives present much of the time, and the data suggest the visitor/worker/patient pattern is related to the situation of dying patients. As was discussed earlier, the stress for nurses in dealing with dying patients is another factor which encourages bestowing the patient role on a relative in order to direct one's efforts toward a "patient" who will recover. The dimensions of the patient role are somewhat different from those of the worker role. The authority of the nurse is increased, emotional distance is decreased and the supportive aspect of the nurse is increased. That is, the patient has greater need of the nurse than the worker has, and so has less autonomy. Increasing familiarity is thus placed in a context of authority for the nurse and dependence for the relative.

Looking at the data, it is not surprising to find that nurses are far more likely to impute the patient role than the worker role. Most of the problem families in the first category, where the staff initiates the problem definition, are in visitor roles. When category one families are cast in patient roles, the real patient tends to remain

as the focus. The patient role usually takes the form of psychosocial discussion of the family by the staff. This is a sort of altercasting-in-absentia, since the family is not always aware of or involved in the discussion of its psychosocial problems. In category three families, those who are crisis problems, the relative is almost always the focus of the nurses' attention. Crisis problem relatives are no longer in the visitor role, except in cases where the relative is rarely present but exhibits difficult behaviour on the occasions of visits, or when nurses cannot overcome their own feelings of "intruding" and are able to avoid the patient and relative to a considerable degree. This was the case with the young female patient and her boyfriend mentioned earlier in the chapter. Aside from these exceptions, crisis problem relatives are in either the worker or patient roles. Interestingly, it is only in the crisis problems that the worker role appears to have been invoked, apparently in conjunction with a patient role. In these cases, when the relative is no longer playing the proper worker role, the nurses attempt to revoke the worker role, leaving the patient role. The latter becomes, as has been pointed out, a "problem patient" role.

On the whole, then, in this hospital, conferring the worker role is less common than conferring the patient role as a means of seeking to control interaction with family members. This may be due in part to the fact that nurses are more familiar with the patient role. Moreover, I would argue that, at a concrete level, the worker and patient roles are indistinguishable in this hospital. The worker role comes to be viewed, in a sense, as "occupational therapy" for the family member. By making the worker role over into a patient role, some of the problematics of the former are reduced.

One benefit of conferring the patient role on family members is that this legitimates the withholding of information from them; for there is, as Chapter Five will demonstrate, no question but that information can be withheld from patients. The data and discussion in the following chapter may be further interpreted in this way.

FOOTNOTES

1 Whether or not McMaster University Medical Center is a "community hospital," and the exact meaning of the phrase itself, are matters of subjective judgment. The important point for this discussion is that the professionals who work in this hospital appear to believe they work in a community hospital. This notion serves both as an organizing principle for thought and action and also as a perceived constraint on behaviour.

2 On the other hand, one begins to appreciate why nurses share such pieces of information as that offered by the nurse at the end of the last example cited on Page 156. The philosophy of psychosocial care, extended as it often is to include the family, leads the staff to feel responsible, or at least to wonder if they are responsible, for what happens to the family. For additional examples of this type of management "failure!"in health care settings, see Light (1972) and Millman (1977).

3 The patient's boyfriend was classed as a relative in this case.

4 This is the same case referred to on Page 149. It is described in more detail on Page 164.

5 An innovative family participation program at a large U.S. general hospital was directly related to an acute shortage of nursing staff (Reissman and Rohrer, 1957).

6 This ambivalence, I suspect, is heightened in this hospital by the emphasis on psychosocial care which would tend to restore a "professional" character to bedside nursing.

CHAPTER FIVE

CONTROLLING INFORMATION

The theoretical framework outlined in Chapter One emphasized the perspective that professionals and laypersons, in their relationships in the hospital setting, come from different social worlds with different and frequently conflicting definitions and goals. As each party seeks to control the situation, the stage is set for struggle, conflict and negotiation. Nowhere is this more evident than in the area of information: it is desired and actively sought by patients and families and is subject to control and manipulation by health professionals. Since norms governing information are largely informal, the giving or withholding of information is highly subject to variation and negotiation.

Information represents power in the stuuggle for control and is thus a pivotal issue in this study of negotiated order.

In this chapter, I will first discuss the general area of information, drawing upon the medical and sociological literature to highlight theoretical issues and empirical research. I will then use the participant observation data to discuss the staff's view of and actions surrounding information. Questions for investigation will include:

How do staff, particularly nurses, perceive the broad area of information-giving or withholding? What are the conflicts between nurses and physicians on the subject? What is the role of the nurse in the information struggle? What do nurses perceive as problems in this area? Are decisions about information-giving made collectively by the team, or by the physician? What is the role of the family in the information struggle? What professional rationales are invoked in giving or withholding information: Are these the same or different for physicians and nurses? Finally, I will discuss patients' views of information, utilizing data from the patient follow-up questionnaire. I shall argue that the results of the patient survey suggest caution in condemning information practices and suggest complexities in the issue which need further research.

As outlined,in Chapter One, the participant observation data were gathered primarily at meetings of health professionals and thus reflect their perceptions of patients and families, of what has taken place or what should be done. The patient questionnaire provides the patients' perceptions of their hospital experiences. While actual interaction between patients, families and health professionals was not observed directly, descriptive data on such interaction may be inferred from the other data sources.

I General discussion

A basic proposition of this chapter is that while patients and families desire and actively seek information, health professionals carefully attempt to control the amount and nature of information their clients are to receive, thus maintaining clients' uncertainty. This phenomenon has been mentioned in almost all studies of hospital care (see, for example, Cartwright et al., 1973, chapter 9; Davis, 1963; Glaser and Strauss, 1965; Quint, 1965; Roth, 1963a and 1963b).

Although physicians justify information control with the assumption that patients do not want to know the truth (Freidson, 1970b:142), research indicates patients do not feel they get enough information (Spelman et al., 1966; Reader et al., 1957; Skipper, 1965b; Pratt et al., 1957; Burling et al., 1956; Ley and Spelman, 1967).

> Several studies have demonstrated that patients tend to be more dissatisfied about the information they receive from their physicians than about any other aspect of medical care (Waitzkin and Stoeckle, 1972).

A study by Cartwright showed...

> ...patients were more critical about the difficulty of obtaining information than of any other aspect of their hospital care (Cartwright, 1964:75).

Even patients with cancer appear to be anxious to know about their conditions and react well to being told (Paterson and Aitken-Swan, 1954; Gilbertson and Wagensteen,

1962; Kelley and Friesen, 1950; Aitken-Swan and Easson, 1959; Fox, 1959; Hinton, 1967).

> ...While doctors prefer not to tell, studies carried out on well individuals, and people who had been informed that they had cancer, suggest that patients themselves would rather be told than kept in ignorance. In all studies there is a tendency for those who have the disease to be most in favour (McIntosh, 1974).

Patients and families want information concerning diagnosis, duration of illness, progress, treatment and prognosis. They want to know what is going to happen and when. In addition, they want information about the hospital and what staff expects of them (Mumford and Skipper, 1967). Denial of information to patients amounts to what may be construed as denial of responsible adult status, with the implication that the patient is not capable of intelligent choice and self-control. Patients are unable to evaluate or make sense of their experiences, or to predict what will happen in the future (Freidson, 1970b). This surrender of adult status, together with the surrender of the body, is held to be a major factor in patient alienation.

Information control is fundamental to the maintenance of staff power over patients and families. Waitzkin and Stoeckle (1972) define information as "that which removes or reduces uncertainty," and theorize that...

> ...a physician's ability to preserve his own power over the patient in the doctor-patient relationship depends largely on his ability to control the patient's uncertainty.

In other words, power rests upon the control of uncertainty which rests, in turn, upon the control of information.

The more information patients or families have, the more they might present management problems, from the staff's point of view. They may demand reasons for co-operating with treatment. If the news is bad, they may create emotional and disruptive scenes and demand sympathy and solicitousness.

In situations where treatment has not been effective and where prognosis is bad, medical personnel are threatened by a loss of stature not only in their clients' eyes, but in their own as well. By controlling information to clients, nurses and doctors protect their professional aura and authority.

There are, thus, both external and internal pressures which contribute to prevalent tendencies to avoid dealing openly and directly with information transmission in these situations.

The flow of information from health professionals to patients and families, with all the manipulations to which the process may be subject, is a pervasive feature of hospital life. Whether information is withheld in total, in part, or not at all, it must flow from the top down, from those with expert knowledge to those without such knowledge.[1] This basic asymmetry in the professional-

client relationship seems inherent and unavoidable to some extent. In a sense, information is always withheld to some degree: even if a surgeon follows a practice of telling a patient everything, the patient must at least wake from the anaesthetic before learning his fate.

Since health professionals have the information first, and must decide how, when and what to tell clients, it is not surprising that these professional duties are taken-for-granted. What is surprising is the extent of this taken-for-grantedness which covers postponing telling, not telling, or giving some information but withholding other, more disturbing information.

This taken-for-granted nature of the health professionals' prerogatives to control information is most apparent in the participant observation data.

It is quite clear from the data that information control is governed by a general consensus concerning the importance of clinical judgment. Information practices thus vary from one physician to another. Underlying this clinical variability are informal rules or norms, such as patient confidentiality and the norm that decisions on information should be approved by physicians, which structure the giving and withholding of information.

II Uncertainty and ideology

The issue of information control, both from staff and client points of view, may be more easily understood, in my opinion, by using the overarching concept of uncertainty. Uncertainty of one sort or another is often mentioned or implied in the discussion of information-related issues and problems by both clients and professionals. Using uncertainty as an anchor for discussion will, I believe, elucidate both medical realities and rationales.

Uncertainty refers to both medical uncertainty, that is, the physician's actual lack of perfect knowledge regarding what will happen to the patient, and uncertainty as a condition of the client, a state which may be controlled or manipulated by professionals who, while lacking perfect knowledge, always have more knowledge than the client and are able to decide what and how much the client will be told. Davis (1963) distinguishes between these two types of uncertainty by using the terms "clinical" and "functional" uncertainty. Clinical uncertainty is related to genuine inability to diagnose or know prognosis, while functional uncertainty, which may be accompanied by clinical uncertainty, aids in the management of patients and families. Davis showed that while clinical uncertainty is commonly cited by doctors as a reason for withholding information,

information may continue to be withheld when conditions have changed to clinical certainty. In Davis' study of polio victims and their families, doctors continued to withhold information about the children's prognoses even after they had a firm prognosis about future disabilities.

The suggestion is, then, that while clinical uncertainty is often a genuine constraint to physicians, it may also be invoked as a reason for withholding information even after it has ceased to exist. For this reason, uncertainty may be called a "rationale" in the control of information.[2]

Clinical uncertainty may pertain to diagnosis.

> The resident describes a male patient whose biopsy that day had revealed a mass in the pancreas. The resident says the surgeons had decided not to do a biopsy since, "If it turns out to be C.A. (cancer) it's inoperable." The nurse asks, "How will you know what he has if you don't biopsy?" The resident replies, "If he has cancer, he will die." (98)

Far more common is uncertainty about the timing, course or outcome of illness. The withholding of information concerning patient prognosis is widespread, according to the medical sociological literature, and indeed is the most frequent type of information withholding found in this study.[3]

> A patient who has cancer is being discussed. A nurse says she doubts whether the patient will leave the hospital. The social worker says, "You mean she'll die here?" The nurse replies, "Yes, but the family doesn't know and she doesn't know either. They haven't told her yet." (199)

In the next example, the doctor says he will give full information to the patient regarding her condition, but avoids prognosis.

> "We will tell her that we didn't get all the metastases, but we're not going to make any predictions." (148)

The rationale given by the surgeon is that of uncertainty.

> "I really don't like to make predictions. All I know is the odds and people do beat the odds." (148)

To be sure, details of course of illness and prognosis are often unpredictable, yet are of vital concern to patients and families. Physicians themselves are socialized to handle medical uncertainty by erring on the side of suspecting the worst, a "Type 2" error (Scheff, 1966: 108-127), but they recognize the tentative nature of these judgments. Physicians feel their patients want them to be omniscient (Balint, 1957, esp. chapter 16), and fear that their tentative statements will be treated as immutable truth; this line of thought is used to justify withholding this kind of information from clients. Physicians also worry that if patients were aware of physicians' uncertainty, they would lose confidence in the doctors' ability to treat them (Roth, 1963a). Physicians, therefore, feel the need to protect themselves and their patients.

Freidson (1970a and 1970b) ties this impulse of self-protection to two basic values of the medical profession, the values of clinical experience and medical responsibility which are learned in medical school. Clinical experience is felt to provide the most valid basis for judgment and decision, and is viewed as superior to textbook knowledge. The profession assigns each doctor ultimate responsibility for his patient, and this is embodied in the value of medical responsibility. Consequently, the physician, Freidson argues, protects himself from assessment and criticism by stressing the uniqueness and uncertainty of each case: only the physician-in-charge can adequately assess what should be done, based on the physician's untestable and invisible "clinical experience."

In the above example of the cancer patient, the surgeon implies that his normal practice is not to withhold a bad diagnosis. He supports his stand by invoking the value of clinical experience.

> The clinical clerk asks the surgeon, "How do you think she'll react to you telling her that you didn't get it (the cancer) all out?" The surgeon replies, "It's been my experience that it very rarely demoralizes patients..." (148)

This example illustrates, as well, the way in which decisions about information are left to individual physicians and how ways of handling such situations are passed on from teacher to pupil in informal, verbal ways, rather than as institutionalized rules or policies.

The extent to which information-giving varies from one individual physician to another, and to which the staff perceive this individualistic element as legitimate, is illustrated by the following excerpt from the participant observation notes.

> The patient in question is a young woman whose condition is terminal. The nurse says, "(the doctor) finally told him (the husband) that she's going to die and (the doctor) doesn't usually do that unless he knows there is nothing more to be done for her." Another nurse says, "He (the doctor) has never done that before. Funny, it's the first time he's come up and actually told a relative that the patient is going to die." (121)

This example hints at another variable, in addition to uncertainty, which affects information control. This variable is ideology. Ideology may be characteristic of a particular physician or an institution as a whole (Strauss et al., 1964; Armor and Klerman, 1968; Jessen, 1958; Bryan, 1968). These two kinds of ideologies affect each other and help explain the presence both of similar approaches and individual differences in the way information is handled in a particular institution. Strauss et al (1964) distinguish between ideologies and operational philosophies. The latter are "systems of ideas and procedures for implementing ideologies under specific institutional conditions"(p.360). Ideologies are mediated through operational philosophies. McIntosh suggests,

> ...each doctor...appears to work out his own modus operandi for carrying out in practice the policy suggested by his ideology (McIntosh, 1974).

Discussing a patient whose operation had revealed he has lung cancer, the nurse says the patient has been told the diagnosis, but that it is not certain whether he knows of the prognosis. The resident questions the nurse, asking if the patient is aware of the prognosis. The nurse tells him that she wasn't aware that anyone had said anything to him. The resident says,

> I think it's bad to tell a patient that he has a time limit. With something like cancer, it's very unpredictable. He could live two years, he could live three years...for a month...five months.(88)

This example illustrates the way in which uncertainty as a rationale passes into individual ideology.

In the following example, clinical uncertainty is implied as a reason for withholding prognosis, but it becomes apparent that even though the doctors have clinical certainty, the patient and family are being kept in a state of functional uncertainty.

> A nurse says about a patient, "The doctors aren't saying anything because it's probable he might be going blind. That's what they've been saying." Another nurse replies, "Dr. ___ says it's not a possibility, it's a certainty, but they don't want to tell his family. He's blind now but they won't tell him that he'll be that way for the rest of his life." (99)

While the withholding of information concerning prognosis appears to be common, it would be untrue to

imply that it is always withheld, even if the prognosis is poor.

> A female cancer patient is said by the resident to have taken the news of her cancer quite well. He says she realizes she has about six months to a year left and would like to spend that time with her daughter in a nearby city.(87)

It is not indicated in this case whether the information was given to the woman as a matter of course, or whether she pressed the doctors for it. What is clear once again, however, is that information-giving varies from doctor to doctor and from case to case.[4]

In addition to information concerning prognosis, patients and families may be denied information about diagnosis and course of treatment.

> Concerning a seriously ill patient, the physiotherapist tells a meeting of nurses and other paraprofessionals, "I don't know whether you know this but she developed a hydrocephalus. The family doesn't know about it yet. (The doctor) doesn't want the family to know that there could be further surgery.(99).

As the preceding example shows, information is withheld from families as well as patients. However, the data suggest that families are more likely to obtain information than are patients. This tendency to give more information to relatives than to patients has been indicated in several studies (Quint, 1964; Fitts et al.,1953, p.903; Oken, 1961, p.1123). McIntosh (1974) notes that, "Relatives of cancer patients are more likely to be informed about the patient's condition than is the patient himself." In the light of the

discussion in Chapter Four, this makes the family a worker, a partner in collusion to withhold information from the patient, a co-worker in helping to prepare the patient for the bad news, and a helper to the staff in paving the way for what is to come.

There is, then, a stratification of information even among clients, with families having more information than patients, and, therefore, more power.

III Staff keep each other informed

A major problem for hospital staff is to keep each other informed of what the patient knows so that staff do not give conflicting stories or inadvertently give more information than they should. Patients and families may question various staff members, seeking information, so the sharing of knowledge of the patient's state of awareness is vital. In the following excerpt, the team members are cautioned against a possible leak in information.

> The patient is an 81-year-old male who has had a knee amputation. The social worker says, "I think someome on this ward is giving his wife the message that he shouldn't be going home. The wife was very careful when I saw her at home today." The resident says the wife shouldn't be told anything by anyone until they are certain about the patient's discharge plans and his management. (87)

The next example, which involves clinical uncertainty, illustrates the need to present a united front. This may include collusion between family and staff in withholding

information from patients; collusion is suggested in the following example and also noted in other studies (Quint, 1964:120; Glaser and Strauss, 1965:31).

> The discussion concerns a male patient who has an inoperable tumour which may or may not be malignant. A nurse says that a resident not at the meeting has talked to the patient's wife already. The resident to whom she is speaking asks, "What did he say to her, do you know...I better talk to him first before I see (the patient) so we can have our stories straight." (98)

It is through the use of such phrases as "have our stories straight" that one grasps the overall acceptance of the fact that patients and families receive "stories". These may be partial truths, but the implication is clear that plain facts are not given straightforwardly or in all cases.

The following example gives further evidence of the problems staff have in keeping each other informed; this is a continuing struggle and renews itself with each advance made by each patient in gaining information. While team meetings serve the major purpose of keeping staff informed about patients' medical conditions, the function of keeping staff informed about patients' information levels, while "unofficial," is of crucial importance.

> Discussing a patient, the nurse says, "He doesn't know what's going to be happening to him at all." The resident says, "I haven't seen his family come in...I wonder if they know about the operation." At this point, the surgeon enters the conference room and says, "I think (the patient) does understand what's happening to him. We are almost certain to take the rectum out...we're going to wait a few years..." The surgeon indicates that he has told the patient and says, "He was very composed when I told him." (148)

IV Decision-making and information control

Decisions on what information is to be given are traditionally the responsibility of the physician.

The physician determines the patient's "diagnostic identity."

> ...physicians are the legitimate definers of the patient's diagnostic identity, whereas nurses are expected to support physicians in their decisions to withhold or to give particular kinds of information...a professional rationale...affirms that only the physician can disclose a patient's diagnosis to him (Quint, 1965).

With regard to dying patients, Glaser and Strauss underline the importance of the doctor in the decision-making process.

> ...since the doctor's responsibility is very great, he is allowed much discretion - unguided by formal rules - on when, what, and how to announce dying to others (1965b).

The rules surrounding information are informal and relatively unstable (Strauss et al., 1963), allowing scope for negotiation. Team meetings could provide an opportunity for such negotiation between health professionals although McIntosh (1974) points out that the final decision on information may be more likely to be made by the senior staff member in conferences or meetings which are public in nature (Lefton et al., 1959; Caudill, 1958), but that in more private settings where status, esteem and privilege are less at stake, the dominance of senior staff members may be less exercised (Rosengren et al.,

1963). In this study, public occasions such as meetings provide the settings for data collection. Negotiation may, of course, occur in private encounters between physicians and other health professionals, but such incidents do not form part of these data.

In this study, where team meetings allow and facilitate exchange of ideas and opinions between various health professionals, and where the team concept encourages, in principle, increased sharing in decisions by all members of the health team, the final decision on what to tell continues to be made by the physician. Decision-making concerning information may be more open to influence by other team members compared to more conventional settings, but decision-making does not appear to become a communal activity.

Physicians not only reserve the right to make decisions concerning information, but also to communicate information to patients and families although they may specifically delegate this task to another health worker.

Several studies have indicated that nurses do not pass information about patients' conditions (Coser, 1962: 75; Davis, 1963:59) and that nurses and other paraprofessionals are not supposed to communicate to patients any information of medical significance without doctors'

authorization (Freidson, 1970b:141).

> At a patient care meeting, two incidents were discussed where patients had inadvertently received the information that they were going home from a duty nurse. The supervisory nurse described this as "putting your foot in your mouth." (27)

Professional norms and the dominance of the medical profession in the organization of medical care provide a partial explanation for such practices. However, nurses may simply lack the information the patient wants, due to the failure of physicians to keep nurses fully informed about the patient's treatment, progress and prognosis (Glaser and Strauss, 1965b).

The importance of guarding against mistakes or slips regarding information is underlined when such a slip occurs.

> The surgeon says, "I don't know whether anyone in this room is aware of it, but the other day the TV girl was in Mrs. ___ (the patient's) room and just happened to tell her how sorry she was that Mrs. ___ had cancer of the stomach. Now Mrs. ___'s biopsy proved to be benign, as we all know. Now I'd like to know how the TV girl got the idea that Mrs. ___ had cancer. I don't know whether it came from any of you girls, but that simply cannot happen...I've made it quite clear that the TV girl is not to come up on our ward again." (90)

The surgeon obviously has the authority to dictate who may or may not come on the ward. By his phrase, "you girls," the surgeon directed his lecture to the nurses,

occupational therapists and social worker at the meeting; the two male residents were thus excluded. Subject to such treatment, it is not surprising that nurses stay in line, whether or not they disagree with practices.

V Information control: problems for nurses

The data strongly suggest that nurses do not necessarily agree with practices of withholding information from patients. They are well aware that uncertainty creates apprehension for patients.

> A nurse says a patient is "apprehensive because the doctors aren't telling him what's happening to him. He doesn't know what's going on." (99)

The implication is that the patient should be told what is happening to him. Such concern reflects nurses' education which stresses this aspect of patient care, as well as the management problems apprehensive patients may create for nurses.

Nurses, although they may disagree with doctors' tendencies to withhold information from patients, appear to accept the limitations of their position.

> In the case of a male patient who is scheduled for a bone scan, the social worker says, "I think the patient should be told what's happening to him. I don't know about the doctors who are working on him. I'm not even sure they read the consults they give me." The supervisory nurse says, "...you're getting cynical, it's not your responsibility or mine to tell the patients." (259)

In discussions where information-giving is involved, nurses' contributions seem to vary according to whether or not physicians are present. When physicians are at the meeting, nurses may offer information-related comments on the patient's condition, and may include, as in the next example, mention of the stress lack of information creates for patients.

> At a patient care meeting, a nurse says a patient is unhappy because he isn't being told what was going on. (27)

However, direct criticisms of information-withholding practices are reserved for meetings where physicians are not present. In the following example, a nurse criticizes doctors for withholding information and using the uncertainty rationale.

> "Doctors are always quick to say, 'How can I tell a patient how much time he has left? He might have six weeks or he might have six months. Who am I to say?' So they end up saying nothing. That's their big rationalization. I think it's a cop out." (250)

The physician's authority and status may be questioned by the nurse in private but are not openly confronted despite the team concept.

While the doctor holds the prerogative of deciding what information to give the patient and family, the burden of managing them and keeping them in the prescribed state of awareness falls directly on the nurse. To

complicate matters, nurses are not always well informed about what a patient or family knows. This creates a serious strain for the nurse.

> A nurse says, "I find I can't behave naturally with some patients who have a terminal illness, because I don't know whether the doctors have told them their prognosis, and I've found this to be very frustrating. I'm finding I have to be cautious of what I say for fear of letting the cat out of the bag." (250)

I offer here a general principle which may explain why staff hold different or opposing views on what information a patient may be given. Whatever facilitates one's work will be viewed positively and what hinders it will be viewed negatively. Hence, as the above example shows, nurses have negative feelings toward keeping information from patients since they bear the burden of controlling their own behaviour so as not to give revealing cues or make verbal slips. They must also deal with patients' apprehension and uncertainty which, as several studies have shown, may be more difficult for the patient to bear than knowing the whole truth (Quint, 1964; Gerle et al.,1960; Skipper, 1965b:79; Meyer, 1955; Lederer, 1952). One cannot say whether the costs of information control are greater for the nurse than the costs of being totally honest with patients. If information control were not practiced, the management of patients might be more

difficult for nurses. However, immediate problems stem from information-withholding, and nurses complain, therefore, about these practices. For physicians, however, who bear the responsibility of breaking the news to patients, it is no doubt easier not to tell. Therefore, physicians are likely to view positively the withholding of information. This is similar to Lorber's findings (Lorber, 1975) that nurses and doctors frequently differed on whether or not a patient was considered a problem. For each, problem patients were those who in some way obstructed work, while patients who were not problems were those who did not interfere with or who facilitated work. Whether with respect to problem patients or the giving or withholding of information, when something hampers control over conditions of work, it is perceived as a problem.

This argument is illustrated in the example of the patient mentioned earlier who would be permanently blind but who had not been informed of his prognosis. The VON, a visiting nurse whose concerns focus on the patient once he is back in his home, expresses her disapproval of withholding this information.

> "I think it's ridiculous not to tell a patient something like that. For example, he can't even get any help from the resources available to him if they don't tell him that he'll be blind. For instance, the CNIB can't do anything for you until you're registered blind...I think it's really important to level with him, especially if he's going to be like that for the rest of his life." (99)

This health professional assesses what should be done according to what is relevant to her job -- providing benefits and community resources and home care, for example -- while doctors make decisions according to what they see as most relevant to their job. Although their rationales are not revealed in the case just mentioned, one might speculate that doctors could feel that telling a person he would be blind for life would be hard to bear emotionally and might dishearten the patient to the point where he would not make efforts to get well or regain some level of self-sufficiency.

In conclusion, I have shown that in this study information-withholding is a common practice. Using the rationale of uncertainty, physicians control the amount and nature of information given to patients and families. Nurses are expected to carry out the decisions of doctors regarding information, and appear to do so. Although they complain in private about information-withholding practices, and express the opinion that such practices work to the disadvantage of patients, nurses do not criticize or disagree with physicians to their faces on this subject. The family appears to have a higher level of information than the patient, a finding that is in accord with those of other studies. This may be explained by the professional norm which supports "telling the family first" but also by the fact that the family is in a better position -- less helpless, less dependent, more mobile -- than the

patient to pursue information. The professional rationales surrounding information are different for nurses and doctors, and reflect the different aspects of patient care with which each profession is concerned.

Clearly, patients have a great deal of information withheld from them, as the data show. The medical argument is that patients do not really want to know more than they do. Doctors express the opinion that patients would not know how to handle some kinds of information, that they would be frightened, and must be, in this sense, protected from themselves.

The participant observation data confirm the kind of information-withholding practices that have been well documented by other studies. However, other studies usually omit the patient's view. Are doctors correct in thinking patients do not really want more information than they get? I turn now to the data from the patient interview schedule, to find out what patients in this study felt about the information they received while in hospital.

V Patients' views on information

The patient interview schedule contained a number of questions which measured satisfaction with information received. These included 13 closed-ended and seven open-ended questions. From the responses, an index of satis-

faction with information was compiled for each study ward at each study period. The scoring range was from 1 to 9, with the lower score indicating higher satisfaction. The results indicate quite a high level of patient satisfaction with information received. The highest score, indicating the least satisfied patients, was 3.4, while the lowest score, indicating the most satisfied patients, was .97. These scores show fairly high levels of patient satisfaction since the median of 4.5 was never closely approached by these results.

While this thesis is concerned with the topic of information in general, and not with ward comparisons, it is interesting to note that there were differences in information satisfaction between the two programme wards, where the psychosocial programme was instituted, and the two control wards. Accessibility to information as perceived by patients improved slightly on both programme wards over the three time periods, but did not improve on non-programme wards. Also, patients on the programme wards perceived themselves to be better informed about things being done to them and expressed less dissatisfaction about the timing and quantity of information received from hospital staff.

It is startling to compare the high levels of patient satisfaction with information received with the evidence of widespread information withholding documented in this chapter. Despite the control practices of staff, patients

appear quite satisfied. Several explanations are possible.

One explanation, or partial explanation, is that patients are socialized to expect incomplete information. Given low expectations, limited information does not lead to great dissatisfaction.

A second factor is that this analysis is not comparative, except between the programme and control wards. Perhaps information is given more readily in this hospital than in traditional settings when patients request it. Certainly, there are indications that the psychosocial programme loosened information control somewhat.

At any rate, compared with other studies, the percentage of dissatisfied patients in this study was in the low range. McIntosh, too, (1977) found a relatively low level of patient dissatisfaction with information.

Perhaps the level of satisfaction would have been lower if patients had been interviewed in hospital, rather than a month after discharge. Perhaps analysis using variables such as education or type of illness would reveal telling differences in patient satisfaction.

However, regardless of the qualifications or speculations one may make, patient satisfaction with information received in this study appears to be high.

In considering and assessing practices of information control in hospitals, one might easily react by blaming doctors and energetically defending the right of each individual to know the whole truth about his/her condition.

Both the present study and McIntosh's work on cancer patients (McIntosh, 1977) suggest this might be a simplistic response, with implications for the patient that might even be cruel. There are delicate and complex questions of ethics and humanity involved, and one must beware of settling for simple answers. While much research has been done on patients' views on information, there is obviously a need for more research in order to better understand patients' feelings and needs in this area, and the most effective and compassionate ways of dealing with them.

FOOTNOTES

1 Some information also flows in the other direction, from the client to the professional, and the withholding of information concerning symptoms, etc., does represent a source of patient control. Generally, though, the competence gap places professionals in the more privileged position with respect to information.

2 Those who employ rationales may offer them in good faith; physicians do not necessarily consciously perceive information control as a power strategy.

3 Because of the nature of the data, and the lack of standards of comparison from other studies, there is really no way of knowing whether the number of examples of any type of information control in this study represents high or low frequencies in any absolute sense. Consequently, I make no suggestion here regarding how one should view frequency of occurrence, but merely wish to point out that certain kinds of control occur more than others in these data.

4 Although doctors appear to base some decisions about what information to impart to patients on judgements about each individual, Scheff (1968) and Roth (1963a) show that these decisions are based upon typologies of patients and their conditions, rather than upon viewing each patient as a unique individual.

IMPLICATIONS

This thesis demonstrates the utility of the control and negotiated order perspectives in the effort to understand worker-client relationships. While these perspectives have been used effectively in a variety of settings, including medical ones, I have extended them to a somewhat different interactional milieu -- hospitalized patients and their families as they interact with nurses. The family, which is defined as a client in this thesis, is an uncommon focus. While both Glaser and Strauss (1965) and Davis (1963) included the family in their investigations, they focussed on extraordinary situations, namely dying patients and crippled children. My study looks at families in a variety of acute care hospital situations and finds the control and negotiated order perspectives appropriate.

The use of these perspectives has allowed a detailed study of how order is achieved in problematic worker-client relationships in one organizational setting, an acute care hospital. Attention has been focussed on process, on how outcomes are achieved, rather than on outcomes themselves. It was seen that worker solidarity in acting toward clients is not a given, but must be worked at continually. While work group solidarity is tenuous even among a homogeneous work group, its maintenance in a heterogeneous work group such as the interdisciplinary health team is particularly difficult.

Control over patients and families must also be worked at and monitored. While control is often maintained at a satisfactory level from the staff's point of view, some patients do become control problems. With these, control strategies must be planned, executed and monitored for success or failure, while the patients continue to employ their own strategies. Control is not a permanent state. It is a sometime affair, and negotiation is the process by which each party seeks to achieve control over the situation and by which an order which is acceptable to both parties, or at least accepted by both parties, is achieved for the time being.

The use of the control and negotiated order perspectives in this analysis has, in my view, made meaningful the elements of interaction between health professionals and their clients.

If the findings of this study hold across other worker-client situations, some generalizations may be made.

While service workers may hold an image of the "ideal" client, they also have notions of acceptable client behaviour, notions which are reasonably consistent with the realities of their experiences at work. Similarly, clients do not really expect to be served by ideal workers and adjust to the more fallible and flawed workers they encounter in the real world. That is, in worker-client interaction, the actors accommodate

a range of deviations from a fully non-problematic ideal. Adjustments, shifts, bargains and negotiations normally occur as part of these non-problematic relationships. Workers accept some deviations from an acceptable client model as legitimate under the circumstances, but disapprove of clients who are clearly perceived as trying to control their situations. Staff censure such behaviour almost as though it were immoral. Client efforts to gain control, when perceived as such, are interpreted as efforts to outwit the staff, to turn circumstances to the client's advantage, and as trying to manipulate the situation.

Chapter Three showed that control efforts are not self-contained within the worker-client relationship, but are influenced and constrained by the wider organizational setting. The organization exerts a variety of constraints over workers; to some extent this may offset the imbalance of power in the worker-client relationship, since the client is less subject to organizational authority and has a briefer relationship with the organization. On the other hand, the organization may allow for solidarity among workers, accentuating the power imbalance in their favour.

To the extent that the nurses in this study are typical of service workers in general, it may be said that specific plans of action in dealing with problem clients are unlikely to be formed without the presence of workers high in the authority hierarchy. Without these authority-

holders, workers arrive at common definitions of clients but do not formulate definite management plans.

It was seen in Chapter Three that workers will seek control by whatever strategic and effective means are available. Attempts at organizational innovation may be subverted to useful tools in the struggle for control. In this hospital, the emphasis on psychosocial care provided a new avenue for increasing control over problem clients. Management problems became redefined as psychosocial problems and could then be treated as such. Staff could thus continue to control the definition of the situation.

Service workers in institutional settings must often contend with a group of secondary clients -- parents, spouses, friends, or other associates of the primary clients. Chapter Four showed how control is maintained over these clients by casting them into roles. The visitor role is preferred by staff, but when this breaks down the secondary client may be enlisted as a helper in aiding the progress of the primary client or may be transformed into a full fledged primary client. In the present study, this entailed casting the secondary client into a patient role, with the helper or worker role a component part.

Service workers, especially those who experience prolonged contact with clients, face the threat of over-involvement with clients; this threatens both the individual worker's self-control and the work group's solidarity, a weakening of which weakens control over clients. One way

of counteracting this threat is the use of typologies in discussing and perceiving clients. This is common practice among nurses as well as other service workers; it serves to create emotional distance between worker and client, to depersonalize the client, to facilitate group solidarity and the formation of common group perspectives, and thus to enhance control over clients.

Problem clients are discussed by the work group. Through the use of typologies, discussion, and systematic plan formation, the group comes to adopt a common perspective and common plan of action toward problem clients, thereby taking a major step toward regaining control.

As discussed in Chapter Five, information control is a major strategy in controlling clients. This is especially significant in relationships between health workers and clients, for the issues are those of life and death. The prerogative of health workers to control information is, to some extent, taken for granted by both workers and clients. However, upon this taken-for-granted base, there is a great deal of negotiation. In this study, the fluctuating, changing, emergent nature of social interaction is nowhere more evident than in the study of information in the hospital. Decisions on what, how much and when to tell the patient are made, revised, changed and updated, depending on individual workers' ideas and clients' information-seeking strategies.

Worker views on the propriety of information-withholding vary according to whether such practices hamper or enhance workers' control over their conditions of work.

In this thesis, I have investigated how workers and clients seek to control their respective conditions. In so doing, certain broader questions became apparent and beg answers. I turn now to a discussion of these questions, and offer some possible answers. These are necessarily tentative; it is hoped that further research in these areas will provide more empirically-grounded understanding.

One of the most troubling questions concerns the dramatic over-representation of females in the group of patients nurses perceived as problems. Why are females considered to be problems so much more often than males?

One possibility is that females actually manifest more problematic behaviour in hospital than do males; this possibility I am inclined to reject, for it does not make sense. Both sexes are faced with the same problems and in fact one might expect that males,

being typically socialized to exhibit more aggressive and less dependent behaviour than females would, in fact, find the patient role more difficult to adjust to than females, and would be more vociferous in their complaints, demands, and more aggressively non-compliant about seeking control.

Most, although not all, of the nurses in this hospital and others are female; it is possible that the over-representation of females in the problem patient group is in some way related to more general, pervasive problems in female-female relationships. Most nurses are younger than the median or average age of patients in this study; perhaps the nurse-patient relationship reflects difficulties in the mother-daughter relationship.

Assuming that both males and females seek to control their conditions in the hospital, it must be that their behaviour is not radically different by sex but that nurses perceive it differently. (This is speculation on my part, for this behaviour was not observed directly; in fact, I argue that the finding of sex differences in this thesis constitutes a major indication for further research.) What I suspect occurs is that male efforts to gain control are far more likely to be perceived by nurses as legitimate behaviours. Demands by males, for example, are perceived as legitimate behaviour, while demands by females are perceived as non-legitimate or problematic behaviour.

Nurses as females are socialized to be subservient to males and to meet their demands. I do not suggest that women passively accept or believe fully in such a role; I suggest merely that at some level socialization to the female role may impinge on the nurse role when the nurse interacts with the male patient with the result that the male is less likely to be perceived as a problem.

It may be that females and males may manifest different types of potentially problematic behaviour. It is possible, for example, that males may tolerate higher levels of pain than females as a consequence of socialization. It would, of course, be interesting to test this hypothesis in actual observation. My own guess is that males on the whole may tolerate more pain, but that some males will not. However, when these males complain of pain, their complaints are more likely to be viewed as legitimate by nurses, while female complaints about pain are more likely to be interpreted and labelled as whining, weakness or childish behaviour.

It is interesting that some of the problem categories -- manipulative, demanding, complaining, complaining of pain, career patients in the sense of hypochondria -- represent stereotypic female strategies in seeking control over their lives; they are the strategies of those who do not have more straightforward power and resources.

As a general theoretical guess, and it can really be called no more, I hypothesize that male patients import

their commanding approach to the world in general into the hospital situation and that it continues to succeed for them.

Another major implication of this thesis arises from the finding that despite the supposed commitment to total patient care and the unique needs of each individual patient, nurses tend to perceive patients as types or categories. This conflict between a professional goal of treating the individual and the tendency to lump individuals into categories has been noted both in hospitals and other situations such as the teacher-pupil relationship in the school, but the source of the conflict has usually been attributed to a professional-bureaucratic conflict. For example, a heavy patient load or too many pupils makes it difficult for the professional to have the time, energy or information individual treatment requires. This study suggests that the failure to treat the client as a unique individual may be more related to the need to control conditions of work than to bureaucratic strains. Further research on professional-client relationships in non-bureaucratic settings would shed more light on this finding.

At a more substantive level, the findings on patient satisfaction with information point to a need to recognize the subtleties and complexities of the condition and relationships of the hospital patient. There is a growing

movement supporting greater rights for hospital patients; this is related to a general consumer's rights movement. At a personal level, I am very sympathetic with these trends. Simultaneously, there is a growing disenchantment with the medical profession. Underlying all these trends is a tendency in many people, certainly in many sociologists, to identify with the underdog. While I support the right and indeed the need of the sociologist to be guided by personal values, I believe it is also important to be wary of being influenced emotionally by the kinds of trends described above. The findings on information suggest, and only suggest, that a blanket policy of giving all information to all patients may be simplistic, although satisfying to the social scientist. There is an entry in the field notes which illustrates the point I wish to make here.

> In a discussion about whether or not a patient should be told he/she is dying, the psychosocial offers the following statement as a general rule: "I think we have to give people credit that they will be able to handle it. We were born to handle our problems." (303)

This is, quite clearly, an ideological position, and this, I believe, must be recognized when policy is being formed or proposed. The pendulum has been moving slowly away from contentment with the doctor's god-like role and actions toward more identification with and concern for the rights of the patient. Such pendulum swings are usually a com-

bination of current fashion and a need for social change; . . my concern is that these two elements be clearly distinguished and that in sociology the latter and not the former be allowed to point the way to sound policy.

Finally, the expansion of the domain of medicine into areas of psychosocial care has implications which were suggested by this thesis. Attention to psychological and social dimensions in the care of hospital patients and their families is increasingly emphasized in contemporary liaison psychiatry (Cleghorn, 1974; Lipowski, 1967a, 1967b, 1968, 1974; Miller, 1973) and more generally in hospital care (Cartwright, 1964; Duff and Hollingshead, 1968; Strauss, 1972). There are many potential benefits for the patient and for his family from a global approach to sick patients. I recognize the value and support the appropriate use of this treatment approach, and the move to humanize the health care system and setting. However, one must ask what is lost, as well as gained. I am uneasy about the expansion of the domain of medicine in its authority to confer the patient role (Illich, 1975; Kittrie, 1971). Nurses and other health professionals, like any workers, can reasonably be expected to maintain autonomy and control over their conditions of work. If conferring the patient role is legitimized by hospital policy and nursing education, these professionals can be

expected to make use of that strategy; Chapter Four supports this expectation and illustrates how the domain of medical authority may be expanded to take in more expertise and more legitimate objects or clients. Further study of the assumptions and behaviour of health professionals may lead to a clearer understanding of the dangers of the inappropriate bestowal of the patient role, better appreciation of the dilemmas of the professional, and enhanced problem solving when families should be involved.

BIBLIOGRAPHY

Aitken-Swan, J. and E.C. Easson
1959 Reactions of Cancer Patients on Being Told Their Diagnosis. British Medical Journal 1: 779-783.

Argyris, C.
1959 The Individual and the Organization: An Empirical Test. Administrative Science Quarterly 4 (Sept.): 145-167.

1960 Understanding Organizational Behavior. Homewood, Illinois: Dorsey Press.

1964 Integrating the Individual and the Organization. New York: John Wiley and Sons.

1972 The Applicability of Organizational Sociology. London: Cambridge University Press.

Armor, D.J. and G.L. Klerman
1968 Psychiatric Treatment Orientations and Professional Ideology. Journal of Health and Social Behavior 9: 243.

Balint, M.
1957 The Doctor, His Patient and the Illness. New York: International Universities Press.

Barrett, John H.
1970 Individual Goals and Organizational Objectives. Ann Arbor, Michigan: University of Michigan, Institute for Social Research.

Becker, Howard S.
1952 Social Class Variations in the Teacher-Pupil Relationship. Journal of Educational Sociology 25 (Apr.): 451-465.

1953 The Teacher in the Authority System of the Public School. Journal of Educational Sociology 27 (Nov.): 128-141.

1961 and Blanche Geer, Everett C. Hughes, and Anselm L. Strauss
Boys in White: Student Culture in Medical School. Chicago: University of Chicago Press.

Bidwell, C.E.
1965 The School as a Formal Organization. Pp. 972 - 1022 in J.G. March (Ed.) Handbook of Organizations. Chicago: Rand McNally.

Bihldorff, J.P.
1975 Personalized Care Assures Patients' Rights. Dimensions in Health Service (July): 36-39.

Blau, Peter M.
1960 Orientation Toward Clients in a Public Welfare Agency. Administrative Science Quarterly 5: 341-361.

Blumer, Herbert
1969 Symbolic Interactionism: Perspective and Method. Englewood Cliffs, New Jersey: Prentice-Hall.

Bogdan, Robert
1972 Participant Observation in Organizational Settings. Syracuse: Syracuse University Press.

Bowers, David G. and Stanley E. Seashore
1966 Predicting Organizational Effectiveness with a Four-Factor Theory of Leadership. Administrative Science Quarterly 11, No. 2 (Sept.): 238-263.

Brown, J.A.C.
1962 Social Psychology of Industry. Baltimore: Penguin.

Browne, Joseph A.
1977 Health Professionals' Participation at Hospital Ward Meetings and the Effect of that Participation on Patient Care Plans. Unpublished Ph.D. Dissertation, University of Toronto.

Bryan, J.H.
1968 Occupational Ideologies and Individual Attitudes of Call Girls. Pp. 252-261 in E. Rubington and M.S. Weinberg (Eds.) Deviance: The Interactionist Perspective. New York: Macmillan.

Burling, T., E. Lentz and R. Wilson
1956 The Give and Take in Hospitals. New York: Putnam.

Campbell, E.J.M.
1972 McMaster University and Medicine: Introduction. Journal Royal College Physicians London, Vol. 6, No. 4 (July): 333-342.

Carpenter, K.M. and J.M. Stewart
1962 Parents Take Heart at the City of Hope. Journal of Nursing 62: 82-85.

Cartwright, A.
1964 Human Relations and Hospital Care. London: Routledge and Kegan Paul.

1973 and L. Hockey and J.L. Anderson
Life Before Death. London: Routledge and Kegan Paul.

Catrice-Lorey, Antoinette
1966 Social Security and Its Relations with Beneficiaries: the Problem of Bureaucracy in Social Administration. Bulletin of International Social Security Association 19: 286-297.

Caudill, W.
1958 The Psychiatric Hospital as a Small Society. Cambridge: Harvard University Press.

Cicourel, A.J. and J.I. Kitsuse
1963 The Educational Decision-Makers. Indianapolis: Bobbs-Merrill.

1968 The Social Organization of the High School and Deviant Adolescent Careers. Pp.124-135 in E. Rubington and M. Weinberg (Eds.) Deviance: The Interactionist Perspective. New York: Macmillan.

Cleghorn, John M.
1974 Organization of Psychosocial Care in a Teaching Hospital. Psychotherapy and Psychosomatics 23: 55-66.

Corwin, Ronald G.
1961 The Professional Employee: A Study of Conflict in Nursing Roles. American Journal of Sociology 66: 604-615.

1963 and Marvin J. Taves
Nursing and Other Health Professions. Pp.187-212 in Howard E. Freeman, Sol Levine and Leo G. Reeder (Eds.) Handbook of Medical Sociology. Englewood Cliffs, New Jersey: Prentice-Hall.

Davis, Fred
1959 The Cabdriver and His Fare: Facets of a Fleeting Relationship. American Journal of Sociology 65 (Sept.): 158-165.

1960 Uncertainty in Medical Prognosis, Clinical and Functional. American Journal of Sociology 66: 41-47.

1963 Passage Through Crisis. Indianapolis and New York: Bobbs-Merrill.

Davies, Celia
1972 Professionals in Organizations: Some Preliminary Observations on Hospital Consultants. The Sociological Review, Vol. 20, No. 4: 553-567.

Dawe, Alan
1970 The Two Sociologies. British Journal of Sociology 21: 207-218.

Devereux, George and Florence R. Weiner
1950 The Occupational Status of Nurses. American Sociological Review 15: 628-630.

Duff, R.S. and A.B. Hollingshead
1968 Sickness and Society. New York: Harper and Row.

Evans, John R.
1970 Organizational Patterns for New Responsibilities. Journal of Medical Education 45 II: 988-999.

Feldman, Jacob J.
1966 The Dissemination of Health Information. Chicago: Aldine.

Ferguson, R.S.
1958 The Doctor-Patient Relationship and "Functional" Illness. Pp.433-439 in E.G. Jaco (Ed.) Patients, Physicians and Illness. Glencoe, Illinois: Free Press.

Fitts, W.I. and I.S. Ravdin
1953 What Philadelphia Physicians Tell Patients with Cancer. Journal of the American Medical Association 153: 901.

Fox, Renee C.
1957 Training for Uncertainty. In Robert K. Merton et al.,(Eds.) The Student Physician. Cambridge: Harvard University Press.

1959 Experiment Perilous. New York: The Free Press of Glencoe.

1970 A Sociological Perspective on Organ Transplantation and Hemodialysis. Annals of the New York Academy of Science 169: 406-428.

Freidson, Eliot
1961 Patients' Views of Medical Practice. New York: Russell Sage.

1963 The Organization of Medical Practice. Pp. 299-320 in H.E. Freeman et al. (Eds.) Handbook of Medical Sociology.

1970a Profession of Medicine. New York: Dodd,Mead.

1970b Professional Dominance. New York: Atherton.

1970c Dominant Professions, Bureaucracy and Client Services. In Mark Lefton and W.R. Rosengren (Eds.) Organizations and Clients. Columbus, Ohio: Charles E. Merrill.

Freidson, Eliot and Buford Rhea
1965 Knowledge and Judgment in Professional Evaluations. Administrative Science Quarterly, Vol. 10, No. 1: 107-124.

1972 and Judith Lorber
Medical Men and Their Work. Chicago and New York: Aldine, Atherton.

French, John R.P. Jr. and Bertram H. Raven
1959 The Bases of Social Power. Pp.150-167 in D. Cartwright (Ed.) Studies in Social Power. Ann Arbor: University of Michigan, Institute for Social Research.

Geer, Blanche, Jack Haas, Charles Vi Vona, Stephen J. Miller, Clyde Woods, and Howard S. Becker
1968 Learning the Ropes: Situational Learning in Four Occupational Training Programs. In Irwin Deutscher and Elizabeth J. Thompson (Eds.) Among the People: Encounters with the Poor. New York: Basic Books.

Gerle, B., Gerd Lunden and Philip Sandblom
1960 The Patient with Inoperable Cancer from the Psychiatric and Social Standpoints. Cancer 13:1206 - 1217.

Gilbertson, V.A. and O.H. Wangensteen
1962 Should the Doctor Tell the Patient that the Disease is Cancer? Cancer 12: 82.

Glaser, Barney and Anselm L. Strauss
1965 Awareness of Dying. Chicago: Aldine.

1965b Temporal Aspects of Dying as a Non-Scheduled Status Passage. American Journal of Sociology 71, No. 1 (July): 48-59.

1967 The Discovery of Grounded Theory. Chicago: Adline.

Goffman, Erving
1959 The Presentation of Self in Everyday Life. New York: Doubleday Anchor.

1961 Asylums. Garden City: Doubleday Anchor.

Gold, Raymond
1964 In the Basement -- the Apartment-Building Janitor. Pp.1-49 in Peter L. Berger (Ed.) The Human Shape of Work. Chicago: Henry Regnery Company.

Goldthorpe, J.H., D.L. Lockwood, F. Bechofer and J. Platt
1969 The Affluent Worker: Industrial Attitudes and Behavior. New York: Cambridge University.

Goss, Mary E.W.
1963 Patterns of Bureaucracy among Hospital Staff Physicians. Ch.6, pp.170-194 in Eliot Freidson (Ed.) The Hospital in Modern Society. London: The Free Press of Glencoe.

Hage, Jerald and Michael Aiken
1967a Relationship of Centralization to Other Structural Properties. Administrative Science Quarterly 12, No. 1 (June): 72-92.

1967b Program Change and Organization Properties, a Comparative Analysis. American Journal of Sociology 72, No. 5 (March): 503-519.

1969 Routine Technology, Social Structure,and Organizational Goals. Administrative Science Quarterly 14, No. 3: 366-376.

1970 Social Change in Complex Organizations. New York: Random House.

1971 and Coral Bagley Marrett Organizational Structure and Communications. American Sociological Review 36, No. 5 (Oct.): 860-871.

Hall, Richard H.
1972 Organizations, Structure and Process. Englewood Cliffs, New Jersey: Prentice-Hall.

Hewitt, John P.
1976 Self and Society. Boston: Allyn and Bacon.

Hinton, J.
1967 Dying. Harmondsworth, England: Penguin.

Illich, Ivan
1975 Medical Nemesis. Toronto: McLelland and Stewart.

Johnson, Miriam M. and Harry W. Martin
1965 A Sociological Analysis of the Nurse Role. Pp.29-39 in James K. Skipper, Jr. and Robert C. Leonard (Eds.) Social Interaction and Patient Care. Philadelphia: J.B. Lippincott.

Kahn, Robert L., Donald M. Wolfe, Robert P. Quinn and J. Diedrick Snoek
1964 Organizational Stress: Studies in Role Conflict and Ambiguity. New York: John Wiley and Sons.

Katz, D. and R.L. Kahn
1966 The Social Psychology of Organizations. New York: John Wiley and Sons.

Katz, Elihu and Brenda Danet
1973 Communication Between Bureaucracy and the Public: A Review of the Literature. Pp. 666-705 in Ithiel de Sola Pool, Frederick W. Frey, Wilbur Schramm, Nathan Maccoby and Edwin B. Parker (Eds.) Handbook of Communication. Chicago: Rand McNally.

Katz, Elihu and S.N. Eisenstadt
1960 Some Sociological Observations on the Response of Israeli Organizations to New Immigrants. Administrative Science Quarterly 5: 113-133.

Katz, F.E.
1968 Autonomy and Organization. New York: Random House.

Kelly, William D. and Stanley R. Friesen
1950 Do Cancer Patients Want to be Told? Surgery 27: 822-826.

Kittrie, Nicholas N.
1973 The Right to Be Different. Baltimore: Penguin.

Kohn, M.L. and C. Schooler
1969 Class Occupation and Orientation. American Sociological Review 34: 659-758.

Kramer, Marlene
1974 Reality Shock. Saint Louis: C.V. Mosby.

Krause, Elliott A.
1971 The Sociology of Occupations. Boston: Little, Brown.

Lawrence, P.R. and J.W. Lotsch
1967 Organization and Environment: Managing Differentiation and Integration. Cambridge, Mass: Harvard Business School.

Lederer, H.D.
1952 How the Sick View Their World. Journal of Social Issues 8.

Lefton, M.
1958 Decision-making in a Mental Hospital: Real, Perceived and Ideal. American Sociological Review 24: 822.

Levinson, Daniel J. and Egene B. Gallagher
1964 Patienthood in the Mental Hospital. Boston: Houghton Mifflin.

Lewin, K., R. Pippitt and R. White
1939 Patterns of Aggressive Behavior in Experimentally Created "Social Climates." Journal of Social Psychology 10 (May): 271-299.

Ley, P. and M.S. Spelman
1967 Communication with the Patient. St. Louis, Missouri: Warren H. Green.

Light, Donald W.
1972 Psychiatry and Suicide: The Management of of a Mistake. American Journal of Sociology 77 (March): 821-838.

Likert, R.
1961 New Patterns of Management. New York: McGraw-Hill.

Lipowski, Z.J.
1967a Review of Consultation Psychiatry and Psychosomatic Medicine, I: General Principles. Psychosomatic Medicine 29: 153-171.

1967b Review of Consultation Psychiatry and Psychosomatic Medicine, II: Clinical Aspects. Psychosomatic Medicine 29: 201-224.

1968 Review of Consultation Psychiatry and Psychosomatic Medicine, III: Theoretical Issues. Psychosomatic Medicine 30: 395-422.

1974 Consultation-Liaison Psychiatry: An Overview. The American Journal of Psychiatry 131: 623-630.

Litwak, Eugene and Henry J. Meyer
1966 A Balance Theory of Co-ordination Between Bureaucratic Organizations and Community Primary Groups. Administrative Science Quarterly 11 (June): 31-58.

Lofland, John
1971 Analyzing Social Settings. Belmont, California: Wadsworth.

Lorber, Judith
1975 Good Patients and Problem Patients: Conformity and Deviance in a General Hospital. Journal of Health and Social Behavior 16, No.2: 213-225.

Macpherson, A.S., Susan E. French and Victor W. Marshall
1974 A Study to Develop an Evaluation of a Psychosocial Programme, A Final Report of an Interdisciplinary Pilot Study at McMaster University, Hamilton, Ontario. Supported by Ontario Ministry of Health Research Grant No. P.R. 402.

Marshall, Victor W., T. Garrison, Z. Fortuna, A.S. Macpherson and S.E. French
1975 Improving Confidence in the Survey through Participant Observation. Paper presented at annual meeting of Canadian Sociology and Anthropology Assoc. (Edmonton, Alta.), May, 1975.

Marshall, Victor W., Susan French and A.S. Macpherson
1976 Aged Former Patients: Dimensions of Health and Health Care. Paper presented at Meetings of the Canadian Association on Gerontology, Vancouver, B.C., November, 1976.

Martin, Wilfred
1976 The Negotiated Order of the School. Canada: Macmillan.

Maslow, A.
1954 Motivation and Personality. New York: Harper.

Mason, P.L.
1960 Group Participation in Decision-Making. Personnel Practices Bulletin 16 (June): 27-32.

Mauksch, Hans O.
1965 Becoming a Nurse: A Selective View. Pp. 327-340 in James K. Skipper and Robert C. Leonard (Eds.) Social Interaction and Patient Care.

McGregor, D.
1960 The Human Side of Enterprise. New York: McGraw-Hill.

McIntosh, Jim
1974 Processes of Communication, Information Seeking and Control Associated with Cancer. Social Science and Medicine, Vol. 8: 167-187.

1977 Communication and Awareness in a Cancer Ward. New York: PRODIST.

Mennerick, Lewis A.
1974 Client Typologies: A Method of Coping with Conflict in the Service Worker-Client Relationship. Sociology of Work and Occupations 1, No. 4 (Nov.): 396-418.

Meyer, Bernard C.
1955 What Patient, What Truth? Pp. 47-58 in S. Standard and H. Nathan (Eds.) Should the Patient Know the Truth? New York: Springer.

Miller, S.M.
1964 Some Thought on Reform. Pp.298-306 in A.B. Shostak and William Gombert (Eds.) Blue-Collar World: Studies of the American Worker. Englewood Cliffs, New Jersey: Prentice-Hall.

Miller, Warren B.
1973 Psychiatric Consultation: Part I; A General Systems Approach. Psychiatry in Medicine 4: 135-145.

Millman, Marcia
1977 The Unkindest Cut. New York: William Morrow.

Mitchell, Jack N.
1966 Cons, Square-Johns, and Rehabilitation. Pp.207-212 in B.J. Biddle and E.J. Thomas (Eds.) Role Theory: Concepts and Problems. New York: Wiley.

Morgan, D.H.J.
1975 Autonomy and Negotiation in an Industrial Setting. Sociology of Work and Occupations, Vol.2, No.3 (Aug.): 203-226.

Mumford, Emily and J.K. Skipper
1967 Sociology in Hospital Care. New York: Harper and Row.

Oken, D.
1961 What to Tell Cancer Patients. Journal of the American Medical Association 86.

Parsons, Talcott
1951 The Social System. New York: Free Press.

1969 Research with Human Subjects and the Professional Complex. Daedalus 98 (2): 325-360.

Paterson, R. and J. Aitken-Swan
1954 Public Opinion on Cancer. Lancet, Oct. 23: 857.

Pearlin, Leonard
1962 Alienation from Work: A Study of Nursing Personnel. American Sociological Review 27, No.3 (June): 314-326.

Pratt, L., Arthur Seligmann and George Reader
1957 Physicians' Views on the Level of Medical Information among Patients. American Journal of Public Health 47: 1277 - 1283.

Quint, Jeanne C.
1964 Mastectomy -- Symbol of Cure or Warning Sign? General Practice XXIX:119.

1965 Institutionalized Practices of Information Control. Psychiatry 28: 119-132.

1966 Awareness of Death and the Nurse's Composure. Nursing Research 15: 49-55.

Reader, G.G. et al.
1957 What Patients Expect from Their Doctors. The Modern Hospital 89.

Reissman, Leonard and John M. Rohrer (Eds.)
1957 Change and Dilemma in the Nursing Profession. New York: J.P. Putnam's Sons.

Rosenblatt, Daniel and Edward A. Suchman
1964a Blue-Collar Attitudes and Information Toward Health and Illness. Pp.324-333 in Shostak and Gomberg (Eds.) Blue-Collar World.

1964b The Underutilization of Medical Care Services by Blue-Collarites. Pp.341-349 in Shostak and Gomberg (Eds.) Blue-Collar World.

Rosengren, W.R. and S. De Vault
1963 The Sociology of Time and Space in an Obstetrical Hospital. Pp.266-292 in Eliot Freidson (Ed.) The Hospital in Modern Society.

Rosenthal, Carolyn, Victor W. Marshall, A.S. Macpherson and Susan E. French
1976 Nurses and Patients' Families: Strategies and Constraints in the Struggle for Control. Paper presented at the Annual Meeting of the Canadian Sociology and Anthropology Assoc., Quebec City, Quebec), May, 1976.

Roth, Julius
1963a Information and the Control of Treatment in Tuberculosis Hospitals. Pp.293-318 in Eliot Freidson (Ed.) The Hospital in Modern Society.

1963b Timetables. Indianapolis: Bobbs-Merrill.

1972 Staff and Client Control Strategies in Urban Hospital Emergency Services. Urban Life and Culture (April): 39-60.

Roy, D.
1952 Quota Restriction and Goldbricking in a Machine Shop. American Journal of Sociology 57, No. 5 (March): 427-442.

Rubington, Earl
1965 Organizational Strains and Key Roles. Administrative Science Quarterly 9: 350-369.

Scheff, T.J.
1966 Being Mentally Ill. Chicago: Aldine.

1968 Typification in Rehabilitation Agencies. Pp.120-124 in Rubington and Weinberg (Eds.) Deviance: The Interactionist Perspective.

Scott, Richard
1965 Reactions to Supervision in a Heteronomous Professional Organization. Administrative Science Quarterly 10, No.1: 65-81.

Singer. Jack N.
1974 Participative Decision-Making about Work. Sociology of Work and Occupations, Vol.1, No.4 (Nov.): 347-371.

Skipper, James K. Jr.
1964 The Social Obligations of Hospitalized Patients: A System Analysis. Unpublished Ph.D. Thesis. Evanston: Northwestern University.

1965a The Role of the Hospital Nurse: Is It Instrumental or Expressive? Pp.40-47 in Skipper and Leonard (Eds.) Social Interaction and Patient Care.

1965b Communication and the Hospital Patient. Pp. 61-82 in Skipper and Leonard (Eds.) Social Interaction and Patient Care.

Spelman, M.S. et al.
1966 How Do We Improve Doctor Patient Communication in Our Hospitals? World Hospitals 2:126.

Stanton, Alfred H. and Morris S. Schwartz
1954 The Mental Hospital. New York: Basic Books.

Strauss, Anselm L.
1964 Psychiatric Ideologies and Institutions. New York: Free Press.

1963 and Leonard Schatzman, Danuta Ehrlich, Rue Bucher and Melvin Sabshin The Hospital and Its Negotiated Order. Pp.147-169 in Eliot Freidson (Ed.) The Hospital in Modern Society.

1964 and Barney Glaser and Jeanne C. Quint The Nonaccountability of Terminal Care. Hospitals, Vol.38 (Jan.16):73-87.

Strauss, Robert
1972 Hospital Organization from the Viewpoint of Patient-Centered Goals. Pp.203-222 in Basil Georgopoulos (Ed.) Organization Research on Health Institutions. Ann Arbor: Institute for Social Research, The University of Michigan.

Sudnow, David
1967 Passing On. Englewood Cliffs, New Jersey: Prentice-Hall.

Waitzkin, H. and J.D. Stoeckle
1972 The Communication of Information about Illness. Adv. Psychosom. Med., Vol.8, Karger, Basel: 180-215.

Waitzkin, H. and Barbara Waterman
1974 The Exploitation of Illness in Capitalist Society. Indianapolis and New York: Bobbs-Merrill.

Weber, Max
1947 The Theory of Social and Economic Organization. New York: Oxford University Press.

Weinstein, Eugene A. and Paul Deutschberger
1963 Some Dimensions of Altercasting. Sociometry XXVI, No.4 (Dec.(: 454-466.

Wessen, A.F.
1958 Hospital Ideology and Communication between Ward Personnel. Pp.448-468 in E.G. Jaco (Ed.) Patients, Physicians and Illness.

1966 The Apparatus of Rehabilitation: An Organizational Analysis. Pp.170-173 in M.B. Sussman (Ed.) Sociology and Rehabilitation. Washington: American Sociological Association.