Uneasy alliances: Belief and action on a geropsychiatric team

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Uneasy alliances: Belief and action on a geropsychiatric team

Abstract
This ethnographic study explores the influence of two competing ideologies, the medical model and the empowerment model, on the actions of staff on an acute geropsychiatric unit. The medical model emphasizes the professional power of the physician and other health care workers. In contrast the empowerment model emphasizes the autonomy of patients and their role in directing their care. Since these beliefs are contradictory, staff may feel conflict no matter how they act. The tacit nature of these beliefs mask the source of this tension. The mission of the unit is to enhance the independence of people over 60 with mental health problems. Staff actions which enhance independence conflict with the strongly entrenched traditions of health care and the expectations that patients will be passive and compliant. Through participant observation, interviews, and document review, this study explores how these belief systems are enacted in the team meetings and less structured interactions among staff, patients, and family members. It closes with questions about the diffusion of the empowerment model in an acute geropsychiatric setting.

Keywords
Sociology, General, Anthropology, Cultural, Health Sciences, Mental Health
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Uneasy alliances: Belief and action on a geropsychiatric team

Crepeau, Elizabeth Blesedell, Ph.D.

University of New Hampshire, 1994

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UNEASY ALLIANCES:
BELIEF AND ACTION ON A GEROPSYCHIATRIC TEAM

BY

Elizabeth Blesedell Crepeau
BS, University of New Hampshire, 1966
MA, University of New Hampshire, 1988

DISSERTATION

Submitted to the University of New Hampshire
in Partial Fulfillment of
Requirements for the Degree of

Doctor of Philosophy

in

Sociology

May, 1994
This dissertation has been examined and approved.

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April 22, 1994
Date
ACKNOWLEDGEMENTS

This dissertation brings to a close an eight year intellectual journey which has transformed my identity from that of an occupational therapist to the dual identity of occupational therapist and sociologist. This seems obvious, but when I began graduate school I did not realize that this transformation would occur. I would like to thank five groups of people who have been particularly helpful to me in this transformation process. The first is my family. Rod, Rebecca, and Amy have sustained me through the long process of doing doctoral work. Their belief in my ability to bring this dissertation to completion has been as important as their help in maintaining the practical aspects of our day to day lives. I have especially appreciated Rod’s love and support for the twenty-eight years of our marriage. It is to him that I dedicate this work.

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study. Finally, Professor Raelene Shippee-Rice has made this an intellectual journey in the best sense of the word. I look forward to our continuing debates and conversations in the future. Now that the "D" is done, perhaps we can do some research together.

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observations and interviews. I value our conversations and evolving friendship and look forward to our future work together.

My final thanks is extended to the staff of the EPU. Their generosity to me was overwhelming. They allowed me to enter their world, exposing the confusion, tensions, and joys involved in their work on the unit. I have tried to adequately transmit the complexity and multiplicity of their experience in this study. Any failure to do so is mine, not theirs.
For Rod

We Two Form a Multitude
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ABSTRACT

UNEASY ALLIANCES:
BELIEF AND ACTION ON A GEROPSYCHIATRIC TEAM

by

Elizabeth Blesedell Crepeau
University of New Hampshire, May, 1994

This ethnographic study explores the influence of two competing ideologies, the medical model and the empowerment model, on the actions of staff on an acute geropsychiatric unit. The medical model emphasizes the professional power of the physician and other health care workers. In contrast the empowerment model emphasizes the autonomy of patients and their role in directing their care. Since these beliefs are contradictory, staff may feel conflict no matter how they act. The tacit nature of these beliefs mask the source of this tension. The mission of the unit is to enhance the independence of people over 60 with mental health problems. Staff actions which enhance independence conflict with the strongly entrenched traditions of health care and the expectations that patients will be passive and compliant. Through participant observation, interviews, and document review, this study explores how these belief systems are enacted in the team meetings and less structured interactions among staff, patients, and family members. It closes with questions about the diffusion of the empowerment model in an acute geropsychiatric setting.
CHAPTER 1

INTRODUCTION

THE SETTING, THE RESEARCH METHOD, AND THE PERSON

This dissertation is about the work of the staff of an acute geropsychiatric unit I will call the Elderly Psychiatric Unit (EPU) at a hospital I will call Hillside. Hillside Hospital is a community hospital in a New England city. In this dissertation I will explore the relationship between the beliefs of the staff members and their actions which may or may not reflect the beliefs they say they hold. This relationship between belief and action is an uneasy one because often times staff hold beliefs which are contradictory. These contradictions come from two competing models, the medical model and the empowerment model. The medical model, the predominant model in health care, reinforces the power of the beneficent physician and health care workers acting in the interest of a cooperative recipient of care (Parsons, 1951; Parsons, 1975). The empowerment model, in contrast, is at its heart political because it emphasizes the autonomy of individuals and the importance of their active involvement in effecting change (Rappaport, 1987). These two perspectives require different kinds of actions on the part of health care workers. Because the mission of the EPU is to enhance the independence of people over 60 with mental health problems, staff actions which enhance independence conflict with the strongly entrenched traditions of health care.
Since these beliefs are contradictory, staff may feel conflict no matter how they act. The tacit nature of these beliefs masks the source of this tension.

These uneasy alliances between belief and action are played out every day. In many cases the conflict is intrapersonal and is created when staff make judgments about whether a patient should walk independently or should be walked by a staff member. The former supports the development of patient independence while the latter assures the patient’s safety. In other cases an uneasy alliance exists between staff members who disagree about some aspect of patient care. Finally, an uneasy alliance exists between the EPU and the hospital. This was brought home to me on my first visit to the hospital to plan the research with Marjorie Coleman, the unit director (a pseudonym as are all other names used in this work). I recorded the following field note that evening.

Today was my first trip back to the hospital in three years. The day was clear, sunny, and very cold. The wind buffeted the car as I drove. When I arrived at Hillside I could not remember where the unit was located. So I went to the lobby. A volunteer stood waiting to help. I told him that I wanted to go to the Elderly Psychiatric Unit. He became flustered and didn’t seem to know what I was talking about. Repeating the request did not allay his confusion. I decided to ask for Marjorie Coleman, the unit director. He looked up her name in the phone book and gave me the house phone to call her. Marjorie’s voice mail answered. Then I paged her unsuccessfully. Finally, not knowing what else to do, he directed me to the elevators and told me the unit was on the ninth or tenth floor.

I walked through a series of hallways filled with framed prints, shiny floors, and polished handrails to reach the elevators. Ascending to the ninth floor, I found myself in the midst of a major reconstruction project. I reentered the elevator and went
to the tenth floor. The elevator opened to a small vestibule. Unlike the rest of the hospital, this area seemed unkempt. The walls needed a fresh coat of paint. A tired plant decorated the window sill. Hand lettered signs said that this was a restricted area and that visitors could not smoke. Opposite the elevator was a small sliding window. I walked up to the window and a staff member slid it open. I asked her if Marjorie was there. She directed me to the eighth floor. I reentered the elevator and looked at the sign for the eighth floor. All it said was "Eighth Floor, Restricted Area." There was no indication that the eighth floor was the Elderly Psychiatric Unit.

Finally, I arrived at the EPU. Elaine, the unit secretary, greeted me warmly. She took my coat and offered me coffee, then gave me a seat to wait for Marjorie who was still in a meeting. A short time later, Marjorie walked out of her office and greeted me with a big smile. After we settled down to business, I told her about my "welcome" in the lobby because I felt it would have been very upsetting had I been a visitor. She was a bit alarmed about my experience and said that she would check into it since "customer service" was an important aspect of the efforts of the hospital (Field Note #1, card ID #9879:2/4/93).

Marjorie treated this incident like an isolated event, unfortunately it wasn't. The staff of the EPU told me that they received multiple messages from others that devalued the unit and their work. Dr. James, the medical director and Peter Tully, the social worker, both told me about a hospital administrator who got lost escorting to the unit an applicant for the psychiatry position. To them, this incident was symbolic of the uneasy alliance between the unit and the hospital. This dissertation focuses on the points of tension or conflict staff experience as they work on the unit. The conflict I am interested in is the one which exists between the beliefs people espouse and their actions. I have chosen not to focus on the interpersonal
conflict which exists on the unit and arises from differences in personality and/or miscommunication.

This dissertation opens with a brief description of the Elderly Psychiatric Unit (EPU) at Hillside Hospital, its staff members, and patients. The first chapter also includes the methodology of the study and a discussion of my social biography. I have included this social biography so that the reader can understand my perspective which, for better or worse, has influenced the questions I asked, the methodology I chose, and the interpretation of the data. The second chapter is a review of the care of the mentally ill from 17th century England to the present. It addresses this care from the perspective of the cultural beliefs, technology, and structure of mental hospitals delineated by Perrow (1965). This review locates the EPU in relationship to the historical treatment of mental illness and highlights the distinctive character of this unit in relationship to other inpatient psychiatric units. The third chapter addresses cultural beliefs and stereotypes about aging and mental illness, the mission of the unit, and staff perceptions about this mission. The fourth chapter develops the concept of empowerment which is one aspect of the mission of the unit. This chapter examines safety issues in relationship to falls because the mission to enhance patient's independence is challenged by the concern about patient safety. The fifth chapter addresses the team meeting and examines three images of team meetings: the professional, the constructive, and the ritualistic. Data from a 1990
exploratory study of the team meetings of the EPU are used to explicate these images. The sixth chapter addresses team meetings in the current study in relationship to the images of the team and the relationship between the empowerment and medical models in the team meeting. The seventh and final chapter recapitulates Perrow's analysis in relationship to the unit's efforts to adopt aspects of the empowerment model. It summarizes the central argument about the conflict between the medical and empowerment models and poses questions about the diffusion of the empowerment model in geropsychiatry.

The EPU at Hillside Hospital

The Elder Psychiatric Unit (EPU) is a sixteen bed unit located at Hillside Hospital in a small New England city. Hillside is a community hospital that provides obstetric, medical, surgical, and psychiatric services to the community. At the time of the study the EPU had been open for about five years. For the first three years the unit had twelve beds. It expanded to sixteen beds about eighteen months before the beginning of this study. Many of the staff who started the unit or were hired during its first year are still working there. The mimeographed information sheet given to patients and their families describes the unit as follows:

The Elderly Psychiatric Unit (EPU) is a 16 bed, short-term, inpatient diagnostic and treatment unit designed to meet the needs of individuals age 60 and up. Our purpose is to provide a range of therapies to help improve independent functioning and quality of life. Various programs, including individual, group, and family therapy are key elements of the program. The
average length of stay varies on individual need, but expectations are that evaluations are completed within a 20 day period.

This is the first hospitalization for psychiatric care for many EPU patients. Diagnoses ranged from various forms of depression and anxiety, dementia, complicated grief reactions, obsessive/compulsive disorders, and manic depressive illness. Several patients had a longer history of mental illness, but these were the exceptions rather than the rule. Most patients had lived productive lives filled with work, family, friends, and involvement in their communities. Patients admitted to the EPU during the period of the study stayed an average of 20.52 days. The range of each admission spanned from 3 days to 52. Several patients were discharged and readmitted during the summer. The causes for readmission were multiple. In many cases patients were transferred to another unit of the hospital to be treated for a medical condition such as pneumonia or heart disease or for procedures such as neurosurgery. Many of the patients had multiple medical problems complicating their care. Other readmissions were caused by poor adjustment on discharge, necessitating further treatment. The twenty day expectation was a goal of the staff that had been established when the unit opened. Patients who needed to stay longer than the expected time were viewed with frustration by staff members. They represented the failure of the unit to deal with their needs in a timely fashion. Delays in treatment were caused by difficulty obtaining guardianships and permissions of guardians for certain
procedures such as electroconvulsive therapy (ECT). Discharge may have been delayed because discharge planning was more difficult to arrange than anticipated. Other delays were caused by the complex conditions of some of the patients, it was simply not possible to accomplish the goals within the twenty day goal.

Patients are typically treated with a variety of medications. Electroconvulsive therapy (ECT) is used with depressed patients who do not respond to medication. Patient behavior is monitored closely for reaction to the medications and dosage is adjusted regularly to reduce negative symptoms and minimize side effects. This is more difficult than it sounds because many patients are on other medications to manage the chronic diseases common with the elderly such as high blood pressure, heart disease, Parkinson’s disease, etc. The interactions between the psychotropic medications and other medications are an important consideration. Marjorie told me that Dr. James, the medical director, is a medication “rocket scientist”. He uses a very aggressive approach to medications because he believes that these are the best tools currently available to treat this population.

The information sheet also listed treatment groups and stated the expectation that all patients will attend the groups “to share problems, solutions and to provide support to one another.” Patients who are well enough are expected to participate in the groups. Groups are not mandatory, however, people who are seen as capable of attending and refuse are viewed
as not being involved in the milieu and therefore not cooperating with their care. The morning always begins with the community meeting from 8:30-9:15. After that patients get bathed and dressed and assemble for a 10:30 group which varies day to day. Groups include family issues, discharge planning-transition, horticultural, reminiscence, cooking and nutrition, and life long learning. The depression teaching and medication teaching groups are important aspects of the educational role of groups on the unit. All of these groups meet on a regular basis. An exercise group led by an occupational therapist meets daily at 1:30. This group provides gentle stretching exercises appropriate for frail elders. On Monday, Wednesday and Friday a more active exercise group is led by a physical therapy aide. Visiting hours are from 2:00-3:00. From 3:00-4:00 more groups meet. These again vary from one day to the next but include occupational therapy, health promotion, and humor groups. The day ends with wrap up at 7:45.

The groups are led by nursing, occupational therapy, and social service personnel and are central to the approach on the unit. As Marjorie explained to me one day, the “magic” of the unit was not just what the staff did for patients but the support the patients gave to each other both in groups and through informal interaction. In addition to the patient groups, a family and friend education and support group meets twice a week on Wednesday afternoons and Tuesday evenings.
EPU Personnel

Thirty seven people were employed on the EPU. Most were professional personnel: psychiatrist, nurses, social worker, occupational therapists, and dietitian. Figure 1 lists the staff and patients referred to in this dissertation. There were several nurses aides, generally, however, no more than one was assigned to a particular shift.

Dr. James is a psychiatrist and medical director of the EPU. He came to the hospital to develop the unit and hired the first people to work on the unit with him. He works long hours and has not taken any extended vacations since the unit had opened. People on the unit admire his intelligence and dedication to the patients and the unit but are at times exasperated with him. This exasperation is tempered because they know that he is overworked and needs to hire an associate, a process which has been fraught with obstacles and delays. Dr. James divides his time between a private practice and the hospital. He typically works at the hospital all day on Monday, Wednesday and Friday. He is readily available by phone at other times. Dr. James is an advocate of aggressive treatment for the mental health needs of the elderly. He uses drugs extensively and patients are hospitalized so that they can be more closely observed for drug reactions. As he explained to me, he can adjust the patient’s medications to the proper level in less than three weeks if they are in the hospital and reduce their symptoms substantially. As outpatients, achieving the proper level of dosage would take much longer.
Figure 1: List of EPU Staff and Patients

UNIT PERSONNEL

Dr. James  medical director
Marjorie Coleman  unit director
Peter Tully  social worker
Sandra Lord  charge nurse
Amy McLean  occupational therapist
Emily Smith  occupational therapist
Molly Madden  dietitian
Cara Ward  nurse
Joanne Weston  nurse
Sally Easley  nurse
Rebecca Douglass  nurse
Charlotte Harris  nurse
Susan Smith  nurse
Lisa Abbott  nurse
Corrine Packer  nurse
Heather Potter  nurse’s aide
Elaine Bailey  unit secretary

PATIENTS

Harriet
Josephine
Iris
Mary
June
Lucille
Bill
Sophie
Bessie
Catherine
John
When he is on the unit he divides his time between talking to patients in their rooms, conferring with staff, and working on charts in the chart room. I only saw him in his office one time during the entire study.

Marjorie Coleman is the unit director. She serves as the administrator of the unit and provides supervision for nursing personnel and other clinical staff. She has a supervisory role over the social worker, occupational therapists, and dietitian who are also supervised by someone within their discipline. This dual supervisory pattern is similar to those reported by Frankel (1989), Caudill (1958), and Stanton and Schwartz (1954). Marjorie had been working in Boston and was recruited by a head hunter for this position. She has extensive experience in psychiatric nursing and administration. She too has a strong commitment to the unit and unit personnel. Marjorie likes to laugh and see the humor in difficult situations. She refers to this as “sick humor,” a phrase used frequently by other unit personnel.

The charge nurse on the unit, Sandra Lord, also was hired during the development of the unit. She had worked as the education coordinator at another psychiatric hospital. She also had extensive clinical and teaching experience. Unlike Marjorie who is outgoing and very witty, Sandra is quieter, very reserved, and at first seemed very serious. However, behind her serious demeanor is a dry wit which would emerge in the quiet comments she made in team meetings. Sandra provides direct supervision of the nursing personnel on the unit. She coordinated all of the team meetings.
until about a year ago when the unit expanded to sixteen patients. Now this leadership role is shared among the nursing staff.

When the unit is full, four nurses, including the charge nurse, are assigned to the day shift. A nurse’s aide also provides coverage. The nurses have responsibility for about four patients each. Typically they care for their primary patients as well as several others. They are expected to assist with groups during the day including leading the community meeting in the morning, the medication teaching group, depression teaching group, and discharge planning group. The nurse’s aide is not assigned a particular list of patients. Instead she handles the morning care for one patient from each nurse’s list. When this work is done she provides assistance as needed throughout the unit.

Peter Tully, the social worker, was one of the first people hired by Dr. James. He too works long hours and has not taken any vacation time since the unit opened. During the study he took four days off and soon after decided to take advantage of a severance package offered by the hospital as the administration attempted to downsize. Peter fulfills a central function on the unit, that of controlling the admissions to the unit and planning for discharge. This function is important because the unit needs to maintain close to 100% occupancy rate. Beyond his role in admission and discharge planning, Peter is the one full time staff member who knows the most about all of the patients. This became more important when Dr. James reduced his
time to three days a week and Marjorie was given additional administrative duties off the unit. Consequently, Peter's sense of responsibility for the unit and his availability make his role central to its smooth operation. In addition to his work with individual patients and their families, Peter runs a family group one evening a week, the weekly discharge planning group and the long learning group.

There are two occupational therapists. Amy McLean was hired when the unit opened and worked full time until her first child was born about two years ago. She now works three days a week, Tuesday, Friday, and Saturday. Emily Smith, the other occupational therapist works full time, ten hours a day Monday through Thursday. She had worked on the unit for about a year and resigned during the summer. She continued to work part time until a new therapist was hired. The new occupational therapist began work at about the same time that Peter Tully left. Because this occupational therapist was so new, I included only Emily Smith and Amy McLean in this report. Both Amy and Emily had worked in mental health prior to coming to this unit. Neither, however, had extensive experience with the elderly. The occupational therapists assess the patient's functional status, i.e. their ability to bathe, dress, and care for themselves independently. They also lead at least two groups every day, the occupational therapy group and an exercise group. In addition they lead weekly cooking and leisure groups. The occupational therapy groups address issues such as assertiveness, stress management, life
skills, leisure activities, aging issues, and current events. The groups vary with the particular mix of patients in the unit at any one time.

Molly Madden is the unit dietitian. She works on two other units at the hospital and spends only a limited amount of time on the unit. She assesses each patient's nutritional status, monitors the diets of all patients, in particular those with nutritional problems, and attends the team meetings. She co-leads the cooking group with one of the occupational therapists.

Finally, Elaine Bailey, the unit secretary, holds it all together. She too came to the unit when it opened, having worked on one of the other psychiatric units at the hospital. Elaine's role is to provide secretarial support to the staff of the unit. She answers phones, makes up charts for new admissions, posts orders, breaks down charts, xeroxes forms, etc. However, as anyone who has worked in an organization knows, a good secretary can hold a group together and enable it to function optimally. Elaine has this quality. Patients, many of whom are confused and anxious, often come to the desk to ask the same question over and over again. Her respectful and sensitive responses to them provide the reassurance and support so necessary with this population.

Development of the Research Questions

My initial aim in undertaking this study of the work of the EPU staff was to understand how the individual clinical reasoning of the members of the team contributed to a unified plan of care. This interest was stimulated by
the Clinical Reasoning Study of the American Occupational Therapy Association and the American Occupational Therapy Foundation, which explored the clinical reasoning of occupational therapists from a narrative perspective (Mattingly and Fleming, 1994; Mattingly and Gillette, 1991). Clinical reasoning is the process a therapist uses to understand and treat the problems of a patient. This process involves the application of the technical aspects of the profession. These techniques are selected and applied based on the therapist's understanding of the meaning of illness to the patient as well as the functional deficits the patient may be experiencing (Mattingly and Fleming, 1994:9-13). This understanding comes from listening to the story of the patient, hence the narrative orientation. Treatment evolves and changes as this story unfolds through the patient/therapist interaction (Mattingly, 1991).

Occupational therapists seldom work in isolation. Their work is linked to the work of other health care professionals. The organization of this work frequently involves a formally established team. I thought it would be interesting to explore clinical reasoning from an interdisciplinary perspective and thereby extend the scope of the Clinical Reasoning Study beyond the confines of occupational therapy. The first step of this process was a study of the meetings of a team working on a geropsychiatric unit (Crepeau, 1994, in press). This initial study was limited to the team meetings themselves and interviews with some of the team members. I found that the
ritualistic aspects of the team meetings, that is, the patterned interaction and
the use of anecdotes to flavor discussion, promoted cohesion of the group and
helped them find intense support for their difficult and challenging work.
Stories and humor played a large role in this process. The stories assisted the
staff in the process of making sense of their patients and their patients’
problems (Crepeau, 1994, in press). This use of patient stories is consistent
with the findings of Mattingly and Fleming (1994).

While conducting the initial study I experienced the impact of the
emergent character of qualitative research. I found the patterned interaction
of the meetings to be both surprising and interesting. Rather than doggedly
pursuing my original research question about the clinical reasoning of the
group I shifted my attention to the ritualistic aspects of the team meeting.
This emergent aspect of qualitative research enabled me to follow where the
data led rather than try to fit the data to the original objectives for the research

The research for this dissertation is broader in scope than my earlier
study because it involves observations of the team meetings and the work of
the staff on the unit as well as interviews with staff. Groups working together
are much more complex than they initially appear and I thought that I could
create some model which represented their work in an orderly fashion. The
level of complexity of the work and the degree of ambiguity with which the
staff had to deal on a daily basis surprised me. Even the concept of the team,
which initially seemed self-evident, became problematic. My current study thus is intended to explore the thinking and actions of health care personnel, particularly with an aging psychiatric population that is not highly valued nor frequently studied. My goal, following Geertz (1973:37), is to describe the unit sufficiently so that the reader can discern elements which are common to other health care settings as well as those aspects of the unit which are distinctive.

As the study progressed the belief system of the unit, embodied in its mission statement, emerged as a yardstick by which staff evaluated their effectiveness. The idealism of the mission statement meant that staff constantly measured their actions against expectations which were difficult, if not impossible, to achieve. The most telling point of tension was the imperative to help patients become more independent and autonomous, while at the same time assuring their safety. Nurses and other staff consistently monitored their actions with patients to meet these two conflicting values. This tension was only one of several uneasy alliances that staff negotiated on a daily basis as they carried out their work. The seemingly orderly routine that staff presented to the patients, their families, and some hospital personnel, effectively masked these tensions. At first, they were not readily apparent to me, although, in reviewing my field notes they were present from the start (cf. Goffman, 1959). The interviews with staff proved to
be especially helpful in delineating and clarifying the conflict they felt when their belief system and actions were incongruent.

The emergent nature of qualitative research could be demonstrated in the evolution of the research questions for this study. The central question remained the same, that of understanding how staff achieved a collective understanding of patient problems and developed a unified plan of care based on this shared understanding. However, the specific questions shifted as I observed and spoke to staff. I realized that the day to day interactions of staff were as important as the team meetings themselves in fostering this collective understanding. Hence, I did not focus as much on the meetings as I had initially intended.

The mission of the unit is to improve the quality of life for people over age 60 that has been diminished by physical and mental illness. Staff aim to restore function and autonomy so that patients can live as independently as possible. The research questions evolved from this mission and the staff’s effort to achieve it.

1. To what extent is the mission of the unit shared by unit personnel?
   a. How is the mission translated into action?
   b. What obstacles exist to its implementation?
   c. How do staff feel about their ability to fulfill the mission?

2. What is the role of power and authority on the unit in relationship to patient care and administrative activities?
   a. What are the sources of power?
b. How is this power enacted?

c. What tensions exist about the use of power?

4. What is the role of team meetings in achieving the mission of the unit?

   a. How do team meetings organize patient care

   b. What is the influence of power on team meetings?

   c. What role do patients play in team meetings?

**Methodology**

The goal of ethnographic research is to describe the culture being studied from the point of view of the people within the culture (Spradley, 1979:3). It is concerned with uncovering the tacit and explicit forms and meanings in a group and how these are combined to create the culture of the group (Gubrium, 1988:26). The interpretation of meaning is a central activity of this form of research. These interpretations, however, are abstractions of the world of the people being studied. Agar (1986:19) recognized this when he wrote, “Ethnography is neither subjective nor objective. It is interpretive, mediating two worlds through a third.”

Because meaning is socially constructed, the interpretation of meaning from another culture is accomplished through the values and beliefs of the observer. These values and beliefs reflect the observer’s cultural background (Agar, 1986:14; Mechanic, 1989b:148). Thus, ethnographic accounts of the same group may vary considerably based on who is conducting the research.
and his or her interpretive process (Agar, 1986:14; Mechanic, 1989b:149). One of the strengths of ethnographic research is its capacity to demonstrate that multiple interpretations exist and that a singular view of a complex social world is not likely to be entirely adequate. This includes the interpretations made by both the researcher (Agar, 1986:14) and those being studied (Gubrium, 1991:154).

This dissertation is an account of my observations of the work of staff on the unit. It reflects my attempt to do research; which is a match between myself, the problem, and the method (Rheinharz, 1984:369-382). Consequently, this project was not distanced research, but a search to understand the work lives of people I have grown to know from observing and living with them for a period of time. I have attempted to report the world as experienced by the staff, keeping this work as “actor-oriented” as possible (Geertz, 1973:114). However, this dissertation also reflects the values I hold, my experience, and the context of my life as a doctoral student, university professor, wife, mother, daughter, sister, and friend. To bring these to the foreground, the field relations section of this chapter deals with my social biography as well as my experiences as a participant observer on the unit. As one of the founders of sociology, Weber, has said, “All knowledge of cultural reality...is always knowledge from particular points of view” (cited in Bittner, 1988: 150, emphasis in the original). While I have tried to represent
the unit truthfully, this interpretation, following Weber, is a reflection of my particular point of view.

Data Collection

This study used three methods of data collection: observation, interviews, and document review. These three sources enabled me to judge the adequacy of the data and interpret them more effectively (Lincoln and Guba, 1985:305-307). I collected data for six months in 1993. The most intensive part of this research occurred during eight weeks of participant observation. During that time I observed fifteen consecutive staff meetings. The observations occurred in the public areas of the unit as well as the areas used exclusively by staff such as the chart and staff rooms. To avoid intruding on patient care I did not observe staff interactions in patient rooms and limited my observations to selected group sessions such as the community meeting and medication group. Again, these observations were limited because of the acute nature of the unit and my desire not to interfere with patient/staff interaction by my presence. Most observations occurred during the day, although I did observe several times during the evening shift.

The Institutional Review Board approval for this study required that patients and staff sign consent forms for participation in the research. The Institutional Review Board proposal and permission forms are in Appendix A. To maintain confidentiality I have replaced the names of the hospital and staff members listed on the form with pseudonyms. Staff were polled prior to
the initiation of the study to gain their support for the project. Nineteen staff members agreed to participate in the study and signed permission forms. Marjorie Coleman, the unit director, or the nurse admitting the patient solicited patient permissions. The family or guardian of patients who were not deemed to be competent to grant permission were asked to sign the forms for the patient. Based on discussions with the IRB at the University of New Hampshire and Hillside Hospital, those patients who refused permission could not be included in the data analysis, although it was agreed I could observe them and record their actions. Of the 50 patients admitted to the unit during the duration of the study 41 granted permission and 9 refused. I tried to avoid situations that included those patients who refused permission. Any unit observations or comments from staff that included a patient who had refused permission were not included in the analysis.

**Observation.** I tried to be as unobtrusive as possible as I observed staff conducting their work. I spent much of my time in the chart room, the nurses’ station, the hallway, and the dining room. I ate lunch with staff in the staff lounge. While I was observing I took brief notes, expanding on them as the opportunity allowed. I typed the notes as soon as possible after I returned from the hospital, typically that evening or the next day. I tried to keep my interaction with patients to a minimum, since they were not the focus of the study. However, I observed them closely when they were interacting with staff because those interactions provided me with important
insights into how staff conducted their work. The nurses' station proved to be an especially useful place to observe patient/staff interactions because people were busy enough to be less conscious of my presence. Also it was the hub of much of the public activity on the unit.

In the team meetings I attempted to be as unobtrusive as possible hoping that staff would forget my presence. Realistically this did not occur. Staff were always conscious of my presence, although they never seemed to be uncomfortable. All team meetings were audiotaped. Initially I transcribed the meetings verbatim. The conventions used for the verbatim transcriptions were adapted from Craig and Tracy (1983:302-305). See Appendix B for the transcription guide. When verbatim transcription proved to be too time consuming, I typed summaries of the audiotapes of the remaining meetings.

**Interviews with Unit Personnel.** I interviewed 22 of the 37 unit personnel. This included all day personnel and some of the evening staff. These interviews were audiotaped and transcribed verbatim. Three interviews were summarized, two because the interviewees did not want to be taped, one because of a malfunction of the tape recorder. The transcripts of the interviews were returned to the interviewees to enable them to correct any errors and to edit or elaborate on what they said. This form of member checking assured accuracy of the data (Lincoln and Guba, 1985:314). The interviews included questions about the mission of the unit, their definition
of team, their description of what constitutes the team on this unit, and their perceptions of the team meetings. I also asked about patients, primarily to understand how staff reflected on their experience with them. See Appendix C for the interview guide.

The interviews began during the intensive phase of fieldwork; however, they extended for a period of four months following this intensive phase of observation. These interviews followed a semi-structured format which enabled me to explore themes and comments which developed during the research. For example, the concept of empowerment emerged as a theme about midpoint in the study. I included questions about this theme in later interviews. I also shared my evolving understanding of concepts with interviewees as the work progressed. Consequently, rather than having the formal character of an interview, I began to think of these as conversations which developed as the staff member and I tried to understand their work on the unit. This trailing out of the interviews provided me with an opportunity to develop and test the themes that were emerging from the preliminary data analysis I was conducting in the same period of time. The emergent nature of qualitative research is facilitated when data collection, coding, and data analysis occur simultaneously (Glaser and Strauss, 1967:43; Lofland and Lofland, 1984:131-132). I was able to explore and clarify issues of patient safety and how staff felt about the dichotomy between assuring safety and enhancing independence. Had I not had this period of overlapping data
collection and data analysis, the development of this theme would have been less complete.

Document Review. Documents such as information given to patients and their families, nursing protocols, the care plan format, assessment forms, were collected. I also collected brochures and other information about facilities which typically received patients discharged from the unit, such as group homes, day programs, and nursing homes. The documents used by the team for their work enabled me to see how this work was organized for the medical record. The mimeographed patient information enabled me to see how the unit projected itself to its consumers. Finally, the brochures from other facilities offered the opportunity to see how staff on the unit presented discharge options to patients and their families. Interestingly, these brochures were beautifully produced with creative use of graphics, pictures, and, color while the patient information for the unit was typed and then xeroxed on colored paper. Although informative, the contrast between the highly produced brochures developed by the other agencies and the xeroxed patient information of the hospital was dramatic.

Data Analysis

To analyze the data I used HyperQual 4.4 which is a MacIntosh based hypercard program designed for qualitative research (Padilla, 1991:4). Field notes are entered into hypercard stacks and then coded in an iterative manner. Because the original stack of field notes is untouched in the coding
process, repeated coding is possible without contaminating the original data. This flexibility proved to be very useful as I tried coding schemes before settling on a consistent approach. HyperQual saves coded field notes to a different stack that can be sorted by codes. These sorted field notes can be printed out by codes, so that all segments of the data relating to a particular code can be printed in one document. All segments are labeled with the source card so that the full field note can be easily retrieved.

This coding and sorting can be conducted directly on the computer without reliance on paper documents. However, I found that printing the field notes and coding the printed document worked better for me than working at the keyboard. After the initial coding, I coded the data at the keyboard rereading the field notes to confirm the original coding decisions. This double reading was time consuming but provided a mechanism for assuring coding consistency.

After several coding trials that did not prove fruitful, the final coding scheme began with classification of the interview and observation data by setting, by speaker, and by the speaker's statements about other people and concepts. The settings included unit-observations that coded any interpersonal interaction I observed on the unit and hospital/unit description that included the physical description of the hospital and unit. When people were speaking either to me during the interviews or during the observations on the unit I coded these utterances by the person speaking as well as in codes
preceded by the word "about." Consequently, categories developed which related to what people said about the unit, about the team, about specific disciplines, patients, etc. By coding in this way I was able to retrieve all statements made by particular people and about particular people or concepts.

After this initial coding was completed, I printed documents which sorted the field notes into these broad categories. These documents were further coded into themes which had emerged as the research progressed. These included the mission of the unit, empowerment, and team. Further coding by themes within these documents yielded greater understanding of the meaning of the themes to the staff of the unit. These themes are developed in the subsequent chapters.

Data analysis from the team meetings followed a different procedure. Because the transcripts did not reflect tone of voice, inflection, and pace of the meetings adequately, I listened to all of the tapes again. I was particularly interested in the construction of the patient problem and how certain staff members contributed to this discussion. I also listened for the discourse about discharge decisions to see how issues of power were reflected in this discussion. I was interested in understanding how the wishes of the patient were reflected in this discussion since the patient was not present. After listening to each segment of the meeting in which a patient was discussed, I briefly summarized the roles of each of the staff members. I also summarized discharge discussions and any other points in the discussion which related to
the issues of power. The themes and insights which emerged from this analysis are contained in the sixth chapter.

Throughout the data collection and data analysis component of the research I wrote memos. These memos provided a way to record my evolving understanding of the unit and assisted in the development of the themes and organization of the dissertation. Again, the emergent aspect of this methodology provided the flexibility to pursue themes which became apparent as I observed and talked to unit personnel.

**Establishing Trustworthiness of the Data**

Rigor in qualitative research is established when the inquiry is perceived to be trustworthy by the reader. Trustworthiness is concerned with the truth value, applicability, consistency, and neutrality of the research (Lincoln and Guba, 1985:288-290). Because ethnographic reports are abstractions of the actual experiences of the people being studied as interpreted by the participant observer, their truth value is built upon how well the researcher describes the culture so that it is plausible to those who were studied as well as the reader (Krefting, 1991:215; Geertz, 1973:3-30; Mechanic, 1989b:147-150). For example, even though patient surveys do not confirm the major findings reported in Goffman’s *Asylums*, the descriptions of the experience of patients within a large mental institution are sufficiently vivid to be credible to the reader (Mechanic, 1989b:147-150). "Thick description” provides the detail and context necessary to assess the
truthfulness of the report (Geertz, 1973:3-30). Truth value is also achieved through a process called member checking. This is the review of the observations and findings by those being studied. Member checking assures that the data and findings reflect the perceptions of the group (Lincoln and Guba, 1985:314).

The truth value of the data is improved by prolonged engagement in the field - one of the standards of ethnographic research. Prolonged engagement enables the researcher to become part of the environment so that trust evolves as the people being observed become comfortable with the researcher. This is thought to reduce the influence of the researcher's presence on the behavior of the group (Krefting, 1991:217). Prolonged engagement carries with it the danger that the researcher becomes enmeshed with the group. Reflexive analysis may help to uncover the conflict between being an insider or an outsider. It is a process by which the researcher examines his or her history, perceptions and interests in relationship to the research (Reinharz, 1984:240-263). Reinharz (1984:240) referred to this as "reclaiming self-awareness." Levi-Strauss has said that to understand structure, one needs to be an observer, an outsider; to understand culture, one needs to be a participant, an insider.

Peer debriefing provides a mechanism for the researcher to check observations, impressions, analytic schemes, and conclusions with a knowledgeable but disinterested person. This mechanism is useful for
exploring aspects of the study that may have been implicit and can be made more explicit through candid and thoughtful exploration with someone else (Lincoln and Guba, 1985:308).

One goal of quantitative research is to be able to generalize the findings of a study to the population at large (Lincoln and Guba, 1985:297). This ability to apply findings to other groups is limited in qualitative research because settings are likely to be quite different from each other. Consequently, sufficient description must be included in the study to enable the reader to judge the similarity between settings (Lincoln and Guba 1985:298). Thick description is an essential component of the qualitative report because it aids the reader in judging whether the findings are appropriate to apply in a different situation (Geertz, 1973:3-30).

In quantitative research consistency, called reliability, refers to the ability to replicate the findings of one study in a second study of similar design. Control of variability from one study to the next is essential for this to occur. This control of variability of data is not the goal of qualitative research; rather, variability is sought to understand the range of experience of research informants (Krefting, 1991:216). Consistency of the data is established by assuring that field notes are accurately recorded and logged and that the accounts from these field notes can be traced back to them. The method of assuring this is called “establishing an audit trail” (Lincoln and Guba, 1985:319). An audit trail enables the reader to follow the process of data
collection and analysis as well as to judge the accuracy of the records (Lincoln and Guba, 1985:317-319). Triangulation of data from multiple sources: observations, interviews, and documents enables evaluation the data in order to understand where consistency, as well as variation in the data, occurs (Krefting, 1991:219).

Finally, neutrality refers to freedom from bias. Because qualitative research represents the particular perspectives of those being studied, the search for researcher objectivity typical of quantitative studies is not appropriate (Lincoln and Guba, 1985:300). Lincoln and Guba asserted that objectivity of the data should be the focus. This occurs when data are confirmed through the use of an audit, triangulation, and keeping a reflexive journal (Lincoln and Guba, 1985:318-319). A reflexive journal that records the thoughts and feelings of the researcher, as well as the daily schedule and a log of the methodological decisions, assists with this analysis (Lincoln and Guba, 1985:327-328). Mechanic (1989b:149) suggested that the social biography of the researcher is also important in this process (cf. Rheinharz, 1984). Keeping a reflexive journal and reporting the researcher’s social biography does not remove bias, rather it enables the reader to evaluate the perspective of the researcher in relationship to the data and the findings (Mechanic, 1989b:149).

The following methods were used to establish the trustworthiness of the data: prolonged engagement, member checking, triangulation of data.
sources, establishing an audit trail, peer debriefing, and keeping a reflexive journal.

**Prolonged Engagement**

The six month duration of the study was sufficiently prolonged to develop trust and to enable the staff to feel comfortable to act naturally in my presence. It also enabled us to have more frank discussions during the interviews, which would not have occurred if I had spent less time on the unit. This led to some ambivalence, because at times I thought staff forgot that I was conducting research on them rather than the patients. This was especially true at lunch time. Initially, I tried to remember what was said at lunch and included that in my field notes. However, sometimes I decided I was overstepping my bounds and chose not to include these observations in my notes. I also excluded discussions with some staff who explicitly told me that this information was confidential and should not be used in the study. This did not occur very often. I was surprised at how many staff members confided in me. At one point I felt that I knew all of the secrets of the unit. The field worker became a confessor.

The time I spent on the unit enabled us to develop a high level of trust. This made me particularly mindful of anything in this report which might create difficulty for individual staff members with the rest of the group. Hence, I told people that I would review the draft dissertation with them if I felt it contained statements that might be harmful or embarrassing. This
reflects the moral obligation I felt to the people who were so generous with their time.

**Member Checking**

The opportunity for staff to review their interview transcripts enabled me to reinforce their control over the content and use of the data. Most made only factual corrections and only one person requested that I contact her if I used certain portions of the interview. She said in a note on the transcript, “I do have to keep working with these people! Things would be nicer if people didn’t know some of the dirt” (Field Notes #54, Card ID #43511.9/21/93). Some of the “dirt” was surprising to me, particularly when major tensions between staff members were revealed that I had not been aware of. During one interview I questioned my observation skills, since the staff member disclosed an important incident I had not observed on a day I was on the unit. This staff member said to me,

**Staff**  Don’t be hurt if I tell you this, because you’re kind of not an inside person

**EBC**  Oh, yes, I know.

**Staff**  and I think people put on their happy face around you all the time

**EBC**  Yea, I think that’s part of it, that stuff

**Staff**  It kind of gets glossed over maybe or-

**EBC**  -Oh, that’s fine, the other thing is that people carry out their function and they’ll talk about the way they feel. No, it doesn’t hurt my feelings at all. That’s one of the reasons that you do interviews is that when you’re in the same
room with somebody else, they're more likely to tell you things.

Staff       Yea
EBC         And at the same time, they are quite likely to tell you what they think you might like to hear too
Staff       umm
EBC         You know, that's always the danger to this kind of research

Staff       Well, I don't see much point in us just sitting down like this together unless I can be straight forward (Field Notes #69, Card ID #10364:11/8/93).

This was one of the last interviews I conducted. The frankness of the staff member in part reflects the extended time we spent together. I don't think she would have been so open earlier in the process. This comment made me realize that my observations were limited by the staff's awareness of my presence. Though an observer, I was also being observed. Prolonged engagement didn't entirely overcome this limitation, however, member checking and triangulation of the data reduced this problem.

I conducted member checks by having all interview transcripts reviewed by the interviewees for accuracy of transcription and clarification or expansion of additional points which occurred to the person after the interview. I also incorporated questions about evolving themes and ideas in the interviews and informal conversations with staff to see if these were accurate reflections of their view of the unit. This enabled me to elaborate and extend the themes as the research proceeded. Finally, I met with the staff
at the end of the field work to discuss formally those themes that had emerged to see if these reflected the experience of the group. This process was especially useful in my evolving understanding of the mission of the unit, the meaning of team, and the pattern of interaction in the team meetings.

**Triangulation of Data Sources**

Triangulation of data sources, as stated earlier, was achieved by collecting data from multiple sources: interviews, observations, and documents. Furthermore, because I interviewed everyone who worked during the days and most evening personnel, I was able to glean multiple perspectives of the work of the unit. This led to a much more rounded view of the unit and uncovered both the consistencies in the belief system and the tensions which existed when these were not consistent.

**Establishing an Audit Trail**

Lincoln and Guba (1985:319-327) described Halpern’s process for establishing an audit trail that involved detailed record keeping and the use of an outside individual to audit the records and process of the study. I kept detailed field notes, a reflexive journal, and methodological journal. Because these were entered on the computer using HyperQual, data were easier to retrieve because all field notes were labeled with identification numbers. Coded and sorted data were labeled with the source card number making retrieving the original field note very easy. At the keyboard, going to the source card was as easy as clicking a button with the mouse. To keep track of
the source of field notes, a citation indicating the field note number, computer ID number, and date is included for each field note referred to in the text. I also indexed and summarized these records in a notebook. The methodological journal recorded all methodological decisions including the various coding schemes, the development of the interview schedule, and the development of themes. These various records enabled me to retrieve the original data that support the findings of the study.

**Peer Debriefing**

Several peers were very helpful during this study. All are social scientists and several are either occupational therapists or nurses. Their knowledge and comfort with qualitative research and the field being studied were significant factors in the peer debriefing process. I found these conversations to be extremely helpful especially in challenging some of my assumptions and my early conclusions. I conducted periodic conversations with three peers about this project. These discussions consisted of discussing themes, observations, questions I had, and sharing some field notes for their reaction. These conversations sharpened my analysis, opening new ways of looking at the data. One peer debriefing session was particularly helpful in identifying the idealistic tone of the mission statements, something I had not realized. The development of the issue of empowerment, the meaning of team, and the routine/out-of-routine aspects of the team meetings were extended and further clarified by these discussions. I am very grateful to these
individuals for their time and effort in this process, because the conversations were significant to my understanding of the issues enmeshed in the data.

**Keeping a Reflexive Journal**

Finally, I kept a reflexive journal which recorded my feelings as they evolved. I know that I would have forgotten these impressions had they not been recorded; it is almost like the first impressions of seeing a new country.

**Social Biography**

I approached this research as a graduate student seeking to complete the final requirement for a doctoral degree in sociology. However, beneath this identity lurked several others which influenced this experience. The two most salient of these were my professional roles as an occupational therapist and university professor. Although I have not worked full time as an occupational therapist for thirteen years, the struggles for independence and dignity of the patients I treated in the past remain real for me. I worked primarily in long-term-care institutions, hence I expected many of the patients on the unit to be similar to those with whom I had worked. They were, but the environment differed in significant ways. The long-term-care institutions in which I worked had some staff who valued and respected the patients in their care. However, in most cases, this group was in the minority. I remember my frustration when patients didn't get the services they needed or when I observed instances when they were ignored, demeaned, or devalued. Fortunately, this unit was different.
As a faculty member in an occupational therapy program, I have tried to instill in the students the necessity to listen to their patients and to design occupational therapy interventions attuned to patient goals. These values are central to my identity. I have struggled with the attitudes of students that reflect the negative stereotypes towards old people that permeate our culture. My grandmother’s very brief but negative experience in a nursing home is a constant reminder to me of the necessity for health care personnel to remember the humanity behind every patient, regardless of their age, physical health, or mental status. One of the reasons I chose an acute geropsychiatric unit as location of this study was to understand how patients were treated in this environment and whether care for the elderly had changed since I left clinical practice.

These dual roles as graduate student and faculty member have been largely beneficial. From my teaching, I know that students must deal with points of stagnation and frustration. Because I have already written for publication, I know what it is like to take on a long term project filled with many ambiguities and short deadlines. These experiences gave me the confidence to endure the times when this research seemed entirely too slow, too muddy, and too uncertain. I knew that this feeling would pass and pattern would emerge from the jumble in front of me. Though, by nature I prefer order, I have learned to be comfortable with the ambiguities inherent in this type of research. While I have tried to describe the work of unit
personnel, I resisted the temptation to reduce it to an orderly model which
denies the variation and complexity inherent in this type of environment.

Presentation of self is an important part of this type of research. My
experience as a therapist and university professor made meeting groups and
giving presentations easier. However, since I was entering this project as
someone who wanted to understand the people working in the unit, I needed
to present myself, not as an expert but as a learner. My ID card, which I had to
wear when I was on the unit carried the label “student.” Marjorie, the unit
director, and I decided that “student” would be the best way to describe my
role since it was closest to the truth. One way I managed my identity was to
dress like the direct care rather than administrative staff. This meant
generally wearing cotton slacks, a blouse, and sneakers. This mode of dress
was somewhat more casual than usual in my work role. But I felt that
dressing this way enabled me to fit in more completely. The anthropologist
must become partly native.

I think the prestige of the role as university professor helped in gaining
access to the field work site although this role had its problems as well.
Because the occupational therapists working on the unit were graduates of
the University of New Hampshire, we had to do some “negotiating” about
my role on the unit. It always surprises me how difficult it is to shed the role
of teacher, not for the teacher herself as much as for her students. One day
Amy, one of the occupational therapists, and I co-led a group. It was my effort
to be of help when the unit was short staffed. As we were planning the
group, Amy said to me that she hoped she didn’t look foolish in front of her
teacher. I was surprised by this comment since I thought of her as the expert,
certainly her knowledge of occupational therapy interventions in this setting
exceeded my own. Fortunately we were able to talk about that and clarify my
role on the unit as a participant/observer. However, I am sure that in
everyone’s mind, I was something beyond the singular role of doctoral
student.

Although I have tried to be objective in recording my observations and
making interpretations during this study, I know that my background has
influenced this process. This was particularly apparent when I found myself
comparing the patients on the unit with patients I had treated in the past.
Because of my experience in long-term-care settings, I was unprepared for the
rapid changes in behavior exhibited by patients as they responded to the
medications they were given. My long-term-care experience also exposed me
to the indifference of doctors, nurses, and others to the needs and feelings of
the elderly. Fortunately, the concern for the dignity of the patients was a
value in the setting under study and was enacted with remarkable
consistency. Engaging in participant observation in a setting which did not
hold this value would have been painful indeed.
Field Relations

As previously stated, this is the second time I have conducted field research at Hillside Hospital. The team I observed three years ago was intact, with the exception of some of the nurses and the dietitian. I felt like I was entering a familiar setting. While the original team was familiar, many of the issues had changed. I discovered this very quickly. The mix of the familiar with the new was unsettling to me. One way I handled this was to compare mentally my previous observations with the current study. Because of my familiarity with the unit from the previous study and the staff's comfort with me, initiating this research was much less stressful. I thought I knew what to expect so, although anxious, I was not overly concerned about my relationship with the staff.

Entry began with a staff meeting a month prior to beginning the research to explain what I would be doing and to answer any questions people had about the project. During this meeting my previous study came up and I explained how this one was broader in scope.

Between the meeting with staff and starting the fieldwork I prepared for the research during several frenzied weeks. I cleaned my study, reorganized papers and books, and bought several loose leaf notebooks for my field notes and about eight microcassettes for taping the interviews and team meetings. I thought I was set. Then I visited a colleague who was just completing data analysis of a series of ethnographic interviews about the
socialization of nurses. She had offered to show me her computer based data analysis program. During the course of the discussion she pulled open a file drawer filled with field notes and a desk drawer filled with tapes. I was shocked. I told her that I had just purchased several loose leaf notebooks and a few tapes and she had a good laugh at my lack of foresight. She warned me to be prepared to buy a new file cabinet or empty one because I would be needing it. She was right. My field notes take up almost one file drawer. I have several notebooks filled with summaries of notes from books and articles, and another file drawer half filled with xeroxed articles.

I knew that field work would be exhausting mentally but I was not prepared for the physical demands of the task. The driving and hours of typing left me wanting to do anything but sit. I have medial epicondylitis, also known as tennis elbow, a condition I acquired not from playing tennis but from typing my master’s thesis. It is generally fine if I do not do things which aggravate it, like driving and typing. I learned that I had to take many breaks to keep the tennis elbow from getting out of control. These breaks slowed down typing field notes, but were a necessary inconvenience. Typically it took three to four hours to transcribe a one-hour meeting and another two hours to check the transcription. Transcribing the interviews was not as difficult; however, I had to listen to my own voice which is something I had not done before. This was not a pleasant experience. The nasal Philadelphia accent which I thought had long since disappeared was
very evident to me. I also felt very inarticulate as I listened to the "ums," "you knows," and other interjections so commonly used in conversational speech. The drive, hours of observation, hours of typing, and time to think about it all left little time for anything else. My mind felt involved with the project most of the time, the details of living disappeared from my list of priorities. This is not a good way to sustain relationships with family and friends.

The emotional toll of this research hit me about four weeks into the study. I found that people were confiding in me and that I knew many things which were not public information. Some of this information dealt with other people on the unit, other with plans for the future. One day after an particularly long and emotional conversation, I came home, ate supper, and went to bed almost immediately. The next day I felt as if I had a hangover. I found that I took on the concern the staff were expressing, because I too felt a commitment to the unit and its mission.

This commitment extended to the patients. Most had little awareness of my presence because I had minimal interaction with them. However, because I observed staff working with them, I became invested in their progress. The lack of progress for some of the patients was especially frustrating while the dramatic improvements of others seemed nothing short of miraculous. I remember returning to the unit after a two day break to find a patient who had been almost entirely immobilized by depression and
Parkinson’s disease participating actively in a discussion group. The impact of the proper medications had created a woman I almost didn’t recognize. This rapid change in people was very surprising to me. My history in long-term-care in which progress is measured in inches and my lack of familiarity with the drugs which are now available for treatment did not prepare me for the rapid changes I saw. Although staff had talked about dramatic changes in patients, it wasn’t until I had seen them myself that I realized the potential for changing people’s lives.

The intense period of participant observation followed four months of interviews. I stopped observing when Peter Tully left. He was a central figure on the unit and I felt that continued observations, while yielding interesting information about how a staff handles change, would only divert me from the core questions of my research. The interviews which followed made that clear and I had to focus staff on their work in the summer rather than current issues on the unit.

During this time I increased my focus on analyzing data. It was a particularly frustrating time because everything seemed important and I had many ways to go with the data. I remember commenting to a friend that everything was muddy. My memos during that period reflect efforts to create pattern out of this chaos, some of the pattern in retrospect looks like trying to fit a square peg into a round hole. The peer debriefings that occurred during this time were very helpful, because verbalizing my thoughts to a
knowledgeable listener who asked questions to extend my thinking was just what I needed.

The interviews also eased the transition from intense involvement to a more marginal role. I was able to slowly take leave so that final meeting with staff and my attendance at the annual goals meeting seemed like a logical and fitting marker to end the research. Fieldwork, it can be said, is like a journey with inter-connected stages, like Bunyan's Pilgrim's Progress: the field worker proceeds from being a newcomer and learner, to old timer, and ultimately to out-migrant (cf. Khleif, 1974a:393).

Conclusion

This research was an activity which consumed much of my time for the past eighteen months. I lived with the people on the unit for six months of this time, however, much of the rest of the time has been spent thinking about them and their experience. The following chapters reflect my interpretation of their world. The focus of this interpretation is the relationship between the beliefs of the staff and their actions. That uneasy alliances exist between their actions and beliefs is understandable. They work in the real world filled with limitations rather than one which is ideal and unconstrained by time, institutional policies, and human frailty. How they negotiate this discrepancy is the focus of this study. To begin this process, however, an historical overview of mental health treatment will provide a context for understanding this unit and its staff.
CHAPTER II

MENTAL HOSPITALS: AN ORGANIZATIONAL REVIEW

This chapter reviews the literature regarding the history of the organization of mental hospitals. As in any organization, the culture of a mental hospital is a negotiated order. This negotiation leads to shared understandings that form the basis for action within the complex relationships of hierarchy and bureaucracy. According to Perrow (1965), three factors of an organization: its cultural system, technology, and social structure, combine to produce its actions or output. In the case of hospitals these actions involve the care and cure of human beings.

This chapter opens with a review of Perrow's argument in relationship to psychiatric care from the work of Richard Napier, an astrological physician in 17th century England to present and the work of the staff of the Elderly Psychiatric Unit (EPU). I will draw on the work of Perrow, Goffman, and Foucault in conducting this historical review. I will attend to the shifts in cultural beliefs and influence on the approaches used in mental institutions. In closing I will focus on the distinguishing characteristics of this unit in relationship to the organization of space. This spatial organization is one aspect of the culture of the unit and the relationships between and among the patients and the staff.
Organizational Culture, Technology, and Structure

As this study progressed the relationship between the belief system of the unit to the actions of the staff assumed greater importance. According to Perrow (1965:912-913) these actions are determined by the relationship between the unit culture, technology for treatment, and unit structure. The analysis of most organizations typically focuses on the structure of the organization because on a day-to-day basis this seems to be most important. Technology, such as medication and electroconvulsive treatments (ECT), seems more important when a mid-range view is taken. In contrast, it is only with a long range view that the cultural beliefs of people within the organization emerge as important (Perrow, 1965:912). Perrow (1965:915) argued that it is technology which drives the change in organizational beliefs and structures and that the lack of significant progress in the care of the mentally ill is caused by the lack of an appropriate technology for care and cure. Since Perrow wrote this analysis in the 1960s a pharmacological revolution has occurred (Lickey and Gordon, 1991), however, his analysis of the relationship between culture, technology, and structure remains an important contribution.

Organizational culture is a negotiated order. It consists of predispositions to act and shared understandings that are used as building blocks for decision making. Perrow (1965:912) identified three factors which influence organizations. The first is the cultural system that sets the goals of
the organization. Cultures are created to establish order in the world (Moore and Myerhoff, 1977:16-17) and serve as a mechanism for handling uncertainty (Trice and Beyer, 1993:1). Cultures grow out of the interaction between people in the group and express their symbolic and collective beliefs. Because they are based on the history of the group they have a degree of stability, however, they are also dynamic and respond to changes within the group and the environment (Trice and Beyer, 1993:5-8). The culture of a group exists in the minds of group members (Schwartzman, 1989:21) and serves to explain and justify their behavior. Cultural beliefs are often emotionally charged and a challenge to the belief systems of the group threaten the group itself (Trice and Beyer, 1993:5-8). The culture of hospital systems addresses the goals and beliefs related to the care and cure of human beings (Perrow, 1965:914). Other beliefs may enter into this culture such as the commitment to the education of health care professionals, the protection of the community from harm, or the obligations to generate profits for the organization (Stanton and Schwartz, 1954:44). The institution and its relationship to the larger community shape its cultural beliefs. Because hospitals are concerned with the care and cure of human beings rather than inanimate objects, the cultural beliefs about people are particularly important. These beliefs shape the treatment approaches and structure of the hospital (Perrow, 1965:914-915). As cultural beliefs change, so do the approaches to treatment, as this review will demonstrate.
"Technology is a technique or complex of techniques employed to alter 'materials' (human or nonhuman, mental or physical) in an anticipated manner" (Perrow, 1965:915). According to Perrow (1965:12), the technology employed will be consistent with the belief systems which direct the goals of the organization. For Perrow, in order for treatment or management to be considered a technology it must be able to be evaluated and replicated. It also must produce sufficient change or improvement to warrant continued use. To be considered a technology, approaches must be capable of being taught to others to enable broader use (Perrow, 1965:915). This characteristic of technology - the ability to be replicated - is important in this review because previous approaches to the treatment of mental illness have failed this important test.

Technological approaches in mental hospitals involve issues of control, care, custody, and cure. Perrow, writing in 1965, claimed that the individual psychotherapy available in small elite hospitals met most of the conditions necessary to be considered a technique. He dismissed claims of cure based on therapeutic milieu and related programs as misleading, calling them instead a "humanizing influence" in large hospital systems which lack an appropriate technology (Perrow, 1965:924-925).

That the technological means for curing mental illness continues to elude us is central to Perrow's argument. The hope that psychoactive medications would effectively manage the symptoms of mental illness had
fallen short until the past few years with the discovery of new medications to manage schizophrenia and depression (Licke and Gordon, 1991). Although antipsychotic medications prevent relapse in schizophrenia, noncompliance and side effects remain significant issues (Estroff, 1981:68-75). Drugs do not enable clients to understand their problems nor learn to adapt to living independently. Dependence on drugs provides evidence to clients that they will never be cured, reinforcing their self image as “crazy” (Estroff, 1981:109). Despite the improved effectiveness of drugs to provide a technological mechanism for control of the symptoms of mental illness, they simply control the symptoms. They do not cure. For the purpose of this paper, I will include approaches involving care, custody, control, and cure as technology, while realizing that some of these approaches do not meet the criteria of technology delineated by Perrow (1965:915).

On the EPU, titration of medications was the primary task of Dr. James, the medical director of the unit. Titration refers to the adjustment of the dosage of the various medications to reduce symptoms and minimize side effects. Because many patients were also being treated for medical conditions, this was a complex process that entailed understanding the primary effects of the medications prescribed as well as their side effects and interactions with other drugs. Groups and other milieu based approaches were thought to support the medical approaches and to assist patients to learn and change so that they could function more effectively when discharged. Performance in
groups also serve as an indicator of response to medication. Patients whose medication are at appropriate levels are more likely to be able to contribute to and benefit from the discussions and activities which occur in the groups.

Finally the social structure of the organization consists of "the arrangement of tasks and persons, including lines of authority, responsibility and communication" (Perrow, 1965:914). This structure is influenced by technology (1965:915) and the cultural beliefs in which it is embedded (1965:914). There is an interdependence between the cultural beliefs which drive the goals of the organization and the technology and structure which combine to achieve these goals.

An historical approach to the treatment of mental illness provides ample evidence of the relationship between culture, technology, and structure. The next section of this chapter reviews the changes in beliefs about mental illness and the subsequent approaches to its management beginning in seventeenth century England.

Approaches to the Care of the Mentally Ill: A Brief Historical Overview

Richard Napier: Seventeenth Century Physician

Richard Napier, an astrological physician in seventeen century England, practiced just prior to the emergence of medical explanations of mental illness (MacDonald, 1981:9). People at this time believed that mental disorder was caused by a combination of natural or supernatural forces such as astrological events, psychological stresses, and physical illness (MacDonald,
1981:172). Napier felt that the stresses themselves, for example, the death of a loved one or difficulties in courtship and marital life, were not the problem. Instead the problem existed in the way people reacted to these stressors (MacDonald, 1981:80-88). These forces acting on the mind and body produced disorders described as folly, moppisnness, melancholia. These descriptors were clustered under one primary category of delirium. Napier typically saw five to fifteen people a day and tried to develop an understanding of the patient by asking questions which would help him understand this patient in the context of his family and community. Because of his astrological orientation, these questions helped Napier situate the patient in relationship to the stars. His goal was to restore the body and mind to a natural order by manipulating the physical and social environment (MacDonald, 1981:185). He used a broad range of approaches such as diet, exercise, prayer, astrology, and such physical remedies as drugs, emetics, laxatives and bleeding (MacDonald, 1981:178). These approaches recognized the interrelationship between mind and body and universe which was central to the beliefs about mental illness at this time.

Because the family was the central social unit of society, few people were sent to asylums. Instead, care was organized within the family unit. Property issues were important both to support care of the individual and to preserve wealth for the family. In reading about Napier's practice the concern for individuals in the context of their families and community seems
strikingly holistic, a quality absent in many approaches to the care of the mentally ill since that time.

**The Great Confinement: Seventeenth and Eighteenth Centuries**

The Great Confinement of the seventeenth and eighteenth century was a turning point in our understanding of madness. From Foucault's (1961/1965:ix-xii) perspective, this shift in understanding marks a broken dialogue which has never been breached. The Confinement was characterized by the development of institutions designed to house those deemed to be social problems: the poor, insane, criminals, and invalids. These hospitals, as they were called, grew out of the belief that society, in the form of the monarch, had the responsibility to care for those who were unable to care for themselves (Cockerham, 1989:17-18). Unfortunately, conditions were horrible because the insane were thought to be more like animals than human beings (Foucault, 1961/1965:69-77). They were crowded in cells, chained to walls, and given few creature comforts of warmth, clothing, or food. Incarceration was the technology used to control and contain madness.

According to Foucault (1961/1965:69-77), the Confinement organized madness by separating the insane from the rest of society. This separation created a belief system that mental illness was shameful and the mentally ill were inhuman and dangerous (cf. lepers, leprosy and leprosarium in ancient society). This interpretation of madness, as a reflection of cultural beliefs,
justified the poor conditions provided for those so confined. This period ended in the early nineteenth century with a brief period of reform called the moral treatment movement. The beginning of this reform is typically dated from the unchaining of inmates at the Bicêtre in Paris in 1793. This coincided with the "Age of Reason," in which Europeans believed in rationality and reason as the supreme guiding principals of human conduct.

Moral Treatment: Eighteenth and Nineteenth Centuries

Moral treatment grew out of the belief that insanity was caused by environmental influences. Consistent with the values of the "Age of Reason," people believed that rationality could be restored through respect, kindness, and the development of habits and routine which would support productive living (Peloquin, 1989:537). This belief in the capacity of the mentally ill to reason contrasted with the confinement in which inmates were thought to be unable to reason or understand. Its assumptions were reinforced by the Protestant ethic of labor, goodness, and morality. The goals of moral treatment were to create an institution that would foster order and rationality. The order and rationality provided by the institution were thought to cure mental illness. Every aspect of the institution reinforced this orderliness, from the interaction between staff and inmates patterned on the family unit and its architecture, to the schedule of the daily activities. The restraints and other forms of inhumane treatment characteristic of the
Confinement were incompatible with this approach. Consequently, they were not permitted in these institutions.

The institutions were planned in ways which reproduced the social structure. Women and men and the various classes were segregated from each other. Instead of bars and iron gates to secure inmates, disguised forms of security such as double windows were used. Beyond the physical structure designed to reinforce orderliness, a daily routine and occupations specific to the needs of the inmates, were the cornerstones of moral treatment. Physical, recreational, and social activities organized by the staff rounded out the inmates’ day (Showalter, 1985:30-33). These activities, combined with the use of reason and willpower, were thought to produce a recovery exemplified by a life of moderation (Showalter, 1985:30-31).

The organization of the institution was based on a fatherly superintendent playing the role of a benevolent authority figure with the docile inmates learning good habits and self-discipline that reproduced class and gender relationships from society at large (Showalter, 1985:30-35). This submission to an authority figure and the use of self-restraint not present in the Confinement has led to critical interpretations of this movement (Showalter, 1985:30-35). Surveillance principles drawing from the concept of the Panopticon allowed for constant observation of inmates. The Panopticon, a circular building, was designed to enable observation without the inmates awareness. Hence, inmates were aware that their compliance with the
expectations of the institution could always be monitored, even when they were not aware of anyone watching them. Privacy in the Panopticon did not exist (Showalter 1985:34). The technology of chains was replaced by the technology of surveillance and self-control.

Foucault (1961/1965:241-278) was especially critical of the use of observation and classification because these objectified and reinforced the separation between inmates and their keepers. The process of objectification created and reinforced an asymmetrical relationship between the keeper and the inmate. From this perspective moral treatment was not entirely positive. The physical repression of the Confinement was replaced by control over the thoughts and actions of the inmates (Foucault 1961/1965:241-278).

To be considered as a technology, treatment approaches must be capable of replication (Perrow, 1965:933). One of the major failures of the moral treatment movement was the inability to apply this approach in settings other than the small and well staffed institutions which pioneered its development. Hence the standard of replicability stated by Perrow (1965:933) was not fulfilled, leading to his claim that moral treatment was not a technology but simply a humanizing effort. After the mid-nineteenth century, when pressure for admitting more people to mental hospitals increased their size, the intimate atmosphere promoted by the moral treatment movement could no longer be sustained. Limited funds and overwhelming patient numbers resulted in the custodial care seen in state
institutions until the deinstitutionalization movement of the late 20th century (Mechanic, 1989a:92-99). I worked for two summers in two of these large state institutions just prior to the deinstitutionalization movement. During that summer I witnessed the dehumanizing aspects of custodial care. The next section will deal with this experience and link it to Goffman's (1961a) classic study, *Asylums*.

**State Hospitals: Mid-Twentieth Century**

In the summer of 1964 I worked as an occupational therapy aide at Philadelphia State Hospital. There were 5,000 patients at the hospital. This number impressed me because there were only 4,000 students at the University of New Hampshire at the time. The hospital grounds were bisected by a major highway entering the city. Distances were so great that we had to drive from building to building. The oldest buildings formed the central core of the hospital. These buildings, erected in the mid-nineteenth century, were graceful brick structures with arches, long hallways, and large windows. The long driveway approaching these buildings from the main road was lined with trees. Green lawns surrounded the buildings, giving the hospital a calm, pastoral appearance. Unfortunately, the pleasant approach was marred by bedraggled patients sleeping on park benches and under the trees. Their appearance reflected the institutional neglect of all aspects of their care beyond the minimal fulfillment of their basic needs for food and shelter. Newer buildings were utilitarian brick structures that lacked even a
modicum of grace and beauty. Buildings were filled with patients, some shouted from the windows at passersby, others paced or curled up on the floors. Privacy and personal space was non-existent. Patients slept in large open wards. Even the bathrooms lacked doors. Patients could be observed at all times, even when carrying out such private activities as going to the bathroom and bathing.

For 5,000 patients, there were twenty-eight people on staff in the Occupational Therapy Department. The ratio of one occupational therapist to 178 patients testifies to the custodial nature of the institution. I remember carrying the keys which symbolized the difference between patient and staff, long tunnels under buildings, and patients walking mutely in lines from their wards to the occupational therapy room. Occupational therapy (OT), which bases its roots in the period of moral treatment, provided crafts, cooking, and other activities for a limited number of patients.

I particularly remember working on one unit which housed severely regressed men. A small group of these men were selected for a rehabilitation program. At the time I was there, they had been in the program for about eight months. The men in each group of about 15 lived together in an enclosed unit, ate their meals together, and attended a full day of activities including physical activity, occupational therapy, and group sessions with both the chaplain and the psychiatrist. The assumption, as I recall, was that the structured social interaction in the groups would foster improved contact
with reality and social skills. These patients may also have been receiving different medications, but I was not privy to that information.

Occupational therapy focused on socialization and task activities. Each occupational therapy session opened with simple exercises such as walking around the room to music, playing follow the leader, or doing calisthenics. Then everyone sat in a circle on big rocking chairs. The therapist introduced herself and the person next to her. Following the therapist’s lead, the patients were expected to take turns introducing themselves and the person next to them. During my time there a major breakthrough occurred, the first patient accomplished the second step, that of introducing the person next to him. The therapist and I were elated at this sign of progress after eight months of effort! Following this social activity the patients worked on a group craft. While I was there it was a button mosaic which involved gluing colored buttons following a design drawn on a large piece of poster board. The poster was passed patient to patient so each could have a turn gluing a button on the board. I remember that this took a lot of coaching and encouragement, perhaps because the patients were incapable of better performance or their total lack of interest in such an activity.

The level of individualization of care on this unit was unusual for the hospital. Typically thirty to forty patients were led to OT in a group, sat at their tables, and worked on the same activities one day to the next. Little conversation occurred and the therapist acted more like a crafts instructor
than someone building problem solving, communication, or other kinds of life skills. More capable patients worked in the hospital laundry, kitchens, and grounds doing the manual labor necessary to support such a large institution. This was justified by hospital administrators as work therapy. Today it would be seen as patient exploitation.

The following summer I worked at the state hospital in Norman, Oklahoma. The general conditions in Oklahoma were even worse than in Philadelphia. Both institutions met the criteria for total institutions described by Goffman (1961a). A total institution “is a place 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 of life” (Goffman, 1961a: xiii). According to Goffman (1961a:4), care in the state hospital system consisted of providing food and shelter for people who were thought to be incapable of caring for themselves or were a danger to the community. Patients were restrained physically. The discovery of phenothiazines and antipsychotics reduced the need for physical restraints. The use of intimidation and power by aides was an overwhelming characteristic of institutional life as was the lack of individualization of care (Goffman, 1961a:6). Constant supervision and lack of privacy enabled staff to assure that patients complied with the rules and regulations. Failure to comply resulted in seclusion or other forms of control (Goffman, 1961a:23-25). The goal of these hospitals was custodial rather than rehabilitative. Economy
was more important than cure and people admitted, generally against their will, seldom were discharged.

The deinstitutionalization movement was generated from the awareness of the shameful inadequacy of care in state hospital systems (Mechanic, 1989a:4-16). These systems reproduced many of the inhuman practices of the Great Confinement, albeit in a slightly more humane form. Physical restraint and separation from society were common characteristics of both. Close surveillance began during the moral treatment movement and continued in state hospitals which provided virtually no opportunity for patients to have any privacy. The authority of staff over patients was almost absolute. Consequently, patients had little or no control over their day-to-day existence. People with wealth were spared the inhumane approaches of state hospitals, however, even the elite hospitals described in the next section were structured to reinforce the control of patients by staff.

**Elite Psychiatric Hospitals: Mid-Twentieth Century**

Stanton and Schwartz (1954) and Caudill (1958) described two elite psychiatric hospitals in the same era, Chestnut Lodge Sanatorium (a pseudonym) and the Yale Psychiatric Institute. Staffing in these facilities was generous, enabling a more treatment oriented approach to care. While these hospitals did not have the warehousing philosophy present in state hospital systems, they still reinforced a passive patient role. This passivity is highlighted in Redlich’s (1958:xi) Foreword to Caudill’s book.
Such a system (the hospital under study) is an authoritarian system. It is characterized by strong paternalism, or possibly paternalism. There is, even in our best mental hospitals, an uncomfortable similarity between our institutions and prisons, albeit very permissive prisons. The permissiveness, however, is that of a nursery, sometimes at the price of human dignity. I often wonder whether some of the rules and regulations of most mental hospitals exist because the patients are infantile or because we infantilize them.

The goals of Chestnut Lodge Sanatorium included protection of the community, care of patients, education, research, and profit (Stanton and Schwartz, 1954:44). However Stanton and Schwartz found that staff avoided discussing the conflict between hospital goals when queried about its purpose. For example, the potential conflict between keeping costs low, thereby assuring a profit, while at the same time providing effective therapeutic interventions.

Intensive psychotherapy was the primary technological approach used at Chestnut Lodge. This was designed to increase patients' insight into their behavior, which would presumably result in improved behavior (Stanton and Schwartz, 1954:9). Although environment encouraged dependency and passivity, care was generally attentive to the patients needs and assured somewhat greater privacy than available at state institutions (Stanton and Schwartz, 1954:48-55). In contrast to state hospitals, patients at the Yale Psychiatric Institute had private rooms. However, they were not allowed to visit with each other in these rooms. The only place to congregate was the living room which was more exposed to observation by other patients and
staff (Caudill, 1958:212-213). Patients spent one hour a day in the psychotherapy. The rest of the day was spent in activities on the wards and hospital grounds. In reading both books one gets the impression of residential facilities which, while attentive to the patients, did not focus on rapid discharge.

The structure of both hospitals was hierarchical with a split between clinical administration and medical care. Great power resided in those who had resources, such as cigarettes and other privileges, thus aides may have exerted more influence over the daily life of the patients than the hospital administration or physicians (Caudill, 1958:85). The separation of clinical and administrative functions created dual lines of authority, causing difficulties when one person overrode the decision of another (Caudill, 1958:83-85).

While these institutions were more humane than state hospitals, they were still institutions. Patients were observed and controlled by rules and medications. This control by staff was overwhelming. Caudill (1958:213) reported that patients had ambivalent feelings about this control. Caudill quoted a patient he called Mr. Osgood, who was commenting on a picture depicting a male and female patient talking in a private room - an activity, however innocent, that was against the rules of the hospital.

"I'd be making a hard time out of it. Let's say a nurse walks in, and you feel guilty at being caught, and resentful of having it broken up, and at the same time you are relieved of the guilty conscience--more or less the idea that authority is easier to take
than freedom...From my point of view, I am in a glass bowl and everything I do is noticed, and to hell with it, it's me take it or leave it" (Caudill, 1958:213).

Observation and lack of privacy prevailed as it did in state hospitals, despite the more comfortable surroundings.

**Milieu Therapy and the Therapeutic Community: Mid-Twentieth Century**

Milieu therapy emerged in the 1950s as well. This emergence was led by the Belmont Unit supervised by Maxwell Jones (Perrow, 1965:943). Milieu therapy assumed that mental illness results from environmental influences, and that shaping the environment to be therapeutic restored mental health (Perrow, 1965:933). This approach, in contrast to most other contemporary approaches to the treatment of mental illness, was nonhierarchical and nonauthoritarian in belief. Four themes, democratization, permissiveness, communalism, and reality, directed the goals of the institution (Perrow, 1965:943). In this approach the community itself was thought to be the doctor, thus all people in it gave and received treatment, regardless of their roles. While the structure of the organization strove to be nonauthoritarian, when social organization broke down, authoritarian leadership took over (Perrow, 1965:944). Also, patients saw their doctors as the ones most central to their care, undermining the attempts at an open and nonauthoritarian system.

Perrow stated that milieu therapy was not a new treatment and that its principles were insufficiently specified to serve as a technology. He further stated that humane treatment does not constitute a treatment approach
(Perrow, 1965:933). This argument is in line with criticisms of the moral treatment movement.

Barbara Frankel’s (1989) study of Eagleville, a drug and alcohol treatment center, described an institution which drew its belief system from therapeutic community and addiction self-help group movements. At Eagleville the goal was to help people addicted to alcohol and/or drugs adopt a sober life style. A sober life style refers to a life free from reliance on alcohol and drugs. Rehabilitation was considered by Frankel (1989:5-9) to be a process of identity transformation in which addicts changed their self-concept and socially designated labels. This process was brought about by group therapy that was highly confrontational. Staff members felt this confrontation was necessary to enable the addicts to strip way their defenses and rationalizations, a necessary first step of the recovery process (Frankel, 1989:9). Like Caudill, Frankel found that a system of dual supervision existed with staff assigned to both disciplinary departments and units. The units were organized into interdisciplinary treatment teams. Typically there were four teams for each unit. However, as in other institutional settings, the informal organization provided a covert and unofficial source of power and influence (Frankel, 1989:27).

In contrast to other settings described so far, Eagleville was an open environment. There were no gates or walls to prevent people from leaving.
Privacy was greater. Residents lived in units which included bedrooms, a living room, and kitchen. Several staff offices were located near the living area. Residents were expected to follow the schedule of the day, which included working to sustain the community, community meetings, and various forms of group therapy. Rules included keeping alcohol and drug free, not sleeping during the day, and staying on the grounds (Frankel, 1989:42-44). Violation of the rules may have resulted in expulsion from Eagleville. “This is a turnabout for those previously confined in prisons or mental hospitals, where punishment takes the form of being kept in rather than being thrown out” (Frankel 1989:45). Thus while open, the rules of Eagleville, like those of other institutional settings, constrained and managed the daily life of its residents.

Emergency Psychiatric Care: Late-Twentieth Century

Finally, Lorna Rhodes (1990) described a nine bed emergency psychiatric unit in her book, Emptying Beds. The book title succinctly describes the goal of the unit which was to stabilize patients so that they could be rapidly discharged from the unit (Rhodes, 1990:38). Unlike psychiatric care prior to the deinstitutionalization movement, patients were shuffled rapidly through the system and returned to the community as soon as possible. Today the career of someone with chronic mental illness is likely to involve multiple hospitalizations in acute units and placements in a variety of community organizations rather than a lifetime admission to a mental
hospital (Rhodes, 1990:38-39). The unit Rhodes studied is an example of this change. Length of stay typically lasted about ten days. Drugs provided the primary technology and were used to reduce disorientation, hallucinations, delusions, and mood disturbances. Once the patients were sufficiently stabilized they were discharged to the most appropriate site, either another inpatient unit or program in the community.

Space was organized to maximize separation between patients and staff. Patients were confined in the unit, which was windowless, stark, and locked from the outside. Patients had separate rooms but these had peepholes and no locks, so that they could be observed at any time (Rhodes, 1990:22-23). Staff referred to the patient area as a “dungeon”, a submarine”, and a “perverse monastery” (Rhodes, 1990:22). Although an activity schedule was posted, Rhodes (1990:17) referred to it as a phantom schedule since the patient’s daily routine revolved around meals, meds, and bedtime. In fact, staff did not want patients to be too comfortable on the unit because that would reduce their motivation to be discharged elsewhere. Rhodes, (1990:24) citing Wilson, commented on the meaning of the patient area,

From the staff point of view, the enclosed and barren space of the back of the unit reflects the poverty and craziness of the patients, revealing them as they truly are. Removed from the everyday world, they are placed in a “holding pattern” that contrasts with the sometimes hectic pace of work in the front of the unit where the staff “engage in activities that resemble the hustle and bustle of a clearing house” (Wilson, 1986:186)
Mental health workers worked in the back of the unit with the patients. They were responsible for supervising the patients. In contrast, professionals spend little time with patients. The focus of their attention was discharge planning. Rhodes (1990:24) reported that mental health workers referred to the professionals as “telephone workers” because of the time they spent on the phone. Patients and the nonprofessionals were relegated to the stark, windowless back area while the professionals worked in the front area comprising the nurses station and screening area. This area carried greater status because it was “correlated with mobility, privacy, and distance from the patients” (Rhodes, 1990:30). Consequently, the spatial arrangements of the unit reproduced its power relations.

**Summary**

Issues of control of the mentally ill permeated this review. The chains of the Great Confinement were released but were replaced with various forms of social and medical control. The understanding of patients in the context of their families and communities remains as important today as it did in Napier’s time. However, the family and community contexts of patients appeared to be neglected by all but Napier. While current pharmacological approaches offer the best hope for management by reducing the most disturbing symptoms of mental illness, they do not provide a full solution to the problem. Significant side effects make compliance a continual issue. Also medications do not mend strained social relationships or help people
reestablish themselves as full participants in society. Technology in the form of medicine may have been one of the catalysts to stimulate change in the cultural beliefs and structures of state hospitals. The existence of units such as the one studied by Rhodes demonstrates the limitations of this change. Simply releasing people from state hospitals has not cured chronic mental illness, rather, as Rhodes demonstrated, it just shifted the care to different types of organizational forms.

The EPU at Hillside Hospital is another link in the chain of institutional approaches to the treatment of mental illness. Because it focuses on the mental health needs of people over 60 years of age, its mission is more specialized. This is the first psychiatric hospital admission for most patients on the unit. These two characteristics of the patient mix are only two of the features which distinguish it from the settings reviewed in this chapter. The next section will describe the organizational and spatial characteristics of the EPU. This review will highlight its distinctiveness from the other institutional settings.

**Acute Geropsychiatry: Late-Twentieth Century:**

**The EPU at Hillside Hospital**

As already stated, the EPU is a 16 bed acute care unit in a community hospital. The unit emphasizes an interdisciplinary approach to manage the multiple psychiatric and medical problems of the patients. Medication, various treatment and family support groups form the technology of the unit.
Patient care on the unit is organized into teams, named teams one, two, and three. The doctor, social worker, and dietitian are on all three teams. Each nurse is assigned to one of the three teams. Presumably, his or her primary patients will also be on this team and most of his or her daily assignments will be drawn from it as well. On a practical basis this does not always occur. The occupational therapists are also assigned to teams. Emily is on teams one and two and Amy is on team three. Team meetings are held Monday, Wednesday, and Friday afternoons from 2:00 to 3:00. A nurse from the team chairs the meeting, which is designed to review the current status of the patient and to project plans for the next week.

The EPU looks like most other units in the hospital. Because it was recently renovated the paint and furniture look new. The colors are soft and calming. The hallways are lined with pictures, mostly soft water colors, which reinforces a calm, quiet mood. The activity level on the unit has an ebb and flow which marks the passage of the day. Generally, the nurses' station is busy when patients are between group therapy sessions, during visiting hours, and at the change of shifts. However, during meals and group sessions when all or most patients are in group it is generally much quieter. The unit doesn't have the stark nakedness described by Rhodes (1990) and is a far cry from my observations of the state hospitals in the mid 60's.

The unit is not locked, although the doors are alarmed so that when someone leaves the area a buzzer at the nurses' station rings. This prevents
“elopements” most often caused by disoriented patients walking farther than they intend. All doors, but the one near Peter’s office which leads to the rest of the hospital, may be locked when a patient who is a “serious elopement risk” is on the unit. This occurred once during the six months I was on the unit. A patient was severely confused and agitated and wanted to go home. The staff had two options: to restrain him or lock the unit. They chose locking the unit. His was the only admission during the six months I observed on the unit which required this action. The alarms were sufficient to assure the safety of most other patients who posed a wandering risk. Patients could request passes to walk on the hospital grounds or go on an outing with family or friends. These passes were routinely given to patients either as part of the treatment goals or to respond to the patient’s wishes.

The unit itself is a long corridor with doors at either end. Figure 2 is a floor plan of the unit. The nurses’ station and elevator entrance is about at the midpoint in this corridor. This entrance opens to a small vestibule and then the nurses station. There are two corridors leading from the nurses’ station. To the left is a short corridor with four patient rooms, a tub and shower room, and two quiet rooms. At the end of the corridor is an emergency exit. The hallway to the right of the nurses’ station leads to the laundry, dining room, sitting room, staff lounge, patient rooms and the offices of Dr. James, Peter Tully, and the occupational therapists. At the end of this hallway is a double door leading to the rest of the hospital. It is this
Figure 2: Floor Plan: Elderly Psychiatric Unit at Hillside Hospital
door which is never locked. The allocation of space, access to this space, and the privacy and freedom it provides or lacks is one reflection of the status of people on the unit (Rhodes, 1990:21-25). The EPU space has varying levels of access from private staff space to space shared by staff, to common space, and semi-private patient space. I will describe the spatial arrangement of the unit from this perspective.

**Private Staff Space**

The most private spaces on the unit were the offices. Dr. James, Marjorie, the unit director, Peter Tully, the social worker, and the occupational therapists had offices. All of the office doors had windows with the exception of the occupational therapy office which apparently was intended to double as an examination room. With the exception of the OT office, anyone passing by could see who was in the office and what they were doing.

Dr. James' office is next to the staff room. It is a bit smaller than a patient's room and is furnished with a wooden desk, credenza, bookshelves and several easy chairs. It is the only office with a wooden rather than metal desk, reflecting the status of the occupant. Family photos and art work decorate the office which is so neat that it looks unused. In fact, Dr. James does not use this space. I saw him in it only once. He works in the chart room and talks to patients in their rooms, the hallway, or the common rooms. Dr. James offered it to me to conduct an interview when he realized
that there was no other space I could use on that day. He apparently extends this courtesy to others.

Marjorie's office is opposite the nurses' station to the right of the door into the unit. It is long and narrow. Her desk is located at the far end of the office so that she is close to the nurses' station but cannot watch the activities directly as she sits at the desk. Windows form the wall between the office and the nurse's station, however, the curtains on the windows remained closed. The window on the door does not have a curtain. In addition to her desk, files, and bookshelves is a small round table. People crowd around this table for staff and team meetings. Marjorie seldom closes her office door and seems to view her office as an extension of staff space rather than her exclusive territory. Staff enter and exit freely and use the table in her office when she is not on the unit. She made it very clear to me that I could use this office whenever I wanted to. If she was away from the unit, I conducted the interviews in this space.

Peter's office is by the other entry to the unit. This office has an orderly calm appearance, but Peter does not spend much time here either. Like Dr. James, he can generally be found on the unit talking to patients, their families, and staff. He also spends a lot of time writing notes in the chart room, leading groups, or attending meetings. He uses his office for some phone calls and meetings with patients and their families. Thus it serves as his private space to carry on some of the more confidential aspects of his job.
Because it is by one of the entrances to the unit, family members may stop to
talk to Peter on their way to visit a patient.

Across the hall from Peter's office is the occupational therapy office and
examination room. This room also has the lockers for staff to keep their
valuables. While the other offices are "front stage" for meetings with
families, this room feels more "backstage." Perhaps it is the mix of the
examination table, desk, and lockers that gives it a more utilitarian tone. The
occupational therapists work on the floor, so this room really is just a place to
keep their things rather than a place to work. Staff use the phone for private
conversations. Patients and staff use the scale which is located by the door.

Although the administrative staff of the unit, Dr. James and Marjorie
have the largest offices and the most prestige, they do not use these offices as
reflections of their power. Dr. James hardly uses his office at all while
Marjorie uses hers as an extension of the staff space of the unit. This attitude
lends a feeling of accessibility to the unit. Staff do not have to enter the
exclusive domain implied by an office to speak to Dr. James. If he is on the
unit people talk to him in the chart room, nurses station or hallway. People
come and go from Marjorie's office and use the table to work when she is
away from her desk. The only time her door is closed is when she is out of
the hospital or if she is meeting with someone and doesn't want to be
disturbed.
Staff Space

Staff space which is closed to patients is the chart room and staff room. The chart room is located adjacent to the nurses' station. It is a small room, labeled "authorized personnel only." This room functions as the central area for communication on the unit and offers greater privacy than the nurses' station. The door to this room remains open except during the nurses' report. Occasionally a patient will come to the doorway to talk to someone, but this is an unusual occurrence. It is in this room that staff read charts and write their notes. A long table and four or five wheeled chairs surrounding it almost completely fill the room. A large board which lists the teams and patients assigned to each team hangs on one wall. Staff notices and the work schedules for unit personnel are posted on bulletin boards. Staff buzz in and out of the room throughout the day to check the boards, read and write in charts and talk with others. The conversation varies from exchanges about patients to informal banter and teasing, the sort of interaction that occurs when staff members are in a less public place. Dr. James uses this space as his unofficial office. If he is on the unit and not with patients he can generally be found in the chart room. It is in this room that much of the informal collaboration occurs between staff members. Because of its proximity to the nurses station it is a convenient place to work, out of some of the activity but close enough to become involved if this is necessary.
The staff lounge has a love seat, easy chair, coffee table, dining table and chairs for four people. A counter with microwave, refrigerator, ice machine, and sink fills one wall. A small bathroom and closet complete the room. Unit personnel use this room for breaks and meals. Other times of the day staff dash in and out for coffee, ice water, or to use the bathroom. Because it is empty most of the time, nurses use it to tape their shift reports.

**Common Space**

Space which is freely used by staff, patients, and visitors is the nurses station, dining room, sitting room, quiet room, and hallway. All of this space with the exception of the sitting room and the quiet room at the end of the hallway, can be observed from the nurses's station.

The nurses' station is divided into staff and non-staff space by a chest high counter which encloses the desk. The ward clerk, Elaine Bailey sits behind this desk most of the day. She greets people entering the unit, answers the phone, and works on the endless paperwork which characterizes health care today. The medicine cart and chart rack are behind the desk in the staff area. Patients, visitors, and staff from the rest of the hospital tend to stay on the public side of the nurses' station and talk to people over the counter. Some staff stand on the public side of the desk to use the counter top to write their notes and observe the corridor at the same time. Because of the design of the nurses' station, seeing to the end of the corridor is difficult.
The dining room is next to the nurses' station. Because this room has large south facing windows it is sunny and bright most of the day. There is a small kitchen unit at one end of the room. At the other end a TV is mounted high on the wall. Tables arranged in a long row dominate the center of the room. Patients eat at these tables. Community meeting, medication teaching group and other groups use this room. On the wall between the windows is a chart that lists the activities for the day. It also has reality orientation information. Safety rules are posted on another wall. Patients often gather here or in the living room between groups. An activity group periodically paints the windows with a seasonal theme, lending a festive air to the room.

A small window at one end of the dining room enables observation from the nurses' station. Staff use this window to monitor the safety of patients. This, the quiet room adjacent to the nurses station, and the hallway are the only areas of surveillance from the nurses' station.

The sitting room is large and sunny. Easy chairs, love seats, rocking chairs, and tables fill the perimeter of the room. A TV and stereo system are mounted in one corner. Games and puzzles are stacked on several of the tables. Group sessions, exercise class, family visits, and quiet unscheduled activities occur in this room. It is quieter and more private than the dining room. The only way that staff can observe people in this room is to be in the room itself or in one of the doorways leading to the room.
The quiet room at the end of the corridor is used as a smoking room for patients and as an area for conversations, testing, or interviewing patients. This room is about the size of a patient room. Because of safety regulations, patients who smoke must be supervised by hospital staff. This room is used as the smoking room because it is relatively isolated from the rest of the unit.

**Patient Space**

Patient space is semi-private in the sense that it is shared patient/staff space. Patient rooms are configured like most hospital rooms with two beds, call bells, a small dresser, privacy curtains, and several chairs. Each room has a bathroom which contains a toilet and sink. The doors to the rooms are open most of the time; occasionally they will be closed when patients are dressing or want additional privacy. When the door is open staff typically rap on the door or call the patient’s name when entering. When the door is closed, staff treat the room as private space, knocking and waiting for a response before entering. It is difficult to observe patients in these rooms without being noticed. This level of observation is consistent with the level of observation common in most hospital settings today.

The second quiet room, a single patient bedroom, is next to the nurses’ station. Staff assign patients who need close supervision to this room, for example, someone who is actively suicidal or medically compromised. A small window allows surveillance of the room from the nurses station. This window has a shade which can be drawn for more privacy. The video camera
that scans the exits from the unit also scans the bed area of this room. This is the only room on the unit which permits such a close level of surveillance.

**Conclusion**

The EPU is a different kind of place. The separation of staff and patient space reflects the power differential between patients and staff. Staff can enter all space in the unit without impunity, while patients are restricted from some spaces. This allocation of space seems to be implicitly sensed by the patients, even those who were confused and disoriented. I was not aware of patients entering the chart room or the staff lounge, although this could have occurred when I was not there. If they did, I do not think staff would have responded in a punitive fashion. However, unlike the unit described by Rhodes (1990) staff and patient areas are equivalent in comfort and decor.

The only windowless room on the unit is the OT office. The most utilitarian spaces are staff, not patient spaces. The two administrators of the unit do not use their offices as reflections of their status and authority. Dr. James almost ignores his office while Marjorie sees hers as an extension of staff space. These attitudes reflect a rather egalitarian approach to the administration of the unit.

In comparison to the psychiatric settings described in this chapter, EPU patients have greater opportunity for privacy and greater freedom of movement. Their bedrooms and the sitting room could only be observed by staff entering the room or standing in the doorways. Hence, this surveillance
would be noticed. Unlike Caudill's (1958:213) observations of the Yale Psychiatric Institute, there were no rules about patients congregating in any areas or leaving the doors open so that staff could observe.

The level of observation and the general atmosphere is more like that of a medical wing in the hospital than the images conjured up from the past. Patients dress for the day and, for the most part, are free from outbursts and other aggressive behavior stereotypically attributed to the mentally ill. Most look like anyone else in their age bracket; not like the images of the insane as represented in art and popular culture (Gilman, 1988). The appearance of the EPU dispels some of the images of mental hospitals from the past, however, this is still a psychiatric setting and patient behavior, which is the marker of progress is still the measure of response to care. Despite the apparent freedom and pleasant atmosphere, patient behavior is observed and interpreted freely. Staff see this as a natural part of their professional role and an important aspect of their daily activities. The classification schemes, observation of behavior, and patient objectification criticized by Foucault (1984:192-203) continues on this unit as a part of the everyday practice of medicine. This daily enactment of professional power is not as obvious as the past because its punitive aspects have been replaced with a sense of benevolent responsibility. But it is clear that it is the staff who hold the power, not the patients.

I have reviewed institutional care from the 17th century to the present. The EPU represents another site for managing people with mental illness. As
such it carries forward the practices of health care which include close observation and objectification of patient problems. However, the pleasant appearance of the unit and relative freedom of the patients represent a distinctive break with many psychiatric settings of the past. The spatial arrangements and practices on the unit are aspects of the belief system of unit personnel. The next chapter will address this belief system, also known as the mission of the unit.
CHAPTER III

THE MISSION OF THE UNIT:

"THE QUALITY OF LIFE IS NOT MEASURED BY AGE."

This chapter examines the mission of the unit. It is the mission which is purported to serve as a guide for the staff as they conduct their work. The chapter begins with a discussion of the influence of culture and belief systems on organizations. I then explore the dual stigmata of insanity and old age, cultural stereotypes to which EPU staff, patients, and their families must attend. Finally I discuss the staff definitions of the mission of the unit. These definitions form the belief system of unit personnel. In an ideal world the mission directs and guides the actions of staff. In the real world, sometimes the actions of staff fall short of the intended mission. When staff fulfill the mission they feel successful, however, discrepancies between their beliefs and actions often cause them much frustration.

Initially I was not aware of the importance of the mission, however, some weeks after I began my research I sat in the chart room with Dr. James, the medical director, and Peter Tully, the social worker. As we read charts, Dr. James and Peter chatted about some patients. A call came for Dr. James. While he was on the phone Peter and I continued reading charts. After a few minutes the tone of Dr. James voice changed, catching my attention. He said, “We have a mission here, we serve a vital regional function.” The term
“mission” caught my attention, I guess because of the emphasis and emotion with which Dr. James spoke (Field Notes #20, Card ID #19817:7/14/93). I decided I should ask him about it when I interviewed him. When I interviewed staff members I asked them for their definition of the mission of the unit. This enabled me to gain an understanding of the beliefs of unit personnel and explore the relationship between the beliefs they hold and their day to day actions on the unit.

Cultural Beliefs

The culture of a particular group structures its belief systems. These belief systems emerge as a way of creating order and certainty where it does not exist (Trice and Beyer, 1993:1-2). “Culture, as it relates to the ordering of life in mundane situations, is both particularizing and universalizing. It mediates the relations of individuals both to their material terms of existence and to each other” (Kapferer, 1986:189, emphasis in the original). The culture and belief system of a group changes over time: it is constantly negotiated in response to changes within the group and to pressures from outside forces (Schwartzman, 1989:185). Belief systems, also known as ideologies, are defined as,

*shared, relatively coherently interrelated sets of emotionally charged beliefs, values, and norms that bind some people together and help them to make sense of their worlds* (Trice and Beyer, 1993:33, emphasis in the original).

These belief systems are more “self-conscious” when they are being generated (Trice and Beyer, 1993:38). Even though they may not be scientifically
verified, the symbolic character of ideological beliefs serves to justify action. (Frankel, 1989:11). An ideology is “the more or less systematic set of beliefs, propositions, and prescriptions serving both to orient and justify action toward an explicit goal” (Frankel, 1989:162). Cultural meanings, because of their longstanding nature, are often implicit. Consequently, they must be made explicit in order to be challenged and changed (Gilman, 1988:3-8).

Popular beliefs are often expressed in negative stereotypes. In regard to mental illness MacDonald (1981:113) has asserted,

Ever since antiquity, insanity has been defined by experts but discovered by laymen. Popular beliefs were significant in determining who was to be considered insane and why. All records are conjunctions of official and lay thought.

Being old and mentally ill places an individual in the center of two of these negative stereotypes. The fearful image from colonial America of the witch as an aged, isolated, and evil old woman survives as one of the many negative symbols of being old (Demos, 1982). Images of violent insanity portrayed by artists reinforce the fear of mental illness (Gilman, 1988). Despite social change, these negative stereotypes continue to shape our perceptions, understanding, and response to older people who experience depression, dementia, and other forms of mental illness. Unfortunately, the old and mentally ill internalize these stereotypes as a form of negative self evaluation. The EPU staff constantly deal with these negative images as they work with patients, their families, other health care providers, and referral agencies. Their work requires that they keep in the foreground the dual
biases against old age and mental illness as they negotiate and challenge these cultural meanings.

**The P Word**

Peter uses the term “the P word” to describe the negative attitudes toward psychiatric illness. This fear and stereotyping of the mentally ill is deeply embedded in our culture. People today, as in the past, are labeled mentally ill because they fail to conform to certain social standards (Mechanic, 1989a:4). During the Confinement in 17th century Europe the poor and insane were housed with criminals. Insanity was equated with animality. The object of the Confinement was to separate those who were thought to be a danger to society in order to secure society from their threats to reason (Foucault, 1961/1965:38-85). Moral therapy brought more enlightened treatment but the insane were still confined in asylums and separated from the community (Perrow, 1965:916-920). This separation continued with the opening of large state hospitals after the Civil War (1861-1865) until the deinstitutionalization movement of the 1960s. Despite changes in our approaches to the mentally ill, the fear and stereotyping continues to isolate the mentally ill from full acceptance in society. Consequently, the chronically mentally ill experience difficulty gaining a positive identity in a society that continues to fear their behavior and reject their humanity (Estroff, 1981:240-248).
My first visit to the hospital last spring that I referred to in the first chapter continued to trouble me as I conducted this study. Why couldn't the volunteer direct me to the EPU? Didn't he know where it was? The hospital is not that large and confusing. Also, why wasn't it more clearly marked on the elevator? In the elevator the only sign the EPU existed was the floor number combined with the words "restricted area" beside it. When the name of the unit is not clearly displayed, the hospital is sending a message that there is something shameful about psychiatric care and mental illness.

Administrative indifference to the unit could be seen as an example of the negative beliefs held by the administration of the hospital itself. Peter commented on this in regard to tensions between the unit and administration.

There is a core group of people on the medical side who don't really believe in this kind of thing at all...For four years we didn't have a visitor up here, but once, from the administration. And I am talking about the key players, so it made me believe that they didn't even know what was going on up here (Field Notes #49, Card ID #40260:9/7/93).

Dr. James also expressed frustration with the administrative indifference. He explained that when they were interviewing a new physician for the unit, the administrator in charge of this process couldn't find the unit to bring the doctor up to see it. He said it was very telling that someone in the administration of the hospital didn't know how to find one of the units in the hospital. Dr. James feels the recent interest in the unit by a new administrator can be explained by the fact that the unit has the highest
occupancy rate in the hospital. It is making rather than losing money (Field Notes #29, Card ID #28813:2/23/92). Thus, from Dr. James perspective, interest in the unit is not based on a commitment to geropsychiatry but to generating income for the hospital. If the unit had not been profitable, administration would have continued to ignore it.

The administrative indifference was reinforced by the negative attitude of other hospital staff to the unit. Susan Smith, a nurse on the unit, experienced this negative response when she transferred from another unit of the hospital to the EPU. She requested this transfer because her aunt had been a patient on the unit and the treatment she received produced "a wonderful recovery" (Field Notes #66, Card ID #49516:10/12/93). Susan's experience with her aunt's admission convinced her that the EPU would be a good place to work. She called Marjorie and told her, "Whenever there is an opening, I would love to come" (Field Notes #63, Card ID #49516:10/12/93). This transfer sparked strong reactions from the doctors with whom she worked, demonstrating the isolation of the EPU from the rest of the hospital. Susan explained, "The first reaction I got from the medical staff when I was coming here, 'you're going to work with the coo coos'?...Oh, absolutely, from doctors and surgeons. They just couldn't understand my doing that" (Field Notes #63, Card ID #49288:10/12/93).

Not only were staff questioned about their desire to work on the unit, they directly experienced negative stereotyping of the mentally ill as they
planned to discharge patients. In one instance this summer a social worker
from another agency called Peter about a referral to a third agency to explain
that the patient would have a hard time getting admitted to the program with
a primary diagnosis of depression. Together they decided to reverse the order
of the patient’s diagnoses so that the secondary diagnosis of chronic pain
would be listed as primary. When he got off the phone he asked Dr. James if
he minded having the order of the diagnoses switched. Dr. James said he
didn’t mind, “that’s the game they ask you to play” (Field Notes #25, Card ID
#61802:7/21/93). In order to get patients admitted to certain programs, Dr.
James recognized that games had to be played. His frustration with this
situation showed in a team meeting when the team discussed another
program that doesn’t like to accept patients discharged from the unit. Dr.
James in referring to this program said, “It’s (the psychiatric diagnosis) sewed
into the back of the collar...It says ‘psych’ and they (the receiving agency) go
‘crock’” (Field Notes #22, Card ID #50604:7/16/93).

Although this stereotyping continues, the community education of the
staff has resulted in more agencies being willing to accept patients discharged
from the unit. To help this situation, Dr. James initiated the development of
a day program that focuses on psychiatric and physical rehabilitation. This
program is designed specifically to deal with older people who are
experiencing problems of both a psychiatric and physical nature. Unlike some
other programs in the area, staff at this rehabilitation program welcome patients discharged from the unit.

Beyond dealing with outside agencies "spooked" by receiving people with a psychiatric diagnosis unit, staff must deal with patients and their families who carry the same fear of mental illness. At one team meeting Peter asked Cynthia Clark, one of the nurses, what she thought of the son of one of the patients. She responded, "I think he's very uncomfortable here…I don't know if he thought people were going to jump out at him and, you know, wrestle him to the ground" (Field Notes #14, Card ID #28047:7/9/93). The son's discomfort was minor in comparison to Catherine's attitude. Catherine was a recent widow who was experiencing what could be described as "a complicated grief reaction." Her family physician told her that he was admitting her for "tests" but did not discuss with her that the admission was to a psychiatric unit. When she discovered that she was on the EPU she was horrified, she said that she felt like she was "Shanghaied." Despite the efforts of staff and patients, Catherine was unable to accept psychiatric help and discharged herself after two days. At the team meeting held the day she left, the team spent a few minutes talking about her. Rebecca Douglass, one of the nurses, reported saying to Catherine,

Listen, maybe he didn't tell you right away because he figured you would not come. Let's be honest, you have this stigma on the brain, saying, "It's a psych unit. I'm not coming." You don't know what could be done for you while you're here. When depression begins to interfere with your daily life you know that something is wrong and you can't function on your own.
There's problems, you need to be here. And she thought about that but then she ruminated and went back right to the same thing, "He didn't tell me. Wait till I see him" (Field Notes #40, Card ID #35263:8/4/93).

Peter responded by saying, "Ok, you run into this once in a while, you know. that's the P word" (Field Notes #40, Card ID #35263:8/4/93).

The "P word" influences many aspects of the daily life of unit personnel. It is an attitude which crops up in interactions with hospital employees, patients, family members, and referral agencies. These interactions reinforce their belief that psychiatric illness is stigmatized by a broad segment of society. Even some patients like Catherine are so fearful that they are unable to accept the help and support the unit offers.

Consequently, one aspect of the mission of the unit is educational in orientation and is directed at combatting the negative stereotypes associated with mental illness.

**Ageism**

The stigma of mental illness is compounded by negative stereotypes about the elderly. These negative stereotypes lead to under treatment of depression in the elderly and diminished expectations by the patient and family members, and health care providers. This is a direct result of ageism. Ageism is

a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender...Ageism allows the
younger generations to see old people as different from themselves; thus they subtly cease to identify with their elders as human beings (Butler, 1975:12).

Like other negative stereotypes, ageism enables people to view others via beliefs they hold rather than via direct and unbiased observations. Ageism brings with it negative interpretations of behavior and carries with it an extra burden for old people. These beliefs may alter actions so that older people, their families, and their physicians may misattribute a treatable health problem to "aging" and may not take steps to see if the problem can be corrected or managed in any way (Rodin and Langer, 1980). Peter cited a Johns Hopkins study which reported that one third of patients admitted to nursing homes were suffering from depression. He saw the unit as intervening in this process by treating the depression so that patients could return home (Field Notes #49, Card ID #42803:9/7/93).

Ageism, like the stereotyping of the mentally ill, occurs in staff, family, and the patients themselves. Even people who work on the adult psychiatric unit are not immune to ageism, even though they should be sensitized from their work with the chronically mentally ill to the negative aspects of stereotyping. As Peter explained,

It can almost be a desensitizing kind of experience. I know in terms of elders, we have needed to use the 10th floor, before we had locks on the doors and could secure the doors. We had people who were too great a risk, they were suicidal, we couldn't provide the safety. And a real negative transference about elders who require quite a lot of hands on care. In fact, when we had to make one of the transfers, I was talking to one of the charge nurses, her term was, "are they a shitter?"...Yea, that's how she
had organized it in her mind. What are we receiving here, are we receiving someone who can organize themselves to get to the toilet or will they do it in their pants. And that was really what mattered to her. So I just said to myself, how desensitizing, how dehumanizing an environment (Field Notes #49, Card ID #42803:7/9/93).

Sally Eisley, one of the nurses, said, “I think a lot of the elders are kind of left by the wayside, like once you’re 70 and older, it’s like well, what’s there for you to do?” (Field Notes #65, Card ID #2275:10/25/93)

One way staff combat ageism is by not discussing the age of patients. This policy was established when the unit opened and is firmly enmeshed in unit practices. The staff of the unit never mentioned the patient’s age in team meetings except for Harriet. Harriet’s primary complaint was that she had been fine when she was 89 but when she “turned 90 everything went wrong.” Because Harriet presented her age as a problem, it became a legitimate reason for staff discussion. The physiological aspects of age are not ignored. Dr. James starts patients on geriatric titrations of medications and the dietitian reviews lab results with an eye for adjusting the findings based on the expected norms for older people. Consequently age is taken into consideration for some things. However, it is a marker of minor rather than major importance. Patients are not characterized by their ages. I never heard “She is in good shape for her age” or other similar statements during my observations on the unit. This I found unusual because age is often a criteria for health professionals to estimate what to expect of a patient.
A tradition in medical presentations and reports is to begin with the sex, age, and diagnosis or presenting symptoms of the patient. This breach in medical tradition seemed jarring at first. How was I to know about a patient without knowing the patient's age? Yet, as my fieldwork progressed I found that this lack of information was not so important. It freed me to look at the patient's behavior as behavior, without concern about the patient's age in relation to the behavior. In terms of treatment goals and discharge planning the focus is on the patient's needs and functional level, not age. Age is moved to the background rather than being placed in its expected position in the foreground.

This is unsettling for doctors and other health personnel who consult occasionally on the unit. At one staff meeting Marjorie mentioned that when one of the medical doctors comes on the floor he likes to know the age of the patients. She said, "I tell him we never talk about the age of the patients."

This prompted the following interchange,

Marjorie I said, "I don't know, I don't know."

Dr. James Its within two standard deviations of either one [people start to laugh].

Amy Its between 60 and 90 [everyone laughing] (Field Notes #14, Card ID #16256:7/9/93).

This doctor clearly felt that the age of the patient was an important piece of information to guide his care. The information is in the chart, so it is
available, but it is not part of the medical record to which staff attend. As the above dialogue indicates, staff view his attitude with humorous disdain.

I found myself in a similar position as the doctor. One day in the chart room Dr. James and another physician were discussing a retired physician who had been having mini-strokes which had resulted in a multi-infarct dementia. Dr. James said that the doctor caring for this man had documented the picture but had not treated the cause of the problem. He said that if he were the family he would sue the doctor for malpractice. The retired physician was someone I had worked with years before. I remembered him as a caring, concerned, and gentle physician. Dr. James said that he still was the same caring person that he had always been. He said that the doctor was demented but that there were levels of dementia. He explained that there was no excuse for leaving the multi-infarct dementia untreated because sustaining any level of remaining cognitive function was really important. Dr. James explained that the doctor and his family wanted him to stay home as long as possible. I observed that the doctor must be pretty old. The conversation stopped dead. Dr. James responded, more sharply than usual, that the quality of life was still very important regardless of age. He never mentioned the age of this physician and shifted the conversation to a rather humorous discussion of the persistence of personality and how we need to clean up our personalities before we “go organic” because that is when our “true colors” show (Field Notes #32, Card ID #3046:7/28/93).
Rather than stereotyping the patients as an amorphous group of old people who have the same needs and desires, staff saw them as individuals.

Cara Ward, a nurse in explaining why she liked to work with the elderly said,

"I cried yesterday because Bob was hugging his wife and I said, "Oh, wow." All the intimacy that they shared as they hugged one another, it just brings it into focus that these are people with valid lives, that had children, that had jobs, that supported our communities. You know, it just got me all, you know. And that's how I look at all of them, so I, they all have wonderful personalities, they are great, they are funny" (Field Notes #59, Card ID #446496:9/28/93).

This construction of patients as people who lived full and rewarding lives was further elaborated by Lisa Abbott, a nurse, when we were talking about quality of life and what that meant in relationship to the mission of the unit.

Lisa said,

"Well, I really feel that if someone is 65 it doesn't mean, that it is a time to sit back and do nothing. I think that there are, that many people can continue enjoying these years. I think that most of us have looked forward to, oh, when we retire we'll be able to do, you know, whatever we've always wanted to do and I believe that this can happen. Sometimes it doesn't, again because sometimes we don't realize that people have these needs that aren't recognized and that they can be helped and they can find satisfaction and meaning in their life" (Field Notes #70, Card ID #10934:11/15/93).

Although staff tried to disregard the patient's age, as Lisa explained the negative attitudes toward old people led to lack of treatment. It was not unusual for depressed patients to misattribute their lack of energy and motivation to age rather than depression. June, a patient admitted for
depression is a good example. In a team meeting discussing June’s progress
Emily, an occupational therapist reported the following:

Its like typical of her. It’s really driving her crazy that she can’t, she can’t take up working, like in housekeeping, like she used to. That sense of doing and what not. She does everything, but she say it’s, you know, it’s more of a chore. It’s more labor to do it than typically when she would go and do it. I mean, she’s like today, “You know I’m worried I won’t be able to damp mop my floor like I used to and loving it. I just hope it’s not my age and you can get my energy back.” And you know, its like, everybody gets tired once in a while too, who wants to keep damp mopping? And she goes, “After 80 years, I still love it. I used to love it.” You know (Field Notes #19, Card ID #42949:7/14/93).

While doctors, patients, and their families saw age as an important factor to consider, the staff of the EPU chose to ignore age as a factor in making decisions about patients. This decision was a conscious one, initiated by Dr. James as a mechanism to reduce attention to age as a criteria for treatment. Staff actively supported this practice and seemed somewhat perplexed when other saw this as strange. This practice marks the unit as distinctive from other medical settings where age is treated as an important patient identifier. This frees unit personnel to focus on the functional capacity of patients and to make treatment recommendations based on their medical and psychiatric status rather than stereotypical beliefs about what should be expected of people of a particular age. Their awareness of the consequences of the dual stigmata of age and mental illness contributed to the mission of the unit.
The Mission of the Unit

The mission of the unit provides a statement of beliefs structure that guide the expectations and actions of unit staff. The mission of the EPU is explicit. In fact it is highly self-conscious. Dr. James has a somewhat messianic view of the unit, that of combatting the dual stigmata of aging and mental illness. Marjorie asks people to discuss the mission of the unit to achieve an understanding of the commitment of staff to the unit and to develop a sense of shared beliefs. So the question of the mission of the unit is one which comes up often. As the previous sections of this chapter demonstrate, the staff is acutely aware of the dual stigmata of age and mental illness. They constantly negotiate the meaning of these stigmata as a normal part of their daily work. The mission serves as an anchor point for this understanding.

According to unit personnel the mission of the unit is to improve the quality of life for people over 60 that has been diminished by physical and mental illness. This is achieved through evaluation and treatment so that patients may regain meaning in their lives and independent function. Quality of life means being able to resume former roles, being engaged in things, not being left out, being safe, making decisions for themselves, and fulfilling their wants and desires. An awareness that the patients are very old creeps into this discussion as the staff speak of the importance that patients having a quality of life for the time that is remaining to them. Staff realize
that some patients may not be able to return to independent living.

However, this remains the goal for everyone since the actual potential of most patients is unknown. Amy, an occupational therapist, focused on restoring quality of life and autonomy as the mission of the unit. When I asked her to clarify what she meant by quality of life she said,

Amy
Keeping in mind the things they want, the things they desire, they are happy. That seems so basic, but that they are happy. I often think a lot of times that Dr. James says that even if someone has dementia, we can’t reverse that, but at least we can make them happily demented rather than sadly demented. So even that is an improvement in the quality of life. Um, so I think of happiness. I think of taking into account their desires, their wants, safety, making them as safe as possible so that they can enjoy their life. So that they are not always worried about being OK. That’s the quality of life. Yea, do what they want, when they want. That they’re happy...There are some things, like you know, with dementia, definitely help the families with their quality of life. What will help reduce their stress, the worries for them. What would make things easier for them.

EBC
So the patient isn’t the only concern then?...

Amy
...Definitely, the care givers, definitely. It’s trying to figure out what would help. I guess one question I try to ask them when they are here is, ”You are going to be here for two or three weeks. Your insurance is spending money for you to be here. What do you want to get out of this place? What do you hope will be different when you leave? What can we fix or alter? What can we do for both family and patient?” (Field Notes #54, Card ID #62801.9/21/94)
The themes of hopefulness and change combined with a sense that patients establish goals for themselves permeated Amy’s interpretation of the mission of the unit.

Dr. James said that the mission of the unit is the philosophical framework that guides their activities. This is not a financial mission rather a “higher mission, a greater vision which provides not just a service but a philosophy.” He explained that the essence of this is the belief that “the quality of life is not measured by age” and that older people are valued members of the community. He drew a parallel by explaining that it makes as much sense to devalue older people as it does to say that a housewife doesn’t work. Dr. James feels that the greater mission is to reframe aging, to combat ageism and that this unit is one component of this process. He said that the administration of the hospital views the unit as an island. Dr. James’ view of the unit is not constrained by the hospital walls, consequently the unit must bring like minded people together to serve patients who need their care (Field Notes #29, Card ID #28813:7/23/93). During another discussion later in the summer he said that the unit was like the sun that sent rays out to the community in ever widening circles so that more and more people could receive competent care.

This very broad view of the unit was not shared as explicitly by other personnel who tended to interpret the mission from a more particularistic perspective. Like Amy’s statement above, staff generally thought of the
mission in relationship to making differences in patient's lives rather than in
the broader system of health care. Most staff emphasized the importance of
quality of life and independence. Nursing personnel tended to emphasize
the medical aspects of care to a greater degree than the occupational therapists
who saw choice and autonomy as very important. Peter Tully, the social
worker mentioned family systems a bit more forcefully. However these
differences between disciplines were minor and reflected the professional
orientations of the speakers more than major philosophical differences.
Someone reading the mission statements of all staff would have a difficult
time knowing the discipline of the speaker.

Emily Smith, one of the occupational therapists, was quite eloquent in
describing the mission. She said,

Emily: The mission of the unit is to provide quality care.
That is my mission. Every patient who walks
through the door deserves that. A patient, for
whatever reason, psychiatric in combination with
medical problems, to get them back to functioning
better. When people come in they are just not
functioning as they ought to, for a variety of
reasons. It's maintaining dignity for them, and
helping them, in a hard time to get back and to
normalize their lives for better function. That is
everybody's role here. I think with the dignity
because a lot of it with aging comes up, issues for
themselves, the whole being treated differently as
they get older. And that is certainly one of the
biggest things that I feel. I also feel like, for this age,
and something that has been vital for me, is really
empowering them and helping them with
assertiveness. Because I think it is a different kind
of generation and they have to learn the
assertiveness and it is not too late to learn
anything. Like when they come to the hospital, to be assertive with their doctor, their nurse, with me, for themselves. And that comes through in every group, that really standing up for themselves.

EBC: So that's an overall philosophy of the unit?

Emily: Yea, yea

EBC: Does that surprise you?

Emily: It was all new for me. I wasn't sure what it would be like. What really surprised me about this unit and about this population is that how it is like every population really. One part of me was thinking it would be so different, but the issues are the same. The issue of loss, of love, of wanting to be independent and the struggles with that, the issues of sadness and difficulty with stress. All of those things, it amazes me that no matter what stage we are in the life course that we are doing the same kind of things (Field Notes #47, Card ID #377958/31/93).

Emily elaborated further on the strengths of this population which she saw as needing help to get over a crisis, and that seeking the help is a positive action that enables people to be open and ready for change. From her perspective, the unit served a function for people in crisis, people who were experiencing multiple losses, sadness, and stress – issues that we all have to deal with. In other words, the patients on the unit were not that different from everyone else, they just needed help to get over a crisis. No sense of stigmatization emerged from her discussion of the patients and their problems.

Cara Ward, a nurse, was considerably briefer, but the central themes of the mission were present. She said that the mission of the unit was
to return the elderly population back to the community as a whole individual and functioning to the best of their capabilities. To give them some dignity back in their life, pleasures in the years that they have left (Field Notes #57, Card ID #76031:9/27/93).

Rebecca Douglass emphasized that people are living longer and should live at the highest level of independence they can achieve. She elaborated on this further by saying,

Depression wasn’t even looked at as an illness in the past. They’re just old, what do you expect to do, help them to live to 90 or 100? And I just think that if they are going to live to 90 or 100, shouldn’t that be depression free and possibly helping them to their optimum level of health? To go back to being the mother, or the grandfather, or the sister, or the brother, or the person that can function in the community (Field Notes #62, Card ID #91801:10/4/93).

These statements are remarkable in their idealistic tone and hopefulness and in the absence of medical and psychiatric constructions of patients and their problems. Most staff see patients and their families as open to change and that their time on the unit is a time to educate both patients and family members so that they can cope better with the problems they are facing. Staff recognize that many patient problems will not go away, even with considerable medication and treatment. They are situations which must be monitored well into the future. However, staff are very optimistic that they can make a difference with patients.

**Failure of the Mission**

Not all patients are success stories. Some stay longer than the expected 20 days, others do not improve as much as the staff had hoped. Staff, in most
cases, do not engage in “blaming the patient” rather they turn their frustration inward to the failure of the staff on the unit to organize care so that a change could occur.

Dr. James was one of the objects of this frustration because he only worked on the unit Monday, Wednesday, and Friday so medications could not be adjusted on a daily basis. Nurses felt that the treatment of patients was slowed considerably by his absence. When the unit first opened he was available daily, consequently, the reduced schedule was a source of frustration to everyone. That the hospital had been dragging its feet hiring another geropsychiatrist only fueled the frustration. This frustration, however, was tempered with the understanding that he had a large practice, was very busy and was dedicated to his patients and the unit. People often commented about his long hours and the fact that he had taken few vacations since the unit opened almost five years before.

There were some divisions between staff members who felt that others on the staff might not have fully internalized the mission of the unit into their actions. Dr. James referred to some staff members who had what he called a “shift mentality” and did not feel responsible beyond the eight hours that they worked. Marjorie said that she had to do “team building” with a small number of staff members whose performance fell short of the expectations for staff.
Several staff members expressed concerns about a few others who they felt demeaned patients and did not support their autonomy in the small interactions which occur constantly throughout the day. One staff member when talking about empowerment said,

It is not empowering to say to a patient who just came out of a group, “You don’t have to got to the bathroom, I just took you 10 minutes ago.” Sorry, you don’t say that to someone. It’s disrespectful of how they feel. “Oh, you have to go again, lets try, or whatever.” (Field Notes #54: Card ID #43729:9/21/93).

When I asked her if this unit was different than other places she worked, she said that despite her frustrations this unit was more cohesive and team oriented than other places she had worked. I felt that the frustration of the staff was, in part, a result of their high expectations for themselves. When patients did not improve, they felt that they had failed the patient because they had not done enough to foster change.

There were several exceptions to this pattern of self-blame, most notably Sophie, a patient who had been repeatedly admitted to the unit and who refused to participate in groups and had to be threatened with discharge if she refused her medication. One staff member said about Sophie

She’s hard because I like her, but yet, she’s tough. I think it’s because she is one of those repeaters, who you never see get well, who makes the caregiver feel totally incompetent. She stirs up all these feelings in us, and sometimes I think she deliberately wants to, which makes me even madder...I feel that we have never met a goal, in how many years she has been here, so she is really frustrating. Are they our goals or are they her goals? I think that about her goals, I don’t think she really has any. Yea, you know, what a pitiful life. You know here is a woman with all these capacities, intellect, she could look really well. I don’t
know, I just have this feeling, I remember saying that to her a lot. “You have so much potential and you won’t even use it.”

And when I see her name on the board (indicating an admission) I’d be, Oh shit (laughs). I have really mixed feeling for her. I feel sad for her, I feel angry at her at times and I really feel like, you know, you want to be the one who does something that changes her life. You want to be the healer...I did it, after all these years, I figured it out? (both laugh). She is one of those people I truly feel like is empty inside and nobody will ever fill it...She is just truly empty. I can’t change her past. I can’t change the fact that her husband committed suicide. I can’t change the fact that she had a shitty relationship with her mother. We can’t change those things and yet she’s yet, she’s just, a lot of those things are the root of all of this, you know (Field Notes #54, Card ID #43729: 9/21/93).

Those patients who stay for extended periods of time challenge the staff and their conception of the unit as a short term evaluation and treatment unit. The unit is intended to be an acute unit, twenty days is the expected length of stay. Some patients exceeded this goal. During the summer the length of stay ranged from three to fifty-two days. Some question whether all patients admitted meet the admission criteria. In the fall, one patient in particular had been in the hospital for more than 80 days. The staff were particularly frustrated with her care because complications obtaining properly signed guardianship papers delayed her treatment for several weeks.

Meanwhile, she stopped eating and became very withdrawn. The concern, worry, and sense of powerlessness of Charlotte Harris, her primary nurse, was overwhelming. Another nurse said that this patient never should have been admitted without guardianship papers. These examples are few in relation to the many successful outcomes of the unit. Nevertheless, they challenge the
belief that through the combined efforts of the staff, patients will improve and be discharged to live with greater independence, quality, and meaning.

Conclusion

While cases like the ones listed above are frustrating to staff, if this unit did not accept these patients who would care for them? According to Peter, only about 20% of the patients on the unit had previous psychiatric hospitalizations. This means that the population of discharged state hospital patients, the chronically mentally ill, were not served by this unit. Marjorie raised this question to me once during the summer as she mused about where these patients were and what kind of inpatient psychiatric care were they receiving during their old age. She asked rhetorically, "Don't we have a responsibility to care for them as well?" No one else seemed to question this admission pattern. In fact, I suspect that some staff might argue that the chronically mentally ill were not appropriate admissions because this was an acute unit.

The successful outcomes outnumbered the failures and were sufficiently dramatic to reinforce the belief system and the commitment of the staff to the unit's mission. Roberta was discharged looking forward to mopping her floor. Harriet was not sent to a nursing home as she and her family expected. Would these women have gone to a nursing home if the unit had not existed? I am sure many unit personnel would argue that their efforts helped these women regain their independence and autonomy. It is
this feeling of efficacy which makes unit staff feel that their work can make a difference in people's lives.

The mission of the unit is to enable people to return to living the kind of lives they want to live, to be independent and autonomous. In discussing this process the issue of empowerment emerged as an important theme. The next chapter will address this theme in its relationship to the medical model and the conflict between these two competing philosophical positions.
CHAPTER IV

EMPOWERING THE PATIENT:

"JUST BECAUSE THEY'RE OLDER DOESN'T MEAN THAT THEY CAN'T THINK FOR THEMSELVES"

In the previous chapter I discussed the mission of the unit which is to enhance the quality of life and maximize independent function of patients admitted to the unit. This chapter will address the concept of independence and the process of empowering patients within a setting which operates in the medical model. I will begin by discussing independence, one aspect of the mission of the unit. Independence is linked to the empowerment model because both locate control within patients rather than professional care givers. In the medical model, this control resides with physicians, and to a lesser extent other health care practitioners. I will discuss the medical model and its relationship to the sociology of scientific knowledge and the social construction of medicine. The traditional authority of physicians is balanced by the traditional role of the patient as a passive object to be treated. This objectification of the patient is one aspect of the professional power which resides in the medical model. I will address power in patient practitioner interactions and the issues inherent in redefining professional power. This chapter closes with questions about the use of the empowerment model with
this population. These questions will be discussed more fully in the final chapter.

From the perspective of professional power, patient empowerment could be seen as implying disempowerment of those providing care: it could be considered a zero-sum game. Health professionals might have to relinquish their control over the patient, a control which is firmly established in the medical model. To help patients reclaim their lives staff must do things such as offer patients choices, consult with them about their goals, and include patients in the decision making process.

Because people labeled as mentally ill may have problems making choices which seem reasonable to others, and staff are responsible for their care, the process of empowerment is particularly complex. Although issues of power and authority were emerging from the research, initially, I was not sure whether this was something on which I should focus. The following conversation occurred as I was beginning to think about these issues. It reinforced for me that this was a theme I could not ignore.

As I was completing the data collection for this study I had a conversation with a colleague of twenty years. The conversation occurred after a meeting as we walked to our cars on a cold, November evening. She is an administrator in a psychiatric hospital and had spent the day working on their policy and procedure manual. She asked me about my work and I told her that power and control issues were emerging as an important factor on the unit. I explained that the staff recognized the need for patients to take more control over their care. However, this desire to give patients control ran counter to their primary socialization as care givers. Thus they struggled to give control while at the same time assuring the safety of the patients. I must
admit, I expected a ho hum response. Speaking to people doing doctoral research is a dangerous social activity, fraught with the risk of hearing an endless account of abstract theories and imponderables. However, rather than a socially appropriate exit from the conversation my colleague perked up. She said that she struggles with this issue every day because she knows that as occupational therapists we should be giving patients choices. Unfortunately, the range of choice within an institutional setting is extremely limited, such as the choice of menu in a cooking group. Her tone of voice seemed to indicate that she viewed this as something of a charade, that the choices were small and really inconsequential in the larger picture of the patient's care. Perhaps it was the time of day, the impact of working on paperwork rather than with patients, or a creeping sense of cynicism about her work. I don't know, but the "window dressing" of choice hung between us in the parking lot as we spoke (Memo #27, Card ID #13260:11/22/93).

As this vignette demonstrates, empowering patients is not a straightforward process.

In Chapter II when I reviewed the history of the care of the mentally ill, the power to control lay with the care-givers not the patients. This control included incarceration, physical restraint, and medication. Eagleville (Frankel, 1989:11-14) and the therapeutic community movement (Perrow, 1965:942-945) of which Eagleville was an heir are exceptions to this pattern. The values of therapeutic communities reflected the ideology of democratization, permissiveness, communalism, and reality confrontation (Perrow, 1965:942). Included in this ideology was the importance of a nonhierarchical organizational structure. These values, however, were challenged by the need to assert authority over patients in order to meet the therapeutic goals of the community. The tension between these conflicting
values was a continual aspect of the environment at Eagleville and contributed to the evolution of its culture. Despite changes in the culture the therapeutic power still resided in the therapists who controlled group therapy sessions, privileges, and discharge decisions (Frankel, 1989:113-116). Perrow (1965:944) reported that patients in the Belmont Unit saw the most senior members of the staff as most important to their care, challenging the explicitly nonhierarchical values of the community. As these examples from Eagleville and the Belmont Unit demonstrate, the power of medicine is a difficult tradition to overcome.

Initially I felt that the issues of power and authority were peripheral to the study. However, they crept into all aspects of the daily life on the unit as experienced by staff and patients. The conversation with my colleague lent support to the idea that this is a central issue in psychiatry. By admitting themselves to the hospital, patients submit themselves to the professional power of the staff. The result of this action is a reduction of their power while they are patients. The professional power of medicine and its institutionalization in hospital bureaucracy means that patients follow doctors orders and institutional rules and routines. This compliance further reduces their sense of autonomy.

On the EPU, as in other health care settings, the choices and decisions made by staff each time they interact with a patient form a critical juncture of the power/authority process. It is in these seemingly small and automatic
interactions that the professional power of staff or the autonomy of patients is reinforced. For example, Cara Ward's actions described below reinforced Lucille's sense of choice about her noon meal. Lucille was just emerging from a catatonic state that was so severe that she had been fed intravenously. She was still not especially responsive but was capable of making choices if given the opportunity.

Cara and some of the other nurses were setting up trays for the patients while the patients gathered in the dining room. Cara noticed that the lunch delivered for Lucille was beef stew and that Lucille was a vegetarian. She muttered that she couldn't remember circling the beef stew that morning. She seemed perplexed but also certain that Lucille wouldn't eat it. When Lucille came into the room she explained what happened and asked Lucille if she wanted the stew. At first, Lucille seemed to want it, then decided not. So Cara said that she would put it next to her tray so that if she decided she wanted it she could get it. A short time later, Cara found a fruit plate that had been delivered for a patient who had been discharged that morning. She took that to Lucille and offered it to her (Field Notes #27, Card ID #27800:7/23/93).

This action, embedded in Cara's attention to other patients in the dining room, demonstrates the importance of such small actions to enhance the decision making opportunities for patients.

In contrast, one nurse told me about a community meeting she observed which she felt was disrespectful and disempowering. We had been talking about the community meeting in the morning and the person who was leading the group.

Nurse: But anyway, this individual walked like a newly appointed general. I swear to God, a newly appointed general. She was shouting, walking back
and forth across the room and reading off the rules about safety. And I thought, this is exactly what these people do not want to hear. They do not want to feel structured, they do not want to feel preached to, they do not want to feel like they are being educated. However, if you ask, “What about safety? Let’s talk about safety. What’s safe around here.” I mean, just a little caring, something different in that, you know. And sure enough, came time for goals, the nurse that sat in to write the goals down, the instructor said, “OK, what’s your goal today?” “Oh, I’m going to try to attend...” And I heard that at least 12 times. It didn’t mean a thing. All they wanted to do was shut her up and they did that (Field Notes #63, Card ID #49516:10/12/93).

These examples, positive and negative reflect two of the many opportunities staff have to influence patients’ sense of competency and control. Cara’s intervention was one which is empowering while the community meeting was not. I believe that small actions incrementally build patient’s beliefs that they can control their lives or they are controlled by others. This belief structure potentially has the capacity to influence their self image and sense of autonomy and hence the outcome of their care. Autonomy and independence, the end goals of the process of empowerment, are central aspects of what is thought to constitute a life of quality. The next section of this chapter will discuss these concepts.

**Autonomy and Independence**

Dr. James’ statement, “the quality of life is not measured by age” reflects a central value of unit personnel. One aspect of the concept of quality of life is independence. Unfortunately old age may be experienced as a series of losses
from physical decline, to the loss of roles, to the loss of friends and loved ones through death. These losses challenge the adaptive capacities of individuals and threaten the achievement of what could be considered “a good old age.” Drawing from the work of Erik Erikson, wisdom emerges from the balancing and integration of forces of despair versus integrity. People who have achieved wisdom are able to maintain their concern for life despite age related physical and mental decline, chronic disease, and approaching death (Erikson, Erikson, and Kivnic, 1986:33-37). It is this ability to handle loss with integrity which contributes to the quality of life. Quality of life is the central concern of unit staff because most problems patients experience cannot be cured. However, with newly developed skills, proper medication, and supportive services patients can regain lives of relative independence and quality.

May Sarton (1984) explored the question of old age and quality of life throughout her journal entitled, *At Seventy*. The following passage comes early in the book as she addressed her feelings about reaching her seventieth year. In reflecting on a presentation she gave about aging she wrote,

In the course of it I said, “This is the best time of my life. I love being old.” At that point a voice from the audience asked loudly, “Why is it good to be old?” I answered spontaneously and a little on the defensive, for I sensed incredulity in the questioner, “Because I am more myself than I have ever been. There is less conflict. I am happier, more balanced, and” (I heard myself say rather aggressively) “more powerful.” I felt it was rather an odd word, “powerful,” but I think it is true. I might
have been more accurate to say "I am better able to use my powers." I am surer of what my life is all about, have less self-doubt to conquer (Sarton, 1984:10).

For Sarton being old is an accomplishment. She is better able to use her powers than earlier in her life and to extend herself in relationship to others.

Perhaps the answer is not detachment as I used to believe but rather to be deeply involved in something, is to be attached. I am attached in a thousand ways and one of them compels me now to leave this airy room high up in the house to go down and get ready for my guests (Sarton, 1984:12).

However, she recognized that old age inevitably may mean disability, illness, and death. But this does not have to diminish the integrity of the individual as the following passage indicates.

Janice came for supper last night. That weekly exchange of our lives has become a precious part of this winter, a kind of anchoring for each of us. In telling her about Exeter I remembered something I had forgotten yesterday, that the mother of someone I stayed with is dying in her own house, beautifully cared for by round-the-clock nurses, unable now to speak (she had Parkinson's). On her bed table is A Reckoning, and from it the nurses read aloud to her. It is what she wants most to hear. I set this moving item beside something Janice told me last night as she related a traumatic day at the Health Center. It seems that for several years the nurses there have been very concerned about an old lady whose son has managed to strip her of her fortune, sometimes locks the house so that the nurse who comes to give her injections and make her comfortable cannot get in. Total neglect. The old lady herself does not criticize her son, and it is illegal for the police to break in so she can have help. Yesterday she was found soaking in her bed, nearly unconscious and clearly near death. The nurse wanted to get an ambulance at once and get her to the hospital, but the son would not allow it. Finally Janice herself got to the woman's doctor, who has not seen her for months, and insisted that he go there himself to see what was what and to give necessary orders. Janice has been through the wringer over this, of course, and looks exhausted. At last it was arranged that two
nurses would go during the night with police escort to do what they could do to ease her death. An appalling story...It's a cold gray day and I feel cold and gray inside (Sarton, 1984:298-299).

Quality of life for Sarton is the ability to use her powers. Being in charge of her life, though complex and demanding, is important to her. The contrast between the two dying women reflects the difference between being able to take action in your own behalf, such as having a favorite book read to you when you can no longer hold a book or speak, and being so disempowered that you allow yourself to be abused by your own son.

The American ideals of independence, self-reliance, and autonomy have created a myth that adulthood is only possible when we are not dependent on others. Interdependence, a sensible response to cope with aging and disability, is inconsistent with this cultural myth (Slater, 1976: Brittan, 1977; Bellah, et al., 1985). Robert Murphy (1990:200) linked this myth of independence to the cultural icon of the cowboy who defended the rights of others.

The characters of Rambo and Shane are part of American values, projections of an uncertain and threatened masculinity, denials of emasculation, assertions of autonomy - all the very opposite of physical weakness and dependence, of disability. The disabled are indisputably the quintessential American anti-heroes...The problems of dependence versus independence, on contingency versus autonomy, are not restricted to American culture - they are a universal aspect of all social relationships. The ability to survive on one's own and to maximize self-determination are essential ingredients of the basic drive to live. We try to shape the social life around us, rather than to become its pawns or victims, and this involves the use of power, however subtle and gentle (Murphy, 1990:201-202).
These words apply to anyone with a disabling condition, physical or mental and reflect the value of autonomy as the essence of a life well lived. That both Sarton and Murphy should refer to the word "power" quite likely reflects the link between a sense of independence and the power to act. This power may be physical power, mental power, or the power of will alone, but power plays its part regardless. Amy, one of the occupational therapists, reflects this emphasis on independence and the power to act when she summarized her concept of the mission, "Yea, do what they want, when they want. That they're happy" (Field Notes #54, Card ID #62801:9/21/94).

Unfortunately, most patients admitted to the unit do not have this sense of independence and autonomy. The belief system of the EPU staff as exemplified in their discussion of the mission of the unit is to return the patients to optimal function. One aspect of optimal function is that patients control their lives and make decisions for themselves. However, the dual stigmata of age and psychiatric hospitalization undermines their sense of autonomy. Additionally, dementia and depression may cloud their judgment and sap their motivation to be independent. This leads to the concept of empowerment.

**Empowerment**

The patients on the unit are enmeshed in a health care system which is organized by the medical model. This model locates the power in the hands of the physicians and other health professionals. Unit staff recognized
that patients needed to learn to regain control over their lives, to paraphrase Sarton (1984:10), so they would be better able to use their powers. Emily presented this perspective when she said,

I also feel like, for this age, and something that has been vital for me, is really empowering them and helping them with assertiveness. Because I think it is a different kind of generation and they have to learn the assertiveness and it is not too late to learn anything. Like when they come to the hospital, to be assertive with their doctor, their nurse, with me, for themselves. And that comes through in every group, that really standing up for themselves (Field Notes #47, Card ID #37795:8/31/93).

Empowerment is an approach to enhance patients’ sense of autonomy. “Empowerment is a process, a mechanism by which people, organizations, and communities gain mastery over their affairs” (Rappaport, 1987:122). This involves helping patients see themselves as capable of effective action rather than being controlled by outside forces. Empowerment may include working with a patient in an alliance to achieve a particular goal or developing the patient’s skills sufficiently so that he or she can achieve these goals without any professional support (Solomon, 1987:88). “The more directly goal attainment can be linked with the client’s own actions, the greater the reduction in his sense of inability to control the environment” (Solomon, 1987:88).

Empowerment, however, is preceded by attending to patient preferences and goals, just as Cara did with Lucille’s lunch. The willingness of staff to intervene when hospital bureaucracy blocks patient preferences or goals is a building block to this process. Elaine Bailey, the unit secretary,
although not responsible for direct care, intervened to enable John to achieve his goal of attending exercise group. This intervention, done without John’s knowledge, prevented him from feeling that his goals were frustrated.

Elaine is at the nurses station. A patient who needs constant monitoring is near the door to the unit, sitting on a gerichair. Elaine has been back and forth several times trying to reassure her and to get her to nap. John has been walking up and down the corridor for a few minutes. He has his jacket on. When he passes, Elaine tells him that the exercise group will be starting in a few minutes. He says that he knows and is waiting for it to start. Elaine continues to watch the patient in the gerichair. The phone rings and Elaine answers it. She confirms that they do not need the hydrogen peroxide that was ordered earlier. From the conversation is sounds like it is in short supply.

Corrine Packer, a nurse, comes into the nurses’s station and announces that John has a CT scan at 1:00. [This is the same time as the exercise group.] Elaine said that he was really looking forward to going to the exercise group. They went back and forth about whether to reschedule the CT scan or not. Corrine leaves to answer a call bell. Elaine calls Radiology and asks if John can be rescheduled to 2:00. She explains that he has an exercise group at 1:00 and that he has been really looking forward to going to it. She says that he has been “chaffing at the rules here” and it would be great if they could reschedule. He is rescheduled to 2:00. Elaine tells John when he walks by and he thanks her (Field Notes #60, Card ID #47187:10/4/93).

This example illustrates the staff members recognition of John’s goal to attend the exercise group and the institutional blocks to this goal which she removes by her actions. Had she not acted, John would have been frustrated even more by his hospitalization, most likely increasing his sense of powerlessness. This first step, that of respecting patient wishes and acting on them when possible, is another example of the small actions that occur every day. These actions either reinforce or undermine the patient’s sense of
control, a belief system challenged by the hospitalization itself. There is a marked discrepancy between the ideology of empowerment, which is thought of in idealized, unlimited, and abstract terms and the day to day reality of the hospital. This reality is reflected in the actions of staff in regard to choice of food and attendance at group activities. The ideology of choice, which is part of empowerment, is linked to the American values of independence and individuation. Limiting choice, a reality within many institutionalized settings, challenges these cultural values of independence, individuality, and autonomy.

Empowerment goes beyond the basic step of respecting and acting on patient’s wishes about seemingly small things such as the lunch menu or attending exercise group. As staff act to empower patients, this means that they must relinquish direct control of patients and the choices they make. Since many patients enter the EPU because they no longer can manage their lives independently, it is not surprising that empowerment is a concern of the staff. However, in empowering patients, staff must understand patients’ perspective as they encourage patients to regain control and autonomy. The complexity of this process is illustrated by the comments of Heather Potter, a nurses aide, about the staff’s attention to patient wishes,

You don’t want the patient to lose out because they might be a quiet person and maybe they weren’t someone who really expressed what they felt all those years, and then, to have their kids tell us, well we think she needs a nursing home.” And maybe she doesn’t really need a nursing home now, you know. I think the patient should have some say in that, their wishes
should be heard, you know. Because they're older doesn't mean that they can't think for themselves. Some of them can't. That's true, the Alzheimer's patients have a very hard time with this. But some of them can, they're just depressed, and we all get depressed (Field Notes #71, Card ID #11407:11/16/93).

Simon (1990:32) asserted that empowerment is a “reflexive activity” which required the individual to be active in seeking autonomy and an organization which responds to this quest in a positive manner. Cara and Elaine's efforts to respond to patient wishes is one aspect of this reflexive process. Heather's caution about quiet patients and their needs only reinforces the importance of the staff's willingness and ability to encourage patients to express their wishes, needs, and goals.

Limits on Empowerment:

Falls - A Threat to Patient Autonomy

The traditions of the medical model and professional authority are deeply entrenched and run counter to the concept of empowerment. Nowhere is this more dramatically seen than in safety issues. Because most EPU patients are frail elderly, falls are a constant concern. The unit kept statistical reports on falls and tracked them carefully to monitor the number of falls, severity of the injury, why they occurred, and how they could be prevented in the future. These reports are indicative of the importance of patient safety on the unit (Field Notes #39, Card ID #33475:8/3/93). The dangers of falls are especially acute because the side effects of many medications include lowered blood pressure and dizziness. The unit follows
a nonrestraint policy predating the new federal mandates. The objective of
the nonrestraint policy is to foster as much mobility as possible to prevent the
deconditioning that occurs when older people are inactive. The unit has
safety rules which include wearing rubber soled shoes, using a call bell, etc.
These are reviewed every day at the community meeting. Unlike the
meeting discussed earlier in this chapter, the ones I observed used this time as
the opportunity for discussion rather than a recitation of the "rules" (Field
Notes #38, Card ID #33475:8/3/93). Because staff feel that patients should not
be restrained, patients are restrained only when no other solution is possible.
While the staff sincerely want patients to be able to move freely, they also
realize that doing so may present a fall risk. Thus, they often are
uncomfortable with either decision they make, because often there is no
clarity about which decision is best.

Bill is one of the more difficult patients on the unit because he is
very unsteady on his feet. He is restless and because of dementia
cannot be trusted to wait for help walking. Susan Smith, one of
the nurses, and Bill walk through the nurses station. As they
walk Susan explains to Bill that he will be having a bath or
shower today and that she will help him get ready for it. Bill
looks perplexed and doesn't seem to understand what Susan is
saying. Susan stops walking and asks Bill to sit down in a chair
in the nurses station. She explains that she needs to do
something for a minute. Bill seems restless. It is clear that he
wants to walk. Susan hesitates, then decides to let Bill walk, but
reminds him to hold on to the guard rails. She turns to another
nurse and says, "He'll just get restless if we keep him sitting."
The nurse looks down the hallway as Bill walks away and nods
her head in agreement (Field Notes #38, Card ID #27238:8/3/93).
This instantaneous judgment to let Bill do what he wants risks a fall, however, Susan justified this decision because of her assessment that Bill will "just get restless" if he sits. For Bill, "getting restless" means becoming agitated. This agitation could escalate into combative behavior that would be difficult to manage. Bill has had such outbursts in the past. By letting Bill walk, Susan balanced the danger of a fall against the negative consequences of increased agitation and combativeness.

Another day, Sandra Lord, the charge nurse, was supervising Bill. This particular day Bill was very unsteady on his feet and needed two people to assist when he walked. This unsteadiness, however, did not dampen Bill's desire to move.

Bill fidgets in a reclining geriatrics chair in front of the elevator. Sandra writing notes in a patient's chart stands on the public side of the nurses station, about six feet from Bill. The geriatrics chair is pushed back into the reclining position and a straight chair is placed under the footrest. This means that Bill's efforts to sit up are fruitless because the straight chair essentially locks the geriatrics chair into a reclining position. Thus while free of a physical restraint, Bill is unable to get up and walk. He is very restless. Sandra who is monitoring him very closely, stops writing, turns and explains that she will take him for a walk as soon as she finishes the next few sentences. Bill continues to be restless. Two nurses passing by reposition him so that he will be more comfortable since his efforts to get out of the chair have him scrunched down. A few minutes later one of the nurses gets him up. She and Sandra walk Bill down the hall. He calms down immediately. After Bill finishes his walk, Sandra returns to her dual tasks of charting and monitoring Bill as he sits in his chair (Field Notes #25, Card ID #19588:7/21/93).

Bill represents one challenge to the concept of empowerment. His ability to make a responsible judgment is clearly impaired. His balance fluctuates daily
yet his restlessness remains high. Thus staff must judge each time he wants
to move how much independent walking is safe, for that particular moment.
His balance is so unpredictable that sometimes he walks freely, other times
with guarding, and still other times with the assistance of two people. Bill
walked, so his goal of movement was fulfilled. However, staff controlled
how he walked, based on their assessment of his balance and when he
walked, based on their other responsibilities. It is hard to know in this case
how much empowerment occurred, if it occurred at all, and to what extent it
is appropriate to think of empowering someone whose memory and
judgment are so diminished.

Falls are more than a legal liability, they can begin a series of a critical
setbacks both psychologically and physically. Many patients never fully
recover from a broken bone or other fall related injury and remain dependent
for the rest of their lives. Thus, decisions staff make reflect a constant
balancing of two conflicting values: encouraging patient autonomy and
control of patients to assure their safety. This constant balancing is reflected
by Heather Potter, a nurses aide. Heather had explained earlier in the
interview that her role was to supervise patients to assure their safety and
comfort and to encourage patient’s independence as much as possible.

EBC Is safety always an issue with you?

Heather Yea, since they can’t afford falls or anything, the
patients themselves, they are older, they aren’t
going to heal that well, and a fall could kill them,
could severely break a bone, could throw them into
such a depression. They might not return to their independence. They might not return home. Safety is a big issue on this floor. Very big and I don’t think the rest of the hospital realizes how very important it is for our patients to really be safe. A lot of the other floors, I know, they just throw these people into bed and forget. They don’t forget about them, I shouldn’t say that. They don’t go in as often as we would because we’re more, what would you say, I mean, we’re more aware of it, or we know that it’s important that they are walking around and that they are safe and trying to get that independence back and that motivation. Yea, I think so.

EBC Patients aren’t Posied very much here, are they? I’m trying to think this summer.

Heather If there isn’t the staff to really make sure he’s safe, or she’s safe, then that’s the best alternative, is to put the Posey on so they are safe. You know, you don’t need the broken bones. You know, we just can’t have it. It’s going to do more harm, besides, just the broken bone, and the depression, and maybe not being able to return home, may not be independent again, it could be just shot right there from one fall. My grandmother fell and it limited her for the rest of her life.

EBC Ummm, I think one, one of the things that I noticed the most, here, is sort of that safety piece is always present with everybody. It’s the effort to keep people up and safe at the same time and how you negotiate that tension between those two because it would be a lot easier if everybody was tied down and they wouldn’t fall.

Heather They’d be real safe then, but they wouldn’t be going anywhere

EBC They wouldn’t be going anywhere.

Heather They aren’t ambulating either, and they aren’t getting reconditioned they aren’t going to get up
and go. I love to see them walk out of here, that would be nice (Field Notes #71, Card ID #11407:11/16/93).

Heather’s reasoning about the Posies reflects this tension. It would be easier to restrain people, but then the goal of the unit to return people to independent function could not be achieved. As Heather said, “I love to see them walk out of here.” Anything less than that is viewed with dissatisfaction because the goals of the unit had not been fully achieved for that patient.

Within the unit itself tension existed about the restraint policy. The hospital restraint policy gave nurses the authority to restrain patients when necessary for the safety of patients and staff. Restraint decisions must be documented in the medical record and patients must be checked on a regular basis. Doctors orders are not required to restrain a patient. Dr. James, however, felt that he should be notified when a patient was restrained (Field Notes #30, Card ID #29327:7/26/93). He strongly opposed restraining patients, so nurses did not like to call him. They felt that this call impinged on their judgment. They felt that he often did not appreciate the need for restraint since he might not be on the unit to observe the behavior directly. One nurse explained her frustration with him by saying that she understood his desire not to restrain patients but that, unfortunately, it was necessary sometimes because patient’s could not be supervised on a one to one basis. The fall down the stairs at the beginning of the summer heightened everyone’s
awareness of this dilemma. Nurses felt great responsibility for patient safety because they often were the ones who decided if a patient should walk and with what type of supervision. As the examples cited above indicate, these decisions were made many times during the day in the midst of other activities.

The dynamics of this process are complicated. The values of society place great power and authority in medicine. Unit staff, as representatives of the medical establishment, have great power over the lives of patients in their care. Complicating this picture is the belief that patients should have autonomy and control; creating conflicts for staff about how far they should assert their authority with their patients, how this authority should be expressed, and in what instances it is important to relinquish control. Medicine derives much of its power from its image as a scientific and objective profession. To create a context for understanding these issues I will review the literature on the authority of medicine and the patient role.

The Sources of Power in Medicine:

The Sociology of Scientific Knowledge and the Social Construction of Medicine

Deeply embedded in our culture is the belief that medical knowledge is based on the foundations of modern science and is effective in altering the course of many diseases (Parsons, 1951:432, Wright and Treacher, 1982:1, Waitzkin 1983:28). Because of this belief in the scientific basis of medical
practice, medicine is perceived to be morally neutral and objective (Zola, 1975:487). Like scientific knowledge, medical knowledge is accorded power because of the technical status and organizational structure of the medical profession (Wright and Treacher, 1982). Because of this status/power, the values embedded in medicine are less likely to be examined because they are cloaked in the aura of science. However, science and medicine are not objective, neutral activities. Rather they are socially constructed. This more critical view of medicine recognizes the interrelationship between the researcher, the scientific community, and the values and beliefs present in society at large (Rittenhouse, 1991; Wright and Treacher, 1982).

The social construction of knowledge is concerned with the processes by which knowledge comes to be socially established as “reality.” The process by which human thought is shaped by the social context from which it arises is an essential focus of this perspective (Berger and Luckmann, 1967). This approach challenges the notion that an objective reality exists and focuses on the construction of reality by individuals as they go about their day-to-day lives. It also recognizes the possibility of multiple realities because each individual experiences the world from his or her own perspective (Schutz, 1960/1967; Berger and Luckmann, 1967).

The sociology of scientific knowledge is derived from this critical tradition. It questions the assumption that science is rational and logical, that scientific statements correspond to reality, and that the empirical evidence
alone decides what statements will be socially accepted (Bloor, 1976). Science is an essentially social activity rather than an objective search to discover order in nature (Aronson, 1984:3). The focus is on the social process by which knowledge is accepted as truth by the community of scholars, not the validity of the knowledge itself. The rationalist tradition, in contrast, is based on the traditional philosophical commitment to epistemological realism according to which truth exists separate from those who study it (Woolgar, 1980).

Bloor (1976) asserted that science is viewed as a sacred activity and that by examining it closely we threaten to expose its profane inner working and the social processes involved in scientific discovery. This challenge to the domain of rational science opens the “sacred” process of scientific discovery to study. Gilbert and Mulkay (1984) refer to this as “Opening Pandora’s Box.” Like opening Pandora’s Box, examining science is a dangerous activity because when we examine it as if it were a normal human activity we threaten to expose the “messiness” of scientific discovery. This exposure will reveal that scientific discovery is not as objective as we have been led to believe, undermining the authority that science holds in modern society. Parallels can be drawn to medical belief systems. By challenging the objectivity of medical practice, the authority of medicine is also challenged.

Empirical evidence in science is ambiguous enough so that choosing the best answer is not always obvious, reinforcing the importance of social pressures in scientific discovery (Fuchs, 1989). Epistemic pressures are really
reified social pressures (Fuchs, 1989:23). Scientific discovery is not solely dependent upon a neutral, objective, and rational process. Instead it is dependent upon the evaluation of knowledge claims within a scientific community so that some emerge as accepted explanations of reality while others are excluded as inadequate (Fuchs, 1989). This process has a social component which the normal view of scientific discovery does not recognize (Fuchs, 1989).

Thus scientific discovery is a sense making activity rather than a rational process of discovering objective reality (Fuchs, 1989). Woolgar (1980:243) explains it this way,

...scientists can be seen as routinely concerned with questions about what exactly is the thing that they have got, whether or not they really have got something, whether or not that thing would make its presence known under different circumstances, as so on.

This statement could readily be applied to many decisions made by staff on the unit, from diagnostic decisions, to discharge recommendations to the small and seemingly inconsequential decision Susan made about whether Bill should walk or not. These decisions are not objective and scientific, rather they are derived from the staff member's social construction of the situation. From a slightly different perspective,

We meet ordinary social actors engaged in everyday conversations, not quasi-philosophers following the rules of the scientific method, we observe competitive owners of intellectual property fighting over credits and priority claims, not polite and disinterested participants in rational discourse committed to the collective search for the truth (Fuchs, 1989:97-98).
Although medical knowledge has the same aura of rationality, sociologists have demonstrated that those social forces that exist in science, exist also in medicine (Wright and Treacher, 1982). One traditional belief of medical knowledge is that it is based on the foundations of modern science and it is effective in altering the course of many diseases (Wright and Treacher, 1982). However, examining the social factors in medicine carries the risk of implying that diseases do not exist.

What is being proposed is not that medicine is unscientific because it is permeated with social forces, but in contrast, that both medicine and science are essentially social enterprises (Wright and Treacher, 1982:7).

When we argue that medical knowledge is a social product not some privileged and asocial penetration of the workings of Nature - we are not implying that it is somehow unreal or spurious; still less that the activities of doctors are bogus or that disease is imaginary. Illnesses really do exist, but as suffering which have no necessary transhistorical, universal shape. The point we are trying to make is of a different order entirely, it is that medicine is a form of social practice which observes, codifies, and understands these suffering, both within its technically organized communities and as part of society at large (Wright and Treacher, 1982:14-15, emphasis in the original).

Comaroff (1982) carried these ideas further when she stated that our social interests are incorporated into our assumptions which then influence what we believe to be implicit knowledge or reality. This reality, however, is not objective knowledge but is socially constructed and is based on our views and assumptions. Lock (1984:122) supports this view by stating, “Medicine by necessity must be social in character and is thus one of the best arenas for
analyzing the dialectic between nature and culture."

The Power of Medicine and Health Care Practitioners

Foucault's concept of biopower related the application of power and knowledge to human life (Rabinow, 1984:17). This was accomplished through the development of scientific categories and the belief that the human body is an object to be manipulated and controlled through the use of a variety of technologies (Rabinow, 1984:17). One outcome of this objectification of the human body is the creation of a passive individual who is subject to the control of others. People are not entirely passive in this process, they submit themselves through a process of subjectification to the external authority figure through which this process occurs (Rabinow, 1984:11). This view of medical practice, in which a physician in authority directs the care of patients through beneficent concern and the application of medical science, is under fire. Zola (1975:503) called for shared decision making between patients and physicians because "patients have so much to teach to their doctors as do students their professors and children their parents." In order to share in this process physicians must give up their authority and enter into the meaning world of their patients (Coles, 1989; Brody, 1987; Kestenbaum, 1982; Paget, 1993; and others). Correspondingly, patients need to assume greater responsibility in the decision making process. This is difficult to achieve because the belief in the authority of medicine is so deeply embedded in our culture.
Values are derived from cultural definitions and those in influential positions control their development (Smith, 1987:19). These values direct and justify behavior (Schwartzman, 1989:21). Those in powerful positions not only produce the values of a culture but act in ways which preserve them (Foucault, 1984:72-74). This dialectical relationship between cultural definitions and power reinforce and stabilize the social positions and values within a group (Frankel, 1989:111). Because those in power develop the values of the culture, they experience this culture as inclusive (Smith, 1987:213). Unfortunately, those who lack power feel that the culture, developed without their participation, excludes them and does not reflect their experience (Guinier, 1994:69, 72; Smith, 1987:19-20). Smith addressed this issue from a feminist standpoint while Guinier spoke as a black woman. This feeling of inclusiveness makes those in powerful positions, even those with good intentions, less sensitive to those who have less power in the system. Toward the end of my research one of the nurses aide’s comments sensitized me to this discrepancy. The belief on the unit is that all staff members are important in the milieu, even the cleaning lady. Dr. James, Peter Tully, and Marjorie mentioned this to me several times. However, this nurses aide does not feel included. She feels she is “just an aide” and doesn’t go into the chart room which she perceives as the domain of the professionals, nor does she share her observations with Dr. James. I am sure he would be surprised to hear this since he views the unit as more egalitarian.
The Patient as an Object

The experience of exclusion applies also to patients in the health care system who exert little power or voice in the development of their cases as presented in the medical records. Health care workers write these records as professional discourses to which the patient’s voice is excluded or filtered through the writer’s interpretation. This exclusion of the patient’s voice is part of the “taken for granted” nature of medicine, obscuring the power discrepancy inherent in this process (Smith, 1990:83-93). Power from this perspective “produces reality, it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production” (Foucault, 1984:205).

The objectification of patients in the team meeting and documentation was questioned by only a few staff members. Although staff firmly assert their belief that patients should be empowered and engage in many actions which give patients choice, few staff recognize that the exclusion of patients from the team meetings contradicted this position. Cara Ward, a nurse, was the only one who directly addressed this contradiction.

Cara We constantly stress that the patient has more rights is responsible for their treatment plan, yet they don’t know what goes on behind these doors. Just what Dr. James tells them is going on and what the plans are.

EBC So the plan gets communicated through Dr. James

Cara Right
Joanne Weston, a nurse, said that patients should come to the team meeting so that they could "be told 'this is what you have to do.'" She explained that by being told what they had to do, patients would be more active in the process of getting well (Field Notes #48, Card ID #39870:9/7/93). Cynthia Clark, another nurse, said that she wished patients could come to team meetings because it would be useful for the patient to hear about his or her progress with all of the team present. She said that this would not be appropriate for some patients because they would not "get it." She explained that she makes an effort to show the care plan to those patients who would benefit from this information (Field Notes #50, Card ID #41453:9/13/93).

While Cynthia's view of the patient's role is still passive, "hearing" has a less authoritarian tone than "being told." These positions are consistent with the sick role articulated by Parsons (1951).

From Parsons' (1975:271) perspective power is translated into the responsibility of the physician to diagnose, treat, and motivate patients to cooperate in this treatment. The power of the physician resides in the formal knowledge of medicine and is expressed in the expert-layman relationship between physician and patient (Freidson, 1975:46). According to Parson's (1975:270-271) patients are not passive recipients of care, they must actively participate in their treatment and treatment regimes. It is clear from his
examples, however, that he feels the shaping of these regimes lies in the hands of the physician. Consequently, their active involvement is really a passive compliance with the treatment regime outlined by the physician rather than a mutually negotiated agreement. This position is similar to those taken by Joanne Weston and Cynthia Clark which places patients in the position of being told or hearing rather than contributing to their care. None of these positions are empowering.

Conn (1993), a physician, demonstrated the difficulty in rethinking the doctor-patient relationship. In this article, written for a lay audience, he articulated two roles for doctors. The first is the “Patient as Partner” (Conn, 1993:25) in which he described several situations in which he enters into a partnership with the patient to decide which course of treatment is the best to pursue. The choices outlined are alternative but relatively equivalent ways of treating arthritis. He described this decision making process as collaborative. It includes a phenomenological component, in that he considers the patient’s opinion as an important aspect of the process. The second role is the “Doctor as Decision Maker” (Conn, 1993:25). In this case the patient must make the decision to follow the doctor’s advise or refuse it. So the choice is not between alternative treatments but a particular course of treatment or none at all. In this second role he articulated the scientific view of medical practice in which the doctor has the technical knowledge and to fail to apply that is to fail the patient. The patient’s role is to comply or face the consequences. While he
asserted that patients share a responsibility in this process this responsibility is really another word for complying with the doctor. They do this by showing that they can be trusted, following the treatment plan carefully, taking an active role in their care and staying informed. Thus while Conn tried to renegotiate the doctor/patient relationship, his effort demonstrates how difficult this process is. Next, I will address power in patient/practitioner interactions.

**Power in Patient/Practitioner Interactions**

Because physicians are perceived to have formal knowledge and skills they successfully negotiate the dominant role in the medical encounter. Treichler, Frankel, Kramarae, Zoppi, and Beckman (1984:64) defined power in a medical setting as

-the negotiated product of a mutually constituted and mutually administered interaction system...If we think of power as a process, as bound to a relationship, then patient-physician interaction becomes not just evidence, but the site where they are established and negotiated.

Frankel (1989:11) emphasized the asymmetry in social relationships based on differential distribution of valued resources. This results in an increased change of prevailing when decisions must be made and implemented.

Frankel (1989:112) defined power as:

...a property of asymmetrical social relations. It is generated by the fact that social values are differentially distributed among persons and groups within a single system of interaction. Where the values possessed are relevant, this asymmetrical allotment of
“goods” enables one party to a relationship to maximize the change that decision-making and action will take place according to their decision.

Those who possess something that is valued have greater power than those who do not, creating asymmetry in the relationship. The scientific knowledge held by the physician and other health care workers acts as a commodity in patient/practitioner relationships. Hence, the professionals in medical encounters, because of their professional knowledge, exert greater power than their patients (Freidson, 1986:213).

**Redefining Professional Power**

A block to empowerment is relinquishing what we have come to think of as professional power, that is making decisions for patients. Conn’s (1993) article demonstrates how difficult this is. A way of understanding this situation is through the concept of “habits of the mind.” Habits of the mind are the approaches and attitudes toward everyday life which are acquired through socialization (Kestenbaum, 1982:6). Through these habits of the mind professionals develop paradigms, or ways of seeing the world, which then direct their action (Kestenbaum, 1982:7-8). For physicians to relinquish their power and authority to patients requires that they suspend their habits of the mind in order to attend to the lived experience of their patients (Kestenbaum, 1982). In doing so physicians can begin to understand illness not only from a scientific perspective, but in relationship to the impact of the illness on the patients’ day to day experience (Strauss, Fagerhaugh, Suczek &
Weiner, 1985). Care from this perspective would include the context of the life of the patient and the patient’s family in the development of treatment approaches (Corbin and Strauss, 1988).

Discharge recommendations from the EPU reflect the staff’s awareness of patients’ goals in relationship to their problems and home environment. For example, Bill was discharged to his home even though staff had many reservations about the long term feasibility of this decision. He had been very difficult to handle on the unit because he was very confused. He hallucinated and at time became combative. Medications failed to fully resolve this problem. However, his daughters wanted him at home rather than in a nursing home because their mother was in a nursing home and they “couldn’t handle” two parents being institutionalized. The staff encouraged them to make alternative plans and arranged for supportive services even though the staff doubted the wisdom of this decision (Field Notes #41, Card ID #31388:8/6/93). The staff actions were empowering to the daughters in the same context that Conn addresses empowerment. Options were discussed with them and they chose which option they felt best met the needs of both themselves and their father.

Like power, empowerment exists in relationships within settings. Rather than looking at power from the perspective of the asymmetrical possession of “goods” (Frankel, 1989:112), a feminist perspective argues that power is the ability to stimulate change (Miller, 1983:4). This approach still
emphasizes the relational aspects of power, however it focuses on the use of power to enhance the development of others. From this perspective, staff would provide the environment for patients to assert themselves, changing the relationship between patient and practitioner. This would create an atmosphere in which patients could develop their abilities and advance their goals (Miller, 1983:4). This involves redefining what is meant by competent care. Rather than making decisions and doing for patients, the typical and appropriate approach in acute care, staff would encourage patients to make choices and do for themselves. This means attending to the small things, the lunch menu or exercise group as well as the more important things such as including patients in team meetings.

Applying this concept to the EPU, power resides in the staff because they have the professional expertise. Despite their efforts to empower patients, the exclusion of patients or their representatives from the team meeting demonstrates the incomplete integration of the concept of empowerment in the actions of unit personnel. If empowerment were a fully integrated aspect of the culture of the unit, team meetings would be structured in such a way that patients or their representatives would be active participants in the meeting. Unit personnel combat ageism by not using age as a criteria for making recommendations about patients, so too, change in the team meeting process to include patients would reflect a greater integration of the empowerment model. However, strong social forces
counter the empowerment model. Because medicine, like science, is considered a sacred activity the reverence and respect accorded to medical practitioners reinforces their power. This lack of full integration of the model may be due to the incomplete diffusion of the patient as partner model through the culture or structural limits influencing the operation of the unit and its context. The next chapter will deal with an analysis of the EPU team meetings in the spring of 1990. This analysis will focus on the three images of the team meeting, the professional, constructive, and ritualistic.
CHAPTER V

THREE IMAGES OF INTERDISCIPLINARY TEAM MEETINGS

The team meeting is a central organizing feature of the unit. Drawing from data in this study and one conducted on the unit in 1990, I will explore how the team used the meeting to define itself and present its mission to itself and others. I will not be concerned with the efficiency or effectiveness of the team meetings, rather, I will focus on how meetings reflect the culture of the unit and the beliefs of the staff. This chapter reviews the literature on meetings and team meetings in health care. It discusses how meetings serve to create and reflect the culture of organizations. One aspect of the culture of medicine is the abstraction of patient’s experience (Foucault, 1963/1975).

Goffman (1974:40-82) referred to this process of abstraction as a cycle of keys and frames of interpretation. This occurs in the meeting as well as other forms of communication. Within the meeting itself, the team functions in three separate but interrelated images: the professional, constructive (Buckholdt and Gubrium, 1979:256), and ritualistic (Crepeau, 1994, in press). I will use a vignette from one meeting in 1990 to explore and explicate these images. A particular feature of the team in 1990 was its high level of cohesiveness. I will conclude with a brief discussion of the implications of this level of cohesion.
Meetings:

Tools of the Organization and Topics for Research

Meetings are an inescapable part of social life (Schwartzman, 1989:62). They exist in most work settings, volunteer, and community organizations. Schwartzman (1989:4) argued that meetings are so pervasive that they have been overlooked by sociologists and anthropologists as topics for study. She found that most research on meetings dealt with studies of meetings as tools to achieve certain organizational goals.

A meeting may be defined more explicitly as a communicative event that organizes interaction in distinctive ways. Most specifically a meeting is a gathering of three or more people who agree to assemble for a purpose ostensibly related to the functioning of an organization or group, for example, to exchange ideas or opinions, to develop policy and procedures, to solve a problem, to make a decision, to formulate recommendations, and the like (Schwartzman, 1989:61)

An important characteristic of the meeting is that it is scheduled by agreement of the group to address some particular aspect of the organization and/or the people in it. Consequently, conversations between people which could address the same topics but are not formalized by the meeting frame, do not meet this definition.

Schwartzman (1989:47-86) distinguished between conducting research on meetings as a topics in and of themselves rather than tools of the organization. To study meetings as tools, researchers address the tasks of the group as it makes decisions. This corresponds to the professional image of the team (Buckholdt and Gubrium, 1979:256). The communication process
and the effectiveness of the group are part of this study of meetings as tools.

Because meetings are not always effective, another aspect of the study of
meetings as tools is to develop methods for improving meetings. The work
of Jabitsky (1988); Toseland, Palmer-Ganeles and Chapman (1986); and Brunell
and Avella (1986) are examples of studies which address the effectiveness of
team meetings and ways of improving the process.

Research on meetings as topics focuses instead on the impact of
meetings on individuals in the organization, how individuals use meetings,
and the meaning of meetings to members of the organization. Meetings as
topic focuses on the influence of meetings on the creation and maintenance
of an organization (Schwartzman, 1989:54-61) and addresses the constructive
(Buckholdt and Gubrium, 1979:257-258) and ritualistic (Crepeau, 1994, in
press) aspects of meetings. The face to face contact in meetings enables
ceremony, strategy, and negotiation to occur (Goffman, 1961b). Without
meetings these forms of interaction would not be available to organizations
and groups.

Goffman (1961b:17-18) characterized meetings as focused gatherings or
encounters. Focused gatherings involve for the participants

...a single visual and cognitive focus of attention; a mutual and
preferential openness to verbal communication; a heightened
mutual relevance of acts; an eye-to-eye huddle that maximizes
each participant’s opportunity to perceive the other participants’
monitoring of him. Given these communication arrangements,
their presence tends to be acknowledged or ratified through
expressive signs, and a “we rationale” is likely to emerge, that is,
a sense of the single thing that we are doing together at the time.
Ceremonies of entrance and departure are also likely to be employed, as are signs acknowledging the initiation and termination of the encounter or focused gathering as a unit. Whether bracketed by ritual or not, encounters provide the communication base for a circular flow of feeling among the participants as well as corrective compensations for deviant acts.” (Goffman, 1961b:17-18, emphasis in the original).

This focused gathering encloses the group in a membrane so that participants are cut off from other opportunities for interaction. A focused gathering does not imply longstanding or consistent group membership; rather simply a strip of interaction among a group of individuals who have come together for a short period of time. The team meeting functions as a focused gathering that is separate from the personnel on the unit even though the same individuals may be in each. In other words, the team meetings themselves have qualities that are separate from the individual members of the group. The team also exists outside of the meeting as individuals or as a group or subgroups that interact in other contexts. The definition of a team meeting is determined by the members present and the purpose of the meeting. The same individuals may interact in another context, however, because the context is different, the interaction is also likely to be framed differently. Lisa Abbott, a nurse, addressed the difference this way:

EBC When you were talking about the team in the abstract, you were talking about coming together discussing the patient, coming up with a story about where you want to go with the patient. Did you have in mind the meeting itself or were you thinking about all kinds of interaction on the floor?
Lisa  I guess I was talking, thinking about the team meeting, but actually that's what I had in mind.

EBC  That's what you had in mind.

Lisa  As I said, on an informal basis, when approaching any of the team members, one on one, ummm, seems to be, maybe more trust or something. An openness, not trust, an openness between the two when they are talking to, umm.

EBC  than in the meeting?

Lisa  Than in the meeting, yes. I don't know, in the meeting it's very structured, and there are times that I have, yes I have, I have to say there are times when it does open up and then people will venture their feelings and their thoughts (Field Notes #70: Card ID #13344: 11/15/94)

Later in the interview Lisa distinguished between reporting and conversation during the team meeting:

EBC  Whereas, out on the unit when you are talking to team members you're thinking, you're not reporting most of the time

Lisa  Uh hum, that's right, there's a sharing of knowledge, of observation, of what we ought to do, and we think we tried this, we're, "do you think we should let Dr. James know, you know can it wait?" This kind of thing, maybe we ought to talk to OT, maybe we ought to talk to PT about it.

Later in the interview:

Lisa  I don't know about anybody else, maybe it's me, I also feel a hierarchy in the team meeting, it's okay to say some things but other things, you don't say...ummm

EBC  Like what kind of things do you feel inhibited about saying?
Lisa said, "Well, I don't know, just kind of observations you know, where I will feel very comfortable going to a nurse saying to another nurse, I just do. "Gee, I find this patient is behaving this way or and I wonder if it's the medication that's doing this, or do you think it could be a panic attack?" Or something like that, you know. Where in a formal team meeting I will feel constrained about that (Field Notes #70, Card ID #13344: 11/15/93).

For Lisa, the meeting frame created a structure and formality which inhibited her communication. She felt that she could not express observations or ideas which were tentative in the meeting, while outside of the meeting frame she would not feel so constrained.

Meetings provide the social form in which teams interact as the field note above demonstrates. They exist within the system itself, but also play a role in producing the system in which they exist. Drawing from Weick, Schwartzman (1989:9) asserted:

Meetings provide the organization with a form for making itself visible and apparent to its members, whereas they also provide individuals with a place for making sense of what it is that they are doing and saying (Weick, 1979:133-134) and what their relationships are to each other in this context.

As Lisa articulated, team communication exists via formal and informal means. The formal mechanisms include team meetings, family conferences, and documentation. It is through meetings that microlevel interaction is meshed with organizational values and structures (Schwartzman, 1989:37). Informal communication occurs any time one team member speaks to another. Lisa's timidity in the meeting reflects the different expectations she
felt when she was in the meeting than when she was on the unit. Her relationship to Dr. James changed based on whether she defined the situation from the perspective of the more formal context of the team meeting versus a less structured interaction with him in the chart room.

Communication as Objectification and Abstraction

Beyond the interaction between staff, which as Lisa demonstrated, has different contexts of communication, each team member maintains communication with the patient and, in many instances, the patient’s family. This sets up a series of frames and keys of communication. Goffman used the term “key” to describe various forms of interpretation or abstraction of a single event (1974:40-82). The experienced event is rekeyed when reported in team meetings, during informal conversations, for the medical record, and again when reporting to the family. This interpretation of the event may vary from one key to another. Jargon will be used in the team meeting and is likely to be dropped or explained during a family meeting. For example, in the team meeting staff members used the expression “on the salt” rather than “lithium” to describe the medication used for people with manic depressive illness. If one of the team members were discussing lithium with a patient or family member, they would be more likely to use the correct terminology and then stop to explain what lithium was and why it was being used.

Documentation is likely to be shaped to meet the requirements of the institution and reimbursement agencies. The medical records emphasize
points important to these groups and de-emphasize or fail to mention
information for which documentation is not required. Consequently,
sentimental and comfort work are not likely to be mentioned in medical
records because documentation of these important tasks is not required
(Strauss, et al., 1985). All of this communication and keying occurs within a
frame or framework that "allows its user to locate, perceive, identify, and
label a seemingly infinite number of concrete occurrences defined in its
terms" (Goffman, 1974:21). If the primary framework is defined as each staff
member's interaction with one patient, this interaction is rekeyed every time
it is communicated to someone else or documented in the medical record.

Given the possibility of a frame that incorporates rekeyings, it
becomes convenient to think of each transformation as adding a
layer or lamination to the activity. And one can address two
features of the activity. One is the innermost layering, wherein
dramatic activity can be at play to engross the participant. The
other is the outermost lamination, the rim of the frame, as it
were, which tells us just what sort of status in the real world the
activity has, whatever the complexity of the innermost
lamination (Goffman, 1974:82).

The care plan developed at the team meeting is an abstraction of the team
meeting which is an abstraction of each members interaction. Each
transformation or rekeying is a further abstraction of the original interaction
which started the chain of keys.

Social forces, such as the context of the communication, are likely to
shape the transition between keys and laminations. Bruner (1986:6) addressed
this process of abstraction or objectification from another perspective by
stating that there is a difference between reality, experience, and expression.

This distinction is particularly important in health care because interpretation of the patient’s experience occurs at the level of expression which is removed from the patient’s reality.

The critical distinction here is between reality (what is really out there, whatever that may be), experience (how that reality presents itself to consciousness), and expressions (how that experience is framed and articulated). In a life history, as I have indicated elsewhere (Bruner, 1984:7), the distinction is between life as lived (reality), life as experienced (experience), and life as told (expression) (Bruner, 1986:6).

What we are dealing with is a series of transformations from the patient’s lived experience, through his or her articulation of this experience to team members, and then a similar series of transformations from the team members’ experience with the patient, to the constructions of the team.

Connected with these transformations is Foucault’s (Rabinow, 1984:9-10) concept of objectification. Through objectification individuals are separated from others by diagnostic categories and spatial organization. This occurred during the Confinement when those who were considered mentally ill were incarcerated with prisoners and paupers (Foucault, 1961/1965:x-xii). The emergence of the clinic, in which patients were divided into wards and organized by diseases, enabled physicians and medical students to focus on the diagnosis and treatment of disease. In this approach to teaching, people with similar diseases can be brought together, compared, and studied. However, this focus on disease rendered the experience of the individuals
less important than the diseases from which they were suffering (Foucault, 1963/1975). This process of objectification as evidenced by the current reliance on diagnostic categories and disease labels is so highly integrated in medicine that it is hard to imagine health care delivery without them. From a phenomenological perspective, health care should account for the patient’s illness experience (Kestenbaum, 1982; Kleinman, 1988). This process of objectification and the various levels of abstraction from the patient’s lived experience to the team, make the process of entering the reality of the patient’s world particularly important and difficult.

Few staff recognized that this objectification was a danger. The team meeting was seen as the arena for discussing the patient and the patient’s problems behind closed doors and without the patient present. Only three people indicated that they saw the absence of the patient as a problem. Lisa described the filtering of the results of the meeting via Dr. James. Joanne Weston, a nurse, said that patients should come to the team meetings so that they could “be told” what to do. Cynthia Clark, another nurse, took a slightly different perspective that of having the patient “hear” about his or her progress in the presence of the team. Without the presence of the patient or a representative of the patient, the observations about the patient and subsequent discussions relied on the staff’s willingness and ability to enter into the patient’s world. This phenomenological attention to the patient’s
lived experience may be part of the definitional process which occurs in the constructive image of the team.

**Interdisciplinary Teams and Team Meetings**

Interdisciplinary teams are seen most often in settings which deal with rehabilitation or chronic illness because the course of care is long, complex, unpredictable, and frequently problematic (Strauss, et al., 1985:11-29). Disease trajectories are difficult to manage because the work involves numerous tasks performed by many people (Strauss, et al., 1985:26). The coordinative function of teams and their interdisciplinary aspects are thought to improve patient care because team members bring their unique professional skills to address patient problems (Ducanis and Golin, 1979:2-3). As the preceding section of this chapter indicated, the communication process that occurs between staff may involve the formal and identified team meetings or more informal collaboration between staff members in cooperative teams that form around a particular act, such as discussing treatment approaches.

The care planning process that occurs in the team meetings is seen as a way to identify patient problems, develop solutions to these problems, and coordinate and structure patient care (Gubrium, 1980a:660; Buckholdt and Gubrium, 1979:256). Developing these care plans inherently assumes that the plans and their subsequent implementation will make a difference to the patient. In other words, that the planning process will rationalize and make more predictable what is essentially an unpredictable and irrational course of
illness (Strauss, et al., 1985:11-29). This formal aspect of team communication supplements the informal interaction that occurs between health care professionals during the working day as Lisa explained in the interview cited earlier in this chapter.

Three Images of Interdisciplinary Team Meetings

According to The American Heritage Dictionary (1992:642) image is defined as "the character projected to the public, as by a person or an institution, especially as interpreted by the mass media" and as "a mental picture of something not real or present." Buckholdt and Gubrium (1979:256) refer to these different perspectives as the images of the team. Schwartzman (1989:38-44) also uses the term image to describe various understandings of meetings. Consequently, this seems to be a very appropriate term to describe meetings because it recognizes that the images developed by the team are constructed and may be projected to represent the view the team wants to extend to the world (Goffman, 1959). Buckholdt and Gubrium (1979:256) identified the professional and constructive image of team meetings. The explicit view of team meetings is the professional image (Buckholdt and Gubrium, 1979:256). Expertise of team members is the focus of this image. In contrast, the constructive image concerns the definitional activity of team members as they try to understand patient troubles (Buckholdt and Gubrium, 1979:257). It is in the ritualistic image that the team defines itself as a group, appreciates its strengths and professional expertise, and identifies the
difference between those who believe in their work and those who do not (Crepeau, 1994, in press).

**Analysis of a Team Meeting: Spring 1990**

Here I will draw upon earlier data and interpret them on the basis of the three afore-mentioned images or perspectives of team meetings. The field data and analysis in this section of the chapter refer to the exploratory study I conducted on the unit in 1990. It was in this study that I observed the presence of the professional and constructive images delineated by Buckholdt and Gubrium (1979) and identified the ritualistic aspects of the meetings. It begins with a vignette that summarizes a particularly dramatic discussion of a patient. I selected this vignette because in this discussion the professional, constructive, and ritualistic images were especially clear.

**Sarah, Depression, and ECT Clothing.**

Everyone gathered in the team room talking among themselves to catch up on the events of the day. Sarah was the first patient. This was the first time the team discussed her. Without any formal announcement, Marjorie opened this portion of the meeting in her “reporting register.” “OK, Sarah, alteration in mental status.” People stopped their individual conversations and attended to the meeting. Amy, the occupational therapist, responded with observations of Sarah’s negative attitude. Dr. James chimed in, “Yes, expressions of hopelessness, helplessness, feeling overwhelmed, very passively suicidal.” He continued to describe her as very negative and
inadequate. "I can't do this because I don't have any clothes." After Doctor James said this, others added examples. Amy said, "I can't do this activity', but she does it. She can't get dressed but she is." The dietitian added that she complained about no appetite but ate her food. The discussion continued in this vein with staff members adding examples to form a perplexing picture. Sarah could do most things required of her while she persisted in her claims of total inability to perform. Finally Dr. James said, "All right, I'm trying to think of anything else...she is status post multiple fractures following a jumping incident eight years ago." This statement began the story of Sarah's previous suicide attempt and her assertion that she is more depressed now than she was then. Sandra reported that Sarah said she couldn't even commit suicide, all she did was break her heels. Dr. James piped in, "I can't do it." Sandra said, "That's what she said, I had to bite my lip to keep from laughing." The group dissolved in laughter at this picture of a woman who felt so immobilized and inadequate that she couldn't even succeed in committing suicide.

The discussion diverged to the term "inadequate personality" which seemed to fit their picture of her. However, this is no longer an official psychiatric diagnosis so they cannot use it. The laughter died away as they discussed Sarah's personality and suicide risk. The mood became somber. In contrast to the frequent give and take at the beginning of the discussion, there were few interjections. People spoke more slowly and quietly. They
discussed the idea of ECT because Sarah had a successful course eight years ago and did not need treatment until this hospitalization. Dr. James said that Sarah agreed that ECT would be good and was not afraid of it. Amy asked if she was cooperating with the idea of ECT. Dr. James replied that she said she couldn’t have ECT because she did not have the right clothing. Amy responded, “What a stupid question.” Dr. James said, “You asked.” There was a lot of cross talk and laughter. The group became animated again. Marjorie added that when she asked Sarah to sign the permission for ECT, Sarah said that she didn’t have the right clothing, so couldn’t sign. “Stupid me, I didn’t understand how the form and the clothes went together, I didn’t see the connection.” People laughed more. Dr. James turned to the OT and said, “Can you design something bold, some ECT clothing?” There was more laughter and cross talk. Someone suggested doing something with paddles. Another said something with lightning bolts. More cross talk and laughter followed.

They began to discuss the legal issues of this woman’s admission and her relationships with family members. The group again became subdued because of her longstanding estrangement from her family. They discussed her return to the group home where she had been living before her hospitalization. The joviality disappeared completely. Peter Tully asked mischievously whether Sarah had the right clothes to go back to the group home. No one picked up on this attempt to lighten the mood. The subdued
discussion continued, eventually returning to the ECT. Everyone seemed to feel this was the treatment of choice because of its previous success, her history of poor response to antidepressants, and her apparent willingness to have it again. However, the sticking point was still her unwillingness to sign the permission form. They talked at length about this dilemma. They tried to be sure that fear of the treatment was not the source of her refusal but came from her overwhelming inability to recognize that she could initiate action. Marjorie agreed to take the form to her again. They closed the conversation with discharge criteria which included getting her mobilized enough so that she could return to the group home. The mood was somber. Everyone seemed caught up in their own thoughts about Sarah and her situation.

Professional Image

Buckholdt and Gubrium (1979) defined the professional image as the perspective of the team members who participate in staffings or team meetings. It is that part of the team’s actions that deals explicitly with members’ unique professional roles and responsibilities (Buckholdt and Gubrium, 1979). The team discussion about obtaining Sarah’s permission, labeling behavior, and planning treatment occurred in the professional image. When team members function within this image, they accept client problems as real and subject to the control of the team.

When team members operate in the professional image, they assume that problems in reaching decisions are a result of failure of the group in the
technical aspects of communication and understanding. In other words, the problems are derived from a lack of experience with the group, the need for better coordination in the group, etc. (Buckholdt and Gubrium, 1979:257).

The professional image makes reasonable the ability of a group of professionals to accurately diagnose and treat human troubles” (Buckholdt and Gubrium, 1979:257).

The professional image of the work of staffings is one that portrays staffers as professionals involved in the serious business of deliberating together, as a team, over varied facets of client care and treatment. It is a highly self-conscious image in that it is the body of beliefs about themselves and troubles they deal with, commonly referenced by staffers when asked about their work, its routines, its ideals, and its shortcomings (Buckholdt and Gubrium, 1979:263).

Articles written about teams typically address this image of the team. Teams are assumed to be able to focus on the whole person because of their interdisciplinary membership. They reduce isolation of team members and provide a mechanism to review treatment plans (Toseland, Palmer-Ganeles, and Chapman, 1986:46-47). Jabitsky (1988) addressed the conflict of roles of team members, particularly in relationship to the authority and legal responsibility of the psychiatrist. “The psychiatrist must utilize his unique expertise in asserting his leadership of the team, thereby achieving the respect of the psychiatric team members for his authority” (Jabitsky, 1988:580).

The interdisciplinary efforts of teams presumably lead to comprehensive treatment plans which address the needs of clients through the application of the professional expertise of the team members. These plans are required by federal and state accrediting agencies and third party
payers (Brunell and Avella, 1986:73). They asserted that plans of care do not always meet the expectations of these agencies because they lack a clear focus and do not have an explicit action plan. They dealt with this problem by outlining a plan by which a consultant assists the team to learn how to interpret the clinical manifestations of the patients and develop plans which address these problems. The approach to this consultation is to treat the problems of patients as self-evident, and unproblematic realities waiting to be discovered. The consultant, interestingly, seems to have the inside track on this understanding via discussions with the patient’s nurse and ward advisor, record review, and interview with the patient. Findings are presented by the consultant to the team and a process is followed to develop care plans based on these findings (Brunnel and Avella, 1986:76-77). This approach to problems in care planning assumes the perspective of the professional image in that the problems in care planning are thought to be of a technical nature which will respond to training efforts. This also conforms to the concept of teams as tools or instruments of the organization which must function effectively to sustain its work.

**Constructive Image**

The constructive image places the staff at the center stage as active members who are involved in defining and sustaining patient troubles rather than in describing and providing care (Buckholdt and Gubrium, 1979:257). These latter activities are consistent, instead, with the professional image
(Buckholdt and Gubrium, 1979:257). In the constructive image staff members engage in debates to identify the troubles experienced by patients and negotiate the meaning of these troubles (Buckholdt and Gubrium, 1979:260-263). The authors asserted that unlike the professional image, the constructive image is generally tacit and that team members are not aware of the creative process in which they engage to create a unified picture from the diversity of their individual perspectives (1979: 263-264).

The constructive image is related to the social construction of knowledge which is concerned with the processes by which knowledge comes to be socially established as "reality." The process by which human thought is shaped by the social context from which it arises is an essential focus of this perspective (Berger and Luckmann, 1967). The constructive image relates to the sociology of scientific knowledge (Bloor, 1976; Woolgar, 1980), clinical reasoning in occupational therapy (Mattingly and Fleming, 1994), and uncertainty in medical practice (Paget, 1988; Strauss, et al., 1985). It recognizes the possibilities of multiple realities because each individual experiences the world from his or her own perspective (Schutz, 1967; Berger and Luckmann, 1967).

The constructionist approach challenges the rationalist view that patient problems are objective and exist separately from the interpretive actions of the team. It is in this image that team members sort out conflicting data to arrive at a common definition of the problems faced by the patient.
Thus team members make sense of conflicting and ambiguous data
(Buckholdt and Gubrium, 1979:263-264). This sense making activity is in the
background. Team members ignore it, just as Bloor (1976) reported in his
observations of scientists in the laboratory. The team functioned in the
constructive image when they discussed Sarah’s living situations and family
relationships. This discussion, phenomenological in orientation, reflected
their attempts to understand Sarah’s perspective and respect it. Unlike the
discussion of ECT in which they felt compelled to ask for permission another
time, there was no discussion of asking her to initiate contact with her family.
Her definition of the situation prevailed. In contrast, their discussion of
Sarah’s assertions of inability to do things when she could do them was
constructed as problematic. Her agreement to have ECT yet her perplexing
refusal to sign the permission form was also viewed as a problem by the team.
Therefore, both problems were deemed appropriate for intervention. Their
subsequent diagnosis and plans to gain her permission to use ECT were
performed in the professional image which is the explicit purpose of the team
meeting. Thus the team shifted from its constructional activities to its
professional activities of describing and providing care.

Buckholdt and Gubrium (1979:258) address the constructive image as a
process in which health care workers discover, interpret, and negotiate their
understanding of the behavior of patients.

The constructive image is one in which staff on occasion see, but
do not commonly notice, that they work as hard at sustaining
the realities of troubles and treatments as they do at providing care and therapy to clients. By orienting their routine attention in staffings to the everyday business of diagnosing and treating clients, staff ignore their own contributions to the ostensible realities discovered there. Staff members continually work at making troubles and their varied features available to themselves for consideration in staffings and then deliberate over the troubles as entities in their own right (Buckholdt and Gubrium, 1979:257).

Gubrium (1991) further discussed this interpretive process as a mosaic of care, to avoid the image of linearity so common in health care. The team meeting, in its constructive image, is the place where this negotiation occurs. It is the public forum for the deliberations of the team as they attempt to understand the patient before them. Because this is a negotiated process, social factors within the group, persuasion, and power are likely to influence the outcome.

**Ritualistic Image**

The ritualistic image, like the constructive image, is generally implicit and thus part of the background experience of team members. Goffman (1967) viewed human interaction as a process that involved a complex network of rituals. Individuals incorporate and internalize these rituals or rules of conduct into their actions, providing the interaction structure that holds society together. Shared meaning characterizes ritual action (Douglas, 1966; Durkheim, 1915/1965). Custom and tradition transmit this meaning. The outcome of these actions is a sense of group cohesion (Douglas, 1966). Medical beliefs have been referred to as dogma and the training of psychiatrists as a conversion experience (Khleif, 1974b), so it is not
inconceivable that the team meetings themselves may assume a ritualistic form.

Usually the rituals that occur in human interaction are an unrecognized aspect of communication. They are the routine through which interaction flows. Moore and Myerhoff (1977) argued that this ritualistic aspect, although overlooked or bracketed, must be examined along with the less patterned, more variable aspects of human communication. It is in the ritualistic image that the team defines itself as a group, appreciates its strengths and professional expertise, and identifies the difference between those who believe in their work and those who do not.

Group solidarity, according to Durkheim (1915/1965), is confirmed through rituals that bring individuals in the group together to reaffirm their collective identity. He studied "primitive civilizations" (Durkheim, 1915/1965:18) because of the greater conformity he assumed to be present in these groups. "Movements are stereotyped: everybody performs the same ones in the same circumstances, and this conformity of conduct only translates the conformity of thought" (Durkheim, 1915/1965:6). The moral support formed by the group in its rituals attaches the individual to the group. Reunions, assemblies, and meetings reaffirm collective ideas (Durkheim, 1915/1965). Mary Douglas (1966), following Durkheim, contended that rituals provide a frame or focusing mechanism that marks off
and controls experience. Thus, group interaction provides a ritualistic
mechanism for the group to reinforce its solidarity and sense of collectivity.

Bailey (1983) discussed patterns of interaction at meetings that have a
ritualistic quality. These involve particular patterns that center on getting the
meeting started, the framework for the middle of the meeting, and ways of
ending the meeting. For this team there were few overt cues to signal the
beginning of the meeting. Typically, after everyone was present Marjorie
would say, “OK, Sarah, alteration in mental status.” She said this in what I
call a reporting register that was quite different from her typical speech
pattern. This change in voice tone was sufficient to get everyone’s attention.
Dr. James periodically summarized the discussion. He, too, used a different
speech pattern, which was dictating in nature, to differentiate the
summarization from his typical conversational speech. The entire group
responded to these verbal signals that were the only markers to show
movement to the next part of the treatment plan.

This pattern of interaction in the group was quite consistent meeting to
meeting. Marjorie called the meeting to order by starting the first plan. Once
she spoke, the group informally discussed the patient and the particular issue.
This discussion was not orderly, people spoke at random, sometimes
interrupting or interjecting comments. Often they would respond to what
another person said. No one led this part of the discussion. At some point,
Dr. James would summarize in the dictating register. Marjorie wrote this
dictation on the care plan form. Typically, the group did not challenge this summarization. Although sometimes a staff member would interject some additional thoughts and Marjorie would alter the summary. In this way she and Dr. James controlled the flow of the discussion from one topic to the next. This control, however, did not extend to the content of the discussion nor the order in which people spoke.

Stock phrases described patients. The one I heard most frequently was “hopeless, helpless, feeling overwhelmed.” These phrases described patients, however, their patterned use and rhythm lent a realistic tone just as pledging allegiance to the flag binds groups together in public gatherings. This patterned interaction and the use of stock phrases lent a predictable aspect to the meetings. The occupational therapist described the meeting as “rote like” which they were in terms of pace and interaction pattern. However, the content of the meeting in the constructive and professional images varied from patient to patient.

Bailey (1983) noted patterned movement between moods of reason and passion, the use of jokes, play, sarcasm, and drama as points to shift these moods. No matter how disparate the mood of team members at the beginning of the meeting, by the time they finished discussing the first patient, their mood was unified. Typically their mood remained unified throughout the meeting, shifting from humor to despair in unison. This vignette contained dramatic mood shifts. In fact, this vignette elicited the
wildest humor and greatest despair that I heard during my observations of 
the group. The use of humor, which was at the patient’s expense, was out of 
character for the team. In my observations of the team meetings, this type of 
humor typically occurred after a long discussion about a patient in which the 
team felt thwarted by their powerlessness to help the patient. One cause of 
this powerlessness was their inability to understand the patient’s problems. 
Other causes were circumstances in the family or social service agencies that 
worked against the best interests of the patient. I believe they used humor as 
a way of cushioning the frustration they felt with the situations of their 
patients. Hence, their inability to understand Sarah’s refusal of ECT most 
likely led to the ECT clothing comments.

Finally, beyond their function to make sense of the patient, stories 
played a role in the development of group cohesiveness. The occupational 
therapist was the source of many of these stories because of her home visits 
with patients. Team members told stories of the driving evaluation, the fifty 
year old candy, and the macaroni stored with cleaning supplies in the 
bathroom several times during my observations. These stories united the 
group by repetition of their collective history. Thus the patterned interaction, 
unity of mood, and reaffirmation of shared history through story telling 
combined to provide a sense of solidarity for the group.
Conclusion

In the first study the team was a cohesive group that met on a regular basis. Because membership was consistent meeting to meeting a high level of trust developed between group members. This enabled the development of a meeting form which was highly patterned and predictable. However, other staff on the unit were closed off from this process creating a sense of two groups on the unit. Joanne Weston described the team as “the elite” and the other staff on the unit as the “workers.” Thus the cost of the high level of cohesiveness within the team was the perception that others on the unit were excluded from planning patient care. Another cost of this highly centralized team structure is that the discussion and subsequent plans might not be adequately transmitted to the rest of the staff on the unit. Without this transmission, staff cannot implement the plans developed by the team. This high level of cohesiveness was not as apparent in the second study. The next chapter reports on the team meetings in the Summer of 1993.
CHAPTER VI

EPU TEAM MEETINGS: SUMMER 1993:

"IT'S DOING, IT'S NOT PEOPLE, IT'S NOT SUBJECT...
IT'S TEAMING HAPPENING

This chapter analyzes the team meetings that occurred in the summer of 1993 and compares these meetings to those of the first study. It also examines the meetings as a reflection of the culture of the unit. Unlike the agreement about the mission statement, staff hold divergent views about the team meetings and their value to patient care. This chapter will deal with this divergence and the discrepancies between the beliefs of the team members about the team meetings and their actions in the meetings. As the chapter title indicates, team work is seen by some as an action rather than a thing. The meetings are one arena for this action to occur. Because the team meeting is a central organizing feature of the unit, these discrepancies are of particular importance.

In the summer of 1993, the patterned aspects of the meetings which had been so consistent in the first study were greatly diminished. This change reflected the expansion of the unit from twelve to sixteen beds and the organization of multiple teams. In this chapter I address the growth of the unit, the division of the unit into three teams, and subsequent changes in the team meetings. I closely examine the team discussion of one patient to
further explicate the professional, constructive, and ritualistic images. Next I examine how exclusion of the patient from the team meetings reflects the dominance of the medical model in unit practices. Finally, I will examine discharge planning to demonstrate the influence of the empowerment model on the discourse of the team.

**Team Meetings: 1993**

I began the second study of the unit, three years after the first. In doing so, I reviewed the work I did in the first study and entered the field with the foolish confidence that I already knew a lot about the team meetings. I did, but the team meetings I observed in this study differed dramatically from the first. Because the unit was organized into three teams, the same people did not assemble meeting to meeting. Dr. James, the medical director; Peter Tully, the social worker, and Marjorie Coleman, the unit director, remained consistent meeting to meeting. However, the two occupational therapists rotated attendance, and the nurses from each team might attend only once every four to six weeks. Molly, the dietitian, attended when she had time. If she was not able to attend, she left notes for the meetings taped to Marjorie’s table. Consequently the configuration of the group changed meeting to meeting. Because the nurse chaired the meeting, each meeting would be led differently, dependent upon the leadership style and skill of the nurse. The patterned aspect of the meetings which had been so consistent in the first study was greatly diminished by this change in organizational structure.
The Professional Image

The professional image, or explicit purpose of the meeting was still front stage. As stated earlier, the professional image deals explicitly with the team members' unique professional roles and responsibilities (Buckholdt and Gubrium, 1979). Staff were very willing to comment on the effectiveness or lack of effectiveness of the team meetings as the following statements indicate. Susan Smith, a nurse, commenting in response to my question about the team meeting process said,

I don’t think that it’s productive. I just don’t think it’s productive. Now we go into critique, generally, I don’t think that the team is productive. Each individual, I think is productive, but when we sit here, that’s three times a week that it happens. I think it is a wasted hour. I don’t think anybody leaves knowing any more or with any more enthusiasm than when they left (Field Notes #63, Card ID #49288:10/12/93).

Cara Ward, another nurse, saw the value of the team meetings. She said,

To me, it is the only way that the disciplines can bring it into a formal manner and have documentation to support that. So that everybody can hear from the other person what is actually going on. For most team sheets, I'm learning as time goes on, you can write a discharge summary from those team sheets, because if you look at the team sheets you can see the progression of the patient's stay or the digression. Whatever might have happened to them in the process. Keep on going, keep on going, and when you get to the last one, they're for the most part better and ready to go out into the community...And the team meeting seems to validate that, all the things that we do all week, all during the week. That's just coming to me. It didn't come right away, the importance of it. It's just to coming to me now that it is valid that every discipline be involved. That's because of my med/surg background where I'm used to just going in and fixing it and leaving them alone (Field Note #59, Card ID #46496:9/28/93).
These statements reflect the explicit nature of the professional image of the team. Both Cara and Susan, like other staff members I interviewed, were quite explicit about their feelings about the effectiveness of the team meetings and their role in the process. Nurses, in particular, felt that their multiple roles as leader of the meeting, keeper of the agenda, and recorder placed them in a subsidiary position to other members of the group. Their irregular attendance at the meeting further marginalized them leading to a high level of dissatisfaction. As Buckholdt and Gubrium (1979) asserted, the professional image remained the predominate image in the minds of team members. Their concern regarded the efficiency and effectiveness of the team meeting itself rather than its constructive or ritualistic aspects.

The Constructive Image

The constructive image, the definitional activities of the team, was still present and remained largely tacit as it had in the previous study. Staff continued to actively construct their definitions of patient problems within the framework of the meeting. These definitional actions were marked by overlapping speech and greater interaction than discussions about patients whose problems were more self-evident. In the latter case the discussions followed a more structured format in which one person reported their observations and others listened. Emily Smith, an occupational therapist, elaborated on this contrast:

EBC Why do you think the team meets, your opinion, not the legal reason?
Emily

I think it is our one chance to really hear from one another, to really get that clear picture. I don’t know always the medical stuff, I may not know what meds Dr. James just started the person on. I like to know the real juicy ins and outs of the family issues, that still are in the notes and in the chart, but it is nice to, sometimes Peter will elaborate. I like to know past history, which also comes up. That is vital, there was a person here, I use as an example, that was an amputee and I was doing ADL’s with her and she said she never wanted to get in the shower. She wouldn’t talk about it. She proceeded to do sponge bathing. And then I spoke to Amy and she said that she had been in a state hospital and she was manic and they sprayed her with a hose. And you know, hearing that, that piece of information from years and years ago, it may be past history but that is important for me. What if I went in there insisting one day that she get in the shower or she get in the tub? And little things like that are important.

I also think it is an important time to share the knowledge you have gained from your patient. To give that information and to also compare because sometimes the pieces of information that Dr. James is seeing is very different from what I am seeing or to let him know that mornings are better than afternoons for this person. But to try to give a little more specifics, and also sometimes elaborate more which you wouldn’t in a note. You know, that certain story, that certain episode, it might be hard to put that, you need to be concise in your notes. But to really let them know what it really was like, that you could tell them, it would be a lot better, a lot easier, than writing it out...

Sometimes I think it does feel like through the motions, if the person has just come in and we don’t know a lot of information, well, we’ll just go through the motions and that’s whose time are we wasting here? We don’t know this patient, we are guessing on some of this stuff or Dr. James is giving
the information cause he is the only one that knows. For me it's helpful to know first hand, what to expect. For me, that sharing piece, it isn't there because

I may not have gotten a chance to check the chart and all that information that Dr. James is going to say at the beginning is going to tell me a little bit about that person.

EBC So what distinguishes between going through the motions meeting is some-

Emily I think when we are really talking. You know how it seems like, OK patient education, like da da da da da, and it doesn't matter that you even say anything someone will keep writing and they will stop and will not be listening. You know when you can tell when people are really getting it, sometimes we will just go on and on and I think sometimes it is the time too. When we are pressed, you know it is going through the motions. What do we have today? Six patients. Let's go, and it doesn't feel like that real nice flow in learning about the patient (Field Notes #47, Card ID #38974:8/31/93).

Emily valued the interaction and the learning about the patient that occurred when "we are really talking." This knowledge comes from direct interaction with the patient. It also comes from talking to others since the "juicy ins and outs" may not be in the chart. The seemingly small detail about the patient who refused to shower made her behavior understandable rather than irrational.

Cara Ward, a nurse, reflected on her work with another patient with complex problems. These problems required "really talking" in the team meeting. Bessie had been in the hospital for over seven months because of
neurological problems which were very difficult to diagnose and treat.
During her entire hospitalization she consistently said that she wanted to
return home. The home she had been born in and where she had lived her
entire life. Because of her medical and psychiatric status it was difficult for
staff to determine whether going home was appropriate for Bessie. The
meeting scheduling Bessie’s discharge occurred after I stopped attending the
team meetings. Cara described her recollection of this meeting to me.

Cara  The other day we had a true, a true goal of what
team should be. We had a problem patient who we
hadn’t been able to decide if she would go to an ICF
or home and the team sat there and thought about
what would be best for this patient. Aside from all
the stuff that was going on and how we were going
to present it to the patient because she had been
refused from all the rehab places. And the team
decided as a team and agreed to word things to her
in a certain way that would make a positive
reinforcement that, “Gee you are doing so much
better that rehab places can’t help you so we’re
going to send you home cause you’re doing so well
with intensive community support and you’ll
attend the day rehabilitation program.” And the
five of us sat there and we invited physical therapy
to come up because they had been working really
closely with this patient.

EBC  Is this Bessie?

Cara  Yea, right and um, that was a true day of what team
can really do for a patient. We started out with me
going out of the room because Bessie was crying
and I told her, “Bessie, the doctor is going to be out
in a few minutes to give you some good news.” So
I had already set her up for some good news. Dr.
James went out and say, “Bessie you have been
doing so well that and we have been following
that.” and she is going home tomorrow. And her
whole attitude and affect has gone like way up. You know she may not do well at home, the fact remains that she should be given a chance to try.

She elaborated further and then said

**Cara**

I sat there and I said, well this is what a team should be. I haven’t done team too much, I’ve done it about six times and that was one of the first teams that I have been to when I really say everybody collaboratively putting their heads together and really thinking about what was going to be best for this patient. Even though they kind of do it, you could see the intent was really not to leave this room until we had made a decision about Bessie, which was great.

**EBC**

So, from what you have said, I have this feeling that there are some meetings with some patients that are talked about in a fairly routine way and then there are other times when you do more of this...And the kind of thing you are talking about with the patient which is reporting, thinking, and then planning and that it is the patients that determine that.

**Cara**

It could be. Some patients are very easy, they are admitted, you titrate the meds, and they go home. But she was a difficult case and it was good to see that collaboration (Field Notes #59, Card ID #46496:9/28/94).

Like Emily, Cara valued the collaboration necessary for Bessie to return home and recognized its necessity in “a difficult case.”

When I interviewed Susan Smith I suggested that some meetings are different than others. She responded

**Susan**

I only go to some, so I don’t know.

**EBC**

Some meetings um, are pretty routine. People say, “da da da, blah, blah, blah
Susan: Right

EBC: And then sometimes there is conversation. Have you ever been in one that there is?

Susan: The reason that there is conversation, is that the patient, the patient created it. The patient is demanding, the patient is demanding attention in essence. The patient is so sick, so neurotic, so depressed, or so something, everybody is taking notice and saying, “What the hell are we going to do with this person?” Now there is conversation (Field Notes #63, Card ID #98478:10/12/93).

The patient demands the conversation. Bessie, because her case was so complex and her goal to return home was so firm, demanded conversation. Conversation is required for those cases in which the standard approaches do not work, unlike patients whose problems are more straightforward. Cara said, “Some patients are very easy, they are admitted, you titrate the meds, and they go home.” It is in the conversations about difficult patients that the team constructs the patient problems, though this construction is not seen as a definitional process. Rather, they see it as a process of discovery in which their knowledge of the patient unfolds before them so they can act in their explicit professional roles. Emily’s search for a “clear picture” of someone reflects her perception of benefit of meetings, that is to discover knowledge about a patient. Discovery does occur in the team meetings, however, knowledge about patients once discovered must be interpreted. The team discussion about Iris reflects a process of active discovery and interpretation. The full transcription with interpretive comments of this meeting are found
in Appendix D. See Appendix B for symbols used in the transcription.

"Determination Plus Mental Impairment Equals What?" Iris was admitted to the unit with the following problems: decreased memory, panic attacks, fearfulness on awakening, tearfulness, and irritability. At the beginning of the meeting Sandra, the charge nurse, and Dr. James focus on her memory problems and anger. Peter, the social worker, reinterprets the anger as a survival skill, reframing the discussion to focus on her social history which apparently included significant poverty at one point in her life. In making this reformulation Peter constructs the anger, not as a liability for Iris, but as a strength which might help her in the future. As the discussion progresses through her social history they return to her cognitive problems and her need for a supervised living situation. However, Dr. James wonders how she will accept living with supervision, returning to their construction of her as angry and somewhat willful. Consequently, they alternate between seeing her as confused and unable to remember things, or willful and unwilling to follow the rules of the unit. These two constructions of her behavior can be seen in the dialogue that follows.

Dr. James (overlap with Emily) the bell, the bell (several overlapping voices here), I love the bell-

Sandra [overlap with Dr. James]-yea

Dr. James She carries the, she's supposed to ring the bell before she gets up (laughter) so she'll bring the bell to the nurse. Its like a-

Emily -yes [overlapping with Dr. James]
Dr. James here's the bell [gestures with hand out in front of him cupped as if to cradle the bell in it] [more gentle laughter]

Iris does not use the bell correctly, i.e., ring it for assistance, rather she brings it to the staff. From one perspective it could be argued that her memory problems were sufficient enough to remember that the bell is important, but not what she should do with it. Another interpretation is that she is cooperative to a limited extent, but she will do what she wants....i.e. that the problem is not memory but a generalized desire to maintain her autonomy.

Emily agrees to do a home evaluation to see how she manages at home. They decide that she should return home if appropriate supervision can be arranged. This involves coordination with the family, her physician, and Iris's acceptance of the day program as a volunteer opportunity. At some point in the meeting Emily tells the group that Iris is anxious to leave the hospital so that she can drive to the mall and shop, a daily activity she missed since her hospitalization.

Emily Spends a lot of money, she said, "I don't like, I don't like to be told what, you know, what I have to buy, I'm buying what I wanna buy." She likes to do that every day. Shop. Spend.

Sandra Um

Peter Determination plus mental impairment equals what? Bankruptcy?

The picture that emerges about Iris is that she is an independent, perhaps stubborn woman, who had cognitive problems. The mix of her willfulness
and mental status make understanding her behavior difficult. Is she carrying the bell rather than losing it because she can't remember what to do with it or is it a way of ignoring the rules of the unit and doing what she wants? These questions were raised several times in the meeting but never fully addressed. The home functional evaluation and neurological work up are designed to answer these questions. The meeting ended with a discussion of Iris’s discharge date and Emily’s plan to conduct a home visit. The outcome of this visit will influence the team’s discharge recommendations.

The Ritualistic Image

The cohesive pattern of interaction, the use of stories and humor, the shift of moods, which were quite evident in the first study were greatly diminished. There are several explanations for this difference. First, the team was not a singular group made of members who met three times a week as it had been in the original study. Rather there was a constant shift of people through the meeting, most notably the nurse who may attend only once every month or even less than that. Because the nurse convened the meeting, set the agenda, and functioned as the recorder for the group, the way that the nurse chaired the meeting determined in large measure the pattern of that particular meeting. The interaction style of the nurses varied considerably as did their ability to be organized and move the agenda at a steady pace. Consequently the meetings did not have a consistent rhythm meeting to meeting even though the basic structure of each meeting
remained unchanged. Thus the group went through the care plan topic to topic, as in the past, but the pace and tone of the group varied considerably from one meeting to another.

The care plan, called the EPU Assessment Tool, was organized into different categories (See Appendix E). In all meetings these were read in order. These included problems related to psychological, physiological, safety, psychosocial/legal issues, orientation and teaching of patient and family, discharge planning and aftercare, and functional performance. Typically the nurse copied the psychological and physiological information from the chart, updating it week to week as necessary. She would read this and Dr. James might make some changes if they were necessary. Safety issues were read quickly, typically this included a statement, “fall risk secondary to med titration.” Other safety issues were also listed as necessary. Most times this item received very little attention, it was almost an automatic part of the plan. It reminded me of the phrase “hopeless, helpless, feeling overwhelmed” that had been repeated so often in the first study. The psychosocial/legal issues discussion generally began with a contribution from Peter Tully. This section of the plan was considered “his”. Others joined in or asked Peter questions for additional information.

Orientation and teaching of the patient and family was also treated quite automatically. Stock phrases were used here as well. Joanne Weston, a nurse, said that she thought it was silly to include orientation and teaching in
the care plan since it was an ongoing aspect of care. The teaching role of the unit was well established and hence did not need much discussion. Typically teaching involved issues around safety and medications. If the patient had nutritional problems, teaching about nutrition also would be listed. On occasion, with a particularly confused person, a comment might be made about the fruitlessness of trying to teach this individual. Family teaching was also addressed here. Peter Tully addressed the discharge and aftercare aspect of the plan. Finally, the functional status would be addressed by occupational therapy. Sometimes the nurse would contribute to this section as well. In contrast to the previous study, there were clearer expectations for particular information from each person on the team. In the previous study, there seemed to be less disciplinary focus, people seemed freer to contribute to any section of the care plan.

During this study, the meetings with little conversation followed the steps as I outlined with little contribution of others while the primary person was speaking. The most rigid pattern of interaction in which everyone took their turn to speak with little overlapping speech seemed to occur with nurses who were highly structured in their organization of the meeting and patients who had problems which responded to care. Other meetings, typically when the patient’s case was difficult or the nurse was more active, had a greater degree of conversation. These meetings were characterized by
more overlapping speech and people speaking throughout the meeting, not just when their section of the care plan was discussed.

The meeting which discussed Iris is an example of one which is quite conversational. However, on closer examination the role of the nurse is largely focused on advancing the agenda of the meeting. During Iris's care plan discussion Sandra spoke 17 times. Of these, eight utterances related directly to advancing the agenda of the meeting. Only two provided information to the team about Iris's mental status and one offered an opinion about Iris's gentleman friend (Field Notes #11, Card ID #22880:7/7/93). Consequently Sandra's contribution to the understanding of this patient was minimal.

In contrast, Joanne Weston, took a much more active role in the discussion of Mary, a newly admitted patient. She advanced the agenda, as Sandra did, but also offered considerable information about Mary. This meeting could be characterized as conversational, like the discussion about Iris. Joanne repeatedly brought Mary's interest in knitting and her history as a painter of portraits to the discussion. She also mentioned her presentation of "claustrophobic kinds of things." She alternated between advancing the agenda which moved smoothly item to item and offering her insights about the patient. These insights reinforced a picture of a woman who knit and painted many portraits, in other words who had been quite accomplished despite her current mental status which is marked by lability, tearfulness,
sleepiness, and confusion (Field Notes #11, Card ID #1869:7/7/93). In this team meeting Joanne was as active as other team members in constructing their emerging understanding of the patient. The contrast between Sandra and Joanne reflects the different approaches the nurses took to attending the team meeting. Some were very structured in their approach and offered little information about the patient while others constantly contributed.

Although the basic agenda of the meeting was the same, as these two examples indicate, the characteristics of the nurse leading the meeting provided a significant influence on the interaction pattern of each meeting. If the pace of the meeting deviated too far from the expected Dr. James might motion to speed up the agenda or someone else might say, “moving along” or something like this. Typically, this would be triggered by a nurse who lost track of the agenda or who paced the meeting very slowly. At one meeting Dr. James patiently instructed a nurse new to leading the meeting about how she could prewrite some aspects of the plan, thereby speeding up the process. Because membership in the group changed meeting to meeting there was no longer a core group which was responsible for planning care of the patients. Rather this responsibility was diffused to all staff on the unit who attended the meeting.

The diminished cohesiveness of the group that planned care may also have accounted for diminished use of humor and stories. The only incident of “sick humor” that occurred during the summer concerned the patient who
bolted from the unit and fell down the stairs. This incident occurred one week prior to the beginning of my observation but was still an open wound for the staff. When this patient returned to the unit after her injuries from the fall were stabilized, her mental status seemed improved. Dr. James introduced her in the meeting as “our diver.” A few interchanges into the discussion Dr. James said:

...We’re talking very primitive cognitive functioning and processing. But she’s smiling and her mood is pretty good, seems to have simple concepts, fair comprehension, will to a degree go with simple one step, uh, commands which is better than before the fall. The only thing I can think of-

Catherine  -Stairapeutics

Dr. James  Well [laughter begins] we essentially lobotomized her and, uh, we gave her some ECT with two sustained seizures [the seizures and brain injury were the result of her fall]. [Someone sighs in the background, laughter continues].

Peter  Drop her on

Amy  Well, now that Lucille’s machine’s not working why don’t we do the same with Lucille? [Lucille is a patient receiving ECT. The ECT had been canceled for several treatments because Lucille had been running a fever. Now that her fever is gone, the ECT machine is broken, further delaying her treatment.] [Laughter really starts here]

Dr. James  Drop her on her head, watch her seize [more laughter].

Catherine  Springboard

Amy  Exercise groups [laughter continues]
Dr. James  We are terrible today.

Amy     Sick humor

Dr. James  Sick, sick

Marjorie  That was worse than usual (Field Notes #22, Card ID #22430:7/16/93).

This was the only incident of sick humor that occurred in the fifteen team meetings I attended. It seemed to provide significant catharsis for the group especially since it dealt with their frustration about Lucille and her delayed ECT treatments and their emotions about the patient who fell down the stairs. Perhaps the shifting membership in the group created sufficient discontinuity meeting to meeting undermining humor and stories as two forms of establishing a sense of belonging.

Consequently, opening the group to new members diminished the cohesiveness created by consistently meeting with the same people. The diffusion of participation to more people on the unit enabled other staff to feel that they had a role to play. It reduced the sense of the team as a single group which met consistently to a group which included a greater proportion of the staff. By pulling others into the meeting, the division between the “elite team members” and the “workers” was weakened.

With the change in team membership, the role of the nurse became problematic. Individual nurses attended team meetings on an irregular basis, perhaps every three to six weeks, leading the nurses to feel the least
comfortable with the team meeting process. However, the nurse also prepared the team sheet, led the meeting, and took the notes. These multiple responsibilities and marginal role in the group made participating in the discussion more difficult. Given these multiple roles, especially the role of secretary, it is little wonder that some nurses felt frustration with their role in the meetings.

This perspective was so dramatic that in the exit review with the staff I raised it as an issue. I explained the multiple roles that the nurses played in the meetings and their difficulties with these multiple roles. I also spoke about the symbolism of the nurse functioning as a recorder for the rest of the group when anyone in the group is equally capable of writing. We discussed these observations and I suggested that two nurses attend the meeting. This would give a broader view of the patient from the nursing perspective. I also suggested that the role of recorder be rotated in the group so that this responsibility is shared on a more equitable basis. People responded enthusiastically to these suggestions and began planning how they could arrange the shifts for two nurses to attend. They decided to implement the shared note taking responsibilities immediately. I felt that these suggestions were justified because the concerns of group were so consistent. This moved the project from one of participant observation to action research in which research findings are used to produce change within the system (Rheinharz, 1992:175-180).
Patient Participation in Team Meetings

The purpose of the team meeting is to plan care. Staff on this unit claim to be patient oriented yet the presence of the patient or the patient’s family was not seen as necessary in the team meeting. This omission is especially interesting in relationship to the mission of the unit and their belief that empowering patients is important. Meetings provide a forum for the group to enact the belief system of the organization (Schwartzman, 1989:9). Consequently this omission reflects an incomplete integration of the beliefs of unit personnel with their actions. That so few people recognized this contradiction speaks to the power of custom and habit in established health care practices.

Joanne Weston used Sophie as an example when she said that patients should be part of the meeting. Sophie was a patient who was well known on the unit. She had been admitted numerous times and had a history of not participating in groups, refusing medications, and in general being very uncooperative in her care. During Sophie’s second admission, when this lack of cooperation became really apparent, Joanne and a nurse from another shift worked together to get a consistent approach with her. This helped but was not enough. Sophie was brought to the team meeting so that the team could discuss with her the need to do her ADLs, etc. Joanne said, “If more patients came to the meetings and were told ‘this is what you have to do,’ maybe they would get more cooperation. Maybe the patients would realize that they had
to be active in the process of getting well” (Field Notes #48, Card ID
#39870:9/7/93).

Cynthia Clark also addressed the patient’s attendance at team meetings. She said that only once since she had been there that the patient came to the team meeting. She said that she wished the patients could come since the guardian always comes to the meetings, if the patient has one. I asked her why she thought it would be a good idea to have the patient there. She replied that it would be useful for the patient to hear about his or her progress with all the team present, to hear it from the group. She qualified this by explaining that this would not be appropriate for some patients, that some would not “get it” (Field Note #50, Card ID #6848:9/13/93). Rebecca Douglas expressed ambivalence about patient participation in the meetings

Rebecca I always said that the patient should be in with the treatment plan and the treatment team, what’s being done for them.

EBC So, you think that patients should be in the meeting?

Rebecca Not necessarily right there, but more active in the treatment plan, so to speak.

Later in the interview

EBC Now you said you thought the patient should be more active in the planning process. How could that work out?

Rebecca There is a lot of legal issues with the confidentiality. I’m not sure how much the patient would be allowed to come in. With the family, some of the times we have the guardian in here or
the power of attorney. And we constantly stress
that the patient has more rights and is responsible
for their treatment plan. Yet they don’t know what
goes on behind these doors. Just what Dr. James
tells them is going on and what the plans are.

EBC So the plan gets communicated through Dr. James?

Rebecca Right

EBC But filtered.

Rebecca um, hum [agreeing]. (Field Notes #62, Card ID
#48527 and #48812:10/4/93).

Rebecca identified an interesting inconsistency. If patients have guardians,
these people attend the team meetings in the patient’s stead. Yet those
patients without guardians have no such representation.

All three nurses articulated different ways of approaching inclusion of
the patients in the team meeting. But just bringing patients into the meetings
may not be enough. Gubrium (1980b:335-337) argued that strategic changes in
team meetings occurred when patients were present. These changes were a
result of the staff’s efforts to present themselves as carrying out their
professional roles in a rational and competent manner. These performance
strategies altered the focus of the meeting from planning care to impression
management.

According to Gubrium, two forms of exclusion occur outside of the
meeting frame. These are planning ahead and doing separate staffings
(Gubrium, 1980b:335-37). In both strategies staff interacted prior to the
inclusion of the patient to organize their plan for the meeting (Gubrium,
1980b:337-339). Other strategies occurred in the meeting frame itself such as “this is your life”, distancing, and subplotting (Gubrium 1980b:339-346). These efforts resulted in continued staff control of the care planning process by keeping the patient in a secondary and passive role (Gubrium, 1980b:346-347). Gubrium’s study demonstrated that including patients in meetings does not automatically increase the patients voice in the process. The process remained staff focused and controlled.

I asked colleagues about their experience of including patients in care planning conferences. Unlike long-term-care where this participation is a requirement (Gubrium, 1980b:335) no such requirement exists for rehabilitation facilities. Hence, it is unusual for patients to be included. Maureen Neistadt (1), departing from usual practice, included patients in the care planning meetings at an inpatient rehabilitation center for people with closed head injuries. She structured these meetings so that they were chaired by the patient and his or her case manager. This change in structure placed the control of the meeting in the hands of the patient. Consequently the meetings were patient centered and directed. She commented, somewhat ruefully, that after she left the facility the care planning process reverted back to the traditional staff focused orientation. This example and the explanations of Joanne, Rebecca, and Cynthia about why patients should be included in team meetings indicate support of Gubrium’s findings. Given the mission of the unit to increase the independence and quality of life of
patients, how was this goal achieved if patients did not participate in the
planning process? The next section of the chapter will deal with this question.

**Discharge Discussions**

Discharge decisions may ultimately be the most important outcome of
care. How staff discuss the expressed goals of patients, direct their care, and
shape discharge recommendations reflect how they attend to patients' goals.
Much of the staff activity is concerned with discharge decisions. The mission
of the unit is to return people to their homes if this is possible. This goal is
achieved by evaluating patients in at home and teaching them new ways of
managing on their own. The home evaluations are ordered for those patients
who want to go home but have either mental status or physical problems that
may make this difficult. The goal of the evaluation is to see how patients
function in their at home and away from the unfamiliar hospital setting.
Safety is a particular focus of the evaluation, both from a physical standpoint
such as the patient’s capacity to negotiate stairs and other physical barriers,
and from a mental status standpoint such as the patient’s ability to use the
stove safely and make emergency phone calls. Because the environment is
familiar to the patient, long-established routines and habits may enable them
to function more independently than expected (Rowles, 1991) The outcome
of the home evaluations are specific recommendations regarding the physical
aspect of the house as well as anticipated supervision needs. As the
discussion of Iris indicated, the home evaluation should answer questions
about whether Iris has sufficient cognitive function to be left alone at home and/or what type of supervision is necessary to assure her safety.

An analysis of the team meeting discussions about discharging patients revealed the way staff articulated discharge issues in the meetings and planned their approach to patients. Typically, staff concerns would be aired and specific recommendations would be made for the patient and the patient's family. The discussion about Iris was typical of discharges which were thought to be problematic. The recommendations flowing from these discussions were framed as information for the patient and the patient's family to use to make a decision about discharge. This information would be shared with family because their support might be an essential component of making the discharge work. The extent of their involvement varied depending upon the patient's ability and the relationship between the patient and family members.

In Iris's case, the home evaluation confirmed staff concerns about her memory and safety expressed at the team meeting discussed earlier in this chapter. A transcription of this discussion is in the second part of Appendix D. The occupational therapist's report at the next team meeting reinforced the importance of Iris's male companion. Emily, the occupational therapist, gave several examples of his efforts to help her even though she wanted to do things for herself. Emily explained how much Iris wanted to be independent and that Iris was beginning to realize that she had to make changes if she was
going to return home. Emily said, “She is concerned. She knows she doesn’t want to fall again and have that unsteadiness” (Field Notes #16, Card ID #20560:7/17/93). Later in the discussion the daughter was mentioned as an ally and the neighbors as supports. But the problematic nature of the discharge was reinforced in the closing exchange.

Emily: But, you know, she really did surprise me, like on the home visit. There were several times, you know, that she wouldn’t answer something safely or appropriately, but then with, you know, her problem solving would turn around so she would get herself out of a jam. You know, that, she was able to, and maybe that’s a survival skill, you know she’s got-

Dr. James: -you should avoid jams-

Emily: -Yea, yea- [chuckling]

Dr. James: -not get your way out of them.

Emily: But she was able to do it. Which, hey, that’s a skill [laughing gently as she talks]

Sandra: yea

Dr. James: That is a survival skill (Field Notes #16, Card ID #20560:7/17/93).

This discharge plan was not easily achieved, however, absent from this discussion were considerations of alternate living arrangements. Returning home was Iris’ goal and the staff endorsed that goal and structured their recommendations and actions accordingly. Dr. James comment about Peter’s need to “creatively corral” Iris reflects the complex nature of this process. For a full transcript of this aspect of the second meeting about Iris see Appendix D.
In all instances, with the exception of Sophie, the staff structured their discharge recommendations to conform to the goals of the patient and in some cases the wishes of the family. Sometimes this meant organizing complex and expensive twenty-four hour care for patients whose mental and/or physical capacity was so diminished that they could not be left alone. Sometimes it meant that family members would significantly increase their care giving responsibilities. Bill returned home despite his confusion and agitation and significant care giver stress because his family preferred this to institutionalization. From a staff perspective his discharge home was unrealistic because he had been so difficult to handle on the unit. Family members were already experiencing considerable stress, making the home placement even more problematic. As Peter said, “We need to discuss alternatives to home based care unless there is a silver bullet” (Field Notes #31, Card ID #29771:7/26/93). No silver bullet was found but the family desires prevailed. To achieve their goal, however, one of Bill’s daughters and her family moved into his home. Even Catherine, the patient who discharged herself against medical advice, was discussed in a way which respected her fear of being on a psychiatric unit. Rather than being angry at her they framed this discussion in a sympathetic way, talking about her fear and regretting that this interfered with her need for care (Field Notes #40, Card ID #35262:8/4/93).
The only exception to this patient-centered approach was Sophie. Sophie tried everyone’s patience. She refused treatment yet managed to get herself admitted to every psychiatric hospital or unit in the area. Peter referred to her as “the Robin Leach of Psychiatric Units.” Her lack of cooperation was so evident that one of the patients in a discharge planning meeting said to Marjorie, “This lady doesn’t want to get better.” During this admission it was clear that forces external to Sophie were going to control the discharge decision which would be either to a nursing home or the state intermediate care facility for people with chronic mental illness. Peter concluded that people from nursing homes would not “buy that kind of problem” once they read her record. Sophie’s pattern in the hospital was consistent with previous admissions in that she would stay in bed most of the day, refuse medications, not bathe and dress, etc. It was very clear that staff were frustrated with Sophie, more frustrated than any other patient admitted during the study. Amy, an occupational therapist, said,

Amy

She’s hard because I like her and I feel like, but yet, she’s tough. I think it’s because she is one of these repeaters, who you never see get well, who makes the caregiver feel totally like incompetent. She stirs up all these feelings in us, and sometimes I think she deliberately wants to, which makes me even madder [both laugh]. I don’t know. Her first two admissions, I was kind of part of her, I tried relaxation tapes, I’d try let’s go out to the store together, let’s get over these fears, let’s try. I was bringing in all of these things for this woman, and she was, ‘no, no, no.’ Balking at everything. And then the third and fourth admission, I got more challenging and confronting with her and saying
you are not doing anything to help yourself, you
want us to fix everything and we possibly can’t.
And like, finally our relationship grew in that sense
because I was able to be much more like direct with
her about what I was thinking and stuff. And I
found that she trusted me a lot more, so in some
ways I feel that we grew closer over the last few
admissions.

EBC

Even though you were being more confrontive
with her?

Amy

Right, right, and even though we still weren’t
making any headway, we weren’t getting anything
resolved and nothing was changing, we were
definitely, she was definitely sharing more, you
know, so. I feel that we have never met a goal, in
how many years she has been here, so she is really
frustrating, are they our goals or are they her goals?
I think that about her goals, I don’t think she really
has any (Field Notes #54, Card ID #43729:9/21/93).

Sophie never cooperated and was discharged to a community crisis bed
awaiting a bed at the state facility. Her desire to return to her apartment was
ignored. Perhaps one of the reason’s staff were so frustrated by her was that
her repeated admissions and noncompliance were a direct affront to their
beliefs about the unit. Sophie directly challenged their belief that their actions
could improve and change the quality of life for their patients. Perhaps,
however, as Amy said, “Are they our goals or are they her goals? I think that
about her goals, I don’t think she really has any” (Field Notes #54, Card ID
#43729:9/21/93). How can patients be empowered if they have no goals?
Conclusions

The team meetings on the unit reflected the growth of the unit and the diffusion of responsibility for planning care to more people. This growth and diffusion resulted in less cohesion between the people who met to plan patient care. The ritualistic aspects of the team meetings changed as a consequence. With few notable exceptions, staff did not notice the absence of the patient in the meetings and seemed to be unaware of the process of objectification which occurred as they discussed the patient. Consistent with Gubrium’s findings, the staff also were unaware of their creativity in constructing patient problems. Despite the absence of the patient from the meetings, the staff in their discharge recommendations kept the patient’s goal as the focus of their concern. Hence, their actions while not empowering to the extent that full patient participation might permit, did reflect respect for the validity of patient goals. Despite the efforts of unit personnel to empower patients, the team meeting reflected the power of the medical model which continued to dominate its structure and organization. The final chapter discusses the questions raised by this study. In particular, I will speculate about the coexistence of the medical model and empowerment model in relationship to an acute geropsychiatric population.
CHAPTER VII

SUMMARY, CONCLUSIONS, AND FUTURE RESEARCH:

BELIEF AND ACTION IN THE REAL WORLD

This has been a journey of understanding and discovery begun over three years ago with my first study of the team meetings on the EPU. In the second study I broadened this focus to observe staff in their daily work as they interacted with each other and with patients. I attempted to enter into the world of the staff of a geropsychiatric unit. In doing so I tried to understand how they conduct their work to improve the lives of the patients they serve. Initially, I wanted to focus on the deliberations of staff during the team meetings. This focus broadened to include an exploration of the beliefs of unit personnel and the extent to which these beliefs were enacted on a day to day basis. This final chapter begins with a summary of the major findings of this study. I then make some concluding remarks and pose questions for further research.

Summary

I began this study with a review of psychiatric care from seventeenth century England to the present. In institutional settings other than the EPU, there was a greater division between patients and staff. Closer observation and greater coercive actions were a routine aspect of psychiatric care in these settings. While still present on the EPU, coercion is almost nonexistent and
observation is greatly reduced. In other settings staff have great power over
privileges and access to certain items such as cigarettes. On the EPU, staff still
control access to smoking. However, this is not used as a mechanism for
punishment or control. Rather, this access is constrained by the availability
of staff time to supervise the smoking. The physical characteristics of the
unit, as well as the social interaction between patients and staff, is more
consistent with a medical or surgical unit than the psychiatric units described
in the literature.

The unit is led by Dr. James who has a clear view of the unit mission.
This mission is twofold. First, it is to improve the quality of life and
independence of the patients admitted to the unit. Patients are seen as people
who have led productive lives and are experiencing psychiatric problems of a
short term nature. These problems are thought to be responsive to the
interventions of the team. Second, the mission is directed at changing the
cultural stereotypes which devalue people who are old and have been labeled
as mentally ill. This broader focus of social change creates a messianic tone to
the unit. In large measure this is due to Dr. James' vision, however, many
staff members have also adopted this view.

The explicit nature of the mission sets clear expectations for unit
personnel. These expectations are highly idealized leading to some
frustration when they cannot be fully achieved. The mission also creates
standards for staff to evaluate people external to the unit. This evaluation
concerns the degree to which others are thought to value and support the unit mission. For example, unit personnel expressed frustration with hospital staff and people from other agencies who did not understand their mission nor respect the need for elderly people to receive competent psychiatric care. The isolation of the unit, both physically and philosophically was reinforced by a hospital administration which was not entirely supportive of the unit. It is ironic that while staff tried to facilitate the independence and autonomy of their patients, they felt isolated and disempowered by the hospital in which they worked.

This isolation was reinforced by the competition between the dominant medical model of the hospital and the incompletely developed empowerment model of the unit. The primary socialization of most staff is in the medical model. The hospital bureaucracy as well as its policies and procedures reinforce this model with its reliance on the authority of the physician to direct patient care. This model constrains unit personnel in what could be described as a Weberian "iron cage" of bureaucratic rationalization and authority. In contrast, the mission of the unit incorporates elements of the empowerment model. In this model, staff assume the role of teachers and facilitators who help patients learn about their problems and develop new ways of coping with them. The teaching focus of the unit is consistent with this approach. Actions of staff reflect the competition between these two models. Staff often feel conflict about
whether to make decisions for patients or to provide the opportunity for patients to make decisions for themselves. This is especially true for safety issues.

The efforts of staff to respect the autonomy of patients while at the same time enact their professional roles reflect the conflict between the belief systems of the medical and empowerment models. The power of the medical model is greater than the empowerment model because of the bureaucracy of the hospital and the primary socialization of the professionals on the staff. The tension between these models seemed to be the greatest in direct patient care when staff had to make decisions quickly, such as whether a patient should walk independently or not. How staff acted either reinforced the autonomy of patients or the powerfulness of staff. That they experienced these decisions with anxiety rather than with the authority of the medical model reflects the infusion of a different belief structure into the dominant medical model. In the past, it is likely that they would not have questioned their professional authority to know what was “right” for the patient.

Despite the introduction of the empowerment model on the unit, team meetings consistently excluded patients reinforcing the professional control found in the medical model. Most staff did not recognize this contradiction. However, despite the patient’s absence from the meetings, staff were consistent in their efforts to attend to the discharge goals articulated by patients and/or their families. Thus, in meetings which objectified patients
and their problems, staff struggled to construct an understanding of the patients which reflected the patients’ world and experience. These struggles were especially apparent with patients whose problems were difficult to resolve. Susan Smith, one of the most severe critics of the team meeting process, said that this conversation occurred because “the patient created it...The patient is so sick, so neurotic, so depressed, or so something, everybody is taking notice and saying, ‘What the hell are we going to do with this person.’ Now there is conversation” (Field Notes #63, Card ID #98478:10/12/93). Meetings about these patients were characterized by more conversation. Team meetings about patients who responded in more predictable ways consisted of reporting the patient’s progress with less overall interaction between staff. Thus two general meeting forms emerged. One which could be classified as conversational the other reportorial. In the conversational form, staff actively constructed their understanding of patients and their problems. In the reportorial, staff reported their observations but did not engage in any form of constructive or definitional activity within the meeting itself.

The meetings in the first study were characterized by a high level of cohesiveness. This occurred because the membership of the team was consistent meeting to meeting fostering a high level of trust and belonging among team members. However, this structure created a barrier between members of the team and other unit personnel. In the second study the
definition of team membership became more fluid. It fluctuated between seeing the team as the people who met to plan patient care to including all unit personnel. The meetings themselves varied substantially meeting to meeting dependent upon the people attending and the leadership style of the nurse leading the meeting.

This study demonstrates that change in cultural beliefs occurs slowly and causes tension and anxiety as an old belief structure is influenced by a new one. The uneasy alliances between the medical and empowerment models testifies to the difficulty EPU staff have with this process. Their efforts, however, demonstrate the need for health care personnel to question the authority of the medical model, most especially in non-emergency situations which require a high level of patient cooperation. The staff of the EPU challenge all health care providers to think of their relationships with patients and family members in different ways. Their efforts need our support because this is the only way that patients and their families will acquire greater control over important medical decisions which have the potential to affect the quality of their lives.

Conclusions

The EPU sits at the intersection of two competing ideologies, the medical model and the empowerment model. EPU staff use both ideologies as they conduct their work. Acting to empower patients in some situations and to take control in others. It is not surprising that staff do not enact their
beliefs consistently for their professional socialization has largely been in the medical model. Furthermore, the unit is housed in an institution which reinforces and supports the hierarchy of the medical model and does not fully recognize and support their mission. This lack of consistency does not reflect incompetence or lack of will, rather this discrepancy is reflected in the distinction between the idealism of their beliefs and the constraints on their actions imposed by real world realities (Gubrium, 1991:8-9).

The medical model and the empowerment model allocate power in opposite directions. In the medical model the professional power of the physician and other health care workers directs the care of patients. In the empowerment model the health professionals return power to patients to enable them to take a more active role in directing their care. The direction of power shifts so that the professional power of the doctor and team members changes from providing care to a teaching/learning role in which patients and professional learn from each other. This involves listening to the illness experience of patients so that treatment can reflect their unique situations rather than the application of a standardized protocol (Strauss and Corbin, 1988:30-34; Reiser, 1993:1013) The fully implemented empowerment model would entail a system in which care is planned collaboratively, respecting the integrity of patients' experience as consumers of medical services (Reiser, 1993:1016-1017). Treatment regimes designed to fit with the routines of patients' lives would increase the level of compliance and presumably the
quality of their lives (Strauss and Corbin, 1988:142). Because the empowerment model implies a voluntary ceding of professional power from the staff to the patients, power thus ceded can be reclaimed when staff choose. The staff actions with Sophie, whom they viewed as uncooperative and manipulative, demonstrate this reversal. Thus, empowerment, because it is given by staff, can also be withdrawn, giving it a flavor of noblesse oblige. From this perspective, the empowerment model could be viewed as a gloss on the medical model - softening the authority of the medical model but not actually replacing it.

There are two reasons for the incomplete diffusion of the empowerment model. The first relates to the relationship between culture, technology, and structure in hospital organizations. The second to the belief systems of patients and their families. Perrow (1965:915) argued that technological change stimulates change in the culture and structure of organizations. Reiser (1993:1013) identified the ethics movement of the 1950s and 1960s as a response to such technological advances as the respirator and kidney dialysis. Political change in the 1960s further stimulated the discussion of ethics and the importance of the patient’s rights to participate in managing their care. This led to the development of the patient’s bill of rights in the 1970s (Reiser, 1993:1014). The empowerment model continues this trend toward democratization and continues to foster changes which
support full disclosure of information to patients. This trend is influenced by the feminist movement in that it is anti-patriarchy and anti-hierarchy.

The development of new pharmacological approaches for depression and other mental illnesses might foster additional change within the system. However, these new technologies have not been in existence long enough for this change to occur. The bureaucratic nature of our institutions and the traditions of professional privileges slow the implementation of the empowerment model. This lag between the changes in technology and the development of belief systems and the structures to support them is consistent with Perrow's argument (1965).

While earlier technological advances, such as the artificial kidney, stimulated an increase in patient rights, the dominance of the medical model persists not only within organizations but in the beliefs of patients and their families. Many patients admitted to the EPU continue to fulfill the expectations of the sick role articulated by Parsons (1951; 1975). They place themselves in the hands of the professionals on the unit because their problems exceed their ability to solve them independently. Emily addressed this issue when she said that patients needed to learn to be assertive in regard to their care, "Like when they come to the hospital, to be assertive with their doctor, their nurse, with me, for themselves. And that comes through in every group, that really standing up for themselves" (Field Notes #47, Card ID #37795:8/31/93).
Many practices and traditions of medicine must change if the empowerment model is to transform medical practice. This will be difficult to accomplish. In addition to the highly entrenched bureaucratic constraints and the expectations of patients, the empowerment model requires that staff relinquish their power and authority. The language used to describe empowerment is revealing. It is an action of people in power to enable someone else to gain power. The action is initiated by those with the power rather than people gaining power for themselves. Marjorie talked about “empowering patients,” not about patients striving to gain power within the system on their own initiative. Emily’s comments are consistent with Marjorie’s. Empowerment from this perspective involves the relinquishing of power by professionals and the creation of an environment which enables and supports the acquisition of greater power by patients.

As this study demonstrated, this is not an easy task, even when people are committed to do so. It is made more difficult when the judgment of patients may be questioned. This raises questions about the ethical limits of the empowerment model in a setting designed for people who are seeking psychiatric care. What responsibility do health care workers have to assure the safety of patients whose judgment is clouded by depression or dementia? When do health care practitioners know that patients are in “their right minds?” The dilemma Amy faced with Bessie reflects these questions. Was Bessie being realistic in her desire to return home? Amy wasn’t sure she
could cope. Practical things like getting her mail, doing laundry and other routine activities were beyond Bessie’s capabilities yet Bessie insisted she “could manage.” That staff struggled so hard with her discharge reflects their ambivalence about her judgment and abilities. That she went home reflects their willingness to follow her desires and risk her safety - a risk she was willing to assume.

The teaching function of the unit and discharge decisions reflects a high level of consistency with the empowerment model. However, this consistency fell down when it came to inclusion of the patient in the team meetings. Patients were consistently excluded from the meetings which addressed their problems and needs, and planned their care. Bessie waited outside Marjorie’s office while the staff debated her fate. Thus while staff said that they were encouraging independence and autonomy their actions in relationship to the team meeting contradicted this belief. However, including patients in the meeting would not assure their full participation. Most likely, as Gubrium (1980b) found, staff would find subtle and not so subtle ways of excluding patient participation. Status differences between a group of highly skilled professionals and a lone patient would intimidate many patients. Lisa Abbott, one of the nurses on the unit, reported that she felt intimidated in the meetings. If she felt that way, it is likely that many patients would as well.

For full participation to occur the pace and language of the meeting would have to shift so that a lay person could participate. Jargon would have
to be translated or avoided. The importance of various observation, findings, and recommendations would have to be explained so patients could understand the implications for their care. These changes would slow the meeting substantially.

With patients present staff couldn’t explore issues in the same way. Emily couldn’t have told the story about Iris’ driving if Iris had been in the room. Nor could Dr. James have responded as he did by saying, “oi vey.” This emotional response would not have been possible in Iris’ presence. Consequently, Iris’s presence would have prevented staff from fully airing their concerns and frustrations. This type of work is stressful. The team meetings provide a way for staff to talk candidly with each other and to support each other in the work they do. Inclusion of the patient would change this dynamic. Whether staff could ever get comfortable enough to include the patient fully when these frustrations were aired is doubtful.

Patient inclusion in the team meetings would expose the uncertainty inherent in medical decisions. This would undermine the perception that the doctor and the rest of the team have a clear understanding of patient problems and their solutions. Demonstrating too much uncertainty to patients would demystify treatment decisions. Much of the authority of medicine rests on the belief that doctors and other health care workers know how to diagnose and treat patient problems. Full empowerment, because it involves full disclosure, has the potential to undermine medical authority
disclosing the mystery behind seemingly "professional" decisions. The comparison to "Opening Pandora's Box" is as appropriate for medicine as it is for science (Gilbert and Mulkay, 1984). Consequently, it is not surprising that staff do not rush to include the patients in their deliberations. It would expose their deliberations to others and undermine their professional authority. At a practical level, beyond this threat to their professional authority, meetings would take more time if patients were included. Staff would have to translate their jargon to lay English and explain the implications of certain recommendations. Most importantly, they would have to listen to the patient's ideas and experiences.

**Suggestions for Future Research**

It is hard to know whether full inclusion of the patient in the decision making process would make a difference in the outcome of care. The empowerment model is built on that assumption. However, this assumption should be tested, especially with a group such as a geropsychiatric population. The ethical implications of the application of the empowerment model with old people receiving psychiatric care needs to be explored. Questions of competency are especially important. Studies could focus on these issues to clarify when and to what extent it is appropriate to foster patients' active involvement in their care and when their judgment is sufficiently impaired so that this involvement is no longer appropriate. Other studies could focus on examination of the long term status of patients discharged from the unit.
Since the concept of empowerment is central to the work of unit personnel it would be interesting to see if patients and/or their families felt more included in the decision making process than prior hospital experiences. Did hospitalization change the quality of patients' lives and in what way was this change produced? Finally, are the morbidity and mortality rates of this group of patients different from a similar group of patients treated in a unit structured more closely on the medical model. This final question addresses issues of efficacy and cost effectiveness. Exploring the outcome of care on a systematic basis would enable staff to understand the impact of their efforts to empower patients and to see if this approach is just window dressing or produces real changes in the lives of patients.

A study could address some of the questions listed above through participant observation and interviewing while people were in the hospital and at intervals after discharge. This study could assist the staff in understanding experience of patients and their families. This type of research could help staff design approaches which maximize the quality of life for everyone. It would be interesting to structure this project as action research which would focus on both evaluation of unit practices and changing these practices to improve the experience of patients and staff and the overall effectiveness of the unit (Rheinharz, 1992:177-180). If the changes already implemented which give patients more power and control prove to enhance quality of life, action research could continue this process of social change.
This could focus on ways to equalize the power discrepancies between patients and staff. Various forms of the team meetings could be tried to see how patients could be included in the process as full participants. This would assure that the patient, not some staff constructed abstraction of the patient, would be heard. For those patients with adequate mental capacity this active role has the potential to be a valuable learning experience. It could give them the opportunity to practice directing their care in the supportive environment of the unit in preparation for returning home where they will have to assume greater responsibility for their care. For patients too incapacitated to assume responsibility for their care, their care-givers would benefit from this practice because managing care in the community requires great sophistication, patience, and assertiveness.

This unit is attempting to create new ways of treating patients by giving them more power in the treatment and discharge planning process. In order to understand power in patient/practitioner relationships a scale could be developed to assess power in these interactions and in relationship to the attention of staff to patient stated goals. Such a scale or observational guide would help in comparative studies in other health care settings to see how power is allocated between patients, their family members, and health care workers. These measures should include verbal and nonverbal data, especially because much of human interaction is transmitted in nonverbal forms.
A fully implemented empowerment model involves redefining the role of health professionals, patients, and their families, and restructuring the health care system. Patients would have to relinquish aspects of the sick role and take a more active part in their care. Staff would have to redefine their professional responsibilities from a concern about caring for patients to the concern that patients are fully informed so that they can take responsibility to direct their care. Patient education would assume an even greater role in the practice of medicine. Staff would have to make an even greater commitment to teaching patients and fostering their autonomy. Ethical issues about the competency of patients would assume greater importance. Given these constraints, it is little wonder that EPU staff feel an uneasy alliance between their idealistic belief system and the actions they perform in the real world.
EPILOGUE

Several weeks before completing this dissertation I was invited to Dr. James' going away party. He had resigned from his position as medical director of the unit, the final act in a relationship with hospital administration which had been difficult from the start. About thirty of the current and former EPU staff gathered to honor his contributions to the unit and to reminisce about their work together. It was a jovial evening, tinged with sadness because their leader was leaving. One of the staff read a poem about Dr. James. The poem captured his humor and dedication and very effectively tweaked him for some of his quirks. There were few dry eyes in the group when the poem was over. Dr. James responded with a short speech which characteristically emphasized the importance of the mission of the unit and keeping that mission primary in their work in the future. He spoke about his new plans for the geropsychiatric population. He described their work together as circles which were separating but would link again in the future.

That evening marked the end of the first era of the GPU. This closure began with Peter Tully's departure about six months ago. Elaine Bailey, the unit secretary, was transferred to another unit several months later, preceding Dr. James resignation by only a few weeks. Marjorie, Amy, and several nurses remain from the original staff, but the founding core has disbursed. Although it is the end of the era some relationships continue. Peter has
joined Dr. James' medical group and in this role works with unit personnel as
they plan to discharge Dr. James' patients. So, while he is no longer a
member of the staff he maintains contact with unit personnel.

Several days after the party I met with Marjorie to review some aspects
of this document and to catch up on the changes which have occurred in the
last few months. I asked about the role of the nurses in the team meetings.
She said that they have not been able to arrange to have two nurses attend as
we discussed in my exit meeting with the staff. She has assumed the role of
the recorder in some meetings. Others apparently do not volunteer to record
the meeting in Marjorie's absence, leaving the note taking in the hands of the
nurse who is leading the meeting. The structural aspects of the team
meetings, therefore, remain the same, with the nurses continuing in their
multiple roles which diminish their opportunity to contribute to the
discussion.

I asked for information about the current status of patients I mentioned
in this dissertation. Between Marjorie, Dr. James, and a phone call to Peter,
they were able to provide this information. Bill was discharged to his home
as his daughters wanted. He died about a month after this discharge. No one
knew the cause of death. Josephine returned to her sheltered care home. She
died about six months after discharge. Harriet continues to attend the day
care program. Peter reported that she has made a number of ninety year old
friends who have helped her "normalize" being ninety. Mary is in a
sheltered care home for Alzheimer’s patients and is doing very well there. Iris continues to live at home with her male companion. Dr. James said that he saw them last week and that Peter’s plan to “creatively corral” her has worked. Lucille was discharged to a sheltered living facility and several months later transferred to another facility in her home town. Her adjustment there is reported to be excellent. Sophie was at the state mental health intermediate care facility. Although the plan when she left the unit was for her to remain there, her guardian told Dr. James that Sophie was mobilizing her forces and had found a lawyer to obtain her release. Finally, Bessie, despite the tenuous nature of her discharge, is functioning well at home. She has weathered several crises including the death of an aunt who had been helping her manage with some of her day to day care.

Change is inevitable in any organization. Eventually the EPU had to face new leadership, however, the next few months will be difficult until the new physician begins and a new era opens. The unit I studied no longer exists as it did last summer. As I write this final chapter I find myself wondering about its future. How will staff manage the changes which lie ahead? Will the mission remain as focused and bright as it was? The next study in several years time will answer these questions and explore the meaning of independence and quality of life for patients discharged from the unit.
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APPENDIX A

UNH I.R.B. # 1232

PROTOCOL FOR RESEARCH INVOLVING HUMAN SUBJECTS
HILLSIDE HOSPITAL

Title of Project: An Ethnography of Geropsychiatric Team Meetings: A Study of Clinical Reasoning

Date: March 8, 1993

Principal Investigator: Elizabeth Crepeau, MA, OTR, FAOTA, Sociology Department and Occupational Therapy Department, University of New Hampshire, Durham, NH.

Co-Investigator: Marjorie Coleman, M.Ed., RN, CNA, Unit Director, Elderly Psychiatric Unit

Investigator Responsible for Correspondence: Elizabeth Crepeau
address: Occupational Therapy Department, Hewitt Hall, University of New Hampshire, Durham, NH 03824 telephone: 603-862-0416

Approval for Submission to the IRB

........................................ Signature of Primary Reviewer

Hospital Departments: (identify those committees or departments affected by the protocol):

........................................ Are any of the following included as research subjects
Signature of the Chairman (Department of Committee)

........................................ minors
........................................ fetuses
........................................ abortuses
........................................ pregnant women
........................................ prisoners
........................................ mentally retarded/disabled

Signature of the Chairman

........................................ Funding Source:
Signature of the Chairman none

........................................ Industrial Sponsors none

For I.R.B. Use Only:

........................................ Date Approved
........................................ Signature of Chairman, I.R.B
II. Description of the Study

a. Purpose: This qualitative study will be anchored in systematic observation of a geropsychiatric team and interviews with its members and will deal with the following issues:

1. To develop an understanding of the function of team meetings in relationship to the delivery of services to the patients on the Unit, to the team members, and to other staff on the Unit who do not participate in the meetings themselves.

2. To describe how individual members of a geropsychiatric team come to understand the problems of their patients in relationship to their professional socialization, work experience, and personality.

3. To describe how individual perceptions of the team members become integrated into an interdisciplinary plan of care. To identify the influence of the membership, structure, organization, group norms, leadership, and history of the group on team decisions.

4. To identify and describe the influence of power and persuasion on team decisions. To identify the distribution of power on the team and the sources of this power.

5. To describe the significance of silence, elation, "sick" humor, and other factors in establishing the mood of meetings and the formation of a sense of cohesion in the group.

6. To describe the influence of factors external to the team: the hospital and its rules, community agencies, reimbursement mechanisms, and family dynamics on team decisions. To identify the extent to which the team explicitly deals with these factors.

7. To describe how the understanding of patient problems is individually achieved by team members and how it is transformed in team meetings. To see how the evolving understanding of patient problems is revealed in the medical record and team deliberations.

8. To explore how the plan of care is implemented by the team members and other staff members not involved in its development.

b. Background

A central issue in health care is the development of treatment plans which will bring about improvement in the patient's condition. In psychiatric settings, nursing homes, and rehabilitation hospitals team meetings or patient care conferences are the arena for the development of these plans. It is at these meetings that patient problems are discussed by members of the team and a consensus is reached regarding approaches to improve the patient's condition. Because team members come from different disciplines, they may interpret and define the patient problems in multiple ways (Buckholdt and Gubrium, 1979: pp. 255). The discussions and negotiations in
which consensus is reached in geropsychiatric team meetings is the central focus of this research.

Patients have multiple biographies which are important for health care personnel to understand. First, they have their experience with their illness; second, their experiences with health care personnel and facilities; and finally, their social biography which consists of their relationships to family, friends, and coworkers. (Strauss and Glaser, 1975: pp. 137-138). These biographies influence the patient's attitude toward their current problems and, therefore, become an important part of the data collected by health care professionals.

The effectiveness of the treatment plan is determined in some measure by the degree to which health care providers listen to and understand troubles presented by their patients (Paget, 1983; p. 55-74). This communication process is influenced by the ability of team members to understand the perspective of the patient as well as other members of the team. Schutz (1967; pp. 97-138) explained that our understanding is based on our knowledge of others and our ability to appreciate the intended meaning of the speaker. This requires that we gain an appreciation of the individual's past experiences from that person's perspective. Unfortunately, our ability to enter the meaning world of another individual is necessarily limited and thus our interpretation of the intended meaning of others is likely to fall short (Schutz, 1967; pp. 97-138).

Further complicating the development of understanding is the constructive or definitional process which occurs when staff members interpret specific problems or behaviors in different ways and negotiate what these behaviors mean (Buckholdt & Gubrium, 1979: 256-257). One reason for this difficulty is that health care professionals are socialized to view patient problems from the values and beliefs of their professions. Thus professional socialization (Freidson, 1986) may undermine the development of complete understanding and consensus in team meetings.

My intention in this project is to observe team meetings and interaction on the Unit itself in order to begin to understand how factors of intersubjective understanding and professional socialization enter into the deliberations of the team and the development of patient care plans. The nature of patient problems is not the object of this study. Rather its focus is the way in which health care providers negotiate the meaning of this information in their deliberations.

References


c. Location of the Study: This research will be conducted on the Elderly Psychiatric Unit at Hillside Hospital in Any City, New England. This is a 16 bed acute unit which is designed as an evaluation unit. Patients typically spend no more than three weeks on the Unit and are discharged to their homes, supervised living situations, and/or nursing homes.

The subjects of the study are the members of the geropsychiatric team. Because patient data is discussed at team meetings, patient permission will be sought even though the data itself is not the focus of the study.

Also, because data will be collected through interaction with staff members on the Unit permission to conduct the research will be needed from all staff members and patients on the Unit.

d. Probable Duration of the Project: The observation period will begin in early July after permission is obtained from Unit personnel and patients. Observations will be made approximately 20 hours/week for 8 to 12 weeks. Data analysis will occur concurrently. The researcher will review findings with the team periodically during the data collection period and for a period of 6 - 8 weeks after data collection has been completed. The purpose of the review is to test the interpretations with the people involved in the study, thereby improving the trustworthiness of the findings.

March ........ submit IRB proposal for review and approval
April ........ obtain approval from Hillside Hospital and submit to UNH IRB
May-June ...... collect permissions from Unit personnel and patients
July .......... begin observations
August ........ begin data analysis and review of findings with Unit personnel
October ....... conclude fieldwork
December ...... conclude data analysis and review of findings

e. Research Plan: This study uses participant observation as the mechanism for collecting data. Subjects (team members) will be observed in team meetings and in their interactions on the Unit. In addition, they will be interviewed periodically during the research. Selected patient records will be reviewed to examine the evolving understanding of patient problems as reflected in the individual documentation of team members and in the plans of care developed by the team.

An important aspect of participant observation is that the researcher becomes so much a part of the setting that his or her presence no longer influences the activities being conducted. Consequently, the researcher will not take an active role in the team meetings and will attempt to be as unobtrusive as possible so that the communication process will not be influenced. Observations on the Unit will follow the same principles, with the researcher performing simple patient related tasks such as serving
food, assisting with walking, assisting in group meetings, and other routine patient care activities. This will enable the researcher to blend in and observe staff communication in settings outside of the meeting itself. The researcher will not participate formally as an occupational therapist, rather for any patient related activities will function in a role appropriate for a volunteer in the hospital.

f. Economic Considerations: Because the research procedures are primarily observation with a limited number of interviews, there will be no cost to the hospital nor to individuals participating in the project. No payments or material inducements will be offered to research participants.

III. Human Subjects

a. Subject Population: This study focuses on the communication process which occurs between the members of the geropsychiatric team during patient care meetings and informally between meetings. The team members will be the primary participants. Because patient data is being discussed, patient permission will be sought even though the data itself is not the focus of the study.

b. Risks: Because this research involves observation only, there should be no risks to team members or patients.

c. Consent Procedure: Members of the geropsychiatric team have given verbal approval to participate in this study. Team members will be asked to sign the attached informed consent (Appendix A). Permission from patients will be sought at the time of admission to the Unit when other permissions and procedures are being discussed (Appendix B). The purpose of the project will be explained and the consent form signed. If the staff member seeking patient permission feels that the patient does not have sufficient understanding of the study to give permission, a family member or guardian’s permission will be sought. A staff member will explain the project so that the confidentiality of patients refusing to give permission will be maintained.

d. Protection of Subjects: The primary risk to staff and patients is breach of confidentiality. This is especially true in a small state with few geropsychiatric units. Confidentiality will be maintained by coding all written transcriptions of tapes and field notes. A record of codes will be kept separate from the field notes so that unauthorized individuals will not have access to confidential data. Audio tapes will be stored in a safe deposit box after transcription for no more than two years following completion of the study. This will enable the researcher to listen to tapes to check interpretations and transcriptions. Any reporting of data will change identifying features of staff members, patients, and the hospital to prevent identification.

e. Potential Benefits: Because staff members will participate in review of the data, they will develop an increased awareness of the communication process which occurs on the Unit and in the team meetings.
Informed Consent
Staff

Invitation: You are invited to participate in a study of the communication process which occurs in the team meetings in the Elderly Psychiatric Unit at this hospital.

Purpose: The purpose of this research is to understand how the communication process influences the decisions of the team regarding patient goals and treatment approaches.

Description: The research involves observation of team meetings and of the interaction between staff, patients, and visitors on the Unit.

Selection of Participants: You have been selected as a participant because you are a member of the geropsychiatric team.

Procedure: Your participation in this research will consist of being observed along with other members of the team during team meetings and on the Unit. Team meetings will be audiotaped and notes will be taken to augment the taped record. Following transcription tapes will be stored in a safe deposit box and will be destroyed two years after completion of the study. To prevent breach of confidentiality, transcriptions and field notes will be coded to protect the confidentiality of all participants and patients.

Risks and Inconveniences: None anticipated

Benefits: None anticipated

Economic Considerations: None

Confidentiality: Confidentiality of your participation in the project will be maintained. All data will be coded so that your identity will remain confidential.

Questions: Before you sign this form, please ask any questions on any aspect of this study that is unclear to you.

Disclaimer: You are free to choose not to participate in this study and if you do become a subject, you are free to withdraw from this study at any time during its course.
**Other Points:** I understand that the Institutional Review Boards of the University of New Hampshire and this hospital have authorized the use of human participants to participate in this research.

I understand that if I have any questions pertaining to the research or my rights as a research participant, I have the right to call Elizabeth Crepeau (862-0416) or Marjorie Coleman (xxx-xxxx) and be given the opportunity to discuss the questions with them in confidence.

I certify that I have read and fully understand the purpose of this research project and its risks and benefits for me as stated above.

.................. Consent/agree to participate in this research project.

.................. refuse/do not agree to participate in this research project.

........................................ Signature of Participant

........................................ Date

........................................ Signature of Principal Investigator

........................................ Phone

........................................ Signature of Person Obtaining Consent

........................................ Phone

This form will not be valid unless the following box has been complete in the IRC office.

| This form is valid only until __________ date |
| IRC Proposal Number ______________________ |
| Initialled _______________________________ |
Informed Consent
Patient

Invitation: You are invited to participate in a study of the communication process which occurs in the team meetings in the Elderly Psychiatric Unit at this hospital.

Purpose: The purpose of this research is to understand how the communication process influences the decisions of the team regarding patient goals and treatment approaches.

Description: The research involves observation of team meetings and of the interaction between staff, patients, and visitors on the Unit.

Selection of Participants: You are not a participant of this study but because information about you will be discussed at the team meetings and your medical record may be reviewed to see how staff member’s understanding changes over time, your permission is being sought.

Procedure: You will have no direct participation in this project.

Risks and Inconveniences: None anticipated

Benefits: None anticipated

Economic Considerations: None

Confidentiality: Confidentiality of all information discussed at the team meetings or retrieved from medical records will be strictly maintained. Team meetings will be audiotaped and notes will be taken to augment the taped record. Tapes will be stored in a safe deposit box for no more than two years after transcription. After that time they will be destroyed. To protect confidentiality, transcriptions will be coded so that your identity remain protected.

Questions: Before you sign this form, please ask any questions on any aspect of this study that is unclear to you.

Disclaimer: You are free to choose not to grant permission for the researcher to hear your care being discussed at the team meetings, to be observed on the Unit, and to have your medical record reviewed. You are free to withdraw from this study at any time during its course.
Other Points: I understand that the Institutional Review Boards of the University of New Hampshire and this hospital have authorized the use of human participants to participate in this research.

I understand that if I have any questions pertaining to the research or my rights as a research participant, I have the right to call Elizabeth Crepeau (862-0416) or Marjorie Coleman (xxx-xxxx) and be given the opportunity to discuss the questions with them in confidence.

I certify that I have read and fully understand the purpose of this research project and its risks and benefits for me as stated above.

............ I, .................................. Consent/agree to participate in this research project.

............ I, .................................. refuse/do not agree to participate in this research project.

...................................................... Signature of Participant

...................................................... Date

...................................................... Signature of Principal Investigator

...................................................... Phone

...................................................... Signature of Person Obtaining Consent

...................................................... Phone

This form will not be valid unless the following box has been complete in the IRC office.

This form is valid only until __________ date
IRC Proposal Number _________________________
Initialled __________________________________
APPENDIX B

TRANSCRIPTION GUIDE

These conventions were adapted from Craig and Tracy (1983: 302-305).

= Indicates that the speech of one speaker to another was heard as a continuous stream of speech. In other words, there was not break between utterances.

((pause))) Indicates a longer than usual pause between turns.

(pause) Indicates a pause within turn.

- Indicates a brief pause within turn.

. Indicates a full stop intonation.

? Indicates a standard question intonation.

! An exclamation; an animated delivery.

( ) Dialogue that was unclear is enclosed in parentheses. When the conversation was not understandable, this break is indicated by empty parentheses.

[ ] Indicates non-verbal communication.

/ / Indicates interpretation of data.
APPENDIX C

INTERVIEW SCHEDULE

date of interview ..............................................................
place of interview ............................................................
name ..............................................................
alias for final report ..........................................................

PURPOSE OF INTERVIEW: Explain purpose...to gain an understanding of
your perspective of the work of the unit, most especially as it relates to the
way you get to know patients, to your thinking and actions in relationship to
patients and how your interactions with other staff members contributes to
your understanding of the patients on the unit. personal data

DEMOGRAPHIC DATA
sex ..............................................................
age ..............................................................
race or ethnicity ..........................................................
religion ..............................................................
place of birth ..........................................................
residence ..............................................................

WORK AND PROFESSIONAL HISTORY
education ..............................................................
occupation ..............................................................
brief work history ..........................................................

HISTORY OF EMPLOYMENT ON THE UNIT ..........................
I. PERSPECTIVE ABOUT PATIENTS:

1. Select a patient from the list who represents a "typical patient" (show list of people who were patients during the summer). Tell me how you got to know this patient.

2. Select a patient from the list who was a "feisty" patient. Tell me how you got to know this patient. What characteristics of this patient constitute your definition of "feisty".

3. Select a different patient from the list who was a "favorite" or someone you particularly liked. Tell me how you got to know this patient. How did your regard for the patient shape your interactions? What made this patient likable.

4. Select a patient from the list who was not a favorite, someone you did not especially warm to or did not like. Tell me how you got to know this patient. How did your feeling for this patient shape your interactions? Why do you think you did not like this patient.

PROBES

1. Did your understanding of this patient change over time? How did this change?

2. What do you think caused this change? Interaction with other people on the unit, discussion at team meeting, interaction with the patient's family and friends, interaction with the patient, changes in the patient's condition?

II. PERSPECTIVE ABOUT THE UNIT

1. In your own words, explain the mission of the unit?

2. How is responsibility for patient care shared on the unit?

3. From your perspective, explain the roles of the other disciplines on the unit? Social service, OT, psychiatrist, and dietary.
III. PERSPECTIVE ABOUT THE TEAM:

1. What does the concept of "team" mean to you?

2. What is your relationship to people from other disciplines on the unit?

3. How is the team the same or different from the personnel on the unit?

4. Who is on the team?

5. How is the team the same or different from the team meetings?

IV. PERSPECTIVE OF TEAM MEETINGS

1. Describe a typical team meeting.

2. From your perspective, why does the team meet?

3. What does the team meeting accomplish for you? Do you derive any benefits from attending the meetings?

4. Do you prepare for the team meeting? How? Does this take a lot of your time?

5. How important is the team meeting in your weekly schedule? What would cause you to miss a meeting?

6. How does the discussion of the team influence your actions outside of the meeting?

7. Do you feel your opinion is listened to at team meetings? Is this the same or different from you other interactions on the unit?

8. Does going to the team meeting change your relationship with other staff on the unit? Those who attend meetings versus those who do not attend.

9. How does the team meeting fit into the web of communication on the unit?

10. How has the rotation of nursing personnel at the meetings influenced the content and the process of the meetings? The
diffusion of information to nursing personnel who do not attend the meetings. The sense of cohesion in the group (the group that meets)?

V. OTHER GENERAL QUESTIONS

1. What does the term "shift mentality" mean to you?

2. What do you mean by checking Lithium levels?

3. What do you mean when you describe a patient as feisty?

4. What role does age play in your thinking about patients? Do you remember a patient's age? Is it important? Why? Has your attitude toward the importance of age changed since you have worked on this unit?

5. I have noticed that people do not use the word "crazy" very often, is there a reason for that?

6. If you used the word "crazy" or "nutso", in what context would you use these terms?

7. What is the relationship between medication/ECT (medical interventions) and behavioral approaches? Do you think both are necessary? Why?

8. How do the nurses aides fit into the communication on the unit. Do their observations get recorded? Heard? What do they contribute to the unit?

9. What are the supervisory relationships between the doctor, unit director, and non-nursing personnel on the unit?

VI. QUESTIONS FOR NURSING PERSONNEL

1. What do you do when you admit a patient? Describe it to me in detail.

2. How does the standardized plan of care influence your actions?

3. What is your relationship/responsibility toward activity (OT) groups?
4. What do you do when you lead a group?

5. What preparation have you had to lead groups, community meeting, med teaching group, wrap-up.

6. How do you feel about leading these groups?

7. How do you prepare for a particular group?

8. Where do you see your role as group leader fit with the rest of your responsibilities on the unit?

9. What do you learn about particular patients from leading groups?

10. How are the groups (community meeting, medication group, wrap-up) organized? Who decides who leads them?

11. What are the written policies regarding physical restraints? Are they followed? Why, Why not? What tensions exist around the use of restraints?
APPENDIX D:

TRANSCRIPTION OF TWO TEAM MEETINGS

TEAM MEETING #1: Iris (Field Notes #11, Card ID # 22880:7/7/93)

Dr. James  OK [shuffling papers] next
Sandra     Iris
Dr. James  Well, did it again
Sandra     [reads from record] decreased memory, problems with panic attacks, awakens fearfully, frequent tearfulness, irritability
Peter      She had good days and then down the tubes
Dr. James  This week showing significant improvement (     ).
Emily      She has been trying to get names like
Dr. James  In your face
Peter      She has not been as intrusive
Dr. James  Continues decreased confusion/disorientation. [This is stated in a dictating register, Sandra writes on the care plan.] (unintelligible)
Sandra     Still underlying instability: both of them were working themselves up into a real tizzy [Sandra is talking about Iris and another patient who is also confused].
Dr. James  Yea, between them they don't have one memory [seeing patient as having no memory]
Sandra     Yea, but they were both getting angry because they knew that neither one did and they we we weren't helping them any and how do you get better if you [continued discussion of impact of no memory]
Dr T  right

Peter  That might be reframed into a survival skill for her, long term [Peter reframes anger to survival skill]

Sandra  um [neutral response - sounds thoughtful]

Peter  Basically when she told us about her early family history about picking out of garbage cans for food to bring home and stuff, you know, nothings going to [Peter brings in family history to support his view of her survival skills]

Emily  (unintelligible) couldn't remember that she had started with PT and when I showed her the exercises got angry that they were making her do these exercises [chuckles a little] so [more examples of loss of memory and anger]

Sandra  yea

Peter  Had a long meeting with the dietitian about her dietary needs, and then wasn't able to, and really blew a cork when her supper came up restricted because the last one was started the second, so [Peter adds more evidence for loss of memory and anger...construction of survival skill seems to be lost at the moment]

Emily  Oh, wow

Sandra  [long pause while Sandra writes on the care plan form] All right, um Psychosocial/legal [Sandra advances the agenda by going to the next part of the care plan].

Peter  Um

Sandra:  Does she live alone, Peter?

Peter  No, she has a male friend who wants to marry her.

Dr. James  Oh, gees [sounds dismayed].

Peter  She doesn't want to marry Mr. Lombardo Um-

Sandra  He's a funny little (sad sack)
Peter He works. He has a job, he has a job, uh I think the concern we have is her capacity to be around the house by herself, uh, so she will probably need the home OT functional safety eval, but um, (unintelligible) Last week she wanted me to get her a job OK, this week-

Dr. James Oi vey [continues to sound dismayed with increasing concern].

Peter I think if we could get her into an adult medical day care, we will be doing her a favor, so

Sandra So, questionable living situation? [Sandra returns to the agenda of “psychosocial/legal issues”].

Peter Yea, well, question her living at all in an unsupervised situation [Peter has concluded that there is a question of whether she can return to her home, however, it is also clear from the discussion that this is where she wants to be, leading to Dr. James’ question].

Dr. James How do we get her to accept that though Peter?[Dr. James’ recognition that they can make recommendations but that Iris must accept these recommendations. Getting Iris’s acceptance may be a problem].

Emily Oh, I know [said with some feeling]

Peter Well, just giving her something to do, uh, when her male friend is not around and is working. [starts out loud, with emphasis, seems a bit defensive] Having either somebody come over and visit with her, a senior companion, or having her go somewhere. I mean, gad, is she safe to be at home by herself? [Questioning her safety.]

Dr. James I:::I don’t think so

Peter Yea...and her daughter is involved, we we have to bring this to the daughter’s attention, and just lay the cards out on the table. This is what we are finding. [Peter brings in the family to “lay the cards out on the table.”]

Dr. James So, when can we get the home functional? [This is the home evaluation conducted by the occupational therapist which helps
the team develop an understanding of the patient's capacity to live at home].

Emily

Um

Dr. James

I'm not feeling that this is that much more I can really do with her [Dr. James admits that his work is done, i.e., meds have done as much as can be done for this woman, now it is up to others, consequently the importance of the home functional evaluation].

Emily

Yea, I can, if she can go tomorrow, I can go tomorrow with her. The problem is, I think, she is going to be damned and determined to do whatever she wants. I mean, she, like with the cane, she is using it to go along with us here and the same way with like the ( ). [Emily agrees that an evaluation is appropriate, but then presents a picture of a woman who will do what she wants if she returns home].

Dr. James

(overlap with Emily) the bell, the bell (several overlapping voices here), I love the bell [The bell refers to the small bell like is used to get a hotel clerk's attention at the registration desk. These are in the dining room and living room of the unit for patients to use when they want to walk. Patients who are fall risks are asked to ring the bell before getting up so that someone can assist them. Iris is one of those patients].

Sandra

[overlap with Dr. James] yea

Dr. James

She carries the, she's supposed to ring the bell before she gets up (laughter) so she'll bring the bell to the nurse. Its like a,

Emily

yes [overlapping with Dr. James]

Dr. James

here's the bell [gestures with hand out in front of him cupped as if to cradle the bell in it] [more gentle laughter] [Sandra and Emily overlap with Dr. James. What Dr. James is arguing is that she does not use the bell correctly, i.e., ring it for assistance, rather she brings it to the staff. From one perspective you could argue that her memory problems are sufficient enough that she remembers that the bell is important, but not what she should do with it. Emily's argument is that she is cooperative to a limited extent, but she will do what she wants....i.e. that the
problem is not memory but a generalized desire to maintain her autonomy.

Peter At least she is not turning it around and shaking it for pepper.
Dr. James Yea
Peter One of the things ( ) [Emily laughs again].
Dr. James That was was Josephine
Peter Josephine
Dr. James Josephine, OK [Peter makes a quick reference to another patient who used the bell inappropriately, mistaking it for salt and pepper. This seems to be a funny aside...but also could be seen as another point in the argument that Iris can't remember...that is it memory loss which explains her behavior, not lack of cooperation. The question of whether Iris lacks the mental capacity to follow directions or doesn't want to abide by unit rule remains unanswered.]
Emily Ok, I'll talk with her about doing it tomorrow
Sandra So the discharge plan?
Peter Well, she'll have to go to go home with the male friend, but with increased home and community based supports. ((long pause)) [Sandra writes in the care plan.]
Dr. James (something unintelligible about the male companion).
Peter I think he is going to be a part of the family
Dr. James Oh [groaning softly] Exedrin headache #4
Peter Tell it like it is, you know, if you don't take your medicine you increase your chances of going to a nursing home (long pause) It's her changes in behavior and mood that got her in here, and the family was called to the doctors about all this stuff, so...[Peter seems to be articulating a position that the patient has a problem which caused her admission to the hospital and that she needs to take some responsibility to make changes so that she can return home rather than going to a nursing home].
Dr. James  So, we need to involve the family doctor as well. [speech has been slow here, flat]

Peter  Right, the hardware's broken, its, do what they do [When he refers to hardware he means that Iris's cognitive losses are due to organic changes in the brain]

Dr. James  Its the pits [this is ambiguous, is the situation the pits, or solely the memory loss...I think he is referring to the patient's total situation]

Peter  I mean I, I don't know if he works that much, but he is around a lot, the male friend, so we have a built in caregiver [Peter is back thinking about her home situation and the possibility of her male friend providing sufficient supervision].

Emily  yea-

Peter  and there are three granddaughters and a daughter, between all of this if we can bill her day program as a volunteer opportunity for her, to use her social skills. I don't know how you want to phrase this [Peter counters with some evidence that it isn't that bad...she has the male friend and in the following statement the rest of the family which is supportive. Also relabeling the day program as a volunteer opportunity for her...sugar coating in a way a treatment program...yet recognizing that this will tap her interest...is this a con job?]

Emily  [Overlapping with Peter] and she drives [said in a flat tone of voice, understated].

Dr. James  That's a- [sounds surprised]

Emily  Its that-She said what she likes to do is take off and drive to the mall, every day, and um walks around the mall and then she goes and gets some groceries, she makes the meal. But everyday she's out, she said, "I can't wait to get out of here so I can take a ride."

Dr T  [groans slowly] (unintelligible seems to be speculating about her driving and spending three hours at the mall).
Emily: Spends a lot of money, she said, "I like, I don't like to be told what, you know, what I have to buy, I'm buying whanna buy." She likes to do that every day. Shop. Spend. [This piece about driving seems to be new information for Dr. James, he sounded surprised. Emily also seems to be adding to the picture of a woman who wants to do what she wants to do, developing a picture of fierce independence combined with a lack of memory and judgment].

Sandra: Um

Peter: Determination plus mental impairment equals what? Bankruptcy? [Peter seems to have come to this conclusion too and summarizes it for the group].

Dr. James: Yep

Sandra: OK, so, Functional Performance? [Sandra moves to the next item on the care plan].

Emily: Um, well. Did you already put down the home visit?

Sandra: Probably for tomorrow?

Emily: Right, and um that she is attempting groups this week, but concentration and energy are still very well low.

Dr. James: Last week they were too high.

Emily: Yea, yea, but now she is more sedated, building back that energy level, um also safety wise too, she is building back her [safety is a prominent concern, as her energy builds up her ability to move safely remains a concern. Since she is more active the opportunity for a fall increases].

Dr. James: But she is steadier now, you know. I'm not going to run every time she gets up on her own. In fact I don't know if it is realistic to think that she is ( ) [Dr. James reiterates this concern and his feeling that she is more steady therefore he is less concerned about her falling].

Emily: She does quite well. Um, she uses the cane when she is reminded to use the cane and like I said, I think half the time she's got it up [Mimicking patient] because she really thinks she
doesn't need it. [again, the argument that she will do what she wants to do... this carrying the cane and not using it is partial compliance, just like carrying the bell rather than using it is partial compliance] Um, and last week where we didn't see her so much with her her mental status, this week it's been, you know it's nice, she just sits and she's talking with us. It just that she is being more cooperative. But clearly with the memory impairment, um, you know it is worrisome to see what she does in driving. [again, back to safety]

Dr. James I would like check to see what neurological work has been done. [Dr. wants to see about objective findings to help determine extent of organic changes]

Emily yea (pause)

Peter There was a lot of (mobility) and perseveration when she first came in here.

Dr. James right

Peter an uh, that's a little better

Dr. James But it presented as a bipolar mixed very unstable. People were saying that was the most severe they had seen, the lady was flipping all over the place. That's dramatically better. Haldol. [bipolar mixed is a diagnostic category which apparently described Iris's behavior on admission. Haldol is a commonly used psychotropic drug].

Peter Haldol, huh

Dr. James Haldol.

Sandra OK

Dr. James I have been debating about putting her on anything else

Sandra Last week we said she would be finished by the 15th, so that will be 8 days? Is that possible?

Dr. James Yea, possible.

Peter: A week from Thursday
Dr. James  In fact, I betcha she'll be out, probably (unintelligible, papers shuffling)

TEAM MEETING #2 (excerpt regarding Iris's home visit and discharge): Iris (Field Notes #16, Card ID # 20560:7/16/93)

Emily  You know, she was like, "shut up, don't tell anybody [about cheating on her diabetic diet]." You know when we were at the house, they were really funny together. He was like answering the questions, like he was excited.

Sandra  Oh, the boyfriend?

Emily  Yea, answering for her, and would be like, "Quiet, this is my time, this is for me." you know. [laughing] But he was like jumping up and getting stuff like as I would ask something, he was like he wanted to be the helper so badly for her.

Sandra  Oooh [said softly]

Emily  and she is so like wants to be independent.

later in the meeting they returned to the home visit.

Sandra  Will Iris be home?

Dr. James  with community based supports of an intense nature. this is going to be one of the most difficult cases for Peter in terms of creatively keeping her corralled but still at home [Peter was not at this meeting] [Listening to the tone of voice and the content the extent of concern about this woman's welfare and goals comes through. I got the impression that if the team did not have such a strong commitment to respecting the patient's goals that another recommendation would have been made.]

Emily  Yes, she is much more agreeable, like I gave her two pages of recommendations and I thought she was, you know, she's got a stubbornness and I thought she'd just say, you know [gestures a "blow off" expression]. But she took them and I think she is very concerned. You know and talked about it in community meeting that she knows she wants to change things in her bathroom and um, very much aware of what she needs to do for
herself. Very surprisingly to me, you know, um. So I think the longer she’s here, she feels as if she is turning around and saying, “yea, I do need some things.” She is concerned with her memory. She is concerned. She knows she doesn’t want to fall again and have that unsteadiness. The boyfriend apparently does the meds in the morning. He puts them out on a dish. [Her willingness to take these recommendations seriously seems to increase their comfort with their recommendations.]

Still later

Emily

Her energy level is improving, she is more alert. Um, she has remained, uh, she does become tearful still and we were just talking about that and the husband that has died, and uh, and I think at times inappropriately tearful still. Um, she is connecting more I think with patients now. It was nice to see, when we went on a home visit, she had friends come out of their trailers to greet this woman [someone in the background says “wow” softly] and and she became tearful cause she, when I spoke to her initially it seemed that she’s got a very distant, you know, relationship with people. When she gets upset, you know, they are out of there in her life, but everybody came and greeted her and it was really nice. I think she’s got a lot of people that check in on her.

Dr. James

Well, relative to how she was, I think, I just can’t imagine her before she came in.

Sandra

Well she said today, I said, “What do you do at home, how do you manage?” “I have lots of nice neighbors,” she said, “they help me out a lot.”

Emily

I think she’s got a lot there

Dr. James

So, OK, we just need to structure family, do you? I think daughter is a big ally here, um, can you get daughter a copy of the recommendations? [Getting the daughter involved seems to make sense, but they exclude the boyfriend.]

Emily

Yes

Dr. James

For she’d probably be more likely to reinforce them than the boyfriend [This exclusion seems to be based on their assessment of his willingness to reinforce these recommendations]
Emily  
Yea, yea

Dr. James  
Definitely not him.

Emily  
I think, um, I mean, if Irene gave the things to boyfriend on the list he would be a reinforcer. But I don’t think she will do that. You know, she wants to maintain control and I don’t think she’d want to open that up for him to see. [Emily also articulates a desire for Iris to maintain control of this information, and that this should be respected. Is part of this the fact that they have no legal relationship? Would they exclude a husband in the same way?] But, you know, she really did surprise me, like on the home visit. There were several times, you know, that she wouldn’t answer something safely or appropriately, but then with, you know, her problem solving would turn around so she would get herself out of a jam. You know, that, she was able to, and maybe that’s a survival skill, you know she’s got-

Dr. James  
-you should avoid jams-

Emily  
-Yea, yea- [chuckling]

Dr. James  
-not get you way out of them.

Emily  
But she was able to do it. Which, hey, that’s a skill [laughing gently as she talks]

Sandra  
yea

Dr. James  
That is a survival skill.

Emily  
Yep

Sandra  
Last week we had eight days

Dr. James  
I’d give it two days. Let Peter work on it today or tomorrow.
APPENDIX E

HILLSIDE HOSPITAL
ELDERLY PSYCHIATRIC UNIT
INTERDISCIPLINARY ASSESSMENT TOOL - WEEKLY REVIEW

(to be completed at team meeting)

Date .................................................................

A. Problems as identified by clinical assessment and/or admission

   Problem

   1. Psychological ..............................................

   2. Physiological .............................................

   3. Safety .....................................................

   4. Psychosocial/Legal Issues ..............................

   5. Orientation and Teaching of Patient and Family ...........

   6. Discharge Planning and Aftercare ......................

   7. Functional Performance ................................

B. New Problems and Needs ....................................
C. Mental Status Changes - to be completed by a psychiatrist

D. Changes in Diagnoses

.................................................. MD
(signature and title)

E. Current Status of Discharge Planning

1. Summary ..........................................................

..........................................................

2. Discharge Timeframe (in days or weeks) ......................

F. Patient Participation

........... participated

........... MD will discuss with patient and family or guardian.

..........................................................

..........................................................

G. Signatures/Titles

.................................................. .................................

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.................................................. .................................

.................................................. MD
(Signature of Psychiatrist)