

**Visible and Invisible Care:**  
An Anthropological Study of Nursing Assistants on a  
Psychiatric Ward in London

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## Abstract

This thesis is based on ethnographic research carried out in a psychiatric hospital in London. It explores the ways in which mental health care is constructed and practiced by different sections of staff. Everyday psychiatric care functions through the management of contradictions between two different approaches. The first will be termed the *official discourse of care* created within professional domains such as Government, NHS and Trust policies. Fundamental to this is a desire for a patient-centred approach where care is ‘therapeutic’ and ‘empowering’. This official discourse structures the ideology which nurses, psychiatrists and Trust management attempt to follow. The second approach here termed the *unofficial approaches of care*, turns the official discourse on its head. It is constructed by the unqualified sector of the psychiatric staff – the nursing assistants (NAs). Typically, nursing assistants who enter into this low paid employment are not motivated by vocation, as the official discourse implies. They are positioned in, what I term, the organization’s buffer zone: the meeting point of the official and unofficial. It is within this zone that the undesirable, but essential areas of care are carried out so that the official ideology of care prevails. While the unofficial domain primarily protects the nursing assistant, it also protects the qualified staff from acknowledging specific aspects of care on the ward. The dependency results in a ‘trade-off’ in which the role of the nursing assistant is made invisible. The specific focus of this thesis not only lends itself to broader debates on the role that contradictions play within psychiatry, but also how the concept of contradictions can develop the anthropology of organisations, policy and work.

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I was fortunate to receive funding from the NHS Trust where my research took place and the Anthropology Department at Goldsmiths College, University of London to carry out this research.

My fieldwork took place in a very sensitive area. Mental health and psychiatry are complex topics that have to work with those that are seen as peripheral to mainstream life. Society is uneasy discussing issues around madness. I therefore deeply thank those that work and live within the institutions of madness. This includes the nursing assistants, nurses, patients, psychiatrists and management in the hospital and Trust where my research took place. They all provided me with amazing openness and willingness towards my research. I would especially like to thank Dr John Moriarty who became a valuable support while also providing official approval for my field research. James Hayes and Gaitree Gunabissoon also supported and encouraged me. It would be too much to mention all the staff on College Ward and in the hospital, but I will never forget the universal acceptance of my position. Although I will not miss the sound of the 'panic alarm' or the practice of restraining of patients, I will miss the everyday

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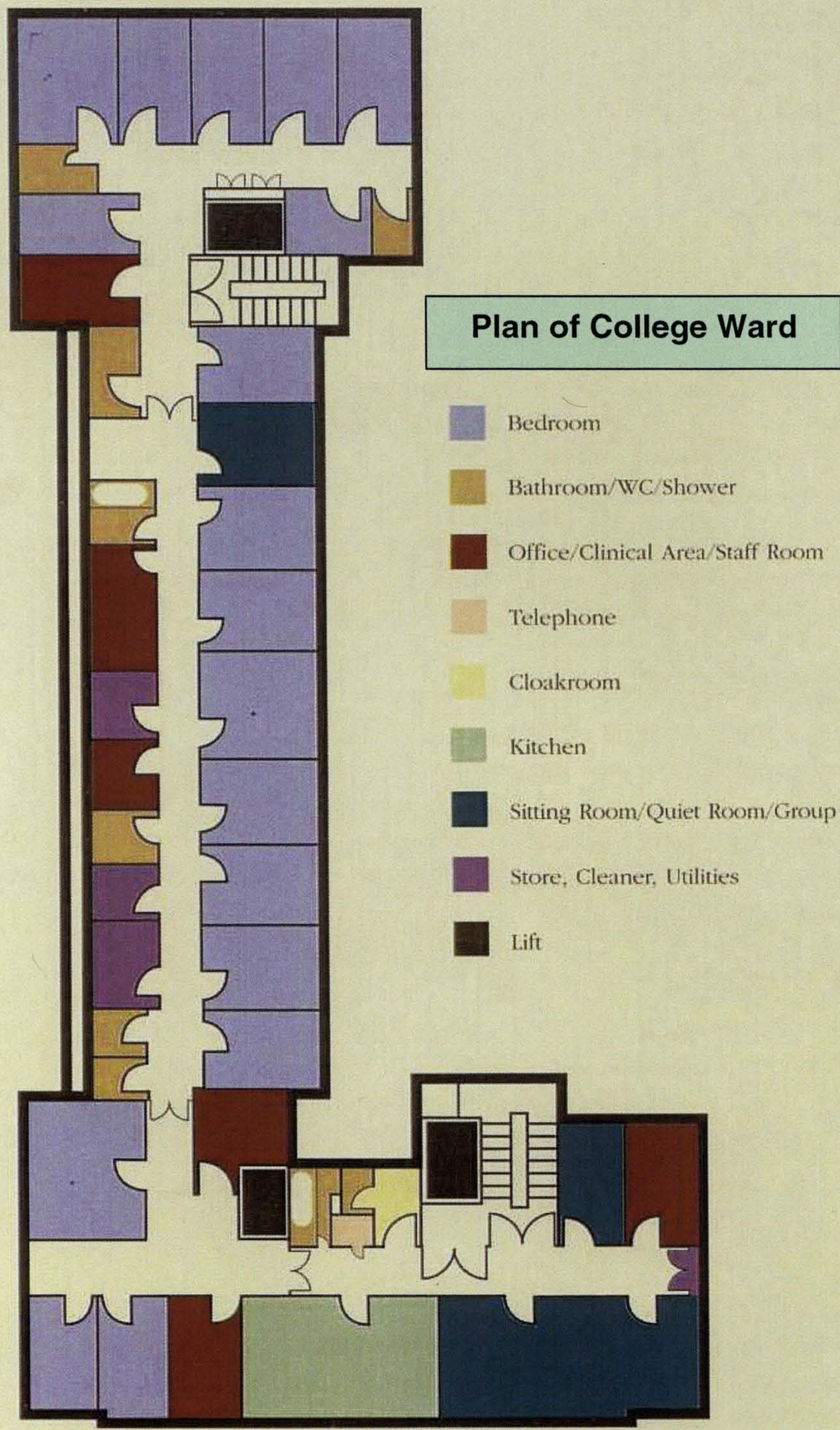
Prof. Les Back and Dr Les Henry at Goldsmiths College and Dr Simon Roberts (Ideas Bazaar), have provided me with friendship and support before and throughout my PhD. I give special thanks to my supervisor, Dr Simon Cohn. Simon's ability to allow me to think and be creative while continuously challenging my thoughts has made me learn so much. He has also become an important friend and I thank him for all his energy and enthusiasm.

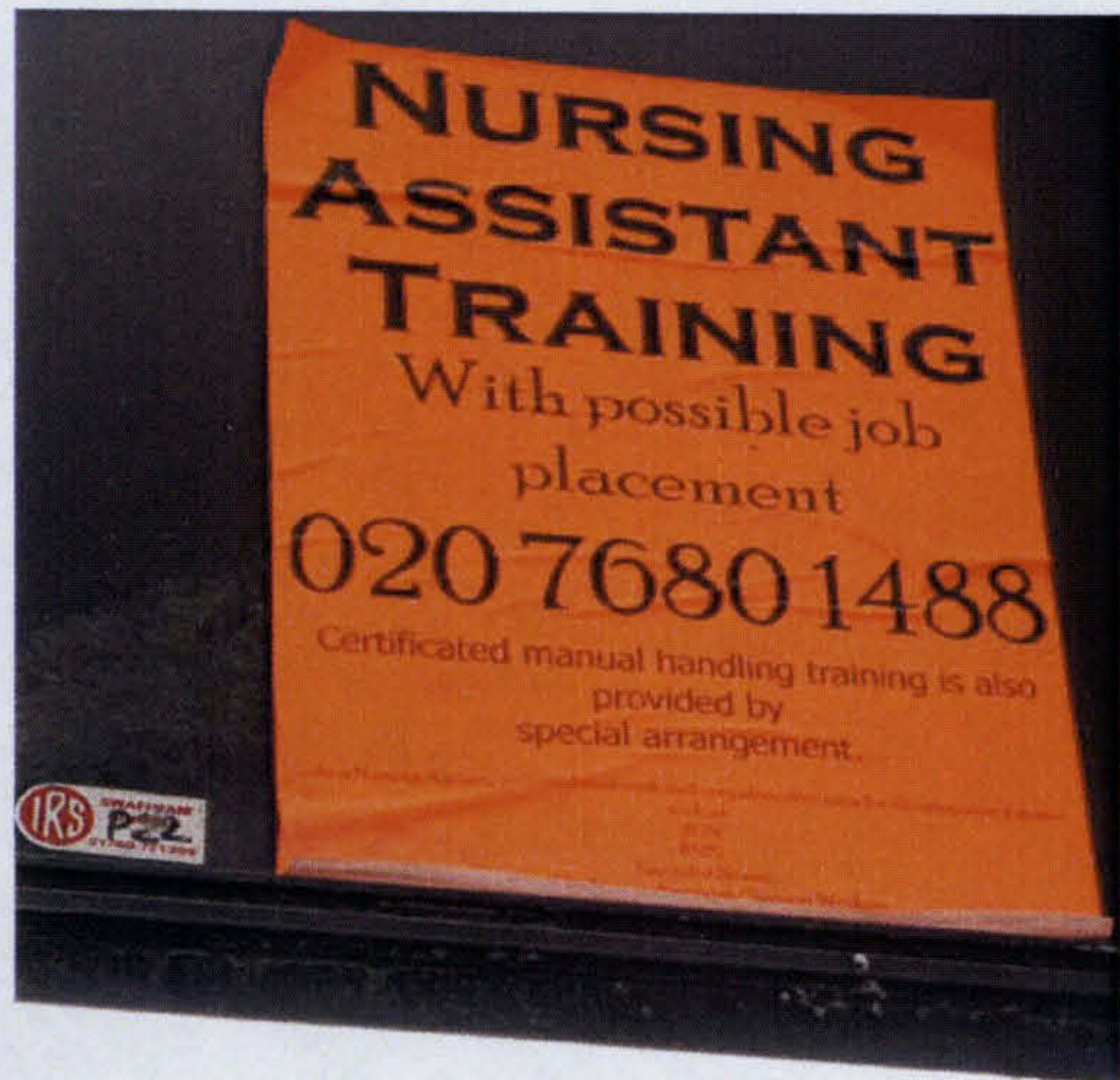
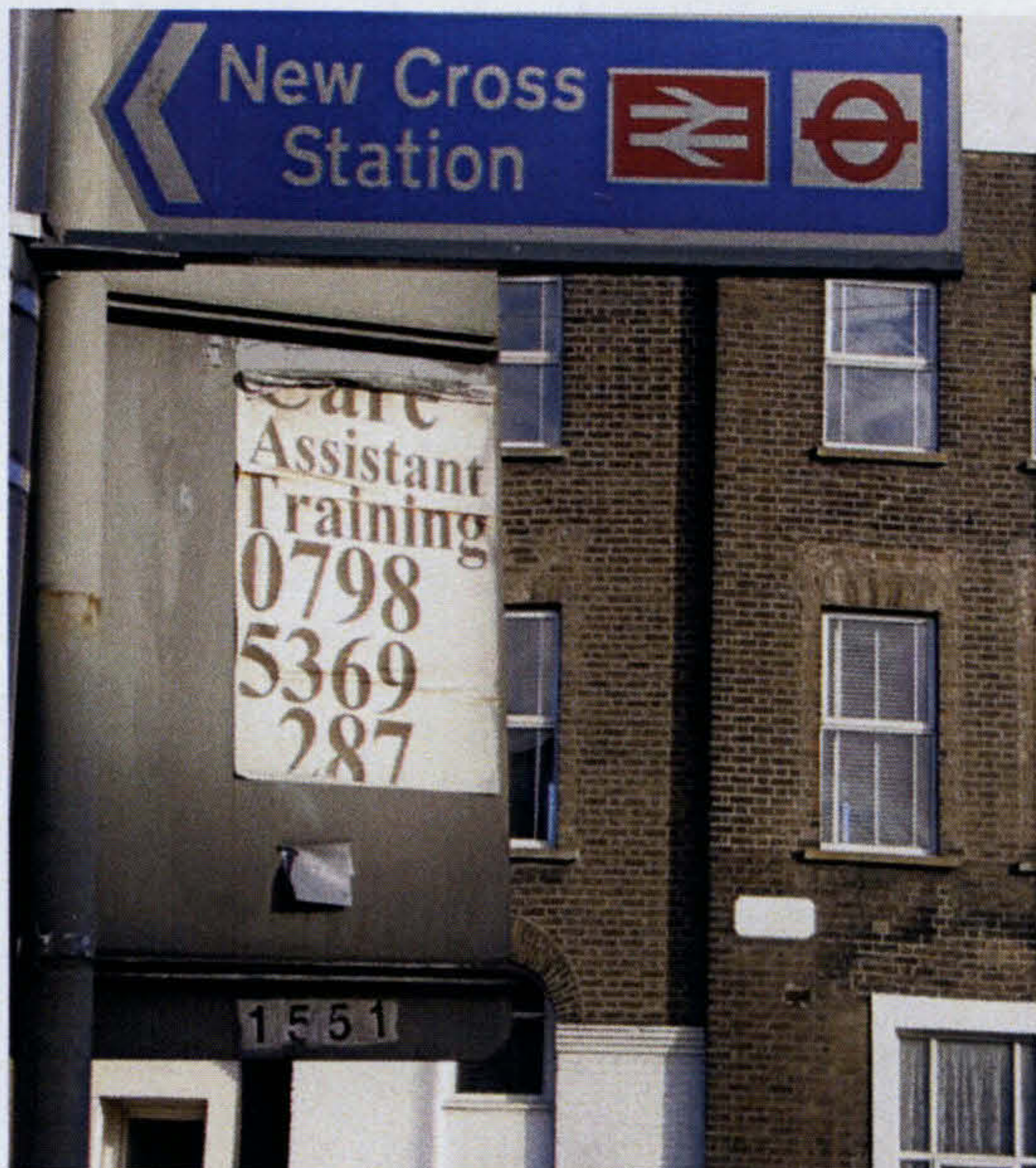
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**For my lovely Miranda**







*We are not important. The work we do is 'mo ye e wa' (do this do that). That is what people back home say we do – we are like servants. It is shameful that we have the chance to come to England and can only find this type of work. That is why it is important that we show people in Nigeria that we are successful and can wear nice clothes.*

(Female Nursing Assistant – College Ward)

Persons at the bottom of large organisations typically operate in drab backgrounds, against which higher-placed members realise their internal incentives, enjoying the satisfaction of receiving visible indulgences that others do not. Low-placed members tend to have less commitment and emotional attachment to the organisation than higher-placed members.

(Erving Goffman, 1961:182)

# I. Introduction

## Part 1 – Setting the Scene

If there is one major contradiction within psychiatry as a discipline it is the fact that it has two general functions that appear to be at loggerheads with each other. On the one hand, it is a medical science that aims to engage with patients therapeutically, while on the other hand, it is an arm of state apparatus that controls and contains individuals against their will under the Mental Health Act (1983). Thomas and Bracken (2001) explain:

The links between social exclusion, incarceration, and psychiatry were forged in the Enlightenment era. In the 20th century, psychiatry's promise to control madness through medical science resonated with the social acceptance of the role of technical expertise. Substantial power was invested in the profession through mental health legislation that granted psychiatrists the right and responsibility to detain patients...(2001:725).

Throughout the history of modern psychiatry, the discipline has never really come to grips with this contradiction (VanDongen 2004)<sup>1</sup>, leading to a

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<sup>1</sup> I will discuss the role of psychiatry and especially this general contradiction in more detail in Chapter Three.

continuous barrage of criticisms and accusations that influence media and public opinion, while also creating numerous changes in Government policies and social thinking. While those working within the discipline of psychiatry are seen to have a unique position of power, they are also hounded and scrutinised through a process of 'do's' and 'don't's'. However, regardless of policies, laws and criticisms, the contradiction remains at the centre of psychiatry. The fact that this never seems able to be eradicated, has led to social thinking demanding that psychiatry has to be 'ultra-moral' and meticulously ethical in its approach to modern day care.

As early as the 18<sup>th</sup> Century, there were drives towards 'moral treatment' that aimed at therapeutic interactions rather than the physical restraint of patients. William Tuke's famous Retreat outside York in 1796 set out to "provide a non-institutional and rural refuge for inmates in which a family atmosphere would be created and employed and exercise would be available to alleviate and occupy troubled minds. Above all, inmates would be treated not as animals, but with kindness and consideration under a benevolent governor" (Samson, 1995:58). Although, the influence of moral treatment sowed the seeds for the beginning of modern day psychiatry, it was the rise of positivism in the 19<sup>th</sup> Century that replaced the moral gaze (Foucault 1989). From this point on, the 'medical model', based within scientific norms and the prestige of the hospital (Littlewood 2000), provided psychiatry with the perceived means to demonstrate its medical and scientific credentials (Bracken 2002). Furthermore, the positivistic approach of the 19<sup>th</sup> Century to understanding mental illness has shaped how psychiatry is

largely understood today. However, such an emphasis on the scientific 'medical model' has promoted a continuous flow of criticism directed at psychiatry.

In the 1960's and early 1970's criticism of psychiatry focused on the labelling of the mentally ill and how this produced social systems of stigma. Thomas Szasz ([1961] 1972) directly challenged the bio-medical model by arguing that 'madness' is itself a socially defined label that is used when a person, or group, are not understood, or liked, while R.D Laing explains in *The Divided Self* (1960) that being schizophrenic is 'playing mad' and making the doctor look stupid and inadequate. Sociologists such as Erving Goffman (1961) argued that psychiatric hospitals create sub-cultures where patients go through a 'mortification of the self' where all objects relating to the individual's self are removed. Thomas Scheff (1966) described mental illness as a label that is given to those that appear not to abide with social norms, while Rosenhan (1973), a psychologist, also challenged the institutional environment of psychiatry by arguing that the medical process reinforces the labels of mental illness. These theorists were loosely grouped together as the 'anti-psychiatry movement'. At the same time as Goffman wrote *Asylums* (1961) Michael Foucault wrote *Madness and Civilisation* ([1961] 1989) where he argued that the construction of mental illness has to be seen as a relative concept whereby the institutions of psychiatry are a phase in the history of the construction of the concept of mental illness.

Adding to these criticisms is the problem of the actual medical processes of psychiatry. Unlike general medical practice, where illness and disease usually focus on the physical body as the object of analysis, disease in psychiatry places

a greater focus on the self rather than on the physical body (Fabrega 1989). Therefore, psychiatric diagnosis implies a medicalization of social and psychological behaviour in a way that general medicine does not. It also has to incorporate cultural, social and psychological areas of understanding illness and disease. However, as Littlewood (1996) argues, psychiatry is encouraged to understand mental illness through a medical process “which encourages us to understand and shape our troubles in a clinical way: as something like a disease which suddenly constrains us from outside our intentions” (1996:245).

Therefore, social and cultural factors are usually placed on the periphery, ignored altogether within the diagnostic process, or positioned within interest groups within psychiatry, like transcultural psychiatry, that still hold on to a biomedical approach that “answers to a series of ‘when is a delusion not a delusion’ questions” (Littlewood, 1998:17). As a result of this struggle to belong within an idealised medical model, psychiatry largely focuses on the development of a universal system of diagnosis and classification (Fabrega 1994, Losi 2000 ). This is largely influenced by the *Diagnostic and Statistical Manual of Mental Disorder* (DSM) (1994), which enables psychiatry to locate illness within a clear medical framework. It directs the clinician towards an understanding of areas of behaviour and emotion as symptoms of underlying disease. It “maintains a hierarchy of diagnostic significance” (Littlewood & Dein, 2000:8). In so doing, the categories created through the DSM frame our thinking about important social matters, and affect our social institutions (Kutchins & Kirk 1999).

Psychiatry has always wanted to be accepted by other medical disciplines as a ‘hard science’. This has made the medical model, as manifested in the DSM,

attractive to the discipline and has led to reluctance in acknowledging that psychopathology arises at some interface of brain and social experience (Eisenberg 1995). Mainstream psychiatry and epidemiology have been criticised for ignoring validity while searching for reliability (Kirk and Hutchins 1992, Nations 1986).

### **Psychiatry in Britain today**

There still remains a strong and controlling scientific core to psychiatry, however there is a general feeling that faith in science and technology to deal, or solve health and social issues is beginning to decrease (Bracken & Thomas 2001).

This, it is argued, has promoted the Government to develop a new relationship between doctors and service users (Gray 1999). This is reflected in Government policies that are beginning to change mental health care in Britain by attempting to create links between mental health and social and cultural domains where there is a focus on disadvantaged social groups and social exclusion. Therefore, there is a drive to promote a holistic approach to understanding and working with mental health issues, and not just locating it within a scientific model.

Since 1997, the British Government has introduced policies that attempt to modernise the way the NHS is run, and how the public perceive their role within it. These policies embrace the notion of 'care' as the core of this change.

Government papers such as The National Service Framework (NSF) (1999) and The NHS Plan (2000) have promoted the concepts of patient empowerment, modernisation and a professional service with better trained and better paid staff. The NHS is now run according to principles of 'empowerment' where the patient



is described as the 'client' or 'consumer' who can choose - and better still advise the 'experts' on - how and when their care should be administered. Care is promoted as 'patient-centred' where the patient and physician form a relationship (Laine & Davidoff 1996) where both have different but equal knowledge about the health issue at hand (Stevenson *et al* 2000, Mead & Bower 2000).

One of the most obvious changes within psychiatric care that has come about as a result of these policies is the focus on the service users' perspective. Thomas and Bracken (2004) state that the "emergence of a wide variety of service user groups has been one of the most significant developments in mental health care in the past 15 years" (2004:361). Therefore, there is a move towards including 'a voice' of those who are labelled mentally ill so that their views, feelings and thoughts can be taken into account in the decision-making about their care and about future NHS policies. Such is the attention on the 'user movement' in the last few years, that service users are now taking an active and central role in research. Rose states that user lead research "involves service users controlling all stages of the research process; design, recruitment, ethics, data collection, data analysis, writing up and dissemination....[T]hey (the researchers) have much to contribute because they have experienced the same problems and services as the participants in the research. They are increasingly being called 'experts by experience'" (Rose 2001:405). Within mental health, therefore, the 'expert' is now supposed to incorporate not just the professional clinicians, but the patients too.

New Government policies and the rise of the user movement are, Thomas and Bracken argue, linked because they reflect other developments: economic, cultural and political. “The rise of consumerism, the increasing importance of the media and the advent of globalisation have had profound effects on our assumptions about the nature of knowledge, expertise and the role of professionals. These trends are part of that wider cultural phenomenon referred to as the postmodern condition” (2004:361)<sup>2</sup>. Government policies relating to health care in general can thus be seen as embracing the age of consumerism. However, as this thesis aims to illustrate, these discourses of care are more problematic when situated within an acute inpatient psychiatric ward in London. The environment of a psychiatric ward makes it difficult to incorporate notions of the consumerism and patient empowerment into daily care because patients are often cared for while being detained under the Mental Health Act. As Sashidharan rightly explains:

Within the current debate about the appropriateness and effectiveness of health care and health services there is a welcome emphasis on moral and ethical, as well as political questions... Within mental health services both sets of questions, those which touch upon the benefits or outcome of health care interventions, as well as those concerned with autonomy of the individual, consumer rights and inequities in the delivery of care, present us with greater problems than any other health care discipline...because of the underlying contradictions within most

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<sup>2</sup> Their use of Lyotard’s ‘postmodern condition’ (1984) questioned how grand theories have lost their legitimacy thus leading him to question the assumption that science and rationality lead to progress and improvement.

psychiatric practice, between cure and control of care and custody”  
(2001:245).

Often this contradiction is masked through professional or managerial discourses around care.

## **Part 2 – Aim of the thesis**

It is worth describing why I chose the topic of psychiatry and mental health care as an anthropological study. I have to admit that I stumbled on the area of psychiatry by accident rather than engineering a pathway into the topic. In my second year as an undergraduate student of social anthropology at the London School of Economic (LSE), I started to work part-time as an agency psychiatric nursing assistant in various inner-London hospitals. Shifts were always available for me where and when I wanted, and the money earned provided a much-needed boost to my student finances.

I had never worked in a psychiatric hospital before; in fact I had never been into a psychiatric hospital before. However, I had carried out voluntary work at a day centre for the homeless in central London for a couple of years which seemed to be adequate experience from the nursing agency’s point of view. The bottom line was that I had no experience or training in mental health care. The nursing agency provided me with a two-hour induction session and then I was away.

I spent 18 months working as an agency nursing assistant, and it was in this time that I became interested in a number of themes within psychiatric care, especially acute inpatient wards and the different sections of staff that make up 'the team'. However, the most striking observation I made was amongst the nursing assistants – the unqualified sector of the nursing staff. The large majority of the nursing assistants I worked with were from West Africa, particularly Nigeria, while most of the qualified nurses were white English, Scottish and Irish, with a minority from Mauritius and Southern Africa. This ethnic divide of the nursing staff existed across a number of hospitals in London. I was struck by the stark divide between the unqualified and qualified sectors of the staff regarding nationality and ethnicity and also their motives for choosing their line of work. What became very clear amongst the nursing assistants with whom I worked was that they did not really want to be working in such institutions but had little other choice. In other words, there was a feeling of being 'stuck' in their employment. Furthermore, they felt that this work was deemed of lower status and 'shameful' the eyes of family and friends 'back home' in Nigeria. Most nursing assistants spoke about their desire to start up their own businesses so as to move out of the rut they had found themselves in. There was a small handful of younger nursing assistants who mainly came from Ghana that were working, like me, to fund their way through their education.

I became interested in how this unqualified sector of staff coped within an environment that they had little desire to be in, in the first place. Furthermore, I was interested in how this influenced their attitudes to mental health work and mental health in general, and how this was negotiated with the other sections of

the staff, especially qualified nurses, who, by and large, became psychiatric nurses because they had a real interest in the work. Although I was already thinking about doing a PhD in social anthropology, it was this curiosity that prompted me to spend the next few years researching this social setting and the stark contrasts between different sectors of staff.

It is important to point out that at the time of my fieldwork the title 'nursing assistant' was one of six titles that the post was known as; as well as nursing assistant they could be called 'healthcare assistant', 'care assistant', 'unqualified nurse', 'A-grade' and finally 'NA' (which is an abbreviation of nursing assistant). When I briefly spoke to the NHS Mental Health Trust Human Resource Department, which the hospital of my field research was part of, about the official title of a nursing assistant, they told me that there was no fixed definition of the job title. Henceforth in this thesis, I am going to refer to nursing assistants as NAs since this was the most common term that was used on the wards.

### **Focus of the thesis**

This thesis explores the social and cultural construction of psychiatric acute inpatient care. It focuses on the unqualified section of the nursing team, namely the NAs, in order to show that the official image of psychiatric care is not, in fact, reflected in the everyday reality of care on the ward. The official image promotes itself as being based on 'therapeutic interventions' through the 'empowerment' of the individual patient or 'consumer'. Within this thesis I call this the 'official discourse of care'. I argue that the official notion is more caught

up in its ideology than in its actual administering of care. Here, I am adopting Marxist notion of ideology where, in relation to ‘capital’ for example, ideology “conceals the hidden essential pattern by focusing upon the way in which the economic relations appear on the surface” (Larrain, 1991:249). Therefore, ideology is used to conceal contradictions and ‘invert reality’ (ibid). It can distort social or natural reality which then strengthens on social group or class over another. By focusing on the unqualified NAs, this thesis will illustrate that there is a parallel and conflicting systems of care to that of the official and its ideological concepts. The unofficial approaches towards care fundamentally challenge the principle on which the official image is built. The tension between official and unofficial systems opens up the question as to how an acute inpatient psychiatric ward works and functions in an efficient way.

The thesis argues that these two differing approaches to care actually rely on each other symbiotically to sustain an efficient and workable system. To demonstrate this, I will interpret ethnographically how the different sections of the staff, both qualified and unqualified, negotiate and understand psychiatric care. This also exposes how hospital, Trust and Governmental policies construct an ideological and official image which is portrayed as the sole discourse of care, yet also potentially contain and allow variation.

### *The official system*

There are two broad areas in which these two competing discourse of care are positioned. I call these areas the ‘official system’ and the ‘unofficial system’. The official system presents itself as the general and objectively accepted framework

that any organisation abides to, so as to provide it with its identity, or public face. The official system is made up of two parts: the first is the formal procedures that are clearly marked out within policy, mission statements, protocols, goals, training and research. The second is the informal procedures that allow groups within the organisation to discover their own methods of completing the requested goals of the organisation. Blau and Scott (1963) explain that the roots of informal systems “are embedded in the formal organisation itself and nurtured by the very formality of its arrangements. Official rules must be general to have sufficient scope to cover the multitude of situations that may arise” (1963: 5-6). The formal and informal procedures are essential for the efficient functioning of the organisation, and it is within these, in a hospital setting, that groups such as psychiatrists, qualified nurses and hospital and Trust management are positioned, and where Government and Trust policies are visibly displayed. The official system must maintain its validity at all costs by being overt and visible in both the formal and informal spheres.

### *The unofficial system*

The unofficial system must not be confused with informal structures that operate to support the official system. Instead, the unofficial system has no formal impact on the official ideology of care other than by ‘invisibly’ carrying out the basic and undesirable tasks, without which the official system would not be able to operate. In my research, the unofficial system is the space that is occupied only by NAs. It is therefore owned by the NAs, and allows them to form mechanisms and techniques that develop their own approaches of care on the one hand, and on the other hand, enables them to act out systems of resistance against the

official system so as to maintain a sense of self within a work environment where they generally feel they have little worth on. In other words, maintaining a sense of self in this space alleviates their experiences of working as an unqualified carer. Essentially, the unofficial system prevents their official task orientated work from becoming anything other than just that, namely work; their work is not in anyway determined by a morally driven desire to care. The unofficial system therefore functions to protect the NAs from an imposing discourse of care that they see as riddled with contradictions.

I have deliberately not mentioned the role of the NA in the official discourse of care, whether formal or informal. Although the official tasks that they carry out are located within the official system, I argue that their work is positioned in what I term the 'buffer zone', which is the meeting point of the official discourse of care and the NAs' unofficial approaches towards care. The buffer zone is where official tasks are carried out that focus mainly on the patient's physical body, such as observation, taking patients out on escorted walks, kitchen supervision and personal hygiene maintenance etc. This form of care does not fit into the ideological image of the official discourse of care, primarily because the focus on the physical body of the patient directly contradicts the official emphasis on therapeutic engagement with the patient as a whole, participating person. In other words, the unofficial contains little if any, focus on the patient's mind and on the empowerment of the patient. The care that the NA gives in the buffer zone frames the patient more as being 'needy' than competent. Therefore, the buffer zone becomes the space where the undesirable, yet essential care is carried out. The key point is that this form of care has to be made invisible



through subtle forms of masking so that the official discourse can claim the sole status of care.

### *Organisations*

It must be pointed out that, while focusing on the construction of psychiatric care this thesis should also be read broadly as an anthropological study on organisations (Wright 1994). In this sense, I am exploring how hierarchy is portrayed through practice and policies. There is a tendency to portray traditional bureaucratic hierarchy as a negative and archaic system within any modern day institution, because it leaves little space for the individuals within the organisation to have any agency (Mommsen 1974). We live in an age where organisations are, or ideally should be, based on 'flexible' (Martin 1994) and egalitarian principles that provide the individuals with a sense of individual adaptability and autonomy within the structure. In other words, there is a move from understanding organisations as a formulised structure to viewing them as organic and flexible 'cultures' (Schein 1985, Stapely 1996). This thesis will illustrate that organisations should not be seen as either one or the other. Instead, it argues that, traditional hierarchy is made invisible so that a image of flexibility, where all individuals apparently have a dynamic role, can be portrayed as a core of the organisation. In my research, for example, the lines that mark out the boundaries between the professionals, such as qualified nurses and psychiatrists, are made to appear blurred and non-hierarchical. However, behind the blurrings of professional lines, a traditional structure of hierarchy still exists. I argue that it is almost by the very masking of hierarchy that it, in fact can be reproduced in the contemporary work place.

In general, by exploring the construction of psychiatric care from an anthropological perspective, this thesis throws up interesting broader themes relating to ideology and the role of masking undesirable, but, essential features of an organisation. Throughout this thesis there are examples that highlight the important role that contradictions play within an organisational setting that, actually work to maintain a system of efficiency.

### **Part 3 – Description of the field and actors**

My fieldwork took place in an NHS psychiatric hospital in Central London and lasted for 18 months. In the interest of confidentiality, I feel constrained not to give further geographical or physical detail about the hospital. At the time of my research, the hospital consisted of three adult acute inpatient wards and one Psychiatric Intensive Care Unit (PICU) which is a locked ward. The hospital also had day services (Occupational Health, Music Therapy, Art Therapy) which catered for day patients and inpatients, a psychology department and a roof garden. All the wards had male and female patients. My research was situated on one of the acute wards, which, for the purpose of this thesis, will be called 'College Ward'. Due to the nature of the work, I was visiting most of the other wards on a daily basis. One of the conditions set down by the hospital management was that I became a full-time, paid NA. They felt that it was not a good idea for a researcher to just 'hang around' because such a presence could

make patients and staff feel uncomfortable<sup>3</sup>. I also had to write a 10,000 word research proposal for the Trust's Ethic's Committee with a detailed description of the methodology, research focus and who would be involved with the research. The proposal had the signature of College Ward's consultant psychiatrist so to show that he was willing for the research to take place on the ward. Due to the research not having a heavy focus on patients, the Ethics Committee felt that the proposal provided adequate information to be passed.

All members of staff on College Ward were provided with a letter from me explaining my research and what types of methods I would be using. I made it clear that they were able to approach myself, the team leader and consultant psychiatrist if they had any questions or concerns. Finally, all staff signed a consent form, agreeing to be part of the research. All staff were very willing to be part of the research

### **The ward**

The nature of a psychiatric ward can be unpredictable at times. College Ward could shift rapidly from being calm into a place where individuals could become frustrated, angry and violent. The environment also changed depending on the day of the week. Weekends were usually quiet and relaxed, while Mondays and Fridays were usually busy due to the ward rounds. Quirk and Lelliott's ethnographic research on psychiatric wards describes this well:

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<sup>3</sup> I discuss this in more detail in Chapter Two

A modern acute psychiatric ward is a highly complex social setting. This scarcity of beds means that the patient group includes people of all ages and backgrounds and with very different types of problems. It is an unstable community in that its membership constantly changes as patients are admitted or discharged, or when staff change shifts.... It is also permeable as the patients continue to interact with family, friends and care workers from outside of the hospital and with patients from other wards (Quirk & Lelliott 2002:344).

However, while the ward did resemble an 'unstable community' there was also room for humour between patients and between patients and staff which could lead to close friendships. It was, perhaps surprisingly, common that once patients were discharged, they would return and use it as a social 'hang out', or a place to get advice from the nursing staff.

College Ward had 20 beds. Three of the seventeen bedrooms were shared rooms. The ward had a large sitting room with a television, hi-fi, and pool table where the patients were allowed to smoke. Just across the corridor was a smaller television room which was non-smoking. The walls of the ward were painted in light pastel shades of yellows and blues that made it resemble a Miami beach house. Each ward had a different colour scheme chosen by the nursing staff and ward managers. The ward below College Ward was decorated in shades of army green. Large framed prints of abstract modern art hung on the corridor walls. These had shatter-proof glass.

The kitchen was open at specific times in the day so that patients could make themselves hot drinks and toast, while all meals were prepared in a larger kitchen on the top floor of the hospital and brought to the wards. Medication time, ward round and handover all took place at the same allocated times, every day or on a specific day of the week. This routinized process gave a sense of order for all those present on the ward.

### **Staffing**

A working day was made up of three shifts; the early, late and night shifts. The early shift started at 7.30am and ended officially at 3.30pm; the late shift began at 13.30pm and ended at 9.30pm; while the night shift started at 9.15pm and ended at 7.30am. The early and late shifts had two qualified nurses and two NAs, while night shift were made up of two qualified nurses and one NA. The staffing level could increase depending on the situation on the ward; for example if a patient was on Level One Observation (this means that a member of staff had to be with the patient at all times), then an extra NA was employed. This would generally be an agency or bank NA<sup>4</sup>.

Qualified nurses and unqualified NAs made up the backbone of the ward staff. Throughout the day, junior psychiatrists, known as Senior House Officers (SHOs) would come in and out of the ward. The two consultants who had patients on the ward usually only came for their ward round. There were also social workers, advocacy workers, housing support workers and art therapists

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<sup>4</sup> Most permanent nursing staff are also part of the Mental Health Trust's bank. The bank is a pool of staff that provides cover if wards need extra staff on a shift. It allows for permanent members of the nursing team to work extra shifts. Using bank staff is similar to using agency

who would come on a regular basis to see specific patients. Finally, there was a permanent domestic staff member: a Jamaican lady in her sixties who washed the floors of the ward corridor every morning, cleaned the kitchen and encouraged patients to clean their own rooms before she vacuumed them.

I am aware that throughout this thesis it might appear to the reader that I have created fixed, clear distinctions between different sections of staff so that they might appear in opposition to each other. For example, in Chapter Four, I discuss qualified nurses and SHOs as two distinct groups within the ward team, while in Chapters Five and Six I describe the position of the nursing assistant (NA) in opposition to qualified nurses. A further distinction is made between the official discourse of care and the unofficial approaches to care. As much as I attempted to explore where these distinctions might not be so clear on the ward, my ethnographic data shows these separations between groups and approaches to care were very real and present on the ward. Off the ward, however, in the pub for example, these divisions would become less stark as members of the different sections of staff tentatively socialised with each other. This shows that it is the ward and hospital environment itself that seems to create these distinctions so markedly. To analysis these divisions I make substantial use of Goffman's (1959) concept of front and back stage performances. This provides a framework in which to examine the meanings and implications that structure these divisions.

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staff, however a bank member of staff is usually a regular member of staff on a ward or within the hospital.

## **Part 4 – Methods of Research**

I have always been interested that everyday interactions have some form of social or cultural meaning. Usually, these meanings are taken for granted; they become normalized and any need for interpretation seems redundant. We are only made to challenge our actions when the social setting is faced with a crisis, or when we enter into seemingly alien surroundings. Anthropology provides the opportunity of seeing the everyday from a new perspective. It approaches these everyday interactions as interesting and fascinating socio-cultural phenomena through an interpretive and analytical process. Therefore, it “views the familiar afresh through focusing on classification and on understanding rationality in social and cultural context....It highlights the value of data gathered informally and the differences between what people say, think, and do” (Lambert & Mckevitt, 2002:210).

An anthropological approach to the everyday, assumes that what is normal is to be taken and challenged. Geertz’s notion of the ‘thick description’ (1973) is a helpful here because it indicates that the meaning behind a social event, or the subtle interactions that occur within that event, often lies at a deeper level than the event or action itself. Therefore, the process of interpreting a social event is multi-layered. More crucially, it is through this multiplicity that meaning can be gained for the social actors themselves. One of the most attractive aspects of anthropology is that it does not attempt to produce ‘facts’, in a positivistic mould. It analyses social phenomena through a creative process of interpretation that never claims to be definitive. This is done both by means of its method i.e.

ethnography, but also, and importantly, through its ability to relate philosophical and theoretical perspectives to these direct observations of social interactions. Therefore anthropology is a social science that is based on ‘doing’, thinking about and interpreting the everyday. It mediates between observing and experiencing to produce deeper understanding of what is usually taken for granted.

### **An Ethnographic approach**

The key point of ethnography is that it must incorporate numerous and varied research techniques that enable the researcher to explore the subtle contradictions between what people say and what they actually do. The ethnographic approach that I used did not abide to any singular technique, rather it was the use of a number of approaches that provided me with the ability to carry out a process of interpretation. Ethnography, then, should not be seen as a technique as such, but a system of creative interpretation. It “decodes and recodes, telling the grounds of collective order and diversity, inclusion and exclusion. It describes processes of innovation and structuration, and is itself part of these processes” (Clifford, 1986:2-3). Fundamental to this research, ethnography “is actively situated *between* powerful systems of meaning” (Clifford, 1986:2).

Savage explains that the way in which ethnography is used, “depends on several factors, including the philosophical stance of the researcher or the practicalities of research funding. There is, for example, no overall consensus among ethnographers about the epistemology, or theory of knowledge, that underpins an ethnographic account” (Savage, 2000:1401). She argues that ethnography has an



essential role within healthcare settings because it is “a way of accessing beliefs and practices, allowing these to be viewed in the context in which they occur and thereby aiding understanding of behaviour surrounding health and illness” (ibid).

### *Ethnography on a psychiatric ward*

An ethnographic approach enabled me to be both flexible while maintaining a focus on the different areas of the research (Hammersley and Atkinson 1995, Atkinson *et al* 2001). Since I did not enter into the field with a set hypothesis, I was able to remain open and decide when to focus more specifically on certain phenomena that arose. The different methods that make up an ethnographic approach create a flexible and adaptive system of field research which meant that I could ‘fit’ into the social environment of the ward and thus appear less of a ‘researcher’ when I needed to. For example, one of the main ethnographic tools I used was participant observation. This was used in two different ways. The first was a more structured approach which I used when attending ward rounds or management meetings. I would take time deciding how my presence would be more obvious in such settings, by dressing in a certain way (see Chapter Two for a detailed account of the use of ‘impression management’). The second use was much more relaxed and resembled more of the romanticized image of ‘hanging out’. In fact, Geertz’s notion of ‘deep hanging out’ (1998) is probably more precise because it implies that although the anthropologist is more flexible, the gathering and interpretation of data is still as analytical as more structured approaches.

Participant observation allowed me to formulate ideas and questions that I wanted to explore in more detail when conducting interviews. When interacting with NAs I would usually use informal interviews, or what I call 'chit-chat'. These interviews would take place on the ward during the working day. With the qualified section of staff (nurses and psychiatrists) I would instigate 'chit-chat' as well as taped semi-structured interviews. I did not conduct taped semi-structured with the NAs because they were usually pressured for time after a shift, having other engagements outside work (such as collecting their children from school). Moreover, there was also an air of reluctance on their part to have their interviews taped. The qualified staff, on the other hand were willing to interact through a more explicit process of interview. Finally, I also used discourse analysis to understand how ward, hospital and Trust policies formulated the way in which staff understood, or misunderstood care and their role of the ward.

### **The problem with researching 'at home'**

All the way through my journey in anthropology, I have felt strongly that anthropology is not just about the distant, foreign 'other'. It has always struck me that observations and theoretical interpretations about 'exotic' groups could just as well be applied to people in the society around me. My own interests in football, music and racism – particularly growing up as a boy in South London – all seemed to be arenas where anthropological thinking seemed highly pertinent. It was not difficult therefore for me to decide, when I was working as an agency nursing assistant in London, that I would carry out anthropological research in this setting.

Although anthropological research *is* carried out within localized settings, it seems surprising to me that there should still be a lingering debate about anthropology 'at home' in the academic literature. The division between research abroad and research 'at home' has rested on the assumption that the anthropologist must enter a new society where their fieldwork starts with a process of alienation and moves through to an understanding of the society (Amit 2000). The anthropologist therefore gradually becomes accustomed to the daily cultural characteristics and 'doings' of the society being researched. Distance and travel from home become central mechanisms for the anthropologist to strip themselves of their own cultural baggage and allow them to gain *authentic* research material. In a sense, the ethnographer is carrying out, 'pure anthropology': the ability to produce genuine accounts of human life. Gupta and Ferguson describe this traditional view as a "hierarchy of purity of field sites" (1997:13). It is assumed the anthropologist 'at home' is unable to gain the feeling of being an alien in an alien surrounding; or in other words, does not have the forum in which to experience culture shock, and therefore is unable to really claim that they are finding authentic meaning from their research material. Thus the real anthropological experience is, as Geertz describes, located in '*being there*' (1988:4) (or being far away) which marks the anthropological reality.

This argument has been an ongoing methodological debate in anthropology for over twenty years. Recent literature has shown that anthropology 'at home' has as much value as any other field research location (Jackson 1987, Clifford 1992, Oakely 1996, Amit *et al* 2000). Rapport argues that the assumption that one has to experience a different culture in a different country is no longer valid: "Here is

a world no longer divided into a mosaic of cultural-territorial segments but conjoined by a complex flow of people, goods, money and information” (2000:73). Following on from Rapport’s argument that the segmentation of cultures is now harder to define within a global setting, I am arguing that the notion of 'home' should no longer exist because the central focus of anthropological research – understanding meaning behind social action - is relevant and present in any country, society or culture.

Another major problem with the concept of ‘at home’ is that for the anthropologist to become accustomed to their foreign culture abroad, they have to make their new environment their home. The anthropologist researching abroad is expected to become familiar with their alien environment and in some way fit into the daily life. The fact is that the well documented emphasis on distance and travel, culture-shock and the learning of a new language are present wherever research takes place.. As far back as the early 1970’s anthropologists such as Nader (1974) argued that culture shock can appear in any research setting and the term is really used as a ploy to attempt to make students study abroad.

Within my own field research I realised that I was not carrying out research in an environment that I was totally accustomed too. In my case, the learning of a new language refers to the learning of psychiatric terms, jargon, slang and so forth. Practically, there was no way in which I could actually live in the hospital; however, the nature of its environment meant that I became totally immersed in its culture, and this created a stark separation from my personal life. The front doors of the hospital were locked and entry was gained by showing the security

guards my identification badge. The building functioned as a structure of containment, keeping a certain category of person within its walls (and also, of course, other people out). I did not automatically belong within it. How then could this ever be seen as anthropology 'at home'?

There are also very positive aspects of carrying out field research near to where you live. It allowed me to have more economic flexibility, as I did not need to rely on funding and private donations (Dyck 2000). I did not have to worry about planning and paying for expensive travel and finding new living accommodation. The hospital was a bus journey or bicycle ride away from my flat and I was also in the position of being able to speak and meet with my supervisor on a regular basis. This allowed me to express ideas and problems that I was encountering while doing my field research. Socially, I was not isolated from my friends and family, which I found very helpful considering that I was researching an environment which was stressful both mentally and physically stressful. Keeping in contact with friends allowed me to distance myself from the field for short periods of time (usually for a few hours in the evening or on days off from work). The idea of creating distance from the field is nothing new; Malinowski described how "if you are alone in a village...you go for a solitary walk for an hour or so, return again and then quite naturally seek out the natives' society, this time as a relief from loneliness, just as you would any other companionship"(1922:7). Having some distance enabled me to reflect on the

information and ideas that I had collected and to separate myself from the daily routine of hospital life.<sup>5</sup>

Finally, it is impossible to claim that London is my 'home' in its totality because it offers different meanings at different times in relation to its organic geographical and cultural map (Caputo 2000). Being a 'native' researcher never really materialised; however, what did materialise was revealing of knowledge of one of the diverse social arenas in London that I had been less aware of before my research took place.

## **Part 5 – Outline of the thesis**

Following on from this introductory chapter, Chapter Two is divided into two halves: the first explores different theories and arguments on the concept of organisations and institutions. I focus on how Weber's (1964) theory on 'Bureaucracy' has been replaced by the concept of 'organisational culture' (Schein 1985, Stapley 1996). I use anthropological theories on organisations (Wright 1994, Martin 1997), policy (Shore and Wright 1997, Wedel *et al* 2005) and culture (Geertz 1973), with an emphasis on how the term 'culture' is used within the NHS (Savage 2000a) to show that both terms; 'bureaucracy' and

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<sup>5</sup> This process of having time away from the field location so as to reflect on the 'goings on' within it, always reminds me of Bertolt Brecht's theories on audience distance while watching his plays. He argued that the audience must always be implicit. "They are not mere spectators but they need to maintain their objectivity and identities; they cannot and must not be expected to surrender them in total identification with either actor or action" (Banks:1985,267). Brecht would use 'Alienation Effects' or *Verfremdungseffekte* to gain this by 'jolting' the audience into realism. Methods involved the actors breaking out into song or keeping the theatre lights on (dimmed) so that each audience member could watch each other's reactions to the play. I saw

'organisational culture' are problematic in their own right. To illustrate the complexity of organisations I will also use Goffman's (1961) concept of 'secondary adjustments'. I start with this topic so that the area of my research, a psychiatric hospital, can be positioned within larger theoretical debates about organisations. This is then revisited later on in the thesis and especially, in Chapter Eight. The second half of Chapter Two explores my role as a researcher carrying out anthropological research in an organisation. Here, I explore issues about entrance and acceptance (Jackson 1987, Back 1993) into the field and the use of ethnography (Clifford 1986) and reflexivity (Okely 1996, Shore 1999, Beatty 1999). I use Goffman's (1959) notion of 'impression management' and 'performance' to further develop these themes around acceptance and field work. The chapter ends by debating what role ethics have in anthropological research (Norris 1993) and whether ethical codes (ASA 2000) can actually become a reality within the research process (Nugent 2001).

Chapter Three explores the concept of care and argues that it is based on a general, but consistent, discourse around morality and vocation (Mackay 1998, Russell 1999, McKeachie and Kohn 1999, Savage 1999). I term this the 'official discourse of care'. I explore the historical development of psychiatry and psychiatric care (Scull 1987, Foucault 1989, Shorter 1997) and argue that psychiatry attempts to abide by the same moral discourses as those of general health care in spite of the past (Laing, Goffman, Szasz) and contemporary criticisms directed at it from the Government, media, and social and cultural

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myself very much as an audience member who was not 'merely a spectator' but nor was I an actor.

theories from outside (Rose 1999) and from within psychiatry (Kleinman 1977, Littlewood and Lipsedge 1982, Littlewood 1990, Thomas and Bracken 2001).

Chapter Four ethnographically explores how the official discourse of care is manifested on College Ward by illustrating the interactions between the different qualified sections of staff: nurses, SHOs and consultant psychiatrists. I use Goffman's (1959) metaphor of the 'theatrical performance' and 'front-stage/back-stage' interactions, while also drawing on Bourdieu's (1977) concept of 'habitus' and Moore's (1986) notions of the way in which practice and interactions generate symbolic meanings within different social spaces. This provides helpful theoretical frames in which to elaborate on how ward space generates different social and symbolic meanings that can result in conflict between nurses and SHOs. I analyse the ward round by drawing on anthropological theory of ritual (Geertz 1980, Bell 1992) to illustrate how its formal structure (Bloch 1989) and power (Rapport 1971, Bourdieu 1977) position the qualified staff in a traditional bureaucratic hierarchy that suppresses the everyday conflict (Turner 1957) between nurses and SHOs and projects the front-stage image of the official discourse of care.

Chapter Five introduces the role of the NA by illustrating in detail how they perceive and administer mental health care. Fundamentally, their approach to care (the unofficial system or approach to care) conflicts with the official discourse of care. Through ethnographic examples, I will show how they formulate defence mechanisms that protect them from the potential threat of the patients. I use Lévi-Strauss' (1978) use of binary oppositions in relation to raw



food and cooked food and anthropological approaches to food (Caplan 1997) and pollution (Douglas 1966, Leach 1964, Tambiah 1969) to explore how NAs create distinctions between safety and danger when interacting with patients at meal times. I use Goffman's (1961) notion of 'secondary adjustments' to illustrate how the NAs' use of defence mechanisms work on a larger symbolic level which functions to protect their own approaches towards care from the imposing official system of care and thus providing them with a sense of self within an environment that they feel excludes them. I will draw on Martin's (1994) concept of practicum, Bourdieu's (1977) concept of habitus and anthropological approaches to the concept of embodiment (Csordas 1994, Lambek 1998) to illustrate how a theoretical focus on the body, as a physical and symbolic social area, becomes an essential part of understanding how the NAs' approaches and models of care are created and practiced socially. The chapter introduces the concept of the 'buffer zone' which is the space where the official discourse of care and unofficial systems of care meet and to some degree co-exist so as to maintain a necessary level of efficiency throughout the shift.

Chapter Six argues that the concept of care for the NAs should be seen as a commodity that is exchanged for financial payment and not as a vocational or moral 'calling'. I will describe the practical reality of their official role by showing that their work is focused on carrying out mundane tasks that primarily focus on the patient's body and not on the 'therapeutic relationship'. Running alongside the official tasks that the NAs carry out, are systems of protest that are situated on the 'front-stage' because they were directed against the official system. On the 'back-stage' there are also socio-economic exchanges and

interactions that have little to do with the official process of care even though they are carried out within the hospital. I argue that these interactions function as a process of resistance that provides NAs with a sense of self within an environment that they have little desire to be in. I draw on Hart's (2000) concept of the 'informal economy' and Parry's (1999) work on the Indian labour in the Bhilai Steel Plant to highlight this point. The chapter ends by discussing how the largely white, qualified nurses understand and interpret such behaviour. Here, I use theories of race and ethnicity (Malik 1996, Solomos and Back 1996) and especially 'whiteness' (Frankenburg 2000, Dyer 2000), to argue that the qualified nurses formulate their understanding of the NAs' apparent lack of motivation and 'greed' for money as a failure to have a moral ethos of care.

Chapter Seven argues that the role of the nursing assistant actually serves to preserve the official discourse of care. However, the key is that the official position of the NA, and the work that they do, has to be made invisible from ward, hospital, Trust and Governmental policies and guidelines. Identifying the official role of the NA also exposes the fact that the official discourse of care contradicts itself because its ideology belies the fact that the reality of practical care does not match up to its aspirations.

Chapter Eight, by way of conclusion, revisits some of the main themes and ethnographic examples throughout the thesis to argue that organisational efficiency within a psychiatric hospital is gained by making the undesirable parts of care and those who carry it out, invisible. However, my additional argument is that the unofficial system actually seeks this invisibility. It is this trade-off that

allows for both systems to remain intact, and the process of mental health care to have some sort of efficacy.

## **II. From within the Organisation: Place, Performance and the Ethical Dilemma**

It was a Wednesday morning and the ward manager on College Ward had come to work an hour earlier than usual. This was due to a pre-planned inspection by the Mental Health Commission that was going to take place the following day in the Hospital. The inspection would take the form of a small team from the Commission who would spend time on each ward interviewing patients that had requested to see them and also reading through patient notes so to check that the appropriate policies and procedures were being carried out by the nursing and medical staff. Hospital and Trust management had notified all the ward managers in the hospital a few weeks prior to the inspection through official written letters and memos. These offered a detailed list of certain areas of procedures and policies that needed to be checked, along with details of how patient information was clearly at hand for the patients on the wards. Qualified nurses were made to check their notes on their patients to see if they had completed detailed care plans and risk assessments.

The ward manager had reminded nurses in advance that he would be carrying out his own checks on the patients' notes so to make sure that care plans and risk assessments had been completed by each primary nurse. He was concerned that the ward had to look 'welcoming' and 'homely' for new and present patients. He had ordered laminated printed posters that he was fixing to the walls of the ward. The posters were there to offer the patients information about the ward and hospital. For example, one poster provided patients with a detailed account of how, if they wished, to lodge a complaint against the care they were being given. Another poster listed the values of the Trust and hospital, while another poster simply explained what to do in an emergency. After spending the morning deciding where best to position the posters, he delegated staff to see if certain areas of the ward were clean and 'respectable'. One nurse checked the laundry room, while another checked the TV and pool room. In the afternoon the ward manager carried out his own inspection of the ward environment.

The reaction of the nursing staff to the Mental Health Commission's visit was one of apprehension and uncertainty. They all felt that they were being treated like children by Trust management. Their response to the ward manager fixing posters to the walls, and inspecting their notes was met with humour. They felt that the ward manager was under a lot of stress with the pending visit and that his actions were becoming more

'erratic' than some of the patients on the ward. However, in general, they could understand the pressure that he was under, but all felt that it was unfair pressure to have.

This short vignette illustrates the formal and informal identities that organisations consist of. On the one hand a visit by a powerful body, such as the Mental Health Commission, results in the Trust and its wards attempting to conform to a single harmonious and formal identity. In order to do so, wards have to temporarily relinquish their own unique and informal identity.

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## **Introduction**

Structure is - "a category of facts with very distinctive characteristics; it consists of ways of acting, thinking and feeling, external to the individual, and endowed with a power of coercion by reason of which they control him" (Durkheim, 1938: 3).

"Within Organisations we will find sub-units that can be referred to as [groups], and such groups may develop group cultures" (Schein, 1985:8).

It is one thing researching the actors working within an organisation who are consciously and unconsciously being controlled by its formal structure. It is another when the organisation requests that the researcher becomes a fully paid member of staff, who then has to negotiate how they are themselves controlled within the organisation, as researcher and as employee. This chapter is deliberately divided into two distinct halves. The first explores the researching of the actors who work within an organisation. It examines how organisations work to meet their desired goals, through the management of bodies. Parts 1-3 of the first half of this chapter offer a review of the literature covering sociological, social psychological and anthropological approaches to understanding organisations. Rather than supporting a single theory, I argue that opposing theories (mainly bureaucratic and 'cultural' theories) on organisations can be applied simultaneously. I suggest that organisations function on loosely bureaucratic structures but that these structures - due to the traditional and negative image they conjure up - are masked by more flexible theories based on an overarching cultural principle. The first half is an essential part of the whole thesis because it locates where the research took place, namely a psychiatric hospital, and also how the concept of organisations in general plays a crucial role in understanding the social and cultural phenomena that I explore in the thesis.

The second half of this chapter explores how I, as researcher, had to become a full-time paid member of staff to carry out my research. It explains how I negotiated my position within the organisation's structures and policies. It focuses on how the hospital became my field of research. I explain how the field

location started off as a defined physical space, in which the hospital walls represented the boundaries, but how interactions with the gatekeepers (hospital management), clinicians and nursing staff meant that there became less well defined because many of these interactions were not necessarily located within the physical walls of the hospital. Thus, my interactions became part of a flexible field of research (Norman 2000)<sup>6</sup>. I also discuss how the idea of entering into what I thought was my clearly defined research site where I would have had a clear role, was naïve and more complex. I became aware that the groups and individuals I was researching were as instrumental as I was, if not more so, in defining where I was situated within 'my' field.

This half of the chapter also explores how I adopted a reflexive, and autobiographical approach to certain aspects of my research in relation to my own cultural background and gender. I illustrate this by using ethnographic examples of situations where I found that my position was being challenged by 'normal' everyday encounters that I was faced. By reflecting on my own cultural background I was able to make sense of these encounters to a certain extent. Furthermore, I argue that this process appeared to be a fairly natural and spontaneous aspect and not a methodological, post-modern tool (Shore 2000).

The chapter ends by arguing that an ethnographic approach makes it difficult to implement or follow a unified ethical approach to fieldwork. The daily interactions between researcher and the researched means that any ethical disposition lies in the subjective judgement of the researcher. This is mainly due

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<sup>6</sup> Karin Norman (2000) explains that "telephone calls to and from the field have served as a

to the nature of the interactions that the researcher faces. My experiences of field work interactions meant that I was, nearly all the time, entering into a game (Hammersley 1989) where my presentation and appearance would change depending on who I was interacting with. Thus I would try to fit into the image that I thought others felt I should represent. Although my calculations were not always right, it highlights the fact that I was manipulating the encounter to gain acceptance and through acceptance gain information. This raises questions that I discuss concerning deceit, lying and the role, if any, that informed consent plays in the 'research game'. Here, I am not attempting to dismiss the value of ethics within the social sciences, but I do question how effective ethical guidelines such as those provided by the Association of Social Anthropologists (ASA 2000) are within ethnographic research. In other words, if I am implying that ethnographic research is deeply seated within subtle forms of interaction between the researcher and researched, then there is a methodological challenge for the researcher to follow such guidelines.

### **Part 1 – The Social Life of Organisations**

There are two general ways that one can approach the concept of organisations. The first is gained by looking through a traditional lens to explore the concept as a bureaucratic structure with a well defined hierarchy and division of labour which aim to achieve the goals of the organisation. The second is to view organisations as 'culture', that is, as complex and organic network of human

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reminder of the open-ended, somehow 'placeless' nature of contemporary fieldwork" (2000:120)



interactions. The latter approach apparently offers a more dynamic way of understanding the phenomenon, while the former is seen as uncritical and out of date by those ascribing to the latter view. Structure is therefore replaced with flexibility.

Here, I will explore these two general views of organisations. First, I will focus on Weber's 'ideal type' model of bureaucracy since his work has been so influential in further debates on this topic. I will then look at the use of the term 'culture' within organisational studies (which includes here organisational/social psychology studies) and within organisational management and policy. Part Two will argue that the use of 'culture' is misleading on two accounts. The first is because it uses traditional anthropological definitions of culture – mainly a Tyloresque approach which is “that [culture is a] complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society” (Tylor, 1958 [1870]:1). This frames culture as a 'whole' with a defined and static image. The second major flaw is that it is assumed that an organisation *has* a 'culture' or *is* a 'culture'. I will criticise this by offering an anthropological critique. The final part of this chapter suggests that it would be more beneficial to research or analyse organisations by re-visiting Weber's concept of bureaucracy, which fundamentally means exploring the ways hierarchy and power are expressed within a modern day organisation. I suggest that by looking at the formal and informal processes and routines, one can then analyse how power and hierarchy work within the organisation's structure. Central to this are the ways in which official policy allows for its apparent official image and requirements to be manipulated.

## **The Framework of Bureaucracy**

The topic of organisations is usually linked to bureaucracy which is the fundamental structure that provides the organisation with the tools so as to appear *efficient*. I will loosely use Weber's concept of bureaucracy to define the processes by which organisations work. Bureaucracy essentially functions as the most rational form of organisation in which it aspires, through conscious rules and goals, to be separate from everyday life (Hirsch and Gellner 2001).

Organisations are then "social units (or human groups) deliberately constructed and reconstructed to seek specific goals" (Etzioni, 1964:3). Such a rational and formalised approach to understanding how organisations work, has placed bureaucracy in a negative light. Du Gay (2000) makes the point that these "are not the best days for bureaucracy... bureaucracy fosters only rational and instrumental human facilities, to the exclusion of an individual's sexual, emotional, or other substantive dispositions" (2000:3).

Weber's concept of bureaucracy rested on the central features of a systematic division of labour where complex administrative problems are broken down into manageable and repetitive tasks, each linked to a specific 'office' which is itself controlled and coordinated under a centralised hierarchy (Beetham 1987). Weber explains that the "organisation of offices follows the principle of hierarchy; that is, each lower office is under the control and supervision of a higher one" (Weber, 1964:331). Therefore what is fundamental in an organisation is an ordering of social relationships and the positioning of individuals into their relevant groups or 'units'. Thus, the presence of a leader and usually an

administrative staff was the defining characteristic of an organisation” (Thompson, 1980:10). Bureaucracy is based on a formalised, top-down structure of authority. The types of system that Weber was mainly describing were new, large and complex; there was a need for processes where tasks could be managed through a specialized division of responsibility. The hierarchical structure of authority co-ordinated the diverse tasks in the pursuit of the organisation’s objectives. Achieving these objectives relies on superior roles at every level to control and subordinate those below them (Blau 1981). Weber described the ideal bureaucratic environment in which to achieve its desired goals as the “dominance of a spirit of domination of formalistic impersonality, ‘sine ira et studio’, without hatred or passion, and hence without affection of enthusiasm” (Weber, 1964:340).

Bureaucracy for Weber was situated in a larger theory of legitimate authority. It was seen as a form of rational authority “resting on a belief in the ‘legality’ of patterns of normative rules and the right of those elevated to authority under such rules to issue commands (legal authority)” (1964: 328). Weber explained that the rise of bureaucracy, with its rational legal structures, was the bedrock for the growth in capitalism. The development of more complex and abstract legal provisions which were needed to implement democratic procedures “themselves entailed the creation of a new form of entrenched monopoly” (Giddens, 1995:22). It was the specialized nature of bureaucracy, with its complex separation of tasks, that became, for Weber, the integral feature of capitalism.<sup>7</sup>

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<sup>7</sup> This of course is different to Marx’s account of the rise and domination of capitalism. Where Weber argued that rational and legal authority, and thus power, through a bureaucratic process was fundamental to capitalism, Marx argued that it was the subordination of the working classes by the bourgeois who controlled the means of production. In Marx’s view the proletariat would

## **Organisations as ‘Cultures’**

The idea that an organisation *has* a ‘culture’ and ‘sub-cultures’ within different departments, or ‘offices’, has been evident within theories of organisational psychology, sociology, management and consultancy since the 1970’s (Turner 1971, Hardy 1976). The concept of ‘organisational culture’ became widely used in the 1980’s and 1990’s as an attempt to move away from the static and oppressive image of bureaucracy. The principle is that ‘organisational culture’ is something that the group develops over time and thus becomes part of the unconscious daily process within their routine. Wright (1994) has identified four ways that ‘the culture concept’ is present within organisation management. They are: 1) Different ‘national cultures’ – the need to manage on a global scale. 2) Management working with people from different ethnic backgrounds in a workforce. 3) Informal ‘values’ held by the workforce. 4) ‘Company culture’ – values formally imposed by management as glue to hold a workforce together (Wright, 1994:2). Let me explore the concept of ‘organisational culture’ by looking at two key writers who are advocates of this concept: Edgar Schein (1985, 1991) and Lionel Stapley (1996)<sup>8</sup>.

### *Edgar Schein*

Schein argues that to really understand how an organisation works one has to view the organisation as a culture. He states that the “concept of organisational

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rise through class consciousness and rise against those subordinating them. Weber argued that the expansion of bureaucracy was not the dictatorship of the proletariat, but the dictatorship of the ‘official’ (Giddens, 1995:38).

<sup>8</sup> Both Schein and Stapley come from a background in social psychology.

culture is especially relevant to giving an understanding of the mysterious and seemingly irrational things that go on in human systems” (1985: 4). Furthermore, he explains that one of the simplest ways of understanding what appears as irrational is to relate it to culture, because culture often provides meaning to what appears as irrational or ‘silly’ (1985). An organisational culture, is reflected through:

*Organisational regulations* – language and ritual of interactions

The *norms* that are involved with the working groups.

*Dominant values espoused* by an organisation – a ‘product quality’

*Philosophy* that guides the organisation’s policy

*Rule of the game* for getting along in the organisation

(Schein, 1985:6)

Schein focuses on the relationship between ‘organisational culture’ and leadership and stresses that the main purpose of leaders are to organise and control culture (1985). He is therefore suggesting that leadership creates the culture that people work and interact in so as to fulfil the aims of the organisation. For Schein, culture is:

...a pattern of basic assumptions – invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal (1985:9).

Additionally, culture, “in this sense, is a *learned product of group experience* and is, therefore to be found only where there is a definable group with a significant history” (1985:7). Organisational culture exists as a unit that is structured, taught, and productive. Furthermore, within the organisation sub-groups are formed where different group cultures develop. Although Schein argues that an anthropological approach to understanding culture is important – that is, that culture is positioned within mental models and cannot be understood on a surface level of interpretation, he still advocates however, that culture needs a clear boundary that is *owned* by a group if one is to gain a successful understanding of it (1991). He explains that culture is only a useful concept if there is an agreed process on how to define it (1991).

### *Lionel Stapley*

Stapley argues that culture should be understood as something that an organisation *is*: “it emerges from social interactions, as the product of negotiation and shared symbols and meanings” (1996:12). He explains that an “organisation, or part of an organisation, may be viewed as an association of individuals, and it is those individuals who develop the constraints that we categorise as structure and culture” (ibid). Stapley’s psychodynamic approach uses Winnicott’s notion of a ‘holding environment’ and ‘basic trust’ in infant development in relation to attachment of the mother. These emphasise the need to create boundaries to help the infant make sense of the world. Therefore the ‘holding environment’ is not just the physical holding of the child by the mother, but also how the mother nurtures the child in their social environment. As the infant develops, they become associated with different or multiple ‘holding

environments'. Stapley expands Winnicott's theory to organisations. He argues that "the organisation becomes a partly conscious and a partly unconscious holding environment for its members" (1996:36). In a similar way that the 'holding environment' provided by the mother influences the personality of the child, the 'organisational holding environment' influences the organisation's 'culture'. Stapley explains that:

...it is how the members of the organisation interact or their interrelations with the holding environment that results in the culture. It is how the members of the organisation perceive the holding environment that results in the unique and distinct culture that is the feature of every organisation (1996:39).

'Organisational culture', for Stapley, develops out of a process of interpretation by the individuals within the work environment. It is the way in which the individuals interpret their position in such an environment that creates the 'culture'.

## **Part 2 - An Anthropological Critique of 'Organisational Culture'**

The main critique of 'organisational culture' from an anthropological stance is that the term 'culture' is used in a very general sense and hence carries with it very little meaning and essence. Martin (1997) cringes at the way in which corporations use the term culture; "it seems so superficial! But nothing than an

almost transparent membrane, would serve well” (Martin, 1997:251). In fairness to Schein and Stapley, they both argue that the use of the concept has been diluted within organisational settings. Schein states that there has been a tendency “in the last few years to link culture with virtually everything” (1985:4), while Stapley makes the point that it could be turned into a “superficial fad, reducing it to an empty, if entertaining, catch – all construct explaining everything and nothing” (1996:6). However, the main problem with Schein’s and Stapley’s approaches to culture within organisations is that culture eventually has to become a definable unit that can be changed, worked on and reborn so that the “mysterious and seemingly irrational things” that Schein sees as part of culture, become rational and understandable. This ultimately leads to all within the organisation and especially the management, claiming that they are all aware of their culture within the organisation. This ‘end-game’; the conscious awareness of ones own culture, reduces culture to an object that can easily be discarded for a new one. Although Schein and Stapley rightly identify culture as a complex phenomenon, their role, professionally, is to simplify its complexity. I am not advocating that the concept of culture cannot be used within organisations, rather, it is how the concept it used that causes concern.

Wright explains that a “ ‘strong company culture’ has been deemed the *sine qua non* of success in the private sector and now no public or voluntary organisation can be without its mission statement” (1994:2). Therefore, ‘culture’ has an appealing ‘ring’ to it within an organisational setting. It sounds soft, less authoritarian and more welcoming to present and potential employees within the organisational setting. It attempts to portray an organic and dynamic ideology



that appears to exist far away from traditional task-driven bureaucratic process. Organisational culture therefore is supposed to exist inside the 'workers' selves' (Martin 1994, 1997) where "they are meant to become better able to work in organisations that, in the words of an organisational training firm, are *flexible and cost effective* while continuously improving service and quality" (Martin, 1997:251). A more hidden aim is to have fewer members of the work-force through ensuring each has the ability to carry out different tasks, make decisions, problem solve and use technology. On a similar line to Martin's argument, Du Guy (2000) suggests that organisations are trying to fit into a climate of 'entrepreneurial governance' that promotes competition, empowerment of citizens and where control moves out of bureaucracy. He argues that this implies that if organisations do not move into a more flexible management style, then they will become stagnant and will not be able to deliver their promises. Rose describes this as 'enterprise culture' where centralization and bureaucracy are replaced by "enterprising activities and choices of autonomous entities" (Rose, 1992: 145) such as organisations, business and people, all striving for individual maximisation. It is these concepts of the 'flexible' structure that organisations are supposedly driven by, that makes the use of the word 'culture' more appealing. For example, Stapley's argument that an organisation *is* a culture implies that there is space for contradiction: individual agency and conscious and unconscious awareness on the one hand, and the idea that *all* consciously belong to its culture and thus feel a desire to achieve its goals on the other.

The way 'culture' is used within organisations results in a "culture of 'culture'" (Savage 2000a). Savage, using the NHS as an example, argues that 'culture' has

become a powerful phenomenon in which its meaning is never clarified.

Therefore, its power rests in the fact that it is analytically empty and it can be subtly manipulated by the policy makers (Savage 2000a). From written documents to daily comments made by NHS professionals ‘culture’ is used in just this fashion. So, in the NHS National Plan (2000):

The NHS is too much the project of the era in which it was born. In its buildings, its ways of working, its very culture, the NHS bears too many of the hallmarks of the 1940’s. The rest of society has moved on (2000:29).

and from a staff member on patient waiting times:

*“The NHS culture of waiting has to change”*. (2000:136)

Both quotes imply that the NHS *is* a ‘culture’. The first uses ‘culture’ to mean the *identity* of the NHS as a whole by showing that it is static and outside society’s demands, while the second quote uses the term to describe how the NHS *functions* on a day-to-day level<sup>9</sup>.

Thus far, I have suggested that it is misleading to imply that an organisation *is* a ‘culture’. It is left as a vague, but yet powerful way of portraying an organisation. Its power rests on the fact that it masks hierarchy while promoting a feeling of

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<sup>9</sup> The image of the NHS is discussed in more detail in Chapter 3.

belonging. In other words, an organisation may be fearful of being seen as hierarchical and powerful, yet attempts to maintain a centralized monopoly of power by denying that it is centralized. Foucault argues that for power to be tolerated it needs to be partly masked. "Its success is proportional to its ability to hide its own mechanisms" (Foucault, 1980:86). I wish to argue that the power of using terms such as 'organisational culture' enables it to disguise the bureaucratic process that actually provides its structure.

Those who espouse the idea of an organisation being or having a culture can be divided into two groups. The first are the theorists, such as Schein and Stapley discussed earlier. The second, are contemporary management and policy makers who incorporate the concept of 'culture' into the everyday fabric of the work environment. What both these groups have in common is that they need to view 'culture' as a measurable phenomenon with clear boundaries.

From a traditional perspective, culture is something that you are born into and which is developed consciously and unconsciously. Entering an organisation as an employee, however, is a conscious decision. The process of *entrance* is one that is dressed with formal and policy-driven processes that are fundamental for organisations because they are "deliberately constructed and reconstructed to seek specific goals", as Eztioni described earlier (1964). An anthropological approach to culture is much more complex and does not set out to try and tame its existence through *making it* a workable and clear phenomenon. For example, Geertz's definition of culture focuses on this. Using a Weberian approach to

culture where “man is suspended in a web of significance that he himself has spun”, Geertz emphasises *meaning* rather than *structure*:

...I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretative one in search of meaning (Geertz, 1973:5).

According to his view, culture is about meaning and understanding, through interpreting how individual agents and social institutions make sense of their social surroundings. Culture, Avurch argues, is “to some extent always situational, flexible, and responsive to the exigencies of the worlds that individuals confront” (1998:20). It is no longer about interpreting a phenomenon and packaging it into a clear definable ‘unit’. Culture must be seen as the process whereby individuals are influenced by the social agencies that surround them – consciously and unconsciously - and how these interactions and experiences are negotiated in an attempt to give meaning to their existence in their social world. Therefore, work, religion, relationships, age, geographical location, to name a few, all influence the individual’s culture. Theories on ‘organisational culture’ tend to fit into a more traditional anthropological approach to culture where it is viewed as an integrated whole or *Gestalt* (Benedict 1934) where coherence was overstated and the influence of individual agency was largely redundant. In general, the problem with this approach to culture is that it “fails to reflect the ‘thickness’ or complexity, of the phenomenological world it seeks to represent” (Avurch, 1998:12). The main problem that theories of ‘organisational culture’

have to deal with is that anthropology today places the concept of culture as an integrated whole as part of its evolution as a discipline.

If the concept of 'organisational culture' is to be used, it should be done so as something that represents the unofficial nature of the organisation rather than an analytical concept that can eventually be identified as a clearly defined unit, as current organisational theories and methodologies seem to be aspiring too<sup>10</sup>. For example, the subtle rules of interaction between people and between sub-groups within the organisation, or how hierarchy wields power in formal, informal and unofficial ways<sup>11</sup> and how individuals and groups negotiate policy, hierarchy and power. . This thesis will illustrate how the culture of the ward and hospital is made up of unofficial practices that directly oppose the official organisational image or desired 'cultural' and cohesive image. The thesis explores the culture of the ward and hospital by including how contradictions and paradoxes are also integrated within the culture. Therefore, I am not denying that cohesion and concepts of a collective are part of culture. Rather, I am criticising the ways in which approaches towards 'organisational culture' do not deconstruct enough how cultural patterns are formed . The concept of 'organisational culture' should also focus on how social and cultural forces outside its structure influence how individuals and groups perceive their place within the organisation and how this shapes how they perform within it. Finally, one has to also deconstruct why those within, or writing about organisations, view them as 'culture'. In other words, *what makes people refer to organisations as a 'culture' ?* A functionalist approach might help this point by regarding the notion of 'organisational

culture' as a form of power that is given to allow for a "generalized capacity to mobilise resources in the interest of attainment of a system goal" (Parsons,1981:79). Organisations are therefore part of a wider societal system and to understand them, one needs also to understand their function in a larger context. 'Organisational culture' is thus a term that fits into society's current desired image of work rather than an actual reality. Politically, it fits into a liberal discourse where individuals are 'governable' "by requiring that they become self-activating and free agents" (Burchell, 1991:119). This false sense of empowerment is something that is not just present within organisations and concepts of work, but also, as I will show in the following chapters, engrained in the concept of how society rationalises about care.

In sum, the flexible, entrepreneurial and enterprising ethos of organisations is encapsulated within the language of 'culture', a language that replaces 'routine', 'centralisation' and 'hierarchy'. The thinking goes that instead of changing the 'structure' of the organisation, management can change their 'culture'. However, as this thesis will argue, the reality is that 'organisational culture' actually exists within a formalised, non-organic framework. The argument that organisations *are* 'cultures' masks the real workings that are more in line with a Weberian concept of bureaucracy than an 'egalitarian' and 'flexible' blurring of roles, responsibilities and hierarchy.

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<sup>10</sup> See for example NHS publications on Organisational Change (2001) that use Schein's concept of 'process' change as one of their main theories.

<sup>11</sup> A classic metaphor to describe this is Weber's 'iron cage' metaphor to describe bureaucracy.

### **Hierarchy, policy and a return to bureaucracy**

The concept of 'culture' or 'organisational culture' is thus a *masking* of the more traditional processes of bureaucracy: a top-down hierarchical structure that is channelled through a complex division of labour. It is this that ultimately generates power and coercion within it. Hicks and McCullough argue that any "understanding of organisations must take account of the different distribution of power between positions in them, and between the occupant of these positions" (1980:27). They argue that power in work organisations can be seen as "the capacity to use resources, for example wealth, status or expert knowledge, to affect others" (1980:28). Power in this sense, along with the way in which management attempts to *mask* it, can provide one with a productive focus for researching organisations. This results in paying attention to the preview discussion in the Introduction of what is defined as *formal* and what is defined as *informal*. The *formal* and *informal* are not new concepts. Blau and Scott (1963) argue that:

The fact that an organisation has been formally established does not mean that all activities and interactions of its members conform strictly to official blue print. Regardless of the time and effort devoted by management to designing a rational organisation chart and elaborate procedure manuals, this official plan can never completely determine the conduct and social relations of organisation's members... In every formal organisation there arise informal organisations (1963: 5-6).

Therefore, groups form their own practices, values and norms that become fixed within the formal structure of the organisation. Official rules depend on such informal group practices so that they can cope with the broad range of situations that may arise (Blau and Scott 1963).

Blau and Scott's account of the *informal* is placed within the structure of the *formal*. It becomes an essential way in which the *formal* solves problems and achieves its goals. The *informal* is then a process of interpretation by the organisation's members. (Thompson 1980).

The generality of 'official rules', as described by Blau and Scott, is also important for a more subtle focus, namely how individuals and sub-groups attempt to maintain a sense of identity or self which they think is hidden from the organisation's formal structure. A good account of this is Goffman's (1961) concept of 'secondary adjustments' which I will develop throughout this thesis. Suffice to say here that secondary adjustments are the processes whereby individuals or groups, particularly at the lower end of the employment scale within an organisation or institution, attempt to maintain a sense of self through subtle changes to the desired image of the organisation. For example, one of Goffman's examples illustrates how psychiatric patients may change their bedrooms to make them more homely. His main point is that secondary adjustments do not go unnoticed but are actually tolerated by staff in authority. Later in this thesis, I will show how NAs similarly attempt to resist official policy with regard to patient care and the carrying out of daily tasks, but that they, too, are given sufficient space to do so.



### *The role of policy*

I have said little about the role of policy<sup>12</sup> in this chapter so far. I would like to end this section by arguing that policy is the central part of an organisation. It promotes the organisation's overall identity or mission through procedure. Policy also formally controls the individuals and groups by formally positioning them in time and space on the one hand, and also allowing them to forge their own apparent control of the space on the other hand. Fundamentally, to understand the influence that policy has, one has to read between the lines of written text and use of language to explore the extent secondary adjustments are allowed to prevail. Therefore policies are “inherently and unequivocally *anthropological* phenomena. They can be read....as cultural texts....or as rhetorical devices and discursive formations that function to empower some people and silence others” (Shore and Wright, 1997:7)<sup>13</sup>. Following a Foucaudian notion of power, Shore and Wright argue convincingly that an essential feature of policies is that their political nature is masked by their ‘neutral’ and ‘legal-rational idioms’. At face-value they appear to be mere instruments for implementing modern day power – driven by the values of ‘efficiency’ and ‘effectiveness’ (1997:8).

Policy therefore, has to represent the moral nature of the system it is presenting. The formality of policy, like “bureaucracy (of which it is a major accessory)....., serve to cloak subjective, ideological and arguably highly ‘irrational’ goals in the guise of rational, collective, universalised objectives “(Shore and Wright,

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<sup>12</sup> I will explore the role of policy in more detail in chapter 7 and how it manifests itself on the ward.

<sup>13</sup> Ironically, it is only since 1997 and the publication of Shore and Wright's book: *Anthropology of Policy*, that the subject has been a topic of anthropological study.

1997:11). Yet the language of policy is rarely subject to investigation or study (Apthrope 1997). I will approach the concept of policy as an anthropological field of analysis and research. An anthropological approach to policy is interested in “understanding the cultures and worldviews of those policy professionals and decision makers who seek to implement and maintain their particular vision of the world through their policies and decisions” (Wedel, Shore, Feldman, Lathrop, 2005:34)”. It also explores how policy incorporates different areas and relationships: from the policy makers to those who have to work with, and negotiate its meaning. Therefore, an anthropological approach to researching policy, as Wedel *et al* explain, “is less concerned with assigning abstract immutable definitions to the term ‘policy’ than with understanding how policy functions in the shaping of society. In other words, the key question is not ‘What is policy?’ but rather, ‘What do people do in the name of policy?’” (2005:35). Throughout this thesis I will provide examples of how policy incorporates and shapes the formal and informal structures of the hospital and ward. Data from the field will illustrate that a psychiatric hospital incorporates these features of an organisation.

### **Part 3 – Situating the Field, the Observed and Observer**

In the introduction to this chapter I explained the chapter was divided into two halves. Part Three explores how my position as a researcher developed within the organisation of a psychiatric hospital and how I experienced the complex structure of it.

Functionalists and structural functionalists have been criticised for their image of the field as a bounded unit that existed before they arrived to carry out fieldwork and continued after they left. A classic example of this is Evans-Pritchard's 'The Nuer' (1940) which portrays Nuer society as untouched by the outside world. Nuer society is represented as neatly organised within the boundaries. This synchronic approach left little room for the text to explore any outside influences, such as the neighbouring Dinka, the impact of colonialism and the socio-political climate of the Sudan. Furthermore, any historical background about why the Nuer were who they were is omitted. The society is portrayed as a static unit where in which structure of the community never changes.

Every society or institution is a dynamic unit influenced by internal and external factors. However, there are still strong similarities between the functionalist image and my field area. For example, the doors of the hospital were locked containing people within its walls away from contact from the outside world. The daily routine gave the feeling that nothing changed, thus promoting a static, framed image of the institution. Regardless of the continual flow of patients and staff, the daily rituals of ward life continued: breakfast, lunch, supper and medication times were always fixed, allowing for the daily routine to remain unchanged and at the same time defining itself as a timeless, unchanging culture.

However, this description is my interpretation of the research site which leaves it open to the criticism of being my own invention. Clifford argues, in relation to ethnographic writing, that the text can be called fictitious because it is “something made or fashioned” (1986:6). The same argument could be relevant

for the anthropologist's understanding of the field itself, because it is something that is created through personal and research interests; it becomes special and fetishised so as to create a defined unit for research. My comparison between my field location and that of the structural-functionalist model is more of an attempt to focus on the principle that research becomes an individual quest which drives towards trying to define the boundaries of the research. In my own case, there were many times when my research led me to visit the Trust Head Quarters to carry out interviews, or to go to weddings, naming ceremonies, pubs and cafes to interact and socialise with staff members. I did not see these events as 'outside' my field of research. In reality, the boundaries therefore became a fluid experience that followed the research subjects out of the structures of the hospital and into smaller informal research settings. It was the focus of the research topic, rather than any geographically defined 'field', that led me outside the physically defined area of the research.

### **The Politics of Acceptance 1 – The Formal Gate Keepers**

The process of gaining acceptance to undertake research within a psychiatric hospital can be a complex journey. Initially, I had to gain the support of the consultant psychiatrist on College Ward. This I did by working as a part-time NA on the ward for a few months while in the preparation stage of my research.

While working three to four shifts a week, I was able to become familiar with many of the staff throughout the hospital. Although I did not have much interaction with the consultant psychiatrist, he would always say 'hello' when we passed each other in the hospital.

After some time working on the ward, I came across him in the nurses' office by himself. I asked him if it would be possible to meet so I could discuss my research proposal with him. He appeared to be very keen and we arranged a time to meet. The meeting took place in his office. He told me that he would be willing for me to use his name as the consultant psychiatrist supervising and so endorsing my field research. He then gave me valuable advice about how I should proceed to gain further permission and also offered to speak to the other consultants, the Senior Head Nurse and hospital management. He also suggested that we met once a month to discuss how my research was developing and whether I had any problems.

*No pay, volunteer, or paid?*

My overall concern was whether I should carry out my field research as an independent researcher or as an unpaid nursing assistant. However, I realised that this dilemma was not for me to decide but for the hospital management. When I attended a meeting with the Senior Head Nurse, she explained that if I were to carry out qualitative research within the hospital, I would have to become a paid, full-time member of staff - a nursing assistant. The reason I was not able to be an independent researcher was due to the sensitive environment within the hospital. In other words, having someone 'hanging around' might make patients nervous. The problem about being an unpaid member of staff there, she explained, centred on the Union (UNISON) seeing my role as unpaid labour<sup>14</sup>.

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<sup>14</sup> Becoming a paid member of staff benefited my position as a researcher for a two reasons. Firstly, I was able to become self-funding and was not pressured to have my research depend on funding. Secondly, the fact that I received a pay slip every month meant that I was able to discuss

She agreed to my research and felt that it was worthwhile and important. I explained to her that it would not involve interviewing patients and this seemed to promote my cause. It was agreed that I could proceed and write to the Ethics Committee to ask for formal approval.

Although this meeting with the Senior Head Nurse went well there were some major factors that shaped the way in which I had to conduct the field research. She determined how I would be professionally positioned. Although the positive point was that I would be paid and would not have to worry about funding over this period, there were some major areas of my research that I would have to approach in a different way. For example, the fact that I was going to become a permanent member of staff would mean that I would have to become tactful as to how, when and where I was 'the researcher' on the one hand, and 'the member of staff' on the other hand.

When the meeting with the Senior Head Nurse began, she had made a half-joking comment that every time she moved to a new job she would always be confronted by a research team or single sociologist or anthropologist who wanted to carry out research within her department. She then explained that she was getting used to these types of meetings. Although I was not sure if this was comforting to me or not, her comment highlighted an important political aspect within the NHS where 'research' has become a fundamental part of its make up, promoting an image of professionalism and development. Management, doctors and nurses were accustomed to much of the academic methodological

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issues concerning finance with other members of staff and understand the bureaucratic system in

terminology within the social sciences. For example, *participant observation*, was mentioned by the Senior Head Nurse, and in much of the nursing literature it is seen as a research method that nurses should think about using when doing their own research. Therefore, some of the groups and individuals within my field of research were familiar with social science research and the positive and negative aspects of it. NHS trusts have Research and Development (R&D) departments that fund and support research. Research has therefore become a political instrument and a sign of professionalism<sup>15</sup>.

### *Ethics Committee*

The final official gate-keeper was the Trust's Ethic's Committee. I had now gained the backing of all areas of hospital management and was therefore in a position to apply for permission to start the research. The Ethics Committee required a 10,000 word proposal stating my aims and objectives and how I was planning to inform and gain consent from the individuals I hoped to research. I produced a detailed report and emphasised key terms and points, including how I would gain informed consent<sup>16</sup> from the members of staff by writing a letter to each staff member and putting it in their pigeonholes. I also mentioned that the consultant psychiatrist would be available to speak to anyone with problems about my research throughout the field research period. The reality was that most of the staff were already aware that I was going to do research within the hospital because I had been working there, part-time, for a few months before the research started officially. The general response from staff was very positive; in fact, my preconceived ideas on how I thought they might react to my research

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more depth.

proved to be somewhat exaggerated. No one seemed to be concerned or very interested in what I was doing; this is not to say that they did not think it was a good topic, but rather they had more important issues within their working environment to deal with than a PhD student researching them. I realised that my naïve, romantic image of fieldwork had to be quickly discarded: the 'red carpet' with accompanying fanfare was not going to be laid out for my grand entrance. Neither was there to be great enthusiasm nor particular reservation or resistance. No doubt, this was also largely due to the fact that I was seen as a member of staff.

The Ethics Committee passed my proposal without having to make any amendments to it. I was sent a list of rules that I had to abide by, many of which were directed at medical research concerning patients. It was the fact that my research was not focusing on patients that made it less of an ethical problem for the committee.

I have shown here that certain forces determined the way in which I would enter the field. I had some room to negotiate the methodological tools of research that I would use and what I planned to do with the material of my research, I was aware that I did not want to distance myself from the different sections of the hospital and Trust management. Thus, the construction of the field became a process of negotiation, which started with the gate-keepers and continued while in the field.

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<sup>15</sup> Professionalism is something I discuss in detail in Chapter 3.



## **The Politics of Acceptance 2: The Researcher's Race and Class**

The process of being situated within the field was ongoing throughout my time there. Like all social scientists race, class and gender all became key components of how I became positioned within the research (Back 1993). In this section I will examine how I had to be constantly aware of my cultural background when interacting with the different members of staff. At first, I had thought that my position as a PhD student, while being a member of the team, would place me in a unique position. However, I realised that it was not the fact that I was a PhD student researching within a hospital while being a nursing assistant that made my position unusual. Rather, it was the fact that I was white and middle class that most defined my place in relation to other members of staff. Other NAs found it hard to understand why I wanted to work as a nursing assistant because I could get a better job. Doctors, staff nurses, social workers, and other sections of the qualified staff perceived me in a different light from the other NAs. For example, if a doctor who did not know me came into the nursing office while I was there, he or she greeted me as though I was another doctor or qualified nurse. Or, they would ask me questions of a professional nature that nursing assistants would not normally be expected to know. For example, take the typical exchange:

**Doctor:** *Can you tell me what the results were for patient X's drug screen?*

**Me:** *Sorry, I am not sure. If you hold a second I will get a qualified nurse who will tell you*

**Doctor:** *Oh, you are not qualified?*

**Me:** *No, I am a nursing assistant on the ward....my name is John.*

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<sup>16</sup> I discuss the role of informed consent later on in this chapter

**Doctor:** *Oh, ok, don't worry then.*

However, when doctors and nurses became familiar with my combined role as a NA and PhD student, I was given tasks and responsibilities that other NAs were not normally given. An example of this would be when a consultant would ring the ward for information on a certain patient, and whether I thought a patient's behaviour had improved or deteriorated over a certain amount of time. Or, I might be asked by doctors and nurses on my view as to whether a patient should be allowed to have unescorted leave or even if a patient needed to be restrained and forcefully given medication. I generally felt comfortable giving my view about a clinical situation on the ward and if I were unsure then I would explain this to the nurse or doctor. Therefore, in the eyes of some doctors and nurses, my position as a NA did not matter; it was the fact that I was white, middle class and studying for a PhD that informed their image of me within the hospital. This perception was directly opposed to the 'norm' of what NAs represented - black, African and untrained.

NAs found this amusing and it became an ongoing joke between some of them and me. Some of the comments made by NAs were, for example, I was regularly teased about it:

**NA:** *Oh you think you know everything (laugh)*

**Me:** *(jokingly) Well I do*

**NA:** *(Laughing) Oh what do you know..., you are just a big baby.*

In general, NAs would comment that it was not their role to offer such information and they felt that they were not paid or trained enough to take on such responsibility.

### **The Politics of Acceptance 3 – The Researcher's Gender**

Back (1993) explains that while carrying out his field research in two South London housing estates, his gender played a major role in how he interacted with his research subjects and how they perceived him. He explains that his gender identity “was not static, but it formed an essential component in the negotiations that took place between myself and the people I was working with. My masculinity was constructed from outside, and although I was involved in this process I was not always in control of it. As a result, the relationships I developed with the female/male respondents were ordered by the *gendered form of participation*” (p230). A similar process arising from the day-to-day interactions occurred with me and my field research.

#### *Interactions with Female NA's*

I entered my post as a NA with little strategy as to how I was going to build relationships with the other NAs. I found, through time, that my relationships with female NAs developed differently to that with male ones, though there were strong areas of intimacy and trust in both gender groups. Rather, it was the manner in which I built those relationships that was different.

Many of my interactions with female NAs were based on chatting about work and the amount of hours we had to do to make enough money, about religion,

and staff politics. A large number of the women carried small, pocket-size copies of the New Testament and would read sections to each other in the staff room or discuss religious issues while on the ward. I was always able to enter into the conversations about religion or the stress of work and parenthood. At times they would praise me for spending time talking to them, and would say that I was different from the 'other white staff'. I felt comfortable asking questions and felt that many of the female NAs came to trust me.

Additionally, some female nursing assistants would joke with me through light heated 'flirting', asking me how my girlfriend was and how lucky she was, or that they wanted to run away with me. They would jokingly mock me by greeting me in Yoruba and then laugh when I could not respond. As my relationships became stronger so did their flirting and joking towards me. Let me describe one encounter with two female NAs which resulted in me being asked sexually explicit questions and then listening to them discussing their own sexual preference.

I walked into the staff room to make myself a cup of coffee. Jane and Laura<sup>17</sup> were having a cup of tea and chatting. Laura is a 37 year old Ghanaian woman and a permanent NA on the ward while Jane is a 39 year old woman from Nigeria who is a bank NA and works on the ward three times a week. They had both been doing this for five years. Jane was sitting down with her copy of the New Testament in her lap. I walked in and made a joke:

**Me:** *Hello, are you two talking about me again?*

**Laura:** *Oh shut up, what do you know? You always want to know everything*

(Laughing)

**Me:** *See Jane, this is how she talks to me every day.*

**Laura:** *We have been talking about you. We want to know how thick you are.*

(Laura makes her hand into a fist and pretends it is a penis). *Are you thick? We women like it thick and hard.* (Laura and Jane are now laughing out loud. Jane has her head in her hands shaking it while clasping her copy of the New Testament) *Come on let me see* (Laura makes a joking attempt to grab my crutch).

I responded by joking. I said that I was horrified that two religious women could talk like that and that I would have to pray for them. My comment made them laugh even more, but it also worked in such a way that it assured them that they had not insulted me. They had shocked me, but I relayed this in reply. I was aware that any sexual joking in the workplace could be construed as against the organisation's policy and I felt it not appropriate to respond by using sexual innuendoes myself. But I was also aware that I did not want to jeopardise the trust that I had built up with them by showing disapproval. By responding to them in a light-hearted way while not engaging in explicitly sexual banter, I think I was able to maintain their trust without seeming judgmental, but also without crossing boundaries of appropriateness.

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<sup>17</sup> To protect the identity of those in my research I will use pseudonyms throughout the thesis.

The result of this example worked strongly in my favour in the sense that both Laura and Jane realised that they could be relaxed around me. From then on I could bring up or discuss areas of their personal life and work experiences. They also felt comfortable talking to each other about personal issues and problems if I was present.

### **Interactions with male NA's**

In contrast, amongst male NA's, conversations were based on news issues, African politics, work issues relating to money and hours worked, entrepreneurial ideas and experiences, and above all, football. Political conversation regularly consisted of two or more men exchanging views, suggesting methods of changing how a certain politician or government was conducting themselves. If political chats were about British politics, I was able to contribute my views to the general discussion. If people were talking about political issues in Africa, I would be more of a second party and occasionally ask questions about the topic. Issues surrounding work and money were more serious as they usually focussed on someone's particular problem. They would usually seek advice on what they should do and compare their problem with other NA's.

Football offered the most entertainment because it tended to result in light hearted arguments about which football team was going to win a certain game and who had the best players. If a football game was being shown on television on the ward, the male nursing assistants would attempt to watch as much of it as possible and delay having to do any work. When a game was shown in the TV

lounge it would be common to hear male nursing assistants shout out loud and scream when a goal or foul was committed<sup>18</sup>. Talking about football allowed for, mocking and laughing. I was able to be an equal participant in this. Football became a central topic that I could use if I wanted to get to know a male nursing assistant and build dialogue.

Generally, it was important that I was able to interact in the work place on a social level and be prepared to discuss issues and convey my own views. This resulted in me not just asking questions, but debating, chatting and joking. Therefore, I placed myself in a position that included being interactive within my field of research. This is similar to Jackson's (1987) idea of 'radical empiricism' and the 'lived experience'. Jackson explains by "turning from epistemology toward the everyday world of lived experience, the radical empiricist is inclined to judge the value of an idea, not just against the antecedent experiences or the logical standards of scientific inquiry but also against the practical, ethical, emotional, and aesthetic demands of life" (1987:13). One's whole experience comes into play, allowing the researcher actively to debate and exchange points of views with others. "It means placing our ideas on a par with theirs, testing them not against predetermined standards of rationality but against the immediate exigencies of life"(14). Jackson's view becomes helpful in my position in the field as a researcher and active member of the society because it encapsulates how that I did not see the environment purely from an objective methodological stand point. Rather, my standpoint became fluid and enabled me to test my position or self through the interaction with others.

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<sup>18</sup> This usually resulted in nurses running out of the nursing office thinking that a patient was hurt

An example of this type of interaction was when I took my cultural 'norms' for granted and consequently, my joking offended a particular male NA. It placed me in a position where I had to examine my own self, in a reflexive way to understand why I had offended him:

Mark was a 40 year old man from Nigeria. He had been working in the hospital for three years full time on the ward below mine. I got to know him when I did some bank shifts on his ward. He would also come and work extra shifts on my ward from time to time. If he was not working on my ward he would still come to the ward to play a couple of frames of pool with me if the ward was quiet.

Much of our conversation was based on sarcastic joking. For example he would walk into the lounge where the pool table was and look at me with a serious face and say:

**Mark:** *Get off your fat arse white boy and set up the (pool) table because I am going to whip your ass....I have put juju on the table so you are jinxed<sup>19</sup>.*

**Me:** *Yeah right, let's see.*

We would end up laughing and then greet each other by shaking hands and asking how work had been going. Playing pool offered a good space to chat and see how life was on the other wards.

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or a fight had broken out.

<sup>19</sup> *Juju* is a commonly used term in Western and central Africa when referring to witchcraft. In Tanzania, for example, it is a nickname for *uchawi* (withcraft). Leseth (1997) explains that it is



One day Mark came to the ward with a new leather Filo-Fax diary with a leather pouch for his mobile phone to fit into. It was the biggest Filo-Fax I had ever seen. He sat in the nursing office with it resting on his lap. I told him that it looked very smart. He replied:

**Mark:** *What would you know, you would never be able to afford something like this (joke)*

**Me:** *Well I would never have enough time to go to Peckham market (Joke).*

Mark then burst into laughter at my comment. We then spoke about work and then he began to joke again:

**Mark:** *John, how can you have a girlfriend and go to university when you dress and look like a thief?*

**Me:** (Laughing) *Well at least my father is not a thief.*

**Mark:** (Not laughing and serious) *Never speak about any of my family like that.*

Mark stood up and walked out of the office and went back to his ward.

I had offended Mark by joking about his father. I had mis-judged the boundaries of our relationship as to what was acceptable and what was not. The joking dialogue was personal and similar to two close friends who joke on a personal level with each other but do not offend each other. My problem was that I took this for granted and therefore joked with Mark within the boundaries of my own

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common for African people to use the term 'witchcraft' as "a popular way to designate the

cultural habitus (Bourdieu 1977). Both our cultural norms were very similar, but the differences were large enough for me to be able to offend him.

Joking among friends and using personal topics such as families and parents is common in my own peer group culture. In turn, this type of joking creates “relations of alliance” which form and organise stable systems of social behaviour (Radcliff-Brown 1952). An example of this was when I was teenager at school. There was a process of 'cussing' (joking, or 'put downs') whereby two males would 'cuss' each other's parents. Much of the 'cussing' was vulgar and crude; however, the aim was to 'out do' your opponent with better 'cusses'; if one of the contestants became offended or could not reply with a better 'cuss' they would lose the exchange. The group watching the exchange would judge who was the winner. Although 'cussing' became an important 'tournament of value' (Appuduria 1986) within my school life to gain status, it has now become a sardonic way that one jokes with close friends today. It is a means of reminiscing about and mocking one's own social upbringing. I took this for granted when exchanging jokes with Mark.

I was able to learn from this example in the sense that I had been made aware of my own cultural background and position in the work environment. This autobiographical account on my own background allowed me to understand *where I was coming from* and why it might have offended Mark.

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harmful employment of mystical power in all its different manifestations” (1997:173).

I apologised to Mark a week later. He came to the ward and I told him that I did not mean to offend him at all. He said that was 'okay' and that the two of us could not offend each other if the joking was directed at each other. He did not want any of the joking directed at his family. I felt that I should also tell him why I had said what I did and that it was part of my upbringing which had started at school. Our relationship became much stronger after this encounter, and the joking continued but I realised any directed to his family was not acceptable and I therefore avoided it.

### *Self-Reflexivity as Method?*

Looking at my social upbringing and my social interactions when I was at school is similar to Okley's (1996) argument for an autobiographical reflexivity. Okley explains that she used reflexivity as a means of looking back on her childhood when she went to boarding school to understand certain areas of her ethnographic material. Thus, autobiography or the reflexive process situates the anthropologist within the core of the field research and not as an outsider looking in, or as Clifford resonating with Goffman's work, describes: "The ethnographer, a character in a fiction, is at centre stage" (1986:14). There was no doubt that looking back on my own social upbringing helped me understand certain ethnographic encounters; however, I never conceived of the fact that I would be forced, quite spontaneously, to use a reflexive approach.

As mentioned above, the process of reflexivity was spontaneous and unplanned and not a methodological tool or a ploy to try and create, as Shore (1999) argues, an "honest ethnographic picture" (1999:26) instead of the static objective

ethnographic images in the past. Shore calls the 'reflexivists' post-modernists who are situated in a "solipsism" or a self-indulgent celebration. He quotes Polier and Roseberry who state that the concept of self-reflexivity is an "egocentric and nihilistic celebration of the ethnographer as author, creator and consumer of the Other" (quoted in Shore, 1999:29). But Beatty (1999)<sup>20</sup> follows Shore's line by arguing that reflexivity is a failed attempt to show "the readers not only the facts but how, in dialogue, the facts are constructed" (1999:95). Beatty goes on to argue that some ethnographic experiences must remain "opaque" and resist analysis.

Reflexivity, as a methodology, is somewhat optimistic because it is so subjective that the ethnographer cannot be totally sure if their approach will actually mean anything or be productive at all. It can also be criticised for creating an image of the 'righteous researcher' facing all the elements of the ethnographic experience whilst *hanging out* with the 'natives'. So, Poiler and Roseberry have a point when describing it as egocentric. However, the issue that they fail to raise is that surely, regardless of methodology, we all fall into a reflexive mind-set at sometime while carrying out research, regardless of whether one takes a more scientific approach or an open reflexive slant. If this is the case, as I certainly experienced in my field research, then being reflexive has nothing to do with being post-modern, but more to do with making sense of everyday interactions that appear new, strange or problematic while carrying out field research.

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<sup>20</sup> Beatty criticises Geertz's description of the Balinese Cockfight resulting in the reader understanding more about Geertz and his wife's position within the ethnographic environment and little about the actual event he was writing about – the cock fight. Furthermore, Crapanzano (1986) argues that Geertz and his wife are cast as individuals within the text while the Balinese people are generalised within the ethnographic detail.

## **The Acting Ethnographer**

While carrying out my field work I was aware that I had interacted in different ways depending on which section of the staff I was engaging with. Some of these interactions were more thought out than others, but the point was that I was always prepared to present a sense of myself in relation to how I wanted the other person or group to perceive me and how I thought they would perceive me.

Erving Goffman (1959) describes this process as a performance where “all the activity of an individual which occurs during a period marked by his continuous presence before a particular set of observers and which has some influence on the observers” (1959:32). The individual must make out that the interaction is an authentic reality while maintaining a convincing ‘front’ – the expected image you present to others ‘front stage’, such as a doctor’s white coat. Thus fronts become a “dramatic realisation” that allow people to convey a message.

Performances can also be carried out by teams that hold the same aims; for example, a board of directors conveying a message to its employees. After the individual or team have come off the stage they move into a relaxed environment, or “back-region” – where performances are “knowingly contradicted as a matter of course” (1959: 110). Thus, for Goffman, the social world is made up of interactions that are situated on a stage where we swap between being actors and audience through an on-going process of ‘impression management’ (Manning 1992).

Goffman argues that this process is part of everyday interactions; however, in the case of an ethnographer, it becomes an important conscious tool within the field. Berreman explains that "the ethnographer and his subjects are both performers and audience to one another. They have to judge one another's motives and other attributes on the basis of short but intensive contact and then decide what definition of themselves and the surrounding situation they want to project; what they will reveal and what they will conceal and how best to do it. Each will attempt to convey to the other the impression that will best serve his interests as he sees them (1972:11)".<sup>21</sup> In my case there my impression management was a complex process because I continually had to interact not only with male and female NAs, but many health professionals who had very different ideas and expectations of me.

When I attended meetings with hospital management or at the Trust's headquarters I would wear a jacket and shoes with an open neck shirt rather than trainers and T-shirt. I would regularly enter the room holding a diary in my hand and carrying a smart bag on my shoulder instead of my usual small ruck-sack. But there were times when I would attend meetings with the hospital's management straight after I had finished a shift. I would then make sure that the casual clothes I wore while at work consisted of casual trousers for example, chino trousers and a polo shirt. I would also make sure that my ID badge was

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<sup>21</sup> Stella Mascarenhas-Keyes (1987) used 'impression management' as a means of gaining access to the different sections of the Goan Village, from women to the 'big-men'. Although she classified herself as a 'native and anthropologist' she still experienced difficulties becoming accepted in her community. She adopted Goffman's notion of 'dramaturigical exercise' and arranged her personal wardrobe so that she had both Western and Indian clothes. When meeting the big-men she wore 'executive, London style clothes' and lipstick. When she interviewed sailors she wore locally made clothes and when speaking with Hindus she wore a sari and 'clip-on' nose ring.

attached to the polo shirt and not to my trouser belt, where it would be less obvious to other people, and potentially contravene Trust policy, that ID badges must be visible at all times. While working on the ward I mainly wore jeans and a shirt, T-shirt, polo-shirt or jumper. I wanted to make sure that my appearance while working was tidy but not too smart

#### **Part 4 - The Ethical Dilemma**

In the last part of this chapter I want to extend the idea that the interactions between researcher and the researched is similar to a performance. Daily encounters such as chit-chat and the use of impression management provide the researcher with subtle techniques to gain trust and acceptance. But the use of these throws up important questions about the ethical relationship between the researcher and the researched. For example, the drive to gain access to the backstage could possibly mean that the researcher becomes party to moral dilemmas (Norris 1993). Norris argues that the “practice of participant observation is, inevitably, interactionally deceitful. Researchers have to cultivate informants and reduce the distance between themselves and those” (1993:131). Norris goes on to explain: “Manufacturing trust requires getting one’s hands dirty, since it is not something that can be promised with declarations of confidentiality”(1993:132). This somewhat, no-holds-bar account of fieldwork leaves the researcher with little scope to adopt an ethically sound approach to their work. May (1993) carries this point forward by stating that the relationship between ethics and social research is a complicated one because the amount of

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control the researcher has over the research process will influence the exercise of ethical decisions themselves. Quoting Bronfenbrenner, May argues that “the only safe way to avoid violating principles of professional ethics is to refrain from doing social research altogether” (1993:43).

What is apparent is that ethnographic research always has elements of ‘covert’ness’. In my case, for example, walking into meetings with consultant psychiatrists consciously wearing trousers and a shirt, clutching to my Filo-Fax, or going for drinks with my research subjects in the pub when they think the researcher is not at work (see Burgess 1984), can all be considered forms of covert research. Akeroyd (1984) points out, “the researcher is never off duty” (1984:145) and furthermore cannot ever be. The idea that covert research<sup>22</sup> is in opposition to a more ethical approach, where the research subjects have consented to the research, is somewhat misleading because the nature of ethnographic research means that there are times when the research has covert elements to it.

When I use the phrase ‘more ethical’ I am referring to the notion that informed consent appears to provide ethical certainty to one’s research. In other words, the research subjects have agreed to the research, leaving the researcher morally placed and entitled to proceed. However, arguments against this idea are centred around the principle that informed consent can also have elements of ‘covert’ness’ because the aims and objectives is given to the researched is

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<sup>22</sup> By covert research I mean where the researcher ‘goes undercover’ leaving the research subjects with no knowledge that you are carrying out research on them. Two classic examples of this is Fielding’s (1981) research amongst the National Front and Rosenhan’s (1982) research in a psychiatric hospital.



frequently 'veiled' (Norris 1993:128-9). Roth (1962) argues that because the researcher does not know everything they want to know at the beginning of their study, secrecy is a common occurrence. He concludes by arguing that social science research "cannot be divided into 'secret' and the 'non-secret'. The question then, is where does the official role of ethics lie within social science research and especially in anthropology where "much of anthropological method is essentially theory-less" (Pelto and Pelto 1996:294).

The answer to this question is difficult. This is partly due to the fact that anthropological research seems unable to stand alongside any structured code of ethics. Anthropological bodies such as the UK's Association of Social Anthropologists of the UK and Commonwealth (ASA) only provide guidelines in their attempt to stand in line with the ethical expectations of modern research principles. In relation to informed consent, section 4 states that: "The principle of informed consent expresses the belief in the need for truthful and respectful exchanges between social researchers and the people they study" (p.3). This appears to be a commonsense view, but it becomes extremely problematic (for the reasons explained above) in anthropological research. Nugent (2001) develops this point by explaining that "anthropological research is not typically a straightforward reciprocal exchange between scholar and subject, nor could it be. The access the anthropologists have to field subjects is premised on a political asymmetry for which anthropology is not itself directly responsible, but without which it would not have the configuration it does" (2001:13). Developing this theme, medical anthropologists such as Marshall and Koenig (1996) have argued that informed consent presupposes a cultural disposition that assumes personal

autonomy and self-determination. These values, they argue, “ often conflict with local traditions that allocate decision-making authority to community or religious leaders....applying western standards of informed consent may represent a form of ethical imperialism” (p.362-3).

The general point must be that applying something like informed consent as ‘good ethical practice’ in anthropological research does not really protect the researched staff in a London Hospital, or the Yanomami - from all the anthropologist’s subtle techniques of research, or the researcher from scrutiny and valid criticism. The challenge for anthropological research is to maintain integrity within the subtle techniques of research, and this calls for an on-going awareness and questioning by the researched, the researcher and his or her peers.

### **Conclusion**

I stated that this chapter was divided into two halves. The first served to locate my research within its broad field – an organisation. I argued that it was too simplistic to view organisations as either bureaucratic or based on a flexible structure. Rather, I argued that organisations hold both of these theoretical points. Both bureaucratic and cultural approaches are interlinked. The key, therefore, is to understand how they function side-by-side. Addressing this I argued that the cultural approach masked the traditional reality of bureaucracy. In other words, anything based on hierarchy is seen as a threat to a modern day approach to

organisations where power is supposed to be shared and top-down relations old-fashioned.

The second half explored some of the main methodological themes that I experienced when carrying out my field research within a organisation. I have attempted to locate these themes in broader anthropological and sociological debates about field research, in general and in organisations. What is apparent is that many of these themes are being continuously debated within the social sciences with little agreement or conclusion. Central to many of these is how research data is gathered and meaning created from it. From where you locate your field research area to how you conduct yourself within the field, everything ties in with a drive to create meaning and in many cases a quasi-element of fact – even if this leads to the researcher resorting to describing their work as ‘fiction’, ‘reflexive’ or a ‘performance’ of micro games between researcher and the researched.

I have discussed how the ethical framework does as much to create an unethical research environment because it appears fundamentally to deny the nature of anthropological research - understanding day-to-day human interactions. Social interaction as a ‘performance’ based on ‘impression management’ is one of the central features that the anthropologist is concerned about researching<sup>23</sup>.

Furthermore, the anthropologist is intrinsically involved with these forms of interactions with the research subjects and in everyday life outside the research

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<sup>23</sup> See Bourdieu's (1977) account of how he was influenced by the work of Erving Goffman in relation to the *habitus*. It is interesting how Goffman's work has not been more embraced within anthropology. Morris (1987 ), briefly describes how Victor Turner uses Goffman to support his theory on ritual.

setting. The ambiguous role of ethical guidelines makes it even more puzzling as to what real function they add to the research procedure and experience.

### III. Discourses of Care and the Role of Psychiatry

The patients' community meeting is supposed to take place once a week on the ward. In reality, there is little conformity as to when it takes place. This usually means that it happens once every two or three weeks. The meeting is designed to allow the patients to raise and discuss issues concerning their stay on the ward. Common raised points focus on the cleanliness of the bathrooms, the quality of the food and access to the kitchen so to be able to make coffee or tea.

The 'community meeting', as it is called in short, takes place in the ward kitchen where those attending it sit around a table. Patients are notified earlier in the day about the meeting, but no one is obliged to attend. It is usually run by a qualified nurse who takes down the minutes of the meeting and also attempts to answer questions. Fruit juice, coffee, tea and biscuits are laid out in the middle of the table for the patients attending the meeting. The community meeting is supposed to last for an hour, but this is rarely the case. Usually, it lasts for anything between twenty to forty minutes.

On one occasion seven patients attended the meeting along with a qualified nurse. After drinks were made, the nurse read out the minutes from the previous meeting and clarified any developments that had taken place. She then asked if anyone had any comments to make. Mark, a 25 year old man, who had been on the ward for a number of months, quickly responded to her question by commenting on the film that some patients watched on video the night before.

**Mark:** *Yeah, some of us watched "One flew over the cuckoo's nest" last night. It was thought provoking. We all sat there in silence and could relate to it. I mean, that nurse...gee I would have just smacked her (laughs). You lot are nothing like that nurse (speaking to the nurse). You treat us more humanely.*

**Nurse:** *Thank's Mark, well we do really try and promote a therapeutic environment here so that you do not feel like the patients in the film. They are not made to have any feelings of worth and hope.*

**Mark:** *Yeah, but that does not mean that some of us still feel like breaking down the doors here though.*

**Nurse:** *What do other people feel? (Looking at the other patients around the table)*

This short description of the ‘community meeting’ and the interchange between Mark and the qualified nurse running the meeting, highlights one of the major contradictions in psychiatric care. This contradiction is based on the tension between having to contain some patients under law while also attempting to care for them through the use of ideological principles that are based on terminology such as ‘patient empowerment’, ‘therapeutic environment’ and ‘community meeting’.

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## **Introduction**

Before entering into College Ward further and looking at the dynamics of the staff in my research, it is important to provide an account of how the concept of ‘care’ is used within the NHS and in general wider context. It is important to note that, throughout this thesis, the concept of ‘care’ relates to the different ways in which it is framed in this chapter. The thesis does not provide one standardised definition, but rather makes the fundamental point that definitions and implementations of ‘care’ in the NHS, politics and the media seem to imply a range of moral principles. This chapter shows how this is the case. It deliberately does not introduce the perspective of NAs because its principle aim is to reveal

how 'care' is wrapped in altruistic discourses that they tend not to adopt. Later on in the thesis, I will argue that these discourses are absent in the NAs' own notion of what they provide on psychiatric wards.

The first half of this chapter will map the different ways in which 'care' has been used as the marker of overall NHS identity. Part One explores how differing definitions have been used to justify the creation and development of the NHS historically. Part Two concentrates on how qualified nurses and doctors are positioned within such definitions. Parts Three and Four focus on psychiatry and psychiatric care in particular, showing how the rise of modern-day practices largely in response to the moral criticisms made by medical, political, media and academic institutions. I argue, however, that psychiatry has always found it difficult to address these criticisms.

### **Part 1 – Discourses of Care and the Altruistic NHS**

The notion of care has no clear boundary or definition. Russell (1999) argues that 'care' is problematic in Western thought and that it should be viewed as multifaceted with different meanings in different languages. He cites three various meanings of care in the English language; 1) care as a sense of caution, 2) care as being concerned, 3) care as a process of looking after someone (1999:65). All of these involve moral implications as well as the implementation of practical techniques. I am interested in the third point: 'care as a process of looking after someone' and how this fits into a core NHS ideology. For the sake

of this thesis I use the concept of 'someone' in an abstract way: 'someone' refers to the individual patient or person in need of care but also refers to society in the sense that the NHS is a State institution which cares for its citizens through the metaphoric image of being a paternal figure. 'Caring for someone' then comes with duties, responsibilities, professional tasks and perhaps labours of love (McKechie & Kohn 1999).

In this way, 'care' both as an ideology and as a practical action is made up of a multi-layered structure of meaning. Therefore, I am not separating nurses from doctors or managers and policy makers in terms of what they all 'do' within the NHS. They all have different roles marked out from each other through training, knowledge and professional status (I will discuss this later on in this chapter) but they all function under the principle of being actors within a 'caring' institution. Within such a setting, care can involve one-to-one staff/patient interactions which now might be called patient-centred care. It can also be more abstract and part of medical research, policy, management, marketing, Information Technology (IT), Human Resources and training, through Research and Development departments (R&D). Therefore, it is situated both on a micro and macro level. Let me develop these points by exploring the image of the NHS as a caring institution.

### **The Caring NHS**

The NHS was formed in 1948 in response to decades of government neglect of the health of the nation. In the early 19<sup>th</sup> Century British Government adopted a *laissez faire* approach to health where it was felt that the market forces would



provide all the wealth and health the nation needed (Henshaw & Howell, 1999). In turn, such an attitude meant that there was the assumption that all those who were poor or physically or mentally unfit were blamed for not contributing to the new utopian vision of the industrial age. The introduction of the Poor Law Act in 1834 condemned these 'misfits' to punishment for allowing themselves to get into such a demeaning position. By the turn of the century, the nation was becoming increasingly 'unhealthy'. This was most obvious when men were deemed too unfit to fight wars, as during The Boar War (Royal 1987). Government began to realise that there was a need for a centralised controlled health system. In 1909 the Liberal Government introduced plans for a National Insurance System that eventually became the National Insurance Act (1911) where by contributions from employers and workers would go towards the establishment of a limited framework to provide pensions and some welfare benefits. This was the beginning of the welfare state.

The creation of the NHS took place amidst national feelings of egalitarianism and an imperative to rebuild the nation that marked the post-war period in the latter part of the 1940's. Klein explains that the "NHS was born into a working class society only slowly emerging from war, where rationing and queuing were symbols not of inadequacy but of fairness in the distribution of scarce resources" (1989:196). Fairness and sharing between citizens was also encapsulated within the general fabric of the NHS where free health was the standard. What is important to note here is that the NHS mirrored a general mood that characterised the nation. In the 40's and 50's it fitted neatly into the general

political drive to nationalise industry creating an assumed collective relationship, or 'imagined community' between the workers and the state.

### *The need for change*

The 1980s' saw a radical shift in how Government perceived the role of the NHS. Whereas the 1940's were based on nationalisation and the collective, the 1980's under Thatcher promoted the fact that society consisted of people taking control of their own lives. National Industry became a resource that was sold to the highest bidder and the concept of the collective was swapped rapidly for the more appealing concept of the individual (Klein 1989). The Conservative government promoted the need for market liberalism through concepts such as 'choice', 'opportunity' and 'responsibility' in the light of the claimed wasteful and inefficient nature of the NHS in the previous years where successive governments were keenly aware of the cost of the ever-increasing demands of the Health Service. Privatisation, marketisation and managerialism became core factors in Conservative policy from 1979 onwards (Rogers & Pilgram 2001). However, the NHS had become a 'birthright' for the British and any party proposing cuts risked a serious loss of votes at election time (Nolan 1993). The key principles of the market force were used as the driving force to enable the nation to take more responsibility over its own health care provision through the choice between public and private health care.

The need for change was further strengthened when the Government commissioned the Griffiths Report of 1983 which paved the way for the Conservative Government implementing business-orientated ideas of

management, internal market forces, competition and profit. This, it was hoped, would lead to a better service and thus better care. The 'new management style' was based around a centralised structure where managers of health authorities were provided with direction from a central lead. Sir Roy Griffiths, the author of the report, commented that "if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge" (cited in Klein, 1989:208).

#### *The development of care in the community*

'Care in the community' also became an important part of the Conservative Government's drive to reshape the NHS. It was supposed to advocate a genuine commitment to improving the care of the vulnerable. The idea was that care should now be based in the community and away from the institutional setting of the 'out-of-date asylums'<sup>24</sup>. However, it is important to note that this concept was present before the Conservative Government got into power in 1979 although the notion of 'care in the community' formed the basis for public policy from 1975-1990 (Butler 1993). It has a long history where it is 'rediscovered' as a solution to the proliferation of asylums (Bartlett & Wright 1999). It became a 'catch all' phrase to describe a range of different services through out history (Rogers & Pilgram 2001). Butler makes the point that the essences of modern day care in the community was partly due to the "emerging therapeutic optimism of the 1950's which was associated with the new drug technology" (1993:42). This led to earlier discharge from hospital. Along with these clinical advances, there were also other key factors that influenced the notion. In the 1950's and 1960's

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<sup>24</sup> I will discuss, in detail, the role of asylums later in this Chapter.

changing perceptions towards mental health care viewed asylums as being associated with detention, custody and danger (Butler 1993). At the 1961 MIND (the National Association of Mental Health) annual conference Enoch Powell stated that: “It is out of duty to err on the side of ruthlessness for the majority of these establishments there is no appropriate use” (Powell [1961], cited in Clare, 1980:414). This was specifically relevant for psychiatric services because it aimed to dismantle the negative image of hospital based care. From the early 1970’s there was a gradual phasing out of large mental hospitals which were replaced by psychiatric units attached to district general hospitals. Clare (1980) explains that psychiatrists generally approved on these changes because it gave them recognition as clinicians within the mainstream of medicine. Their professional work was now positioned alongside their medical colleagues. The public liked the idea that treatment was local and not in a remote asylum. Finally, it made more economic sense to treat patients in existing general hospitals, while it was thought that community care would reduce hospital admissions.

The general philosophy behind care in the community promoted ‘self help’ where individuals and their families and friends would be a central part of the process. In a positive light, ‘care in the community’ was heralded as a move away from the institutionalisation of patients and an effective way of re-directing funds into other areas of the NHS. This, it was thought, would alter the negative image of psychiatric care. However, critics argue that it had more negative points than positive points. Bartlett and Wright (1999) state that care in the community “holds a dubious distinction of being universally supported in principle, and universally condemned in practice” (1999:16). They point out that ‘chronic’

under funding, poor co-ordination and rivalry amongst professional bodies were some of the main negative factors. The move to community based care also divided patients into two broad groups; dangerous and safe patients. However, hospitals were unable to offer minimal secure settings for patients who did not fit into these two groups. These were the patients who were 'at times' dangerous, or who delved into petty crime. The criminal system coped by imposing long prison sentences (Clare 1980). Community care was also unable to provide adequate care to elderly mentally ill patients, while there was a general lack of support for relatives that took on much of the caring role (Creer & Wing 1974). Scull (1994) makes the point that this form of care "masquerading as community care" (1994:7) has led to a renewed interest in the positive meanings that can be applied to the notion of 'asylum'. While Furlong (1996) argues that the term 'care in the community' is misleading because it implies that it is in directly the opposite of the care given in asylums. This "gives rise to the notion that asylums are isolating places, devoid of social structure" (1996:162).

Regardless of the criticisms laid at the door of the Government in the late 1970's and 1980's, the Conservative era radically reshaped how the NHS was to be run. Centralisation, performance targets and, in 1992, the introduction of the Patients' Charter, aided by league tables, were all designed to develop a national standard of care. It created a new focus on health and the NHS, "marking precisely the kind of shift of power from providers to consumers envisaged in the Griffith Report" (Klein, 1995:212). The economics of business within the NHS was now brought into the open; however, the Conservative Government still promoted 'care' as the core principle in measuring success. The terms 'care in the

community' and the 'Patients' Charter' are cases in point where economic factors could be disguised under the banner of improving or modernising 'care'. The introduction of New Labour in 1997 prompted the Minister of Health to state "care in the community has failed" (Dobson 1998). However, the drive to modernise the NHS that the Conservative era had started was embraced by New Labour.

### *The need for modernisation*

Since 1997, New Labour have attempted to fine tune the health policies of the 80's by again promoting the notion of 'care' as the core concept in arguing for change and development. Government papers such as The National Service Framework (NSF) (DoH 1999) and The NHS Plan (DoH 2000), and 'Shifting the Balance of Power' have promoted the concept of patient empowerment, modernisation and better paid staff. The NHS is now run according to notions of the client, consumer, service user or patient can choose, and better still, advise the 'experts' on how and when care should be administered. 10.1 of the NHS Plan sums this up:

Patients are the most important people in the health service. It doesn't always appear that way. Too many patients feel talked at, rather than listened to. This has to change. NHS care has to be shaped around the convenience and concerns of patients. To bring this about, patients must have more say in their own treatment and more influence over the way the NHS works. The reforms outlined here give patients new rights and new roles within the health service (2000:88)

The patient-centred approach currently lies at the core of the NHS. The more traditional bureaucratic system of health care - that is, where the doctor is the omnipotent holder of medical knowledge, where the nurse is the vocational servant to that knowledge and the patient is the lay receiver, is now officially redundant. Although, at present, we still have the professional doctor, he or she is now competing with the new 'professional nurse' and the almost 'professional patient'. The central term here is 'the expert patient'.

Whereas in the pre-Thatcher era there was a standardised process of care, there are now new tensions between the 'professional' and 'lay' – and also between commerce/privatisation and free health care. Recent Governmental policies on the NHS are now neatly positioning such issues as public/private partnerships as part of the all embracing morality of care. We are left with a combination in which care and consumerism live in harmony. Paragraph 2.12 of the National Plan echoes this.

Today, successful services thrive on their ability to respond to the individual needs of their customers. We live in a consumer age. Services have to be tailor-made not mass-produced, geared to the needs of users not the convenience of producers. The NHS has been too slow to change its ways of working to meet modern patient expectations for fast, convenient, 24 hour, personalised care (2000:29)

In reality, however, we still place the metaphor of the NHS as the 'moral person', caring for its citizens by providing free health care at the core of any development of the NHS. Stacey (1998) rejects this claim of the patient being a consumer of care where they become empowered. She argues that the term consumer "is a political one, in the sense that it has been used by certain social actors to legitimate alterations in the power structure" (1998:54). She goes on to argue that the ideological image of the patient in partnership with clinicians "is not an equal one, for the professionals then are always in the most powerful position...A patient also lacks choice because of a shortage of professionals and/or amenities, his own lack of knowledge, reinforced by bureaucratic complexities" (1998:57). Therefore, the use of terms such as 'consumer' or 'partnership' do necessarily not create a new power base for patients; if anything it hides the fact that the existing bureaucratic power structure, still persists.

But what about the actors who actually work within the NHS? How do they view their changed role and what does care mean to them?

## **Part 2 – The Natural Disposition of Nursing**

I think it is important here to explore in more detail the role of nursing to try and understand how this emerging multifaceted language of 'care' has been framed within an institutional health care setting. Traditionally, the idea that 'nurses care' while 'doctors cure' has positioned nursing in an inferior position to their more 'informed' colleagues (Mckechnie & Kohn 1999). The common picture



is one where doctors training legitimises their delving into scientific theory and owning the label of 'expert' in the medical environment. Nurses are commonly identified with a natural disposition to care – a vocational calling. Therefore, in the past, training and the acquisition of scientific and medical knowledge have been seen as on the periphery of their identity and role. Rather, their highly gendered image is often associated with women mopping the brow of the 'needy' patient and helping them back on the road to recovery. What is fundamental to this representation is that caring is often seen as 'natural' and an extension of 'maternal love'.

Medical and bureaucratic notions of care, however, are seen differently; they can be regarded as being set in 'progressive time' where medical science leads to development and change. Nursing, which is associated with a more 'hands on' notion of care, is set in 'static time' (McKechnie & Kohn 1999). In other words, it never changes, because it is based on a natural disposition to care.

### **Gendering care and the lack of professional status**

It is a crucial concept to further consider gender when exploring concepts of care in the NHS setting. The natural disposition to care is routinely associated with the domestic sphere (Garnarnikow 1978) and the role of the woman, or more crudely, the housewife. Nursing work is "often seen as an extension of work that women are expected to carry out in the domestic sphere" (Abbott & Meerabeau, 1998:7). Medicine and the role of the doctor in the public sphere takes on the image of the male in the public sphere who acquires specialist

knowledge that in turn holds the apparatus for decision making and fundamentally for control.

This subservient gender division of labour (Oakley 1998) has resulted in the nursing profession challenging its inferior image. It has tried to claim that its role is, or should be, based in a professional domain precisely because of nurses' superior knowledge of the ward environment and their close interaction with patients. In the 1980s the introduction of Project 2000 was an attempt to give student nurses a theoretical grounding and less day-to-day contact on the wards in a drive towards a professional status. It was argued that qualified, professional nurses are more likely to be involved in management and supervisory roles (Hurst 1992). Project 2000 also promoted the role of the primary care nurse who would move away from a task-oriented role to a more patient-centred role similar to that of a doctor. Finally, nurses were handed more responsibility by taking on more tasks, such as treatment decisions usually assigned to the junior doctor (Mackay 1998).

### *Defining a Profession*

What might be meant of nursing as a profession? Friedson (1994) has argued that the concept of a profession should "refer to an occupation that controls its own work, organised by a special set of institutions sustained in part by a particular ideology of expertise and service" (1994:10). He argues that professions carry or develop autonomous strategies so as to heighten their own social status and corner the market by excluding other competitors (Friedson 1970, see also Abel-Smith 1988). Therefore power over others becomes a key feature of the professional where supremacy is only gained through reaching a high status, which in turn can

only be achieved if one has experienced being dominated or controlled in a junior position. Ultimately, superior knowledge must leave competitors and clients in a state of ignorance and thus dependency (Pilgrim & Rogers 1999). Etzioni (1969) writing prior to the more recent nursing drive to redefine their role, argues that nursing should be seen as semi-professional in comparison to doctors because the training is shorter, there is a lack of a specialised body of knowledge and there is less control and autonomy. This adds up to a legitimate but inferior status. More recently Rafferty (1996) echoes this, claiming that nurses are more concerned about moral values than intellectual knowledge. However, Witz (1998) challenges these views by arguing that “because women are not men, ‘semi-professions’ are not professions” (1998:241), while Davis (1995) argues that nursing should be seen as a ‘new profession’ where the role of nurses is to engage with patients, work with health care professionals and make reflexive use of their experience and expertise.

What has become apparent in nursing literature is that while there has been a move to try and package the role of the nursing into an ‘expert’ field the consequence has been to establish that role which only ‘they’ have the expertise to execute. Therefore, although there is a call for a professional status, it is the ‘caring’ nature of nursing that is often presented as the central aspect that distinguishes it from other disciplines, especially doctors. Mackay argues that “the idea of vocation has given a special quality to nurses and nursing work – one of putting patients first. The attractions of being ‘a professional’ and establishing nursing on an equal footing with medicine cannot be denied, but something intrinsic to nursing practice would be lost if the vocational element were extinguished” (Mackay 1998:68-9).

### *Nursing Space*

I think that there is an underlying argument which Mackay is not tackling: that nursing identity is not shaped only by the vocational 'calling' and caring aspects, but also by the physical and psychological space in which nurses operate. This space, which is most commonly the ward, dictates the way that they take on a supportive role to the doctor and a nurturing one for the patient. And so, because they are confined not only by a specific type of space (the ward) and specific timing (the shift) but also a supportive role, nurses have been forced (maybe sub-consciously) to attempt to control and define the space and their role within it as their 'expert' field. Although I will discuss this point in more depth in the next chapter by using ethnographic examples, it is pertinent to include a good example of this here.

Savage's (1997,1999) ethnographic study on how a 'process of domestication' presents the ward as generating a feeling of a domestic rather than one of a public space. Processes of domestication function by nurses making decisions about the ward environment, and how they interact with patients. For example, allowing patients to use the phone, making tea and coffee for the patients and making decisions such as removing the nursing desk so as not to create a barrier between the nurses and patients. Patients described the environment as a 'home from a home' and 'like a family'. Savage also describes how the informal use of the nurse's body is fundamental in creating a sense of closeness between themselves and the patients, arguing that this is part of the 'therapeutic relationship'. Doctors would often be criticised for standing, rather than showing any genuine

relationship, when speaking to patients. This space, Savage argues, is neither masculine or feminine but a contested, ambiguous, unfixed space in which struggle and resistance are possible. It is a political space where non-technical and non-theoretical knowledge has become more legitimate (1997)<sup>25</sup>. In Chapter Four I will argue that the concept of closeness is used by nurses to promote their expertise when attempting to promote their professional status.

So far in this chapter I have put forward the idea that care, in spite of its apparent diversity of meaning, nevertheless retains validity within the medical and political discourses of health care. Fundamentally, however, the concept of care carries an underlying moral dimension in that care means ‘giving’ to someone who appears to be in more need.

### **Part 3 – The Rise of Modern-day Psychiatry and Psychiatric Care**

How does this moral image of care discussed so far in the chapter fit into psychiatric care and the discipline of psychiatry in general? One can say with confidence that the general image of psychiatry and the psychiatric hospital is one that does not match the ‘home from home’ comfort zone that was described by Savage earlier. Words are often used in the media, academia and within psychiatry, that highlight the negative experience of psychiatric patients such as ‘punishment’ ‘dehumanisation’ ‘institutionalisation’; a movement named the ‘*antipsychiatry movement*’, and some service users pointedly call themselves

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<sup>25</sup> In the next chapter I will explore this notion of space and the ‘process of domestication’ in

'survivors'. All these are indicative of psychiatry having been transformed, as it were, into a dangerous and somewhat 'evil' wing of medicine. In a recent Radio 4 programme, 'All In The Mind' (8 July, 2003), psychiatrists were discussing the image of psychiatry in Hollywood films. They pointed out the general genre of Hollywood/Psych films portrayed psychiatry and the individual psychiatrist at best as unsympathetic and controlling, and at worst 'evil' and outright dangerous. Generally, film characters suffering from mental illness get better through love and help from family and friends. However, Gabbard and Gabbard (1999) argue in their book *Psychiatry and the Cinema*, that the positive and negative image of psychiatry actually moves in waves. For example, during the 'Golden Age' in the 1950's and the early 1960's psychotherapists and psychiatrists "were most often characterized as competent healers and admirable human beings" (1999:78). They cite films such as the 1956 version *Invasion of the Body Snatchers* and Hitchcock's 1960 film *Psycho* in which the image of psychiatry has a "consistently positive image" (1999:78). They argue that the end of the Golden Age "coincided with an equally abrupt and unexpected decline in government (US) support of psychiatric research and education" (1999:103). Probably the most famous of the 'Fall of Grace' films, based on a book, was *One Flew Over the Cuckoo's Nest* of interest is that the role of anti-depressants and anti-psychotic medication rarely feature as a positive feature in the films. Since the Enlightenment and especially since the rise of the Asylum Era to the present, the mind has been a focus of extensive research. At the same time, such research has also been an attempt by psychiatry to legitimise itself as a medical, and fundamentally, a scientific discipline.

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more detail by using ethnographic accounts

However, to fully understand the nature of psychiatry and psychiatric care in its present form, it is important that I explore the evolution of modern day psychiatry from a historical perspective.

### **Asylums and science**

Psychiatry, as a medical discipline, came into existence in the mid 19<sup>th</sup> Century. The actual term 'psychiatry', Nolan explains, was first used in 1846 by asylum doctors in an attempt to create it as an emerging branch of medicine (Nolan 1993). Butler (1993) states that the creation of asylums in the 19<sup>th</sup> Century not only produced new types of buildings to house the people deemed 'mad' but "it also created an institutional base for the development of new professions who claimed expert knowledge in the care and control of people with mental illness" (1993:4). The asylum system was structured by the doctors working in the new discipline as something that would appeal to the values of society at that time. Ideally, it would make a contribution to the nation's ideals and industrial development by getting people back to work. However, Scull (1996) argues that in reality asylums did not live up to these values because the concept inherited "darker overtones of the Victorian age, as initial expectations....were intended as philanthropic foundations degenerated into more or less well-tended cemeteries for the still breathing" (1996:7) Nolan argues that the emergence of the asylum system "reflected the increasing power of the State over the lives of individuals in the mid-19<sup>th</sup> Century. Although the asylums wrapped their aims in medical rhetoric, as state-funded institutions their purpose was essentially social and lay in welfare administration" (Nolan 1993:45). Commentators such as Jones (1991) and Scull (1987) argue that

the rise of the asylum system was based within a humanitarian discourse located in the upper classes. In general, they regarded it as a paternalistic morality designed to protect upper and middle classes from the lower classes. By placing psychiatry within hard science and medicine, it could legitimise its existence and development, allowing the state to justify its containment of the poor. Social control, as Foucault argues ([1961]1989), was now possible through the growth of the new profession and a new medical discourse that was becoming firmly based in the hospital. The role of the asylum, especially in the Victorian era became a system of confinement for those society judged as being a social nuisance, an economic burden or a danger to others (Butler 1993).

Although control became an important factor in the asylum era, Shorter (1997) argues that the “rise of the asylum is the story of good intentions gone wrong” (1997:33). He acknowledges that there is a split among commentators in the interpretation of the asylum era and as to why it failed. On the one hand, some argue that the system failed because of the increase in mental illness in that era, while on the other, others argue that the failure occurred because people were being contained in asylums without being mentally ill but merely because they were misfits or outcasts. Therefore, there is a split demarcating neuroscience from psychosocial understanding. The neuroscientific side is linked with pathology; the psychosocial line views the social universe as being intolerant of deviance. Shorter sides with a more neuroscientific interpretation due to the changing patterns of psychiatric disease in the 19<sup>th</sup> Century. He also accepts that there are psychosocial reasons for the increase in patients; he says that, instead of this increase being associated with a need to control those deemed deviant, it was



because of the already existing population of mentally ill people that were originally housed in madhouses, or workhouses, or with family and being then moved into asylums. His main point is that “at the end of the story, the asylum fails. But this does not represent a failure of the biological paradigm as a model of diagnosing and treating patients. It represents the tragedy of individuals whose good therapeutic intentions were overpowered by events....The history of the asylum era is the story of how progressive and humane aspirations became relentlessly and repeatedly disappointed” (1997:33-4).

The historical interpretation of the asylum era, and the general increase in those diagnosed mentally ill throws up three distinct, but linked arguments. A Foucaudian approach which views the rise of the asylum as a means of controlling, not just the mentally ill, but those deemed part of the deviant paradigm of the times<sup>26</sup>. The second follows a more Marxist approach that links the growth of the asylum era to the growth of industrialisation and capitalism. Scull (1979) argues that there was a need for an able labour force. All those deemed non-able were medicalized. The third is in line with the argument Shorter offers: that the rise in mentally ill people was part of an increase in new illness as such as alcohol psychosis, and new perspectives of urban living.

Regardless of the differing historical interpretations on the socio-political reasons behind the apparent increase in mental illness and the growth of psychiatry as a discrete discipline within medicine, the nature of the treatment offered is significant. By the middle of the 18<sup>th</sup> Century there were calls for treatment to be

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<sup>26</sup> I discuss the influence of Foucault in more detail in Part 4 of this chapter.

based within a progressive scientific framework, with - and this is important - a moral approach to caring for the mentally ill. At the end of the 18<sup>th</sup> Century, William Tuke and Phillippe Pinel, while being hailed as the pioneers of scientific psychiatry, also promoted a humanistic side to practice. In England, Tuke started the Retreat in 1796 where the main ethos was that inmates were treated with kindness and not as animals (ibid). Carpenter (1980) argues that Tuke “sought to reproduce in the Retreat the intimacy of family relations, with the lunatic as a dependent child and himself as the authoritative patriarch; force was to be used as a last resort” (Carpenter, 1980:126). Physical restraint was replaced with self constraint through religious teaching. In France, Pinel had “international influence of *traitement moral*, rejecting medical therapies of blood-letting and caging in favour of moral suasion” (Samson 1995:58). The main aim of moral treatment was to help the patient to control themselves and their own lives. In 1847 Dr Connolly established the “no restraint system” at the Hanwell Hospital where the general idea was to have one attendant to every fifteen patients (Seager 1968). However, Nolan (1993) argues that such luxurious use of labour became unpopular because of the financial burden that it put on asylums. Regardless of criticisms of moral treatment (Doerner 1981), its influence on psychiatric care highlights a central theme in this thesis in relation to care and especially the role of nursing, where nursing and care is associated with a maternal disposition that works to encourage and empower the patient on a road of recovery.

### **The role of the attendants**

Associated with the need for the rest of the medical profession to see psychiatry as a worthy fellow, doctors and superintendents started to call for the attendants

to be better trained so that their role could also fit into this new and vibrant wing of medicine. This was first brought to the fore when the Medico – Psychological Association (MPA) was founded in 1841. The aim of psychiatry was now positioned so as to provide cure. ‘Caring’, which was predominately associated with the attendant or nurse, was placed on the periphery of the psychiatric process (Mitchell 1984). Therefore, the doctors of the asylums felt best equipped to teach and educate the attendants into this new system so that no one else could influence them and so that the attendants could suitably support the role of the doctors (Carpenter 1980). Alongside the notion of training, was the assumption that those directly looking after the patients, the attendants, had to be able to apply a moral ethos to the care that they offered. The asylum era therefore, mirrored the general social trend of its time, in which innovation and moral order were central. The Lunacy Act of 1845 insisted that local authorities had to provide provisions for psychiatric patients. It was felt that the state could show its humanity through the construction of such grand buildings. These buildings were usually built in the countryside or on the outskirts of the town. The construction of such buildings reinforced the argument that psychiatry be seen as a worthy part of medicine and medical science. The Lunacy Act of 1845 also based much of its demand for change on this scientific endeavour where it was felt that this new approach to dealing with the mentally ill would cure the individual and return them to the workforce. Therefore, the training of attendants was seen as a process of social reform (Barnard 1968).

Replacing the ‘keeper’ of the 18<sup>th</sup> and early 19<sup>th</sup> century who was usually the owner of the ‘madhouse’ or employed to run them by 1845 ‘attendant’ was the

preferred term. The attendant was there to 'attend' to the institution as well as the patients, which usually meant that they had to make sure that the asylum was clean, that the patients were controlled and orderly, and that there were adequate supplies of food. Ultimately they were servants to the superintendents. The general image of an attendant was of a man who had often spent time previously working as farm labourer or in other areas of the manual workforce, or who was an ex-soldier. In general, male attendants were seen as "solid" and "stout men" (Nolan and Chung 1996). Size and strength were commonly desired attributes. In 1885 the MPA produced *The Handbook for the Instruction of Attendants on the Insane*. The handbook directed attendants to impose discipline on patients by setting an example of industry, order, cleanliness and obedience. The principles laid down in the book were in direct line with the general hospital where routine, order and discipline "were seen as analogous to the principles of hygiene which governed the hospital" (Carpenter 1980:128). The new asylum would become a place of reform and treatment through its resemblance to the general hospital. The reality was that much of the training was based within scientific discourses and not nursing discourses. At the same time attendants were asked to learn while being underpaid, working long hours, feeling undervalued, and they saw that practitioners working in medicine and not nursing provided their training.

Women were also attendants, but by the end of the 19<sup>th</sup> Century were called 'nurses'. They were mainly young women, who would have otherwise gone into domestic service. The work was harder than serving the gentry, but had the attraction of full board and lodging. In general, by this time male attendants were viewed as unemployable in other professions (Abel-Smith 1977). It was common

that attendants would lodge in the asylum where they worked and usually would sleep adjacent to the wards. It was also common to employ ex - patients as members of staff, while it was also known for staff and patients to be buried side-by-side in the asylum cemeteries (Nolan and Chung 1996:38). Ironically, at the same time of this drive to train attendants, the pioneer of general nursing, Florence Nightingale, viewed mental health nursing as inferior to general nursing. Therefore, the role of the attendant seemed doomed, caught between two untenable positions, and would remain static and undervalued in the asylum.

Most asylums demanded long working hours with low pay. It was felt that the best type of attendant came from the same social class as the patients. Dr Connolly of the Hanwell Hospital in the mid 19<sup>th</sup> Century argued that attendants should come from the same class as those who are qualified to be upper servants. His desired attendant would ideally come from the 'respectable' and not 'rough' section of the working class (Carpenter 1980). In 1891 Burnett wrote that "persons with gentle up-bringing, as attendants...would never be induced to perform many of the duties of attendants in a pauper asylum, and they would be out of sympathy with the tastes of the patients" (Burnett 1891: 630). There was a general view that attendants should be from lower classes so that they could understand the everyday needs of the patients and could "devote themselves to the amusements and companionship of the inmates" (ibid). Burnett echoed the moral treatment viewpoint by suggesting that attendants "shall look upon the patients from the doctor's point of view, in some degree at any rate, and that he shall always regard himself as the true guardian and friend of each individual

patient committed to his care” (Burnett 1891:640). Attributes that a good attendant should have were:

A high moral character, a good education, strict temperance, kind and respectful manners, a cheerful and forbearing temper, with calmness under irritation, industry, zeal and watchfulness in the discharge of duty, and above all that sympathy which springs from the heart, are among the qualities which are desirable. (Tuke 1884 cited in Nolan 1993).

Nineteen years later, the image of the asylum attendant had changed little in regard to their desired attributes. In 1903, Merton noted that the key aspects to becoming a ‘first-class’ attendant were:

Good health, an equable temper, youth, power of observation of symptoms mental and bodily, intelligence, kindness of heart, unselfishness, great patience, a pleasant manner, tact, firmness and power of insistence, average strength, great staying power, coolness, force of character and an instinctive knowledge of human nature” (Merton 1903: 246).

Although the running of asylums was firmly based on order and cleanliness, it is apparent that the desired image of the attendants was based on their ability to

interact with the patients in as much of a humane way as possible. The idea of cultural similarity; between patient and attendant, was seen as central to this.

#### **Part 4 – From Anti-psychiatry to ‘Anti-psychiatry’<sup>27</sup>**

Part Three showed that what is pertinent, especially for this chapter and the thesis in general, is that writings on the asylum era have focused at the failings of the period. Such failings seemed tied to the birth of modern-day psychiatry, enthralled with becoming part of the new generation of medical discovery through science. Such optimism was often based on flimsy scientific knowledge, and led to crude medical testing on helpless individuals.

Accompanying the failure in asserting a science-based medical discipline, many writers also focused on the draconian image of care. The large Victorian buildings were often located on the edge of towns away from the ‘boundaries of normality’ and little attention was given to the individuals inside. Particularly, Pinel and Tuke’s influence on moral treatment has been condemned by Foucault (1989) as being based on the moral and social order of the ‘madman’. What is fundamental about many of these writings on the rise of psychiatry is that the ‘bleakness’ they portray and their analysis of the process of care have continued to pertain to every major step of psychiatry’s development as a medical discipline. However, Part Three also illustrates that the asylum era attempted to

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<sup>27</sup> The term ‘anti-psychiatry’ was coined by Miller (1986). He argues that psychiatry has always had critiques that one should talk about ‘anti-psychiatry’ in the plural, rather than ‘anti-psychiatry’ in the singular. Below I will use the term ‘anti-psychiatry’ to refer to the movement of sociologists and psychiatrists in the 1960’s.

develop and incorporate a moral ethos into how it perceived care. One could argue, the basis for modern day discourses of psychiatric care was born.

Part Four explores how 20<sup>th</sup> Century and recent 21<sup>st</sup> Century critiques of psychiatry have focused on the same issues pervious as writings on the asylum era and the rise of psychiatry. At the centre are the conflicting positions of the scientific and the more humanistic approaches to care. Moreover, I want to argue that such critiques of psychiatry actually become part of psychiatry's fabric by being incorporated into its training programmes for student and junior doctors and nurses, becoming integral to its own discourse; they are then assimilated into its system of training and become established as essential texts for student doctors, nurses, psychologists and social workers to read. Miller makes a key point:

Critiques of psychiatry are not wholly external to its functioning. They can be related to what we can term modernizations of the psychiatric apparatus, as well as to failed strategies for its reform...The critiques mounted against psychiatry, both from inside and outside, are a significant element in this process of modernization and transformation (Miller 1986:13).



Therefore, I argue that far from critiques being positioned ‘outside’ and holding an objective standpoint, they actually become manifested within the care process by adding new discourses to the already broad phenomenon of psychiatric care.

### **The Rise of the ‘Anti’**

In the first half of the twentieth century psychiatry was caught in a dilemma. On the one hand, psychiatrists could warehouse their patients in vast bins in the hope that they might recover spontaneously. On the other, they had psychoanalysis, a therapy suitable for the needs of wealthy people desiring self-insight, but not for real psychotic illness. Caught between these unappealing choices, psychiatrists sought alternatives.... these alternatives had an aura of desperateness about them....The asylums were filling, and psychiatry stood helpless in the face of disorders of the brain and mind” (Shorter, 1997:190).

Shorter shows that in the first half of the twentieth century, psychiatry was resembling similar desires to those it had at its birth (1997). Central to this was the need to become its own distinct discipline – identifiable as separate from the new and exciting process of the therapeutic relationship between psychoanalysts and the often wealthy paying patient. The scientific drive saw methods of biological treatment that were, and still are, seen as unsavoury or even barbaric. In 1930 the Mental Health Act renamed asylums ‘mental hospitals’, and lunatics were relabelled ‘persons of unsound mind’ and finally, where patients could

become patients on a voluntary basis (Rose 1986). This period saw the use of insulin coma therapy and by the mid-thirties, psycho-surgery was being used (Rose 1986). The most significant treatment used was Electro Convulsive Therapy (ECT). It was seen as effective by some and as morally and ethically unacceptable by others. This was largely because little was known about how it worked and also because of the distressing physical image of a patient having ECT administered to them, shaking violently on the treatment table. While Rose makes an important point by arguing that although the physical treatments of the 1930's and 1940's were often labelled as ineffective they enabled the psychiatrist to portray themselves as healers and not just as superintendents of the asylum. In the 1950's there was the discovery of psychoactive drugs which were seen to have positive effects on those patients suffering from schizophrenia and severe depression. The key feature of this discovery was that patients could now be treated in the community and away from the mental hospital. However, Rose goes on to argue that the "move away from the asylum has extended the range of social ills seen to be flowing from psychiatrists' disturbances and has, simultaneously, psychiatrized new populations" (Rose 1986:83). For Rose, therefore, the move from the draconian care of the asylums to care based on a more open and individual relationship did not, in effect, change things fundamentally. Both styles of care arose from the same demands of society, namely that we all conform to society's norm.

### *'Anti-psychiatry'*

The driving force behind much of the negative criticism that psychiatry experiences today began in the early 1960's when certain psychiatrists and

sociologists wrote about the role of psychiatry in a new and challenging way. A collection of these authors became known as the 'anti-psychiatry movement'. Four main individuals are associated with this group: the sociologists Erving Goffman and Thomas Scheff, and the psychiatrists Thomas Szasz and R.D Laing. The central principle of their critique of psychiatry was based on "an epistemological thesis, the assertion that the objects of psychiatric knowledge and technique – mental illness – either did not exist as an objective phenomenon or did not exist as an illness appropriate for medical attention" (Miller and Rose 1986:2). Therefore illness was not seen as medical but as a product of the social, political and legal framework of authority. The anti-psychiatry movement was then also situated within a larger socio-political climate in which academia was challenging authority and the state apparatus, including the medical establishment.

The anti-psychiatry movement also placed much of the critique of psychiatry around a negative image of psychiatry that was based on crude treatments such as ECT along with medication and institutionalisation as forms of social control. This was manifest through controlling deviance scientifically – thus legitimising its practices, whether, legal, psychological, physical or pharmacologically. The standpoint of the anti-psychiatry movement was also being supported in the more mainstream media. The most relevant example of this was Ben Kesey's book *"One Flew Over The Cuckoo's Nest"* (1961) which portrayed life in a large psychiatric institution in America where ECT were often administered in the 'Shock Shop' as a form of punishment or means of social alignment when individual patients attempted to express any form of agency that did not fit into

the desired social norms. The interest that was generated by media description and also by the critiques of psychiatry at this time reaffirmed the stance that mental illness was socially constructed and not biologically based. It was thought that the medical model could not make sense of psychological distress and that such as labels as schizophrenia were devised by the medical establishment, to give them scientific credence and to justify hard and fast diagnosis and treatment. Two significant quotes by one of the authors, Thomas Szasz, sums up the general disposition of the movement in his classic book *The Myth of Mental Illness* (1972 [1961]).

It is customary to define psychiatry as a medical speciality concerned with the study, diagnosis and treatment of mental illness. This is a worthless and misleading definition. Mental illness is a myth. Psychiatrists are not concerned with mental illnesses and their treatments. In actual practice they deal with personal, social, and ethical problems of living....we must recast and redefine the problem of 'mental illness' so that it may be encompassed in a morally explicit science of man (Szasz 1972:269).

Szasz's calling for an anthropological or sociological approach to understanding mental illness was a key feature of the anti-psychiatry authors. He was keen to incorporate a symbolic interactionist approach to his work because it threw light

on the meanings that are negotiated by various social actors involved in a drama or ritual (Pilgram and Rogers 1999). Mental illness was seen as a process of 'acting out' a game where the individual rebels against the expectations of society and the medical institution they are usually housed in. Laing explains in *The Divided Self* (1960) that being schizophrenic is 'playing mad' and making the doctor look stupid and inadequate. In a similar vein, Goffman (1967) argues that it is not being depressed or hallucinating or being socially withdrawn that constitutes symptoms of mental illness, but rather experiencing such behaviours in a social setting where other people's social norms become challenged. Therefore, 'impression management' and conformity to the socially accepted rituals of the everyday are key to not being labelled deviant and mentally ill.

In *Asylums* (1961) Goffman focuses on the everyday experience of the mentally ill patient in a large psychiatric institution and how such an environment, not the symptoms of the individual, moulds the patient into being mentally ill. Goffman called psychiatric hospitals 'total institutions' which are places of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round life. In society at large, sleep, play and work are three separate spheres of activity. In total institutions, however, these are carried out under the same roof and are tightly scheduled and controlled. There is also a strict division between patients and staff and both parties have negative stereotypes of each other. The aim of the mental hospital, according to Goffman, is to subordinate free expression by a 'process of mortification' where the individual is humiliated in different ways, such as being deprived of their

personal belongings and clothes, having to ask for cigarettes and at times being restrained. Then they enter into a phase where they reject their past self through 'confessionals' with staff and in ward rounds. The end result is that the patient finds it almost impossible to find any privacy and has very little sense of autonomy.

The anti-psychiatry movement embedded itself deeply in sociological theorising of the time. Such a focus emphasised mental illness as a social construction leaving any medical, or scientific reasoning redundant. As a means of offering an alternative approach to care, the anti-psychiatry movement, especially Laing, advocated therapeutic communities and family therapy as a positive move away from the institutional setting of the mental hospital. Here, one could argue that the likes of Laing were echoing the humanistic objectives of Pinel and Tuke (as discussed earlier).

#### *Anti 'anti-psychiatry'*

The attack on the institution of psychiatry by the 'anti-psychiatry' commentators influenced the way in which psychiatry conducted itself, especially in Britain and the USA. Szasz and Laing's work spread into mainstream public readership, while Goffman's work impacted greatly on academic thinking. However, it has also been argued groups like the anti-psychiatry movement and other commentators at that time, such as Foucault (who I will discuss later in this chapter) have had little impact in actually improving psychiatric care. While showing the inadequacy of the positivist framework for the understanding of mental illness, they have "made it that little bit harder for a powerful campaign

of reform in the mental health services to get off the ground” (Sedgwick, 1982:41) by attempting to minimize the concept of mental illness by portraying it as an invention or historical account. Sedgwick also argues that we “have not got here a colony of ‘subversives’, or even the theoretical base for an ‘anti-psychiatry’ which would be able to agree on some working alternatives – conceptual or tactical – to the current dominant framework of psychiatric treatment” (1982:22). Clare (1980) argues that the positive public reaction towards the anti-psychiatry movement is largely due to psychiatry and its ‘poorly’ developed state. In turn, the public become “ready prey...for any spokesman [of anti-psychiatry] who peddles a simple answer to the difficult philosophical and practical questions facing psychiatry” (1980:3). Clare goes on to claim that much of the movement is based on “semantic gymnastics” (ibid) where the complex issues of disease are simplified in a deceptive fashion for the public to consume.

While Clare focuses largely on the lack of focus on the complex nature of psychiatry, others have criticised the movement for being too biased and sociological in its focus. Weinstein (1982) argues that much of the qualitative research frames the patients as powerless and open to humiliation and negative institutionalisation, while hospital staff are portrayed as insensitive and unconcerned about patient recovery. Linn (1968) makes the point that much of the observational data is one-sided which creates a homogeneous conception of the patient’s world. Like Weinstein, Linn argues that experiences of the patients in hospitals are often written about as being negative and embittered. Gove (1982) focuses on how the disciplines of psychiatry and sociology have differing

ways of understanding human behaviour. Psychiatry implies that human behaviour can have irrational components where mental illness is a reflection of this state. Sociology, he argues, tends not to focus on irrationality but instead positions the individual or organisation as acting in their own best interests. Therefore, sociology is more functionalist in its approach. The conflict between the two disciplines occurs, Gove argues, because the sociological approach sees the patient “as almost always either acting consciously in the best interests (the behaviour is manifestly functionalist) or sub-consciously in their best interests (their behaviour is latently functional)” (1982:292). The labelling of someone mentally ill is actually attempting to control them from acting outside the dominant social norms created by the ‘powerful others’ (ibid). Miller (1986) argues that in modern day psychiatry the position of the anti-psychiatry movement is now on the ‘waste side’ and is ‘shunted’ into sociological literature. This, he suggests, is because they only focused on two areas of psychiatric treatment – institutional care and medicalization. In contrast the “dominant model of contemporary psychiatry is not the isolated and deranged individual, but the mildly distressed individual in the family and in the community” (Miller 1986:29). Because of this lack of in-depth focus on psychiatry, theories such as labelling theory, have been judged as being ‘invalid’ as a general theory of mental illness (Gove 1982).

### **The New ‘anti’s’ - Post Structuralists and Psychiatristy**

At the same time Goffman was writing *Asylums* in 1961, Foucault wrote *Madness and Civilization* ( [first published in English in the UK in 1967] 1989), where he argued that psychiatry was essentially concerned with moral regulation



of the body and not with medical cure or economic factors. Foucault traces the rise of modern day psychiatry by providing a 'pre-history' of the discipline that ends with the emergence of psychiatry with the introduction of 'moral treatment' (Foucault 1989). He explains that their legendary influence would transmit mythical values that 19<sup>th</sup> Century psychiatry would accept. However, Foucault argues that while Tuke's York Retreat was seen as an act of liberation, it "would serve as an instrument of segregation; a moral and religious segregation which sought to reconstruct around madness a milieu as much as possible like the Community of Quakers" (1989:231). Religion became the core of reason, by being the 'concrete form' of what is not mad. The mad person therefore was controlled by being placed in a 'moral element' where the madman "must feel morally responsible for everything within him that may disturb morality and society and must hold no one but himself responsible for the punishment he receives" (1989: 234). For Foucault, the need to control madness was more important than curing it (1989). In this sense, the madman became an object of punishment within the asylums by imprisoning madness in a moral world.

The 'Deviancy theorists' of the late 1960's and 1970's viewed Foucault as part of their movement. 'Deviancy' was one "of sociology's most ambitious attempts to comment not only on the existence of psychiatry as a sociological fact, but on the inner validity of psychiatric thought and activity" (Gordon 1986:269). Instead Foucault asks the question how "did our culture come to give mental illness the meaning of deviancy, and to the patient a status that excludes him" (Foucault 1976:63)? Unlike the 'anti-psychiatry' phenomenon, Foucault was less concerned with eradicating the diagnostic process of psychiatry than with

explaining that each stage of civilization has held its own concepts of 'madness' which in turn reflect the general social climate of its time. In this way, the diagnostic process and scientific and psychological trends in treatment, are part of social history. The key for Foucault was to work out how and why certain discourses in history came into existence. This, he argued was essentially a study of power. Power, in this light, is used in two ways. The first is so that a discourse can exist and the second is through a discourse, which controls what people think and know and, therefore, how they exist. For Foucault, the rise of psychiatry was not just about the management of the body through physical treatments and containment but also through the influence of therapeutic interventions on the mind. For example, instead of interpreting moral treatment as a positive move away from the draconian treatments of the asylums, Foucault, as I have already stated, argued that it was just as controlling as the hard asylum system because it treated patients as children and demanded moral conformity. Physical restraint was replaced with self restraint through religious reason (Foucault 1989). The middle of the 18<sup>th</sup> Century saw the rise in a new form of power that dismantled moral treatment where the physician now focused his knowledge in the norms of positivism where psychiatry would now become focused on the origin of madness and its organic causes (1989). As positivism became more influential the power of the doctor becomes more focused on the fact that they are believed to possess medical power rather than their power being "borrowed from order, morality, and the family" (1989:261). Psychiatric practice, for Foucault, "is a certain moral tactic contemporary with the end of the eighteenth century, preserved in the rites of asylum life, and overlaid by the myths of positivism" (1989:262).

Foucault's work has influenced a large body of sociological theory. Mainly framed within post structuralism, sociologists such as Rose and Miller have closely used and developed a Foucaudian approach to critiquing psychiatry in modern society. Rose (1999) develops Foucault's notion of Western man being a 'confessional animal' defined by the moral ethos of care and being cared for, where the "vocabularies of the therapeutic are increasingly deployed in everyday practice addressed in human problems" (1999:218). We are subtly conditioned to enter into this confessional relationship within the therapeutic process. This does not mean necessarily entering into a traditional therapeutic relationship because the concept of the 'confession' is everywhere and embedded in mass media for all to consume. It functions as a process of 'self-regulation' where 'we', the consumers, heal 'ourselves' rather than being cured by someone else. Therefore, individuals are urged to "become ethical beings, beings who define and regulate themselves according to a moral code, established precepts for conducting and judging their lives, and reject or accept, certain moral goals for themselves" (Rose, 1999:244-245).

Rose uses the notion of the confession as a means of analysing how the concept of mental health has spread to all domains of social life. Principally, this develops a process of self-regulation that moulds the individual into a moral subject. Whether or not this is a fair interpretation, it does show, firstly, that mental health is a phenomenon that is present within many areas of society and not just present within a medical domain and secondly, that the notion of self-

regulation becomes another discourse of care to add to the already vast thesaurus of the meanings of 'care'.

### **Embedding the 'Anti' into Psychiatry**

The key point in this chapter has been to point out that 'care' has many different discourses that can either appear to overlap with each other, or be positioned at opposing ends of the spectrum. I have tried to show that the concept of 'care' needs to be located within a larger framework where the medical, political, economic and sociological spheres all take part in defining its existence and function. What I have argued so far is that regardless of differing notions, there seems to be a core assumption that 'we' all know what it 'means' and what it is 'supposed' to do. If it does not live up to our expectations then a new discourse of care is created to replace the previous one. Care-in-the-community replacing asylum care is a good example.

Part Four mapped how psychiatry has been closely followed by a critique that has come from within its own discipline, from psychiatrists and psychologists, and from outside, mainly from sociological, philosophical and historical interpretations. The important point is that most critiques seem eventually to become part of psychiatry's make-up. Foucault, Szasz and Goffman's work are now seen as 'text books' for students of psychiatry and other mental health disciplines. Thus, by being regarded as educational tools, these works have become part of the process that they initially were opposing. The 'Anti' has consequently been transformed and absorbed into the discourse of care that becomes an internal process of surveillance where nurses watch doctors and

vice-versa, so to check each others' behaviour that might indicate a leaning towards institutionalisation, disempowerment and containment of the patient. All three areas are often presented at any mental health conference as the three main examples of bad practice.

On a managerial level, care is transformed into a bureaucratic process of auditing all services to regulate 'good practice' through the NHS's Clinical Governance. On the Department of Health's web site The Chief Medical Officer, Sir Liam Donaldson defines clinical governance as:

A system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

On the same web site, it states that:

Above all, though, clinical governance is about the culture of NHS organisations. A culture where openness and participation are encouraged, where education and research are properly valued, where people learn from failures and blame is the exception rather than the rule,

and where good practice and new approaches are freely shared and willingly received<sup>28</sup>.

Clinical governance is seen as probably the main driving force in providing patient-centred approaches to health care and creating the government's desired idea of the 'expert patient' as discussed earlier in Part One of this chapter. As the Department of Health website explains, it "involves putting in place the information, methods and systems to ensure good quality. It means identifying problems early, analysing and correcting them. It entails high calibre leadership from the chief executive, medical director and nursing director at the top of the organisation to the clinicians in the front line of delivering care to patients. Strong effective teams almost always mean good care, weak, dysfunctional teams are bad news for quality"<sup>29</sup>. Therefore management, and even the Information Technology (IT) departments within hospitals and Trusts, are now seen as part of the all-embracing care process.

Clinical governance, it could be argued, is arrived at through a holistic process of surveillance where all the different agents within the clinical governance process are being monitored, and thus controlled, through a range of audits and policies in order to ensure 'good practice'. 'Good practice' is then publicly put on show

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<sup>28</sup> (<http://www.doh.gov.uk/clinicalgovernance/index.htm>)

<sup>29</sup> (<http://www.doh.gov.uk/cmo/progress/clingov/index.htm>)

for other agents and the public to see. Bad practice also has the same public show, but it is used to shame trusts and departments.<sup>30</sup>

### *Racism and psychiatry*

Although 'good clinical practice' runs through the whole of the NHS, it plays an essential role in psychiatry because it is seen as the main instrument to ensure that service users are receiving the right type of care in the midst of continuous criticism of the psychiatric system.

One of the most important criticisms of psychiatry in the last fifteen years is that it has failed Black communities in the UK. These attacks come from outside and from within the discipline. Sashi Sashidharan, Professor of Psychiatry at Warwick University, has stated "there is no single aspect of contemporary psychiatric care within which Black or South Asian people are not disadvantaged" (2001:244). Research has also shown that overall, Black people are over-represented in compulsory admissions to the services and those aspects of services where contact is coercive. Hospitalised Black patients are two to three times more likely to be involuntary patients under the Mental Health Act (Littlewood 1992, Fernando and Ndegwa 1998). It has also been argued that this excessive detention of Black service users was independent of diagnosis (Littlewood and Lipsedge 1989; Davis *et al.* 1996). While Littlewood and Cross's (1980) study showed that black outpatients compared to white outpatients received more anti-psychotic medication, McKenzie, who is a clinical

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<sup>30</sup> The main example of this is the Government's rating scheme (Commission for Health Improvement, or CHI) that awards the top Trusts 3 Stars for prompting 'good practice' by meeting targets that have been set out by CHI.

lecturer in psychiatry and a psychiatrist, challenges discrimination within the NHS:

The Metropolitan police has been accused of institutional racism because its culture produced discriminatory practice which it had no effective strategy to eradicate. If we continue not to organise to stamp out discrimination the NHS will rightly be accused of the same. But that is not the reason we should be developing services. It is morally indefensible for a system to witness disparities in health between groups and do little or nothing about them (1999:617).

While there are also claims within psychiatry that there could be links to racism being a cause of mental illness (Chakraborty and McKenzie 2002).

These voices have developed – and currently are developing from within psychiatry. The Postpsychiatry movement founded by Bracken and Thomas in Bradford argues that psychiatry has its foundation on a ‘context based approach’ where the “social, political, and cultural realities, should be central to our understanding of madness’ (Bracken and Thomas 2001:726). They go on to argue that science, as seen in clinical effectiveness and evidence based practice, should not be the main driving force behind clinical practice because it plays down the importance of human and social values in research and practice. “All medical practice involves some negotiation about assumptions and values. However, because psychiatry is primarily concerned with beliefs, moods,



relationships, and behaviours this negotiation actually constitutes the bulk of its clinical endeavours” (ibid). Finally, they state that Postpsychiatry “distances itself from the therapeutic implications of antipsychiatry. It does not seek to replace the medical techniques of psychiatry with new therapies of new paths towards ‘liberation’. It is not a set of fixed ideas and beliefs, more a set of signposts....” (2001:727).

This last quote is important because it shows that the criticism of psychiatry is firmly based within psychiatry itself. Instead of being ‘anti’ psychiatry they are ‘anti’ the dangerous process whereby psychiatry sees itself as primarily fixed in a positivist discourse which determines how patients are diagnosed and treated, and which sees the psychiatrist as ‘expert’ which then legitimises their custodial role. What is fundamental is that they do not reject ‘psychiatry’ as a medical discipline. Unlike the anti-psychiatry movement that rejected ‘madness’ as a medical and scientific concept, these criticisms of psychiatry of the late 20<sup>th</sup> Century and the very early part of the 21<sup>st</sup> Century in British psychiatry advocate a ‘new moral treatment’ that incorporates an holistic approach to understanding the individual service-user by marrying the scientific with the social and cultural in order to provide a humanistic approach towards ‘care’. Of course, there are parallels with Goffman, for example, in relation to issues of control and the social and political power of the psychiatric system, but one could also argue that the ‘anti-psychiatry movement’ of the 1960’s and 1970’s, although apparently radical was, in fact, a continuation of the 19<sup>th</sup> Century concept of ‘moral treatment’ or ‘moral management’ (Walk 1961). Critiquing psychiatry, from within or from outside its institution, has been part of the development of modern

psychiatry from its modern birth from the late 18<sup>th</sup> Century to present day. It is the 'critique' and its differing discourse of care that provides a constant reminder to the practice of psychiatry where 'the moral' remains present in the care process. It is the link or bridge between the scientifically defined medical model with its apparent lack of agreement and diagnosis and the custodial role that results from this scientific expertise.

### **Conclusion**

This chapter has argued that the concept of care is inevitably problematic because it has no clear meaning. Instead, 'care' is based on different discourses that either complement or oppose each other. I have shown that there are many different areas within social life that claim to be, or to give 'care'. Furthermore, as I have shown in Part Two and Three, criticisms of psychiatric care frequently enmeshed within the training and practice of psychiatry itself. Central to any discourse of this kind is the need for a moral justification of how it is implemented or why it becomes needed. Political and economic decisions on health are masked by moral justifications about improving 'care', while critiques that emphasise control and subordination within psychiatric care highlight the lack of moral focus. More crucially, however, the fact that the criticisms of psychiatry become part of the psychiatric discourse is a vital aspect of the development and growth of the styles of psychiatric care in its broadest sense.

Throughout this thesis I will refer to 'care' as being based in moral discourses. This chapter has discussed 'care' from a broad point of view and in quite general terms. However, in the following chapters, I will mainly focus on how differing discourses of 'care' are perceived and negotiated more specifically on an everyday basis in a psychiatric ward. The next chapter follows on from this, by describing, ethnographically, the power dynamics between qualified nurses, junior doctors and the consultants on College Ward. It will show how ideas of professionalism and the control of specialist knowledge are located within the general discourse of 'care'. As mentioned in the Introduction of this thesis, the nursing assistant (NA) will not be introduced until Chapter Five. This is largely due to the fact that the role of the nursing assistant within the official discourses of 'care' is both distant and complex. Chapter Five onwards, will explore in detail why the position of the NA is not fully integrated into the organisational structure, and how they are perceived as a threat to the official discourses of 'care'.

#### **IV. Caring for Care: Social Space, Hierarchy and The Office Door**

The weekend on College Ward is usually less busy than weekdays. There are no meetings relating to patient care. Some patients are also on leave for this time, returning on Monday morning. Staff and patients spend time watching television together, playing pool and going on walks into the centre of London, or if the weather is fine, arranging picnics in a local park.

This weekend was like most others. The duty doctor (SHO) was sitting in the nursing office reading the sports pages in a newspaper and joking with staff about football. He was wearing an open neck shirt and a pair of jeans (the usual dress for a SHO working through the weekend). There was a relaxed atmosphere between the staff nurses and the SHO.

The male nurse-in-charge had also been taking part in the light hearted banter. However at one point he asked the SHO if he could talk to him about a patient whose behaviour had become erratic over the weekend. He showed the SHO the medication card and indicated that the nurse wanted an increase in the PRN medication for the patient. The SHO appeared surprised that the PRN medication was already at a fairly high dose and explained to the nurse that he didn't feel he could increase it. The nurse began attempting to convince the SHO that it was necessary to increase the medication and that it would be reviewed following day, Monday, at the ward round. The SHO shows little sign of listening to the nurse while writing in the patient's medication card. At this point the nurse caught the eye of another nurse and winked at them, indicating that he was trying to convince the SHO to increase the medication. The SHO then looked up and explained to the nurse that the medication should never have been prescribed at that level in the first place. Once the nurse realised that the SHO was not going to change his mind, he asked if the SHO himself would go and tell the patient that there could be no change in medication. The SHO said nothing.

The conversation returned to light-hearted chat about football. By the time the SHO left the ward to respond to his pager, he had not been to tell the patient. The nurse was angry and explained to other nurses in the nursing office that he felt that the SHO had deliberately not told the patient so as to leave the 'dirty work' up to him.

This interaction provides insight into the nature of the qualified nurse/junior doctor relationship. Although they both seem comfortable relaxing together on a weekend shift, they both have different views of their role in relation to the care of patients, authority in decision-making and status in relation to each other.

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## **Introduction**

In the previous chapter I argued that the concept of care is generally based within a moral discourse that implies that those who care must have a desire, or vocational calling to do so. This I call the official discourse of care. I argued that 'care' is not just something that nurses or doctors 'do' but is also constructed as an ideology within different social and health domains, such as medical, nursing, political, economic and the media. These dimensions have further developed to the extent that the patient has been framed as a consumer and 'expert', working alongside the doctor and nurse.

This chapter explores some of these main arguments and themes by introducing ethnographic examples from my research. I will illustrate how nurses and doctors structure, interpret and carry out the official discourse of care in a day-to-day

acute ward environment<sup>31</sup>. I argue that by examining the way in which they use and conceptualise the physical space of the ward offers insight into the variations on how each section of qualified staff – nurses, SHO's, and the consultant - view their role in relation to each other and in relation to administering mental health care in general.

I will use Goffman's (1959) concept of 'front-stage' and 'back-stage' to understand the interactions between the various sections of the qualified staff. His metaphor of the 'theatrical performance' provides a helpful framework in which to analyse the stark distinction between nurses and SHOs and the management of conflict that arises between them. Goffman argues that in social situations individuals have to project a self that has a 'positive social value'. This is done by acting out a performance that aims to portray a desired image to an audience. The performance represents the individual's 'front' which works as "the expressive equipments of a standard kind intentionally or unwittingly employed by the individual during their performance" (Goffman, 1959:32). The 'front' implies that the performance is acted out in an appropriate setting which in the case of College Ward is the nursing office and the ward round.

This chapter will analyse three distinct 'fronts' of official care: the first is formal care which relates to nurses and SHOs; the second is nurses' informal care which is performed solely by the qualified nursing staff and thirdly, what I term supra-formal care which is manifested twice a week in the ward round where the

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<sup>31</sup> It is important to keep in mind that there are variations as to how care is administered on psychiatric wards. In my case all my general points and arguments are formulated from ethnographic data gathered on an acute setting and not from other types of psychiatric wards/environments.

presence of the consultant suppresses any conflict existing between nurses and SHOs. The examination of these interactions as seen in terms of 'front-stage' and 'back-stage' provides a clearer understanding of how official care is enacted.

Part One describes formal and nurses' informal care by illustrating how the SHOs and nurses perform and negotiate their roles within these different types of care. The formal and nurses' informal represent two differing fronts that require an understanding of their rules and codes. Bourdieu's (1977) and Moore's (1986) approaches of the way in which practice and interactions generate symbolic meanings within different social spaces will provide helpful theoretical frames to elaborate on the understanding of formal care and nurses' informal care. Part Two uses an ethnographic example that brings to light how the use of the physical space of the nursing office on the ward specifically represents different approaches to care. The ethnography illustrates how the nurses' and SHOs' professional etiquette often appear to be in opposition to each other, which can result in disagreements and conflict.

Part Three introduces the third area of official ward based care: supra-formal care and the role of the consultant by providing an ethnographic description of a ward round as an 'ideal-type'. Part Three analyses the ward round by using ideas of ritual to show that the subtle process of creating and maintaining hierarchical order amongst the various sections of the qualified staff through suppressing conflict. I argue that exploring how the body is used within such settings provides one with a more in-depth understanding of hierarchy, power and

discourse. Part Four describes the situation after the ward round and how the nurses attempt to reclaim a sense of authority on the ward.

It is important to explain here that there is no mention of nursing assistants (NAs) in this chapter. I have decided that it will focus solely on the qualified sections of the ward staff or *team* and how they formalise approaches to care on the ward. As described in the previous chapter, it is this 'professional' remit that is promoted as the essence of good practice of ward-based care. This image excludes the often problematic and contradictory position of the NA. Chapters Five, Six and Seven will discuss the role of the NA and show how their views and ethos fundamentally contradict the official approach.

### **Part 1 – Formal and Informal Care**

It could be said that the staff on College Ward carry out the bureaucratic and legal procedures so that the care process is efficient, co-ordinated and professional. However, this is an over-simplification of the institutional model of care; it is problematic because it assumes that each section of the ward staff is dove-tailed into their rightful positions, leaving no room for contradiction or conflict. Looking at the daily interactions of staff with each other and with patients in the physical space of the ward would provide a better understanding of how institutional and official care is implemented by the staff through looking at their daily interactions with each other and with patients in the physical space of the ward. Codes and rules guide interactions of this nature, which can be



subtle or more official in appearance; yet they can also create professional conflict. This can occur between patient and nurse/doctor, or between nurse and SHO. In this chapter I will focus on the conflict between nurses and SHOs. Often such conflict is situated within struggles of control over how patient care is administered. The desire of the nurses, on the one hand, to claim control of *their* ward through specific forms of care which can only be associated with nursing and, on the other hand, the SHOs' rejection of consuming or adopting any model of nursing care or inability to do so, are the fundamental reasons for such everyday conflict. As discussed in the previous chapter, nursing approaches to care have been associated with the representation of the ward as a domestic and private space where the interactions between patients and nurses create a "family-like" environment (Savage 1997, Wicks 1998). Nurses feel that their control of this space is threatened by what they often perceive as the clinically ridged approach of the SHOs when on the ward. A commonly held perception by the nurses is that doctors are unable to adapt to the environment created by the nursing team while still attempting to claim authority on the ward.

Conflict between nurses and the SHOs<sup>32</sup> occurs when each group strives to claim a sense of authority on the ward by often presenting conflicting 'fronts' that challenge each other's practice of care, such as when the SHO attempts to implement their rules of interaction with patients over that of the nurses<sup>33</sup>. This often happens when one group's use of ward space, like the nursing office,

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<sup>32</sup> I am only focusing on conflict between nurses and SHOs here. Later in this chapter I will illustrate the role of the consultant on the ward and how conflict between nurses and SHOs becomes suppressed.

<sup>33</sup> Sinclair (1997) suggests that conflict between housemen and nurses is rare due to the reliance that housemen have on nurses. Conflict is more common between nurses and SHOs when medical and nursing discourses clash.

conflicts with the other group's policy on how interactions with patients should be conducted in that particular space. Different areas of the ward can, at times, be conceptualised through different rules of interaction and values towards care.

### **Differing approaches to care in the ward**

As mentioned in the introduction, there are three types of official ward-based care. The focus here is on the first two of these that make up the everyday structure of care. The third, as I will discuss in Part Three only occurs twice a week in the ward round.

#### *Nurses' and SHOs' Formal Care*

Formal care comprises all the daily official medical and nursing procedures that are carried out. These include clinical tasks, attending meetings such as ward rounds and handover. Meetings take place in rooms on the ward where the space reflects the official nature; this could be in the nursing office or an allocated room. Interaction within this space requires nurses and SHOs to portray the right bureaucratic image of *being* a nurse or doctor. Therefore, the rules and codes of interaction appear to be neatly positioned within the official framework of the hospital. Shared formal care can be conceptualised as providing a necessary meeting point between the nursing model and doctor's model of care. This is based within the traditional hierarchy whereby the nurse provides information to the SHO so as to enable them to make a decision. Nurses however would argue that they should be on an equal footing with the SHOs in the decision-making process

Formal care between nurses and SHOs is about planning and implementing patient care. This involves discussing care plans and administering medication and other clinical procedures that have been discussed with the consultant in the ward round. The patient - nurse/SHO space becomes formalised with bureaucratic rules of interaction when formal care is being instigated. When nurses interact with patients on this formal level, the space symbolically reflects the formal meaning of the interaction. A good example of this is at medication times<sup>34</sup> when patients line up outside the medication room waiting for their daily medication to be handed to them by two staff nurses. The medication room door is designed like a stable door where the top half opens and the lower half is locked. This safeguards the nurse against the potential of a patient becoming threatening if refusing their medication or of a patient attempting to access medication themselves. Procedures like this illustrate how the type of interaction structures the space in such a way as to conform to the meaning of the interaction. The important point is that the rules of interaction within this space are rarely challenged and all the actors usually know where the lines of classification between patient and nurse or doctor are drawn.

The role of the SHO is different to the nursing approach when engaging with patients. The SHO only comes to the ward in an official capacity when they have to 'give a medical'<sup>35</sup>, interview a new patient, 'write up' a patient for medication, attend ward rounds or other meetings on the ward, and respond to urgent requests from the nursing staff. Patients can not normally request directly to see a doctor.

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<sup>34</sup> Other psychiatric hospitals have different systems of administering medication such as a medication trolley that moves from room-to-room

<sup>35</sup> 'Giving a medical' describes the performing of a physical examination, usually by the SHO, on all new admissions.

SHOs can only allocate a certain amount of time for each task or request and are usually reluctant to deviate from their pattern. Whenever nursing staff pressure them to see certain patients or carry out a specific request outside of the routine, they will usually stress that they need to attend another ward or were late for a meeting. Time is therefore an important factor in how formal care functions. It demands the ordering of specify ward spaces at certain parts of the day.

Handover and ward round fit into this model, as does medication time. At the weekends there maybe more informal visits to the ward by the SHOs (as described in the vignette at the beginning of this chapter). These informal visits are more about 'killing time' than fulfilling formal tasks.

#### *Nurses' informal care*

The second area of care I want to categorise is informal care. This is not necessarily in direct opposition to the formal; however it relies less on the uniformed organisation of time and space and more on the nurses' ability to work accordingly to the unpredictable nature of the ward, and taking on the more varied social and psychological effects that the ward can have on individual patients. Hansen (1997) refers to this as a discourse of caring in which it has as its reference "the patient's individual body, his or her feelings and illness experiences, and the representational uses of the body as a natural symbol in conceptualising nature, society and culture" (1997:100). Whereas formal care demands that nurses interact with patients and members of the clinical team in a learnt, official and formalised way, informal care functions only between nurses and patients, often on a spontaneous level at different times throughout a shift. Informal care necessarily blurs the boundaries in the patient/clinician encounter

through interacting with patients on a social, 'everyday' level. The divisions become less formal and the hierarchy less overt, leading to the nurse and patient being able to expose more of their back stage to each other. This could happen through having cups of tea or coffee together on the ward outside official designated times, watching TV or playing pool, eating with patients at meal times and having informal chats with patients in their rooms. There are times when a qualified nurse would be carrying out a task that is part of formal care within an informal setting. For example, having a one-to-one meeting with their allocated patient away from the hospital and clinical environment, in a café or on a walk. The work that the nurses carry out in this space is no less professional than their work in the formal space, but it demands a subtlety only gained by them having an in-depth knowledge of the patients and this fundamentally comes down to their time spent on the ward.

The SHO never enters into this informal space, remaining fixed in the formal while interacting with nurses and patients on the ward<sup>36</sup>. Furthermore, they are either unaware of or unable to access the rules and codes that the nurses use in the nurses' informal space. It could be that their inability is situated within their own understanding of their role as a doctor that they have learnt through training and socialisation. They become fixed in their approach to care, which determines how they try to inhabit the space. They only move out of this space when entering into a supra-formal space of the ward round<sup>37</sup>, thus moving even further away from the informal. Informal care is therefore situated only within a nursing

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<sup>36</sup> I must again stress here that I am only describing ward based care. I am not trying to imply that SHO's remain static while away from the ward.

domain. It provides nurses with the ability to understand and work with the challenging ward environment and patients.

### **The use of space in nurse and SHO performance**

The different performances that are acted out determine how time and space are used by the nurses and SHOs. To develop this important point it would be helpful to explore the concept of space anthropologically. Bourdieu (1977) argues that the socialisation of space can only come about through practice. Social space is formed through the action and interactions of the actors resulting in it reflecting a group's 'ways-of-doing'. His analysis of the Kabyle house uses binary oppositions that work as metaphors to create meaning. He argues that the symbolic meaning in these oppositions does not exist independently within the structure but become active by the actions of the actors. The ethnographic example in Part Two will highlight how the different symbolic meanings of the nursing office only come into play when the relevant social actors perform their different roles. Following Bourdieu, Moore (1986) argues that the organisation of space should not be seen as a direct reflection of cultural codes and meanings, but instead as a context that is developed through practice and interaction. The spatial order is therefore connected to the practical historical interpretations placed on it by the interacting actors. Moore (1986), in pursuing the idea of space, uses Geertz's concept of 'cultural text' as an analytical framework that emphasises meaning while also looking at notions of social strategy and strategic interpretation. Arguing against a structural approach to space that attempts to reduce everything to its core structure, Moore explains that the "irreducibility of

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<sup>37</sup> It must be stated that SHOs do at times speak to patients in their rooms, but only if there is a

text applies to all types of texts – a literary text is not reducible to its sentences (meaning of), a spatial text cannot be brought down to the structure of its material parts and understood as a mere conglomeration of events” (1986:86). Text can be seen as a product of ideology of the lived conditions of social reality. In this way the use of space text does not merely reflect or reproduce ideology, but actually transforms it into a particular and irreducible representation, so becoming an “instrument of knowledge” and also a political tool. Moore interprets space as a system of classification that generates meaning through the use of metaphor. She explains that “metaphor is conventionally understood as rhetorical and expansive. It is held to locate itself in the gap between what is said and what is meant. It proceeds from the literal to the figurative, and in doing so creates meaning” (1986:76).

Bourdieu and Moore’s analysis of the ways in which meaning is generated in social spaces has a relevant bearing on my interpretation of the ward space. My ethnographic data in this chapter illustrates how the ward space signifies different meanings at different times in relation to the performances being enacted. Ward space can be interpreted as a social space with an array of symbolic meanings and metaphors.

In Part One I have described how time and space can be used to understand the way in which the ward space encapsulates two different types of care. I have shown how these forms of care have defined rules and values associated with them and how there is a certain amount of crossover between the nurses’ and

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need to follow a formal procedure like carrying out a medical check on the patient and especially

SHOs' models. I mentioned that there is often room for conflict and tension between these two groups; in the following section I intend to describe how the two models can come into conflict. As mentioned earlier, I will discuss the third area of care, supra-formal care in Part Three.

## **Part 2 – Performance, Conflict and the Office Door**

In the previous chapter I outlined certain debates in nursing which mainly focused on the roles that nurses have and aspire to. Much of the recent literature argues for a more professional approach, breaking away from the traditional image of the 'Florence Nightingale' nurse whose *raison d'être* is based on a vocational calling, and moving towards professionalization with the emphasis on the nurse's unique ability to understand patient needs (i.e. informal care).

Sociological and anthropological literature (Wicks 1998) examines the subtle nature of the relationships that nurses forge with the patients and how many of these relationships are positioned within a symbolic 'domestic' environment in which the nurse takes on a maternal or parental role. The patient becomes the 'needy' child. The use of the body, and tone of voice all add to this process (Hansen 1997). This type of ward environment provides a sense of empowerment for the nurses which is largely based on the fact that the patients apparently trust the nurses more than they do the doctors. I have some difficulty with this domestic image of nursing care because it frames the nurse in a vocational, gendered space in which the fixed role they have is similar to a housewife or mother. I wish to argue that the nurse is in a privileged position because they

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if the patient is new to the ward and scared of its environment.



have the ability to oscillate between both styles – the formal and informal. This allows the nurse to change and re-structure their interactions with patients. For example, a nurse would be in a formal space when handing out medication to a patient and then, later in the shift, interact in the informal space, with the same patient, while playing pool with them.

The fact that nurses have the ability to change from one style of care to the other, allows them to read and understand the ward on different levels. But this flexibility means that their position becomes problematic when interacting with SHOs on the ward. Often it is the SHO who cannot understand the nursing informal codes of interaction resulting in them demanding that the interaction falls under the formal codes and rules of care. Conflict occurs when nurses, at certain times, expect the SHOs to interact with them or a patient in a different way. The ethnographic example below illustrates how and why this conflict arises.

### **The Nurse, the Patient, the SHO and the Nursing Office Door**

Generally the office door was kept open by means of a wooden block and patients would come and sit down and chat with the nurses in the office. If an SHO was also present in the office patients would be tempted to approach the doctor to ask questions concerning discharge or medication but would be told that they would be seen later in the day to discuss the issues. On this particular occasion, the nurse-in-charge was sitting in the nursing office writing a report. An SHO was also sitting in the nursing office writing in a patient's notes. The nurse and doctor were writing their notes when a patient approached the door and

asked the nurse if she could sit in the office because she was bored and lonely.

The nurse replied by inviting the patient to take a seat.

**Nurse:** Sure, lovey, come in.

**Patient:** Thanks...hello doctor.

**Doctor:** (*frustrated tone*) Hi.....look, do you mind coming back later I am busy writing these notes..

**Patient:** But Amanda (*the Nurse*) said I could come in...

**Nurse:** I know... why don't you pop back in a few minutes and I will make us both a cup of coffee.

So the patient leaves the office

**Doctor:** (*frustrated tone*) *Why is the door always left open? How can anything be done that is confidential here if patients are always coming in?*

**Nurse:** *Well it is a nursing decision to keep the door open so that the patients don't feel excluded and if there is something that is confidential we ask...nicely (sarcastic tone)... for the patient to leave the office.*

**Doctor:** *Right*

The SHO puts the notes down and pen in her pocket and begins to leave the office without saying goodbye.

**Nurse:** *Sorry, could you please put the notes away in the file after you use them...thanks (sarcastic tone).*

The SHO does this and leaves without saying anything. The nurse looks at me and shakes her head then explains to me:

**Nurse:** *I can't believe her (the doctor). What a fucking wanker talking to Mary (the patient) like that.....ahhh that makes me so angry.*

A few days later the ward manager walked into the nursing office and knocked the wooden door block away so that the door closed. He began to explain to the nurses present that some SHOs had complained to him that they did not agree with patients being allowed to sit in the office because it did not allow for a boundary between patients and staff. The doctors felt uneasy when they were writing notes in the office while a patient was also sitting in there. The nursing staff were angered that the doctors were trying to assert their authority about how the ward should be managed. They felt that it should be a nursing decision as to how the office is used and that the doctors had to respect their system. One nurse stood up from their chair and said;

**Nurse:** *Who the fuck do they think there are? They are never here anyway when we need them.*

The Ward Manager told the nurses in the office that he had explained to the SHOs that it was the nurses' decision that the patients could sit in the office and that if they felt that they did not want a patient in the office, they could ask the patient to leave. For a few days following this interchange the nursing staff made sure that the door remained open when doctors were writing notes. The door was not mentioned again.

This example illustrates the dynamics between the nurse's ability to move freely between different forms of care while the SHO remained fixed within the formal. The open/closed opposition of the office door became the visual sign that classified the different social meaning of the nursing office space. When the door was open it indicated nurses' informal care allowing for the office to include rather than exclude any interaction with patients. When shut, it became the wall the formal boundary between the staff and patient.

The SHO was fundamentally in the formal domain and found that the oscillating process did not fit into her role as a doctor. Sitting down, chatting and having coffee with patients would place their work outside their professional medical framework and furthermore into an image that they associated with nursing<sup>38</sup>.

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<sup>38</sup> I must state that I am not trying to imply that the SHO's inability to oscillate between spaces is a negative thing. Much of the SHOs' time is spent visiting wards, dealing with nurses' requests, writing notes, answering their bleep etc. They are therefore having to move from one position or place to the next quite quickly and would not have the time or opportunity with the system as it is to engage with the informal care on the ward, unlike the nurses who would usually be present on the ward do most of their shift.

The nurse response to the SHO's dismissive interaction with the patient indicated their disapproval of what they saw as the SHO acting out a traditional doctor/patient relationship (Armstrong 2003) where importance was placed on the rendering of "clinical judgment and medical claims over the patient benign, and conveying a 'medico-centric' image of trust" (Bury, 1997:77). The desire of the nurse to keep the door open was embraced in the nursing 'ward policy' so as to legitimise their position. But is also served to exclude the SHO from being fully accepted into the ward because they did not own the policy; the office door became not just a physical system of exclusion and inclusion, but also a political instrument.

The position of the SHO is one of an 'outsider' who comes on to the ward and attempts to carry out their tasks in a formal learnt way. However, as the office door example illustrates, they can find themselves competing with different performances and fronts. Goffman explains that "if the individual takes on a task that is not only new to him but also established in the society, or if he attempts to change the light in which his task is viewed he is likely to find that there are already several well-established fronts among which he must choose" (1959:37). The office door example shows that the SHO does not adopt a 'well established' nursing front, but instead leaves the ward and retreats to her 'back stage' region, which was usually in the junior doctors' office on the ground floor of the hospital. Since "fronts tend to be selected, not created, we may expect trouble to arise when those who perform a given task are forced to select a suitable front for themselves from several quite different ones" (1959:38). The SHO's refusal to adopt a nursing front led to conflict between two competing fronts and marked

out the clear distinction between the type of care SHOs abide to and the type that nurses abide to. Goffman specifically highlights the difference between a nursing front and a doctor's front by stating that they are poles apart and that "many things that are acceptable for nurses are *infra dignitatem* for doctors" (1959:38).

An extract from an interview I carried out with a staff nurse on College Ward further illustrates the tension between the nurses' informal front and the SHOs medical front.

*It's really nice to work with an SHO who will sit down with a difficult patient and take a risk. But then you have another brand that go, "Oh no, it's a Sunday and I am not sure what to do, so I think we will keep them in here till the consultant can see them in the week". It's just nice to be able to discuss things with people. The relationship with the nurse and SHO should be an equal relationship. There are a lot of staff in the hospital who will always check things out with the doctor before doing anything; but I will make the decision and only ask a doctor for advice...But that would be much more of a discussion to let them know what I am going to do. I think the all-powerful doctor thing has to go, I am just as capable of talking down an aggressive patient as a doctor is, or look at a patient's medication chart and make decisions there (Alice – Staff Nurse, College Ward).*

Alice's comments provide a clear insight into what the relationship with SHOs is like and how the relationship could be. The inability to take a risk, combined

with the apparent need to claim a superior status on the ward, are common perceptions held by the qualified nurses. Often nurses describe SHOs as being 'like spoilt children' or 'wet behind the ears'.

This tension seems to occur more between the staff nurses and SHOs than between the staff nurses and consultant psychiatrists. This is not to say that there is no conflict with the consultants, but the access nurses have to the consultant is less frequent and is based on more formalised meetings leaving little room for conflict. The nurse/consultant relationship is more formal due to the greater distance between the two in the hierarchy and to the limited time the consultant is on the ward. As a result the two respective roles become defined. If the nursing staff is in disagreement with the consultant, they will at times channel it through the SHO whom they use as a messenger to relay the nurses' desires or complaints to the consultant. Rarely do they confront the consultant directly. The nurses also sometimes use the distant position of the consultant as a weapon against a SHO if the SHO is not doing what the nursing staff wants. They might threaten the SHO that they will ask the consultant directly to tell the SHO to do what the nurses want. This in turn makes the SHO look inferior to the nurses.

### *Processes of domestication*

There are similarities here with Savage's (1999) concept of the domestication of the ward by the nurses as discussed in the last chapter. The nurses on College Ward felt that by excluding the patients from the office, they would create a crude power divide and an unhelpful barrier. The nursing staff understood that many of the patients are on the ward for weeks or months, and that exclusion

from the nursing office would therefore create a “prison-like” atmosphere. Nurses often used the metaphor of the prison when describing the patients’ position on the ward. They explained that the open nature of the office gave them more chance to talk with patients because they often did not have enough time to do so on the ward. They also said they felt confident asking patients to leave the office when it became busy or something confidential had to be discussed. Most patients would leave straightaway. This transition from being included to being excluded can be one of seconds and there is little structure, or protocol as to when or how it will happen. For example, a nurse and patient might be engaged in conversation when the telephone rings. The nurse answering will change their tone of voice and become more serious. The person on the other end of the phone is told to “hold on”. The nurse then turns to the patient and asks them to leave. The door block is removed and the door of the office shuts. The closed door also works as a sign to other patients not to enter. It makes the office space one which becomes formal, clinical and professional where the informal, everyday interactions can no longer exist. In general, the door of the nursing office both works as a physical boundary between “us” and “them” on the one hand as an invitation to a more communal space on the other.

#### *Resolving conflict through the ‘team’*

The disagreement with the nurse and SHO regarding to the office door was resolved by the ward manager speaking with the SHOs and explaining to them that it was the nursing decision to have the option of keeping the door open so as not to exclude patients. The inclusion of the ward manager created a nursing ‘team’ identity. Here, the performance moved from being acted out between two



individuals to being acted out by a more collective team. Goffman explains that a “team...maybe defined as a set of individuals whose intimate cooperation is required if a given projected definition of the situation is to be maintained” (1959:108). When the ward manager entered the nursing office to explain to the nursing staff what he told the SHOs, the social space of the nursing office had a nursing identity. Due to the absence of the audience (the SHOs) that the nursing team performance was directed at, the nurses (the team performers) became their own audience and this required them individually within the team to foster a shared definition of the situation which worked to enhance their sense of identity.

The SHOs physical position on the ward remains on the front-stage, largely because the role is fixed within a medical discourse. However, most SHOs also inhabit the role of ‘visitor’ because they work on a six month rotation scheme where they work under a different consultant every six months. This results in them learning techniques to perform this role which also include exit strategies from the ward when needed, such as, explaining to the nursing team that they have a meeting to attend on another ward, or that they need to meet with a patient on another ward. Their exit strategies allow them to move quickly into their back-stage and avoid potential conflict with the controlling team. Once the SHO leaves the ward, the nursing team move into their back-stage region where they can air their grievances to each other about the apparent inadequate role of the SHO while on the ward. Ironically, this usually happens in the nursing office where the office door is closed to give the impression to patients that the office is being used for formal and official means, while actually the nurses joke and mock the SHO’s behaviour and inability to perform appropriately. It is here that

the team represents a 'secret society' (Goffman 1959) where impressions made front-stage can be both constructed and contradicted (Sinclair 1997).

The large majority of ward based interactions between the nurses and SHOs results in the nurses representing the audience, leaving the SHOs in the awkward position of performer. The main reason for this is due to the fact that the nurses have control over the social setting of the ward which enables them to introduce and arrange 'strategic devices' for determining the information the audience desires. Crucially, for the nursing team this provides them with a sense of a 'secret society' (Goffman 1959).

I have explored two of the three areas of professional psychiatric care on an acute ward and described how the space of the ward becomes a manifestation of the type of care being exercised, whether this is through direct contact with a patient or between members of staff. By demarcating different areas and approaches I have also shown that nurses and SHOs don't always interact in a harmonious way. Hidden within this tension is conflict over who controls the ward. Hansen explains that "the ongoing processes of negotiation (between nurses and doctors) by means of discourses of power are more about getting access to the symbolic capital which is recognized within the field" (1997:90). In Hansen's research the struggle for power is identified as being over the sick body; in a similar way, my research shows that the struggle for the symbolic capital between nurses and SHOs relates to the need to be able to manage and design care in a particular style. The important point is that the conflicts between the nurses and SHOs are contained within the broader official discourse of care that both groups abide to.

As I will explain in Chapter Five, the type of care that the nursing assistants abide too is largely located outside this discourse.

Conflict is suppressed by the presence of the consultant who runs the twice-weekly ward round. This fundamentally alters the power dynamics of the ward and places the nurse and SHO within the desired bureaucratic structure that tends to provide a general stability over time. Part Three will now examine how ward round achieves this.

### **Part 3 – The Ward Round, Ritual and the Official Discourse of Care**

In the introduction to this chapter I stated that I would divide official care into three broad areas. Formal and informal care have been discussed as being within the nursing and SHO domain. I explained that the formal is where nurses and SHOs interact together, while the informal is located purely within a nursing domain. In Part Three, the ward round represents the third area of ward-based care which I term 'supra-formal'. Supra-formal care is the ideal bureaucratic front-stage of the official discourse of care where all three sections of the official ward team (nurses, SHOs and the consultant) are unified and where the conflict which was highlighted in Part Two is suppressed. This unification comes about through a ritualised "professional etiquette" (Goffman, 1959:95) where each individual within the team performs their officially designated role.

## **Description of the ward round**

The conventional image of the ward round is usually that of a consultant in a white coat with his<sup>39</sup> junior doctors and a head nurse moving from patient to patient and bed to bed. The setting is always in a general hospital where the patient's illness is located within the body. A ward round on a psychiatric ward is different. Instead of the movement from bed to bed, the psychiatric ward round takes place in a designated room on the ward where the patients enter one-by-one when called by one of the nurses.

The main attendees are the consultant psychiatrist, two SHOs and a staff nurse from the ward. There could also be social workers, a pharmacist, interpreters, a patient advocate, representatives from housing support teams and family members that would attend for a specific patient. Therefore, the room can get quite full.

The ward round usually starts with the consultant usually entering the room where the staff nurse and the SHOs are already sitting, waiting for him. The consultant sits down in the same seat every week and quickly says hello. If there are students, or other people in the room that he does not know, he will ask them to introduce themselves to him. The momentum of ward round, once the consultant has entered, is of a high tempo. The nurse hands the consultant a piece of paper with a list of patient names and their diagnosis, legal status and date of birth. This offers the team a structure within which to discuss each patient in turn and to decide which should be seen. The nursing team and SHO might already

have drawn up a list of patients they feel the consultant should see, and the consultant might also request to see a specific patient, especially if they had been recently admitted to the ward. A patient might also request to see the consultant during ward round.

Before each patient enters the room, the consultant is given a brief handover. This would include a report of the patient's behaviour over the previous week, issues around medication, organising possible discharge from the ward and discussing the individual's housing and medical and social support. Part of the handover is given by one of the SHOs who might have written key points on a piece of paper. The consultant directs questions to the SHO concerning the patient and whether certain plans and appointments have been followed through. He might also make suggestions in relation to ways in which the SHO could approach certain areas of the patient's care. This is a crucial and official part of ward round where the consultant changes role from medic to teacher. However, this role is only carried out between the consultant and SHO and not the qualified nurse.

Once the formal handover has been given to the consultant, he begins to see the patients. He might first indicate to the people present in the room how he would want to approach the meeting with each patient and how long he would ideally like to see them for. He then asks the nurse to invite the patient into the room. The patient would either be waiting outside the room or otherwise they would be in their bedroom. The initial contact between the patient and the people in the

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<sup>39</sup> I describe the consultant as being male due to the actual fact that all the consultants that I

room depends on certain factors. For example, if the patient is new to the ward or psychiatric services, they can appear to be quiet and shy and unaware of the procedure and etiquette that the ward round has. If the patient is experiencing severe psychotic symptoms it could be difficult to engage them in conversation and to make sense of what they say.

The interaction and conversation is solely between the patient and the consultant. The SHOs and nurse take a back seat and do not enter into the conversation unless the consultant asks either one a specific question. Often the nurse positions their role as 'note-taker' where they enter notes and decisions made by the medical team into the ward round book. It is only once the patient leaves the room that the staff nurse and SHOs become involved and interact more. This process is repeated for each patient, and only stops when the consultant decides that it is time for a coffee break.

The coffee break takes place in the ward round room. Coffee and tea would usually already be there on a tray in thermos flasks. The break in the proceedings indicates a chance for the consultant to make any phone calls or check mobile phone messages. The staff nurse checks decisions that were made or informs the rest of the nursing staff if the status of a patient has changed. For example, a patient might have been granted a certain amount of leave, or the observations on a certain patient might have been increased or decreased. SHOs continue writing in the patients' notes. Rarely is the break structured around having time to relax and chat. The key point is that it is almost always the consultant who indicates

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worked with were male.

when the coffee break happens. Often the consultant will ask one of the nurses or SHOs to pour them a cup of coffee or tea because they are usually writing in patients' notes or filling out and signing forms for patient leave.

The coffee break usually lasts for fifteen minutes and once ward round gets under way again, the same format follows as before. When the last patient has been seen and discussed by the team, the consultant thanks those present and quickly leaves, although there are times when he might have to sign a form that the staff nurse presents to him. The staff nurse and SHOs carry the patients' notes back to the nursing office to be filed away.

### **Ritual and discourse**

Focusing on the ward round as a clinical procedure allows one to understand its official function. The ward round is a critical part of the weekly environment in which decisions are made through the exchange of information. It is where all the relevant actors are allocated their role within the care process. As the description above shows, it is the consultant who ultimately manages it and decides how care will be administered to individual patients. The authoritarian position of the consultant, the importance of decision-making and the stringent use of time, formalise the space where ward round takes place so that its image is one of clinical and bureaucratic importance and formality. However, the ward round structure works in more ways than this. Analysing the ward round by using theories of ritual illuminates deeper meanings beyond it just being a crucial regular medical procedure in the structuring of care.

### *The role of ritual*

An understanding of ritual enables one to decode routinized and habitual social interactions. Rituals are carried out within social interactions rather than being phenomena that impose themselves on social settings. Bell explains that “ritualization is a particularly mute form of activity. It is designed to do what it does without bringing what it is doing across the threshold of discourse and systematic thinking” (1992:93). Geertz (1980) argues in a similar way by suggesting that in ritual, the everyday world and the world we imagine are joined under a single group of symbolic forms. The fusing of ritual with the everyday makes its unconscious workings hidden within the social setting.

Fundamental to rituals is the fact that they address conflicts and contradictions in society. Bourdieu (1977) makes the point that rituals disturb the ‘natural’ taxonomic order so as to impose the re-ordering of ‘culture’. Thus, rituals aim to re-confirm a desired ideology which attempts to impose itself on everyday contradictions. The performances of rituals work by appearing to be opposites of the perceived social environment so that feelings of anxiety and fear can be unconsciously removed and order and direction (however static or mute such direction might be) can be put in place. Rappaport (1971) argues that ritual is the opposite of explanation. The core of the understanding of ritual here is that it is concerned with the maintenance of power. The ward round echoes both Bourdieu’s and Rappaport’s points because its formalised approach leaves little room for the everyday conflict between the nursing team and the SHOs.



The ward round becomes a ritual which is formalised through its periodic appearance and practice, use of language, the social environment and use of the body by individuals and groups. The ritualistic aspects of the ward round are similar to Bloch's (1989) theory on how political and religious rituals carry with them a sense of formalisation where all the participants' roles and positions are accepted and unchallenged. Language becomes formalised and embedded in the ritualistic process allowing for little room to for argument or resistance. Thus, one of the main functions, Bloch argues, is that the formalising nature of rituals allows for structures of power and hierarchy to remain fixed and unchallenged leaving the *status quo* in place. He explains that: "It (formalised language) is really a type of communication where rebellion is impossible and only revolution could be feasible. It is a situation where power is all or nothing...total refusal is normally out of the question" (1989:29).

The ward round is based on a formalised structure that dictates the behaviour of all the actors involved. Its formal environment demarcates itself from the everyday ward environment. This distance from the everyday encapsulates a sense of importance and focus. The closed room, fixed seating arrangements and regimented time use adds to this appearance. The consultant always sits in the same place; someone who is not aware of this would be reminded by other staff not to sit where he sits. The nurse and SHOs also sit in the same seats every week. The consultant takes on a lead role, initiating when the ward round starts and finishes. The ritual aspect of the ward round has a practical function in that it allows for clinical and bureaucratic decisions to be made in a set way without room for substantial challenge. The ritualised use of the physical space, time and

the hierarchy of the actors, contributes to the fact that resistance and debate are very rare within the ward round. Therefore, the unified team 'front' is performed by the actors with little resistance from the individual team members (Goffman 1959).

The role of ritual in the ward round becomes a mechanism where conflict is controlled. This is similar to Turner's (1957) notion of 'social dramas' where rituals become "social mechanisms brought into play to reduce, exclude and resolve that conflict" (1957: 89). He explains that although conflict was constantly present in everyday life, rituals prevented the conflict from influencing or controlling the society's structure. Gluckman (1963), however, argues that rituals are not about solidarity and cohesion, but are rather about exaggerating conflicts so as to present an image of unity regardless of the conflict. Therefore, 'rituals of rebellion' appear to be in opposition to the power structure, but by being enacted in fact actually re-affirm the power structure by allowing for conflicts to be exposed within a controlled environment. The ward round could be seen more in terms of a functionalist model in that it appears to strive for some sort of cohesion where everyday tensions between the nurses and SHOs are rendered less significant by the ritualistic presence of the consultant. Whereas ritual for Gluckman 'exposes' conflict to gain unity, the ritual of the ward round 'suppresses' conflict, or renders it inconsequential, or denies that it exists at all. In other words, the everyday conflict on the ward is dismantled rather than being reversed and in doing so places each section neatly into their bureaucratically desired place of the hierarchical order.

### *Discourse and the body*

Due to its ability to control conflict and thus provide an ideal 'front-stage', the ward round becomes the purest form of the official discourse of care on the ward. Its ritualistic characteristics orders the actors' bodies to perform in a way that portrays the official discourse. Therefore, discourse, can be seen as "historically constituted bodies of ideas providing conceptual frameworks for individuals, made material in the design and creation of institutions and shaping daily practices, interpersonal actions and social relations" (Frankenburg, 2000:458). Discourse shapes ideas and statements that in turn express the values of the institution. Foucault's approach is helpful because he shows that different discourses also generate knowledge and power, transforming themselves into claims of expertise. A Foucauldian approach to discourse refers to "ways of talking or thinking about a particular subject that are united by common assumptions" (Giddens, 2000: 675). Power grows through discourse by shaping general attitudes towards a specific phenomenon; it organizes and structures thinking. For Foucault, it is as much to do with practice as with language; "but also what is represented through language" (Grillo, 1997:12). Foucault states that discourse can be treated as:

"...the general domain of all statements, sometimes as an individualized group of statements, and sometimes as a regulated practice that accounts for a number of statements" (Foucault, 1972: 80).

Mills argues that Foucault is interested “less in the actual utterances/texts that are produced than in the rules and structures which produce particular utterances and texts. It is this rule-governed nature of discourse that is of primary importance” (1997:6). This is crucial in understanding how hierarchy within the ward round is generated because it is not just how the consultant speaks and expects others to speak, but it is as much to do with how the actors within the team learn to accept the rules through practice. The official discourse of care is not confined to the spoken word or written policies, but is also located in the ritualised use of space and time and the symbolic use of the body as seen through posture and clothing. This space becomes the formal front-stage where all the individuals act out the official discourse resulting in a unified performance.

The reasons why individuals of the ward round team sit in a particular place in the room, for example, reflects the rules that structure the official image of the ward round. A Foucauldian approach allows one to move further out from the spoken and written form, to explore how discourses culturally structure one’s identity.

Discourse can be interpreted anthropologically as being shaped by culture while also creating and reaffirming cultural principles. “It is discourse which creates, recreates, modifies, and fine tunes both culture and language and their intersection” (Sherzer 1987:296). Discourse can be expanded beyond a narrow understanding of language to incorporate day-to-day practice as is evident in the ward round. The concept of practice frames systems of meaning which are communicated through language, both written and spoken, but critically also

through the body. It is through practice as well as language that cultural dispositions are learnt and become embedded within an individual's or group's cultural identity. In Chapter Two I questioned the reductionist theories on 'organisational culture' mainly because they avoid exploring how discourses, practice and the body become essential analytical processes when researching culture.

The body is a key component in understanding the ways in which ritual influences interaction both through the clothes that are placed on it and how the body is used to reflect the meaning that the ritual produces. This interpretation draws on Bourdieu's (1977) notion of the *habitus*<sup>40</sup> and bodily praxis or *hexis*. The *habitus* is the set of structuring principles and understandings that generate practice (1990). The body is central to it. Bourdieu argues that the body is the enactment of cultural principles, which are based on learnt processes and experiences. It is within the bodily *hexis* that the personal or subjective sphere connects with the more structured social sphere. For example, Jackson (1983) uses Bourdieu's phenomenological approach to the body when studying gendered-based ceremonies among the Kuranko of Sierra Leone. He argues that there is a phenomenological "approach to the body praxis which avoids naïve subjectivism by showing how human experience is grounded in bodily movement within a social and material environment" (1983). Strathern and Lambek (1999) make the point that the body is a critical cultural object of research:

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<sup>40</sup> Although Bourdieu seems to always be linked with the term *habitus*, he rightly acknowledges that anthropologists and sociologists in the past have also used the term to explain similar points. Marcel Mauss' article 'Techniques of the Body' (1979) refers to the term *habitus* to illustrate how

“...we can understand the nature of such things as selfhood, practice, sociality, and religious experience only when we bring the body explicitly into the picture....and problematize its presence both in the thought and practice of our subjects and in our own theories about them” (1999:12).

As in Bourdieu's view, the body becomes central in understanding the individual and the group's understandings of the world they live in, because it expresses and asserts meaning most pertinently.

The body is therefore the link between the individual world and the shared cultural world. Bourdieu uses the concept of the bodily hexis which “is political mythology realised, *em-bodied*, turned into a permanent disposition, a durable manner of standing, speaking and thereby *thinking*” (1977:93). The bodily hexis is not, then, just about learning rules and codes, but is about codifying social distinctions through the body. Fundamentally linked to this is the idea that habitus is also a process of asserting power through its unconscious shaping of practice rather than through the conscious process of learning. Practice in the social arena, or what Bourdieu calls the ‘field’, is produced primarily through routine or normalisation and without conscious reference to the body and knowledge. In the case of the ward round the performances within this social space are determined by the actors' position and by the dominant cultural discourse. In the case of the ward round on College Ward, the power of the dominant cultural discourse – medical and bureaucratic – influences the

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the body learns to engage with and incorporate cultural norms, for example how soldiers learn to

interactions and practices within this social 'field'. The 'higher up' one is (in this case the consultant and SHOs) the more 'symbolic' and 'cultural capital' is gained over those that do not fit into the same institutional position (the nurses). For Bourdieu, the body could become a ritualised body through the interaction of the body with a structural and structuring environment (1977). He states that:

It is in the dialectical relationship between the body and a space structured according to mythico – ritual oppositions that one finds the form par excellence of the structural apprenticeship which leads to the em-bodying of the structures of the worlds that is, the appropriating by the world of a body thus enabled to appropriate the world. (Bourdieu, 1977: 89)

Bourdieu sites the influence of Goffman's notion of total institutions (1977:94) to illustrate how the process of embodiment become unconscious leaving the way for the individual to be transformed or 're-cultured' into a 'new man'. There are also similarities with Bourdieu's notion of practice and, as I have discussed earlier, Goffman's notion of performance (1959). Both illustrate that practice and interactions are largely performed unconsciously to portray an individual's or groups' desired cultural disposition.

The concept of 'habitus' develops Foucault's concept of discourse and practice because it incorporates practice by showing how the body becomes woven into a cultural web where it acts out and displays learnt cultural principles. Therefore

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march or individuals dig soil in a culturally specific way.

an anthropological approach to discourse demands a broad focus. Sherzer argues that:

“Since discourse is an embodiment, a filter, a creator and recreator, and a transmitter of culture, then in order to study culture we must study the actual forms of discourse produced and performed by societies and individuals” (Sherzer 1987:306).

By exploring the concept of discourse through anthropological concepts, such as ideas of ‘habitus’ and embodiment, a deeper understanding is gained of the subtle ways in which meaning is generated. Embodiment and the use of the body explore how particular experiences are used to legitimate authority or to subvert or challenge it. This becomes key to understanding the ways in which psychiatrists and nurses attempt to maintain or challenge systems of authority.

In the ward round hierarchy, authority and power become subtle processes that are hidden behind the formal processes. Along with Bourdieu’s notion of the body and the habitus and theories on rituals that describe its formalised nature, one can see how power is generated and continually reproduced and how individual actors perform the required discourse so to create an official front-stage. The centrality of the body, positioned within the formalised and periodic nature of ritual becomes a fundamental tool for power through its interactions, or defined clusters of relationships, with others. Bell makes the point that



“ritualization is a strategic play of power, of dominance and resistance within the arena of the social body” (1992:204)<sup>41</sup>.

### *Clothes and bodies*

The hierarchical order is also visible through the bodily praxis and the dress of the actors, which in turn incorporates the ritualistic meaning. The consultant nearly always wears a suit and tie. This formally places him within the official bureaucratic position that represents his authority. This dress also reaffirms his superior medical knowledge when interacting with patients who usually expect that knowledge and power should be visibly represented within a formal dimension. This is a conscious performance of the consultant’s front-stage that displays an expected image to his audience which includes the nurse, SHO, other professionals and also the patient. The consultant’s dress reaffirms his hierarchical position in relation to their status in the ward round team, the ward and the organisation; as a consultant on College Ward explains:

*I have no idea if it (dress) is important in the sense of it being good because it is all about custom. There is evidence that patients like and expect their doctors to be conservatively dressed. You have an institutional role as well as being a fatherly role.*

The hierarchical position of the consultant is described both as *institutional* and *fatherly* enhancing the male/female and public/domestic association of authority

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<sup>41</sup> In Chapter Five I will develop the idea about the relationship between the body and discourse

and professional status. His comment also shows that he is aware of his position and therefore the appropriate 'front' that he has to convey.

The hierarchical order of the ward round team is also illustrated by the nurses' dress which is the complete opposite of the consultant's. Jeans, trainers, t-shirts and casual shirts are common garments worn by both male and female nurses on the ward. Only their I.D card, clipped onto their belt, identifies them as nurses and distinguishes them from the patients. I was often told that this was deliberate in an attempt to break down visible boundaries of authority and control between themselves and the patients. This is similar to the nurses' use of the nursing office and its door. The most common dress for SHOs is shirts, chinos or black jeans and shoes for the male doctors and skirts, smart black jeans or trousers, smart/casual top and shoes for the female doctors. All the SHOs wear I.D badges and also have bleeps clipped to their clothing. Their smart/casual appearance means that they are easily identified on the ward. Symbolically their dress represents their conflicting positions on the ward. By being neither completely smart (like the consultant, nor completely casual (like the nursing staff) their 'in-between' status is confirmed. However, the implication is that they are on an evolutionary path from junior to senior doctor.

Dress works as a very visible form of classification (Eicher 1995) which separates each section of the staff into hierarchical order. In the ward round setting, dress is one of the central components of the meaning that ritual generates. Before any speaking between the actors, or any ward round procedure taking place, the relative positioning is visible through the dress. Tarlo (1996)

explains that clothes “are both part of us and superfluous to us. What this suggests is not that clothes have any particular meaning, but that their peculiar proximity to our bodies gives them a special potential for symbolic elaboration (1996:16). In the ward round dress both reflects the self of the person that wears them, while also reflecting the bureaucratic self. Dress therefore mediates between the public and private and biological body with the social and official body.

### *Posture*

Following on from the symbolic meaning of dress, the actors’ posture also confirms the hierarchical order of the ward round. The nurse’s body remains static and regimented, moving from their seat only if the consultant requests them to: asking a patient to come into the room or retrieving specific information for the consultant from the nursing office. The nurse usually remains fixed in their seat with the ward round notebook balanced on their knees while making notes on the individual patients. The nurse’s role determines that their posture is physically ‘enclosed’ by the practical task of writing notes. They are hunched over with their heads bowed down while writing notes preventing them from having as much eye contact with the consultant as the SHOs have. The SHO also remains static; however their engagement with the consultant is usually more active, even while seated, as they explain and summarise care and clinical issues. SHOs tend to look down at notes only when they have been asked a question by the consultant and are unable to provide the answer straight away. Finally, the consultant has a more dynamic and active use of the body that exudes their authoritarian position. He will stand and greet patients when they enter the ward

round room, shaking their hands and suggesting they “take a seat”. These actions position the consultant as the ‘owner’ of the space, similar to that of a manager of a company, formally greeting someone into *their* office. The consultant also requests that other members of staff introduce themselves.

The consultant becomes active after the patient leaves. Often he will write in the patient notes so as to provide official clarity on medication or leave for the patient. Medication cards and leave forms also have to be signed by him. The consultant is able to write in the notes and sign the forms while explaining to the nurse and SHO what clinical and care procedures need to happen. He often picks up the patient notes from where they are on the floor and when finished, places them quickly on the floor in another pile. The consultant can be seen as having greater freedom of movement based on his indisputable dominant position in the hierarchy within the ward round.

#### *Ritual and the coffee break*

The coffee break marks the half-way point in the ward round. To a certain extent, it allows for the actors to relax from their formalised roles and the intense procedures of the ward round. However, their learnt roles within the hierarchical structure seem to ‘spill over’ into the coffee break. The two extracts below highlight how the ritualized and hierarchical nature of the ward round influences the way in which coffee break is negotiated.

*I always felt that I had to make the coffee, not because everyone would not, but because everyone seemed paralysed because they felt that they had to wait for me to make the first move. It was a bit like the queen or something "we cannot move until the consultant makes coffee". I am always shocked when I see some medical staff being old fashioned and seeing the nursing staff as there to look after us. Nurses pick up on that very quickly. If you don't have this then nurses are often happy to look after you because I think it is often in their instinct to be quite good at looking after people.*

*(Interview with a male College Ward consultant)*

*I was not the nurse in ward round, but I was asked to pop in to discuss one of my patients. During the break for coffee, the staff nurse who was in ward round began a discussion with a social worker about a care-plan. The SHO stood in front of the male senior staff nurse, who incidentally has worked here for some time, and began stamping her foot and whining, "Oh don't discuss that with him now (to the social worker), we need him (the staff nurse) to make coffee". She then turned to look around the room and smirked. As you can imagine, I did not return the smile. With this the SHO instructed him of what she would like to drink and sat back down. Arrrrrrggg! This is a very recent story and one that made me recoil in horror. I wanted to confront the staff nurse and ask him why he let the*

*SHO do that to him. Incidentally, he has recently been in an acting F grade position<sup>42</sup>...so much for role modelling.*

(Interview with Senior Staff nurse on College Ward)

The seemingly uneventful coffee break actually incorporates the hierarchical order that the ward round generates. If we look at the consultant's extract, he consciously seems aware of his authoritarian position, so much so, that he is able to acknowledge the effect that his position can have. He also realises the hierarchical structure present by explaining his dislike of some SHOs expectations of the nursing staff. However, at the same time he is also accepting the nature of this structure by implying that nurses ultimately carry a natural disposition to care, by their apparent desire to look after the doctors by 'wanting' to make them coffee. This echoes of the gendered division of labour between the medical and nursing spheres of care as discussed in Chapter Three.

The second extract, by a senior staff nurse, can also be interpreted as reaffirming the hierarchical order of the ward round. The SHO and the two nurses are acting out their ritualised positions by recreating authoritarian/subservient relationships. On the one hand, the SHO is demanding that the nurse stops discussing a clinical issue with a social worker so that he makes coffee for her, while on the other, the nurse passively obeys. It is interesting to note the way that the senior nurse approached this interaction. She stated that she 'wanted' to confront the nurse to ask why he was so willing to carry out the SHO's wish. Here then, the compliant

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<sup>42</sup> A qualified nurse who is in a 'acting' position implies that they are temporarily on a higher grade. This usually happens when a permanent member of staff is away from work due to ill

nurse is seen as 'letting the side down' and allowing the SHO to 'get away with it'. Goffman describes this as a team member (the male nurse) not "maintaining their line during a performance. When a member of the team makes a mistake in the presence of the audience, the other team-members often must suppress their immediate desire to punish and instruct the offender until, that is, the audience is no longer present" (1959:94). However, the senior nurse never actually confronts the male nurse after the event takes place. Furthermore, the senior nurse never attempts to publicly support the nurse and question the SHO's inappropriate behaviour. The main point is that outside the ward round environment, the senior nurse is able to identify the problematic nature of the SHO's attitude and the threat to the nurse's claim to certain areas of authority and control. However, the extract illustrates that within the ward round environment the senior nurse did not actually confront the actions of the SHO. The fact that she did remain silent is a key point about the power of the ritualised roles because her actions preserved the hierarchical structure of the ward round.

### **Binary oppositions in the ward round**

The decoding of the ritualistic characteristics of the ward round also indicates the important symbolic value of binary oppositions<sup>43</sup>, which enhance the asymmetrical ties of dominance and subordination (Ortner 1989)<sup>44</sup>. This also suggests how ritual and its use of oppositions create a sense of 'order' (Bell,

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health or that the position is in the process of being filled.

<sup>43</sup> Hertz (1973 [1909]) was probably the first to use binary oppositions in relation to the symbolic meaning of the body. He argued that the left/right divide promoted the rationalized dominance of the right.

<sup>44</sup> Ortner uses binary oppositions in relation to practice theory. She argues that this is "a theory of the relationships between the structures of society and culture on the one hand, and the nature of human action on the other hand" (1989:11). Her use of oppositions is most evident in her work that focuses on the gender and the different identities of men (culture) and women (nature).

1992: 104). Earlier in this chapter I mentioned that Bourdieu's use of binary oppositions to understand the social space of the Kabyle house was used not only to throw light on the social meaning in a structuralist sense, but also to understand how symbolic meaning was generated through the activities and performances of the social actors. I have divided the binary oppositions into three categories:

- 1) Oppositions between the environment of the ward round and the everyday ward
- 2) Oppositions between the consultant and the nurse
- 3) Oppositions between the consultant and SHOs

**Ward Round**

Formal

Scientific

Closed

Management

Professional

**Consultant**

Professional

Suit

Management

Male

Power

Command

**Ward**

Informal

Social

Open

Managed

Domestic

**Nurse**

Skilled

Jeans

Secretary

Female

Subservient

Obey



**Consultant**

Senior

Teacher

Suit

Father

**SHO**

Junior

Student

Chinos

Son

I have deliberately not included a section of oppositions between nurses and SHOs because the formality of the ward round ultimately limits interactions between the nurses and SHOs by reaffirming their distinction and different roles. The conflict between the nurses and SHOs, as is evident in the less formal day-to-day interactions, is suppressed and eradicated. The presence of the consultant is central to this suppression and eradication of conflict. The ward round is usually the only time that he is physically on the ward; daily contact with the consultant is usually through telephone calls or messages via the SHOs or nurses and rarely through physical interaction. The consultant's action of entering the ward at a regular, specific time marks the dividing line between informal and formal care and supra-formal care. Supra-formal care represents the area of the care which is fundamentally controlled by the consultant and therefore yields power over the nurses and SHOs. The consultant always remains at the top, in the dominant position. The nurse is fixed at the bottom through their fairly muted presence and limited professional status (in relation to a doctor). But the most interesting position is that of the SHO. When they are involved in the day to day

care on the ward it is though they are having to compete with the nurses who claim to have the superior philosophy of care. However, the presence of the consultant in the ward round alters their status reaffirming their medical position as higher than that of the nurse. The metaphors for the SHO of the 'student' and 'son' are helpful because they symbolise the SHO as someone on a journey of development and maturity, hoping one day to graduate to (or grow into) the role of consultant.

In general, the position of the SHO fits loosely into Van Gennep's (1965 [1908]) influential theory on ritual where he argues that there are three phases to ritual.

- 1) Separation, or preliminal.
- 2) Liminal phase – The placing of an individual outside the society
- 3) Postliminal – Transition into a new status.

The SHO oscillates between the first two phases before eventually graduating to the third and final stage. Maybe it would be more accurate to argue that the first phase – separation, is moving from being a student doctor, while the liminal phase is being an SHO on a ward and the postliminal phases is being a Senior Registrar and then a consultant. The ward round acts as a reminder to the SHO of what will eventually come to them: that their current removal from safety in the liminal stage will one day be compensated for through their promotion and therefore authority in the postliminal stage. A similar example of this is Turner's (1974) notion of *communitas*. He explains that the liminal stage of the initiation ritual that Ndembu neophytes experience leads to them developing a sense of

unity and shared experience as a group due to the humiliation that they have experienced. This resonates with Goffman's (1961) account of how patients in a psychiatric hospital go through processes of self-mortification, where their sense of self is stripped from them. However, the key difference between Turner's notion of *communitas* and the experience of patients in a total institution is that the patient remains a patient until discharged while the neophytes eventually becomes part of the community. Sinclair's (1996) study of the training that medical students go through also uses Turner's argument to show how medical students in their liminal stage and "on their way to status evaluation" (Sinclair, 1996:26) have to also go through processes of "teaching humiliation" as part of this process.

#### **Part 4 – Resuming Normality**

In Part Three, I argued that the ward round has ritualistic qualities that create and maintain a traditional, bureaucratic, hierarchical structure where all three sections of staff are neatly positioned. The formalisation of time and space leaves little room for resistance and change in the power structure. Even when the rigid, formal environment comes to a short halt through the coffee break, the actors ultimately remain in their ritualised places. The ritual of the ward round works to stamp authority over the nurses' and SHOs' every day interactions and management of the ward. It dispels any tensions and conflicts by suffocating them through the implementation of traditional authority. It is through the denial of the everyday, rather than the acknowledgement of conflict, as Turner originally argued, that the ritual creates social stability.

### **Post ward round**

Straight after the ward round, the suppressed tensions between the nurses and SHOs tend to surface again and remain active until the next ward round in two or three days' time. It is during this period that we can examine the ways in which that the nursing staff try and reclaim a sense of authority and control on the running of the ward. They attempt to re-assert their dominance on the ward, breaking away from the bureaucratic and paternal dominance that they had to endure for the previous last three and a half hours. Subtle techniques are used in an attempt to reclaim their control. Their desire to move from a passive role to a dominant one is channelled through trying to control how the SHOs conduct themselves on the ward straight afterwards. There are several post ward round techniques by which the nursing staff attempt this.

The nursing staff have a strict sense of what roles and responsibilities they have and the ones SHOs should have. Nurses on College Ward felt that, all too often, the SHOs expected the nursing staff to carry out tasks that they were supposed to do themselves. One way that some staff nurses tried to control the role of the SHO was by shaming them in front of the consultant just as he was leaving the ward round room. This was usually done through joking, for instance, telling the SHO that they were lazy and had to take all the patients notes back to the nursing office and file them away. Although this type of joking might seem like a light hearted comment, it had a undercurrent of seriousness.

**Nurse:** “*You know you are very lazy, you never put the notes away as you are supposed to. I am not going to let you leave the ward unless you do it.*” [laughs]

**SHO:** “*What are you saying? I am never lazy...I am always busy*” [laughs while picking up some, but not all, of the notes]

If the consultant had already left the room, the nurse then would confront the SHOs in the nursing office in front of the other nursing staff. Here, the joke turns into more of a command.

However, not all jokes or commands work in favour of the staff nurse. Some SHOs would either refuse to file the notes on the grounds that they were too busy and had to go to another ward, or that they would play a ‘double bluff’ on the nursing staff by asking them politely if they could put the notes away because they had to go and see a patient. This would put the nurse in a position where it would be hard to refuse. Another technique is where SHOs leave the ward round room while talking to the consultant and carry on the conversation as they leave the ward, thus being protected from the nurses by being in the domain of the consultant. This would infuriate the staff nurses as they were usually left to file the notes away and remain in the passive or subservient role for a longer period of time.

#### *The passing on of ward round information*

The procedure after the ward round is that the information about the care of patients discussed needs to be clearly passed on to all the other members of the

nursing team. This is usually done in the next main nursing hand-over (usually the afternoon hand-over) in which the nursing staff discuss the issues raised and the new tasks and procedures that need to be carried out with the nurses coming to the next shift. All the information from the ward round would have been recorded in a book, allowing all the nursing team the chance to refer to it. The official passing on of information in the handover would also allow the nursing staff to discuss, as a team, any problems that they were concerned about in relation to the consultant's decisions. This might result in a senior nurse contacting the consultant or one of his SHOs for further clarification and discussion if they felt that they needed clarity about a decision. If the staff nurse who was present during the ward round was also present during the handover, they would usually have a central role because of their first hand knowledge of ward round. The nursing handover provides the nurses with an autonomous space free from the influence and constraints of the ward round. The following ethnographic example from a handover meeting highlights this:

Ian, a senior staff nurse, had been present in the ward round and was handing over information to the nursing team in the handover. The ward round book was placed on his knees where he was able to refer to specific information on the patients discussed. He began to explain to the nurses that he felt that the medical team seemed unable to make any concrete decisions. Throughout his handover he would use language like 'fucking bonkers' when describing some of the consultant's decisions. He explained to the afternoon staff that in ward round, the consultant was "faffing around" when trying to make a decision on a patient's care. The other nurses in the handover were laughing at Ian's description and

seemed to sympathise with his sentiments. So, although the handover represents an official space for the passing on and discussing of information from the ward round, it also provides a space that allows the nursing team to air feelings about the medical team. This nursing space becomes a 'backstage' that provides room for their collective identity to be regained in opposition to the authoritarian medical influence.

The position and role of the nurse in the ward round is something that has been discussed in-depth in nursing literature (Mallik 1992). In the *Journal of Advanced Nursing* (1992) an article discussed this issue:

Nurses should be educated to assert themselves in ward rounds in order to fulfil roles they prescribe for themselves, and all professionals should aim towards more democratic, equal discussion....Certainly, as team members, nurses must have a role of the skills and efforts of all members are to be co-ordinated in an egalitarian structure which is essential to effective communication and co-operation (Busby & Gilchrist,1992:339).

Here the authors call for an 'egalitarian structure' so as to improve communication and create a 'democratic, equal discussion'. It does not mention the consultant, but reflects on the nursing position in opposition to the given hierarchical order. If we look at two further examples of nursing reactions post the ward round, they similarly suggest a rebellious or resentful disposition where

they attempt to claim back some of their 'nursing self' by criticising the medical environment of the ward round. Below is an extract from an interview with the consultant on College Ward where he mentions similar points:

*The discussion and thinking about the care is informed by what the nurses bring into ward round. One of the funny things about the role of the consultant is that you are removed in ward round role a bit although you have a funny mixture of being front line in the terms that you are the person who sees the patient, and the patient, hopefully, has a good primary relationship with you. But equally that is channelled through the nurses. So, if for example I went to ward round and everyone tells me that someone is being...the sorts of words that are used, "difficult to manage" or their "behaviour is a problem", that is influencing me as much as what the patient says to me. So we have to have a discussion about it and then, I suppose that I would hope to take the lead on....either take the lead on what the care should be, or reassure or fine tune the lead the nurses have already taken. In a way I hope it's the latter because if it is me that is directing it then I think that that care would feel wrong. So it should be that the nurses should have some ideas or suggestions or even some disagreements in their team as to what the best approach is.*

(Interview with consultant on College Ward: 2000)



The consultant's points are similar to those of Busby and Gilchrist because he recognises the nurses' influence, their insight into individual patients and the best possible routines to appropriate care. He also suggests that he would prefer that it was the nursing staff that take the lead role in the care. However, his position is still one of authority and control as implied by his saying that he would still need to 'take a lead' or 'reassure or fine tune the lead the nurses have already taken'. Here the paternal image once again comes to the fore. The consultant goes on to describe his frustration with the role that some nurses have in the ward rounds:

*My only agenda is to make sure the patient gets the best care. I want therefore to be informed, I want to be challenged, and what I find frustrating, where I found myself exasperated because I felt that I was not being told anything coherent here and I think that the anxieties may be about what I will say or not say, can have a paralysing effect if people don't feel free to say it how it is. Often what happens is that a student nurse will come in and, if you like, from a nursing perspective, rather naively will say "but I had a cup of tea with the patient and they said that they were ok"...and that is priceless information. Somehow that gets filtered out by some nursing model or something like that...The more assertive nurses might see my role as unnecessary and just that they see me as someone who has to sign this or rubber stamp something. I don't see that as right either, but overall I find that slightly healthier than people (nurses) being told what to do, because that means on a day-to-day*

*basis they can't be very confident. So I would much rather feel that I was gently steering people than telling them "do this and this".*

This last extract is ideally placed to end this chapter because it comes from the consultant, namely the individual who ultimately wields the authority as to on how patients are officially cared for. He portrays the need to be able to locate and mediate the differing political discourses while also maintaining his need to have authority. His comment that he would rather 'gently steer people' portrays a person at the top of the hierarchy who, without making it too obvious, is able to observe the political nature of the ward while also not letting it get too out of hand.

### **Conclusion**

This chapter has identified three types of official ward-based care: formal, nurses' informal and supra-formal care. The two main ethnographic examples have illustrated how these different official forms of care are enacted on the ward. I have shown that the roles of the nurses, SHOs and the consultant when enacting these forms of care, are congruent with Goffman's notions of 'front-stage' and 'back-stage' performances. The physical space of the ward becomes imbued with social and symbolic meaning due to the performances being staged within it. My ethnographic data has shown that interactions between nurses and SHOs often result in conflict due to a tension between their different views

towards patient care. It also illustrates that the ritualistic quality of the ward round suppresses this conflict. The ritual, which includes the use of the body, dress, posture, formalised medical language and use of time and space, reinforces a traditional bureaucratic hierarchy which lends to the impression of a unified team exercising the official discourse. The ward round becomes a theatrical performance of a desired discourse. The chapter concludes by showing how it is only outside the ritual of the ward round that the nurses can regain a sense of control of the ward.

More generally, I would argue that although there are opposing views of care between the nursing and medical discourses, both points of view can in fact be seen as co-existing under the broader umbrella of an official discourse of care where the common aim is the optimum care of the patient. However, the next chapters will introduce the role and position of the nursing assistant (NA) and show how their approach to mental health care directly contradicts this official discourse. The remaining chapters will also explore how and why an organisation can maintain an efficient system when it appears riddled with such contradictions.

## ***V. Caring is Dangerous! The Role of the NA and Their Construction of Care***

“Every time you take a Tupperware container from your fridge, put a Tupperware container in your microwave. Or store a Tupperware container in your freezer – you can thank Earl Tupper”.

(Extract from the official Tupperware web site)<sup>45</sup>

“Boiled food is life, roast food death”.

(Lévi-Strauss 1978:486)

### **Introduction**

This chapter introduces the role of the nursing assistant (NA). As stated earlier, this section of the caring staff has not been addressed thus far because it was important to describe the official discourse of care clearly so that the NAs can be seen in relation to it. I will show, by exploring the NAs' concepts and understandings of mental health care, that they embody an approach to care which conflicts with the official discourse. This I term 'unofficial approaches to

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<sup>45</sup> <http://www.tupperware.com.au/dir063%5Cwebtupp.nsl/pages/companyprofile>  
Earl Tupper was the inventor of Tupperware.

care'. The evidence in my data has shown that these two forms of care are located in stark opposition to each other with little visible grey area in-between. This opposition is therefore apparent between how I present the relationship between the qualified section of staff and the NAs. The NAs have an uneasy position because they are the unqualified section of the care team that views the moral ethos of the official discourse as based on contradictions. These contradictions stem from the daily care on the ward that positions the patient as 'normal' and 'empowered' on the one hand but also 'unpredictable' and needing 'containment' on the other. NAs are in a position of having to continually construct and maintain boundaries of understanding and classification that form physical and psychological barriers and defences between themselves and the official discourse of care.

Part One describes the official role of the NA on the ward as seen through their job descriptions and Trust policies. I will also show, by using Trust statistics and my own ethnographic data that the large majority of NAs are from West Africa and specifically Nigeria. This will have a relevance in Chapter Six where ethnicity and race of the staff is discussed in more detail in relation to the care that they give. Part One goes onto describe the NAs' view of care that frames the patient as 'needy' and 'child-like' which is more akin to the patient in a general hospital than in a psychiatric hospital. This will show how and why NAs oppose the official image of a psychiatric patient. Part Two will use Goffman's concept of 'secondary adjustments' to show how NAs create defence mechanisms to protect themselves from the contradiction that exists between the institution's concept of the patient and their own. I will draw on an ethnographic example of

mealtimes to illustrate how this problematic contradiction manifests itself within every aspect of the NAs' working day. Through the perceived physical threat of becoming 'polluted' by the patient's unpredictable behaviour at meal times, NAs attempt to protect themselves when interacting with them. However, this physical threat (this is mainly through bodily fluids) is also a manifestation of a larger threat to their understanding of mental health care from the official approach to mental health work. Part Three develops some of the points discussed in Chapter Four by using Bourdieu's (1977) concept of habitus and Martin's (1994) idea of practicum. I will illustrate how a theoretical focus on the body, as a physical and symbolic social area, becomes an essential part of understanding how the NAs' approaches and models of care are created and practised socially. Part Four will introduce the 'buffer zone' which is that area where the official discourse of care meets with the unofficial and where official, but undesirable tasks are carried out. These tasks are mainly carried out by NAs. I argue that instead of NAs entering the official domain, it can be read more as a meeting of two opposing ideologies in a 'buffer zone' where both the NA and qualified nurse would, ideally not want to enter. Importantly, this chapter illustrates that NAs rely on their ability to improvise care rather than use learnt theoretical approaches in order to complete their allocated tasks.

### **Part 1 - NAs on the Ward**

An NA is not required to have any formal qualification in mental health care but must have had previous experience in working within a health care setting. Often

the NA will gain this by carrying out unpaid work experience on a ward through a nursing agency. However, some NAs might have completed a National Vocational Qualification (NVQ) in general or mental health care. They must have the ability “to deal sensitively and tactfully with difficult and demanding people” and “to behave in appropriate and professional manner”<sup>46</sup>. Their practical role is to carry out checks, or observations, on certain patients on the ward, take patients out for escorted walks, serve meals, make beds and spend time watching television, chatting to and generally socialising with the patients. At the end of every shift the NA enters a short written description on their allocated patients for that shift.

During the NA’s employment, it is possible for them to go on short courses. These are varied and include Basic Food Hygiene, First Aid and Prevention and Management of Violence and Aggression (PMVA) which includes the physical restraining of patients. These courses are also attended by staff nurses and, at times, ward managers.

The official Trust’s job description for a NA/Health Care Assistant or an A grade states:

The post holder will provide support to the teams, carrying out assigned tasks in direct and indirect patient care and according to competence as judged by the nurse in charge, ensuring each patients quality of life is promoted, and their safety and well-being maintained.

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<sup>46</sup> This is from the Trust Job Description for nursing assistants.

Under 'Clinical Duties' of the job description, the NA is expected "to recognise each patient as an individual with the same range of rights, needs and emotions as anyone else (and) to promote the dignity and self-esteem of all patients at every available opportunity".

The NA is primarily positioned within a role as an unqualified aid to the nursing team through following commands from nurses. In Chapter Six I will discuss in more detail how the various tasks actually frame the NA outside, or on the periphery, of the official discourse of care. However, for the rest of this chapter I want to explore the ways in which NAs negotiate, and frequently reject, the official discourse of care. Part Two will focus on patient meal times on the ward to show how they become a central arena for this negotiation.

Official Trust statistics<sup>47</sup> show that out of a total of 142 full-time NAs, 71 are from a 'black/African' ethnic background. The 'black/African' category is very general here and does not seem to differentiate between different nationalities in Africa or the Caribbean. In the hospital of this study, 90% of the NAs were from Nigeria. This is in contrast with the majority of 'black/African' qualified nurses who came from Southern Africa, mainly Zimbabwe and South Africa (See Appendix 2).

In my ethnographic study of College Ward, this ethnic and racial mix of staff was evident. Therefore, my exploration of different approaches to acute

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psychiatric ward-based care and organisational structure inevitably had to embrace issues of ethnicity and race. As will be expanded upon in Chapter Six, unacknowledged racism amongst white qualified nurses became a key conceptual tool in defining the attitudes and actions of NAs.

### **The NAs view of care**

Whereas the nursing, SHO and consultant voices are intrinsic to their role and the official discourse of care they embrace, the NAs' voice is not about a distinct discourse of care. As will be shown in this and the following chapter through data and analysis the official discourse of care does not hold much relevance for the NAs: neither for the position of their role in the whole policy and organisational structure of the Trust/hospital/ward nor for themselves and their role as carers. Their interpretation of care and what a 'patient' is, is largely defined within a culturally based framework rather than a learnt understanding based on formal nursing or medical training. In ways, NAs are left to devise their own concepts of care while 'on the job'. The NA's voice about care is therefore mainly evident in their 'back-stage' regions on the ward corridors where social conversations between themselves take place. A traditionally paternalistic attitude, analogous to a parent/child relationship, frames their view of care.

When I asked NAs what mental health care was like in Nigeria, they all would respond that there was more discipline *back home*. They felt that patients in this country had too many rights and were able, therefore, to abuse the system. One female NA told me:

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<sup>47</sup> Official Trust statistics were provided by the Trust's Human Research (HR) Department on my

*'Back in Nigeria if a patient does not want medication they are made to take it...and they get better'.*

Interestingly, much of the discussion on the need for more discipline would almost seamlessly move into discussions on methods of discipline for their own children; such as hitting or 'grounding' their children when they had disobeyed orders. The conversation would usually conclude by the NAs justifying the discipline used, explaining that their own children were grateful for the strict discipline that they received in their younger years. The two important points here are that firstly, the NA treats the psychiatric patient as a child that needs discipline to progress out of their *'up side down and inside out'*<sup>48</sup> state of mind. This could be seen as being in keeping with Foucault's analysis of 18<sup>th</sup> Century 'moral treatment' at the York Retreat where everything "is organised so that the insane are transformed into minors" (1989:239). Foucault reduced this idea down to a succinct maxim: "Madness is childhood" (ibid). Secondly, the NA generally understands mental illness as a process that follows the same journey as most illnesses found in general hospitals: the patient gets better by accepting their passive role and complying with their treatment.

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request. They were e-mailed to me as an attachment. See Appendix ? for a copy of the statistics.

<sup>48</sup> This was a description used by a NA to describe a patient's behaviour.

### *General patient vs psychiatric patient*

There is a major difference between the image of a patient in a general hospital compared to a patient in a psychiatric ward. The image of a patient in a general hospital is one where they are confined to their bed and are dressed in helpless and vulnerable clothes – pyjamas, dressing gowns and slippers. The patient's relatives bring food, drink, newspapers and magazines to the bedside as a means of supporting the patient. Nurses are dressed in nursing uniforms that indicate their grade and position on the ward, or if they are an agency nurse. This creates a visual boundary of carer and patient, while the doctors enhance this boundary through short, formalised interactions with patients. Helman describes that:

the ill person is removed from family, friends and community at a time of personal crisis. In hospital they undergo a standardised ritual of 'depersonalization', becoming converted into a numbered 'case' in a ward full of strangers. The emphasis is on their physical disease with little reference to their home environment, religion, social relationships, moral status, or the meaning they gave to their ill-health(1994:82).

This image of a general hospital shows that the individual patient becomes detached or alienated from their normal 'everydayness' through the process of, what Brian Turner describes as a system of ritual where the individual becomes a 'full time patient' (1987:170).

Although there are clear examples of techniques that are used, especially by the nurses and patients, to domesticate the ward space so as to personalise the experience of being a patient, there is still a clear demarcation between those who are ill and those who are not.

Within the acute psychiatric wards, however, the image of the patient is very different to that of the patient on a general hospital ward. Instead of a culture of differentiation there is an attempt to create an atmosphere of 'normality' in order to provide the patient with a feeling of 'being human' and being included. For example, the patient is actively encouraged to wear their own clothes and not wear hospital pyjamas during the day. If the patient only has a limited amount of their own clothing they can 'visit' the clothing room where second-hand clothes are kept.

The wards in the psychiatric hospital have video rental cards so that patients who have leave can go and rent films to watch with other patients and staff. Each ward is provided everyday with two national newspapers of the ward's choice<sup>49</sup>. There is a TV room with a pool table and CD player. There are carpeted floors in most bedrooms, and a drinks machine in the corridor where patients can buy a number of canned fizzy soft drinks that are priced the same as in a local shop.

Certain mealtimes in the week work in a similar way to create a feeling of normality. Breakfast on a Wednesday is a Full English Breakfast, Friday Lunch

is Fish and Chips (this is in-keeping with the Christian custom of eating fish on a Friday) and Sunday Lunch is always a Roast. All staff members wear civilian clothing so as not to create an obvious authoritarian division. As mentioned earlier (in the previous chapter), the only item that differentiates staff is their ID badges that they clip onto their clothing.

The physical boundaries that divide the official nurses' space from the patients' living space are, at times, more flexible allowing certain patients to socialise with the nursing staff. For example, as indicated in Chapter Four, a patient could be sitting in the nursing office chatting or reading the newspaper while a staff member is writing confidential notes on another patient<sup>50</sup>. A nurse might sit in a patient's room, perched on the edge of the patient's bed, and have a chat and a cup of tea or coffee with the patient.<sup>51</sup>

As well as these physical symbols of the outside world, there are more subtle forms of normality such as the way in which some patients and nurses communicate with each other. For example, a male staff nurse in his early thirties addressed a tall well built male patient as 'Big J'. The patient replied informally suggesting a pool game: "*Let me thrash you at pool then Tim*". Football is a common topic of conversation discussed between the male nursing staff and male patients, while on a Sunday when the ward is usually quiet female staff might plait a female patient's hair or suggest tips for make-up.

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<sup>49</sup> On my ward the national newspapers were the Guardian and Daily Mail and on a Sundays the Observer and Sunday Mail.

<sup>50</sup> The example in Chapter Four of the office door is a good example of this.

<sup>51</sup> This is not to say that on general ward, nurses do not attempt to do this. Savage's example of the 'process of domestication' as discussed in the last two chapters is a good example. This Chapter illustrates that the informal interactions are also common on psychiatric wards.

Quirk and Lelliot (2002) explain that some discharged patients happily return to pay social visits to staff and patients in ‘their ward’ or use the ward as their first point of contact when they need advice or support” (2002: 334). The ward can, at times, offer patients a social space for informal and informative exchanges and interactions. Therefore, in contrast to patients on a general ward, the psychiatric patient is made to negotiate their stay for both medical attention and for social and economic encounters. In other words, elements of the ‘normal’ daily routine of the outside world seep into the ward.

### **Pseudo-normality**

Both the physical and non-physical symbols of normality create an environment that represents a *pseudo-normality*. The concept of pseudo-normality refers to the notion that although the atmosphere on the ward attempts to re-create certain social norms which occur outside the physical structure of the ward, it is a manufactured version of the outside. There is an inherent contradiction in the framework within which staff work on a daily basis: caring for patients while claiming to regard them as ‘non-patients’. These informal and ‘normal’ interactions only take place when the patient is behaving rationally and being ‘competent’ when communicating, i.e. not psychotic or aggressive. The patient then has to present an appropriate ‘front-stage’ (Goffman 1959) with obvious social characteristics of etiquette relating to the outside world that allows them to

appear 'normal'. If the patient appears unwell, the informal relationship moves into an official one between the staff and patient<sup>52</sup>.

### *The daily routine*

The daily routine of the ward reflects this pseudo-normality. Patients are encouraged to get up at a certain time each day explicitly to fit into a 'normal' routine. This is usually around breakfast or just after breakfast time when medication is administered. There are two points here. The first is that some of the medication that is given to some of the patients makes them tired<sup>53</sup>, making it hard for them to get up. These states of tiredness are what some staff nurses in the hospital call 'Concrete Duvet Syndrome' and 'Survivor' groups call 'The Liquid Cosh'. The second point is that the attempts of persuading patients to wake up in the morning mirrors the perceived normal working pattern that exists outside the walls of the hospital, yet the patients usually have no jobs to go to. The routine at weekends also attempt to mirror the image of normality by enhancing the traditional routines of someone in employment. Here, patients are allowed to 'lie-in'. On a Sunday, for some patients, this can be until the afternoon when Sunday Lunch is officially delivered to the ward at precisely 12:20pm.

If we revisit the beginning of Part One we can see that the image of the patient in the general hospital fits nicely into an 'ideal-type' of what a patient should look like and what they should experience while in hospital. What is important for the

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<sup>52</sup> Laing (1960) would question this view and argue that the informal relationship should pertain to all circumstances.

rest of this chapter is that the process of disempowerment experienced by the general patient is what, in the eyes of the NA, the psychiatric patient should also experience. For them, the psychiatric patient is perceived as 'ill' and therefore 'needy' and docile.

## **Part 2 – Eating with Patients and the Need for Defence Mechanisms**

Central to this chapter is the claim that NAs attempt to form a clearly defined understanding of mental health that psychologically and physically shapes how they offer care to the patients on the ward. NAs create defence mechanisms that work to protect their notions of mental illness and mental health care. I will show that these defence mechanisms are similar to Goffman's (1961) notion of *secondary adjustments*. Goffman defines secondary adjustments as:

....any habitual arrangement by which a member of an organisation employs un-authorized means, or obtains un-authorized ends, or both, thus getting around the organisation's assumptions as to what he should do and get hence what he should be. Secondary adjustments represent ways in which the individual stands apart from the role and the self that were taken for granted for him by the institution (1961:172).

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<sup>53</sup> The main types of medication that causes these feelings of tiredness are depots (an injection that slowly releases the medication) that is given to patients for a blunting effect of negative feelings.



Goffman uses this term specifically in relation to how psychiatric patients ‘make-out’ while being inpatients in the hospital (1961). Through secondary adjustments the patient maintains a small sense of their self that is maintained despite the institution’s expectations of them. The individual demonstrates how they are not totally controlled by the institution, for example, re-arranging their rooms and personal space, using their own mugs at coffee and tea times, having a kettle in their room and taking coffee granules, milk and sugar from the kitchen to their room. This enables the patient to break the boundaries and rules of the institution. Secondary adjustments are usually subtle and the staff either do not notice them or accept that they are relinquishing a small part of power. It is significant that secondary adjustment does not appear to be interpreted as a direct challenge to the institution, but rather is usually seen as behaviour that is a symptom of the patient’s underlying illness.

The limitation of Goffman’s use of secondary adjustments is that he creates a distinction between staff and patients. In other words, the patients rely on secondary adjustments whereas the staff do not, because, according to Goffman, they fit into the official regime of the institution. This is called in contrast *primary adjustment* where the individual (staff member) is bonded to the organisation (Manning, 1992:112). However, though mainly focusing on the position of the patient, Goffman does briefly explain that secondary adjustments can occur in most organisations among staff down the professional ladder. He states that:

Persons at the bottom of large organisations typically operate in drab backgrounds, against which higher-placed members realise their internal incentives, enjoying the satisfaction of receiving visible indulgences that others do not. Low-placed members tend to have less commitment and emotional attachment to the organisation than higher-placed members. In consequence they seem more likely to make wide use of secondary adjustments (1961:182)

It is this use of secondary adjustments used by ‘low-placed members’ of staff that I am interested in. NAs fit into this mould and rely on the ability to create and use secondary adjustments as a key part of their everyday working lives. The commonality between patients and NAs rests on both striving to maintain a sense of self that lies outside the official policy, whilst the institution seems either not to notice it, or to tolerate it<sup>54</sup>. What is paramount is that the NA, along with the domestic staff on the ward, are the lowest ranking staff. They have very little authority, personal incentives, training or passion to enter into such employment<sup>55</sup> and very little authority within it. Along with the patient, the NA relies on their own sense of self to ‘make-out’ (Goffman 1961) while carrying out official tasks on the ward. The ethnographic example below illustrates how this secondary adjustment works as a defence mechanism that protects the NA from the organisational ‘culture’. This defence mechanism does not provide an alternative to caring, since it is not actually about care at all. The key is that it works to defend a boundary of understanding that the NA ascribes to, which in

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<sup>54</sup> In Chapter 6 I will develop this discussion of secondary adjustments by exploring how NAs use the ward and hospital space for interactions that exist outside any discourse of care.

turn allows them to negotiate when and where their own conceptualization of care comes into play.

### **Meal times – constructing pseudo-normality**

The ward kitchen is open at selected times in the day for meals and for patients to make coffee and tea. At daily meal times a food trolley is delivered from the hospital kitchen to the top floor where the food is prepared and cooked daily. Usually a NA prepares the kitchen by piling plates next to the trolley and serving the food to the patients. The patients queue outside and wait for the door to be opened by the NA. All meal times are at the same time everyday. Some patients might queue five minutes before the doors are opened so they can be first in the line. Once opened the NA shouts out “*supper time....supper time*”. A NA or a staff nurse at the far end of the ward will hear this call and start to notify patients at that end of the ward.

There is usually a choice of two dishes for the main course and sponge and custard or fresh fruit for dessert. Individual patients can also make their own coffee, tea or soft drinks. After collecting their food they sit at one of two large square tables that seat between eight to ten people. A radio plays music softly. Once a patient has finished eating, they empty their remains into a waste bin and then place their plate and cutlery next to the sink where the domestic worker stands waiting to wash up.

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<sup>55</sup> Why NAs become NAs is something that I explore in Chapter Six.

When most patients have their food, members of staff come into the kitchen to help themselves from the trolley. They collect a plate and either dish up their own portion, or the NA, who is still serving the food, does it for them. If a member of staff is busy the NA saves a plate of food for them in the heated compartment of the trolley.

Hospital and ward policy promotes the idea that members of the nursing staff partake in meal times and eat with the patients. This allows members of the nursing staff to interact and spend more time with patients. Furthermore, it is supposed to break barriers of difference between the staff and patients, enhancing the view that the patient is treated as an individual who is taking part in 'normal' daily activities. Most of the conversations are based on mundane topics, such as films that were watched the night before on TV or football news. The eating of the same food and from the same set of plates and cutlery attempts to create a sense of 'sameness' between the nursing staff and the patients even if this 'sameness' only lasts for a few minutes each day. I stress the brevity of this time because straight after the mealtime it is medication time when patients line up outside the medication room and, very obviously, become patients again.

This ethnographic example shows how hospital policy and individual nurses strive to promote a patient-centred approach to care in which the patients are not treated as a collective group but as individuals. However, this example is only relevant to one section of the nursing team, namely the qualified nurses. NAs, on the other hand, adopt defence mechanisms to try and avoid these close interactions with the patients at meal times.

### *Constructing boundaries through Tupperware*

Meal times can be seen as ritualised processes. As I have pointed out, patients queue outside the kitchen before the door has been opened because they have become accustomed to the opening times. The way the patient collects their food, where they sit and how long they have to eat their food never changes – except on Christmas Day when the kitchen is left unlocked all day and a full English Breakfast and Christmas Lunch is provided. These everyday ritual procedures position the patient within the ward structure and fundamentally define them as a patient.

In the kitchen there are a number of locked cupboards that store breakfast cereals, coffee, tea, sugar and bread. These cupboards also store the NAs' Tupperware. Once the patients have been served their food, NAs will unlock the cupboard to get their own Tupperware box. Their own cutlery is wrapped in paper napkins and placed in the Tupperware. The NAs then approach the dinner trolley to help themselves to the food. Unlike most of the qualified nurses, NAs are reluctant to sit with other patients and opt to stand or sit next to other members of staff while eating. If they decide to sit at one of the tables, then frequently a newspaper or a pillowcase from the linen cupboard is placed on the seat so that their clothing does not touch the chair directly. After eating, the NA washes their eating utensils and wraps them in a paper napkin before placing them in the Tupperware box to be locked in the cupboard for the next meal.

Although the defence mechanisms are created to different degrees, all NAs protect their bodies from becoming polluted by the seemingly chaotic behaviour or incomprehensible illnesses of the patients. Protecting the body through the use of Tupperware and newspapers directly protects the NA from bodily fluids of the patient such as saliva and blood. When I asked a female NA, whom I had known for over a year, why she did not eat from the same plates and with the same cutlery as the patients she replied cryptically by saying, “*you don’t understand, you don’t have children*”. The threat of becoming polluted in some way by a patient becomes a direct threat to their environment outside the hospital. Often female NAs would describe their home environment by emphasising order and cleanliness. This, then is in direct contrast to their perceived disorder of the hospital. The home represents a space of rationality, normality, order and safety while the ward represents a space of irrationality, disorder and danger.

The NAs’ negotiation of what is and what is not safe can be further developed by using Lévi-Strauss’ use of binary oppositions between cooked and raw food. In his book *The Origin of Table Manners* (1978) he describes that the way that food is cooked results in the method being associated with the classificatory domains of nature/culture and dangerous/safe. He explains that in “all forms of cooking, the food is not just cooked; the process must be carried out in some particular way” (1978:478). He argues that there is a ‘semantic field’ that is made up of three types of food; the *raw*, the *cooked*, and the *rotten* which lend themselves in every culture as a means of expressing oppositions, both on a cosmological and on a sociological level. Levi Strauss develops this theme by exploring the opposition between two types of cooked food – roasted food and boiled food.

Roasted food is associated with nature while boiled food is associated with culture. The argument is that while roasted food is cooked with fire (nature), boiled food “necessitates the use of a receptacle (a cooking pot for example), which is a cultural object; and symbolically, in the sense that culture mediates between man and the world, and boiling is also a mediation, by means of water, between the food which man ingests and that other element of the physical world: fire” (1978:480).

How does the idea of ‘boiled’ verses ‘roasted’ fit into the NAs use of Tupperware? This question can be answered by looking at when food and eating is considered dangerous. Food becomes dangerous when the NA is unable to have a sense of control. By a ‘sense of control’, I mean that the NA is unable to choose the type of food or how it is cooked. Therefore the act of eating turns into a pivotal process so that the NA finds a way to assert their control both on a physical and symbolic level. Although the food that arrives to the ward from the kitchen is already cooked, it has to pass through a process of being symbolically ‘cooked’ by the NA. The Tupperware box acts as the cultural receptacle object (the cooking pot) that mediates and cultivates the food from being symbolically raw and dangerous (nature) to one of safety (culture).

The pre-cultivated or the ‘unprocessed’ food can be analysed on a wider sociological level because, for the NA, it is associated with the two groups that they fundamentally oppose: the qualified nursing staff and the patients. As mentioned earlier in this chapter, the eating habits of these two groups aim to create a pseudo normal environment that challenges and threatens the NA’s

understanding of what psychiatric care is and how broader concepts of 'normal' and 'abnormal' are negotiated. For the NA, the domestic sphere becomes a metaphor for normality and therefore culture. It is an organised, rational and safe place where interactions are carried out between like-minded people. When I had occasion to visit NAs' homes, I was often shown the kitchen and told that it was the central part of the home and had to be kept clean and well run. Everything in the cupboards had their rightful place and large Tupperware containers were used to store spices and dried herbs. In one home, the wife told me that the work surface always had to be clean because it was continually being used for the preparation of food.

Like boiling food, the use of Tupperware becomes the microcosm of a larger set of rules that NAs live by. Tupperware has been discussed in Alison J. Clarke's (1999) book, *Tupper: The Promise of Plastic in 1950's America* as something that, through rituals of gift-giving at parties, become transformed commodities "into artefacts of a profound significance far outweighing their monetary value" (Clarke, 1999:170). The sociological role of Tupperware on a psychiatric ward would support this.

#### *Classification through the taboo of eating*

My research data illustrates that the way NAs prepare and consume food reveals a process of creating and maintaining boundaries of classification between what is perceived as taboo and non-taboo. Anthropologists have argued that the use of taboos maintains classificatory systems (Douglas 1966, Leach 1964, Tambiah 1969). The taboo functions by keeping certain objects and categories apart.



Pollution occurs when the boundaries of classification between separate categories, and therefore difference, become challenged. Therefore, to “follow a taboo...is to shore up a system of cultural distinctions and to prevent connections from forming between cultural domains that must not be mixed” (Bamford 1998:158).

For the NA, the importance of acting within certain rules becomes the essential component in preserving certain classificatory systems. More specifically, it is the act of eating that is surrounded by danger and taboos and the food which represents the meeting point between two diverse classificatory systems of appropriateness. Caplan explains that,

...food is never ‘just food’ and its signification can never be purely nutritional....it is intimately bound up with social relations, including those of power, of inclusion and exclusion, as well as with cultural ideas about classification, the human body and the meaning of health (1997:3).

It is not specific types of food that cause these rituals of protection at mealtimes. Rather, the general act of eating food at mealtimes creates a fear of contamination. Mealtimes mean that the NA and the patient are taking part in an identical function; eating the same food at the same time, from supposedly the same plates and cutlery, while expected to carry out the same mealtime etiquette. Douglas (1999) explains that:

“It (the meal) bounds the area of structured relations, within that area rules apply. Outside it, anything goes” (1999:250).

For the NA, however, the etiquette and rules associated with eating originate and are developed in the domestic space of the home and therefore become challenged by the ‘un-homely’ nature of the ward and the people who live there – the patients. Mealtimes become the only time in a shift when staff and patients interact as equals. I have shown that that NAs refuse to enter into this, somewhat contradictory, interaction with the patients. Rules do apply to the meal times but they hold starkly contrasting meanings to the three groups involved. For the patients and qualified nurses, mealtimes attempt to evoke a sense of normality (or pseudo-normality) through both parties ‘acting out’ a domesticated daily activity. For the NAs, mealtimes have the opposite effect. Rather than ‘acting out’ a process of normality, the NAs defend their clear classificatory model of what is normal and what is not normal. The line of difference is drawn through the very visible use of physical objects.

The NAs’ eating habits are an attempt to fix the patient’s position in the ward structure as ‘a patient’. Their behaviour physically and symbolically classify what is and what is not mentally ill, what is dangerous and what is safe. In general, for the NA, the hospital represents a space of irrational actors and contradictory and hypocritical policies which is in contrast to spaces outside the hospital, and especially in the home where rationality prevails. Therefore, the NA’s comment, mentioned earlier, when she put my lack of understanding about

her eating habits down to my not having children, reinforces this point. In her eyes if I had a stronger idea of 'home' (i.e. by having children, I would have understood her reasoning). The home signifies a safe, rational and controlled environment where their children follow rules that parents set down for them.

The continuous drive by NAs to maintain boundaries of order results in conflict with both the qualified nurses and the patients. The qualified nurses resent that the NAs refused to follow official policy and ideology on care<sup>56</sup>, while many of the patients become aware of the NAs' eating habits and experience this as being stigmatised and isolated. Near the end of my field research an advocacy group was set up and met once a week to allow patients to air their views on issues surrounding life on their wards. The issue which was brought up most often was NAs eating habits at meal times. The meeting's minutes were pinned to every ward's notice board; one stated that:

One member (patient) said that he objected to staff walking around with food, as if they are hiding it or as if they are afraid to eat with residents. He said that some staff has [sic] terrible manners and walk around with food to avoid sitting with residents. This practice has been observed by Group Advocacy Workers, who have seen staff eating their meals away from patients.....Members said that they are very unhappy at the way they are treated at meal times by some members of staff, [sic] and would

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<sup>56</sup> I will explore the conflict between NAs and staff nurses fully in Chapter Six and Seven.

like to see improvements because they are at present being treated like kids (Patients Council: 17<sup>th</sup> August 2000).

The last point, that patients felt they were being treated like 'kids', clearly fits into many NAs' understandings of mental health care.

What is continuously at play is the NAs' attempt to protect themselves from the 'abnormal' and 'dangerous' behaviour of the patients and from the official view of mental health care, as discussed in Chapters Three and Four, which is in opposition to the view held by the NAs.

### **Part 3 - Meaning through practice and the body**

Part Two has provided a clear example of how the body is used in a practical and symbolic way. The use of physical barriers, such as Tupperware protects the NA's body from being polluted by the patient and it also protects the NAs' own understandings and models of care from an imposing official discourse.

The official discourse of care discussed in Chapter Three and Chapter Four, and the unofficial approaches to care discussed in this chapter, illustrate conflicting cultural norms of engagement and practice articulated through a wide variety of social activities. The official discourse of care is clearly stated and transparent,

appearing in policy and official documentation<sup>57</sup>, fitting in to a more traditional concept of discourse. The ethnographic examples in Chapter Four explore how this is interpreted, practised and acted out on a daily basis.

The NA's unofficial approaches to care is more complex. It lacks any formal documentation, it emerges more through learnt practices, shaped on the one hand by cultural dispositions towards care, and on the other, by the low position of the NA in the work place. Therefore, what is not spoken is as important as what is spoken. The meaning generated by these unofficial patterns and practices is particularly communicated through the body. Importantly, both the official discourse of care and the unofficial systems of care rely on the bodily hexis to communicate their meaning.

Informal utterances also play an important role within this unofficial space because they work as subtle reminders for NAs of the values they hold in relation to how they administer care and perceive mental health care. The example earlier in this chapter of how some NAs describe patients as 'kids' is helpful because the image of a child signifies a broader idea of how the patient should be cared for and understood. In other words, children need maternal and paternal leaders that discipline and advise them so that they grow to become developed individuals. This is also the case for patients, as is perceived by NAs.

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<sup>57</sup> There are more examples of this in Chapter Seven.

### **Speaking through the body**

In a similar vein to the ethnographic example of the ward round in Chapter Four, the NAs' unofficial approaches towards care are played out largely through how the body is used in practice. As already discussed in Chapter Four, an essential element of the idea of 'habitus' is that it includes a set of structuring principles and understandings that generate practice (Bourdieu 1977, 1990). The NAs' systems of care fundamentally focuses on the body: both on the containment of the patient's body and also through their own bodies as a means of embodying their understandings and 'habitus', while rejecting others.

It might be more productive to interpret 'habitus' as a process of embodiment because the "distinction between the body as either empirical thing or analytic theme, and embodiment as the existential ground of culture and self is crucial to capitalizing on..." (Csordas, 1994:6). Embodiment is "a state or a person that results from the continuous interaction of body and mind or rather their conceptualisation as elements in a larger unity, the body/mind manifold" (Stathern and Lambek, 1998:6). Crucially, it "surpasses language rules, ideal models; the performance is always more than the script" (Lambek, 1998:120) and it can be "a valuable starting point for rethinking the nature of culture and our existential situation as cultural beings" (Csordas, 1994:6). The key focus then, is on the "interweave between body and culture" (Devisch, 1998:127). In the NAs' case it can certainly be said that performance is more than script.

In the example of the meal times, the NA's bodily praxis portrays an understanding of care that is framed within a stark divide between what is safe

and unsafe. This example and the example of the ward round in Chapter Four show that it is the way in which the body is used that reflects official discourses and unofficial approaches of care. These create and attempt to maintain perceived ideologies of normality, mental illness, care and work.

### **Practicums and habitus**

It is through practice that the ideologies towards care, and fundamentally, the culture of organisation are reproduced. Therefore, practice becomes key to understanding how and why certain discourses and understandings develop. Many of my ethnographic examples have shown how work itself, and the position that a person holds in the work place, defines the type of care articulated. To illustrate this, Emily Martin (1994) has described work place practice as *practicums*. Practicums are processes that generate *configurations*, which are clusters of ideas and practices within institutions. Martin explains that practicums are more about change than habit and may be practices learnt in adulthood. They “involve learning about new concepts of the ideal and fit person,...but learning that is often less formally structured” (1994:15). Importantly, she goes on to explain that:

...where practicums are used inside an institution, such as a corporation, the complex combination of physical and psychological experiences evolved often means that the ‘teachers’ are not exactly in control of the outcome (1994:15).

There is a difference between Martin's idea of practicum and Bourdieu's habitus because practicum is learnt behaviour in new specific surroundings, such as the work place, and function as a means of maintaining competency whereas habitus is imbued into the individual from childhood. In relation to the official and unofficial models of care, Martin's concept usefully highlights how the 'teachers', or those with knowledge and authority, do not necessarily control how an individual or group construct their practicum. This is particularly relevant in the case of the unofficial approaches to care where the NAs' practicum appear to be in opposition to those of qualified nurses and doctors.

How a person learns these practicum is related to where they are positioned in the work place. For example, qualified staff have learnt processes that start in a formal setting and are then shaped through experience and practice. These processes shape how they perceive and administer mental health care. The NAs' practicum are learnt, informal processes that attempt to protect themselves from the danger of pollution from the patient and the threat of the official discourse of care (or 'the teachers'). Though it is the general habitus that sits at the core of both the official discourse of care and the unofficial approaches to care, the practicum work as competent techniques which maintain the structure of each system.



#### **Part 4 – Practicums in the Buffer Zone**

The use of practicums by the NAs are most apparent when they are required to carry out allocated tasks. Throughout a shift there are times when NAs have to interact with the official discourse of care. This is mainly while carrying out tasks that have been designated to them by the nurse in charge of the shift. Tasks range from escorting patients to shops or the post office, or interacting with patients in potentially more intimate ways. In the case of the latter it is interesting that when a NA is required to bath, wash or dress a patient, for example, there never appears to be a tension arising from the risk of being polluted because the NA is required to put on a disposable apron and gloves before carrying out the task at hand. Task-orientated work allows the NA to don official garments which act as protection against the physical threat of pollution from the patient.

Tasks such as bathing or dressing patients throughout the day prompt qualified nurses to praise the NAs for carrying out these ‘difficult’ or ‘demanding’ tasks:

*“Mary (the NA) you are wonderful..... The way you have coped with patient X all day.....I don’t think I could have done that”.*

This comment was made in relation to a NA bathing and dressing an elderly female patient who was incontinent. In this way the role enables the NAs to

position themselves, temporally, within one area of the official discourse of care, albeit a traditional one where the patient is seen as *needy*. Critically, these official tasks fit into the way NAs perceive patients should be cared for. In other words, the apparent inability of the *needy* patient to care for themselves resembles a patient in a general hospital rather than a psychiatric patient.

From the NAs' point of view, the *needy* patient is officially cared for through formal procedures and tasks during which crucially there is a focus on the physical body of the patient. Examples of this are bathing the patient or escorting to the shops. The care offered at meal times however, is meant to be more therapeutic and 'person-centred'. As discussed earlier, this causes a disruption to the NAs' process of offering care because their own expectation is that while the patient is in the hospital they are always *needy*, always ill and always a threat.

### **Defining the Buffer Zone**

I want to introduce a further idea in order to discuss just how the ward nevertheless functions in a stable way. The buffer zone is the space where the official and unofficial systems of care meet and to some degree co-exist so as to maintain a necessary level of efficiency throughout the shift.<sup>58</sup> This space enables NAs and qualified nurses to translate and accept each others' approaches to care at a safe distance. For the NAs the zone enables them to carry out required tasks in a general fashion that suits their understanding of care. For the qualified nursing staff, the buffer zone allows them to allocate those tasks that do not ideally fit into their own discourse of care but that nevertheless need to be done.

Crucially, the main focus of where care is situated within the buffer zone is the patient's physical body. Such tasks are largely undesirable from the official standpoint because they demand an attention to the management of the physical patient and not to a therapeutic engagement or in other words, the management of the patient's mind. The official system subtly attempts to deny that caring for the physical body is a feature of care by allocating the tasks to the NAs (I will discuss this further in Chapter Seven).

### *Improvising Care in the Buffer Zone*

The majority of tasks that the NAs carry out in the buffer zone require the use of practicums. One of the key points about the practicums is that management, or in this case the qualified nursing staff, do not have control over how the tasks are completed. Therefore, practicums are similar to the use of secondary adjustments discussed earlier. For this reason the NAs are able to rely on their own improvisation to complete the tasks allocated to them. The need to improvise creates a system of protection against the perceived negative attitudes held against them by qualified staff and the organisation. The majority of tasks rely heavily on the use of the NA's body to control and contain a patient's behaviour and movement. By physically controlling a patient's behaviour the NA feels secure and free from criticism from the qualified staff.<sup>59</sup>

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<sup>58</sup> This theme will be developed in Chapter Seven, but in this chapter it aims to provide a general account of how the two discourses of care interact. Chapter Seven will analyse this interaction in more detail.

<sup>59</sup> Of course there are times when this use of the NA's physical body as a means of containing the patient's behaviour and not as a means of evading criticism from the qualified staff is poorly done. Here, the NA might stretch their leg across the patient's bedroom door so as to prevent the patient from leaving their room. These actions usually arise when the NA has had to follow the patient around the ward and has become tired, and frustrated with the patient's behaviour.

The ethnographic example below shows how carrying out Level One Observations<sup>60</sup> on a female patient has two objectives for the NA. On the one hand, the NA tries to calm the patient's seemingly erratic behaviour. On the other hand, the NA is also attempting to portray themselves as a competent member of staff who is able to complete the task.

*'Being on' Level 1 'Obs'*<sup>61</sup>

A 21 year old female patient was admitted on to the ward after the police had arrested her at her home. Her mother had reported that she was being verbally and physically threatening towards her. The patient was known to the staff at the hospital as schizophrenic and had relapsed into a psychotic state after failing to take her medication. The medical team had placed the patient on Level One Observations. This means that a member of staff, usually a NA, has to be at an arm's length from the patient at all times. If the patient enters their room the NA usually sits or stands outside the room.

On this occasion, the patient's behaviour was constantly manic. She was pacing, jumping and running up and down the ward's corridor. Her speech was erratic; she spoke quickly and her sentences were disjointed and made little sense. She got into behavioural patterns where she would run up and down the corridor shouting and would then quickly run into her room, lie on her bed for a few seconds and then repeat the pattern. This meant that the NA carrying out the

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<sup>60</sup> Level 1 observations means that a member of staff has to follow a patient wherever they go on the ward. Officially, the nurse has to be at an arms length to the patient so that they do not attempt to harm themselves or others, or abscond from the ward. On most occasions it is the NA who carries out this task. There are also level 2 observations that require a member of staff to check where certain patients are on the ward. This usually happens every 10-15minutes.

<sup>61</sup> 'Obs' is the slang term to describe observations.

Level One Observation was constantly on the move from one end of the ward to the other. When the patient entered her room the NA would sit on the chair outside her room and then jump up seconds later to follow the patient again.

Each Level One Observation on the patient lasted for one hour before another NA would take over. Within the shift a NA would carry out between 2-3 of the Level One Observations on this particular patient. The hour-long observations became more and more tiring. The patient, in this example, was on Level One Observations for over a week. At times the patient would stand close to the NA's face and shout abuse: often about her mother being "the devil" and a "fucking bitch". The draining nature of the observation caused the various NAs to react and cope with the situation in different ways. Some would slowly stand up from their chairs when the patient started to run up-and-down the corridor, or wait for the patient to get to the end of the corridor before standing up and quickly following. Other NAs would raise their leg across the door or place the chair in the doorway so the patient would be contained for a slightly longer time in their room. NAs would resort to issuing demands, such as '*sit down*', '*stop running around*' and '*I don't understand what you are saying...calm down*'. At the same time the patient showed little sign of understanding what the NA was saying.

#### *Rose Improvising Care: I*

Rose was a 48 year old Nigerian woman who worked as a 'bank' NA. She had been asked to work for a week on the ward because of the special observations

on the patient.<sup>62</sup> Because Rose was booked for a week and was not a permanent member of staff, she spent most of her time carrying out the Level One Observations. Rose explained to me that she was becoming tired with “*all the running about*” and wished that the patient’s behaviour would settle.

Later on in the week, I noticed that Rose had begun to engage with the patient more personally. There were two main examples of this. The first was when the patient’s mother came onto the ward. The nursing staff had notified the security to inform them when the mother was coming so that staff were ready for any violent behaviour towards the mother. When the mother came out of the lift, the patient started to shout abuse. The two staff nurses appeared from the nursing office and one asked the mother if she would come into the office for a chat. The door was shut but the patient remained outside the door looking through the glass window and shouting further abuse. Rose stood in front of the patient with her back up against the door. She spread her arms out wide to stop any attempt by the patient to enter the office. She explained to the patient that she had to calm down or “*they will take you and inject you*”. The use of a warning was an attempt to try and calm the patient. The use of word “*they*” could be seen as a way of Rose attempting to distance herself from the other staff so that the patient would trust her and then calm down.

#### *Rose Improvising Care: 2*

The second example of Rose developing her own techniques through improvisation occurred after the mother had left the ward. The patient carried on

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<sup>62</sup> When there is a Level One Observation an extra member of staff has to be booked. This is

with her ritualised behaviour, but spent more time playing a radio loudly in her bedroom and dancing to the music. Other patients were beginning to complain that this was “*getting-on-their-nerves*” and that the music was “*too loud*”. Rose again attempted to create closer links with the patient as a means of controlling her behaviour. She did this by entering the patient’s room and holding the patient’s hands while dancing with her. The patient was only able to concentrate on the dancing for a few seconds, before running up and down the corridor again.

Rose’s work was made more difficult as she was caring for a patient who seemed unable to respond to her. Rose had to work within a framework that made sense according to her own understanding of the patient’s illness; regardless of whether or not the patient understood her. Her personal attempts at befriending the patient had had a minimal effect if any at all, on the patient’s mental state at the time. But Rose persistently cared for the patient in an unorthodox fashion in relation to the ward, hospital and Trust policy of carrying out Level One Observations.

Key to Rose’s actions was that she felt embarrassed by the patient’s behaviour:

*‘I feel that everyone will think that I cannot do my job and that it is my fault that she (the patient) is like this’*

Rose felt that she should be seen to be doing something when the patient was shouting and screaming: she should be trying to control her. The friendship that

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usually a NA, and in this case it was felt that it would be better if the NA was female.

Rose was attempting to create through dancing, verbal warnings and threats became linked with the fear of not being seen to be 'doing my job'.

Rose's and the other NAs' use of improvisation means that care frequently takes a form that contradicts official policy, but that reflects and supports the NAs' understanding of how they should conduct themselves. The example of Rose shows how the body is often used in an attempt to control the patient's behaviour, endorsing by the attitude of regarding the patient as a child or 'needy'. While some NAs used their bodies as a form of discipline against the patient, such as blocking the patient in her room by stretching their legs across the door way, Rose attempted to befriend the patient by dancing with her, or warning her that she might have an injection administered by 'them' if she carried on with her behaviour. In all cases, the aim is to control the patient's behaviour through the physical use of the NA's body so that NAs protect themselves from any negative judgement from the qualified members of staff. Importantly, being perceived as being 'unable' does not result in NAs feeling that they are failing in their jobs and diminishing the chance of further career development. Rather, being seen as 'unable' is interpreted as being weak and therefore threatens their stable position on the ward. In other words, they want to complete their allocated tasks, not because of a desire to care, but to be able to earn a living within a work environment which they have not chosen and with which they do not want to be associated.<sup>63</sup>

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<sup>63</sup> As I will discuss in Chapter Six, entering into the caring profession for financial reasons does not sit comfortably with the desire official image of the organisation.



The use of the body by the NAs in the buffer zone is an example of how the NAs act out practicums. The reason for using these individually created practicums is to defend firstly their fundamental understanding of care which is to interact with the patient as a *needy* individual and secondly their attitude towards such work which involves not being criticised by the qualified staff.

### **Conclusion**

This chapter has introduced the role of the NA. Until this point in the thesis, I have deliberately denied the NA any agency in an attempt to provide a clear interpretation of the official processes that shape mental health care on an acute psychiatric ward. However, by bringing the NA into the discussion, I have begun to illustrate that the care process on a ward is more complex than is portrayed in the official discourse.

I have shown that NAs are continuously negotiating how they embrace the practical and moral demands of being a 'care giver'. As shown in the case of mealtimes, there is a clear rejection of the complex demands that the official discourse of care expects from them. Answering such demands is riddled with feelings of being in danger; both to the NA's physical body, and also to their perceptions of what their jobs entails. On a practical level, the official task-orientated work that they carry out is often demanding and stressful, as the case of Rose shows. Tasks often mean that the NA has to care for patients without the training and knowledge that qualified nurses have acquired. Therefore, the NA is

left to use their own knowledge and experience to formulate a system of coping that allows them to complete the task as best they can. In Rose's case, she had to create a manner of coping due to the demanding nature of the patient's behaviour so that she was *seen* to be doing her job well, while also wanting to protect the patient by befriending her in a maternal way so as to help her behaviour settle.

In Chapters Three and Four, I argued that the official discourse of care has within it different discourses that, at times, oppose each other; such as nursing and doctors discourses. However, both have at their core a common goal that emphasises the ideology of the official system. The NAs' unofficial approaches to care, I am arguing, is in opposition to this. The patient is always framed as being mentally ill, needy and dangerous, leaving little space for interacting with them within the desired framework drawn up by the official discourse of care. For the NA, the patient cannot be conceived of ever being empowered in decision making. Instead, the patient is perceived as a child that is in need of firm boundaries to provide them with the ability to 'get better', as Rose tried to do.

Where the official discourse of care promotes choice and normality (or pseudo-normality) through therapeutic relationships, unofficial approaches to care promote a passive patient who interacts within a disciplinary relationship negotiated by the care-giver. Once the patient is seen to be active, such as at mealtimes, the NA has to resort to protecting their systems of classification through the physical construction of defence mechanisms. Fundamentally, their models of care are practised through the use of their bodies and physical tools such as Tupperware boxes. The body – both theirs and the patients' becomes the

field in which their ideology and beliefs are shaped and maintained. It becomes the central area of control in an otherwise contradictory and threatening environment, in which the patient is allowed to metamorphose at certain times of the day into a rational thinking person within a pseudo-normal environment.

In the next chapter I will explore in more detail the attitudes held by NAs towards their work and how they use secondary adjustments (Goffman 1964), not merely as coping mechanisms, but as systems of protest and resistance that are structured around the unofficial use of hospital and ward space.

## VI. Caring for Money:

### Systems of Protest and Resistance

‘Money’, which is a short-hand way of saying capitalist relations, market values, trade and exchange, ushers in a world of moral confusion...[it] complicates the moral order, turning what was formerly black and white into greyness.

(Macfarlane<sup>64</sup> cited in Parry and Bloch, 1989:17)

#### **Introduction**

The last chapter introduced NAs by exploring how they negotiate and understand the administering of mental health care on College Ward. The main focus was to illustrate how and why NAs form opposing approaches to care from the official one. This chapter aims to explore further the position of the NA by concentrating on how they perceive their work and their low status in the hospital and how they are perceived by the qualified nurses. It shifts from looking at care *per se* to focusing on NAs’ attitudes towards work and the ways in which they use the ward and hospital space for subtle systems of resistance to the official discourse

of care and of protest against their low and inferior status in the work place. It will be shown that forms of protest can be seen for example, in the mocking and teasing of young black African qualified nurses by the NAs and in their use of the ward 'communication book'. I will also illustrate that unofficial socio-economic interactions on the ward and in the hospital exist as systems of resistance against their official role.

Part One starts with an ethnographic vignette which reveals that the NAs motivation for their work is predominantly economic and their status in the hospital is akin to that of a servant. I will describe the practical reality of their official role by showing that their work is focused on carrying out mundane tasks that primarily focus on the patient's body and not on the 'therapeutic relationship'. These tasks are allocated according to regimented time slots on the 'allocation sheet' and show how NAs' bodies are marshalled on the ward. A comparison is made with E.P Thompson's (1991) account of factory workers and industrialisation.

Part Two explores systems of protest and resistance. Acts of protest mainly took place on the 'front-stage' because they were directed against the official system. Acts of resistance mainly occurred on the 'back-stage' where the NAs were attempting to forge an autonomous space. These will be illustrated with ethnographic examples, firstly of how an NA attempted to find a channel of communication for his voice of discontent through the use of the ward communication book (protest) and secondly how unofficial economic trade is

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<sup>64</sup> The reference for this is, Macfarlane, A (1985) 'The root of all evil', in D.Parkin (ed.), *The*

carried out (resistance). I will draw on Hart's (2000) concept of the 'informal economy' and Parry's (1999) work on the Indian labour in the Bhilai Steel Plant to highlight the position of the NA. I emphasize the point that the concept of care for the NAs is framed as a commodity that is offered in exchange for money and not as a moral disposition to care. However, the focus on money is not one of greed but one of survival and the need to earn a basic living.

Part Three shows how white qualified nurses attempt to understand the NAs through discourses of racism. My data indicated that white nurses could be seen as interpreting the NAs' approach to care as being one of greed and idleness where the NA only cares about money and has no empathy with the patient. I go on to show that an unconscious racial stereotype is employed in the nurses' 'back-stage' to try and make sense of the NAs behaviour. As a result they create a discourse of 'whiteness' (Dyer 2000) as a benchmark of what is acceptable care. This has implications for how black African qualified nurses interpret the NAs. The nurses have to negotiate their position in relation to the NAs along lines of ethnicity, gender and age where the NAs attempt to make them feel inferior. The black African qualified nurses also feel inferior in relation to the white qualified nurses and feel that they were constantly being observed by the white nurses in relation to their professional identity.

### **Part 1 – Work, Position and the Official Space**

The ward was settled and most of the patients were either on-leave, asleep or watching TV. At the far end of the corridor were two female NAs sitting and chatting to each other. I had little to do so I walked over to where they were to see what they were chatting about. Samantha and Florence were each holding small red-covered copies of the New Testament and explained to me that they had been reading extracts from the gospel together. Florence enthusiastically told me how important it was to pray as much as possible so that the 'Lord looks after you'. The little red books were often carried around by NAs in their pockets or hidden in a magazine or newspaper. Informal prayer meetings, such as this one, would be a common feature amongst NAs. Such meetings were spontaneous with little need for organisation which, therefore, allowed them to be formed and dissolved in a few seconds. Below is an extract from the conversation I had with Samantha and Florence.

Samantha excitedly said to me:

**Samantha:** *I am going to Nigeria John.....It will be so nice to see my family and eat nice food”.*

I asked Florence if she was also planning to make a trip to Nigeria soon as well but her reply was somewhat different:

**Florence:** *I cannot go, it is too expensive, I have bills to pay here and it would be too hard to save for it. The last time I was there was six years ago.*

Samantha started to laugh at Florence.

**Samantha:** *How can you say you cannot go? It is important that you see your family there. If you put your mind to it and work hard you can make the money to go. You must pray to the Lord more so that you can go to Nigeria’.*

Florence appeared to be angry at Samantha’s instruction.

**Florence:** *How can you say I must pray to the Lord. I pray all the time, while I am at work, at home and when I am shopping. You pray for the wrong things that we are not taught – you pray for self gain’.*

Samantha turned her head away. She then started to explain to me that she tried to go once a year to see her family so they know she is well. I asked her what her family thought of her job as a NA

**Samantha:** *I do not tell them that I am an NA, I make out that I work in an office. People think badly that someone could go to London and end up as a NA’.*



Florence interrupted to explain that she tells her family what she does.

**Florence:** *When I was a domestic I told my family – why should I lie'?*

Samantha carried on talking about her trip to Nigeria without acknowledging Florence's comments.

**Samantha:** *When you go to Nigeria you wear nice clothes to show that you are doing well and you buy gifts for friends and family'*

Florence then asked Samantha:

**Florence:** *Why pretend to have money? This is not what the Lord taught us'.*

Florence appeared upset and started to walk down the corridor to the nursing office; Samantha looked at me and rolled her eyes.

I carried on the conversation with Samantha exploring some of the reasons why she and many others did not tell family and friends in Nigeria that they were working as NAs. Samantha

explained that she felt that NAs' work went unnoticed by the qualified staff.

**Samantha:** *We are not important. The work we do is 'mo ye e wa' (do this do that). That is what people back home say we do – we are like servants. It is shameful that we have the chance to come to England and can only find this type of work. That is why it is important that we show people in Nigeria that we are successful and can wear nice clothes.*

A week or so later Samantha arrived for her shift with a bunch of flowers and a couple of boxes of chocolate for the staff. She came into the nursing office with a smile on her face. She told the staff in the office that her husband had got a job as a computer technician for Motorola Telecommunications. She explained that he would have to travel between London and Germany. The rest of the staff, although visibly pleased for Samantha, seemed slightly confused as to how to respond to the flowers and chocolate. Alice, a staff nurse, stood up from the desk and gave Samantha a hug. Her visit home to Nigeria now could be something that she could embrace, speaking about the wonders of Motorola.

### **Working on the Ward**

It is hard to define the actual work that NAs do without slipping into an oversimplified definition based on the 'tasks' they perform. However, it probably is

just that. Their work is not about entering into 'therapeutic relationships' with patients, or about clinical decision-making within Multi Disciplinary Teams (MDTs) based on a professional ideology and training as with qualified nurses. Work for the NA has a more routine nature, starting at the beginning of the shift with the check-list to see if patients are in their correct places. As we have seen already, tasks often include opening the kitchen and being the monitor for meals and coffee and tea times, carrying out Level One and Two observations, bathing patients, escorting them out of the hospital, watching TV with patients, collecting medication from the reception and making beds when patients are discharged.

According to my observations, there are only three occasions when the NA adopts a more medical approach to their work. The first is at the end of the shift when they are supposed to make a written entry in the notes of their 'allocated patients', commenting on their moods, behaviour, hygiene etc. The second is when one team hands over information on all patients to the next nursing team at the beginning of a new shift. The NAs are also encouraged to handover their patients. "*Oh I hate this...why do I have to do this, why don't they (the nurses) do it...they get paid more*" became a regular comment from some NAs. The final interaction with the medical model is when a patient has to be restrained of a patient. NAs, who have been trained<sup>65</sup> in C&R (Control and Restraint) or PMVA (Prevention and Management of Violence and Aggression) are called to the ward to form 'a team' to carry out the restraint. This is the only time when a NA can

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<sup>65</sup> All nursing staff are expected to carry out training that relates to their work. The ward manager usually decides what type of training each member of staff has to do, such as Control and Restraint or Food Hygiene training. These courses are usually seen as essential training for staff. Members of staff can also request to go on specific courses such as Basic Counselling Skills. Requested training has to be approved by the ward manager. Training courses can last for a half day, up to 2 weeks or longer.

actually be in charge of a medical procedure, particularly if they are in the position where they are holding the patient's head. Restraining requires two other members of staff to take hold of each arm of the patient and another to lie across the patient's legs (if on the floor). Being positioned at the patient's head means that the nurse or NA can observe the whole situation around them and dictate when the patient should be moved or, as they say, "dropped" to the floor. The NA carries out mundane, non-clinical time-tabled tasks, apart from spending a few minutes entering a paragraph in the patients' notes (which have to be checked and counter signed by a qualified nurse before the notes are filed away) and handing over to the on-coming shift and restraining patients.

### *The Allocation Sheet*

Timetabled controlled tasks, in this context, can be described as follows. At the beginning of each shift the nurse-in-charge would fill in the allocation sheet – an A4 piece of paper. This sheet lists the names of the staff working on that shift and maybe the names of a couple of student nurses if they are on placement on the ward. The nurse-in-charge would be listed at the top of the list, then another staff nurse and then the two NAs (the students' names are squeezed in somewhere). Running horizontally next to each name would be between 4-5 patient's names allocated to each staff member for that shift. Below the names are sections to be filled in to allocate when each NA has to carry out a specific task. For example:

13:30-14:30 John C (me) Level Two Observations

14:30-15:30 Ben Level Two Observations

14:30-15:30 John C, Kitchen.

15:30-16:30 John C Level Two Observation.

In between these tasks might be specific tasks such as escorting patients to their flats or taking them for a walk or to the shops.

The sheet becomes a major focus as it dictates how relaxed or busy the shift will be. If you are allocated to carry out the last Level Two Observation on the late shift you would be unable to 'get off' early. It may be that an NA only has half an hour in the shift where they have not been allocated a specific task. During this 'unallocated' time, the NA is officially expected to have a one-to-one 'therapeutic' meetings with their 4-5 patients before returning to the allocated tasks. Therapeutic meetings are not scheduled into the allocation sheet. In reality, the therapeutic meetings rarely happen. The ideal scenario for the NAs is when the ward is going through a 'calm period', such as when many patients are on leave. This enables them to be free from writing in their allocated patient's notes, handing over or having one-to-one chats. Of course, the opposite is more common when the ward is very busy and there are a number of difficult situations or patients: one patient on Level 1 Observation, many Level Two Observations, violence, escorts etc.

At the beginning of each shift, certain NAs would quietly approach the nurse-in-charge to make personal requests for the allocation sheet. For example, some might prefer carrying out the lunch or dinner duties, while some might wish to do less patient escorts outside the hospital. Whether or not the requests were

successful depended on how busy the ward was and which nurse was in-charge of the shift. Twenty minutes later the allocation sheet would be stuck to one of the shelves in the nursing office so that all the team knew what to do and this would indicate that the shift is underway.

The NAs' official routine means that there are similarities between their role and the concept of Fordism, where the NA's role and time allocation have all the hallmarks of a factory worker where decision-making and devolved responsibilities are non-existent (Giddens 2001). E.P Thompson (1991 [1967]) also supports this point. He argues that the introduction of modern industry and factory work meant that work was structured by time and a strict use of the clock. This replaced work being based around the different seasons of the year. Along with this strict time controlled routine was the rise of a distinct divide between work time and leisure time, leaving little or no room for these two to merge. Tasks now demanded finely tuned co-ordination and consistent productivity. In a similar way to the rise of factory work, the allocation sheet for NAs becomes central to controlling their work pattern on a shift because it determines where and when their presence is required so as to meet the needs of the ward and hospital. This regimented time structure and their lowly position within the hospital structure, produces feelings of subordination of being under valued. NAs explained that they are stuck and unable to get promotion even though they were doing much of the staff nurses' work. Although not factory workers, their feelings of constraint and lack of agency in the work place are all too similar.

## Part 2 - Systems of Protest and Resistance

Ong's research (1987) on female factory workers in Malaysia supports Thompson's argument. Ong argues that before young women started working in factories they would work within a 'traditional' Kampong lifestyle that was largely unsupervised. Their work was task-orientated but the women made this more bearable by sharing jokes and singing songs. However, the introduction of factory work replaced the 'traditional' lifestyle with time-controlled discipline and constant surveillance by the male management. Such a detachment from their desired working life results in small acts of resistance: for example, becoming possessed by ghosts.

As a result of the kind of work NAs did in the hospital, systems of protest similarly arise that attempt to carve out areas of control and independence. Some are centred on ethnicity and nationalism; for example, when Nigerian NAs gossip and mock the younger but senior qualified nurses from South Africa, Botswana and Zimbabwe. Mocking would be directed mainly at the male nurses and would involve telling the nurses that their whole attitude was 'bush' and that they acted as though they were from the 'village'. If teasing were directed at female Southern African nurses the female NAs would stress age instead, arguing that they should not order older African women around. In Chapter Two I explained how my joking relationship with a male NA formed part of our friendship. I illustrated how I mis-read the boundaries of what was and was not acceptable.

However, joking relationships between West African NAs and black Southern African staff nurses was political because they 'playfully' enabled the NAs to attempt to assert power over the staff nurses. Joking, mocking or teasing is a 'safe' system whereby the NAs can attempt to assert their influence over the younger staff nurses because the joking relationship requires that those being mocked do not take offence. Radcliffe-Brown explains that any "default in the relationship is like a breach of the rules of etiquette; the person concerned is regarded as not knowing how to behave himself" (1952: 103). The mocking was usually responded to by laughing, thus diluting the underlying significance of the comments that aimed at the NA trying to claim respect and a little authority over the nurse. More effective and direct systems of protest were enacted through official procedures on the ward. This would usually be through the communication book.

### **A method of Protest: Francis and the Communication Book**

The communication book is basically self-explanatory. It is kept in the nursing office and is used by all the staff to note phone messages, important events, chores that need carrying out, and general grumbles that individual staff members might have about the running of the ward – such as dirty cups being left in the staff room. However, sometimes the comments are more significant. On one occasion, a staff nurse wrote that Kate, one of the two-deputy ward managers, would be visiting the ward with her new baby boy. The entry suggested that the staff donate some money so that a small present could be bought for Kate and the baby. Staff members from all grades thought that this would be a good idea and furthermore, they were all keen to see the baby and Kate. However, one male NA



called Francis took exception to this entry and wrote a long paragraph in the communication book explaining how unfair it was that he was not given a present or card when his baby had been born a year earlier. This is what Francis wrote:

*To All*

*Reference to this collection stated above. I had my baby before her (Kate) and not even a card from the ward, talkless (sic) of collection. I will make it clear that on no account should anybody come to me for any collection here and let nobody collect on my behalf....everything here is based on your grade.*

Francis had been working on the ward for two and a half years and for a few months had mentioned to me that he was feeling worthless in his job. He had resorted to doing night shifts rather than day shifts to reduce his contact with patients and the endless routine of carrying out the tasks. He would also spend time questioning and criticising issues of ward and Trust policy such as annual and sick leave, and procedures of staff complaint. He would study other people's shifts in the Off Duty folder to see who had got more extra (or over-time) shifts or was taking regular sick leave. If he felt someone was getting an unfair share of extra shifts he would make an entry in the communication book, pointing it out to all the staff and indirectly shaming the nurse who authorised them. The use of official policy for Francis and many other NAs to point out bureaucratic 'wrong doings' was common. However, qualified nurses would explain to me that many NAs would use policy to their own advantage, such as gaining extra shifts, sick leave and time owing, and were rarely were bothered with patients' well being.

A qualified nurse called Caroline was shocked by Francis' entry in the communication book and pointed it out to me. Other NAs thought it was funny but also felt that it was inappropriate to have written it. When Mike, the other deputy ward manger, came on to the ward for the late shift, he read the entry and slowly shook his head and smiled.

The collection finally took place a few days later. Mary, an NA, was asked to carry out the collection. When a staff nurse asked her if she was going to approach Francis she became angry and insisted that everyone should get something, especially as his baby was going to be christened a month later. Another NA agreed and added that there cannot be a rule for one and not the other.

There was, consequently, a divide in attitudes towards Francis's entry about the collection. The qualified section of the staff kept a low profile while discreetly being appalled by the entry, while the NAs agreed that Francis should be bought something for his son's christening and that it was wrong to collect just for the qualified nurses. But these systems of protest are more than just a drive to create equality in the work environment. They also work as coping mechanisms by which the NAs can try and make sense of their position on the ward, both individually and collectively by projecting their frustration into the public domain.

So far, I have argued that being an NA is a mundane experience where the work is shaped and controlled by the clock. Room for self-expression rarely exists. Instead, NAs rely on small and largely ineffectual acts of protest. Francis did get a present for his son's christening or 'naming ceremony', but only the NAs took up his invitation to attend. The initial image of work is therefore one in which the lower you are in the hierarchy, the less value is placed on your role, resulting in less commitment to doing a good job. However, there is more to the position of the NA than their official role. Behind the controlling timetables and the mundane chores are forms of informal economic and symbolic exchanges, for example, through the selling of mobile phone cards, food, cloth and clothing. The next section will describe how this functions through the manipulation of the official use of space on the ward and in the hospital more generally.

### **System of Resistance - Trading on the Ward**

Peter was a 47-year-old Nigerian man who had been working in the hospital as a NA for three years. He carried a small black diary in his trouser pocket. Stuffed into the diary was endless pieces of paper. These had lists with the names of all the people that owed him money for phone cards. The scraps of paper were kept from falling out by an elaborate use of elastic bands that were tied together and wrapped around the diary. Peter would habitually start unwrapping and re-wrapping the elastic bands while talking to me.

*Hey man, look at all these people that owe me money....He (pointing at one of the names) owes me £85, I rang him but he has not returned my call....He is a Muslim brother like me, how could he disrespect me?*

In Nigeria, Peter used to trade in cloth, electrical goods and cars. Such was his expertise that he knew where one could get the best deals in New York, Japan, Hong Kong and South Korea. On one occasion I was speaking to Peter about a patient I had to escort back to Hong Kong. He told me that Hong Kong was one of his favourite places. He used to go there to buy video machines and clothing to bring back to Nigeria. When he started these trips he would buy five or six machines and pack them in a special way so that he could carry them as hand luggage. As his trading business expanded he would import the items as cargo and collect them in Nigeria.

Peter got his pen out and a scrap piece of paper and wrote down for me the 4 stages needed to complete a successful business trip abroad. These were:

1. Find the cheapest flight to the country you are going to. This might take a day but you can save a lot of money.
2. When you get to the town, book into a B&B and don't spend more than £20 a night. Every town has cheap accommodation.
3. Spend a day walking around the shops so you can see which ones are doing the best deals. This will also give you time to observe what the latest styles are in clothing and electrical goods; look at what the women are wearing.
4. Make good friends with the people that you are buying from so that if you return to the same town they will remember you and give you a good deal. Trust also builds up.

Peter stressed that trust is how you become a good businessman. He had to leave Nigeria as he was shot at by gangsters who demanded a share of his profits. His wife, two daughters and a son still live in Lagos.

Peter was a 'floating A Grade' (NA) which meant that he could be called on by any one of the wards if they needed extra staff for a certain period in a shift. He was therefore never permanently on one ward. However, his base was at the main reception desk standing or sitting beside the security guard. Under the desk, Peter stored his phone cards and other goods that he had for sale. On two of the four wards he also had lockers where he stored clothing to sell. Peter would also store bush meat (when he had it) and dried fish in the refrigerator which was officially used to store medication that arrived from a pharmacy based at a nearby hospital.

When Peter had something to sell, word would rapidly go round the wards and NAs would make separate trips to meet him. At other times, he would go directly to them. In the locker room he would produce two or three shirts and carefully unfold them. Then he would tell you the price and remind you about the good quality of the goods. Usually the clothing would be brought to the UK from the US by people who had previously asked Peter for information about working. It was a form of payment in exchange for his information. Peter used their gifts to make money. But it was phone cards that Peter sold daily.

Peter carried the phone cards either in his pocket along with his diary, or in a plastic bag. Payment for these cards was either made there and then or later

through his 'diary credit system'. The actual purchase of a card only took a minute or two. His position as a 'floating' NA in the hospital meant that his sale of cards could be flexible and adaptable to fit the circumstances in the hospital at any time, for example, a member of staff on a ward in the hospital would contact him either at the reception desk or on his mobile phone. He would then visit their ward to sell the card. Another method would be an NA working in another hospital, would ring Peter on his mobile phone to ask if they could buy a card. Peter would then take a new, unused one and scratch off the strip of foil on the back to reveal the user code. He would then, in a whispered tone, read out the number over the phone. The client would write the number down, enabling them to use the credits on the card, without actually having it. The name of the customer, like everyone else who used Peter's credit system, would be immediately written onto one of the loose pieces of paper in his diary.

I asked Peter why he sold the cards even though by a quick calculation, he did not make much money from their sales – about 10% commission on each card. He replied that he had a natural business mind and that, if he did not keep it working, it would disappear. Peter would continually share entrepreneurial ideas relating to business ventures. These included buying a second-hand estate car and small freezer from Hackney Market so that he could sell frozen beef and goat at the hospital, or starting up a 'Peter style' franchise of fried chicken joints that one day would become a world-wide phenomena. They were ways, I think, which allowed Peter to cope with the mundane nature of the work. Resistance, for Peter, was to act out a grand imaginary status which he could possibly have

had if the gangsters had not forced him to leave Lagos. As Gaston Bachelard says: “Imagination augments the values of reality” (1994 [1969]: 3).

Although Peter was the main trader in the hospital, other NAs would also sell items. Mary, a 42 year old Nigerian woman would occasionally bring in Italian handbags or make-up. The system for selling these items would be similar to Peter’s but without the complex credit system. Instead, Mary would simply phone other female NAs on other wards and throughout the shift they would then visit her. Many of these transactions would take place in the staff room, out of the view of any nurses and patients. There was also a system of currency exchange (Sterling into US Dollars) offered by another NA. Probably the most elaborate form of trading was carried out by one NA who would park imported cars from Japan outside the hospital for specific customers (not hospital-based) to view.

#### *The use of resistance to create social links*

Sociologically, the use of hospital space by NAs like Peter, Samantha and Florence was such that they were turning the official, utilization of the space on its head. The medication refrigerator, staff lockers and staff rooms being used for economic interactions were all part of a greater resistance against assimilation into different ethical and moral values of care and work that made up the official discourse of care. Like the different meanings of space created by nurses, SHOs and the ward consultant, which I discussed in Chapter Four, hospital space for NAs was also a fluid concept. However, it has little to do with care and

endorsing the institution's values but more to do with the NA's particular role and employment circumstances.

These examples of resistance do not support Thompson's and Ong's arguments that the strict focus on the clock prevents the workers from having any non-work time. In fact, the example of Peter shows that much of his time while at work is spent having and arranging socio-economic interactions with other NAs in the hospital. Parry's research on a "notoriously leisured segment of the Indian labour force, workers in a large-scale public sector enterprise" (1999:3) helps support my argument. He focuses on the Bhilai Steel Plant and argues that "much factory work cannot really be represented as the all-day everyday grind...Instead, a good deal of it is better described as consisting in long fallow periods of comparative idleness punctuated by bouts of intense activity – in the very terms which Thompson used to characterise task-orientated pre-industrial work" (1999:3). The same can be said for the NAs. However, it must be stated that while the NAs are able to find time for themselves within the work place, their overall attitude to the hospital is one of disdain.

Exchange as a means of creating and reproducing social relations is well documented throughout anthropological literature. Elaborate ceremonies such as potlatch and gift economies (Mauss 1990) and the Kula (Malinowski 1922), to less elaborate systems of exchange such as immediate-return systems and delayed-returned systems (Woodburn 1968, 1982) have all largely focused on the social implication exchange systems have on the social group and social relations. The NAs' economic exchange of goods as a system of resistance is



similar to Hart's concept of the 'informal economy', which relates to "the mass of economic transactions that takes place beyond effective state regulation" (2000:99). The economic exchange system carried out by NAs in the hospital as a means of creating social relations reflects that of the Frafra migrants in Ghana that Hart discusses. The Frafra incorporate personalised social relations to their economic enterprise partly because "they often missed the point of bureaucracy, since the state was for them a remote, sometimes threatening, preserve but not an intrinsic part of everyday life" (2000:100). The Frafra, like NAs, also worked within the lower sectors of the labour force such as servants and cleaners. Where the state was remote for the Frafra, the official discourse of care is remote for NAs. The NAs' informal economy works on a psychological level by disrupting the bureaucratic work pattern. The exchange of goods for money also provide a sense of unity within the marginalised group. Therefore, unity is created through resisting the official expectations of their work and one means of achieving this is through the rather mundane exchange of everyday consumer goods.

The role of Peter, the NA, is that of the capitalist entrepreneur who is seen as a hero (Hart 2000) amongst NAs because his actions and sense of risk heighten the collective sense of resistance. His status loosely resembles that of a 'big man' (Sahlins 1963) who has no political and official status as a leader. Instead his prestige is maintained through his ability to provide goods to other NAs while also competing successfully against other NAs who think that they can also sell similar goods. However, those outside the group, in other words, the qualified section of staff interpret the exchanges as acts of greed and a rejection of the moral obligation to care within the official role. What becomes evident is that

these forms of exchange work as a secondary adjustment where a sense of self and group identity is formed. As Simmel (1978) argues, exchange itself creates the bonds of society.

By focusing only on those areas of policy that are relevant to their self-interest, NAs are positions in opposition to what the institution expects from them: caring for patients. These areas of self-interest include 'time-owing' (overtime) and issues around pay, or persuading the nurse-in-charge to allocate them the kitchen duty so they can sit down and read the paper. The NAs' focus in the work place is primarily one of money. Whether this was Francis comparing his shifts with others or Samantha and Florence, arguing about the shame of not having enough money and disrespectful job, or Peter trading phone cards and cloth, money is the central concern.

The point is that becoming an NA is not about entering into a caring profession which entails enhancing a patient-centred approach. In reality, their position is more akin to that of the domestic staff (the cleaner) than the nurse. This attitude is evident in a comment made by the new ward manager on College Ward.

*If you want to get on in a psychiatric ward the first thing you must do is get the nursing assistants and domestics on your side.*

The ability to offer professional care, as stated in the Trust policy and in the NAs' job description (see Chapter Five), seems to ignore the real motivation and status of the NA. 'Caring for money' must be interpreted as a system of survival

rather than 'greed'. It shows the need to secure a basic level of income; both in and out of the workplace. Therefore, it is helpful to interpret care, in relations to the NAs, as a commodity that is exchanged for money and not a moral obligation and ideologically a 'free gift' as the official discourse of care aspires to.

Qualified nurses tend to see the NAs' approach to care as being one of idleness and greed, while, as discussed in previous Chapters, see the care that they provide as about forging relationships with individuals through therapeutic discourses. Parry and Bloch (1989) make the important point that the "symbolism of money is only one aspect of a more general symbolic world of transactions which must always come to terms with some absolutely fundamental human problems. They state that money has two identities which they describe as "devilish acid or as instrument and guarantor of liberty" (1989:30). For the NAs, money, along with trading on the ward, becomes the latter because it allows them to forge a sense of self, distant from the official work routines and ideologies. In Part Three I will show that the qualified nursing staff interpret the NAs' apparent 'greed' for money as the 'devilish acid' that potentially erodes the moral structure of care that they themselves abide by. The organisational structure of the ward has two forms of exchange that represent opposing philosophies of care: one that is rooted firmly to care being exchanged for money, while the other form representing a gift that creates a bond between the carer (qualified nurse) and patient. The acceptance of the care/money exchange in the case of the NAs and the rejection of this from the official discourse of care creates, as Simmel argues, a diverse structure of social integration (1978).

### Part 3 – Understanding through race

This part describes how the white qualified nurses<sup>66</sup> attempt to understand and come to terms with the NAs' apparent lack of interest and dedication to their job. I argue that white qualified nurses use discourses of racism to try to rationalise NAs' behaviour and apparent inability to adapt to the official ideas of care. Often the use of race is situated within a subtle and unconscious use of language that appears rational. However, by exploring the nurses' use of language and their thoughts I argue that their rationale is actually embedded in discourses of racism, especially 'whiteness' and cultural norms. This results in the NAs being represented as 'outsiders' that are "deficient in some particular characteristic" (Littlewood & Lipsedge, 1989: 26) thus allowing their characteristics to be contrasted unfavourably with the white nurses. They represent 'nature', while the white nurses represent 'culture' (Littlewood & Lipsedge 1989). Racism becomes a doctrine or ideology that is associated with power of one racial group over another (Fernando 2002).

Ethnographic data is used to situated race and racism within the language of perceived cultural norms of care. These cultural norms are transmitted through the hidden<sup>67</sup> discourse of race. The norm becomes the 'given'; individuals or groups that are outside the fixed boundary of normality are reduced to an inferior

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<sup>66</sup> I am only focusing on qualified nurses and not doctors because doctors tend not to interact with NAs on a daily basis while and thus do not encounter the unofficial interactions that I have described in Part 1 of this chapter.

<sup>67</sup> I use 'hidden' because as I will show, the first ethnographic example illustrates how the interactions between white qualified nurses are hidden through the physical location from other

psychological position– they become subordinated. A focus on racism, as Solomos and Back (1996) argue, has moved away from one that looks at racism through a ‘monolithic’ lens to one that incorporates a range of historical formulation. For example, there is a need to examine the interconnections between race, nationhood and nationalism rather than focusing on the biological differences and inferiorities of a group. In relation to racism in England, these ‘interconnections’ place the concept of ‘Englishness’ in direct opposition to ‘blackness’ (Gilroy 1987). This ‘new racism’ becomes a defence of an English or British way of life resulting in discourses of racism being intertwined or hidden in the language of culture and nationalism. Solomos and Back explain:

In the case of new racism race is coded as culture. However, the central feature of these processes is that the qualities of social groups are fixed, made natural, confined within a pseudo-biologically defined culturalism.....The semantics of race are produced by a complex set of interdiscursive processes where the language of culture and nation invokes a hidden racial narrative (1996:18-19).

Malik (1996) argues in a similar vein to Solomos and Back by stating that the “key merit of a cultural view of difference is that it does not appear to have any connection with ‘race’ at all (1996:187)”. This point of view recreates “the assumptions of racial thinking but in a form that can allow cultural exclusivists

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black staff, but the language became overtly racist. The second example illustrates how racist

to deny that they are being racist” (ibid). Adopting a discourse of cultural difference and not racial difference allows for the “notion of ‘inferiority and ‘superiority’ (1996:128)” to become acceptable in the mainstream.

The white nurses’ denial of being racist is important. This denial produces not only feelings of ‘rightness’, but also a concept of a standard (Delgado & Stefanie:2001) or normality (Frankenburg: 2000). Therefore ‘being normal’ as Solomos and Back argue “is colonised by the idea of ‘being white’” (1996:22). Malik locates such denial within the socio-historical fabric of British culture by suggesting that racism “is seen as an outlook foreign to the British tradition, the product of extremist politics alien to the culture of moderation, compromise and consensus that supposedly characterises that British polity” (1996:191).

It may be useful to move away from talking about ‘Englishness’ and move towards the concept of ‘whiteness’. In effect, ‘Englishness’ and ‘whiteness’ mean the same thing – a white Anglo-Saxon race. But, as mentioned above, ‘Englishness’ attempts to hide its own race while using the discourse of race to refer to the ‘other’. The general assumption is that white people have no race. Dyer (2000) explains that this “assumption that white people are just people, which is not far off saying that whites are people whereas other colours are something else, is endemic to white culture” (2000:540). The non-white subject becomes a tool of the white subject where they are denied room for autonomy and there is little acceptance of difference. Therefore, whiteness, as Frankenburg (2000) argues, “refers to a set of locations that are historically, socially and

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language is used unconsciously by the nurse.

politically, and culturally produced and, moreover, are intrinsically linked to unfolding relations of domination” (2000:451). Using the concept of ‘whiteness’ enables me to locate racism within a social setting and between two ethnic groups. It also permits me to analyse why white qualified nurses are in denial that their actions could be racist. The administration of care, in the white nurses’ view, is framed within a procedure that appears ‘normal’. However, such a view, regardless of how unconscious it is, is also surrounded by a historical and cultural legacy that ultimately frames it.

### **Visible care, invisible race.**

I would like to start this discussion by describing two ethnographic examples to illustrate how race and discourses of racism become key components for nurses in understanding the role of the NA. I will then analyse the ethnographic accounts by introducing wider theories and debates on race and racism.

#### *Example 1 - The Bed Managers’ Office<sup>68</sup>*

I was on my break and decided to visit Jill who was Bed Manager for the shift. One of the wards was having a stressful time with two Level One patients and a patient that was having to be escorted to another hospital. This meant that the staffing on the ward would be stretched. The nurse in charge of the ward was a

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<sup>68</sup> The Bed manager is usually an F-G grade staff nurse that organises and manages the availability of beds in the hospital. Time is spent trying to find beds for potential patients that are in A&E departments at other hospitals, in other psychiatric hospitals, detained by the police, or have referred themselves to the hospital. They are in constant contact with doctors, social workers, and the police. On late shifts, the Bed Manager post is on a rota with different experienced nurses taking their turn. On weekdays there are permanent nurses for this role. The office is situated next to the 136 room, which is named after the 136 police section that authorises the police to detain and transport an individual to a psychiatric hospital. It is in the 136 room, which is also known as the assessment room, that the potential patient is assessed by a doctor. The Bed Manager usually has a pivotal role in the assessment, locating possible bed space and

white female who was 32 years old. She had been working in the hospital for one year. She had to arrange with the bed manager to get transport (ambulance) to transfer the patient to the other hospital. The patient had to be escorted by a staff nurse because they were under a Section. This added to the work load of the nurse in charge because it would leave her as the only qualified member of staff. She came down to the Bed Manager's office to speak with Jill about the situation on her ward. Jill responded by saying "Poor thing" and explained to the nurse that she would come to the ward and stay there to provide extra help if the other staff nurse had to escort the patient. Jill could be contacted on her bleep if she was needed as Bed Manager.

The nurse started to explain how the NAs were not helping with the problem on the ward because they had 'their own agenda'. She explained that the NAs were not carrying out their jobs and instead had their attention on other things. She started to list the areas that frustrated her about the NAs she had to work with on her ward. The main areas she mentioned were based around:

- NAs not knowing their job description
- having their own control without listening to the staff nurses, resulting in more stress for the staff nurses
- spending most of their time sitting down talking. (The nurse mimicked an over-weight woman sitting down).
- NAs speaking in their own languages in front of the patients. She felt that this was unacceptable. (She then

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accessing important notes and other possible information through telephone calls and sending and



impersonated African people speaking, by speaking in an invented African language and accent).

- NAs not caring, reflected in the fact that they never talk to the patients.
- NAs being enthusiastic when it came to a ward social night out but were “lousy” when it came to work.

The nurse said that a black African female qualified nurse described to her how NAs use work as a way of forming a social base. The nurse then told us “*and this is a black nurse saying this*”, implying that if a black nurse says this it must be true and devoid of any racist undertones.

Although the nurse was aware that NAs have to work extra shifts to make a decent living, she went on to associate the NAs with older staff nurses who had been working on wards for many years and had never sought promotion. She described these qualified nurses as being dictatorial towards patients. They are “*prison-like in their care for the patients*”. She explained how older nurses were “Acting A grades”. “Acting” or “acting up” is a term given to qualified nurses who take on a temporary promotion, usually to cover when a senior nurse is on-leave. In this case the nurse is implying that the older staff nurses are actually “acting down” because they are adopting the same style of care as the NAs. The nurse ended her conversation with Jill and me by sighing and returning to her ward.

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receiving faxes.

These sorts of discussions about NAs remain hidden, and only take place between white nurses in spaces located away from NAs and other black qualified nurses. This 'back stage' scenario is in complete opposition to the 'front stage' which attempts to promote a harmonious 'team' identity. The back stage works to protect the white nurses from accusations of racism. Being accused of racism is something of which the white nursing staff are conscious and genuinely keen to avoid. Accusations of racism are more often interpreted by the nurses as stemming from the NAs' inability to conform to the working rules and tasks, ward policy and Trust policy, than as a prompt to critically analyse their own behaviour. Furthermore, accusations of racism, or the threat of such accusations, represent for some nurses the inability of NAs to understand and accept the theoretical and moral frameworks of care.

*Example 2 – Extract from an interview with a white staff nurse*

The second example of back-stage expressions of frustration is an extract from an interview with a white female qualified nurse on the ward who openly talks about the NAs inability to interact properly with patients. She talks about her concerns about race. Her description also illustrates the tension between the threat of being labelled racist and, at the same time, her inability to analyse her own actions to assess whether they are or are not racist.

*I loathe the way the people talk and communicate.... how some people talk to patients. I would love to sit them down and ask them what therapeutic value that has. I don't think it is right for patients to be punished for expressing their ideas. It seems that every part of a patient's*

*behaviour is turned into part of their mental illness. We are all really guilty of that. I think it comes down to training, even how someone writes notes and what they are trying to convey in the patients' notes. There is a lack of education that goes on the ward and people are here for very different reasons. The reason why people come to be a NA...It's down to money and so that's very different to why I do it. I mean when I am here I am here to work 100% with the patients and I when I go home I fret and fuss about what's going on in the ward. You really turn it over in your mind what is going on.*

Here, the qualified nurse describes a clear distinction between the ethics behind her own reasons why she entered into nursing and those of the NAs. Her morals lie firmly within the image of the official discourse of care while she attempts to rationalise the NAs' unofficial approaches towards care by implying that they fundamentally do not care either for the patients for their work. She creates a general image of the official discourse of care being based on a positive morality while the unofficial is based on individualism and greed.

She develops this theme in the interview to describe that the NAs' greed within their work leads to NAs using racism as a means of influencing some decisions made by the qualified white nurses that directly effect them. In the same interview, the qualified nurse explains how the 'off duty' and the planning of shifts seem to be one of the main areas where these accusations are used.

*We are in the situation where I feel that if I make a mistake with the 'off duty' I am going to be called racist. When I added a white A Grade's (NA) name (Jason) to the off duty last month, I had all the backlash from that. I have colleagues who also feel that same. But hopefully we can find common ground with some of the A Grades and some of them are much older than me and have different experiences.*

She goes on to explain how this 'backlash' developed.

*Basically we were down an A Grade, and Jason wanted to work here. I made sure that the regular NAs had bank weekend shifts<sup>69</sup>. But then the whole race thing came up. Some started to complain saying that I gave Jason a line of shifts and not someone else because Jason is white and gay. It was huge and I felt... oh my god this is deep. The whole undercurrent of bad feeling. So I sat down with some of them and they all said it was fine. The fact was that it was nothing to do with colour but was due to him being a good A Grade that enjoyed his job. What was scary was that I had this awareness about it. It's constantly there, you have all this awareness about race when doing the off-duty. Oh my god I must have 'so-'n'-so' with 'so-'n'-so'. It's such a shame and a hard issue to tackle.*

*My issue when doing the off-duty is that staff can have the days off they request but the main thing is that the patients will have good care. But*

*the back lash I got was that NAs complained that I gave too many bank shifts away. At the end of the day no one can do more than two three long days on top of their normal hours. I asked them to tell me the extra shifts they wanted to do but still they were angry that I gave spare shifts to him. It all comes down to money I think.*

This extract captures one of the core issues in this chapter. NAs enter into this form of employment solely for economic reasons while qualified nurses enter into this profession to 'care'. The nurses in both examples clearly reflect the tensions between themselves and the NAs by reducing everything down to the NAs' desire to make money and lack of interest in their job; this is frequently entangled in a language of race and ethnicity. In the second example, the nurse's frustration increases when simple nursing tasks, such as arranging shifts in the 'off duty', have the potential to provoke accusations of racism. The nurse relies on her assumption that her own motives are morally higher than the perceived self-centred attitudes of the NAs, to dismiss any accusations of racism.

Accusations of racism are often seen by nurses as a technique used by the NAs to gain control. However, in the above case, the regular NAs actually continued to receive their requested shifts. The question, then, is why were the regular West African NAs using race and racism as a means of questioning the shifts the white NA received when they already had 'first pick'? It implies that the NAs were using racism as a mechanism to pre-empt any chance of the nurse showing favouritism to the new NA because he was white.

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<sup>69</sup> Bank weekend shifts are desirable over time shifts for NAs because the hourly rate is more

The nurse explains that the ward was in need of an extra NA and that they needed someone to take the place made vacant by the leaving NA. However, she also introduces her moral disposition towards care by implying that the white NA was good at his job and furthermore ‘enjoyed his job’<sup>70</sup>, implying that the patients were being provided with the ‘best possible care’. ‘Enjoyment’ of one’s job is seen by the nurse as something that does not exist for the majority of NAs who, because of their drive of money, show little or no job satisfaction. The idea of ‘enjoyment’ can be extended further and seen as a signifier of a patient-centred ideology to care.

‘Enjoyment’ becomes an expression of ‘good practice’ and shows a willingness to understand and a desire to enter into caring work. It represents the white nurses’ image of ‘normality’ within the caring environment – or, the official discourse of care. The practices of Black West African NAs are in opposition to this view and directly threaten the nurses’ order of care. It is here that ‘enjoyment’ implicitly becomes a signifier for ‘whiteness’ and ‘whiteness’ the signifier of normality. Jason, the white NA, was not surprisingly quickly positioned into a prominent position on the ward through his aptitude to communicate the appropriate signs. Furthermore, his race became the *very visible* vehicle to allow for the transmission of such signs because it was naturally expected that he would conduct himself in such as way.

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than that for a week day. If an NA carries out a double shift or long day on a Sunday and both are bank shifts then they can make up to £100.

In the first example, a white female nurse explained to Jill, the bed manager, and me that NAs were 'good fun' on the social nights but were "lousy" when it came to work. The nurse implies that the NAs are lazy. She then imitates an overweight black female NA sitting down<sup>71</sup>. She further illustrates this point by complaining that the NAs speak in their mother tongue and how this was not fair on the patients<sup>72</sup>. Both aspects clearly allude to socially constructed essentialist notions of race.

The conflict between the NAs and the white nurses becomes symbolic of the fears of the declining nation or culture. Wallman (1978) makes the point:

Because black immigrants and national decline happened together, they are readily associated.....Aspects of English identity *require* that boundaries of colour and outside status be congruent. (1978:214).

The NA takes the role of the immigrant and the declining nation is represented by the declining standards of care. Hence, Jason, the white NA becomes the standard and ideal image of an NA for the white qualified nurses because they both speak a common language and share an 'imagined' field of whiteness. A normal way of administering and enjoying care become the hidden classifiers of the boundary between the white nurses ("us") and the black NAs ("them").

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<sup>70</sup> If a ward has to use a bank or agency NA for a few shifts they ideally like to keep that same NA for those shifts so that the NAs, qualified nurses and patients become accustomed to each other.

<sup>71</sup> The use of a racial stereotype of black women being overweight is common. The BBC reported on Jeffery Archer explaining that 30 years ago most black women were overweight. [http://news.bbc.co.uk/1/hi/uk\\_politics/415994.stm](http://news.bbc.co.uk/1/hi/uk_politics/415994.stm). This can be seen to be in contrast to white women who are not overweight and therefore lead a more healthy lifestyle.

<sup>72</sup> Incidentally, it was common on the ward to hear Afrikaans being spoken between white SHOs from South Africa, however, the same complaints were not aired by the nursing staff.

Normality and enjoyment in the work place become associated only with being white; they form a boundary of exclusion in spite of the complaints by white nurses that they wish that the NAs would engage with their model of care. Wallman (1979) makes that point that racist exclusion “is a version of ethnic boundary keeping which constitutes a fixed liability to the racial minority designated ‘out’, what-ever the advantages expected or gained by those designated ‘in’ (1979:x)”. Gilroy (1987) makes a similar point by linking discourses of race in Britain to British discourses of nationalism. He argues that language such as “Island Race” presents the notion of the nation as both biological and cultural. The “Island Race” creates an image of exclusion of that attempts to maintain the “memory of imperial greatness” (1987:69). Hall (1992) echoes Gilroy’s points by arguing that regardless of how fragmented a society is, nationalism creates the image of a totality that attempts to represent a biological truth. This can be done by turning “the clock back, to retreat defensively to that last time when the nation was great, and to restore past identities” (1992: 295). On College Ward, the boundaries are established, not only because of the white nurses’ *ownership* of ‘normality’ and ‘enjoyment’, but, as I have argued in Part One, the NAs’ refusal to enter into the white nurses’ notions of care. This is fundamentally because the work the NAs do is, in their eyes, badly paid and has an unqualified status. Acceptance of the white nurses’ idea of care would mean that they were accepting their low socio-economic position in London as fixed.

Racism becomes the system of classification where the white nurses are able to draw a crude distinction between their formal process of care and the



inappropriate, unofficial practices of care enacted by many NAs. The use of a mainly unconscious racist discourse enabled the nurses to develop a sense of shared feeling and standards that fit in a similar fashion to discourses around nationalism. For the white nurses this represents a natural community that lives and thinks under the same 'political roof' (Gellner 1983) where the ideologies of care and work that they aspire to are biologically a given.

### **Black qualified nurses, NAs and the 'watchful eye' of the white nurses**

Tensions between NAs and black, mainly Southern African, qualified nurses take on a different social meaning to those described above in regards to white nurses. Instead of these being based on racial and nationalistic discourses the tensions arise largely around issues of ethnicity, age and gender. Generally, the conflicts are more about age and gender than issues of care. Most of the qualified nurses were educated in South Africa but trained as nurses in England or Scotland. They have difficulty in asserting control over the NAs because they are younger. Gender is also seen as a cause for conflict when young female qualified black nurses have to assert their authority over older male and female NAs. Both groups describe these conflicts in relation to the absence of an African system of authority, power and respect. Southern African qualified nurses would specifically describe Nigerian NAs in relation to a 'Nigerian style' or 'natural disposition towards fraud and corruption'. Nurses from South Africa, Zimbabwe and Botswana would discuss how one could 'spot a Nigerian a mile away' in their own countries and how the police in these countries would always be arresting Nigerians for having false number plates on their cars or being in possession of false passports. West African NAs would criticise the black

qualified nurses for thinking that they were superior because they were qualified and from Southern Africa and also for their lack of respect towards them. They would attempt to de-value the quality of the nurses by describing them as 'bush', meaning that they were from the rural or village areas of their countries and hence were uncivilised and badly educated.

The black nurses also had to manage how they were perceived in the eyes of the white nurses as to how they conducted themselves as professional nurses within the official discourse of care. Black nurses therefore had to make sure that their performances within the official 'front' were convincing. Some white nurses explained to me that they felt that they had to have a coaching role with many of the 'African' nurses and that they had to 'keep an eye on them'. On a number of occasions black qualified nurses described that they felt under pressure from both white nurses and NAs. At one point in my field research, I was approached by a 25 year old black South African 'D' grade nurse who was crying. She asked if she could talk to me in the staff room. She explained that she felt she was being bullied by two older female NAs who were accusing her of implying that they were not supporting her on shifts when she was the nurse-in-charge. This had been building up for nearly a month. However, she also expressed her anxiety to me that because of this, the white nurses thought she was unconfident and unable to deal the situation with the NAs. This illustrates that black nurses have to negotiate two different social fronts: the first is an official front where they need prove their professional competence and the second is in relation to the NAs where they have to negotiate their position within a cultural hierarchy of gender and age.

## **Conclusion**

NAs' relationship with patients fits neatly into an economic exchange system where care is something that is sold for a wage. Money also becomes a central component in their forms of resistance through their informal economic interactions that I have described.

This explicit motivation diverts attention and time away from possible assimilation into the official discourse of care and work, as described above in the example of the allocation sheet and the ordering of their mundane tasks. Acceptance of their official role would fix the NA's identity in the work place as unqualified and subordinate. Values of this nature would contradict their own cultural models of status, and their understandings of mental health care. The result would be that they would symbolically cement their existence firmly in the world of the migrant worker in London, and away from 'home' (mainly West Africa). Therefore, the NAs have to resist the mundane reality that their role implies and they devise means of maintaining a sense of self through protest and the creation of secondary adjustments illustrated through the an 'informal economy' within the hospital space.

The notion that care can be a form of economic exchange and that a hospital, especially a psychiatric hospital space, can become a shopping bazaar for a section of its work force, runs uncomfortably against the institution's general

understandings of what a psychiatric hospital should represent. However, it is this focus on money that reluctantly binds the NAs to their contractual tasks. This means that the white qualified nurses have to cope with and understand the NAs' apparent lack of interest in their job. They do this by unconsciously using discourses of race, specifically 'whiteness', which provides them with an explanation of the opposition between themselves and the majority of NAs. While the NAs are attempting to resist assimilation into, and acceptance of, their socio-economic position, the white nurses are indirectly associating the NAs' focus on, and perceived greed for, money with the declining standards of care on *their* wards. Caught in between are the black African qualified nurses who inferior within the 'white discourse of care' and feel uneasy about their position with fellow-African NAs.

In the next chapter I will look at the ambiguous position of the NAs in the broader context of the organisation. The official discourse of care has always to be visible and thus on the 'front-stage' whereas it is in the interests of the organisation to keep the unofficial approaches to care invisible and in the 'back-stage' region of its structure.

## VII. Desiring the Invisible: Linking the Official with the Unofficial

### Introduction

Throughout the chapters in this thesis, I have used the terms ‘official’ and ‘unofficial’ in relation to how the various groups of staff understand mental health care. This chapter will develop the understanding of these terms by examining two characteristics that care can take, which I call *visible* and *invisible* care. Visible care is the official face of the institution. Invisible care is unofficial and carried out by NAs on the ward. In Chapter Five, I showed that this sort of invisible care is carried out in the ‘buffer zone’; the space where the official and unofficial systems meet. It consists of tasks such as carrying out observations on patients, escorts, or serving meals. Fundamentally, NAs’ work in the buffer zone focuses on the physical body of the patient, rather than engaging with the patient in a ‘therapeutic’ way.

This chapter argues that the role of the NA has to be made invisible so that the image of official care remains tied to its proclaimed ideology and thus is the only visible form of care. This will be done by showing how invisibility is constructed at four different levels of care. Part One will focus on everyday ward meetings. By analysing the daily ward handover, I will show that NAs are placed on the

periphery of the meeting, thus making their role marginal. The interactions between the qualified nursing staff and the NAs during this period becomes the closest meeting point between the official discourse of care and the unofficial notions of care. These daily ward interactions, I argue, mask the general contradictions between both approaches. Part Two discusses how the written text in hospital pamphlets for patients and posters on the walls of the wards exclude NAs from the notion of 'the team'. Instead, 'the team' consists of all the different professionals. Therefore, it becomes a place where membership is granted to those that have been through the relevant educational process which then forms the acceptable knowledge. Part Three illustrating how Trust Observation Policy attempts to portray observations as a therapeutic intervention, when in reality, observations are designed to monitor and control the movement of the patient's physical body, a task that is carried out by NAs. Finally, Part Four moves out of the ward, hospital and Trust by showing how national policies, papers and guidelines from State agencies such as the Department of Health (DoH) are based on an ideological level of official care which, in turn, works to reinforce the official message given to Trusts, and their hospitals. These documents focus on the Multi-Disciplinary Team (MDT) as the heart of 'therapeutic care'. As in the example of ward and hospital pamphlets, the MDT has little or no room to include the NA.

Overall, this chapter will argue that at all levels of the official discourse of care, the construction of invisible care through masking becomes an essential part to maintaining its ideology. The further out one moves away from ward-based care, the less visible the image of the NA is, and importantly, the care that they

officially provide; that is, care that primarily focuses on the physical body of the patient. Therefore, it is not just the NA that is made invisible but also the image of the physical body of the patient. Fundamentally, if this form of care were to become present within such literature, it would challenge the ideological image of the official discourse of care and expose the realities of psychiatric care on acute wards.

### **Part 1 – Creating Invisibility on the Ward: The role of the NA in handover**

Before discussing visible and invisible care, it is important that we briefly flag-up a point made earlier that the position of the NA is similar to that of the 19<sup>th</sup> Century asylum attendant (see Chapter Three). Both the attendant and the NA were, or are, by-and-large untrained, entering into their role for financial reasons rather than a vocational commitment. The attendant was described as coming from sections of Victorian society that were largely treated as outcasts, such as farm labourers, ex-soldiers and members of the working classes. The contemporary NA in London follows a similar image by largely belonging to minority ethnic groups, mainly from West Africa, and being poorly paid. Both the Victorian attendant's duties and the modern day NA's role have as their purpose the control the patient's body. The paradoxical situation is that the official image of care that focuses on the patient's mind and well-being is threatened by the official role of the NA.

## **Handover**

The handover is a meeting where the nursing staff exchange or hand over information about patients to the new shift. The handover takes place three times a day, effectively marking the end of one shift and beginning of the next. It is usually held in the staff room on the ward and is attended by qualified nurses and NAs.

The length of the handover can vary depending on the time of day. For example, the handover between the early shift and the late shift, which starts at 13:30, lasts up to one hour, whereas the handovers between the night shift and early shift and between the late shift and the night shift usually last between 15-30 minutes. The afternoon shift is the main time when the nursing staff can discuss specific patient care and broader issues, such as things discussed in the ward round. It is also the time when appointments and phone calls are made in relation to patients. The shorter handover functions to summarise major events that happened on the ward and to give a general account of each patient's behaviour. Usually, the nurses who have been on a late shift or a night shift want to finish the handover quickly so that they can leave the hospital. Often the nurse-in-charge handing over will describe the behaviour of each patient as being 'fine' or 'slept well' and then swiftly move on to the next patient. Only if there was an incident on the ward would the nurse-in-charge spend any more time detailing behaviour.

Below is an ethnographic description of an afternoon handover. I have chosen to use the handover to illustrate how the NA is positioned within 'the team', in order to show that the NA becomes an invisible member of the team.



### **Afternoon handover and the silent NA**

The afternoon handover starts at 13:30 and usually lasts for 45-60mins. It is attended by all the nursing staff (qualified nurses and NAs) that will be working on the late shift, the staff nurses from the early shift and at times the ward manager.<sup>73</sup> Each ward has an assigned room where the handover takes place. The room in College Ward was called the Multi Disciplinary Team (MDT) room. This was the biggest room and could fit up to 10 people in it. It is also used for ward rounds and other meetings. The chairs were positioned around the edge of the walls creating a semi-circle. The floor was covered in a beige lino and the armless seats were cushioned, covered in plastic. The door was always locked so patients could not enter the room while the handover was taking place. Some of the staff attending the handover would arrive on the ward just before it started to make themselves a hot drink before entering the MDT room with their drinks. If a staff member arrived late they would usually go straight into the handover without putting their coats and bags in the staff room.

The role of the NA differs in the handover depending on whether they are coming on to the late shift or had been working on the early shift. The former attend the handover, while the latter spend most of the time on the ward carrying out observations and answering the telephone. They would only enter the handover when called to give information on their allocated patients. I would argue that both are predominantly inactive and that this results in them becoming

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<sup>73</sup> At this time the ward manager usually attends meetings. Usually the ward manager will receive a individual handover when they start their day at 09:00am

invisible. I will examine these two different roles a little more so as to illustrate how this invisibility is created.

### **The on-coming shift and the use of official language**

The most striking aspect of the afternoon handover is the stark division of roles between each section of staff. The qualified nursing staff act out a relationship of 'giver and receiver'. The 'giver' is the nurse-in-charge from the early shift who hands over to the 'receiver', the nurse-in-charge for the on coming shift (in this case, this would be the late shift). The 'giver of information' is supported by other qualified nurses who were on the same shift, while the 'receiver' is supported by qualified nurses who will be working alongside them on the new one. Information, then, is solely situated within a qualified nursing domain, where nursing language and nursing and medical procedures frame the handover. This exchange is not just based on information about individual patients, but also an exchange of nursing and medical knowledge related to issues discussed in ward rounds and other medical and nursing meetings that the on-coming nurses would need to be informed about. Those without such knowledge are consequently excluded from the exchange of information. There is a need to use specialist language when conveying information to each other; it is how qualified nurses have learnt to exchange information on the one hand, and what the organizational structure demands as standard protocol. However, those without such knowledge become excluded from this exchange of information. Language plays a crucial role in maintaining the official discourse of care.

The use of nursing and medical language excludes the NA from becoming an active participant in the handover. NAs are not the active 'receivers' or 'givers' of information because the type and style of the information that is produced and shared is not within their knowledge. In other words, the NAs do not have access to the knowledge, and therefore, the language used by the qualified staff, leaves them as mute and invisible actors. For many NAs, the handover was often described as 'boring' and 'irrelevant' in relation to what they actually had to do in their job. These feelings often manifested themselves in behaviour such as arriving late, falling asleep or attempting to covertly read articles from a newspaper positioned on their lap. Some NAs would actively try to take notes on a specific patient's care. But this was mainly for their own information and not as a means of engaging with or becoming part of the 'giver' and 'receiver' relationship. At the same time, it gave the impression to the qualified nursing staff that they were taking an interest in what they were discussing. An NA explained:

*It is important for me to know what is going on with the patients, so I know who has done this and who has done that. But it is hard because the nurses speak to each other. I then write for myself and at least I am not doing nothing. I feel that I will look stupid if I ask a question or say I don't understand.*

(Male NA).

The apparent lack of interest that NAs demonstrate in the handover does not go unnoticed by the qualified staff. It would often be discussed between the

qualified nursing staff in spaces away from NAs, as discussed in Chapter Six. The qualified nurses would criticise the NAs' lack of understanding and involvement. Although they were aware that NAs do not have the same training, and thus knowledge, they still would stress that the NAs should be able to acquire a basic understanding of the specialist terminology, simply by spending a period of time in the ward environment.

*I know that sometimes we go on, but this is important. We have to pass on this information to the on-coming shift and also discuss what was decided in ward round. If we didn't then we would not be doing our job and we would therefore be putting patients at a risk. I think that we try to involve the NAs because we are a team at the end of the day, but sometimes it is impossible. It's not them making the decisions.*

(Male qualified nurse)

#### *Feeling embarrassed*

I briefly described in Chapter Six how one NA would tell me that they preferred not to handover their allocated patients because they were embarrassed that they might get information wrong. This was a common view held by many of the NAs that I worked with. They felt that they were being judged and scrutinised by the qualified staff if they did not hand over information on patients in an appropriate way. All staff were expected to follow a procedure that had been designed and agreed by the qualified nurses and ward manager. The policy for

handover would be printed on an A4 piece of paper, laminated and posted on the walls of the MDT room with specific points that had to be addressed in each handover, such as stating the patients status, whether they were on a section, and if so what type of section, whether they were entitled to leave and how much etc. The reality was that such a policy, once decided, would be closely followed for the first few weeks of its creation by all the staff and then loosely used when individuals were doing the handover.

Usually, when an NA did their handover, they would focus on the everyday and mundane behaviours of their allocated patients. For example, they would describe a patient by stating that:

*They attended to their personal hygiene.*

*Slept a lot, but got up for medication and lunch. They ate well.*

*No signs of talking to themselves.*

The result, is that, although the NAs may take part in the process of handing over information, they nevertheless become excluded from what is, supposedly, an opportunity to become active members of the team. Instead, they fall into a silent position where their information sits underneath the more illustrative and formal language of the official domain. This can be compared this with the analysis of the ward round in Chapter Four where it is shown that the qualified nurse is positioned in an inferior position to the Consultant psychiatrist and the junior

psychiatrist (SHO) due to the psychiatrists' ownership of medical knowledge and a senior bureaucratic position. The chapter argued that the ward round worked as a ritual that formalises space and time so as to clearly position each actor in their rightful hierarchical position, both in a medical and bureaucratic sense. Here, the handover as a ritual, works in a similar way. Where the qualified nurse becomes the 'note-taker', or secretary, in the ward round, the NA becomes inferior and symbolically invisible. However, the major difference is that the qualified nurses learn to resent such a position and strive for more authority in the care process, while the NAs yearn for, or attempt to protect, their invisibility.

Therefore, their role in handover, for example, has little meaning in the planning of patient care. Their lack of access to formal nursing and medical knowledge naturally positions them in a secondary role. Furthermore, as I showed in Chapter Six, their way of coping with their status on the ward is then interpreted by the qualified staff as a reluctance to learn the official and formal ways of thinking. Yet, there are attempts to include them in the handover by allowing them to hand over their allocated patients. This is ideological because it tries to portray the staff as a 'dynamic team' which works together in a fluid and competent way. The reality is that the 'team' resorts back to being hierarchical and focuses on an exchange between the qualified staff. Furthermore, the 'dynamic-ness' of the team is further thwarted by an active attempt by many NAs to avoid being included. This usually results in the qualified staff interpreting the NAs' unwillingness to handover as an unwillingness to care, while the NAs are either fearful that the information they might hand over is inaccurate, or they feel that their contribution would be of little worth to the whole process.

Beneath these daily activities and interactions is a deeper issue. The point is that being excluded from the formal procedures of handover allows the NAs to protect themselves from engaging with the ideological demands of the qualified nurses. In other words, their exclusion makes them symbolically invisible. Furthermore, their exclusion allows the qualified nursing staff to claim the handover as a forum solely for nursing knowledge away from the formal demands of the clinical discourse held by the doctors (as discussed in Chapter Four) and bureaucratic rules held by hospital and Trust management. Therefore, invisibility is a semi-conscious system of negotiation where both opposing parties actually benefit.

## **Part 2 – Constructing Invisibility through Hospital Pamphlets**

Part Two will develop the theme of invisibility by arguing that the medical, bureaucratic and ideological image of care results in an unconscious masking of the NAs' role. The NAs' role does not fit into the flexible and dynamic image of modern day psychiatric care and the general image of care that the Government and the NHS portray (as discussed in Chapters Three and Four). This desired image is not overtly promoted but instead is hidden within hospital pamphlets and posters. The key point is that the organisational need to reduce the visibility of the NA is not because of the NA's apparent lack of willingness to do their job properly, or because they lack the ability to engage with patients therapeutically, or even because they sell mobile phone cards, meat and clothing while working

and thus break policy procedures, as discussed in Chapter Six. Rather, the work required of an NA is itself seen as a threat to the image that the organisation attempts to portray because it primarily focuses on the physical body of the patient and not on the 'therapeutic' engagement with the patient's 'mind'. Below I will explore how the organisation's official image is portrayed through ward pamphlets and posters which effectively erase the role of the NA and their primary role of caring for the physical body of the patient.

### **'Welcome to College Ward'**

Every new inpatient is given a glossy colour brochure welcoming them to the hospital and the ward. It provides a general description of the hospital, which includes how many wards there are, visiting times and the types of services that the hospital can provide, such as an advocacy service. Inside there is a separate 'pull out' pamphlet that welcomes the patient to the specific ward that they will be staying on. The pamphlet allows for the ward to claim their own identity and process of care through an individualised mission statement written by each ward manager. Central to all mission statements is the focus on portraying care as a participatory concept where the individual patient has a key and productive role in shaping their own care.

Under the heading 'Staffing' the College Ward pamphlet states that:

While you are an inpatient you will be allocated a nurse, called a 'Named Nurse', who will be responsible for co-ordinating your care. Your care



will be provided by staff drawn from the 'multi-disciplinary team', this will include: nurses, doctors, and social workers and sometimes occupational therapists, psychologists, psychotherapists and physiotherapists.

Under the heading 'Care' the College Ward pamphlet states that:

We aim to provide a respectable and supportive service responsive to your individual needs. You will be invited to attend meetings to plan your care while in hospital and for later when you are discharged...A copy of your care plan will be available for you when you are discharged from hospital.

There are three important points that emerge from these two extracts from the College Ward pamphlet that highlight the desired organisational image. The first is that the care provided by the organisation encourages the involvement of the patient in its design while also incorporating different types of care and not just a medical and nursing model. The multi-disciplinary approach conjures up an image of a modern and professional service where the individual patient becomes cushioned by a holistic and expert approach. The second point is that the image of care here is one where the patient is 'invited' to meetings about their care plan so that the care plan can be respectful and 'supportive' to the 'individual needs'

of the patient. Once the care plan has been deemed a success by the patient being discharged, the patient is given a copy of their own. The first of these two points fits into government discourses of care stated in Chapter Three by which the patient becomes empowered through having choice in how their care is designed. The third and final point is crucial to the organisation's ability to keep the role of NA excluded from the discourse of 'the team'. The practical reality is that a new patient will probably have more contact with an NA than the nurse, doctor, social worker, occupational therapist, psychologist, psychotherapist or physiotherapist, yet the NA is excluded from appearing in any form, such as text or pictures, in the pamphlet. While the College Ward pamphlet aims to provide a new patient with a general understanding of the ward, it physically masks the role of the NA.

#### *Printed ward posters*

The role of NA is also excluded from the printed ward posters that is posted on the ward walls on an A4 printed page. This specific poster outlines a 'Philosophy of Nursing' in an attempt to unify the staff as a 'team'. Its public display works to remind the nurses about their role and the importance and professionalism of nursing and care. Furthermore, by displaying it on the walls of the ward, it also functions as another mission statement that states the ward's moral principals of care towards the patients. In other words, it enables the patients to monitor that the nursing team are following the principles stated on the poster. The first paragraph maps out the 'purpose of nursing':

To care for and support individuals from their birth to their death, using skills and knowledge acquired to aid people in promoting their own equilibrium of health. Also to help them in ill-health and disability to develop a greater understanding of health and illness in order to empower them to achieve interdependence or where this is not feasible to promote a degree of interdependency that will encourage development of their own self esteem and self image.

Point six of the policy stresses:

That the care given is client-centred and its aim is to improve the patient's physical, social and psychological functioning. The nursing care is guided by nursing theories and research-based practice. Through education, the nurses can help to promote their patient's knowledge in order to develop the patient's confidence in their ability to achieve their full potential. This will also facilitate the patients in making informed choices regarding their care.

In a similar vein to the pamphlet, these ward posters exclude the NA as an active participant in the team. The first extract lays out the moral standpoint that the staff strive to abide by, while the second promotes nursing professionalism, as discussed in Chapters Three and Four. The key here is that access to the moral

principles of care can only be gained through the process of training and knowledge. Therefore, the NA could not be seen as an active participant in such policy because they do not hold the required qualifications.

### **Working with the body**

In Chapter Five, I introduced the concept of the buffer zone. I described this as a space where the official discourse of care meets with the unofficial model of care so as to maintain a necessary level of efficiency throughout the shift. For the NAs, the zone enables them to carry out required tasks in a way that suites their understanding of care, while for the qualified nursing staff, the buffer zone allows them to allocate those tasks that do not fit into their desired discourse of care. The important subject here is the patient's body because it is within the buffer zone that the majority of 'undesirable' tasks are allocated to the NAs, allowing the qualified nurses to distance themselves from the fact that many aspects of care focus on the physical body of the patient.

To develop this idea that care is also about the physical management of the patient's body, it is necessary to re-visit the work that NAs do on a daily basis. By exploring their official role again, I will argue that the role of the NA principally focuses on the patient's body that is at odds with the official discourse of care. As discussed in Chapter Three, and also through ethnographic examples of qualified nursing care in Chapter Four, the core discourse of care emphasises a 'patient-centred' approach to care through the 'empowerment' of the patient as a 'user'. Therefore, care has to be vocational, morally and ethically driven, and not driven by an individual's financial needs. The patient is presented

as being in a position of getting themselves better through engaging in therapeutic relationships, accepting invitations to meetings about their care and showing a willingness to accept all dimensions offered through a holistic approach.

However, the work that NAs do does not attempt to empower the patient in the official sense. Their work primarily controls the patient's body and their behaviour on the ward, which in turn gives space for a formal therapeutic relationship that many qualified nurses work towards. For example:

- Carrying out the nominal role at the beginning of every shift
- Carrying out level 1 and 2 observations with patients
- Escorting the patient outside the hospital premises and to hospital appointments
- Buying soft drinks, cigarettes, newspapers for patients with no leave
- Serving meals to patients
- Collecting dirty bed linen
- Physically restraining patients
- Being positioned always on the ward so as to be able to always observe the ward environment.
- Cleaning and bathing patients that need assistance.

What is evident from this summary of the NAs' daily tasks is that little space is left for the desired therapeutic environment that the official discourse of care demands. In fact, they frequently produce the opposite effect. Empowerment and choice are replaced by overt control through the observation and restriction of the patient's movements. The control of the body, in this respect, fits into two aspects of Foucault's historical account of power. At one level, the patient's body is controlled through physical intervention, for example, the physical restraining of the patient when deemed essential for the patient's own mental and physical well-being or for the safety of other patients. Here, there is also an emphasis placed on positioning the patient's body to be present at the right places and at the right times, for example, at set meal or medication times where the patient is expected to attend. The other more subtle dimension is the patient being controlled by the NA carrying out observations and thus creating a system of surveillance (I will expand on this later in this chapter by analysing Trust Observation Policy).

### **Part 3 – Constructing Invisibility through Trust Policy: Observation and the Observers**

So far in this chapter, I have argued that the official role of the NA does not complement the official ideological image of psychiatric care. Here, I will argue that, although the official system attempts to mask the role of the NA, it nevertheless actually relies heavily on NAs carrying out official tasks. Their very absence from policy allows for the official discourse to exist as an unchallenged

philosophy of care. In other words, the fact that the NAs' task-orientated work which primarily focuses on the physical body, is not promoted as a positive aspect of psychiatric care, allows for the qualified nurses, doctors and Trust Management to maintain their desired ideology and leave the undesirable, but essential, work to the NAs.

The Trust Observation policy attempts to mask this potential threat by implying that the observational process can and should be therapeutic for the patients.

Below are four extracts from the policy that attempt to portray this image.

1) Observation is an important skill for all staff. The aim of observation is to prevent potentially suicidal, violent or vulnerable patients from harming themselves or others or from being harmed by others.

2) Observation is not simply a mechanical or custodial activity. It should be integrated within the planned activities of each individual. The engagement of the patient should always be sought although they may not always want to. It should aim to minimise the extent to which patients feel that they are under surveillance. The nurse should convey to the person being observed that they are valued and cared for and being listened to. It is therefore essential that patients are allowed to express their feelings and frustrations in a safe manner.

3) At all times during handover of care from one nurse to another, the patient should be involved and informed of their care. This can give the patient a sense of autonomy and helps to build trust.

4) It is recognised that observing patients who are potentially suicidal, vulnerable or violent is a most demanding intervention. Observation is deliberately designed to thwart the patient's aim. Consequently patients on an enhanced level of observation may be angry with staff. The whole process may be deemed custodial and dehumanizing, however, with skill and care it can be experienced as a caring intervention.

Extract 1 provides a clear explanation of why some patients are observed by staff. It is a preventative measure to reduce the threat of harm. However, extracts 2-4 attempt to introduce the official discourse of care by focusing on its disposition towards patient empowerment and therapeutic interventions. Extract 2 emphasizes the importance of reducing the process of surveillance by allowing the patient to express their feelings. Extract 3 urges for patient empowerment through being informed and 'involved' in their care. Finally, extract 4 acknowledges the dehumanizing effect that observation could potentially create. It also contradicts itself by stating that observation, far from being dehumanizing, can actually be a therapeutic and caring intervention. Furthermore, the policy on observation informs that the staff member carrying out the observation must have the ability to identify when there are "therapeutic opportunities in observation".



However, what these ‘therapeutic opportunities’ are, is not defined within the policy.

On an organisational level, observation cannot be deemed as care because it involves the surveillance and marshalling of bodies. It, therefore, has to be re-worked, through the language of policy so that it can fit into the official image of care. However, in reality the task of observation naturally becomes a necessary form of surveillance to prevent harm being caused. The fact that it is a form of surveillance means that it is a negative process which, in turn, isolates itself from the desired image of care. In extract 3 it states that “it (observation) should aim to minimize the extent to which patients feel that they are under surveillance”, while in extract 4 it states that “observation is deliberately designed to thwart the patient’s aim”. There is a contradiction between the two statements. The first urges for the sense of being under surveillance to be reduced while the second statement explains that the reason for observation is to foil the patient’s intentions to cause harm. It is this second statement that actually comes close to acknowledging that care is not just about providing empowerment or choice to the patient.

Surveillance and the control of patients’ bodies becomes part of the official tasks that the NA carries out on a daily basis. Level One or Level Two observations require that the NA monitors the patient’s movements and behaviour on the ward<sup>74</sup>. The official rationale for this system of observations is that if the patient wanted to commit suicide, they would not be able to anticipate when the next set

of observations would take place. Importantly, however, the inherent contradiction of surveillance is mediated by the NAs' tasks: *they* tend to do the 'gazing' and report back to the qualified staff who then monitor a patient's behaviour from a distance. In other words, it is the NAs that become instruments of surveillance.

In summary, it is this focus on the body as an object of control and not an object of the mind (as it is viewed in a therapeutic relationship between carer and patient), that results in the need of the role of the NA to be invisible. Body, not mind, therefore endangers the official image of psychiatric care.

### **Masking reality through policy**

In reality the qualified nurses and hospital and Trust management on one side, and the NAs, on the other, practically act out their intention not to be a dynamic team because both groups abide to different systems of care that, when challenged, become incompatible. Hospital pamphlets, ward posters, mission statements and policy exclude the NA from its print and yet still portray the care on wards as holistic; involving many different agencies (including the patients, family and friends) working harmoniously together. Therefore, hospital literature attempts to make the tasks that NAs carry out as peripheral, or invisible to a holistic and therapeutic engagement with the patient. Or, if the task is too important, such as in the observation policy, it masks all the 'nasty', but essential aspects of the task by blurring the process so that it somehow fits into the desired official discourse of care. This point is also echoed by Apthorpe (1997) who,

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<sup>74</sup> Level Two observations requires the NA to check the patient at irregular intervals in each hour

when discussing the anthropological significance of policy, suggests that it works more to persuade an action or process rather than demand an action. The Observation Policy in this chapter is a good example of this because it attempts to leave room for the member of staff to search for ‘therapeutic opportunities’ and structure the observations to appear as a caring process and not a system of surveillance. The individual member of staff is supposedly given the freedom to forge this relationship. Furthermore, it portrays the observer as flexible and dynamic by allowing for a therapeutic discourse while masking the mundane nursing or custodial role that observations also require. The irony is that it is the NAs that mainly carry out the observations and do not have any formal training to distinguish what is, and what is not therapeutic.

#### **Part 4 – The Homogenous Construction of Care**

Most of the argument in this chapter is based on my own ethnographic data which shows how there are systems of masking that are played out on a ward, hospital and Trust level. I now want to move beyond this ethnography and illustrate how State policy and literature on mental health care creates a more formalised and ‘pure’ version of the official discourse of care. This is largely due to the distant contact it has with the everyday setting of wards and hospitals. Crucially, for such a purification of policy, the role of the NA is again placed on the periphery of what the official discourse of care is. However, what also becomes clear is that the image of the physical body of the patient also becomes

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so that the patient never predicts when the NA will check on them.

invisible. Part Four will analyse official literature and policies that aim to achieve this image of care. They are: Improving the Quality of Psychiatric Inpatient Care in London (IQPIL) (2003) and Department of Health (DoH) reports called Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision (2002), The National Service Framework for Mental Health (1999) and finally The National Service Framework of Mental Health – Five Years On (2004)

### **Standard for Care on wards**

Particularly significant is a report called Improving the Quality of Psychiatric Inpatient Care in London (IQPIL) (2003). The London Regional Office commissioned the Health Advisory Service (HAS) to review the quality of acute mental health care in patient wards across London. It focused on whether wards had a “clear therapeutic purpose, sufficient numbers of skilled and committed staff working in a multidisciplinary manner in a good physical environment and [were based] within an organisation which supports their development” (2003: i). The general findings in the report emphasized the point that the overall environment of psychiatric care in London’s acute inpatient wards resulted in staff finding it difficult, on occasions, to follow the prescribed image of care. The report becomes a critique, not of the official discourse of care, but of the fact that the official discourse can at times become less visible in practice. The report becomes a marker or warning to Mental Health Trusts that when care is not visible, it then resembles an oppressive and controlling and dangerous environment for the patients.

It is interesting to note the ways in which the NA is represented in official literature such as this Report and, particularly, how masking occurs to disguise or ignore their actual position within mental health care in London. As I will show below, invisibility is mainly illustrated in this Report by focusing on the apparent lack of attention by teams on the value of 'team work'. The focal point is on staffing issues as a collective. Importantly, the Report also positions the NA within the official discourse of care by championing their 'unqualified status' as a positive support to 'the team'.

#### *The importance of 'the team'*

The ward-based team is defined in the report as those staff that "input into the whole ward, are on hand to discuss issues for individual patients, the patient population as a whole and the overall ethos of the ward" (2003:29). The ward team is seen as one half of the multidisciplinary team (MDT) while the other consists of "professionals who provide a valuable service for individual patients or groups of patients in the form of in-reach activity within a general caseload spread across many service areas" (2003:29). The ward MDTs comprise nurses, medical staff, occupational therapists and pharmacists and, at times, psychologists. The 'team' can therefore be split into two sections – ward-based and ward/community-based.

The report does, however, state that the 'team' can be negatively affected by a number of factors. It names, for example, the retention of nursing staff and a dependency on agency staff, lack of support towards training and 'staff development', a lack of ward supervision, and finally the "excessive demands"

made on staff from an organisational level. In a DoH report called '*Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*' (2002), section 4.4.6 states:

There needs to be commitment from provider organisations and the relevant professional groups to target multi-disciplinary input to evidence based treatment programmes for service users on the ward and to contributing expertise to the effective organisation of the ward as a therapeutic enterprise. This input needs to be planned, consistent and reliable and not dependant on the interest or enthusiasm of individual practitioners.

Such criticisms are directed at organisations perceived to be neglecting the official discourse of care; or at least taking it for granted. It is important to view these types of reports as forms of ultra-hierarchical authority or guardians of the official discourse of care that continuously provide firm reminders to the psychiatric institutions that they have to maintain a 'therapeutic' focus towards care. The quote above is a good example of how a Weberian concept of the 'iron cage' manifests itself within reports and policies. It emphasises the point that the actual structure of a ward itself has to be a therapeutic 'enterprise', while also stating that therapeutic care needs to be uniformed and distant from the creativity of one single practitioner.

### *NAs and the 'team'*

The concept of 'profession' is important because it identifies the 'members' of the MDT as those that have trained and are skilled, therefore legitimising the 'therapeutic opportunities' that are offered to the 'individual' patient. As discussed in Chapter Four and earlier in this chapter, the concept of the MDT is made visible through ward and hospital patient pamphlets. What is key about the image of the MDT is that it gives an impression that the different professions within it are structured on an equal level of authority. In other words, each group provides their own expertise that then comes together with the other expert knowledge to form the therapeutic base for inpatient care. Hierarchy is not a 'top-down' image, but 'flat' and apparently egalitarian.

Crucially, the '*Improving the Quality of Psychiatric Inpatient Care in London*' (*IQPIL*) (2003) analysis of 'the team' does little to include the NA. Like Trust policy, hospital pamphlets and the case of the handover, the NA is an excluded member of the staff who carries out all the 'undesirable' tasks which are absent from the official discourse of care. As mentioned earlier, the *IQPIL* Report does attempt to include the NA as an actor within the ward environment by exposing the positive aspects of their 'unqualified' status. In Section 5.21 (the only section focusing on the NA in the Report which consists of three short paragraphs) the Report, it states that:

Unqualified nursing staff are, by definition members of the nursing workforce who have not completed nurse training but assist qualified

nurses and other professionals in their duties. This does not mean that these members of the nursing workforce are “unskilled” as many have considerable experience in the caring profession and provide a valuable resource for the whole profession. In addition, being freed from organizational demands such as ward reports and other aspects of bureaucracy means that unqualified staff often have more time with patients. Within this, many are competent, capable and caring (2003:38).

At first glance, this seems to be a sympathetic and positive statement in regard to the role of the NA. It appears to do very little to make their role invisible and seems to be actively promoting it - so much so that it even acknowledges the fact that it is the NA that spends more time with patients. It also states that many are seen as “competent, capable and caring” individuals. However, if this statement is compared with earlier ones about MDTs as a means of carrying out “therapeutic opportunities” and how care is visualised and conceptualised in an official capacity, it is then possible to interpret this statement about NAs as not fully identifying the actual role of the NA and the work that they do. Care then remains located within the MDT; that designs individually-tailored care. It is also however, largely designed at an organisational level where much of the routes of care that are discussed and implemented, are influenced by bureaucratic policies. The very heart of where official care is shaped is itself part of the larger organisational and bureaucratic structure. It is therefore possible to interpret its portrayal of the NAs’ role as problematic because, while it emphasises the point that the NAs distance from organisational and bureaucratic procedure means that



they have more time with patients to care, it also explains that for care to be adequate, it has to be designed by professionals and within a structured team. The reality is that what the NA actually does cannot be explicitly integrated as care because it is not designed within such a setting. The image of the NA becomes nothing more than a token gesture in acknowledging their presence on the ward. This is fundamentally done by attempting to create a positive and somewhat utopian image of their role where their 'unqualified status' appears to carry some sort of therapeutic value.

### **Changing the whole structure of care.**

In 1999 the Department of Health (DoH) published a 'National Service Framework for Mental Health' that was designed to restructure the way mental health care was perceived. It focused on making sure that the work force was skilled and well organised so as to offer a high standard of mental health care. A skilled workforce meant that qualified staff had to be competent to deliver "modern mental health services" such as cognitive behavioural therapy and "complex medication management" (1999:108).

It states that:

All education and training...should stress the value of team, inter-disciplinary and inter-agency working. Service users and carers should be involved in planning, providing and evaluating education and training...Senior management should establish an organisational culture which enables leadership within mental health services to flourish,

inspiring and promoting innovation with a leadership which reflects the complexity of mental health care (1999:109).

This passage from the report clearly emphasises three crucial points that I have raised throughout this thesis. The first is its focus on the team, the second is the involvement of service users in the care planning and lastly that the organisation's culture should allow for innovation and leadership which reflects the 'complexity' of mental health care. In other words, the culture should be dynamic and modern.

In 2004, the DoH published the 'National Service Framework For Mental Health – Five Years On' that aimed to report on how the 'National Service Framework For Mental Health' (1999) had developed. What stands out from this report is how it portrays an idea of the team. When discussing the increase in staff numbers since 1999 the chart below shows what constitutes the team.

	Mental health workforce (whole-time equivalents)			
	1999	Sept 2003	Change	% Change
Consultant psychiatrists	2,524	3,155 <sup>1</sup>	631	25%
Mental health nurses	34,974	39,383	4,409	13%
Clinical psychology	3,763	5,331	1,568	42%
Psychotherapy	365	631	266	73%
Art/music/drama therapy	416	477	61	15%
Occupational therapy <sup>2</sup>	10,792	13,053	2,261	21%
Approved social worker	N/A	4,200		
<sup>1</sup> DH medical and dental workforce census June 2004 <sup>2</sup> Generic – not specialist mental health				

For the purpose of my argument, I am not concerned with the official meaning of this chart which illustrates the increase in staff. Instead, by looking at the left hand column, we can see that the NA does not appear as part of the mental health workforce. Instead, the mental health workforce resembles the MDT as described in the *IQPIL* (2003) report discussed above.

Although this is now a well documented point in this Chapter, the report also shows that patient attitudes to staff and the care that they receive is very positive. Under the title – “Treating service users with dignity”, the report uses The ‘2004 National Patient Survey’. They state that the survey shows that

....the overwhelming majority of patients were positive about the way that they were treated by mental health professionals. They reported feeling that they were treated with respect and dignity, that they were

listened to and given time, and that they had trust and confidence in staff (2004:67).

Although one cannot deny the positive attitudes that patients have towards the staff and the care they receive, one can, however, question the focus the survey used to define the staff. The chart below from the report highlights the problem.

National Patient Survey 2004 – Mental Health Service User Views												
Professional	Respect and dignity (% of patients)			Listening carefully (% of patients)			Trust and confidence (% of patients)			Time to discuss condition and treatment (% of patients)		
	Yes	Some extent	No	Yes	Some extent	No	Yes	Some extent	No	Yes	some extent	No
	Psychiatrist	79	18	4	68	27	5	59	33	10	60	27
Community psychiatric nurse	81	12	2	81	16	3	73	20	7			
Other health professional	83	14	3	77	19	4	69	25	8			

(DoH, 2004:67)

Again the NA is left out as an active member of the team. However, their exclusion from such a sensitive survey protects the official image of care from having to address any possible contradiction that exists. I have shown in my ethnographic examples throughout this thesis, that the NA's role is primarily to marshal the physical body of the patient, while they themselves largely view the patient in a child-like manner. The example of the patient meeting in Chapter

Five illustrates the frustration that patients have with the NA for making them feel like children. So, if the NAs were to be included within broader official literature, they would destabilizes the official image of care.

### **The physical body and the hidden contradiction**

In Chapter Three, I showed that psychiatry and psychiatric care are based on a well-documented contradiction. Briefly, it is a discipline that attempts to cure through medical and therapeutic approaches, while being an arm of the State's custodial law. The former role is the desired image, while the latter image frustrates the purely medical wing of psychiatry by implying that it must also contain, and not solely cure, patients so as to protect society from the dangers of the mentally ill. The contradiction has been evident since Pinel and Tuke introduced the concept of the 'moral treatment' of patients and the anti-psychiatry movement that argued that psychiatry *per se* was a fabricated concept which was about control due to the types of treatment it offered in asylums and its lack of ability to understand mental illness. More recently, of course, a small number of tragic cases reported in the media have highlighted the same issues arising since the shift towards care in the community<sup>75</sup>. This tension has been present throughout the history of modern day psychiatry. From unqualified attendants of the 19<sup>th</sup> century to qualified nurse, from asylum care to community care, from medication to therapy and from containment to care, are all shifts that have been fundamentally influenced by this contradiction. And as I have argued in Part One and Part Two of this chapter, the contradiction still remains embedded within psychiatry, although today it may be more subtle and has

become part of a hidden and excluded section of the official discourse of care which is acted out in the buffer zone.

While the physical body is not part of the current image of psychiatric care (excluding the recent rise of neuroscience), it remains the most central focus of activity on an acute psychiatric ward. The holistic approach that the patient is supposedly receiving only appears in sporadic stages throughout the week. The consultant may only see the patient for an average of 5 minutes a week, while each 'key nurse' may only have 'therapeutic' contact with their patients once or twice a week if time permits. Daily inpatient care is actually given by the NA who is carrying out their daily tasks as instructed by the qualified nurses. The contradiction is that daily care is not the care that it is documented in policy and team meetings but a masked process positioned between the subtle interactions of the official and unofficial.

One important point to this chapter has been to show that the further one moves away from a focus on the ward, the more pure the image of care becomes. This is largely because policy and government documents are removed from the complex and often 'messy' reality of the ward leaving them free to portray their ideology. An example of this is the image of the team portrayed in the 'National Framework for Mental Health – Five Years On' document discussed above. This even allows National policies and documents to include (although briefly) the NA by acknowledging their supportive role on the ward while also not having to expose the reality of their work: the image of the nursing assistant becomes an

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<sup>75</sup> The BBC (2002) reported on the Andrew Ackroyd who was hospitalised for 10 years after

invention, or 'ideal-type' of how the official would like them to be. However, portraying the NA in such a way in ward, hospital and Trust policy would be too risky because these policies are too close to the reality of everyday care and thus could potentially expose the contradictions. Fundamentally, the masking or exclusion of the NA enables the official discourse to mask the reality that mental health care, in an acute setting, largely focuses on the physical body of the patient. The focus on the physical body of the patient is instead replaced with discourses around the patient as an active participant in the design and management of their care.

#### *Culture of the ward*

In Chapter Two I argued that theories on 'organisational culture' approached the phenomenon of culture as an integrated whole. I questioned this point by arguing that it was reductionist and therefore avoided other crucial aspects that are part of a culture. The interplay and continuous negotiation between the official and unofficial as illustrated in this thesis shows the importance of including themes and interactions that appear outside the perceived culture. What is of importance is that the ward and the hospital are forced to negotiate the bureaucratic and ideological portrayal of care. In other words, hospital management, consultant psychiatrists, SHOs, and qualified nurses all have to juggle the official ideology with the daily reality of psychiatric care; a reality that for a large part of the day requires that the care provided focuses on the physical body of the patient rather than focusing on care being of a therapeutic nature. It is this juggling act which largely shapes a ward's own cultural identity from an homogeneous official and

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stabbing a student. On his release he killed his Father.

bureaucratic image. Where this negotiation is often enacted is within the buffer zone – the meeting place between the official discourse of care and the unofficial approaches to care. Here, the unofficial approach largely focuses on the patient's physical body. However, the short vignette at the beginning of Chapter Two is a good example of how a ward can quickly attempt to change its individual cultural identity so to appear to be performing the required front-stage image of the official system; in this case the image that the Mental Health Commission expected of it for their inspection. The ward manager spent time fixing laminated posters to the walls of the ward while also arranging for qualified staff to check that the ward looked clean and respectable. He also reminded the qualified nurses that they had to make sure that their patient care-plans were up-to-date so that the ward and hospital could not be criticised for not caring for the patients properly. What this vignette illustrates is that, when needed, the ward can change to fit neatly into the required bureaucratic and homogeneous identity by masking the reality of the ever-present contradiction of care. The ward pamphlets that are given to patients on their arrival to the ward provides another example of attempts by the hospital management and ward managers to portray the care on the ward as something that reflects the official discourse of care that is neatly described in the Department of Health's literature. As discussed earlier in the chapter, the most striking similarity between the pamphlets and broader official literature is that they both promote patient empowerment, while denying the existence of the NA and therefore the existence of the reality of care that will be offered; a focus on the physical body.



It is therefore important to stress that while each ward can be interpreted as having their own distinct cultural identity, this does not represent an attempt to be in opposition to the broader official discourses of care. Rather, the ward culture stems from the fact that the individual actors in it are continuously coping and negotiating, both unconsciously and consciously, on an everyday level with the general contradiction surrounding psychiatric care. The powerful State agencies, such as the Department of Health (DoH), are removed from this physical environment of the ward and hospital and therefore do not have to engage with the contradictions. Instead, Government and policy makers are largely left free to produce and reaffirm a 'pure' version of the official discourse of care. This is passed down to the staff on the wards to ideally act out on a daily basis. The reality is, that the culture of the ward relies on its staff to do just that – act.

### **Conclusion**

This chapter has illustrated how the role of the NA is removed from the official image. This is because their official role is based in the space where essential, but 'un-therapeutic', work is performed. The fact that this work does not concentrate on the patient's mind, through therapeutic opportunities and patient empowerment, means it has to be suppressed at different levels within the official representations.

I have explored four different levels of masking. At the ward level, the example of the daily afternoon handover was given; although NAs were officially part of it, they were positioned as mute actors unable to contribute. This was due to a perceived lack of training and knowledge and also because they themselves did not share the same ideological principles of care as the qualified nurses. The second level explored how ward and hospital pamphlets masked the role of the NA by excluding them in the text. Instead, the staff that made up the core of the ward 'team' were portrayed as trained professionals. The third level illustrated how Trust policies, that were largely relevant for procedures that existed in the buffer zone, had to be manipulated so that they appeared to fit into the official image of care. I used the example of observation policy to show that although the task used techniques of surveillance to protect the patient from harming themselves or others, the policy still had to portray the task of observing as being therapeutic in its nature. Therefore there was an attempt to place a focus away from care being about the physical patient's body to care being therapeutic and empowering. The final level moved further away from the ward by exploring how, on a regional and national level, DoH literature such as guidelines and commissioned reports worked to warn Trusts that care had to be 'therapeutic' at all times. The reports and policies gave the message that Trusts have to be seen to be designing and administering care that empowers the patient to have a voice. Like the example of the hospital patient pamphlets, the core of care is seen as being within the MDT, leaving little room for the inclusion of the NA. Fundamentally, the official discourse of care, at the broader level, is left largely free from engaging with the contradiction between care focusing on the physical body and care focusing on therapeutic engagement with the patients. Therefore,

official literature is able to portray the positive ideological principles of care rather than the more 'messy' reality that the ward staff are faced with every day. This partly results in individual wards and hospitals having their own culture that negotiates this reality. Crucially then, what all levels of masking attempt to do is to exclude the fact that the physical body of the patient is a place where much of the daily care is focused. By making those that provide this type of care (the NAs) both symbolically and physically invisible allows, at least ideologically, for the preferred image of care to appear dominant and therefore visible.

The final chapter, the conclusion to the thesis, will explore how the process of making undesirable care invisible becomes a trade-off with the unofficial.

Fundamentally, it is this trade-off that actually enables the everyday running of a ward and hospital to maintain a sense of efficiency.

## VIII. Conclusion

### Introduction

If there has been one major theme throughout this thesis, it is the idea of contradiction. Each chapter has shown how beneath what we think is going on, there lie alternative ideologies and practices that challenge the 'given', or official approaches. My argument in this thesis has concentrated on three areas of contradictions. The first focused on the discipline of psychiatry which has always had to deal with a swathe of criticism so much so that criticism has actually become part of its fabric. The attacks arise from the contradiction inherent in psychiatry's professional role: namely, being a medical and scientific discipline that attempts to 'cure', while also having a 'expert' legal status within the judicial wing of the state apparatus. Secondly, the thesis has argued that contradictions exist within the practice of psychiatry and how it perceives care, resulting in undesirable aspects of needing to be made invisible. This has contextualised my account of the NA role on the ward. Thirdly, and much more broadly, I have implied that modern day organisations, beyond simply the psychiatric hospital, function also by negotiating contradictions in relation to hierarchy, authority and efficiency.

The array of contradictions ranges from the level of the individual ward, through to the level of hospital and Trust policies, and finally to the larger level of Governmental policies and guidelines. What has become clear is that care is

situated within two different types of care: the official and unofficial.

Fundamentally, these two general areas appear directly to contradict each other's approaches, practically, morally and ideologically. This research has shown that the official portrays itself as the only discourse of care, though in reality, acute inpatient psychiatric care was seen not to exist without allowing for the essential role of the unofficial approaches and ideologies towards care.

This chapter will conclude that contradictions actually play crucial roles in enhancing the efficiency of the daily running of a psychiatric acute inpatient ward. It reiterates the reasons why this seemingly disjointed process of caring actually functions as a competent system within an organisational framework. This will then allow me to make a more general argument relating to the role that contradictions could actually be making to the efficiency of organisations in general.

In Chapter One, I defined the official system as the general and objectively accepted framework that any organisation abides by. It carries a formalized identity and system of efficiency. Ideology plays an important role in shaping and validating the official system's identity. In the thesis I loosely base the concept of ideology on Marx's definition because it best illustrates how ideology is used to conceal contradictions and 'inverted reality' (Larrain 1991).

### **The ward round re-visited**

As discussed in Chapter Two there are two main components of the official system. The first are the formal procedures that are clearly marked out within

policy, mission statements, goals and training, while the second are the informal procedures that allow groups within the organisation to discover their own methods of completing procedures and tasks (Blau and Scott 1963). These two sections, the formal and informal are essential for the efficient functioning of the organisation.

In Chapter Four, I used the ethnographic example of the ward round to illustrate the relationship between the formal and informal. I argued that the ward round was a formalised, clinical meeting where time and space became ritualised within a medical field, leaving little room for debate and disagreement. I also argued that the ritualised nature of the ward round meant that different sections of staff participating within it were positioned within their rightful bureaucratic places, as desired by the formal hierarchal structure. The ward round therefore fits into a typical Weberian model of a bureaucratic system in which there was a clear 'top-down' power base and the different 'units' had clear roles so that the multiple tasks could easily be managed (1964). Thus, everyone naturally 'knows their place' in the scheme of things, and importantly, the structure prevents the possibility of resistance to the hierarchy, especially from nurses.

Any possible tensions between the nursing staff and SHOs is acted out outside the structure and setting of the ward round and usually out of view of the consultant. It is here that the informal processes come into play. After the ward round the qualified nurse reclaims the role of controller by implementing informal nursing policy. The SHO, as a junior psychiatrist, has to adapt. One example discussed used was the nurse demanding that the SHO file the patients'

notes back in the nursing office. This was an attempt to assert a sense of authority and ownership on the ward, over the SHO and medical dominance in general. The issues of the nursing office door being kept open as much as possible so as not to exclude the patients from interacting with the nursing staff, is another example of nurses' attempting to retain a sense of authority through informal methods. The SHOs would often find that this informal policy would challenge their way of working on the ward, and often felt that they were being exposed to patients' demands unnecessarily and in some cases unfairly.

However, any attempt at challenging the nursing staff would be interpreted as a direct threat to the nursing policy and authority on the ward. At the same time, the exclusion of the SHO from the informal structures of the ward, actually enables the SHOs to maintain their identity within a more formal and medical structure. I used Goffman's (1959) metaphor of the theatrical stage to develop these themes so to illustrate how nurses and SHOs act out their desired roles as an attempt to claim authority on the ward.

In summary, the key point relating to both the formal and informal, is that they are located firmly within the official system, both bureaucratically and within relation to the official discourse of care. The official therefore, has two clear components which together achieve the desired efficiency.

### **The unofficial system re-visited**

I have made it clear that the informal aspect of the official system and the unofficial system are quite distinct. This is why I deliberately excluded the role of the NA in the official framework and only introduced them into the thesis in

Chapter Five as they epitomise the workings of the unofficial system. Although the tasks that they carry out are located within the official domain, I illustrated that their work is positioned in the 'buffer zone' which is symbolically the meeting point of both the official and unofficial systems. The NAs effectively prop up the official system by carrying out the undesirable, invisible tasks without which the whole enterprise would come to a halt.

The unofficial system is the space owned by the NAs in which processes evolve which give the NA their own sense of identity in the work environment. This is in line with Goffman's (1961) notion of secondary adjustments as discussed in Chapter Five. Although Trust and hospital management are probably under the illusion that they have a formulised image of what the NA is, it became clear to me, through the use of Goffman's secondary adjustments that the unofficial space that the NA inhabits goes largely unnoticed by the official apparatus; and, in as far as it *is* noticed, there is an unconscious imperative to keep the NA and their domain invisible.

So how did NAs structure care within this unofficial system? It seems to me that intrinsic to the NA's unofficial discourse of care is the clear assumption that a patient is always a patient. In Chapter Five, I argued that the NA's approach is fundamentally affected by their view of the patient as being a potential threat and danger. From the NA's point of view, this is simply the result of the patient being diagnosed with mental illness, leaving them, in the NAs' view, as unpredictable. The way in which the NAs deal with this is by taking on an authoritarian and parental role. Often, NAs would describe patients as 'child like' and insist that



firm discipline and boundaries would help the patient develop and ‘get better’. The care that they offered allows little room for negotiation. For the NAs this form of care seems completely logical in relation to the way that they construe mental illness.

The NAs’ approach to care is played out largely through how the body is used through practice. I used Bourdieu’s (1977) notion of the habitus, in which the body is the enactment of cultural principles that are based on learnt process and experiences. It links the individual’s subjective world and the shared cultural world. The NAs’ understanding of care fundamentally focuses on the body; both on the physical containment of the patient and through protecting their own bodies from pollution outside.

A good example of this was my ethnographic account, in Chapter Five, of meal times. This daily routine illustrates the NAs’ enactment of care. Fundamentally, this was shaped by the perceived threat of being polluted by the patient in the hospital and further a field in their ordered and safe environment outside the hospital. It was perceived that pollution existed from coming into contact with patients’ bodily fluids while the NA was serving out food. Therefore, they physically created barriers to protect themselves from this, by, for example, using their own Tupperware containers which they kept locked away in the kitchen cupboards, instead of using hospital crockery and utensils, or by standing up while eating so as not to have to sit next to patients. The qualified nurses would sit with the patients and eat the same food from the same plates as the patients, interacting with them as through they were ‘normal’, and not mentally ill (I

referred to this as pseudo-normality). I have put forward the idea that apart from physical pollution, there was also a risk of symbolic pollution by the official discourse of care to the NAs. The NAs' need to protect themselves is therefore, as much about preserving their own model of care as simply the physical threats. Rituals, such as the use of one's own Tupperware containers, work to maintain this stark division between what is normal and safe and what is, from the NAs' perspective situated within the seemingly chaotic and dangerous sphere of the official discourse of care.

The NAs' model of care is structured and developed within the unofficial system. It lies outside the formal boundaries, leaving it free of the official ideology. However, this creation of care is only possible and tolerated due to the marginal position of the NA and their invisibility in the organisation; an invisibility that the official and unofficial systems require. So, the NAs' model of care fundamentally works as a defence mechanism against the official discourse of care which is ultimately incorporated in the daily ward activities, and beyond, in the official policies of the Trust.

### **Trading Invisibility**

In Chapter Seven I argued that for the official discourse of care to appear as the dominant form, it has to rely on masking undesirable, but vital, everyday components of its work. The next step is to make those, to whom these undesirable, but official tasks have been allocated, invisible actors on the ward. These are the NAs. As described in Chapter Seven, their invisibility is brought about through, amongst others, marginalisation within handovers, not being

named in printed pamphlets and Trust and Governmental policies in relation to care. However, this process is not totally controlled. Crucially, it is not only the official that desires the NA to be relegated to a mere shadow, but it is the NAs themselves who also desire their presence not to be fully acknowledged. Daily routine demonstrates how, in reality, there is a trade off between the official system and the unofficial system.

How does this trade-off work? Compatibility comes about by means of the mutual toleration: the official system's visible ideological status which promotes care based on 'therapeutic opportunities' and patient empowerment, is accepted by the unofficial system while the unofficial system's presence is over-looked by the official. In Chapter Seven I described how systems of 'masking' allowed the organisation to present its official image within its desired discourse of care. Importantly, masking also benefits the NAs because it allows the unofficial to exist by denying that it exists. In other words, the NAs gain a conceptual space, the unofficial system, where they can forge their own approaches towards care, which goes largely unchallenged.

The reality is that the official system holds power through hierarchy. The unofficial system, in contrast, holds power because the NAs are relied upon to carry out the undesirable work. The unofficial presents work, therefore, as a system of ransom over the official. The unofficial manipulates the ideological structure of the official, which claims that care works through flexible, but coherent units that function together within its organisation. A good example of this is in Chapter Five, where I describe how patients in an advocacy group made

official complaints about the role of the NA at meal times. The patients described themselves as feeling that they were being treated as children and not being valued. The minutes of the meeting were pinned to the notice board on the ward. The essential point here is that the actual wording of the minutes did not identify NAs as the culprits; rather, they were referred to as 'staff', creating a false image of a homogenous staff group or unit. Although qualified staff and hospital management were aware that this problem was located with NAs, they did not confront them as a group. Rather, 'all staff' were 'reminded' that they were supposed to interact with patients at meal times. The point is that the official could not publicly identify NAs as the problem at meal times because it would bring to light discrepancies and conflicts between the different discourses of care that though known, are not addressed.

This stand off allows for the unofficial system to expand and develop within its own space. As discussed in Chapter Six, secondary adjustment moves from being one of shaping the unofficial model of care, to creating space for the NAs to preserve a sense of self through socio-economic interactions, such as the selling of phone cards, 'bush meat' and clothing – interactions that have little to do with their official work, but more to do with earning extra income and claiming a sense of self in an environment where they have little purpose officially and little desire to be in such an environment at all. I described these activities and interactions as being methods of resistance against the official ideology. In a similar way to the administering of care in their own system, the selling of goods provides a further wall of protection against the moral principles of the official

that assumes that, while its staff are active on the ward, they are caring, and doing so because of a moral and vocational incentive.

The NAs are positioned in a social world of negotiation that enables them to cope with the multi-layered exigencies that they face. They are in a strange place, trying to make sense of it and also trying to make the experience meaningful for themselves. Being positioned at the bottom of the organisational structure provides them with a sense of flexibility that the qualified nurses do not have. It is in such a space that the NAs are able to maintain a model of care that is free, in their eyes, of contradiction, and works to support their own moral values regarding mental illness, work and their own existence. Invisibility becomes their saviour – it offers them a sense of freedom in exchange for doing only what is explicitly stipulated with regard to the official system.

### **Organisations**

At this point I want to step back from the specific context of College Ward and makes some more general observations about organisations. In Chapter Two I outlined two opposing views of contemporary organisations: a bureaucratic view, and a view that organisations can be regarded as a special cultural group. In the case of the latter, the term ‘hierarchy’ is replaced by a more egalitarian and organic image of management (Martin 1994, 1997). In this chapter I have revisited this dichotomy and drawn on some of the ethnographic examples from pervious chapters to show that there is not so much of a difference between these two approaches after all. In addition to what was stated in Chapter Two, I suggest here that both bureaucratic and flexible organisational cultures actually rely on

each other in order to create an efficient system. It is wrong to conceptualise organisations as located solely in either camp. Rather, organisations function simultaneously as bureaucratic institutions and as flexible systems that allow for negotiation as a means of masking the reality of hierarchy. In reality, flexibility and the modern day management styles frequently rely on the fact that there actually exists a traditional hierarchical structure hidden behind the overt ideology of flexibility.

My argument has moved beyond the difference between formal and informal systems of work as a means of achieving efficiency (Blau and Scott 1963). By drawing on my ethnographic examples, I have shown that the key to understanding organisational structure is to focus as much on what is *not* supposed to be going on (the unofficial system) as on what *is* officially going on, formally and informally and ideologically and practically. In the case of a psychiatric hospital in London, although contradictions exist, the process of caring within the organisational structure still functions in an efficient way. It functions because the different systems of care, the official and unofficial, maintain their identity by each denying that the other exists. Far from trying to suppress each other's position, there is a negotiated stand-off which allows for the unofficial to be invisible.

We are left with an interesting image of power within an organisational setting.

While we may be led to believe that hierarchy is now more, dynamic and egalitarian, it may be, in fact, structured even more on Weber's theory of bureaucracy. In my research, I explored how the official structure of the Multi-

disciplinary Team (MDT) was one in which there was supposedly a flexible team of professionals working together to enhance the care of individual patients. The key is that there is an apparent lack of hierarchy based on the fact that the team is made up entirely of 'professionals' who all provide different forms of expertise. However, the reality is different. The practicality of such a system becomes problematic, for instance, when meetings such as ward rounds take place. Here, the need for traditional hierarchy as a means of structuring and supporting care become not only necessary but visible. The defined role of each member of staff is clearly located within a traditional hierarchical structure because a clear division of labour becomes necessary to fulfil the various bureaucratic requirements of the system. Here again we are faced with another contradiction. Just as the official masks the existence of the unofficial, the flexible and dynamic approach to organisation masks the reality of the need for traditional hierarchy.

### **Final Thoughts**

This thesis has focused on the complex area of psychiatry, and more importantly on how psychiatric care is conceptualized. By carrying out anthropological research, I have shown that the way in which care is construed is complex; so much so that, at times, it might appear irrational and contradictory. I have also challenged the assumption that organisations in general have appeared to relinquish the more traditional structures of authority in favour of more fluid and flexible systems. I hope the idea of official and unofficial systems of work can be explored on a broader scale so as to gain further understandings of the functioning of other organisations. This might be within other areas of health and medicine, non-health related public sector institutions or within the commercial

sector. Ultimately, I am suggesting that the invisibility of the unofficial system within organisations could be a rich and important area for anthropological research which could lead to a deeper understanding of organisations function.



## Bibliography

- Abbot, P & Meerabeau, L (1998) Professionals, Professionalization and the Caring Profession. In Abbot, P & Meerabeau, L (1998) *The Sociology of the Caring Profession* (2<sup>nd</sup> Edition) London: University College London
- Abel-Smith, B (1977) *A History of the Nursing Profession*. London: Heineman
- Amit – Talai and Knowles (1996) Introduction: Against Parochialism and Fragmentation. In Amit – Talai and Knowles (Eds) (1996) *Re-Situating Identities: The Politics of Race Ethnicity Culture*. Ontario, Orchard Park, London: Broadview Press
- Amit, V (2000) Introduction. In Amit, V (ed) (2000) *Constructing the Field: Ethnographic Fieldwork in the Contemporary World*, London and New York: Routledge
- APA (1994) *Diagnostic and Statistical Manual of Mental Disorders*, (4<sup>th</sup> edition). Washington, DC: American Psychiatric Association.
- Appadurai, A (1986) Introduction: Commodities and the politics of value, in Appadurai, A (ed) (1986) *The Social Life of Things: Commodities in Cultural Perspective*. Cambridge: Cambridge University Press
- Apthrope, R (1997) Writing development policy analysis plan or clear: On language, genre and power. In, Shore, C & Wright, S (eds) (1997) *Anthropology of Policy: Critical Perspectives on Governance and Power*. London and New York: Routledge.
- Armstrong, D (2003) *Outline of Sociology as applied to Medicine* (5<sup>th</sup> Edition), London: Arnold.
- Atkinson, P *et al* (eds) (2001) *Handbook of Ethnography*. London: SAGE
- Avruch, K (1998) *Culture and Conflict Resolution*: Washington DC: United States Institute of Peace Press.
- Back, L (1992) Gendered Participation: Masculinity and Fieldwork in a South London Adolescent Community. In Bell, D & Caplan P, Karim, W (eds) (1992) *Gendered Fields: Women, Men, and Ethnography*. London: Routledge
- \_\_\_\_\_ (1996) *New Ethnicities and urban culture: Racism and multiculturalism in young lives*. London: University College London Press
- Bamford, S (1998) To eat for another: taboo and the elicitation of bodily form among the Kamea of Papua New Guinea. In Lambek, M & Strathern, A

(eds) (1998) *Bodies and Persons: Comparative Perspectives from Africa and Melanesia*. Cambridge: Cambridge University Press.

Banks, R.A (1985) *Drama and Theatre Arts*. London, Sydney, Auckland, Toronto: Hodder and Stoughton

Barnard, H.C (1968) *A History of English Education*. London: University of London Press.

Barth, F (1969) *Ethnic Groups and Ethnic Boundaries*, London: Allen and Unwin

\_\_\_\_\_(2000) *Boundaries and connections*. In Cohen A (ed) (2000) *Signifying Identities: Anthropological perspectives on boundaries and contested values*. London and New York: Routledge

Bartlett, P & Wright, D (1999) *Community Care and its antecedents*. In Bartlett, P & Wright, D (1999) *Outside the walls of the asylum. The history of care in the community 1750-2000*. London: Athlone

Beatty, A (1999) *On Ethnographic Experience: Formative and Informative (Nias, Indonesia)*, in Watson, C.W (1999) *Being There: Fieldwork in Anthropology*. London, Sterling, VA USA: Pluto Press

Beetham, D (1987) *Bureaucracy*. Milton Keynes: Open University Press.

Bell, C (1992) *Ritual Theory, Ritual Practice*. New York and Oxford: Oxford University Press

Bell, D & Caplan P, Karim, W (eds) (1992) *Gendered Fields: Women, Men, and Ethnography*. London: Routledge

Benedict, R. (1937) *Patterns of Culture*. New York: Houghton Mifflin.

Berreman, G. (1972). *Behind Many Masks: Ethnography and Impression Management*. In Gerald Berreman (ed.) (1972), *Hindus of the Himalayas: Ethnography and Change*. Berkeley: University of California Press.

Blau, P.M & Scott, R.W (1963) *Formal Organizations: A comparative approach*. London: Routledge and Kegan Paul.

Blau, P.M (1981) *The Comparative Study of Organizations*. In, Grusky, O, Miller, A, George (eds) (1981) *The Sociology of Organizations, Basic Studies*, Second Edition. New York and London: The Free Press.

Bloch, M (1989) *Ritual, history, and power: Selected papers in anthropology*. London: Athlone.

Bloch, M & Parry, J (1989) *Introduction: money and the morality of exchange*. In Bloch. M & Parry. J (1989) *Money and the Morality of*

- Exchange*. Cambridge: Cambridge University Press
- Bourdieu, P (1977) *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.
- \_\_\_\_\_ (1999) Language and Symbolic Power. In Jaworski, A and Coupland, N (1999) *The Discourse Reader*. London and New York; Routledge
- Bracken, P (2002) *Trauma: Culture, Meaning and Philosophy*. London and Philadelphia: Whurr Publishers
- Bracken, P. & Thomas, P. (2001) Postpsychiatry: a new direction for mental health. *BMJ*, 322, 724–727.
- Burchell, G. (1991). ‘Peculiar interests: civil society and governing “the system of natural liberty”’, in Graham Burchell, Colin Gordon and Peter Miller (eds) *The Foucault Effect*, Hemel Hempstead: Harvester Wheatsheaf
- Burdett, H.C (1891) *Hospitals and Asylums of the World, Vol 1*. London: Churchill
- Burgess, R (1991) *In the Field: An Introduction to Field Research*. London and New York: Routledge
- Bury, M (1997) *Health and Illness in a Changing Society*. London: Routledge
- Busby, A.& Glichrist B. (1992) The role of the nurse in the medical ward round. *Journal of Advanced Nursing* 17, 339-346
- Butler, T (1993) *Changing Mental Health Services: The Policies and Policy*, London, Chapman and Hall
- Caplan, P (1997) Approaches to Food, Health, and Identity, in Caplan, P (ed) (1997) *Food, Health and Identity*. London and New York: Routledge
- Caputo V, (2000) At ‘Home’ and ‘Away’: Reconfiguring the Field for Late Twentieth-Century Anthropology, in Amit, V (ed) (2000) *Constructing the Field: Ethnographic Fieldwork in the Contemporary World*. London and New York: Routledge
- Carpenter, M (1980) Asylum nursing before 1914: The history of Labour. In *Rewriting Nursing History*, Davis, C (ed). London: Groom Helm
- Chakraborty, A and McKenzie, K (2002) Does racial discrimination cause mental illness? *British Journal of Psychiatry*, (2002), 180, 475-477
- Clare, A (1980) *Psychiatry in Dissent: Controversial Issues in Thought and Practice* (2<sup>nd</sup> Edition). London and New York: Routledge

- Clifford, J (1986) Introduction: Partial Truths, in Clifford, J & Marcus, G (eds) (1986) *Writing Culture: Poetics and Politics of Ethnography*. Los Angeles and London: University of California Press
- Cohen, P (1996) Homing Devices. In Amit – Talai and Knowles (Eds) (1996) *Re-Situating Identities: The Politics of Race Ethnicity Culture*. Ontario, Orchard Park, London: Broadview Press
- Crapanzano, V (1986) Hermes' Dilemma: Masking of Subversion in Ethnographic Description, in Clifford, J & Marcus, G (eds) (1986) *Writing Culture: Poetics and Politics of Ethnography*. Berkeley, Los Angeles and London: University of California Press
- Creer C, Wing J K (1974) *Schizophrenia at Home*. Surbiton: National Schizophrenia Fellowship
- Csordas, T.J. (1994) The Body as Representation and Being in the World. In Csordas, T.J (ed) (1994) *Embodiment and Experience: The Existential Ground of Culture and Self*. London: Cambridge University Press.
- Davis, C (1995) *Gender and the Professional Predicament in Nursing*. Buckingham: Open University Press
- Delgado, R & Stefanic, J (2001) *Critical Race Theory: An Introduction* . New York: New York University Press.
- Doerner, K (1981) *Madman and the Bourgeoisie*. Oxford: Basil Blackwell
- Department of Health (1999) *National Service Framework for Mental Health: Modern Standards and Service Models*. London: DoH
- \_\_\_\_\_(2000) *The NHS Plan. A plan for Investment, A Plan for reform*. London: The Stationary Office
- \_\_\_\_\_(2002) *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*. London: DoH
- \_\_\_\_\_(2004) *The National Service Framework: Five years on*: London: DoH
- Devisch, R (1998) Treating the affect by remodelling the body in a Yaka healing cult. In Lambek, M & Strathern, A (eds) (1998) *Bodies and Persons: Comparative Perspectives from Africa and Melanesia*. Cambridge: Cambridge University Press
- Douglas, M (1966) *Purity and Danger*. London: Routledge and Kegan Paul.
- \_\_\_\_\_(1975) 'Deciphering a meal', in Douglas, M, (1975) *Implicit Meanings: Essays in Anthropology*. London: Routledge and Kegan Paul

- Du Gay, P (2000) *In Praise of Bureaucracy: Weber, Organization, Ethics*. London: SAGE
- Durkheim, E (1963) *The Rules of Sociological Method*. New York: The Free Press.
- Dyck, N (2000) Home Field Advantage? Exploring the Social Construction of Children's sports, in Amit, V (ed) (2000) *Constructing the Field Ethnographic Fieldwork in the Contemporary World*. London and New York: Routledge
- Dyer, R (2000) The Matter of Whiteness. In Back and Solomos (eds) (2000) *Theories of Race and Racism: A Reader*. London and New York: Routledge
- Eicher, J.B (1995) Introduction: Dress as Expressions of Ethnicity. In Eicher, J.B (ed) (1995) *Dress and Ethnicity*. Oxford: Berg.
- Eisenberg, L. (1995) The social construction of the human brain. *American Journal of Psychiatry* 152:1563-1575.
- Etzioni, A (1964) *Modern Organizations*. Prentice – Hall, Inc: Englewood Cliffs, New Jersey.
- \_\_\_\_\_ (1969) *The Semi-Professions and their Organisations*. New York: Free Press
- Evans-Pritchard, E.E (1940) *The Nuer*. Oxford: Oxford University Press.
- Fabrega, H. Jr (1989) The Self and Schizophrenia. *Schizophrenia Bulletin*, 15:277-290
- Fernando, S (2002) (2<sup>nd</sup> Edition) *Mental Health, Race and Culture*. Hampshire and New York: Palgrave
- Fernando, S. Ndegwa, D. Wilson, M. (1998) *Forensic Psychiatry, Race and Culture*. London and New York: Routledge
- Fielding, N (1981) *The National Front*. London and New York: Routledge
- Foucault, M (1972) *The Archaeology of Knowledge*. London: Tavistock
- \_\_\_\_\_ (1976) *Mental Illness and Psychology*. New York: Harper and Row.
- \_\_\_\_\_ (1977) *Discipline and Punishment*. Harmondsworth: Penguin
- \_\_\_\_\_ (1986). *The History of Sexuality, Vol 1*. New York: Vintage

- \_\_\_\_\_ (1989) *Madness and Civilization*. London and New York: Routledge
- Frankenberg, R (2000) *White Women, Race Matters: The Social Construction of Whiteness*. In Back and Solomos (eds) (2000) *Theories of Race and Racism: A Reader*, London and New York: Routledge
- Friedson, E (1970) *Professional Dominance: The Social Structure of Medical Care*. New York: Atherton Press
- \_\_\_\_\_ (1994) *Professionalism Reborn: Theory, Prophecy and Policy*. Cambridge: Polity
- Furlong, R (1996) *Haven within or without the hospital gate: A reappraisal of asylum provision in theory and practice*. In Tomlinson, D & Carrier, J (1996) (eds) *Asylums in the Community*. London: Routledge
- Gabbard G.O, Gabbard K (1999), *Psychiatry and the Cinema*, (2<sup>nd</sup> edition). Washington, D.C.: American Psychiatric Press.
- Garnarikow, E (1978) *Sexual Division of Labour: The case of nursing*. In, Kuhn, A and Wolpe, A.M (eds) *Feminism and Materialism: Women and Modes of Production*. London and New York: Routledge.
- Geertz, C (1973) *Interpretation of Cultures*. New York: Basic Books
- \_\_\_\_\_ (1980) *Negara: The Theatre State in Nineteenth Century Bali*. Princeton: Princeton University Press
- \_\_\_\_\_ (1983) "From The Native's Point of View": On the Nature of Anthropological Understanding', in *Local Knowledge: further essays in interpretive anthropology*. New York: Basic Books
- \_\_\_\_\_ (1998) "Deep Hanging Out", *The New York Review of Books* 45 (16); October, 22
- Gellner, E (1983) *Nations and Nationalism*. London: Blackwell
- Giddens, A (1995) *Politics, Sociology and Social Theory: Encounters with Classical and Contemporary Social Theory*. Cambridge: Polity Press
- Gilroy, P (1987) *There Ain't No Black in the Union Jack*. London: Hutchinson
- Gluckman, M (1963) *Order and Rebellion in Tribal Africa*. Glencoe, Ill: Free Press
- Goffman, E (1959) *The Presentation of Self in Everyday Life*. London: Allen Lane

- \_\_\_\_\_ (1961) *Asylums: Essays in the Social Situation of Mental Patients and Other Inmates*. Harmondsworth: Penguin Books
- \_\_\_\_\_ (1961) *Encounters: Two Studies in the Sociology of Interaction*. Harmondsworth: Penguin Books
- \_\_\_\_\_ (1967) 'Mental Symptoms and Public Order'. In *Interaction Ritual: Essays on Face-to-Face Behavior*. New York: Doubleday Anchor
- Gordon, C (1986) Psychiatry as a problem of democracy. In Miller, P & Rose, N (1986) *The Power of Psychiatry*. Cambridge: Polity Press
- Gove, W.R (1982) Current Status of Labelling Theory. In Gove, W.R (ed) (1982) *Deviance and Mental Illness. SAGE Annual Review of Studies in Deviance Vol 6*. London: SAGE
- Gray, M. JA. (1999) Postmodern medicine. *Lancet* 1999;354:1550-3.
- Grillo, R.D (1997) Discourse of Development: The View from Anthropology. In Grillo, R.D and Stirrat R.L (1997) *Discourses of Development: Anthropological Perspectives*. Oxford and New York: Berg
- Gupta, A & Ferguson, J (1997) Discipline and Practice: 'The Field' as Site, Method, and Location in Anthropology, in Gupta, A & Ferguson, J (eds) (1997) *Anthropological Locations. Boundaries and Grounds of a Field Science*. Berkeley, LA and London: University of California Press
- Hall, S (1992) the Question of Cultural Identity. In *Modernity and its Futures*, Hall, Held, McGrew (eds). Cambridge: Polity Press & Open University
- \_\_\_\_\_ (1999) 'The Local and the Global', in A.D King (ed), *Culture, Globalisation and the World System*. London: Macmillan.
- Hammersley, M & Atkinson, P (1995) *Ethnography: Principles in Practice*. Second Edition. London and New York: Routledge
- Hansen, H (1997) Patients' Bodies and discourses of Power, in Shore, C & Wright, S (eds) (1997) *Anthropology of Policy: Critical Perspectives on Governance and Power*. London and New York: Routledge
- Hardy, B.C (1976) *Understanding Organisations*. Harmondsworth, Penguin.
- Hart, K (2000) *The Money Bank*. London : Profile Books
- Health and Social Care Advisory Service (2003) *Improving the Quality of Psychiatric Inpatient Care in London (IQPIL)*. London: Health and Social Care Advisory Service

- Helman, C (1994) *Culture, Health and Illness* (3<sup>rd</sup> Edition). Oxford, Boston, Johannesburg: Butterworth-Heinemann,
- Henshaw, R & Howells, B (1999) *Health*. London: Hodder & Stoughton
- Hertz, R (1973) 'The Pre-eminence of the Right Hand: A Study of Religious Polarity'. In Needham, R (ed), *Right and Left: Essays on Dual Symbolic Classification*. Chicago: University of Chicago,
- Hickson, D. J., & McCullough, A. F. (1980). Power in organizations. In G. Salaman, & K. Thompson (Eds.), *Control and ideology in organizations*. Milton Keynes: Open University Press
- Hirsch, E & Gellner, D (2001) Introduction: Ethnography of Organizations and Organizations of Ethnography. In Hirsch, E & Gellner, D (eds) (2001) *Inside Organizations: Anthropologists at Work*. Oxford and New York: Berg.
- Hurst, K (1992) 'Changes in nursing practice 1984-1992', *Nursing Times*, 88, p54
- Iles, V & Sutherland, K (2001) *Managing Change in the NHS – Organisational Change: A Review for Health Care Managers, Professionals and Researchers*. NHS SDO
- Hobbs, D & May, T (1993) *Interpreting The Field: Accounts of Ethnography*. Oxford and New York: Oxford University Press
- Jackson, A (ed) (1987) *Anthropology at Home, ASA Monograph 25*.
- Jackson, M (1983) Knowledge of the Body. *Man*, 18, 327 –45
- Kirk, S. & H. Kutchins: *The Selling of DSM: The Rhetoric of Science in Psychiatry*. New York: Aldine de Gruyter, 1992.
- Klein (1989) *The Politics of the NHS*. Essex: Longman Group
- Knowles (1996) Racism, Biology, and Psychiatry. In Amit – Talai and Knowles (Eds) (1996) *Re-Situating Identities: The Politics of Race Ethnicity Culture*. Ontario, Orchard Park, London: Broadview Press,
- Laine, C & Davidoff, F (1996) Patient-Centered Medicine: A Professional Evolution. *JAMA* January 10 1996 – Vol 275, No. 2
- Laing, R.D (1960) *The Divided Self: The Existential Study in Sanity and Madness*. London: Penguin Books
- Lambek, M (1998) Body and mind in mind, body and mind in body: some anthropological interventions in a long conversation. In Lambek, M &



- Strathern, A (eds) (1998) *Bodies and Persons: Comparative Perspectives from Africa and Melanesia*. Cambridge: Cambridge University Press
- Lambert, H and Mckevitt, C (2002) Anthropology in health research: from qualitative methods to multidisciplinary. In *The British Medical Journal* Vol 325 27 July 2002 pp. 210-212
- Leseth, A (1997) The Use of *Juju* in Football: Sport and Witchcraft in Tanzania. In, *Entering the Field: New Perspectives on World Football*, (eds) Armstrong, G, & Giulianotti, R,. Oxford & New York: Berg.
- Lévi-Strauss, C (1978) *The Origin of Table Manners: Mythologies*, Volume Three. Chicago: University of Chicago Press
- Linn (1968) The Mental Hospital from the Patient Perspective. *Psychiatry* 31:213-223
- Littlewood, R (1996) Psychopathology, embodiment and religious innovation. In *Psychiatry and Religion*. Bhugra, D (ed). London: Routledge
- \_\_\_\_\_ (1998) *The Butterfly and the Serpent: Essays in Psychiatry, Race and Religion*. London and New York: Free Association Press.
- \_\_\_\_\_ (2000) Psychiatry's Culture. In Skultans, V & Cox, J (eds) (2000) *Anthropological approaches to Psychological Medicine: Crossing Bridges*. London: Jessica Kingsley Publishers
- Littlewood, R and Cross, C. (1980) 'Ethnic minorities and psychiatric services'. *Sociology Health and Illness*, 2, 194-201
- Littlewood, R and Lipsedge, M (1982) *Aliens and Alienists: Ethnic Minorities and Psychiatry*. London: Routledge
- \_\_\_\_\_ (1989) (2<sup>nd</sup> Edition) *Aliens and Alienists: Ethnic Minorities and Psychiatry*. London: Unwin Hyman.
- Littlewood, R and Dein, S (2000) Introduction. In, *Cultural Psychiatry and Medical Anthropology: An Introduction and Reader*. Littlewood, R and Dein, S (eds) (2000). London: Athlone Press
- Losi, N (2000) Understanding the needs of the displaced: some elements on the Kosovo case. In *Psychosocial and Trauma Response in War-torn societies. The Case Study of Kosovo. Psychosocial Notebook* Vol 1, November 2000
- Lyotard, J.-F. (1984) *The Postmodern Condition: A Report on Knowledge*. Manchester: Manchester University Press.
- MacKay, L (1998) Nursing: Will the Idea of Vocation Survive? In. Abbot, P & Meerabeau, L (1998) *The Sociology of the Caring Profession* (2<sup>nd</sup>

Edition) London: University College London

Malik, K (1996) *The Meaning of Race: Race, History and Culture in Western Society.* , London: Macmillan Press LTD

Mallik, M (1992) The role of the nurse on the consultant's ward round. *Nursing Times*, January 29, Vol 88, No5, 1992

Malinowski, B (1922) *Argonauts of the Western Pacific.* London: Routledge

Manning, P (1992) *Erving Goffman and Modern Sociology.* Cambridge: Polity Press

Martin, E (1997) Managing Americans: Policy and changes in the meaning of work and the self. In, Shore, C & Wright, S (eds) (1997) *Anthropology of Policy: Critical Perspectives on Governance and Power.* London and New York: Routledge.

\_\_\_\_\_ (1994) *Flexible Bodies: The role of immunity in American culture from the days of Polio to the age of Aids.* Boston: Beacon Press

Mascarenhas – Keyes, S (1987) The Native Anthropologist: Constraints and Strategies in Research, in Jackson, A (ed) (1987) *Anthropology at Home.* ASA Monograph 25.

Mason, D (1995) *Race and Ethnicity in Modern Britain.* Oxford: Oxford University Press

Mauss, M (1979) 'Body techniques'. In *Sociology and Psychology: essays by Marcel Mauss.* London: Routledge & Kegan Paul

\_\_\_\_\_ (1990). *The Gift: forms and functions of exchange in archaic societies.* London: Routledge.

McKechnie, R & Kohn, T (1999) In Kohn, T & McKechnie, R (eds) (1999) *Extending the Boundaries of Care: Medical Ethics and Caring Practices,* Oxford: Berg

McKenzie, K (1999) Something Borrowed from the Blues: We can use Lawrence inquiry findings to help eradicate racial discrimination in the NHS. *BMJ* 1999;318:616-617 ( 6 March )

Mead, N & Bower, P (2000) Patient-centeredness: a conceptual framework and review of the empirical literature. *Social Science and Medicine.* 1 (2000) 1087-1110

Merton, H (1903) *A Complete System of Nursing,* (2nd Edition). London: Sampson Low, Maston & Company

- Miles and Torres (1996) Does "Race" Matter? Transatlantic Perspectives on Racism after "Race Relations". In Amit – Talai and Knowles (Eds) (1996) *Re-Situating Identities: The Politics of Race Ethnicity Culture*. Ontario, Orchard Park, London: Broadview Press
- Miller, P (1986) Critiques of psychiatry and critical sociologies of madness. In Miller, P & Rose, N (1986) *The Power of Psychiatry*. Cambridge: Polity Press.
- Miller, P and Rose, N (1986) Introduction. In Miller, P & Rose, N (1986) *The Power of Psychiatry*. Cambridge: Polity Press
- Mills, S (1997) *Discourse*. London and New York: Routledge.
- Mitchell, J (1984) *What is to be done about Illness and Health?* London: Penguin
- Moore, H (1986) *Space, Text and Gender: An Anthropological Study of the Marakwet of Kenya*. Cambridge: Cambridge University Press
- \_\_\_\_\_ (1994) *A Passion for Difference: Essays in Anthropology and Gender*. Cambridge: Polity Press
- Mommsen, W (1974) *The Age of Bureaucracy. Perspectives on the Political Sociology of Max Weber*. New York: Blackwell.
- Morris, B (1987) *Anthropological Studies of Religion: An Introductory Text*. Cambridge: Cambridge University Press
- Morris, B (1991) *Western Concepts of the Individual*. Oxford and Washington DC: Berg.
- Nader, L (1974) Up the Anthropologist: Perspectives Gained from Studying Up, in Hymes, D (ed) (1974) *Reinventing Anthropology*. New York: Vintage Books,
- Nations, M. Epidemiological research on infectious disease: Quantitative rigor or rigormortis? Insights from ethnomedicine. In C. Janes, R. Stall, S. Gifford (eds). *Anthropology and Epidemiologies: Interdisciplinary Approaches to the Study of Health and Disease*, Dodrecht: Reidel
- Nolan, P (1993) *A history of mental health nursing*. London: Chapman & Hall
- Nolan, P and Chung, M.C (1996) Science and the early development of mental health nursing. *Nursing Standard 10* (48), 44-47
- Norman, K (2000) Phoning the Field: Meanings of Place in involvement in Fieldwork 'At Home', in Amit, V (ed) (2000) *Constructing the Field: Ethnographic Fieldwork in the Contemporary World*. , London and New York: Routledge

- Norris, C (1993) Some Ethical Considerations of Field-work with the Police, in Hobbs, D & May, T (1993) *Interpreting The Field: Accounts of Ethnography.* , Oxford and New York: Oxford University Press
- Nugent, S (2001) The Yanomami, Science and Ethics. *Anthropology Today.* June 2001, vol 17, no 3 pp10-14.
- Oakley (1998) The Importance of being a nurse. In Mackay, Soothill, Melia (eds) (1998) *Classic Texts in Health Care.* Oxford and Boston: Butterworth-Heinemann
- Okely, J (1987) Field work up the M1: Policy and Political Aspects, in Jackson, A (ed) (1987) *Anthropology at Home.* ASA Monograph 25.
- Ortner, S (1974) 'Is female to male as nature is to culture?' In Rosaldo, M & Lamphere, L (eds) (1974) *Women, Culture and Society.* Stanford: Standford University Press
- \_\_\_\_\_ (1989) *High Religion: A Cultural and Political History of Sherpa Buddhism.* Princeton: Princeton University Press.
- Parkin, F (1982) *Max Weber.* Routledge: London and New York.
- Parry, J (1999) *Lords of Labour: Working and Shirking in Bhilai.* Draft copy-LSE
- Parsons, T (1981) Cooperation in The Sociology of Organizations. In, Grusky, O, Miller, A, George (eds) (1981) *The Sociology of Organizations, Basic Studies,* Second Edition . New York and London: The Free Press.
- Rappaport, R.A. (1971). "Ritual, Sanctity and Cybernetics." *American Anthropologist.* 73:59-76.
- Rapport, N (2000) The Narrative as Fieldwork Techniques: Processual Ethnography for a World in Motion, in Amit, V (ed) (2000) *Constructing the Field: Ethnographic Fieldwork in the Contemporary World.* London and New York: Routledge
- Pelto, P.J and Pelto G.H. (1996) Research Designs in Medical Anthropology. In Sargent Carolyn F., Johnson T. M (eds)(1996) *Medical Anthropology Contemporary Theory and Method* (Revised Edition). Westport C.T.: Greenwood Publishing Group
- Pilgrim, D and Rogers A (1999) *A sociology of mental health and illness* (2<sup>nd</sup> edition) Open University Press, Buckingham.
- Rafferty, A.M (1996) *The Politics of Nursing Knowledge.* London: Routledge
- Rogers, A and Pilgrim, D (2001) *Mental health policy in Britain*

- (2nd edition). London: Palgrave
- Rose, N (1986) *Psychiatry: the discipline of mental health*. Miller, P & Rose, N (1986) *The Power of Psychiatry*. Cambridge: Polity Press
- \_\_\_\_\_ (1992). 'Governing the enterprising self'. In, Heelas, P & Morris, P (eds) (1992) *The Values of Enterprise Culture*. London: Routledge
- \_\_\_\_\_ (1999) *Governing the Soul: The Shaping of the Private Self*. 2nd edition. London: Free Associations Books
- Rose, D. (2001) *Users' Voices: The Perspectives of Mental Health Service Users on Community and Hospital Care*. London: Sainsbury Centre for Mental Health.
- Rosenham (1973) 'On Being Sane in Insane Places'. *Science*, vol 179, no 4070, pp 250-8.
- Roth, J (1962) 'Comments on "Secret observation"'. *Social Problems*, vol 9, no 3, pp 283-4.
- Royal, E (1987) *Modern Britain: A Social History 1750-1985*. London: Edward Arnold
- Russell, AJ (1999). Taking Care? The Depo-Provera Debate. In Kohn, T & McKechnie, R (eds) (1999) *Extending the Boundaries of Care: Medical Ethics and Caring Practices*. Oxford: Berg
- Quirk and Lelliott (2002) Acute wards: problems and solutions A participant observation study of life on an acute psychiatric ward. *Psychiatric Bulletin* (2002) 26: 344-345
- Sahlins, M (1963) 'Poor Man, Rich Man, Big Man, Chief', *Comparative Studies in Society and History*, 5(3) 1963
- Samson, C (1995 2<sup>nd</sup> Edition) *Madness and Psychiatry*. In Turner, B (1995) *Medical Power and Social Knowledge*. London: SAGE
- Sashidharan, S (2001) Institutional Racism in British Psychiatry. *Psychiatric Bulletin* (2001), 25, 244-247
- Savage, J (1997) Gestures of resistance: The nurse's body in contested space. *Nursing Inquiry* 4: 237-245.
- \_\_\_\_\_ (1999) Relative strangers: Caring for patients as the expression of nurses' moral/political voice. In , Kohn, T & McKechnie, R (eds) (1999) *Extending the Boundaries of Care: Medical Ethics and Caring Practices*. Oxford: Berg

- \_\_\_\_\_ (2000) Ethnography and health care: *British Medical Journal* vol 321 (2 December 2000) 1400-1402
- \_\_\_\_\_ (2000a) The culture of 'culture' in National Health Service policy implementation. *Nursing Inquiry* p230-238
- Scheff, T.J (1966) *Being Mentally Ill*. Chicago: Aldine
- Schein, E.H (1985) *Organizational Culture and Leadership: A Dynamic View*. San Francisco, Washington and London: Jossey-Bass Publishers.
- \_\_\_\_\_ (1991) "What is culture"? In Frost, P, Moore, L.F, Louise, M.R, Lundberg, C and Martin, J (eds) *Reframing Organizational Culture*. London: SAGE
- Scull, A (1982) *Museums of Madness*. London: Penguin Books
- \_\_\_\_\_ (1996) Asylums, utopias and realities. In Tomlinson, D & Carrier, J (1996) (eds) *Asylums in the Community*. London: Routledge
- Seager, C.P (1968) *Psychiatry for Nurses, Social Workers and Occupational Therapists*. London: Heinemann
- Sedgwick, P (1982) *Psycho Politics*. London: Pluto Press
- Sherzer, J (1987) A Discourse-Centred Approach to Language and Culture. *American Anthropologist, New Series. Vol. 89, No2 (Jun., 1987), 295-309*
- Shore, C & Wright S ( 1997) Policy: A new field of anthropology. In, Shore, C & Wright, S (eds) (1997) *Anthropology of Policy: Critical Perspectives on Governance and Power*. London and New York: Routledge.
- Shore, C (1999) Fictions of Fieldwork: Depicting the 'Self' in Ethnographic Writing (Italy), in Watson, C.W (1999) *Being There: Fieldwork in Anthropology*. London, Sterling, VA USA: Pluto Press
- Shorter, E (1997) *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. New York: John Wiley & Sons
- Simmel, G (1978) *The Philosophy of Money*, London: Routledge
- Sinclair, S (1997) *Making Doctors: An Institutional Apprenticeship*. Oxford and New York: Berg
- Skellington, R (1996 2<sup>nd</sup> Edition) *'Race' in Britain Today*. London: SAGE
- Solomos and Back (1996) *Racism and Society*. London: Macmillan Press.

- Stacey, M (1998) The Health Service Consumer: A sociological misconception. In Mackay, Soothill, Melia (eds) (1998) *Classic Texts in Health Care*. Oxford and Boston: Butterworth-Heinemann
- Stapley, Lionel F. (1996) *The Personality of the Organisation. A Psych-Dynamic Explanation of Culture and Change*. London and New York: Free Association Books.
- Stevenson, F. Barry, C. Britten, N. Barber, N. Bradley, C. (2000) Doctor-Patient communication about drugs: the evidence of shared decision making. *Social Science and Medicine* 50 (2000) 829-840
- Strathern, M & Lambek, M (1998) Introduction Embodying sociality: Africanist-Melanesianist Comparison. In Lambek, M & Strathern, A (eds) (1998) *Bodies and Persons: Comparative Perspectives from Africa and Melanesia*. Cambridge: Cambridge University Press
- Szasz, T (1972) *The Myth of Mental Illness*. London: Paladin
- \_\_\_\_\_ (1973) *The Manufacture of Madness*. London: Paladin
- Tarlo, E (1996) *Clothing Matters: Dress Identity in India*. London: Hurst and Company.
- Thomas, P. & Bracken, P. (2004) Critical psychiatry in practice. *Advances in Psychiatric Treatment* (2004), vol. 10, 361–370
- Thompson, K (1980) The Organizational Society. In Salaman, G & Thompson, K (1980) *Control and Ideology in Organizations*. Milton Keynes: Open University Press.
- Turner, B (1987) *Medical Power and Social Knowledge*. London: SAGE
- Turner, B.A (1971) *Exploring the Industrial Sub-Culture*. London: Macmillan
- Turner, V (1957) *Schism and Continuity in African Society*. Manchester: Manchester University Press.
- \_\_\_\_\_ (1967) *The Forest of Symbols: Aspects of Ndembu Ritual*: Ithaca, N.Y: Cornell University Press.
- Tylor, (1958 [1870]) *Primitive Culture*, New York: Harper and Row
- VanDongen, E (2004) *Worlds of Psychotic People: Wanderers, 'Bricoleurs' and Strategists*. London: Routledge
- Van Gennep (1965) *The Rites of Passage*. London: Routledge
- Walk, A (1961) The History of Mental Nursing. *Journal of Mental Science*, 107, 1-17

- Wallman, S (1978) The Boundaries of 'Race': Processes of Ethnicity in England, in *Man*. 13. 1978 p200-217
- \_\_\_\_\_ (1979) The Scope for Ethnicity. In Wallman, S (ed) (1979) *Ethnicity at Work*. London: Macmillan Press
- \_\_\_\_\_ (1979) Introduction. In *Social Anthropology of Work, ASA Monograph 19*. London and New York: Academic Press.
- Weber, M (1964) *The Theory of Social and Economic Organizations*. London: The Free Press of Glencoe, Collier – Macmillan Limited.
- \_\_\_\_\_ (1981) Bureaucracy. In, Grusky, O, Miller, A, George (eds) (1981) *The Sociology of Organizations, Basic Studies, Second Edition*. New York and London: The Free Press.
- Wedel, J Shore, C, Feldman, G & Lathrop, S (2005) Toward and Anthropology of Public Policy. *The ANNALS of the American Academy of Political and Social Science*, Vol. 600, No. 1, 30-51 (2005)
- Weinstein, R.M (1982) The Mental Hospital from the Patient's point of view. In Gove, W.R (ed) (1982) *Deviance and Mental Illness. SAGE Annual Review of Studies in Deviance Vol 6*. London: SAGE
- Wicks, D (1998) *Nurses and Doctors at Work: Rethinking professional boundaries*. Buckingham: Open University Press
- Witz, A (1998) Professions and patriarchy. In In Mackay, Soothill, Melia (eds) (1998) *Classic Texts in Health Care*. Oxford and Boston: Butterworth-Heinemann
- Woodburn, J (1968). Stability and flexibility in Hadza resi- dential groupings. In R.B. Lee and I. DeVore (eds.), *Man the hunter*. Chicago: Aldine.
- \_\_\_\_\_ (1982). Egalitarian societies. *Man*, n.s., 17:431-51.
- Wright, S (1994) Culture in anthropology and organizational studies. In Wright, S (ed) (1994) *Anthropology of Organizations*. London: Routledge and New York.



## Appendices

### Appendix I Official Trust Statistics: Ethnic breakdown of all nursing staff

2001

(source: TRUST HR department)

		Ethnic Origin	Total
UNQUALIFIED / NURSING ASSISTANTS	GRADE A	Black-African	1
			1
	GRADE A	Bangladeshi	1
		Black-African	71
		Black-Caribbean	19
		Black-Other	11
		Chinese	1
		Indian	1
		Not Known	4
		Other	15
		White	
		Eng/Scot/Welsh	12
		White Irish	4
		White Other	3
	GRADE B	Black-African	25
		Black-Caribbean	9
		Black-Other	4
		Chinese	1
		Not Known	4
		Other	21
White			
Eng/Scot/Welsh		36	
White Irish		1	
White Other	3		
GRADE C	Black-Other	1	
	Not Known	1	
	White		
	Eng/Scot/Welsh	2	

QUALIFIED NURSES	GRADE D	Black-African	2
		Black-Caribbean	2
		Black-Other	1
		White	
		Eng/Scot/Welsh	2
	GRADE D	Black-African	13
		Black-Caribbean	3
		Chinese	1
		Indian	2
		Not Known	2
		Other	5
		White	
		Eng/Scot/Welsh	5
		White Irish	2
		White Other	1
	GRADE E		1
		Black-African	47
		Black-Caribbean	23
		Black-Other	5
		Chinese	7
Indian		11	
Not Known		12	
Other		38	
White			
Eng/Scot/Welsh		70	
White Irish		13	
White Other	7		
GRADE F	Black-African	25	
	Black-Caribbean	6	
	Black-Other	2	
	Chinese	1	
	Indian	3	
	Not Known	5	
	Other	11	
	White		
	Eng/Scot/Welsh	35	
	White Irish	6	
	White Other	2	
GRADE F	Black-African	1	
	Indian	1	

		Ethnic Origin	Total
<b>WARD MANAGERS</b>	GRADE G		1
		Black-African	13
		Black-Caribbean	11
		Black-Other	2
		Chinese	6
		Indian	6
		Not Known	8
		Other	12
		White	
		Eng/Scot/Welsh	109
		White Irish	11
	White Other	4	
	GRADE G		1
		Black-African	1
		Black-Other	1
		Chinese	1
		Other	3
		White	
	Eng/Scot/Welsh	3	
	White Irish	1	
GRADE H	Black-African	1	
	Black-Caribbean	2	
	Black-Other	2	
	Chinese	1	
	Indian	1	
	Not Known	1	
	Other	5	
	White		
	Eng/Scot/Welsh	29	
	White Irish	4	
White Other	1		
GRADE H	Indian	1	
	White		
	Eng/Scot/Welsh	2	
	White Other	1	
GRADE I	Black-Caribbean	1	
	Not Known	1	
	Other	2	
	White		
	Eng/Scot/Welsh	10	
	White Irish	1	
White Other	1		

Total Staff	886
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## Appendix II The Nursing Assistant Job Description

Appendix 3.1

### Mental Health NHS Trust

#### JOB DESCRIPTION

Title: Nursing Assistant - ADULT & MHE  
Grade: A  
Responsible to: Bank Co-Ordinator  
Responsible to (whilst on duty): Nurse in Charge  
Accountable to: Senior/Lead Nurse (where working)  
Hours: As required  
Base: Throughout the Trust

#### JOB SUMMARY

To assist the qualified nursing workers on the ward, carrying out assigned tasks in direct and indirect patient care and according to competence as judged by the nurse in charge.

#### MAIN DUTIES AND RESPONSIBILITIES

##### 1. Clinical

- 1.1 To be aware of, and assist in meeting the needs of the patient as specified in the care plans and directed by the Nurse in Charge.
- 1.2 To assist patients as appropriate in all activities of daily living.
- 1.3 To recognise each patient as an individual with the same range of rights, needs and emotions as anyone else.
- 1.4 To promote the dignity and self-esteem of all patients at every available opportunity.
- 1.5 To assist qualified nursing workers in the assessment of patients.
- 1.6 To observe and report to the Nurse in Charge/Primary Nurse any changes in the patient's condition or other relevant information.
- 1.7 To assist qualified workers in the implementation of individual care plans.
- 1.8 To participate in social and recreational activities with patients, either in a group or on a one-to-one basis.
- 1.9 To undertake supervision of patients as delegated and within sphere of own competence.

1.10 To be aware of and adhere to agreed procedures for delivering care.

1.11 To be aware of own limitations and make these known if asked to perform beyond own competence.

## **2. GENERAL**

2.1 To help maintain a safe environment for both patients and workers.

2.2 To promote and maintain good working relationships with colleagues.

2.3 To be aware of, and adhere to, Trust policies and procedures.

2.4 To be aware of and understand your responsibilities in relation to the policies/procedures regarding:

- (a) fire
- (b) medical emergency
- (c) health and safety issues

2.5 To carry out non-clinical duties, including bedmaking, care of patients' personal clothing, preparing light refreshments for patients where necessary.

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### **Health and Safety**

The [redacted] Mental Health Trust has a Health & Safety Policy. All individuals working within the Trust should be aware of the responsibilities placed on them under the Health & Safety at Work Act 1974, to ensure that agreed safety procedures are carried out, and to maintain a safe environment for employees, patients and visitors.

### **No Smoking Policy**

The [redacted] Mental Health Trust has a 'No-Smoking' Policy, and all Trust buildings and vehicles are designated as smoke-free areas.

### **Alcohol**

Alcohol is not permitted whilst on duty.

### **Equal Opportunities**

You are expected to be aware of, and adhere to, the provisions of the Trust's Equal Opportunities Policy.

### **Confidentiality**

Any information relating to patients or workers remains confidential. Disclosure of personal, medical, commercial information, systems passwords or other confidential information to any unauthorised person or persons will lead to the Trust no longer using your services.



PERSON SPECIFICATION

NURSING ASSISTANT GRADE A - ADULT & MHE, BANK SERVICES

FACTORS	ESSENTIAL	DESIRABLE
PHYSICAL REQUIREMENTS any aids/adaptations required	<ul style="list-style-type: none"> <li>• Declared medically fit by the Occupational Health dept. to perform the duties of the post.</li> <li>• Sickness (or attendance) record that is satisfactory to the Trust, to be checked at interview.</li> </ul>	
EDUCATION/ QUALIFICATIONS	<ul style="list-style-type: none"> <li>• No formal qualifications necessary</li> </ul>	
PREVIOUS EXPERIENCE paid/unpaid relevant to job	<ul style="list-style-type: none"> <li>• At least 6 months experience within last 3 years working with adults and/or elderly with mental health problems</li> <li>• Sound understanding of the needs of these patients</li> </ul>	
SKILLS, KNOWLEDGE, ABILITIES	<ul style="list-style-type: none"> <li>• Ability to work co-operatively with wide range of people</li> <li>• Ability to communicate clearly and effectively - verbal and written</li> <li>• Ability to deal sensitively and tactfully with difficult and demanding people</li> <li>• Ability to build up a good rapport quickly with workers and patients</li> </ul>	
ATTITUDES, APTITUDES, PERSONAL CHARACTERISTICS	<ul style="list-style-type: none"> <li>• Willingness to work flexibly</li> <li>• To behave in an appropriate and professional manner</li> <li>• Understanding of confidentiality and willingness to comply</li> <li>• Basic understanding of multi-cultural issues in field of mental health</li> </ul>	<ul style="list-style-type: none"> <li>• Keep up to date with current issues in NHS and mental health field</li> </ul>