Ph.D. Thesis

Communication among mental health nurses: A field study of mental health nursing practices

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Preface

This thesis is about communication among mental health nurses. This topic is approached by means of theory and methods bordering on several academic disciplines: nursing, medicine, sociology, and linguistics. In this sense, the research is, borrowing a phrase by Arthur Kleinman, ‘written at the margin’ of traditional academic disciplines. An advantage of this marginal position is the opportunity to try out crossovers between seemingly disparate approaches to studying professional communication; a disadvantage is that there is no single disciplinary paradigm serving as the backbone of the approach. At times I would have preferred to be engaged in disciplinary ‘puzzle solving’ rather than designing durable hybrids between different theories and methods.

The analysis is grounded in a field study at two psychiatric hospital wards in Denmark. In many ways the fieldwork research was a solitary task where I was best characterised as ‘a lone ranger’ meticulously struggling with the organisation of immense amounts of data and systematically reflecting on impressions of someone else’s daily life. However, this notion of solitude does not quite acknowledge the help and support I was given working on the thesis. I am very grateful to Centre for Innovation in Nursing Education in the County of Aarhus, which financed the PhD study. Furthermore, I appreciate the openness provided by the hospital’s staff, patients, and management who let me study the everyday live on the wards. I realise that having a curious observer hanging around can be quite stressful. My gratitude also extends to my supervisors Associate Professor Helle Ploug Hansen and Professor Raben Rosenberg who supported and guided the study. Helle was involved in all stages of the research process and Raben gave particular advice regarding the study design and writing up the study. Helle and Raben were very different supervisors and at times I felt that the demand on me was something like: ‘draw a square circle’! Frustrating at times, the combined supervision taught me a lot.

I have been absolutely ruthless in asking people to read drafts of the analysis as it was progressing and in starting discussions of topics that I might have been the only one obsessed with. My thanks go to: Ulli Zeitler, Christian Bjørnskov, Maureen Buus, Len Bowers, Patrick Callahan, Alan Simpson, Anne Marie Rafferty, Anthony Pryce, Kathy Rowan, Judith Green, Kristin Bjöörnsdottir, Sioban Nelson, Jocalyn Lawler, Mett Marri Læsggaard Madsen, Kirsten Frederiksen, Kirsten Beedholm Poulsen, Marianne Thrane Larsen, Heidi Eskegaard Jensen, Lisbeth Hybholt, Helle Østermark Sørensen, Sanne Angel, and Helle Johannesen and the group of ‘humanistic’ PhD students at the Faculty of Health at The University of Southern Denmark. My family, close colleges, and friends (home and abroad) have devotedly helped to make ends meet in the logistics of everyday life and in therapeutically distracting my mind when I was becoming too much of a nerd.

Marie Arentoft painted the front cover “text in context” inspired by our discussions about people and communication: www.plus-art-aarhus.dk.
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Introduction

The introductory part of this thesis is an overall outline of three basic reasons for studying the everyday practices of mental health hospital nurses with a particular emphasis on communication among the nurses. First, I will describe recent changes in the organisation of the mental health services. These organisational changes are interesting, since they challenge mental health hospital nurses into adapting their professional practices accordingly. Second, I will argue that an understanding of the mental health nurses’ practices enacted without the patients’ active participation is central for a fuller understanding of mental health nursing. Third, I will provide a short historical review of the most influential conceptions of mental health nursing practices. I will argue, that the legacy inherent in the most dominant conceptions is founded on theory rather than on empirical investigations and, moreover, that these conceptions are continuously taken up by practitioners and researchers, representing a major analytical challenge. These three basic reasons lead to the description of the aim of the present study and an overall outline of the thesis.

The mental health hospital in the mental health services

In Denmark, and most of the Western world, there was a major shift in social policy towards people with mental illnesses in the second half of the 20th century. The shift was characterised by de-institutionalisation: the number of mental health hospital beds was reduced considerably1. Compensation for the reductions, extensions of care in the community, was not implemented at the same pace as the reductions, in part because of economic recession in the 1980s. Several opposing and/or overlapping reasons for the shift of policy have been suggested: liberal, humanitarian, financial, medical, pharmaceutical, and libertarian explanations (Simpson 2004, chapter 1). The reasons for the shift in Denmark were further entangled in the politics related to the organisational and administrative transfer of the mental health services from the state to the counties in 1976 (Bjerrum 1998). At an organisational level, the shift blurred the previous boundaries between the hospital-based health services and the community-based social services: the administrative responsibility for the coordination of treatment was spread across several institutions located in different parts of the public sector. In an effort to fully integrate these services the administration was reorganised across public sub-sectors, and the most recent development has been organisational struc-

1 In 1977 the total number of adult mental health beds in Denmark was 8806; in 2003 the number was 3672 (These data were kindly provided by the Department of Psychiatric Demography, University of Aarhus).
tures with inter-professional teams offering integrated outward services (Indenrigs- og Sundhedsministeriet 2004).

An integral part of the shift of policy was the changing role of the mental health hospitals, cf. (Prior 1991). Prior to the shift, the mental health hospitals were ‘total institutions’ characterised by the containment and management of a relatively stable group of mentally ill persons cut off from the rest of society (Goffman 1991 [1961])². Mental health hospitals now manage movements of a continuously changing population of patients (Rhodes 1995, 32). The shift from containment to movement has radically altered the hospital’s function in the overall health care services. Furthermore, as nurses are central participants in hospital treatment and care, the shift in the policy has had an ongoing effect on the traditional role of the mental health hospital nurses and has created new and unprecedented demands on the nurses’ everyday practices (Delaney et al. 1995; Higgins, Hurst, & Wistow 1999; Thomas 1996; Thomas et al. 1999a; Thomas et al. 1999b). Michelle Cleary has outlined how the shift in policy brought a number of changes to mental health hospital nursing. First, hospitalised patients are relatively more acutely ill and their situation and needs for treatment are highly complex. Patients have more severe mental health symptoms and present more disturbed and problematic behaviour, which may be influenced by various forms of substance misuse. Second, referrals to hospital are commonly made for stabilising treatment and patients are discharged as soon as possible to other parts of the health care services, notably community mental health services and outpatient treatment. Third, involuntary admissions and high occupancy rates are often reported in international literature. Fourth, service users are able to voice their increasing expectations to the mental health services (Cleary 2003a; Cleary 2003b; Cleary 2004)³. Cleary’s list of changes indicates that mental health nurses must adapt and qualify their professional practice to meet these changes. However, research into these institutional changes and the demands on the mental health nurses’ role and practices is very limited, cf. (Higgins, Hurst, & Wistow 1999).

The current study was designed to enhance our understanding of mental health hospital nurses’ daily practices within these recent institutional changes. In the next section, I take a step back from the changing everyday realities of mental health hospital nurses and sketch a line of inquiry which accentuates the importance of studying the interrelationships between everyday mental health nursing practices and the clinical knowledge produced in these practices.

² References have been added a year of first publication [in square brackets] when my reprints were more than 10 years younger than the first editions.
³ Cleary’s claims can to a certain extent be substantiated by demographic studies of changes in Danish psychiatry. For example, throughout the 1990s occupancy rates and the use of forced medication and mechanical restraint were increasing. The length of admissions is decreasing and substance misuse is widespread (Munk-Jørgensen & Perto 2000; Poulsen & Olsen 2002).
Working away from the patient and divisions of labour

In the following section, I argue that what nurses observe in clinical interactions with patients is shaped by social and institutional conventions for observing and sharing observations, and, further, that a significant part of this work takes place without the patients’ active participation. In *The birth of the clinic*, Foucault described the patient’s body as a discursive field being opened for scrutiny by the medical gaze at the end of the 18th century (Foucault 1997c [1963]). Inventions of new technologies and institutions for examining and containing the body formed parts of a machinery making it possible not just to read and interpret the body’s surface, but to make visible what was previously invisible inside the body (Armstrong 1983, 1-6). In this sense, the production of clinical knowledge was – and still is – contingent on a specific distribution of illness and, moreover, the patient’s body in the hospital bed was the natural locus for the production of clinical knowledge.

Working up clinical knowledge is a central part of mental health clinicians’ everyday work. The production of clinical knowledge is influenced by a number of social constraints which not only limits what counts as relevant clinical knowledge but also how this knowledge must be accounted for in order to be regarded as relevant. 1. Formal discourses on mental health establish privileged meanings about the signs and symptoms of mental health (Brown 1990; Crowe 2000a; Crowe 2000b). However, in everyday work formal perspectives are interspersed with informal, lay and commonsensical frames of understandings (Griffiths 2001; Hak 1998). This tangle of formal and informal realms marks out a vast field of potentially relevant clinical knowledge in everyday practice. 2. The production of clinical knowledge is done within formal and informal conventions for how to account for a clinical observation so it becomes an ‘objective fact’, cf. (Smith 1978; Smith 1987). 3. Divisions of labour at the mental health hospital create different types of encounters between patients and different groups of clinicians, resulting in different types of observations and different ways of accounting for them (Barrett 1996). 4. The technologies available for recording observations and the institutional routines influence the process of working up clinical knowledge through their social and material constraints, e.g. (Berg 1996; Heath, Luff, & Svensson 2003). These four observations, although they draw on disparate social theory, belong to the same overall line of inquiry and point to the crux of the current thesis: clinical knowledge is always informed by social processes.

In the modern clinic, the complex divisions of labour have disseminated the physical body as the locus of clinical knowledge to the extent that many clinical examinations are made without the patient’s physical presence (Atkinson 1995, chapter 4). In mental health institutions clinical knowledge is produced in more or less direct interactions between patients and clinicians. Obviously, interviews and other examinations of the patients are used
to work up and produce institutionally relevant information; but, also, during more mundane activities, for instance, social chit-chat at a meal, clinicians may observe phenomena potentially relevant to the assessment and treatment of the patient. Moreover, because many psychological phenomena are not directly observable, such observations are hard to treat as exact ‘givens’ in the same sense as a measure of height or weight. Mental health staff, therefore, routinely account for and share observations and engage in debates about the relevancy and meaning of the observation in relation to the specific patient. In this sense, clinical knowledge is worked up both in interactions between clinicians and patients as well as among clinicians.

Mental health nurses are continuously negotiating the social distance to the patient. For example, a whispered conversation about the patient between nurses in the ward living room will create a ‘back-regional’ area amid the physically present patients, cf. (Goffman 1990 [1956], chapter 3); patients are excluded from fully participatory interactions in this back-stage area. In this social, interactional sense, producing clinical knowledge away from the patient – at a distance – refers to situations where the patient is not actively participating in the production of clinical knowledge.

In order to achieve a comprehensive understanding of mental health nursing practices the current study gives analytical attention to the clinical practices away from the patient and how these practices influence the production of clinical knowledge. In the next section I will describe of some of the most central professional conceptions of mental health nursing as they continue to have a major influence on research of mental health nursing practitioners and their practice.

**The legacy of American nursing theories and the rationality of mental health nursing practitioner**

The design of empirical studies of mental health nurses’ practice will always be informed – more or less deliberately – by the adoption of theoretical assumptions about the central characteristics of these practices; in a historical context such assumptions can be viewed as being part of the profession’s conceptual legacy and playing an important part in the creation of the profession’s identity. However, in some studies the conceptual influences of these assumptions are not fully recognised, which leads to the unchallenged reproduction of certain, dominating perspectives on practice. In terms of avoiding an unreflective adoption of conceptions, this section provides an outline of the most influential ways of conceptualising mental health nursing practice, notably the notion of the rational practitioner as one who acts according to formal theory.
In Denmark there is no tradition for empirical research of mental health nursing practice. The Danish literature on mental health nursing has historically been normative, theoretical reflections and recommendations (Beedholm 2003). Up until the mid-1970s mental health nursing practice was theorised as an unspecialised – but qualified – set of common sense domestic and personal skills performed by women (Buus 2001). These conceptions mirrored the values and gendered practices of the patriarchal bourgeois household, see for example (Faurbye 1954). The literature was specific to mental health through presentations of descriptive psychiatry. After the mid-1970s the literature was heavily influenced by American mental health nursing theory, in particular psychological theories on the therapeutic value of interpersonal relations, see for example (Welner & Skrumsager 1974).

The Danish reception of American mental health nursing theory was relatively late; it began a couple of decades after the initial, groundbreaking theorising in America. The American mental health nursing theories of the 1950s and 1960s were simultaneously an attempt to underpin a theoretical basis for mental health nursing and, later, an attempt to promote the scholarly discipline of nursing in general\(^4\). The promotion of a respectable academic discipline of nursing followed two different strategies: either an adoption of the medical model or the definition of the discipline’s subject matter in psychological terms of interpersonal relationships. This latter strategy was an attempt to break away from the discipline’s historical reliance on medicine. However, in spite of the two strategies’ apparent differences they both adopted a general scientific methodology which indirectly subscribed to a conception of the professional nurse practitioner as acting according to applied theory, cf. (Beedholm 2003).

The American mental health nursing theories were rarely empirically founded and were either derived from theory or inductively derived from idiosyncratic observations of practice. The instructive tone is exemplified here by a quote by the pioneering Hildegard Peplau on responsible communication, read legitimate and professional communication:

“Talking with patients is easy when the nurse treats the patient as a chum and engages in a give-and-take of social chit-chat. But when the nurse sees her part in verbal interchanges with patients as a major component in direct nursing service, then she must recognize the complexity of the process. Social chit-chat is replaced by the responsible use of words which help to further the personal development of the patient. It is this complexity which distinguishes the verbal part of the professional nurse’s work from the verbal approach a layman might use toward a sick person.” (Peplau 1960, 964)

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\(^4\) This dual attempt, where mental health nursing could be regarded as a speciality or as part of basic nursing, created a tension in mental health nursing and in the educational curricula, because the incorporation of the sub-discipline into general nursing continuously threatens to subvert the sub-disciplines borders (Olson 1996). Commenting on Olson’s article, Peplau suggested that this ‘tension’ rather should be thought of as a failure to define the differences between basic and graduate levels of mental health nursing education: the appreciation and definition of specialised mental health nursing would delineate the speciality’s borders (Peplau 1996, 14).
The quote can be interpreted as an example of some of the constitutive distinctions in Peplau’s conception of professional mental health nursing practice. The academic quest to legitimise and specialise nurses’ professional practice was advanced through the conceptualisation of the nurses’ responsible, therapeutic actions as theory-led and purposeful/intentional; the opposite to this positive conception was the irresponsible, haphazard, and commonsensical actions (Tilley 1995; Tilley 1999), see for instance (Orlando 1995 [1958]; Peplau 1960; Peplau 1962; Peplau 1988 [1952]; Travelbee 1972).

Steven Tilley analysed how the American theories were mediated by British nursing scholars. Tilley exemplified, through an analysis of Annie Altschul’s seminal quantitative observation study, Patient-nurse interactions (1972), how the American view of therapeutic mental health nursing as theory-led and purposeful was adopted in Great Britain. Tilley argued, from an ethnomethodological stance, that Altschul’s use of analytical categories external to the nurses’ own practice – the American conception of responsible nursing practice – made it impossible for Altschul to conceptualise the everyday rationality of the clinical nurses; in other words, the assumption of the American dichotomy ‘theory led and purposeful vs. intuition and common sense’ structured Altschul’s study and developed into an analytical bias of the interpretation of the findings, namely, that the nurses did not act rationally and theory-guided. Tilley argued that the subsequent British nursing literature has been flawed by a search for the accountable mental health nurse as a practitioner who works goal-oriented and on the basis of a recognisable body of knowledge (Tilley 1995; Tilley 1999).

It is worth noting that empirical validation of the benefits of specific kinds of patient-nurse interactions has been minimal (Ersser 1997; Geanellos 2002; Lützén 1993; May 1990). The lack of empirical evidence of the benefits of formal mental health nursing interventions is probably linked to the character of mental health nursing: the professional skills are hard to define and identify – for both practitioners and researchers. Several studies have documented that nurses describe the greater part of their skills in terms of personal qualities (Gijbels 1995, 461-462; May & Kelly 1982, 192; Wilmot, Legg, & Barratt 2002, 609-610). Descriptions of mental health nursing as personal qualities are potentially very problematic as they are venomous to the American nursing theorists’ aspirations to advance theories guiding the mental health practitioner.

5 Tilley’s analysis of the adoption of American nursing theory is limited to the conceptions of the mental health nurses’ practices. The American influence goes beyond this, for instance a hegemonic individualist ideology which restricts the questioning of social causes of mental illness (Leighton 2004).

6 Not surprisingly, with the wisdom of hindsight, Altschul concluded her book with an intriguing ambiguity: the nurses do not work therapeutically but their intuition and tact was valued as central for good practice (Altschul 1972).
Tilley’s analysis was concerned with the analytical conflation of the mental health nurses’ words – which reflected a practical rationality – and the conceptions handed down by American nursing theory. Because mental health nursing practitioners do not only describe their actions using everyday terms but also draw on formal theory and professional ideals in their description and evaluation of their practice, such a conflation is obvious to make for researchers.

In an ethnographic study, Joy Bray briefly described mental health nurses expressing a gap between how they intuitively wanted to work with the patients and what was accepted by the institution, or what was supported by theory (Bray 1999, 302). This showed that the nurses evaluated their practice according to the dominant ideas on the primacy of theory-based practice and were conscious of institutional constraints. Unfortunately, Bray did not go into any detail on the character of the nurses’ intuitive ideas. Kim Lützén described nurses who were experiencing a moral conflict in a schism between what they felt to be the principles of ‘good’ psychiatric care and what was actually done (Lützén 1990;Lützén 1993). Jan Kåre Hummelvoll and Elisabeth Severinsson aimed at explicating mental health nurses’ practical knowledge and their complex working situations by combining participant observation on an acute psychiatric ward with interviews of 16 mental health care professionals. Hummelvoll and Severinsson described nursing as lacking professional autonomy and being dominated by ‘the medical model’ and, further, the authors argued that the institutional demand for effectiveness prioritised the medical model, which left the nurses with an awareness of a discrepancy between their professional ideals and reality (Hummelvoll & Severinsson 2001a;Hummelvoll & Severinsson 2001b). As these studies exemplify, practitioners are often reflectively aware of the dominant ideals or theoretical principles of practice, and experience a gap between the theoretical rhetoric and their everyday practices. The practitioners’ reflections can be a further challenge to researchers of mental health nursing practice as they add to an image of formal theories actually being applied in practice.

Thomas et al. suggested a further interpretation of why the mental health nurses often refer to ideals when they describe their practices. The authors suggest that because everyday practices are experienced as difficult the mental health nurses explicitly or implicitly compare them to ideals or ideal situations (Thomas, Beaven, Blacksmith, Ekland, Hein, Osborne, & Reno 1999a;Thomas, Hagerott, Hilliard, Kelly, Leichman, Osborne, & Thurston 1999b, 7). Because mental health nursing practitioners do not only describe their actions using everyday terms but also draw on formal theory and professional ideals in their description and evaluation of their practice, such a conflation is obvious to make for researchers.

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7 The conditions outlined by Tilley are not specific to nursing. First, a notion of the competent actor’s actions as applied theory was criticised by Donald Schönh as ‘technical rationality’ – a legacy of positivism (Schöhn 1983;Schöhn 1987). Second, the problem of how to conceptualise the rationality of practice has been discussed extensively among social theorists, see for instance (Bourdieu 1998 [1977];Garfinkel 1984 [1967];Giddens 1999 [1984];Porter 1993).

8 Cleary suggested the changing practices of mental health hospital nurses as a central reason for a widening gap between the rhetoric of mental health nursing and the daily practices (Cleary 2003a;Cleary 2003b).
Thus, this interpretation adds a further twist to the conception of theory and practice because the nurses’ reflective articulations of a conflict between theory and practice are conceptualised as part of the nurses’ rhetorical practices. This means that the analysis is not only concerned with what the nurses’ say but also with why they reflect on and articulate their practices as they do. The conflicts between theory and practice are constructed and/or drawn on by the nurses to fulfil certain practical aims – as resources for action, see also (Crawford et al. 2002;Leishman 2003;Leishman 2004). In this sense it is possible to identify certain theories or ideals in nurses’ reflections on their practice and, further, to offer interpretations of what social effects the particular constructions of the ideas have.

The argument forwarded here is that nursing theories leak into the general currency of thinking about practice and that this condition represents a theoretical problem that researchers of mental health nursing practice must engage in their interpretation of nurses’ practice by effectively separating the participants’ reflections about practice from their own analytical concepts of practice.

As indicated throughout this section, conceptions of mental health nursing practice can be viewed as part of the profession’s legacy. I have highlighted the dominant notion of the rational practitioner as applying theory and outlined a theoretical pitfall related to the examination of the practitioner. Throughout this thesis the analytical emphasis will be placed on understanding mental health nurses’ everyday practices without evaluating them from veiled normative, professional ideals. Finally, conceptions of mental health nursing are not merely theoretical concerns; they have real implications for nurses in practice: for their understanding of their work, their professional identity, and, ultimately, for the care of patients.

The aim of the study and an outline for the thesis

The aim of this study is to generate an advanced understanding of the professional practices of mental health nurses in the changing hospital context. It is focused on communication between mental health nurses away from the patient: how clinical knowledge is produced through the nurses’ mutual communication in their everyday practices. The approach is an explorative and descriptive fieldwork study. The combination of detailed analyses of mental health nurses’ communication and contextual descriptions of everyday practices is the basis for interpretative inferences about the distinctive characteristics of everyday mental health hospital nursing practices. The analyses give particular and detailed attention to:
1. Communicational patterns and conventions inherent in the nurses’ written records and the act of writing these records.
2. Communicational patterns and conventions related to handing over information between the nurses’ work shifts.
3. Communicational patterns and conventions related to interdisciplinary treatment conferences.

The analyses of the three areas are presented as individual papers, and the results are used as parts of a more general analysis of mental health nursing practices.

Chapter 1 is a review of the literature relevant to a descriptive, empirical field study of mental health nursing practices. The three chapters on communicational patterns (Chapter 4, 5, and 6) have individual reviews, while the review in this chapter is restricted to the literature specifically adding to an overall understanding of mental health nursing practices. Exceptions are made for literature that did not fit into the papers, either because of spatial limitations or because it was not relevant for the readers of the journal targeted for publication. The chapter is brought to a close by an outline of a possible explanation for the limited research on communication between mental health nurses away from the patients.

Chapter 2 contains a presentation of the research settings and of the epistemological position taken throughout the thesis. Further, I will describe the methods and concepts used throughout the study, particularly ‘social practice’, ‘the production of clinical knowledge’, and ‘discourse analysis’. Finally, the chapter concerns the author’s ethical considerations in relation to a field study in mental health settings.

Chapter 3, *Nursing scholars appropriating new methods: The use of discourse analysis in scholarly nursing journals 1996-2003* is an analysis of the variety of ways discourse analyses have been used by nursing scholars. This analysis identifies and discusses the problems and the values of nursing scholars adopting the approach, in particular the problem of integrating an analysis of text and larger social structures.

Chapter 4, 5, and 6 are individual papers presenting detailed analyses of mental health nursing practices. Chapter 4, *The genre of mental health nurses’ written records*, is concerned with the pragmatics of mental health nurses’ records and the practices of writing records. The analysis shows how the records are written by means of an everyday understanding of mental illness and ‘life on the wards’, and, moreover, how the practices of writing shape the information recorded. Chapter 5, *Mental health nurses handing over information about patients*, is concerned with the recurrent organisations of handovers and how they influence the information shared. The analysis stresses the handover’s conventions and how
informal positioning among the nurses influences the content of the handover and, moreover, how the participant’s ‘knowing the patient’ in advance makes requests for additional information about the patient redundant – thereby closing more elaborative discussions. Chapter 6, *Interdisciplinary conferences*, is concerned with the conventions for sharing information at interdisciplinary team conferences. Here, the main finding is related to a ‘disorder of discourse’ between the professional groups, who struggle to integrate their professional descriptions of the patients into a single perspective.

In Chapter 7, *Mental health nurses negotiating clinical knowledge*, interpretative inferences are made across the detailed studies in order to present a more coherent analysis and synthesis of mental health nursing practices. The chapter also contains discussion of the overall validity of the study. The thesis closes with a conclusion of the main lines of argument, and an outline for further research is suggested.
Chapter 1. A review of the literature on mental health nursing practices and communication among nurses

In the following review, literature relevant to the thesis will be presented and discussed. There was neither a mainstream canon of literature nor a set of standard methods pertinent to studying communication among mental health hospital nurses in their daily practices, and the review will, consequently, be wide ranging in terms of the reviewed studies’ research aims, methods, and study contexts. The review was complex because, firstly, the studies were grounded and designed within a variety of academic traditions each working with different aims for its research. Some interpretative approaches would, for instance, aim to describe a situated understanding of the everyday experiences of the various participants in a given context. Other approaches aimed at describing the social actions and conventions intrinsic to a social event: these approaches evaded the explication of subjective meaning. Secondly, only very few studies were aimed specifically at analysing mental health hospital nurses’ mutual communication. This meant that insight on mental health nurses’ mutual communication and communicational skills had to be both located in, and extracted from, broader studies of communication, such as communication in community mental health settings or at interdisciplinary team meetings. Thirdly, the institutional settings in which the studies took place were often inadequately described; they could be very varied which further complicated comparisons of findings. The meaning of relatively simple descriptive terms, as for instance ‘closed ward’, ‘record’ or ‘nurse’, could vary significantly.

The review is organised under four inductively derived headings. 1. Observational field studies of mental health nurses. These were quantitative observational studies aimed at describing mental health nursing practice. 2. Interpretative field studies of practitioners in mental health hospitals. These studies were interpretative analyses aimed at understanding health

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9 Systematic literature reviews related to a research subject bordering on the health sciences, the social sciences and the humanities were done in several databases to ensure that – in principle – all relevant references from each academic field can be found. For instance, a study of communication among health care personnel could appear in a health scientific database but also, and maybe exclusively, in a sociological or linguistic database. Therefore, searches were performed in the following four databases that jointly cover the research subject adequately according to size and availability: CINAHL, PubMed, Sociological Abstracts and Linguistics and Language Behaviour Abstracts. Search strategies could not be transferred between the databases because the bases’ taxonomic structures of search terms were different reflecting different thresholds for relevance in relation to topics and methods. For instance, ‘charting’ was indexed in the CINAHL thesaurus because ‘charting’ was acknowledged as a common part of nursing practices. ‘Charting’ did not exist in PubMed and the best alternative was the MeSH term ‘communication’. In Sociological Abstracts and Linguistics and Language Behaviour Abstracts there were several specifications of ‘communication’ but none related to nursing, health care, or healthcare professions. Summing up these experiences with searching in several databases, despite that the research subject was located on the borders of the health sciences, the social sciences and the humanities; the main part of the literature relevant for this study was indexed in the two health sciences databases.
care practitioners working within the specific institutional constraints of a mental health hospital. 3. Detailed analysis of written communication by mental health nurses. These studies were concerned with the semantic organisation of the everyday writings of mental health nurses. 4. Detailed studies of clinical language use among mental health practitioners. These studies were the most comprehensive studies of mental health practitioners’ use of language. Before the chapter is concluded, the relative absence of research of mental health nurses’ mutual communication will be discussed briefly by pointing to parallels between the history of sociology of medicine and the academic discipline of nursing.

1. Observational field studies of mental health nurses

Observational studies of mental health nurses have given limited attention to nurses’ mutual communication. This is thought provoking, as Allen pointed out, because a number of studies had indicated that nurses actually spend more time talking to each other or to other clinicians than to patients – in quantitative measures it must have some importance (Allen 1981). Observational studies have drawn disheartening conclusions regarding the practices of mental health nurses: nurses engage in custodial activities and institutional routines rather than therapeutic activities (Altschul 1972;Cormack 1976;Cormack 1983;Hodges, Sandford, & Elzinga 1986;John 1961;Oppenheim 1955;Sandford, Elzinga, & Iversen 1990;Towell 1975;Tyson, Lambert, & Beattie 1995;Whittington & McLaughlin 2000). In the early observational study of how nurses spend their time at two suburban general psychiatric hospitals in London, Oppenheim concluded on the nurses’ attitudes: ”The impression gained was that most nurses feel, that they must get on with their ”work” and that only if they have a free moment should they talk to patients; almost any other duty seems to take precedence over ”talking to patients”.” (Oppenheim 1955, 59). Cormack identified a striking difference between the prescriptive literature on nursing and the actual nursing observed at four Scottish psychiatric hospitals and suggested conceptualising mental health nursing as a wide sense of psychotherapy: “[…] a valuable form of unsystematic and unrecognised therapy.” (Cormack 1976, 89). Cormack’s suggestion questioned the dominant theoretical conceptions of mental health nursing (the American legacy outlined in the current thesis’ introduction) including the methods used in quantitative observational studies. None of the quantitative studies challenged the validity of their pre-defined observational categories. As Whittington and McLaughlin on the one hand note, simply spending time with patients need not be psychotherapeutic (Whittington & McLaughlin 2000, 261), but, on the other hand, the potential psychotherapy in an non-interactive activity such as ‘staying away from an agitated patient’ was not satisfactorily captured in these studies. Thus, the validity of the quantitative observa-
tional studies could be questioned, because the categories did not sufficiently capture the situated character of mental health nursing.

The observational studies presented in this section do not provide detailed analysis of the communication among mental health nurses or account for the production of clinical knowledge; they were primarily concerned with communicative interactions between nurses and patients and categorising distinct nursing actions. Generally, they painted a rather depressing image of mental health nurses as acting in line with institutional regimes and not spending sufficient time in therapeutic interactions with the patients. As stated above, the analysis of these studies can be used to question the validity of categorising the nurses’ actions according to prescriptive theories or according to categories external to the clinic. This reservation towards interpretations based on pre-defined categories was central to the choice of methods for this thesis: a realistic and valid account of mental health nurses’ practices was conditioned by a researcher both observing and participating in everyday nursing practices and drawing on interpretative categories both internal and external from this context, cf. (Chouliaraki & Fairclough 1999, 62).

2. Interpretative field studies of practitioners in mental health hospitals

Several field studies described mental health professionals as pragmatically working to make ends meet in the realities of everyday work. In the study by Strauss et al., abstract treatment ideologies were described as being mediated by the practical everyday necessities; Ideology was here defined philosophically neutrally as “a shared or collective set of psychiatric ideas” (Strauss et al. 1964, 8); and ideology was seen as mediated and implemented by ‘operational philosophies’ working in the institutions. This distinction between ideology and operational philosophies is important as it emphasises a difference between abstract psychiatric ideas and the ideas inherent to everyday practice.

Michelle Cleary’s ethnographic fieldwork took place in an Australian 22-bed psychiatric hospital ward (Cleary 2003a; Cleary 2003b; Cleary 2004). The purpose of the study was to describe how the mental health nurses interpreted their everyday practice and Cleary collected data for five months by means of participant observation supplemented with five discussion groups among the nurses and 10 face-to-face interviews. Cleary identified four overall cultural themes: 1. Delivery of nursing care (Cleary 2003a), 2. Relationships, power and control (Cleary 2003b), 3. Overwork (Cleary 2004), and 4. Professional attitudes and support. A general theme was that the nurses continuously struggle to balance institutional re-

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10 In line with this argument, Purkis argues that crucial social aspects of nursing practice have not be addressed sufficiently in the central trends of nursing research and, further, drawing on Giddens and Garfinkel, that research should focus on the ‘knowability’ of the nurse practitioner (Purkis 1994).
quirements to fulfil what they believe to be their therapeutic obligations. Cleary stated pertinent to overwork:

“It was perceived that, in addition to existing duties, they had been given ‘a lot more tasks to do’ as the years ‘have gone by’. These roles were seen to be at the expense of spending time with patients and compromising traditional expectations concerning nurse-patient relationships.” (Cleary 2004, 56).

The strength of Cleary’s study was exactly such descriptions of the nurses’ beliefs. Even though the study was based on fieldwork, there were only very few concrete descriptions of day-to-day nursing activities. Therefore, Cleary’s study was primarily concerned with nurses’ perceptions of their day-to-day work rather than their behaviour\(^{11}\) and the complex interplay between the nurses’ actions and their perceptions of these actions.

Jan Kåre Hummelvoll and Elisabeth Severinsson aimed at explicating mental health nurses’ practical knowledge and their complex working situations by combing participant observation on a Norwegian acute psychiatric ward with interviews of 16 mental health care professionals\(^ {12}\) (Hummelvoll & Severinsson 2001a; Hummelvoll & Severinsson 2001b). They concluded that the institutional demand for effectiveness prioritised the medical model, which left the nurses with a stressful awareness of a discrepancy between their professional ideals and reality.

“The nurses wish to promote a practice based on a humanistic and, consequently, holistic orientation towards the patient’s situation. This presupposes the patient as a person. However, there are implicit characteristics of ‘acute psychiatry’ (i.e. the acute, unpredictable and treatment effectiveness, coupled with a medical model dominance), which contradicts the desired practice.” (Hummelvoll & Severinsson 2001b, 20).

Hummelvoll and Severinsson’s interpretations rested on a deliberate invigoration of a classic professional distinction between nursing and medicine, read good and bad. However, it was arguably feasible to identify a schism between ideals and reality but the inferences linking these two realms to nursing and medicine were not substantiated empirically. Furthermore, the presentations of results are hard to decipher, first, because descriptive accounts were mixed with normative reflections, and, second, because the results were not presented as a coherent gestalt, but rather as a list of themes pointing in different directions.

Joy Bray’s ethnographic study of psychiatric nurses included 1 years participant observation at three psychiatric wards and semi-structured interviews with 15 trained nurses (Bray 1999). Reflecting on the observational studies’ general conclusion – that mental health

\(^{11}\) Unsurprisingly, this study therefore has strong resemblances with Cleary’s previous work based on interview-data (Cleary & Edwards 1999; Cleary, Edwards, & Meehan 1999).

\(^{12}\) Hummelvoll and Severinsson have published extensively about the particular acute ward, e.g. nurses’ perceptions of manic patients (Hummelvoll & Severinsson 2002) and factors influencing the nurses’ sense of job satisfaction and experience of ethical dilemmas (Severinsson & Hummelvoll 2001).
nurses did not act therapeutically – the purpose of the study was, thus, to investigate what a beneficial relationship between nurse and patient was. Bray pointed out three themes: 1. The nurses found it emotionally stressful to engage in close relations to mentally disturbed patients. 2. The nurses had a set of ‘distancing techniques’ that were both personally and institutionally sanctioned. 3. Congruent care – “when nurses relate towards patients in the way which they feel is right.” (Bray 1999, 302). Reflecting on her experiences in the field, Bray described the nursing work as emotionally very stressful and suggested to interpret the nurses’ distancing techniques’ as social defences against anxieties caused by the closeness to the patients.

Bray’s study suggested that the nurses found working with disturbed patients very stressful and through behavioural techniques they balance a distance to the patients to minimise their perception of stress. Moreover, the nurses found it difficult to link their own understanding of ‘good’ nursing actions to the formal theories on mental health nursing. The interpretation was intriguing because it offered a social-psychological explanation of the nurses’ actions\(^\text{13}\) rather than an evaluation of the nurses’ behaviour with formal theory as the golden standard. The results of Bray’s study were, to a certain degree in line with the studies of Cleary, Hummelvoll and Severinson’s reviewed above, difficult to review because of the use of ‘theme’ as the main concept for organising the results. It was unclear what a theme was or referred to, and for that reason it was unclear what the relationship between multiple themes were and how themes from different studies could be contrasted and compared, cf. (DeSantis & Ugarriza 2000).

Eli Haugen Bunch’s fieldwork study of a locked psychiatric ward in the United States focused on understanding nurses’ communication with schizophrenics as a balance between professional and clinical mandates while the nurses fulfilled the institutional requirements of the ward (Bunch 1983). Bunch described the ebb and flow of institutional routines and activities, but maintained that it was impossible for the nurses to accurately predict how busy the ward would be at a certain time because of unanticipated events, such as new admissions. Bunch found that the nurses interpreted and acted towards the patient according to a ‘noisiness scale’: violence, disruption, nuisance and irrelevance (Bunch 1983, 85-86). Nursing actions were categorised as active or passive\(^\text{14}\). According to Bunch’s descriptions, the noisiness scale was based on a cognitive decision of the individual nurse:

“The nurse’s understanding of the patients’ verbal and nonverbal actions and the structural requirements are influenced by her theoretical knowledge and clinical experience.

\(^{13}\) A further step in this line of inquiry would be to analyse the complex interrelationship between the nurses’ and the patients’ techniques for maintaining relational distance.

\(^{14}\) Bunch’s interpretation of the nurses’ response to noise was more generous than Towell’s. Towell described noise as a disruption of nursing routines rather than a focus for intervention (Towell 1975).
How knowledge is operationalized will depend in part on the nurse’s cognitive and emotional characteristics.” (Bunch 1983, 77).

This conception of the nurse emphasised the decisions made by the individual nurse, and Bunch did not account for any debates in the team of nurses on how to collectively perceive ‘noise’ and how to respond as a team.

Lorna Amarasingham Rhodes described, on the basis of ethnographic fieldwork in an emergency psychiatric unit, staff members’ experiences of their practice. The analysis was aimed at three overlapping topics: 1. A basic contradiction: Staff must treat patients sufficiently but at the same time discharge them quickly to make room for new admissions. 2. The staff had a range of strategies, verbal and nonverbal, to overcome the contradiction. 3. The staff members’ subjective awareness of their contradictory mandate and the context-sensitive knowledge needed in their everyday activities. This basic contradiction continuously served as Rhodes’ grounds for making inferences on the staff’s actions. Rhodes concluded on an analysis of staff members’ presentations of patients that the language used combined the formal language of psychiatry and casual comments and, further, that presentations did not follow a predictable format. The discussions were ultimately aimed at the pragmatic actions and decisions needed in order to separate the patient from the ward.

“The staff spoke from a place, a position, that was specific and local, grounded in the exigencies of a particular set of constraints and possibilities. What they spoke about was their own situated understanding, not likely to be duplicated elsewhere, of the contradictions emerging from their spot in time and space.” (Rhodes 1995, 173).

Goffman and Foucault inspired Rhodes’s analysis. Foucault’s critique of modern institutions was used to identify the staff’s knowledge as ‘subjugated knowledge’: resisting psychiatry and institutional demands (Foucault 1991 [1975]; Foucault 1997a [1961]). Goffman’s critique was applied to point at the institutional ‘underlife’: staff adjusted their practices to the institution and used institutional margins to their advantage (Goffman 1991 [1961]). In Rhodes’s analysis the staff was perceived as a team working under the same contradictory conditions and the collaboration between the professions was not a topic for research, further, the analysis did not offer very detailed accounts of the language used.

Compared with the observational studies, the studies of institutional necessities accentuated, firstly, that different mental health institutions, with their inherent ideologies and divisions of work, imposed different constraints on the work of the professionals. Secondly, that mental health staff members worked pragmatically to make ends meet within these institutional constraints. Further, the studies indicated that the mental health professionals to a certain extent were reflectively aware of these constraints. Therefore, pure and coherent ideologies of treatment and care will probably not be observable in clinical practice; but must instead be extrapolated from the traces of miscellaneous ideologies working in everyday
institutional life\textsuperscript{15}. A further reservation pertaining to searching for ideologies is that it may create a focus on explicable ideologies (and their hybrids) at the expense of the study of the coherency and power of the practical logic inherent in the practices of nurses pragmatically getting on with their work in the everyday institutional settings.

3. Detailed analysis on written communication by mental health nurses

In this section, four empirical studies of mental health nurses’ written language will be reviewed. The reviews are a ‘mental health nursing supplement’ to the review in the introduction to the analysis of records in Chapter 3 which was specifically appropriated for publication in a journal on social science and health and illness.

Crawford et al. reported an empirical study with an experimental design of how nurses write records (Crawford et al. 1999)\textsuperscript{16}. 26 nursing students and three trained nurses wrote a report with a length of approximately 500 words after seeing a video film of a clinical interview lasting about ten minutes. The interview was a psychiatrist interviewing a person about his problems. The instruction to the participants was to judge whether or not the person should be recommended for hospitalisation and to report their observations and their reasons for the recommendation. The report should be written as if professional colleagues were the recipients. The analysis of the reports included a quantitative comparison of the reports’ wording with wording in English in general and an analysis of the use of linguistic forms and expressions, such as modality, nomenclature, binominal expressions, reported speech, and textual structure. The analysis was concluded with a comparison of the students’ report and the trained nurses.

The wording in the film would undoubtedly influence the wording used in the report, but the analysis contained neither information about the expressions used in the video sequence nor reflections on their influences on the reports. This was surprising as a central warrant for an experimental design, rather than a naturalistic, was that the reports refer to the same event. The only place the study design was discussed is in relation to the frequent use of modal verbs, modal auxiliaries, and ‘hedging’. According to the authors, these words could be used as techniques for avoiding a contradiction with the researchers’ expected interpretation of the video. The validity of the conclusion, that there was a relatively frequent use of words related to the person’s emotions and needs, was hard to evaluate as it could be

\textsuperscript{15} Neither Altschul nor Bunch were able to identify a treatment ideology among the nurses they observed. This quest for the identification of a nursing ideology was undoubtedly part of a professional nursing ideology aiming at explicating a knowledge base for mental health nurses and claim professional autonomy.

\textsuperscript{16} The authors collaborated on several publications about communication/linguistics and mental health. Some of these served as theoretical substantiations and further explanation of this particular study: (Brown et al. 1996; Crawford, Brown, & Nolan 1998; Crawford, Nolan, & Brown 1995).
contingent on the research setting rather than the characteristics of a mental health nursing genre. The most interesting results were linked to the differences between the reports; Crawford et al. concluded that the very small variations between the reports was evidence of a tight genre of reporting (Crawford, Johnson, Brown, & Nolan 1999, 338).

Wanda K. Mohr described a study based on a content analysis of the progress notes of 26 of 26 patients’ admission to hospital (Mohr 1999). The analysis was part of a broader study of patients’ experiences of hospitalisation in a mental health institution; as part of this study the 26 patients were interviewed and their medical records examined. The documentary material extended to 1824 pages. The patients had been admitted to different wards and it was not possible to track the author of any specific entry. Mohr’s analysis was split into two: First, a content analysis of the 1824 pages identified 4321 phrases. They were inductively grouped into 9 mutually excluding themes. Last, the results were interpreted, “de-constructed”, inspired by Foucault’s notions of the interrelations between knowledge, power and professional practice.

Content analyses have in qualitative methodology been criticised for de-contextualising data through categorisations and for trading off membership understandings in the process of categorisation (Silverman 2000). Mohr did not re-contextualise the results in her interpretation: there was no explanation of the distribution of themes. For instance, the theme ‘Non-sense’ (1 %) referred to senseless phrases or phrases that were formulated foolishly: “pt. was consequenced for inappropriate behaviour” (Mohr 1999, 1056). However, a possible interpretation of the phrase was: the patient behaved inappropriately and therefore the staff imposed sanctions. The counter interpretation of the phrase demonstrated that it was not meaningless, albeit the formal grammar was incorrect. Mohr’s analysis excluded the social context for production and distribution of the phrases: without context the phrases were vulnerable for normative evaluations.

Results from Mohr’s broader study were also presented in a paper co-authored with Noone (Mohr & Noone 1997). This analysis was concerned with the adjectives used in descriptive entries in the 26 ‘medical records’. The most frequently used adjectives and/or value-laden words were compiled and subjected to a Q-sort analysis. A Q-sort analysis was a quantification of subjective evaluations in which an informant evaluated a given quality on the basis of explicit criteria for the evaluation. First, 10 expert psychiatric nurses indicated whether a term was pejorative or non-pejorative and suggested two synonyms for the term. Last, the term was evaluated on a four-point Lickert scale from the somewhat negative/positive to the most negative/positive. The results were adjectives, appearing with a cer-

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17 Mohr mentioned “charts”, “medical charts”, “medical records”, “progress notes” and “flow sheets”. The analysis was made of progress notes but it remained uncertain if they were solely written by nurses.
tain frequency, related to the nurses’ mean evaluation of the term. For example “Manipulative” appeared 40 times, was evaluated as very pejorative, and was given synonyms such as “tricky”, ”sneaky”, “untrustworthy” and ”deceitful” (Mohr & Noone 1997, 329).

Mohr and Noone argued that there were differences between the terms’ dictionary meanings and the nurses’ meanings, which reflected the situated character of language use. More, it was suggested that “quiet” was evaluated as being very positive and that this term was used in situations where the patient did not come to the staff’s attention. Such claims remained speculative without contextual, observational data.

Trish Martin and Annette F. Street explored ‘evidence of the therapeutic relationship in forensic psychiatric nursing’ (Martin & Street 2003). The purpose of the study was to examine how forensic mental health nurses describe their patients and the nurse-patient relationship in case file entries. A convenience sample of 1278 nursing entries in 17 patient files were subjected to content analysis. Moreover, Martin and Street chose to interview five nurses experienced in planning and evaluating nursing interventions. The main conclusion about the case files was that that they reflected an orientation towards custodial care, namely because of an impersonal style of writing and a way of describing which gave no details about the patient’s needs or responses or nursing interventions. The readers of the reports had to make inferences about the patient’s condition based on descriptive ‘snapshots’ of the patients’ behaviour (Martin & Street 2003, 547).

Martin and Street construed two parallel, analytical ‘gaps’ in their interpretations. First, they pointed to the ‘gap’ between what the expert nurses said during the interviews and how they wrote about their practices: therapeutic nursing practice vs. custodial care. Such differences between ‘what is said’ and ‘what is done’ was predicable as the representations are produced in two very different social contexts fulfilling different purposes. Second, the interpretation locates a ‘gap’ between the nurses’ representations of their practices and theoretical ideals for nursing practice. The following quote exemplifies how the nurses’ descriptions of their practice are devalued with reference to formal theory:

“In the interviews, nurses reported the importance of the nurse-patient relationship and contended that their practice was therapeutic and holistic. However, they failed to support their claim by identifying the processes that are essential to therapeutic practice.” (Martin & Street 2003, 549)

Thus, Martin and Street evaluated the nurses’ descriptions according to their own theoretical ideals, and because they did not inquire about the descriptions social context, cf. Mohr above, the social meaningfulness of the nurses’ language use evaded them and left nothing but evidence of insufficient practices.
G. E. Chapman analysed ‘24-hour community report documents’ from a therapeutic community at a mental health hospital (Chapman 1988). The aim of the study was to analyse professional nursing practice by analysing what mental health nurses shared in the documents about patients and routine events. A 24-hour community report was a distillate of the events in the community written by the ward sister on night duty. The reports had a formal structure and described daily routines punctuated by disruptive events. First, the reports were categorised inductively into 7 categories. Last, statistical cross-tabulations were made to identify correlations between the 24-hour reports and the nurses’ personal report writing style, the community size, or the stability of the community. Results indicated, even though the sample sizes were small, that the nurses’ style of reporting were similar; the number of patients did not influence the reports’ length or content; that there were correlations between the number of admissions and entries of the categories: ‘interpersonal relations’, ‘family relations’ and ‘violence’. This suggested that new admissions into the therapeutic community lead to an increased reporting of topics related to these categories. In other words: new admissions rather than the size of the community seemed to disrupt the community.

The results were discussed in relation to Garfinkel’s notion of mundaneity and Foucault’s notion of surveillance. The nurses’ discourse differed from a medical-technical discourse by the use of mundane language and from a psychological discourse by descriptions of interpersonal relations via everyday activities. This was interpreted as an all pervasive system of surveillance (Chapman 1988, 263).

The overall and important conclusion, which can be extracted from the studies of the practices of writing, is that nurses’ reporting adheres to strict conventions for writing. However, the studies of the written records were not designed to include detailed descriptions of the everyday practices as the social context of their practices. They therefore do not add to a situated understanding of mental health nurses’ practices of writing, or of how nurses read and interpret the record, or of the record’s importance as a physical artefact which can be mislaid, slammed on the table, or filled with paper. In this sense, the results of the detailed analyses of mental health nurses’ written language use were of limited interest because they lack social relevance through the analytically absence of social context.

4. Detailed studies of clinical language use among mental health practitioners

The review in this section is pertinent to two studies of detailed language use in mental health settings which were concerned with detailed analyses of the communication among mental health professionals.
Robert J. Barrett did not take the perspective of the mental health professionals, and Barrett’s analyses were more critical of the effects of the professionals’ practices compared to Bunch and Rhodes (Barrett 1988; Barrett 1996). Barrett’s study was an ethnographic analysis from an Australian hospital specialising in the treatment of schizophrenics. Barrett underscored continuously how the institution works on the patient’s subjectivity until it ultimately produces ‘the chronic schizophrenic’. According to Barrett, mental health nurses not only formally observed patients continuously, they also took note of patients in activities “[…] not expressly clinical or therapeutic.” (Barrett 1996, 56). Further, the nurses’ closeness to the patient gave them access to what they expressed as ‘what the patient is really like’, which was in opposition to medical staff members who worked at a distance. The nurses’ knowledge was not very theorised and they would occasionally make fun of newcomers’ use of theoretical concepts or references to theorists. The divisions of work led to a difference in the way medical and nursing staff members perceived the patients. Barrett summed the difference up in the following way:

“For psychiatry [medical staff members], a patient’s actions were seen as symptoms of underlying forces, be they biological or psychodynamic. Nurses would characterise the same actions as behavioural, indication that the patient was trying to elicit a response, especially from the nurses themselves.” (Barrett 1996, 59).

However, the differences did not lead to continuous conflict among the perceptions of the patient. Discussions at the teams were dominated by medical staff: psychiatrist set the framework for discussion and controlled the questioning and the intellectual tenor (Barrett 1996, 90). The language at team meetings was lay language, even though it contained technical words. Barrett claimed that the simple, common sense language bridged the differences between the professional groups and notes that an abbreviated description was a sign of specialised clinical expertise (Barrett 1996, 95-97).

According to Barrett, clinical discourse, practices of talking and speaking, was based on a variety of accounts of observations and the debating of them. Particularly, written discourse described the patient as a case; spoken discourse formed the moral trajectory of the patient. Talk added a notion of agency: the patient’s actions were evaluated according to perceptions of the patient’s wilful control of actions. Barrett’s analysis drew heavily on Foucault’s notion of the disciplinary institution as machinery producing knowledge about the individual subject, and Barrett stated that the psychiatric casework had the most powerful effect on the patient. The analysis described the mental health professionals as discursively working the psychotic person into a schizophrenic, but unfortunately Barrett never specified the link between the staff’s construing a case and the patient’s identity.
Lesley Griffiths’ study of two community mental health teams was focused on language use and the linguistic resources drawn on by the team members (Griffiths 1997; Griffiths 1998; Griffiths 2001). The analysis was inspired by discourse analyses focusing on strategies for categorising patients and turn-take organisations. The teams worked as gatekeepers as they discussed whether or not to accept referrals of mentally ill persons. The teams mainly negotiated and categorised the ill along a distinction between the categories “the worried well” (inappropriate referrals) and “seriously mentally ill” (accepted referrals) in order to organise their work and to control work pressure (Griffiths 1997, 63). The analyses showed in conversational detail how the referrals were worked into fitting categories and how dominant relationships between professional groups were negotiated in the same process.

Griffiths’ description of the linguistic repertoire used by the teams was particularly interesting. The language used in the referrals and the language of the rank-and-file team members was contrasted: “[…] the rhetorical force of expert professional knowledge is countered by a more informal occupational rhetoric, based on street wisdom and local knowledge.” (Griffiths 2001, 689). In the quote, Griffiths conceptualised the rhetorical forces as linked to different types of knowledge contingent on the particular divisions of work between medical staff and rank and file team members. Further, the categorisations were accomplished in discussions by means of narratives and particular orderings of the information about the patient. Finally, personal, local knowledge itself did not always need to be explicaded. Griffiths gave an example, where a family was already ‘known’ by staff, and the team rejected the request for referring the family to the team even though there was no explicit reference of any exact and up-to-date knowledge about the family. The debate of the relevancy of the referral was repressed by statements of already knowing the patient (Griffiths 2001, 689-693).

Both Barrett and Griffiths criticised ‘labelling theories’. Griffiths argued that labelling studies have accentuated the significance of the label and neglected to study the actual micro-social processes of labelling (Griffiths 2001, 680, 696). Barrett argued that labelling theory asserts that the hospital imposes “a false and stigmatising identity on the patient” (Barrett 1996, 3). The point was, probably, that the social order making persons susceptible to be labelled as mentally ill (Schef 1975), was not only pertinent to the hospital (which in a sense would make the label ‘false’): it was based on more common sense ideas of mental illness.

The studies in this and the previous sections described a selection of communicational practices of mental health nurses. In the studies, nurses were conceptualised in different relationships with their organisational contexts. Nursing practices were perceived as constrained
by the organisational order; nursing practices were also perceived as part of the continuous re-production of institutional orders and linguistic conventions which included providing certain identities for nurses, patients and other stakeholders, as well as maintaining the institutional divisions of work. The studies by Barrett and Griffiths accentuated the analysis of language and language use which allowed detailed analyses of how the linguistic practices both re-producing institutional structures and the production of clinical knowledge. Both studies, in particular Barrett’s, drew on ethnographic data external to the descriptions of linguistic practices in order to situate them institutionally and to warrant inferences drawn between linguistic practices and clinical practice in general. The combination of these different types of data created well-authenticated arguments about mental health nursing practices; such a combination of sources of data and methods for analysis was used for developing the central lines of argument in this thesis.

**Digression: Explaining the bias in the literature**

This final section offers suggestions as to why there was a comparative absence of detailed studies of mental health nurses’ work away from the patients, including their mutual communication. All academic disciplines actively construct their fields of inquiry and define themselves in this process, cf. (Kuhn 1996 [1962]), and an examination of the structuring constituents of academic fields can indicate why certain topics are neglected in empirical research. In the following section, I will discuss parts of the academic legacies of the academic fields of the sociology of health & illness and nursing and give indications of their effects on the practical organisation of research in health care settings.

According to Paul Atkinson the conceptual distinction between illness and disease has been central within the sociology of health and illness (Atkinson 1995, chapter 2). Illness was the subjective experience of being diseased; disease was the pathological biological process. The distinction was homologous to the ‘classical’ sociological and philosophical distinction between culture and nature. The meaningful constituents of culture had to be interpreted; and the facts of nature were ‘givens’ existing independently of interpretation. The split has made it possible to conceptualise a field of meaningful social action, for instance Parsons’ seminal definition of the sick person as acting rationally within a social system (Parsons 1951, chapter 10). According to Atkinson the backdrop of the constitutive distinction between illness and disease was that illness was given a privileged position within the sociology of health and illness: disease and clinical fact were not scrutinised as products of social action since they were perceived as biological facts, as ‘givens’ (Atkinson 1995, chapter 2;Berg 1992, 153-155). In this sense, the contrast between illness and disease limited the
possibilities of creating an adequate sociology of the production of knowledge in health care settings\textsuperscript{18}.

Further, sociological investigations in the wake of Parsons were focused on the patient’s personality in relation to treatment. This led to a substantial literature on communication in medical encounters between the patient and the physician, in particular the consultation. The preference for this particular type of encounters emerged because of, on the one hand, an interest in the political character of the asymmetrical encounter between a lay person and a clinical expert, which paved way for the analysis of power and control (Have 1995, 251-254), and, on the other hand, the practical availability of these encounters. A consultation is planned in advance, which allows for a researcher to ask for the consent of the participants to be observed and recorded. The division of work at health care institutions therefore created biases of the detailed studies of communication because medical staff members, in particular the high ranking, had more planned interactions compared to other clinical staff members. Therefore, as argued above, further analyses of communication in health care settings may have to rely on other types of data than audio or video recorded data such as field notes (Hak 1999, 440).

There was a long tradition within the sociology of mental health for examining the social processes inherent in the development and modification of categories of mental disorders; this tradition could be traced back to Durkheim’s work on the rules that define ‘the normal and the pathological’ in society and which reinforce societal norms and values (Busfield 2000, 545; Durkheim 2000 [1895], chapter 3). In spite of this interest in the constitutive part of social processes in what counts as mental disorder, it did not inspire to a thorough and continuous interest in detailed examinations on how mental health professionals’ work up these categories in everyday clinical practices.

To a large extent dominant nursing discourses followed the same path as medical sociology into the study of illness and the relationship between laypeople and professionals. The most dominant discursive forces within nursing since the middle of the 20\textsuperscript{th} century were ‘nursing theories’: “an ahistorical meld of humanist philosophy and various methodological frameworks” (Nelson 1997, 234). These theories had a major influence on nursing’s understanding of itself and on the development of nursing research and knowledge. Central to the rhetoric of nursing theories was patienthood: the patient was a subject who experienced illness and the nurse’s relationship with the patient was a therapeutic instrument (Ersser 1997; May 1995). Furthermore, since the configuration of the modern nurse in the latter half

\textsuperscript{18} Atkinson further argued that an anthropological conception of medicine as a cultural system accentuated assumptions of medicine as a homogeneous, coherent, and unchanging scientific body of knowledge which drew attention from the socially organised production of clinical knowledge (Atkinson 1995, 25-30).
of the 19th century, nursing has had an ambivalent relationship with the medical profession, its use of science, and its attempts to elaborate and dominate ‘the health field’ (Dingwall, Rafferty, & Webster 1988; Rafferty 1996). The professional striving to carve out an academic discipline different from the medical profession accentuated a contrast between care and cure parallel to illness and disease; the consequences were also parallel: a neglect of studies of the socially situated production of ‘nursing knowledge’ 19.

The neglect of detailed studies of communication among nurses was discussed in relation to the historical and conceptual constituencies of the disciplines of the sociology of health & illness and nursing. It was suggested that both disciplines share an orientation towards ‘illness’ which precluded the study of the social production of clinical knowledge, which was regarded as a given. This thesis is a contribution to this tender field of health care research.

**Conclusion**

As described in the introduction of the thesis, the aim of this analysis was to advance our understanding of the professional practices of mental health nurses by focusing on the production of clinical knowledge in their mutual communication. The literature included in the review provided only to a limited extent research based and detailed knowledge about mental health nurses’ production of clinical knowledge in their professional practices. However, read as a whole, the studies indicated how professional nursing practices were organised, how some communicational structures were locally and conventionally organised, and, finally, that conventionalised interactions among the professionals had a profound influence on the care and treatment of the patient.

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19 Social researchers have questioned the biomedical interest in the patient’s subjectivity and view on treatment. Armstrong argues that the biomedical gaze expanded the search for the aetiologies of disease through the adoption of sociological survey techniques thereby creating an interest in the patient’s idiosyncrasies and subjective meanings. Thus, the medical interest in the patients subjectivity did not come forth as the endeavour of humanistic enlightenment (Armstrong 1984).
Chapter 2. Setting, theory, methods and ethics

The overall research aim of understanding mental health nursing practices was answered by combining strategies for field research with detailed analyses of language use. Fieldwork at two mental health hospital wards was aimed at creating a situated understanding of nurses’ everyday practices and their subjective experiences of these. Detailed analyses of language use at the two wards were aimed at describing the local conventions for language use and the production of clinical knowledge and at explaining these in the light of the everyday clinical practices and the institutional order.

This chapter contains an outline of the theoretical framework underpinning the field analysis and the discourse analysis. First, I provide general information about the research settings. Second, the concepts central to the analysis are explicated: communication, social practices, the production of clinical knowledge, and the relationship between language use and social practices. Third, I describe the methods for collecting and working up data and, fourth, the formal ethical provisions and selected moral dilemmas related to a fieldwork study in a mental health setting.

Study context: General information about the wards

In this section I describe the research settings. These descriptions serve as a context in which the results must be considered and understood. Information is provided about the wards, about the patients, and about the nursing staff.

Background data about the wards

The research fieldwork took place between January 2002 and February 2003 at two adjacent wards at a Danish University Hospital. The wards will throughout the thesis be named Ward A and Ward B. The hospital was part of a National Health Service Trust consisting of four regions.

The sampling of the wards was initially a purposive sampling (Bernard 1995, chapter 4): all the general, adult wards were sought out at the University Hospital. However, a number of wards were considered unfit for research because the researcher knew the staff from his previous practice, and a number of wards did not have the resources to participate because of their participation in other research and development projects. From the three remaining wards, two gave positive responses about participating in the study. For these pragmatic reasons they were included in the study; there were no data indicating that the wards could not be regarded as being typical wards, cf. (Have 1999, 50-52).
The two wards were part of the same regional section and admitted patients from similar geographical areas, characterised by both urban and suburban areas. The wards were general adult ‘special observation’ wards and had similar capacity for admissions: 16 single bedrooms. The official policy at these wards was that distressed patients should be given close and perhaps constant observation rather than imposing more drastic sanctions, such as locking the entrance door, or medical, physical and/or mechanical restraint. Treatment at the hospital was integrated with the community mental health services. This meant that the regular medical staff worked both in the community and at the hospital in an effort to maintain the highest level of continuity in the treatment of the severely mentally ill. Further, it meant that medical staff members would often have anticipated re-admissions.

Both wards were recently refurbished and were located in an old building originally built as an asylum. The wards were designed as long corridors with rooms along both sides. The corridors were right angles and had the main entrance at one end. However, Ward A had the main ward office in the middle of the ward and a living room at the far end. Ward B had the main office near the entrance and the main living room in the middle of the ward. These architectural differences influenced the daily routines and the social life of the wards, cf. (McMahon 1994; Tilley 1995, 148-152): it was easier to split the daily activities in Ward A into two (meals, routine meetings etc.) compared to Ward B. This meant that a relatively smaller number of people where present at many reoccurring communal activities in Ward A.

The nurses worked in shifts. On the dayshift between 7 AM and 3 PM five qualified nurses on average would be on duty, along with a number of student nurses. On the evening shift three nurses and eventually a student would work from 3 PM to 11 PM. The night shift consisted usually of two nurses. There was an ‘ebb and flow’ (Bunch 1983, 69) of the level of activity at the wards; some of these fluctuations were recurring and predictable, others were isolated and unpredictable. The level of activity was to a certain extent linked to the nurses’ shifts; the ward atmosphere could sometimes change dramatically when one shift succeeded another. This event was recognised by some nurses, who would sometimes just sit and wait for nurses to leave and things to settle down. Moreover, the staff’s conflicts with patients would occasionally escalate or disappear in relation to a shift, suggesting that the conflicts were somehow bound to specific persons.

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20 At Ward A a relatively large number of nurses were permanently working evening and night shifts. This meant that the nurses would rotate relatively less between shifts compared with Ward B. Not only was changing shifts physically exhausting, it also spoiled the nurses sense of continuity in their work because they would have a minimum of contact with the patients during the night and no personal influence on decisions on treatment.
During a shift, the nurses would be engaged in a number of recurring activities and have the opportunity to plan special activities with the particular patients, for whom they were responsible for. Mostly the nurses seemed engaged in unstructured, ad hoc interactions with the patients. Often their activities were interrupted by the patients, other staff, or by themselves because they were multi tasking and would stop what they were presently doing to take care of something more important.

**Background data about the patients**

Data on the patients’ gender, age, length of stay and diagnosis were available. The demographic data described the patients hospitalised at the wards *during* the periods of fieldwork. *Diagnoses* were not categories valuable in the process of interpretation during the fieldwork but they were valuable for comparisons with psychiatric and social science literature, cf. (Estroff 1985, 44-46)\(^{21}\).

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<th>Men</th>
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<td>Ward A</td>
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<td>F10-19</td>
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<td>F20-29</td>
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<td>F30-39</td>
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<td>F40-49</td>
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<td>F60-69</td>
<td>3 (7.1 %)</td>
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Table 1. Diagnostic characteristics of the patients\(^{22}\).

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\(^{21}\) Later in this chapter, the study’s epistemological position is described as constructionism. Constructionism treats taken-for-granted knowledge as problematic; medical diagnoses are prime examples of taken-for-granted knowledge. However, by means of ‘ontological gerrymandering’ a boundary was created between the concepts that were treated as problematic and those that were not, Woolgar and Pawluch in (Potter 1996, 184). The aim of the thesis determined which ‘constructions’ to foreground as problematic and which to treat as unproblematic. Medical diagnosis was not treated as problematic here, and that decision is of course open for the regress of infinite constructionist analysis, cf. (Potter 1996, 177-187).

\(^{22}\) In WHO’s diagnostic taxonomy of mental health disorders, ICD-10, the broad diagnostic categories are:

- F00-09: Organic, including symptomatic, mental disorders.
- F10-19: Mental and behavioural disorders due to psychoactive substance use.
- F20-29: Schizophrenia, schizotypal and delusional disorders.
Numbers of admitted patients during the periods of fieldwork: Ward A: 75, Ward B: 101. The difference reflected the difference of the length of fieldwork at the two wards: 4 months on Ward A and 6 months on Ward B. The numbers included only patients who were discharged from the wards and not patients transferred to other wards. Further, unfortunately, it was not possible to differentiate between admissions and re-admissions (in the whole region 29% of all admissions in the second half of 2002 were re-admissions). Re-admissions biased the statistical calculation; for instance, in Ward B a female patient with the ICD-10 diagnosis F19.25 was re-admitted four times (see Table 1 above). The patients’ gender and age are described in Appendix 1.

Length of stay: Ward A: 29.5 days (occupancy rate: 83.0). Ward B: 18.8 days (occupancy rate: 96.2). The average occupancy rate for the Trust in 2002 was 89.8% and the different occupancy rates and the average length of stay indicated that nurses on Ward B worked under relatively more strain.

Common for both wards were high proportions of the diagnostic groups F20-29 and F30-39. Among women these groups had similar sizes; among men F20-29 was relatively large. The distribution of diagnoses in the total number of days of psychiatric hospitalisation in Denmark in 2003 (both sexes and all ages) was: F00-09: 5.4% ; F10-19: 15.9% ; F20-29: 31.7% ; F30-39: 24.3% ; 40-49: 11.1% ; F60-69: 7.0% (Source: The Danish Psychiatric Central Research Register). Thus, considering that the wards were general adult wards and the number of patients was relatively small, the distribution of diagnosis was not remarkably different from the distribution across Denmark.

Background data on staff members

Demographic background data on staff members were collected by means of short individual interviews. Most interviews were audio-recorded, and during the remaining interviews I took field notes. A year prior to the fieldwork there had been a major reorganisation of the Trust, which meant that all staff members from the whole region were shuffled and allocated into new teams. This meant that only a limited number of the team members had worked together previously. In general, they had not worked together for longer than 1-1½ years. The following data presentation provides a general impression of staff members at the wards: data about nurses in training or substitutes for nursing staff are not included. The statistics summarised below are described in some detail in Appendix 1.

F60-69: Disorders of adult personality and behaviour.
"Others" refer to X and T diagnoses.
The staff members on Ward A were on average 4.5 years older than staff members on Ward B: 43.7 years compared to 39.2 years. The distribution between the genders was similar on the wards: on average about three women to one man.

The nurses’ experiences in mental health were quantified, and the nurses on Ward A had almost twice as much professional experience as the nurses on Ward B: 13.2 years compared to 7.5 years. However, at both wards the distribution of experience was uneven. On Ward A, 8 staff members (42%) had 3 years’ experience or less, the remaining 11 had more than 12’ years of experience (58%). On ward B, 17 (77%) had 8 years’ experience or less, and the remaining 5 (23%) more than 20 years’ of experience. Thus, at both wards there was a group of relatively inexperienced staff members and a group of more experienced staff members, but as the mean values indicate, staff members on Ward A had more experience than staff members on Ward B.

A similar proportion of the staff members had a long basic health care education\textsuperscript{23}: one third of the staff (66%) had a long education. Moreover, the staff members on Ward A were better educated by means of professional courses compared to staff on Ward B, where 36% of the staff had not attended a professional course since the completion of their basic health care education\textsuperscript{24}.

Summing up the most important similarities and differences between the wards: The patients’ had similar diagnoses, age and gender, albeit there was a relatively higher turnover and shorter length of stay on Ward B. The nursing staff members were on average more experienced and better formally educated on Ward A compared to Ward B. Unfortunately, very limited data were available for a formal comparison of the two wards with ‘an average Danish adult mental health ward’; however, the descriptions above do not indicate that the wards are extraordinary.

The following sections are concerned with a presentation and discussion of the theories underpinning the study. The study was inspired by Norman Fairclough’s theory and analysis of discourse in which language use is conceptualised as constrained by both micro and macro societal structures. However, Fairclough’s theory and method were not specifically designed for field studies of communication in mental health institutions and it was relevant to expand Fairclough’s theoretical approach with a set of concepts that would allow a better

\textsuperscript{23} Basic health care educations were divided into short educations (auxiliary nurses trained for less than two years) and longer educations (registered nurses, occupational therapists and physiotherapists). The nurses had been part of several different educational schemes, but generally the theoretical training was round 6 weeks and the practical training 10 weeks. A registered nurse is educated in general nursing, and the nurse can, two years after registration, apply for a specialisation through a one year course at the training program in advanced mental health nursing.

\textsuperscript{24} A short course denotes a project day or a course with the duration of less than 10 days of teaching. A long course denotes a course longer than 10 days of teaching.
conceptual grip of the institutionally situated communication. In the following four sections, communication and discourse will be related to: social interaction, the incorporation of macro societal structures, institutional practices, and to the notion of ‘the production of clinical knowledge’. These concepts are not in conflict with Fairclough’s theory of discourse as they are elaborations of theories already inherent to Fairclough’s theoretical framework. The four sections precede and link up with a detailed presentation and discussion of Fairclough’s theory and analysis of discourse.

**Communication and interaction**

The overall approach to studying mental health hospital nursing practices was based on an interactional conceptualisation of communication. The maxim of the interactional paradigm was that meaning is produced through social interaction. The interactionalist Gregory Bateson conceptualised communication as the exchange of information; and information was defined as a ‘difference which makes a difference’ (Bateson 1972, 315). These definitions underscored the role of the interpreter of information, the person for whom a difference makes a difference. A receiver of information is someone who can process and interpret information based on shared meanings. Communicative messages include linguistic and non-linguistic signals or symbols. Interpretation is influenced by a person’s knowledge of a situation and his or her mental condition, cultural background etc. Communicative messages are, therefore, largely dependent on the person processing information, rather than on the intended meaning of a message produced by someone.

This was a wide definition of information, because any behavioural action has the potential of making a difference to someone. Further, because a receiver can learn to expect a message, a missing message can provide information. Therefore, passivity and silence can be full of information for the expectant receiver; and people are continuously, intentionally and unintentionally, communicating with someone. It is not possible to not-communicate because behaviour has no opposite. As Wilden concisely put it: “In a communications system, nothing never happens” (Wilden 1987, 124).

Information is always conveyed by a code and in order for two persons to understand each other they must have a common knowledge of the code. However, Bateson accentuated the influence of the temporal and situational context as part of the sense-making process. The point was that communication does not only rely on an intersubjective understanding of

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25 Information is regarded as the building blocks of messages, see for instance (Bateson 1972, 400; Bateson 1977, 243).
the communicational principles but also on how the message is contextually situated. Thus, the importance of the principle of intersubjectivity, that which is necessarily shared by communicating parties, was diminished in this view on communication.

The interactional view on communication therefore regarded people’s communicative actions as responses to situations rather than simple conceptions of communication as exchanges of goal-oriented messages along straight lines (Sarangi & Roberts 1999; Schiffrin 1994). The challenge of adopting the interactional view on communication in this analysis was that the interpretation of the communicational interaction had to rely on inferences about the participants’ ‘background knowledge’ of the linguistic communicational codes, the communicational conventions, the situation, and the cultural context, cf. (Fairclough 1995, chapter 1). This was a challenging interpretative process because I would routinely and reflexively interpret communicational events in a way that would make sense to myself; in other words, the danger of routine was that the indexical reference of a communicational event was naturally understood and ‘repaired’ by me, cf. (Garfinkel 1984 [1967]; Potter & Wetherell 1987, 187). Therefore, the analyses of the communicative practices at the wards included a reflective analysis of the my situated interpretations, cf. (Alvesson & Skjöldberg 1994).

In line with the interactional model of communication, the present study was designed to establish an understanding of the everyday communicative practices at the wards during an extended period of fieldwork and, further, to systematically reflect on these practices through detailed discourse analyses, cf. (Chouliaraki & Fairclough 1999, 61-62). The next section is concerned with a theoretical clarification of ‘social practices’.

**Social practices and habitus**

Social practice was a central concept in the description of the everyday activities of mental health nurses. In advancing a theory for social practice Pierre Bourdieu put forward three modes of theoretical knowledge which are all opposed to practical knowledge: 1. Phenomenological knowledge, 2. Objectivist knowledge, and 3. Knowledge concerned with the dialectic relationship between the objective social structures and the agent’s embodied dispositions through which the social structures are actualised (Bourdieu 1998 [1977], 3-4). Bourdieu criticised phenomenological knowledge, the explication of the primary experience,

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26 Bateson regarded context, defined as ‘pattern through time’ (Bateson 1979), as meta-communication influencing how people interpret social interactions. This notion of context as pre-established and determining meaning differed radically from an ethnomethodological notion of context. Garfinkel regarded context as reflexively produced by people in situ: as simultaneously constituted in and constitutive of social action (Garfinkel 1984 [1967], 1). In this analysis, Bateson’s notion of context as pre-established and constraining was pursued.
for lacking reflections on its own possibility. Bourdieu claimed that objectivist knowledge becomes possible after an epistemological break with the primary experience. Bourdieu criticised objectivist knowledge precisely because of this discharge of the study of human experience, as human experience gives the agent’s world its natural character. In order to transgress the dichotomy of subjectivism and objectivism and inquire into practical knowledge, Bourdieu introduced a second epistemological break: social scientists must reflect on and objectify their scientific practices. The third mode of theoretical knowledge, Bourdieu’s own position, inquires into the dialectics by which objective societal structures are internalised by agents who externalise these structures through their practices: a constructivist structuralism. Bourdieu’s concept ‘habitus’ is construed to explain how objective conditions are inscribed in the bodies of the agents, who are endowed with a practical sense for getting on in that environment (Bourdieu 2000).

"The structures constitutive of a particular type of environment [...] produce habitus, systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations which can be objectively "regulated" and "regular" without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of a conductor.” (Bourdieu 1998 [1977], 72).

Bourdieu’s notions of the character of social practices led him to a theory on the genesis of social practices. This genesis is related to the dialectics between habitus, history in the body; and field, a social space with an objective history and structure (Bourdieu 1998[1977];Bourdieu 2000). The world is internalised into the agent’s body; and the agent externalises theses internalisations through his or her orientation towards the world, and in his or her practices. In this sense, every aspect, material or symbolic, of a social event influences the agent, but the habitus is only formed or changed by prolonged and intense impressing.

The advantage of adopting Bourdieu’s conception of social practices and habitus in this thesis was that it explains the agent as not being fully consciously aware of the meaning in

27 Bourdieu’s two epistemological breaks imply a theory of scientific knowledge and a reflective sociology (Bourdieu & Wacquant 1996;Callewaert 1996) in the tradition of the French historical epistemology (Broady 1991) which is not employed in this thesis.

28 It was difficult to find an exact definition of Bourdieu’s notion of ‘practical knowledge’ because Bourdieu’s theoretical interest lay in the conception of how to explain ‘what’ enables the agent’s acts of practical knowledge, rather than practical knowledge per se. In this thesis practical knowledge was defined as the acts informed by the practical sense which was generated by the agent’s habitus.

29 Bourdieu regards language use as subordinated social processes (Bourdieu 1991): linguistic habitus mediates objective social conditions and language use. Exactly this subordination was criticised by Hasan (Hasan 1998), see also the discussion in (Chouliaraki & Fairclough 2000).
his or her practices without thereby rendering the agent less rational. Action was therefore not rendered a mere epiphenomenal effect of social structure. The informants’ accounts to the researcher were regarded as quasi theoretical reflections of their practices, in that they were rationalisations and not descriptions of the underlying principle, the habitus (Bourdieu & Wacquant 1996). Further, in opposition to alternative conceptions of practice, such as Giddens’ psycho-social theory of structuration (Giddens 1999 [1984]), Bourdieu’s conception of practices underscored the inertia of social practices. This last observation was particularly important for the study of mental health nurses’ practices. In a study of general nursing students, Eriksen indicated that the nursing students were endowed with an everyday nursing-habitus (dispositions for caring for others) which was produced through everyday social life (influenced by class structures and divisions of work in families etc.). However, through education and institutional structures it was transformed into a professional treatment-habitus (Eriksen 1992). In this thesis, the notions of an everyday nursing-habitus and a professional habitus were used to theoretically account for how commonsensical notions of mental illness were brought into professional practices and how the nurses had a practical sense for getting on with their work on the mental health wards.

**Institutions and the local accomplishment of social order**

Bourdieu’s conception of habitus could thus be used to explain how the everyday practical sense of mental health nurses feeds in to the institutional nursing practices. In order to further theorise the nurses’ practices in the institutional setting I shall turn to Dorothy Smith’s conception of ‘institutional ethnography’.

Dorothy Smith’s pivotal argument is that there is a coincidence between gendered divisions of work in capitalist society and the conceptual relevancies of sociological discourse. In other words, women’s practices, interests and experiences are shaped by ‘the ruling relations’ of society and this particular standpoint of women is not captured by sociologists because sociological discourse is also gendered in the sense that it abstracts the particular and local actualities of women’s everyday life. Smith’s ‘institutional ethnography’ is thus devoted to developing a sociology that inquires into the social relations – concerted sequences of social action – that organise people’s (women’s) everyday experiences. An institution is defined as: “[…] a complex of relations forming part of the ruling apparatus, organised around a distinctive function […] (Smith 1987, 160); the distinctive property of the organised practices of the ruling apparatus is the capacity to transcribe the actualities of everyday life into abstracted and generalised forms of action. Smith argues that women’s work to a large extent mediates the relation between the abstracted, conceptual mode of action and the actual, concrete forms on which the former depends; the mental health nurse has direct and
immediate contact with the patient and tidies up this complexity into an abstraction – a case
history (Smith 1987, 84). Smith conceptualises this ‘split’ between the material, local world
as it is experienced and the abstracted, conceptual world as a bifurcation of consciousness
(Smith 1987, 84-85).

Dorothy Smith’s theoretical outset is Marx and Engels’ conception of the social as ex-
isting in people’s concerted activities and practices; social reality is brought into existence
through co-actions which continuously and routinely (re)affirm people’s common reality.
Smith combines this tenet with Garfinkel’s ethnomethodological inquiry which explicates
how people accomplish social order in the ongoing activities of everyday life (Smith 1987,
122-127). Garfinkel stated that people reflexively and ‘rational-adequacy-for-all-practical-
purposes’ accomplish organised social activities (Garfinkel 1984 [1967], chapter 1); which
means that people display the coherency and rationality of a social setting through their in-
teractions. Moreover, people use the ‘documentary method of interpretation’ in their recog-
nition of what goes on in daily life; ‘documentary’ refers to a person’s linking of an appear-
ance to a presupposed pattern of meaning: the appearance documents the pattern (Garfinkel
1984 [1967], chapter 3). Smith’s analytical outset is thus that social relations are the matrix
through which our experiences are determined (Marx and Engels) and that it is possible to
unravel these social relations through the study of people’s practical accomplishment of their
actions (Garfinkel).

“Order arises in and is accomplished by the actual practices of actual individuals, in-
cluding their practices of reasoning, interpreting, rendering what has happened ac-
countable. The generalizable properties of social relations in the institutional mode are
accomplished in people’s actual practices. The relation between ideology and the actual-
ities it glosses and makes accountable is continually worked up and maintained, on
the one hand, by practices aiming at and intending the institutional description, includ-
ing those that enforce such practices, and on the other by the development of innova-
tive interpretive forms within the ruling apparatus (and generally by those participating
in professional and academic discourses) that extend or rehabilitate interpretative
schemata as the changing character of events or the widening scope of control re-
quires.” (Smith 1987, 175-176).

The value of Dorothy Smith’s institutional ethnography is that it emphasises that accounts
are worked up in and mediated by institutional relations and texts (Smith 1974;Smith 1984),
and, further, that these institutional practices intersect with other social relations, such as
gender or class, which may determine people’s experiences without their knowing. Smith
theorises a split between women’s everyday practices and how they are abstracted by ra-
tional administrative institutional practices creating a bifurcated consciousness; in this sense
Smith adds to a further theorising of the intersection between the everyday nursing-habitus
and the professional treatment-habitus mentioned above.
Smith describes rational administrative practices as an abstracted, conceptual mode of organisation that has continued to gain influence through the 20th century. In a study of the impact of these ‘managerial’ practices on nursing, Traynor relates managerialism to a combination of a deeply rooted desire for visibility in Western thought and the invention of new technologies; a combination that advances formal, rational and controllable industrial processes (Traynor 1999). Thus, this line of inquiry accentuates the study of the organisational impact of managerial practices and technologies in health care settings.

The production of clinical knowledge and constructionism

In the sections above, I argued that communicational meaning is never objective but always relative to an interpreter’s understanding of the situation; and, moreover, that the interpreter’s resources for producing and interpreting meaning are constrained by social structures which are re-produced through social practices. In this section, I will outline the epistemological position informing the thesis, constructionism. Further, I introduce the notion of ‘producing clinical knowledge’ in order to enable an analysis of how clinicians make sense of the clinic and how clinical practices constrain the processes of producing and interpreting clinical meaning.

Kenneth Gergen was a central figure in the defining debate on constructionism, and he summed up four central and interrelated constructionist assumptions which are all related to the study of how people describe and explain the world they live in (Burr 2003; Gergen 1985). The four assumptions are presented here in order to specify the epistemological position underpinning constructionism. **First**, a scepticism towards the world as it is taken for granted; this means analysing the social and linguistic conventions related to our understanding of social categories. **Second**, if social categories are without essences because they are contingent on social conventions, it is possible to view and analyse common sense understandings as situated historically. **Third**, inter-subjective understanding and knowledge of social categories are negotiated in social interactions. **Fourth**, the way in which people understand their world influences social action (Gergen 1985). Gergen’s project was to position constructionism within psychology, but also sociologists working within an interactionist and interpretative paradigm, such as symbolic interactionists and ethnomethodologists, can be regarded as constructionists because they analyse the ways in which people interpret and act in the world they live in, see for instance (Bateson 1972; Blumer 1969; Garfinkel 1984 [1967]). Gergen’s claims reflected an anti-realist and a moderate idealist position because reality was understood as always being mediated by social and mental processes, and because it was conceived to be impossible to compare our perceived reality with reality to determine truth and accuracy.
Before adopting a moderate constructionist position, a further clarification was needed regarding the construction of knowledge and meaning; in this study, social practices constitute knowledge and meaning and, therefore, both material and mental aspects of social life were regarded as constituents of understanding and knowledge of social categories.

Gergen’s claims led to relativism, as truth becomes relative to a specific cultural practice. This particular view on knowledge, essences, and realism is central to postmodern thought, cf. (Cheek 2000). The constructionist epistemology is a social epistemology in which situated social determinants for knowledge and understanding are analysed: knowledge, and the truth it conveys, is interpreted as a receptor of social meaning, and therefore formed, constrained, and constructed in society. The present study adopted a moderate constructionist position in order to pursue the analysis of the social conventions of mental health clinicians’ work up of understanding and clinical knowledge.

In order to further conceptualise and analyse the taken for granted social categories at the mental health hospital, the term ‘the production of clinical knowledge’ was adopted from Paul Atkinson’s notion of ‘the production of medical knowledge’. The notion was coined by Atkinson to delineate that medical knowledge was worked up in clinical practices and to avoid the connotations of ‘construction’ which carried connotations of individual and mental activities (Atkinson 1995, 37-59). In Atkinson’s own words the focus of his sociological analysis was the: “[…] socially organized practices and transactions by which facts, findings, representations, opinions, diagnoses – all the elements of practical medical knowledge – are produced and reproduced.” (Atkinson 1995, 45). In this quotation, an opinion was described as an element of clinical knowledge, and that comparison strongly suggests that ‘clinical knowledge’ was not knowledge in a strict philosophical sense (in Plato’s sense as justified true belief). Thus, the analysis of clinical knowledge was concerned with the representations of clinical experiences; the transformation of clinical experiences that render them socially actionable by achieving social form – by becoming clinical knowledge, cf. (Smith 1987, 50). Moreover, in this thesis the metaphysical questions about the ontological status of ‘clinical knowledge’ were bracket and there were no philosophical claims about the constitution of social or material reality by this knowledge, cf. (Collin 1997)\(^\text{30}\).

When the constructionist researchers accentuated the question of the necessity of social categories and knowledge they also accentuated the paradox of reflexivity - that the researchers’ knowledge is also socially constructed - and it becomes unclear which credence research findings should be given. In this thesis the answer to the difficulty of reflexivity was

\(^{30}\) There is an important distinction between the clinical knowledge produced by the clinicians and the practical knowledge evident in the knowledgeable clinicians’ production and interpretation of this knowledge. The study of the production of clinical knowledge involves both an analysis of the orderliness of clinical knowledge and an analysis of the practical skills inherent in the production of this knowledge.
to create an analytical split which suspends the paradox. *On the one hand*, a realistic view of the researcher working in the research setting was adopted, allowing for reflexive evaluations of validity and reliability according to the specific standards within the scientific community. *On the other hand*, a constructionist conception of the construction of understanding and knowledge in the social setting was adopted by means of a ‘methodological relativism’. Methodological relativism is a concept taken from the ‘Strong Programme’ (Potter 1996) which implied a relativistic stance towards claims of true or false beliefs in the field. Methodological relativism enabled the researcher to examine how such claims were negotiated rather than their ‘objective’ truth-value: this means that the knowledge produced in the clinic was not examined according to its accuracy but to how it was produced and negotiated among the clinicians.

Through the previous sections on communication, practice and construction the epistemological position taken in the thesis was outlined. The overall position was a moderate constructionism: clinical knowledge was perceived as construed through the mental and material aspects of social practices. These practices were contingent on both social and institutional structures. The researcher’s knowledge was regarded as relative to the sociological paradigm and therefore not to an invariant social reality. The next section is concerned with the outline of the theoretical and methodological approach to the production of clinical knowledge and how language use and social practices were interrelated and conventionalised.

**The analysis of discourse and social practices**

Language use was central to mental health nursing practices and in this section I outline the relationship between language use and social practices through the presentation and interpretation of a model for understanding the links between texts, discourse, and social practices marked out by Fairclough (Chouliaraki & Fairclough 1999; Fairclough 1992; Fairclough 1995; Fairclough 2001)31. Fairclough’s model and outline for discourse analysis was chosen for this analysis because it offered the most integrated framework for analysing social and linguistic conventions for the production of (clinical) knowledge.

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31 Fairclough’s conception of language use as a social practice remained constant, but the definition of discourse and the outline for analysing discourse changed throughout the body of his work. Generally speaking, the definition of discourse was expanded from the social practice of using language (Fairclough 2001, 14) to include semiotic elements of social practice (Chouliaraki & Fairclough 1999, 38; Fairclough 1995, 4-10). The model for analysing discourse was not adapted to the changing conception of ‘discourse’ but gave increasing attention to the detailed analysis of social practices related to language use. In the section below, *Discourse and social change* (Fairclough 1992), was used to describe the links between language use and social practice because it presented the most comprehensive analytical approach, had a conception of discourse which was limited to language use, and an analytical framework suited this particular conception.
Fairclough (1992) defined discourse as *spoken or written language use* to delineate, firstly, that discourse is a form of social practice rather than an individual activity or a situational reflex; language use is regarded as simultaneous action and representation and, therefore, discourse must be analysed as both social action and as linguistically organised text. Secondly, there is a dialectic relationship between discourse and social structure: language use is both constituted by and constitutive of social structure. The dialectic relationship is important because an accentuation of social structure would render an understanding of language use as socially and structurally determined; conversely, an accentuation of language would imply an idealist understanding of social structure as determined by language use.

The difference between discursive practices and social practices is the linguistic form and the specific cognitive processes presupposed in the production and interpretation of language. Fairclough’s pivotal argument was that discursive practices are part of social practices and that discursive practices are linguistically organised. In agreement with this argument, Fairclough’s model for analysing discourse was an attempt to combine discourse analyses focusing on the linguistic organisation of text; on micro-sociological analyses focusing on discourse in social interaction in the continuous production of social structure; and on macro-sociological analyses, focusing on links between social structure and social practices. The model is illustrated graphically as three Chinese boxes:

The "Three-dimensional conception of discourse" (Fairclough 1992, 73; Fairclough 1995, 98).

With the model, Fairclough basically carved out an analysis of text in a situational context in a wider socio-cultural context, and the analytical scope of the model can be exemplified by considering ‘the medical case presentation’. The medical case presentation is in its
written and spoken form *textually* organised to objectify the disease of the patient and remove signs of personal doubt on behalf of the presenting physician. Case presentation is rehearsed in conventionalised social *interactions* among physicians. Moreover, the medical representation of the physical body can be linked to an overall bio-medical system of thought which structures a vast range of medical *practices* and re-enacts a particular view of treatment, disease and the body.

The implications of researching language use using Fairclough’s three-dimensional model was a ‘*description*’ of text. Description was not a purely technical linguistic text analysis but also an interpretation of the textual characteristics in relation to the interpreters understanding of the wider social practices. Texts were regarded as traces of ‘text production’ and had to be ‘*interpreted*’ as an element of discursive practice and as cues for how to the interpreters understand the text. As outlined in the section on interactionism, textual ambivalence is reduced by the textual and situational context and by the member’s or the researcher’s resources for interpreting. The researcher’s resources for interpretation were therefore part of the research process of drawing inferences between specific instances of text and language use and wider social organisation. ‘*Explanation*’ was a reflective interpretation of how the member’s interpretation and the researcher’s interpretation of a given text were embedded in wider social practices. Thus, the overall analysis was a hermeneutic interpretation of text based on a theoretical preconditioning of linguistic and social structures as well as a reflective analysis of the researcher’s interpretative resources.

According to Fairclough, language use has simultaneous representational, relational and identificational processes; this embodying that one cannot linguistically represent the world without simultaneously identifying oneself and relating to other people in particular ways. These processes are therefore part of the construction of social reality, social relations and ‘selves’ (Fairclough 1992). In the following sections the three dimensions of the Fairclough’s analysis are further explicated and accounted for.

**The analysis of discourse as text**

Fairclough’s outline for an analysis of text was selective and eclectic, but mainly inspired by the school of Systemic Functional Linguistics founded on the work of Halliday (Andersen, Petersen, & Smedegaard 2001;Eggin’s 1994;Halliday 1994). Text was defined as authentic products of social interactions (Fairclough 1992). Systemic Functional Linguistics sought to develop a holistic theory about language as a social process as well as an analytical methodology permitting the detailed and systematic description of patterns in language (Eggin’s

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32 These three functions of discourse were chosen by Fairclough inspired by Habermas (Fairclough 2001, chapter 3).
1994). The theory was complex and it described language as stratified in three semantic layers realised in a situational and cultural context; language is structured to make three kinds of meaning simultaneously: ideational, interpersonal and textual. Ideational meaning is about how experiences are represented in language. Interpersonal meaning is concerned with the relationship between language users. Textual meaning is concerned with the textual organisation of meaning in language.

Fairclough’s text analysis was organised under the headings: vocabulary, grammar, cohesion, and text structure. Textual meaning was analysed both in formal, stylistic elements, such as metaphors, and in alternative wordings and textual structures.

Fairclough’s text analysis was modified according to the data material and according to Danish grammar. The latter reservation was related to sentence structures where some word orders, for instance, were relatively more common in one language: some ways of constructing textual images were remarkable in one language but perfectly common in the other. The former reservation was related to the level of detail: Fairclough’s analysis was primarily designed to analyse short and printed texts, this method was not always relevant for the analysis of text based on audio recordings or fieldnotes. Therefore, Fairclough’s outline for a text analysis was read as suggestions for analysis out of which some were useful in some situations and superfluous in others. Further, in the presentation of a text analysis – and a discourse analysis in general – only findings relevant to the aim of the analysis were presented, the rest were considered as rough workings with limited value for the reader.

**The analysis of discursive practice**

The analysis of discursive practice was concerned with the production, distribution and consumption of text. This included the analysis of the situated production of text, how text was distributed outside its immediate context of production, and how text was interpreted and/or negotiated by the consumers. The production and interpretation of text were regarded as doubly constrained. First, through internalisation of social structure, the participants had internalised an understanding of the conventions for action in situations of production and interpretation, cf. Bourdieu’s notion of habitus. Second, these (institutional) situations had conventions regulating what linguistic and interpretative resources were drawn upon by the social actors (Fairclough 1992, 80).

The analysis of discursive practices drew on two major strands of thought in order to formulate a conceptual framework for analysing how the production, interpretation and cir-

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33 The value of using Systemic Functional Linguistics compared to a formal grammar, such as (Diderichsen 1976), was not always made clear by Fairclough, but was probably related to the efforts made by Systemic Functional Linguistics to create an integrated theory of language and parts of social life.
calculation of text were constrained. First, *conversation analysis* followed basic assumptions from ethnomethodology: mundane social life is meaningful for the participants, their actions are reflexive, accountable and organised, and this organisation can be described and analysed. Ethnomethodology aimed at describing members’ methods for producing social organisation (Garfinkel 1984 [1967]; Heritage 1984). Through an inductive analysis conversation analysts produce theories of the detailed social machinery working in everyday talk-in-interaction. Conversation analysts have described in detail a large number of conversational orders based on the analysis of the sequential order of conversation first developed by Sacks, such as: turn-take organisation, preference organisation, topic-control, overall and sequential order, and repair-organisation (Atkinson & Heritage 1984; Sacks 1995; Sacks, Schegloff, & Jefferson 1974; Schegloff 1987; Schegloff, Jefferson, & Sacks 1977; Schegloff & Sacks 1973). Conversation analysis can be *applied* in the analysis of talk in *institutional contexts* (Drew & Heritage 1992; Have 1999; Heritage 1997). In applied, institutional conversation analysis the mundane conversation works as the golden standard in order to describe how members orient to the institutional context; the analysis is initiated by a technical analysis of *how* the institutional context is accomplished, followed by an analysis of the institutional constraints (Silverman 1998).

Second, the notion of *intertextuality* implied that every textual statement in some way is a re-actualisation of other statements (Fairclough 1992, Chapter 4). Utterances – texts – are understood as more or less explicitly linked together and the analysis of intertextuality is aimed at identifying how texts were transformed through the conventions for producing text and how the conventions are transformed. Texts were in this sense reworking earlier texts and anticipating future texts and interpreters of text; therefore, text *per se* possesses some constitutive social powers. Intertextual links can be sought in dialogical turn-takes or across longer time spans, and traces of intertextuality can explicitly be found in speech reportage, presupposition, negation, metadiscourse and irony (Fairclough 1992, 117-123).

Fairclough’s analysis of discursive practices was extended with a further reading of conversation analysis as this particular strand of inquiry elicited a number of interesting features of the negotiated production of clinical knowledge.

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34 Context is not taken for granted in conversation analysis; it is accomplished by the members. The sequential analysis of conversation enables an analysis of members’ intersubjective understanding: a turn shows how the previous utterance is subjectively interpreted; and the following turns display eventual misunderstanding and if the interpretation was inter-subjectively understood. In this sense the conversation serves as the context for interpretation and it displays members’ understanding of the situation (Schegloff 1992; Schegloff 1997).

35 Fairclough notes, that the term ‘intertextuality’ was coined by Kristeva in her reading of Bakhtin (Fairclough 1992, 101).
Orders of discourse

Fairclough suggested the concept, ‘order of discourse’ for the analysis of the social and linguistic conventions for language use. An order of discourse was a total configuration of elements constraining and constituting meaning and social action in specific instances of language use. The elements in an order of discourse included: genre, activity type, style, and discourse. These four elements contained the regularities identified in the analysis of text and discursive practices. 1. A genre, which is regarded as the overarching term of the four, is a conventionalised communicative event shared by members of a community and formed by the practical social purposes the genre has, cf. (Bakhtin 1986; Schryer 1993). 2. Activity types resemble genres in that they are “[...] goal-defined, socially constituted, bounded, events with constraints on participants, setting, and so on, but above all on the kinds of allowable contributions.” (Levison 1992, 69). Activity types were described in terms of the structural organisation of an activity, for instance the conventionalised activity of handing over information about a patient. 3. Style was defined along three main parameters: tenor (the social relations of power and solidarity), mode (the amount of feedback and the role of language), and rhetorical mode. 4. Discourse is here used by Fairclough in a Foucaultian sense: a discourse works as an abstract, autonomous, super-individual formation of statements constitutive of specific fields of knowledge (Fairclough 1992, 129; Foucault 1997b [1969]). Fairclough’s use of the same word for two different concepts was confusing because the exact meaning of ‘discourse’ had to be read out of the context. The theoretical consequences of this mixture will be discussed in the section on Fairclough’s eclecticism below.

The analysis of discourse as social practice

Fairclough draws on Althusser’s notion of ideology: that the world, as we experience it, our actions, and our understanding of our self, is constituted by ideology. Ideologies are, in this sense embedded in materials, in practices, and in thoughts; and the ‘ideological state apparatuses’ were regarded as the mechanisms working on manipulating and controlling subjects to sustain the dominating power relations (Althusser 1971). Further, Fairclough drew on Gramsci’s concept of hegemony which indicated the societal struggles to define ideological meanings (Fairclough 1992, 91-93): hegemony is the achievement of political leadership through the partial fixation of ideological meaning, cf. (Laclau & Mouffe 1985). Fairclough suggested conceiving discourse as part of ideological struggles: meaning, as it is constituted through orders of discourse, is part of the continuous struggle for hegemony.

This conception of ideology was important for the interpretation of communicational events: Fairclough argued, that communicational events should be analysed for their ideological content. This meant that the naturalised character of the more or less implicit idea-
tional propositions in a text and/or the more or less conventionalised interpersonal interactions should be analysed as potentially ideologically invested rather than common sense, precisely because ideology operates through common sense. Therefore, ideology is always part of language use and, thus, the reproduction of ideations, social relations and subjectivity.

On Fairclough’s eclectic approach

Fairclough was eclectic in his use of theory and this digression is concerned with the formulation of a reservation towards Fairclough’s eclectic approach to discourse analysis. The problem was related to the use of the concept of discourse in two different senses as described above: first, discourse in a Foucaultian sense as a socially constitutive, autonomous formation of statements and, second, discourse as the actual social practice of using language. The theoretical problem is related to the abstraction of results from an analysis of (linguistic) practices, an analysis of discourse in the latter sense, in order to identify and analyse discourse as constitutive formations, in the former sense, cf. (Alvesson & Karreman 2000, 1127) and the analysis presented in Chapter 3.

In a reading of Foucault, Fairclough adopted some central insights on the function of discourse: for instance: discourse is socially constitutive and intrinsically related to power (Fairclough 1992, 55-56); Fairclough insisted that the Foucaultian analysis of discourse should include actual instances of discourse to counter the disadvantages of the very abstract Foucaultian analysis. Fairclough strongly implied, through a juxtaposition of the aims of Foucault’s discourse analysis and the aims of sociolinguistic discourse analysis, that these aims were almost identical:

“Discourse analysis [Foucault’s] is concerned not with specifying what sentences are possible or ‘grammatical’, but with specifying sociohistorically variable ‘discursive formations’ (sometimes referred to as ‘discourses’), systems of rules which make it possible for certain statements but not others to occur at particular times, places and institutional locations.” (Fairclough 1992, 40).

Fairclough contended that sociolinguistics in the 1970s would call such a conception of discourse for ‘sociolinguistic rules’, social rules of language use.

Fairclough adopted the Foucaultian conception of discourse and the theoretical assumptions about the functions of discourse; Fairclough did not adopt a Foucaultian analysis of discourse: Foucault’s discourse analytical units were statements and they were not part

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36 “The atom of discourse” is ‘statements’: neither entirely linguistic nor exclusively material (Foucault 1997b [1969], 79-87); neither visible nor hidden, but identifiable in words, phrases and propositions (Deleuze 1999[1986], 1-22).
of Fairclough’s analysis. However, the Foucaultian conception of discourse appeared in Fairclough’s work as part of the concept of ‘orders of discourse’ and Fairclough did not provide any direction on how to identify or analyse this type of discourse. The main problem with this adoption of Foucault’s theory is, therefore, that Fairclough’s analysis implied that the two conceptions of discourse could be analysed within the same textually orientated discourse analytical framework: that a textually oriented analysis of language use, cutting across the variations and synthesising linguistic data, could lead to the identification and analysis of discourses in the Foucaultian sense. Fairclough is undoubtedly correct in asserting that it is possible to abstract from language use to a larger societal unity but whether this structure is a discourse in Foucault’s sense remains unsubstantiated.

Concluding on Fairclough

Fairclough’s three-dimensional model for discourse analysis was an argument for viewing language use as part of social practice as well as an outline for the combination of analyses covering linguistic, micro-sociological, and macro-sociological methods. Fairclough aimed at cutting through the variation of linguistic characteristics of language use and identifying overarching discourses and other social constraints, see a similar socio-linguistic approach outlined in (Sarangi & Roberts 1999). The backdrop to this integrating method was that it involved a number of very different theoretical perspectives on linguistics and social analysis; Fairclough was a methodological bricoleur (Denzin & Lincoln 2000). Therefore, working with the model invoked the potential danger of combining partly incommensurable theories and levels of analyses. Further, the danger of combining incommensurable theories meant that the researcher had to further study the theories Fairclough suggested in order to evaluate more precisely to what extent Fairclough circumscribed theories in order to integrate them into his model and moderate the researcher’s own interpretations and use of theory accordingly. The argument advanced here is therefore in line with Alvesson and Karreman’s, who acknowledge theoretical tensions but suggest downplaying theoretical rigour ‘for the benefit of social relevance’ (Alvesson & Karreman 2000, 1134).

The objection against and the challenge of Fairclough’s eclectic combinations of theory did not corrupt the central arguments in Fairclough’s work: that discursive practice is a social practice and that ‘orders of discourse’ are socially produced and re-produced structures constraining social practices. It was this conception of situated language use, cutting across the theoretical legacies of linguistics and sociology that gave Fairclough’s analysis its analytical power and warranted its central position in this thesis.

Fairclough’s discourse analysis was adopted for the thesis to further the analysis of the production, negotiation and distribution of clinical knowledge. Fairclough’s analysis was
constructionist and offered a *detailed* analysis for linguistic organisation of verbalised clinical knowledge as well as the interactional negotiation of such knowledge. Further, Fairclough’s approach supplemented Bourdieu’s argument for conceptualising social practices as constraining by analysing the institutional constraints inherent in the institutional ‘orders of discourse’. In the next section the methods for collecting data and the management and work-up of data are described and accounted for.

**Datacollection and datamanagement**

In this section I describe the methods for collecting and managing data: participant observations and fieldnotes, audio-recordings, interviewing, and collecting documents from the setting.\(^{37}\)

**Participant observation and fieldnotes**

A central method for collecting data for the study was participant observation and the related writing of fieldnotes and informal ad hoc interviewing. Participant observation was chosen as a research method as it was appropriate for fulfilling the research objectives of obtaining a situated understanding of the mental health nurses’ everyday practices (Bernard 1995, chapter 7; Hammersley & Atkinson 1996). In order to observe mental health nursing practices, the researcher was present in the same situations as the mental health nurses, in order to gain a more complete understanding of the nurses’ practices and experiences. As described above, it was assumed that practical knowledge to a certain extent is embedded in the informant’s practice rather than being fully available for the informant to verbally account for (Bourdieu 1998 [1977]; Hansen 1995; Larsen 1999)\(^{38}\). This practical knowledge was not directly accessible through participating in the same situations as the nurses. The nurses would experience the situations differently from the researcher because of influencing factors such as prior situated experiences, knowledge, competency and responsibility (Savage 2000). The researcher’s *participation* in the daily practices was on one hand “the peripheral member researcher” (Adler & Adler 1994) because of the position and role taken by the researcher in the setting; and on the other hand ‘insider research’ (Simpson 2004) because I had practiced five years earlier as a mental health hospital nurse and therefore had some previous knowledge of practices in a similar field. *Observations* were regarded as mediated by the situated

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\(^{37}\) I use the term ‘datacollection’ knowing that the metaphor erroneously suggests that data are available for the researcher in the same sense as money; but it is the conventional term for describing the process of working up data.

\(^{38}\) This is not – playing on the ironic distance between what people do and what they say they do – an argument for regarding naturalistic observation as more valid compared to interviewing respondents. Both means for data-production can be seen as social events and analysed as such (Atkinson & Coffey 2002).
and participating researcher and are not limited to visual observations. Observation, therefore, included negotiations of membership role, identity and impression management, as well as experiences of an embodied subject (Savage 2000).

Participant observation was focused on the nurses’ communicative practices with the emphasis on their production of clinical knowledge between themselves. This focus carved the study out of two larger fields of inquiry: the overall institutional production of clinical knowledge and mental health nursing practices in general. A study of these larger fields of inquiry would include detailed analyses of the practices of all professional groups, clinical encounters with patients, and recurring institutional events outside the ward. The limits of the field of research was defined by the communicational practices of the nurses and cut across time and space as they involved a number of technological artefacts. For instance, written communication allowed the nurses to communicate through time and walkie-talkies and phones to communicate through separate space. Participant observation was initially focused on the formalised communication in office areas, such as recurring meetings. Later this strategy was refined with detailed observations of patterns of communicational practices and technologies, such as reading, writing, and reporting. Further, these observations were explored by analysing how practices varied through time: through the day, evening and night as well as through the week. Last, the researcher was kindly allowed to accompany and closely observe a small number of individual nurses throughout most of a working shift.

Fieldnotes were both written in the ward office during periods of observations and after periods of observation in areas such as the common ward areas or in situations where pen and paper seemed intruding in the concrete situation. Fieldnotes were initially ‘jottings’ or ‘scratch notes’ (Emerson, Fretz, & Shaw 1995;Sanjek 1990) written into extensive fieldnotes the same day or the following day. A system for distinguishing between quotes, descriptions, reflections and theoretical interpretations was developed to enhance the reliability of the fieldnotes, cf. (Silverman 2001).

Observations were focussed on specific happenings involving individual nurses or groups of nurses. However, these strategies were hard to pursue in a busy milieu where the nurses would circulate between the patients’ rooms, the common area, and the office area. At times there were a substantial number of overlapping interactions and conversations and often interactions were not discrete: a debate would go on intermittently for a whole shift with participants continuously coming and going to, for instance, the office area. ‘Inscription’ was further condition challenging observations: the moment where the researcher makes a cognitive note disrupts the ongoing flow of social life and participation in the field is interrupted for a moment (Clifford 1990). On the wards this meant, that actually hearing what the nurses
said to each other was difficult; and the ability to anticipate and follow the nurses shifting attention between one another was impaired.

**Audio-recording**

To a certain extent audio-recording was a solution to some of the limitations to recording by means of fieldnotes. An audio-recording allowed the researcher to rewind and listen to the spoken interactions again, and analyse minute facets of the spoken interactions and combine these findings with the concomitant fieldnotes. Audio-recordings were only made of recurring planned meetings on the wards; this practice was a continuation of the bias pointed out by Hak (1999), see Chapter 1: recordings were mainly centred on planned interactions. The interface microphone had a cord, was the size of a large wristwatch and a small red lamp indicated if it was switched on: this was to ensure that people could know whether or not they entered a room which was audio-recorded.

At both wards 21 consecutive handovers were recorded. On Ward A six interdisciplinary conferences were recorded. On Ward B seven interdisciplinary conferences were recorded. Further, on Ward A five nursing conferences were recorded. I listened to all the recordings and wrote summaries. Listening to the recordings was the ground for selecting a number of the recordings for transcription, using a number of pre-defined conventions for transcription from conversation analysis (Hutchby & Wooffitt 1998;Psathas & Anderson 1990)\(^{39}\). I personally transcribed the material and gained detailed knowledge of the material during this process. The reliability of accurate transcriptions was maintained by continuously analysing both the transcription and the recording which lead to a continuous refinement of the transcription. The transcriptions of the six handovers extended to exactly 100 pages and the transcriptions of the four conferences extended to 221 pages.

There were two translations of the data; first from spoken to written language and, second, from Danish to English. All analyses were made on the Danish dataset. Transcriptions are in the thesis presented in the papers with a minimum use of conventions for transcription; this was done to preserve a certain level of readability. The extracts were already hard to read because of the transformation of speech to writing: there are false starts, discourse markers, etc. The data extracts selected for Chapter 5, and 6 were further translated into English. The general problem with the translation of language was whether to translate the origi-

\(^{39}\) Selecting the recordings to transcribe was motivated by the wish to analyse the most unremarkable events, for example, some Friday afternoon handovers were quite unrestrained among the nurses and therefore they were disregarded, as well as using the recordings with the highest quality of recording. Therefore, handovers at two Tuesdays were selected for transcription. None of the recordings of interdisciplinary conferences attracted the researcher’s attention as being unusual and the selection of two consecutive conferences was made at random.
nal text exactly (word-by-word) or alternatively aim for preserving the natural (local) sound in English (Have 1999, 93-94)\(^{40}\). The strategy chosen for the translations was to prioritise the preservation of sound; the strategy was chosen because a distorted sound seriously corrupts the readability of the texts, which were already under pressure. To ensure some transparency of the process of translation of language, and to give the Danish speaking reader a sense of the sound of the clinical jargon, the Danish and the English versions of the transcriptions can be compared in Appendix 2. Further details about the conventions for transcribing are given in Chapter 5 and Chapter 6.

**Interviewing**

As an integral part of their work the nurses would discuss and reflect on their experiences of working with the patients and on the ward. Such events were valuable for gaining insight into the ‘world’ (Ardener 1989; Hansen 1995; Hastrup 1989) of the nurses and central for understanding the situated experiences of their practices. A continuous ‘informal ethnographic interviewing’ (Agar 1996) took place in order to further the study of the nurses’ experiences. Except for a small recorded structured interview with each of the participating nurses, questioning took place during the natural flow of activities in which participant observation took place or at an appropriate time after the event. Informal questions and interviews were used to create a deeper understanding of the social activities observed. These interviews were open-ended and negotiable in the sense that they were not structured and would often turn back on the researcher’s questions and interest in the setting. Towards the end of the fieldwork these often free-flowing discussions were used both to explore more detailed research aims and to present and reflexively debate preliminary results from the study.

**Collecting documents from the field**

A number of different documents in use at the wards were collected through the fieldwork (Hodder 2000). As described in the section about Fairclough, documents were regarded as traces of text production, and they were interpreted as parts of discursive and social practices. The text material was very reliable because the researcher did not influence the text production. Working the material into data involved selecting relevant samples for analysis. There were two overall categories of documents. *First*, ready printed documents. They included for instance: information leaflets for patients, ready printed sheets for a variety of

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\(^{40}\) To make the best translations of the clinical ‘sound’ I discussed the translations with English and Australian mental health nurses. However, occasionally the precise sound of the clinical jargon was impossible to translate correctly.
records, critical incident forms etc. Second, documents written by the nurses as part of their everyday practices. They included for instance: nursing records, ‘scraps’, formal evaluations of nursing students etc. A substantial text analysis and discourse analysis was made of photocopies of nursing records, see Chapter 4.

**Dataanalysis**

The process of analysing data went on throughout the fieldwork and continued after the fieldwork had ended, cf. (Lofland & Lofland 1984). Analytical concepts were continuously developed and worked up on the basis of both theoretically conditioned ideas about the field and on the researcher’s experiences and interpretative reflections in the field.

The aim of the study did not dictate specific and structured field observations of the nurses’ mutual communication, and during the fieldwork analytical concepts were used to heuristically guide field observations. The analytical concepts would function as points of reference from which empirical phenomena were systematically observed and explored. Analytical concepts were defined during the fieldwork, where a section of the fieldnote recordings was designated theoretical reflections. The analytical notes consisted primarily of links between theories from the literature and particular field-observations as well and reflective descriptions of surprising and counter-intuitive happenings at the wards.

Towards the end of the fieldwork, the analytical concepts were worked up by defining their exact content and their relationship to other analytical concepts. For instance, I was stuck by how well informed the nurses seemed about patients that had previously been admitted. This observation led, firstly, to the systematic exploration of handing over information about the patients, and, secondly, to the systematic analyse of ‘prior knowledge’. This analytical concept of ‘prior knowledge’ meant that the dataset was interpreted from a specific perspective and that new data was collected about ‘prior knowledge’: analytical concepts guided the field observations, informal interviews, and the analysis of documents and audio-recordings. At first these interpretative processes were concerned with the ethnographic material, but later the discourse analyses would also yield insights into the concepts. Throughout the analysis, heuristic and preliminary analytical concepts were worked up by defining the concepts and their relations to other concepts or by defining more detailed aspects of the concepts. The goal was to define analytical concepts that would challenge the dataset by viewing them from novel analytical perspectives.

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41 ‘Scraps’ were the personalised notes written by nurses during the shift. They could be interpreted as mediating formal documentary methods and clinical practice (Hardey, Payne, & Coleman 2000).
Setting, theory, methods and ethics

Working up the analytical concept of ‘prior knowledge’ meant to systematically explore how prior knowledge in any conceivable form could be traced in the dataset and if these instances could be explained as linked to each other, cf. (Hammersley & Atkinson 1996, chapter 8; Miles & Huberman 1994).

The detailed analyses of language use, based on the collected documents and on the audio recordings, were almost exclusively made after the fieldwork had ended. These analyses represented a more deductive approach because they included a number of technical linguistic, grammatical, and interactional preconceptions of language and language use. A linguistic dataset does not automatically point to its social significance, and the analytical concepts were used to theorise and interpret the links between the linguistic observations and their social meaning. In this manner, analytical concepts were worked up and tested through the theoretical preconditioning of the fieldwork, the researcher’s experiences and reflections during the fieldwork, the parallel discourse analyses made after the fieldwork, and finally, in the early stages of the analysis, and the respondents’ comments on the preliminary results.

Ethics

This section is concerned with the general, formal legal provisions for a health care field study and the moral issues related to trust between the informants and the researcher, with particular focus on the quality of data.

Formal legal provisions

The study-proposal was sent for examination at the local research ethics committee. However, the proposal was not fully examined here as a preliminary review concluded that the study did not include a significant element of bio-medical research and therefore lay outside their jurisdiction, cf. Act. No. 402 of 28 May 2003. This, very unfortunately, meant that the study did not have the ethical/legal backing of the committee system in case of complaints and, further, that access to patients’ health data was not granted. This latter concern meant that access to patients’ data instead had to be applied for through the National Board of Health, which gave permission to access relevant information in medical and nursing records, cf. Act. No. 482 of 1 July 1998. The National Board of Health granted permission on condition that information about the study for the patients was displayed on a visible notice written in a plain and easy comprehensible language. The notice included general information about the study’s aim; that patients had the right not to have any information related to them included in the study; that I was subjected to the same professional secrecy as staff;

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42 [Lov om et videnskabetisk komitésystem og behandling af biomedicinske forskningsprojekter].
43 [Lov om patienters retsstilling].
that no information that could be attributed to a specific patient would be published; how the study would affect the daily lives of patients; and, finally, what formal permission had been granted in relation to the study. The notice is reproduced in Appendix 3.

The permission from the National Board of Health reversed the principle of the informed consent. According to the Helsinki Declaration, consent to participate in a research study is a decision freely-given after having been informed about the study, cf. (Scocozza 1994). In the present study the consent to participate was automatically implied from the outset and the patient had to declare that he or she did not wish to participate in the study by actively withdrawing this consent. One patient did not wish to participate in the study and no information related to this patient has been part of the study’s data. The National Board of Health reversed the principle of consent for pragmatic reasons: The effort required to receive an informed consent – informing and asking every new patient entering the ward – would disturb the patient disproportionate to the impact the study had on the patient. Further, the principle of asking everyone for consent could not be carried out completely because staff would often talk about former patients, who could not easily, if not impossible, be asked to give an informed consent.

The study was reported to The Danish Data Protection Agency (Record number 2001-41-1429) and data were handled in agreement with The Act on Processing of Personal Data (Act No. 429 of 31 May 2000)44.

Ethics and fieldwork among mental health staff

Access to the field was negotiated top-down through the hierarchical hospital management. On the first ward I had a meeting with the ward nursing management and representatives from the staff prior to the fieldwork. Here, the study’s aim and the anticipated implications for the staff and patients were presented and discussed. This information was in turn discussed among the staff members at the ward. I was invited to meet the whole group of staff, including the medical staff, and give a short introduction to the study. At this meeting the staff gave provisional collective consent to participate. On the second ward the ward nursing management invited me to introduce the study to the staff at a monthly staff meeting. Unfortunately, and to my surprise, staff members had received no prior information at all about my arrival that day or about the study. The staff members present at the meeting gave provisional collective consent; however, the sudden introduction of the study did stimulate a certain level of ‘reluctance’ (Adler & Adler 2002) towards me and the study.

44 [Lov om behandling af personoplysninger].
The question of informed consent was repeated individually or in small groups to all staff members, including the medical staff. Two staff members declined to take part in the study and subsequently no data material originating from these persons was analysed. All proper names in the data material presented in this thesis are fictitious.

On both wards I experienced a period of crisis in my relationship with a number of staff members. These crises were all in some sense related to trust – and lack of trust – between the researcher and the informants. The crises are emphasised here as the informant-researcher relationship directly influence the quality of the data material.

Rhodes summed up her ethical concerns during fieldwork at an acute mental health unit with a one-liner: “there was “no non-guilty position”” (Rhodes 1995, 3). It was impossible to be loyal to everyone and represent the interests of all stakeholders. I had committed myself to understanding the everyday practices of the nursing staff.

**Back regional informality.** The back regions of mental health nursing do not comply with the professional standards or official policies typically associated with the practice. Front and back regions differ in their levels of formality (Goffman 1990 [1956]). Displaying informality, characterised by for instance profanities or harsh/derogatory statements about fellow staff/patients, made some staff members anxious about my opinion and interpretation of their practice. In these situations I would state that my aim was not to expose the staff to public contempt by publishing back regional profanities but to present a rich, situated understanding of everyday mental health nursing practice to a public audience.

**The researcher's interpretative monopoly.** Occasionally, staff members would ask me about my analyses and opinions: I would share parts of the ongoing analyses and link these with examples of present situations. Several times this led to anxiety because it became evident to the staff that I analysed their practices by means of interpretative frameworks they had no knowledge of. In other words, it became painfully evident that they communicated more than they thought they did. I sent the extracts used in drafts for publication for inspection by the informants to evaluate if anonymity was preserved adequately and to give an opinion on whether they found the depicted situations unusual.

**The researcher as a disrupting nuisance.** Part of the fieldwork involved detailed and prolonged participative observation including asking questions about the actions of the staff. Such questions and the presence of the researcher annoyed some staff members at times. This was potentially disturbing as it would ultimately have consequences for future field-research at the hospital, cf. (Hammersley & Atkinson 1996, chapter 10). The strategy in order to avoid these situations was to spend a lot of time ‘hanging out’ without obviously recording observations, but rather taking part in professional and private discussions and help-
ing out with simple daily duties. This strategy worked in a metaphorical sense as a Trojan horse (Fog 1992; Fog 1994): my continual presence in everyday conversations made staff forget my role as a researcher and in the flow of informal and common talk they may have revealed more than they would have done if the role as researcher was clearly demarcated, cf. (Bernard 1995, chapter 7).

The audio-recordings were made at the end of the periods of fieldwork on the wards. The spoken interactions captured seem ordinary and relaxed and I regard this as evidence of a successful strategy towards gaining the trust of the informants.

Summary

Throughout the chapter the theoretical conception of the research object and research field was explicated and discussed and the strategies inherent in the practical fieldwork were outlined. The approach was a field study whose aim carved out a part of the nurses’ everyday practices - their communicational practices *among themselves* - and, further, the approach included an analysis of discourse in order to study the constructed details of clinical knowledge and the socially negotiated production of this knowledge. The approach combined ethnographic insight into the everyday practices in the clinic with the detailed analysis of language use in order to create the relevant grounds for reflectively interpreting the nurses’ professional practices.

The following Chapter 3 is an analysis of nursing scholars’ appropriation of the constructionist method ‘discourse analysis’ which is further theorising linked to the discussion of constructionism and the analytical scope of the concept of ‘discourse’ presented above. The following chapters 4, 5 and 6 are empirical analysis of situated communicational mental health nursing practices. These chapters are written as articles and therefore there will be minor repetitions in their sections on theory and method.

Abstract
The analysis of discourse is appropriated by nursing scholars. ‘Discourse analysis’ covers a wide spectrum of approaches to analysing meaning and language and there is no widely accepted definition of either a concept or an analysis of discourse. A sample of the discourse analyses indexed in the CINAHL database was analysed in order to identify which notions of discourse and discourse analysis are preferred by nursing scholars. The results showed that nursing scholars prefer approaches to discourse which resemble mainstream qualitative research avoiding social life and interaction. Explanations for these findings are briefly outlined.

Keywords: Discourse analysis, methodological research, serial publications, edit and review, social sciences

Introduction
The progress of nursing as a scientific field must involve not only the appropriation of methods developed in other fields but also rigorous application of these methods in nursing research. Many methods have been appropriated for describing, explaining and predicting nursing-relevant phenomena by nursing researchers and the processes of appropriation and application of methods can yield more general knowledge about the research preferences nursing scholars have.

A method recently appropriated into nursing is discourse analysis. One of the first papers on discourse analysis in nursing was written by Powers, who argued that discourse analysis should be considered as a method for nursing inquiry (Powers 1996). However, Powers drew on several very different conceptions of discourse and it remained unclear precisely what was meant by the term ‘discourse’, beyond a general definition of an organised group of statements. Furthermore, what logical links were there assumed between the conceptions of discourse and the methods used to analyse ‘discourse’. Since Power’s request for analysing discourse, the number of discourse analyses published by nursing scholars have increased, but it is frequently still not clear what is meant by either ‘discourse’ or ‘analysis

45 A slightly revised version of this article was published in Nursing Inquiry 2005 12(1): 27-33.
of discourse’ or what has been gained by the application of these methods compared to mainstream social theory or qualitative research.

The confusion demonstrated in Power’s text is intrinsically linked to the fact, that ‘discourse’ is a congested concept; for instance, in the introduction of The Discourse Reader Jaworski and Coupland list more than 10 definitions of ‘discourse’ (Jaworski & Coupland 1999), and more could be added. Three reasons might be given for this confusion. First, ‘discourse analysis’ is conceptualised differently according to the theoretical legacies in a wide range of academic disciplines: linguistics, literature theory, philosophy, the history of ideas, social sciences, psychology etc.; there are also significant conceptual differences within some of these disciplines. Second, it may be confusing because ‘discourse’ has become closely associated with the ‘post-modern’ and ‘social construction’ movements across traditional academic boundaries. Third, discourse analysis always involves the study of meaning and language, which marks out an enormous field of inquiry, which continuously threaten to subvert disciplinary boundaries, which in turn accentuates the policing of disciplinary borders through a proliferation of distancing definitions of theories and methods.

In 1992 Lupton published, what has since become, a central paper on discourse analysis among nursing scholars (Lupton 1992). In this paper, Lupton defined discourse as: “a group of ideas or patterned way of thinking which can both be identified in textual and verbal communications and located in wider social structures.” (Lupton 1992, 145). This specific definition together with a number of paraphrased variations of it is the definition most frequently referred to by nursing scholars, see for instance (de Lacey 2002;Hazelton 1999;Lagerwey 2003). However, this definition does not clarify two central features of discourse. First, there is no specification of how to conceptualise the cohesion creating groups or patterns identifiable in text, verbal communication or social structure. Consequently, this allows searching for a variety of formal and or functional groups and patterns in text, verbal communication and social structures. Second, there is no specification of how to conceptualise the link between textual and verbal communication and social structure. All in all, Lupton’s definition is very general and it neglects a succession of theoretical pitfalls and unsettled arguments regarding the formalities and functions of discourse. This lack of specification allows a range of theoretical conceptions and analyses of different relationships between text, context and social life. Further related to this, there is no specification of what ‘ideas’ and ‘ways of thinking’ do; what does it mean that they are there? Again, this allows a variety of theoretical conceptions of what is actually analysed and how analyses should be performed ranging from formal linguistic analyses of ideation to sociological inquiries of social practices.
The aim of this paper is to identify and discuss the methodological preferences nursing scholars have when they appropriate various versions of discourse analysis and to evaluate the rigor with which these methods are applied.

Method

The scholarly nursing papers analysed in this paper are all indexed in the CINAHL database. ‘Discourse analysis’ has been a Thesaurus search term in CINAHL since 1997. The textually ambiguous definition is: "A method that focuses on the significance and structuring effects of language to discover meanings.” A thesaurus search (“‘discourse analysis’ and ‘nurs*’”) limited to journal articles in English published between 1996 and 2003 revealed 109 articles\(^\text{46}\). The limitations imposed by the choice of database, language and publication type were made for practical reasons but the selection did represent a body of articles relevant to this analysis of mainstream scholarly nursing work. The material was reduced further to include only articles presenting an analysis; the disregarding of purely theoretical articles, comments etc. left 74 articles.

The systematic analysis of discourse analyses was designed to identify where the studies are positioned within the wide range of theoretical and methodological possibilities allowed by Lupton’s definition. First, how is a study framed as an analysis of discourse? This is used as part of an inductive categorisation of the studies, which shows what kinds of discourse analyses have been adopted by nursing scholars. Second, which analytical units are used in the analysis? This is used in order to pinpoint the crucial link between data and the analytical constructs of discourse. Third, how are data contextualised for interpretation? This is used in order to identify the theoretical contextualising of data in relation to the process of interpretation. Fourth, how is the consistency between the framing of the study, the units analysed and the interpretation of data? The relevance of analysing methodological consistency is accentuated here, as there is no widely recognised methodological standard by which to evaluate the analyses. A heuristic method for measuring the internal consistency and summing the results up was developed: after asking the three questions mentioned above the overall consistency of each study was evaluated and the study characterised as inconsistent, as having some consistency, or, finally, as being very consistent.

Results

1. How are the studies framed as analyses of discourse?

The 74 studies varied in topics and methodologies. Concepts of discourse and the analysis of discourse were more or less central for the analyses presented, ranging from a peripheral tool for identifying verbal exchanges in an ethnographic study, such as (Pulsford, Rushforth, & Connor 2000), to the analysis of ‘discourse’ per se in published texts, such as (Traynor 1996). Further, the material for constructing data also varied. Previously published text was analysed in 34 studies; interview transcripts were used to construct text for analysis in 32 studies; and in 14 studies interaction or conversation was analysed. As the interview data were not studied in terms of social interactions, the choice of data clearly reflects a preference for studying the social through textual analyses rather than studies of real time social interaction and practice.

Several articles did not define or explain the chosen approach to discourse but most of the articles were ‘front heavy’. This phrase indicates that presentations of the theoretical approaches to discourse take up a lot of room: the sections on introduction and method often had a high lexical density and were written in a theoretical and specialised language. In most articles with a definition of discourse the emphasis was on the functions of discourse rather than formal characteristics of discourse; an example among many was de Lacey’s study of metaphors (de Lacey 2002). In the introduction of her article de Lacey presented a reading of metaphors’ social functions as rhetorical devices but not a set of formal characteristics of a metaphor: it was not evident how she identified a metaphor as such or differentiated it from metonymy or other stylistic features. ‘Front heaviness’ can be interpreted as a consequence of the preferred types of data, such as interview transcripts and already published texts, as mentioned above: Theory about the constructive powers of language and the relations between discourse and social structures is needed in order to foreground and conclude about the social, which is otherwise played down through the preferences for specific types of data. The accentuation of functional definitions rather than formal definitions is discussed further in the next section on ‘analytical units’.

Theory on discourse can involve a wide range of linguistic subjects for analysis. All studies included one or both of the following discourse analytical features, which were all

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47 Because of the specific variation of the studies it was not fruitful to categorise them according to typologies from mainstream canons of discourse analysis. An inductive approach was better suited for capturing variations between the selected articles.

48 Studies of social interaction include for instance clinical examinations of specific linguistic competencies. The number of studies concerning interactions in nursing contexts is less than 10.
linked to the key features of Lupton’s definition: *Discourse as patterns of representations and discourse as related to social practice.*

The first and most common approach to discourse was to regard it as patterns of representations. This is a very broad category, as it allows for the analysis of a range of subjects, in one way or another, referring to groups of ideas or patterns in text. These might include, for example, belief systems (Barclay & Lupton 1999), someone’s social constructions of ‘something’ (Shefer et al. 2002), and discourses of ‘something’ – for example – Nursing Diagnosis (Powers 2002). These studies described coherent patterns of these subjects, but they often included notions of discursive struggles in or between patterns of representations. This sometimes paved the way for the construction of counter narratives, e.g. Crowe and Alavi’s (Crowe & Alavi 1999) analysis of the metaphors used in a woman’s narrative about being mentally ill. Crowe and Alavi offered an alternative, post-structural and feminist interpretation of the metaphors as figurative and literate, and were hence involved in a discursive struggle about the right to define the meaning of the woman’s words and experiences. Further, these studies could include deconstructive readings of textual categories in order to identify the contingencies of the seemingly natural, for example Lane and Lawler’s analysis of a brochure informing women about pap smear (a clinical gynaecological examination) (Lane & Lawler 1997). In this analysis the brochure’s notion of vaginal space was rejected, because it was informed by a gendered discourse of sexual penetration.

The second approach to discourse was to accentuate the analysis of discourse as related to social practice. As stated above, this relationship was argued for by the use of theory; however, the theories varied in their conceptions of central notions of the relationship between social practice and discursive practice: e.g. post-structural theorists tend to argue that discourses are the mediators of reality; most others recognise a relationship between language and other social practices. Lagerwey presented a historical discourse analysis of the discursive frames in which missionary nurses at Rehoboth in New Mexico practiced in the first part of the 20th century (Lagerwey 2003). The discursive frames were conceptualised as inherently ideological through their constitutive effects on reality. For Lagerwey there is a difference – mediated by discourse – between the text and the social practices in which it is embedded; analysing text is to analyse frames for understanding practice, not social practices *per se*. However, in other analyses, inspired more heavily by post-structural literature, this difference is sometimes abandoned. Quested and Rudge analysed a procedure manual for last offices (a burial rite) (Quested & Rudge 2003). Here, textual representations of the ritual practices are analysed by means of theory on linguistic representation and performance. Discourse is conceptualised as including social actions, for instance, giving an injection is a discursive practice. This implies an approach to discourse where meaning and the social institu-
tions upholding meaning can be studied using the same method. However, the theoretical position is abandoned at the end of the article where it is stated that textual analysis only gives a limited access to practice, which implies a position where discursive practices and textual representation influence social life by different means. In other words, the two positions are confused in the analysis and such confusion occurs typically when eclectic approaches to discourse are designed.

In a similar vein, only very rarely were reflections offered on the construction of data, such as contextual conditions for interviews, the characteristics of the genre from which specific texts originate, the specific social practices related to the production of the analysed texts, and so on; these are all factors influencing the interpretation of the texts and are called upon in most literature on qualitative or micro-sociological research. An example of this lack of consideration of the character of data was my historical analysis of psychiatric nursing textbooks (Buus 2001). I concluded that there was a major discursive rupture in the representations of the work of mental health nurses. However, the rupture could also be explained with emphasis on changes of the textual genre: for instance that nurses start authoring nursing textbooks. This means that the discursive rupture identified may become possible through the introduction of nurses as authors rather than through a change of the conceptions of mental health nursing and nurses’ work.

2. Analytical units

The analysis of analytical units was made in order to identify more specifically by what means the analysts identify cohesion in text and/or social structure. Nevertheless, the analysis of the analytical units used in the discourse analyses was problematic. One could choose to rely on what the analysts say they do, which is risky, because of a potential gap between intentions and actual analysis. The alternative is to identify which units are actually used in accounting for the analysis; still, this also created some uncertainties, as the length of many scholarly articles does not allow space for presentations of rough workings and details of analysis. In the current analysis, however, the emphasis is on the latter strategy, including carefully searching for signs of the use of alleged units.

In about half of the analyses analysed here there was no information about what exactly the unit of analysis was. This problem of uncertainty caused by the lack of definition about units was most prevalent in studies aiming to describe discourses per se. In about half the studies the analysis was focused on a construct different from discourse but involving studies of the use of language or subjects theoretically related to discourse. Examples of these constructs were “narratives” and “subject positions” (Crowe 2002, 126), “construction
of identity” (Halford & Leonard 2003, 202), ‘metaphors as rhetorical and discursive devices’ (de Lacey 2002, 45), ‘rules of language and how they are used for construction’ (Rudge & Morse 2001, 67), ‘communication formats’ (Adams 2001, 98). However, in most of these studies the discourses used to contextualise these constructs were not identified through a separate analysis or by reference to previous studies but appear as common sense constructs in large numbers: there seems to be nothing which can not have its name on a discourse.

The lack of specification of analytical units means that readers of the analysis are not given insight in how data are analysed, which in turn questions the validity of the conclusions. An illustrative example of this is a study by Ashworth, Gerrish and McManus (2001) which aimed to identify underlying discourses of nursing educators’ claims about the professional performances of Master of Nursing students. One of the results was, that there was a “general underlying discourse of interprofessional practice” (Ashworth, Gerrish, & McManus 2001, 627); and in support of this result they referred to official policies on health professionals. However, the ‘fit’ between the claims from the interviews and official documents on policy remained unclear, i.e. the second problem of Lupton’s definition. There was no specification of what – which analytical unit is used – constitutes a discourse; therefore, the assumption of a link between the claims of the informants and documents remained speculative. Further, this lack of attention to accounting for method made it hard to differentiate between simple constructions of themes in the informant’s claims and other kinds of coherence in what they say. For example, in the conclusion that there is “a discourse in which nursing is construed as involving great competence in practice” (Ashworth, Gerrish, & McManus 2001, 627), it was impossible to distinguish what was simply stated by the informants from constructions on a different order, coming from an ‘underlying’ discourse.

The confusion of themes and linguistic categories, such as discourses, can be camouflaged by the use of theory. As described in the previous part, theoretical considerations, particularly those on the functions on the functions of discourse, were mostly explicated in the articles, and theory was occasionally used in order to revitalise the social in the interpretation of data. This was most often done in analyses combining inductive approaches such as content analysis or grounded theory with (theory about) discourse analysis.

As stated in the introduction, Lupton’s definition allows for many different approaches to what constitutes the pattern in discourse. In one third of the analyses, the initial step of analysis was an inductive thematization of textual data, possibly by means of Grounded Theory or content analysis. This was followed by an interpretation in order to identify discourses. In a study by Hazelton news paper items were examined in order to identify how mental health related news was constructed (Hazelton 1997). The first step of the analysis was an inductive categorisation according to the content of the news texts. Six categories
were constructed. The second step was to make explicit which interpretative frames, discourses, were underlying the themes: “Despite considerable diversity and complexity of the mental health-related news items identified, it is possible to tease out only a restricted set of narratives, discourses and images through which debates surrounding mental health reform can be evaluated.” (Hazelton 1997, 79-80). The interpretation led to five ‘semantic domains’, but it was not clear, based in the information about method, how discourses - the semantic domains - in any way differ from the six themes, other than being another layer of comments.

There are a number of problems related to the lack of precision when conceptualising discourse. In the previous part, the problem was mostly related to the possible range of conceptions of discourse, including what they are and how they function. In this section, the analysis of what units are used in the identification of discourse indicated a general lack of clarification about what was analysed, especially regarding the question of ‘what’s new’ about discourse analyses, compared to phenomenology or hermeneutics, other than a theoretical stance towards the functional aspects of language. The next section is concerned with the design of the analyses.

3. Contextualisation

An analysis of language is always done in relation to a contextual feature. As stated above, the analyses concern a range of constructs, e.g. discourses, narratives, subject-positions etc. However, because the conceptions of discourse vary and because units of analysis are rarely specified, it can be difficult to identify what is being analysed and within which context. Most commonly, an analysis was made of a discursive construct which was related to a context identified by reference to literature or by common sense.

In de Lacey’s study mentioned above, metaphors were related to notions of discourse as wider socio-cultural phenomena. For instance, a woman who did not become pregnant after IVF-treatment stated: “You think, ‘Where’s all the money gone?’ Down the drain” (de Lacey 2002, 48). This statement was interpreted as a metaphor part of a liberal discourse of investment; a discourse which was identified through reference to already performed research. Rudge and Morse made a double analysis, as they analysed both ‘a discourse of non-traditional medication’ and ‘the experimental and embodied metaphors present in two schizophrenics’ narratives about being ill’ (Rudge & Morse 2001). The analysis showed that the schizophrenics used expressions related to bio-medical frames of understanding mental illness, but that these expressions were loaded with metaphors of experience; all in all positioning them as both part of and as different from biomedical discourses. A further variation
on contextualisation was made by Adams, who studied how linguistic interactions between families and nurses construct the identity and position of people with dementia (Adams 2000). This study was one of the few concerned with data on actual social interaction. First, there is an analysis inspired by conversation analysis: in this part of the analysis the conversation served as the context for the interpretations. Second, there was an analysis of positioning and identity inspired by post-structural theory, where the context for interpretation was discourses or interpretative repertoires identified in official policies.

Finally, there were many references to Michel Foucault’s concepts. These played either one or two roles in many of the studies. First, many references were made to Foucault’s poststructural views on power and discourse. These were often ignored in the actual analysis, and other theories were used instead, e.g. (Irving 2002). Second, his concepts were used to contextualise findings, for example, discourses of surveillance, notions of subjectification, etc. Almost ironically, the influence of Foucault was so powerful that the categories from an inductive analysis were constructed as exact matches to three of his concepts, see (Curtis & Harrison 2001); the analysis therefore functioned as a reification of Foucault’s concepts.

4. The internal consistency of the studies

As indicated by some of the examples above many of the analysed studies contained methodological weaknesses in the analysis of discourse. Methodological weakness functions as a domino effect as an unclear framing, the use of unspecified units, and an eventual unclear contextualisation of a discursive construct will haunt the consistency through the remaining sections of the analysis. A study accounting for the theory and method applied as well as applying this method with rigor and a conclusion within the scope of the theoretical limits was defined as having ‘high’ internal consistency. ‘Some’ internal consistency was defined by the same overall consistency but with missing or confused accounts of the theory and methods applied. Internal inconsistency was identified in the links between the accounts of theory, method, application and conclusion. In quantitative measures, 30 of the 74 studies (41 %) presented are evaluated as having some internal consistency, out of which 16 (22 %) are evaluated having a high consistency.

Conclusion

Discourse analysis offers a range of different approaches to the analysis of language and meaning. Nursing scholars have certain preferences when they appropriate these methods and, further, a substantial number of the studies analysed in the current study lack theoretical and methodological consistency.
In the present analysis it was clearly indicated that the scholarly nursing journals mainly publish discourse analyses of discourse as representation rather than interaction; *social life was generally not present in the analyses*. Through the preferred data, the manner in which themes were constructed and the way in which theory was used, the social was excluded by transformation into patterned representations which were reflected upon by means of theory as if they functioned as the ‘real’ thing. Studies of discourse could include for example linguistic or interactional analyses. These areas of inquiry hardly get any attention in scholarly journals. This conclusion may be influenced by the use of the CINAHL Thesaurus to collect the body of studies, as it is possible that the process of indexing articles only categorises certain discourse analyses under the specific search term. A alternative way of explaining eventual biases in the collected body of articles is to turn attention towards the authors of the analysis: nursing scholars⁴⁹, who may chose to publish in journals which are not indexed in CINAHL: A scholar working with discourses related to health issues can hypothetically chose between publishing in ‘health journals’ or ‘discourse journals’. It is unclear whether research produced by nurses penetrates other disciplines and therefore is less open to peers specialised in the adopted methods. In other words, there might be less pressure on nursing academics to ‘tidy up their act’ when publishing in nursing journals.

It is difficult to pinpoint *what’s new about discourse analysis?* The studies analysed resemble mainstream qualitative nursing research: Inductive studies in particular Grounded Theory and hermeneutic-phenomenological interview studies or text analyses (often including a practical or moral point as a conclusion). This specific preference for qualitative studies is contingent upon the historical constitution of the nursing profession, including the professional strive for academic recognition. Historically, the strive towards academic and professional recognition can roughly be described as dual: one strategy has been to approach medicine by copying the methods and ideals of the medical profession, and another separating from medicine by claiming a specific, unique knowledge base for nursing (Rafferty 1996). However, depending on the ideological construction of the professional mandate (Dingwall & Allen 2001), nursing research belonging to this second strategy can be described as ‘leftovers’ or as ‘rich pickings’ from the time when medical science took possession of rationality, ethics and quantitative science, leaving the highly gendered domain of everyday morality and qualitative quasi-science to nurses. Therefore, the specific and limited appropriation of discourse analysis by nurses can be regarded as a mere continuation of this practice.

⁴⁹ 10 % of the articles were written by authors without a nursing background, e.g. occupational therapists, physiotherapists, midwives and historians.
The use of theory, especially combining post-structural theory with mainstream sociological theory, is not straight forward and it haunts several of the analysed studies with inconsistent approaches and/or with obscure descriptions of theory and method. A harsh interpretation is that the apparently innovative edge about using discourse analysis is a twist of post-structural theory giving the field of analysis an aura of frontline research, c.f. (Alvesson & Karreman 2000; Bredsdorff 2001). A discourse analysis of discursive patterns in Danish texts on nursing has shown that there is a continuous, systematic transformation of theory from the ‘original theory’, an interpretative mediation by nursing scholarship to, finally, the nursing textbook (Beedholm 2003). A consequence of this transformation is a reification of the theory and the construction of practically applicable concepts, a prime example being Heidegger’s ‘sorgen’ which is adapted into theories of everyday caring. The study indicates among much more that future research into “the discourse analysis of nursing discourse analysis” and the processes of appropriation of theory by nurses could prove to be very informing.

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Chapter 4. The genre of mental health nurses’ written records

Abstract

Written records are central means to the construction of institutional facts. In this article, written nursing records from two Danish mental health hospital wards were analysed. The analysis followed the outline for analysing discourse set by Fairclough (1992) which included elements of a formal and a functional linguistic analysis of the records as well as a sociological analysis of the social organisation at the institution. The genre of these written records had a range of specific textual features and was influenced by both everyday discourses of mental health and specific psychiatric institutional discourses. In order to understand the intended meaning of a record, readers needed prior understanding of both the genre and the specific person being described. The records were informal and imprecise which reflected that they were records from an institutional realm where nurses and patients were engaged in everyday life activities together. The language used to describe the patients created images of socially competent but non-interacting persons.

Keywords: Mental Health, hospitals, pragmatics, fieldwork, written records.

Introduction

Records and recording are central parts of institutional, fact-constructing mechanisms, as recording is a vehicle for ‘inscribing’ facts about patients who, to a certain extent, will appear in the institution as records (Schryer 1993). According to Dorothy Smith, institutional records are: “[...] forms that externalize social consciousness in social practices, objectifying reasoning, knowledge, memory, decision-making, judgement, evaluation, etc. [...]” (Smith 1984, 60). Newcomers learn the local, professional discourse partly through the practices of reading and writing records. Furthermore, as records are regarded as legally binding documentation of the actions of staff in health care institutions, they are important in shaping relationships between institutions and between institutions and society in general. More recently, written records have received increasing attention, both nationally and internationally in line with a politico-judicial tightening of patients’ rights and a medico-administrative desire to develop international, standardised methods for documenting actions of staff in health care institutions.
The sociological study of records and recording within health care has almost exclusively been restricted to the study of medical records. The sociology of medical records is a heterogeneous field because records can be studied either per se – as records – or as part of medical practice – as recording. In the former sense, records, as linguistically organised documents, have not been given much sociological attention beyond differentiating between structured and non-structured journals and descriptions of medical shorthand. In the latter sense, recording, many studies of medical practice include reflections on writing, keeping and reading records – usually as part of a larger field analysis.

Analytical emphasis has been put on different aspects of the process of recording, namely, the generation of the record, the interpretation of the record, and the sharing of recorded information. First, some studies accentuated how information about a patient was generated and put into print as a medical record. Macintyre and, later, Bowler examined how information for records was made in conversational interactions between professionals and pregnant women at an antenatal clinic (Bowler 1995; Macintyre 1978). Their observational studies were primarily focused on how pregnant women were categorised by the clinical staff and the extent to which these ‘labels’ were negotiable in the interaction between the staff and the women. Second, some studies accentuated how medical records inform health care professionals in their interpretation of their patients. Here, documentary information about a given patient precedes his or her meeting with a professional. An example was Hak’s study of how written records inform professionals’ construction of facts about a patient (Hak 1998). Hak compared audio recordings of clinical interviews with records available before the interview and records made after the interview. Hak described how professional interpretations of a patient were contingent on the documentation available to the professional in advance of the interview. In this sense, printed records were analysed as interpretative frames around new encounters which retain certain, ‘old’ images and observations of the patient. Third, some studies analysed how medical professionals share and negotiate recorded information. Records circulate institutions but their content can be negotiated by their interpreters. Griffiths studied gate-controlling mechanisms produced by two community mental health teams (Griffiths 2001). The teams negotiated recorded cases, referral notes, and decided whether or not to accept patients. However, ‘cases’ were presented to teams and images of the patient emerged through selective reading of the record and through the subsequent comments and discussions. The information provided in the record, therefore, was negotiated and bent to fit the most preferred diagnostic labels of the team. The above division in three is crude but demonstrates that research on recordings will be contingent on where in the process of generating, interpreting and sharing records, the research is focused and on what organisational purpose the record has.
There are also differences between theoretical perspectives on records and recording. Many sociological studies follow Garfinkel and Bittner’s ethnomethodological tenet: records and recording must be explained by being intrinsic to the practices from which they are produced (Garfinkel & Bittner 1967; Hak 1992; Rees 1981). A slightly different perspective is offered by Berg who emphasised the need to analyse daily practices and the use of technologies rather than the practices of accounting. Berg opposed a radical, social constructivist approach and insisted on viewing the medical record as a technological artefact of medical practice and, therefore, a mediator and transformer of such practice (Berg 1996). Berg’s analysis focused on the practice of reading and writing a variety of different records in a hospital setting. Berg suggested a conceptualisation of records as a unit of any written recording made by a professional. In this sense, the interplay of different recording systems became a potential research object and the suggestion was a step towards recognising records – characterised by permanence, transferability and facelessness (Wheeler 1969) – as part of a larger entity of communicational activity in institutions.

Records and recording are shaped by, and shape, institutional practices (Schryer 1993; Smith 1984). The design and function of records varies according to different institutions and the purposes they fulfil. Yet, nurses’ records – as opposed to medical records – have not been subject to much sociological study. Nurses’ recordings can be part of the medical record – in medical records the professional hierarchies are maintained giving the physician a privileged position and leaving the nurses ‘silenced’ (Berg 1996; Parker & Gardner 1991). However, nurses often have separate records and recording systems. These do not share the powerful characteristics of the medical record because they serve other purposes and because they are structured by other institutional practices. Records made by mental health hospital nurses have not been examined thoroughly from a socio-linguistic perspective50. However, it has been shown that the genre of mental health nursing records has a tight structure (Chapman 1988; Crawford, Johnson, Brown, & Nolan 1999).

The objective of this article is to contribute to our understanding of mental health hospital nursing practice by analysing the characteristics of the language used in nursing records in the light of the institutional setting in order to explain why the nurses write reports as they do and how professional accountability is accomplished through writing records. The records are examined as examples of a specific mental health nursing genre; genres are conventionalised communicative events shared by members of a community and are formed by the social purposes they serve (Schryer 1993). The analysis of genre combines textual and socio-

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logical analysis (Fairclough 1992), and the analysis will include descriptions of the social practices related to writing and using the record as well as the textual organisation of the reports.

The analysis draws on data from fieldwork for a broader study, the aim of which was, to explore how patterns of communication between nursing staff influence the construction of clinical knowledge about the patients. It was during this fieldwork, it became evident that the daily practices of the production, distribution and consumption of written nursing records is a central part of how the institution constructed facts about patients.

**Methods**

**Setting**

The setting for this study was two adjacent wards at a Danish university mental health hospital, ‘Ward A’ and ‘Ward B’. Both wards were general, adult ‘special observation’ wards. The official policy at these wards was that distressed patients should be given close and perhaps constant observation rather than imposing more drastic sanctions such as locking the entrance door or medical, physical and/or mechanical restraint. The wards had a similar capacity for admissions, 16 single bed rooms, and similar characteristics of staff and patients. Staff members have an average age of around 40 years. About ¾ of staff are female. About ½ have an education lasting more than three years. However, staff members at Ward A had on average more years of mental health experience (13.2 years) compared to Ward B’s (7.5 years). The patients were 40 years on average; the women were on average 5 years older than the men. Slightly more men than women were admitted. Regarding diagnosis among women: ½ have diagnosis from WHO’s ICD-10 diagnostic group F20-29 (schizophrenia, psychosis etc.) and ¼ from F30-39 (mood disorders). Among men more than ½ had a diagnosis from F20-29. During the fieldwork Ward A had a lower occupancy rate (83.3 %) compared to Ward B’s (96.2 %). Ward A had a higher average length of stay (29.5 days) compared to Ward B’s (18.8 days).

**Subjects**

Nurses’ records in the two wards were the subject of study. The nurses would add to the records during every eight-hour shift and use the written records at the spoken report between the shifts in the twenty-four hour day. The nurses wrote a hand-written record on their patient(s) which was then read aloud to the nurses on the following shift either by the author of the record or a nursing colleague on the same shift.
Data collection/management

For the broader study, fieldwork on the wards lasted six months (Ward A) and four months (Ward B). Empirical material collected included: audio recording of staff meetings; text documents produced by the nursing staff; participant observations and fieldnote recordings of staff interactions; background interviewing of staff members; and ward occupancy rates and lengths of stay.

The records analysed in the present study were written on the 35 patients admitted to either of the wards in the two hospitals during a selected week of intense observation towards the end of the fieldwork at each ward. During these weeks, all spoken reports were audio recorded. All relevant text documents were photocopied, as the originals were needed at the hospital. Those relevant to the selected weeks were extracted for analysis. Routinely, records were hand-written in three colours signifying the three shifts. Such features made the copies hard to read and, therefore, a typed transcription of the material was made using a precise procedure for ‘translating’ and interpreting, cf. (Mishler 1991). To minimise errors, the typed transcripts were compared with the original photocopies by an assistant who marked discrepancies. These were then discussed and changes made according to the consensus reached. The data used in this study derives solely from text documents, fieldnotes and background interviews.

Data analysis

Data were analysed influenced by Fairclough’s conception of discourse, which underscores the function of language as both social practice and a means of representation, as well as Fairclough’s outline for analysing discourse (Fairclough 1992). The basic tenet for the analysis was an integrated conception of discourse which included a linguistic text analysis and a sociological analysis and interpretation of data. At the heart of the linguistic text analysis are assumptions and analytical approaches taken from systemic, functional linguistics which include a simultaneous analysis of ideational, interpersonal and textual meaning (Andersen, Petersen, & Smedegaard 2001;Eggin 1994;Halliday 1994). Fairclough’s approach includes the description of both stylistic features and features of genre, patterns of cohesion, the use of metaphor, and the wording of the records. The sociological analysis concerning the generation, interpretation and sharing of records has primarily been made from happenings and events repeatedly described in the fieldnotes, but, further, inferences were made between the textual features and their social functions among the nursing staff.
Ethics

The study was designed to comply with the weighty ethical concern about observing mentally fragile and ill patients. Given that the presence of a six-foot male researcher who was neither staff nor non-staff could be quite disturbing and several patients expressed an initial anxiety about the researcher’s presence. The fieldwork took place mainly in ward offices and common ward areas and only in the patient’s rooms after explicit invitation from the patient. Therefore, a considerable part of daily working routines in the wards was not systematically explored.

The National Health Service of Denmark gave permission to access relevant information about the patients and the researcher was subjected to the same professional secrecy as staff. Access to the wards was initially negotiated through the hospital management and subsequently with staff on the relevant wards. Information about the study: objective; methods; right not to participate; right to withdraw a previously given consent at any time; etc. was given to all patients and staff. One patient and two members of staff refused to take part in the study and no data about, or originating from, these persons has been analysed. All proper names in the transcripts have been changed.

Results

The results will be presented in two overall sections. Firstly, a text analysis of the nurses’ patient records - the shorthand, vocabulary and voices used; their cohesion and coherence; and their ideational features. Secondly, there is a description of nurses’ practices related to record and recording based on an analysis of fieldnotes. This section will include a discussion of the results as evidence of a particular mental health nursing genre.

Four extracts of data will be presented. The extracts were selected in order to render a fairly direct impression of the records in sequence, and to highlight central characteristics of the entire corpus of the nurses’ patient records. Each extract will consist of three consecutive records (following day, evening and night shifts) describing twenty-four hours for each of the four patients. During the translation compromises were made in order to retain some of the characteristics of this Danish mental health nursing shorthand (and slang) rather than adopting to English nursing shorthand, e.g. “a walk without notice” rather than ‘AWOL’ [absent without leave], which would alter the analysis significantly. In Danish some of the written reports sounded rather clumsy and this clumsiness was retained in the translation.
1. Shorthand, vocabulary and voices

In this section, words, wording and syntax will be examined in the nurses’ records, and these features will be related to the question of ‘whose voice was presented in the text’? Pre-printed on the record was the word “diary” but the characteristics of the language used spoils the notion of the record being a ‘diary’. The use of proper names for medication and the use of abbreviations and acronyms gave the record a technical air. For a reader with no prior knowledge, they would be close to meaningless. Often, commercial names for drugs could be recognised, as such, because of their place in the record and/or because of their special sound i.e. ‘Cisordinol’, ‘Lysantin’, ‘Eanox’ etc. Only rarely, and indirectly (and usually from Latin), will the name convey information about the effect of the drug i.e. ‘Stilnoct’ (sleeping night medicine) or ‘Diazepam’ (tranquillizer). The use of abbreviations and acronyms was frequent. There were common, medical abbreviations and acronyms, such as, ‘re:’, ‘GP’, ‘physio’, ‘PRN’ etc.\(^5^1\). Further, there was frequent use of abbreviations and acronyms of words and phrases related to the daily activities in the ward, such as, ‘treat. conf.’, ‘obs. lev.’, ‘ONL’, ‘livr.’.\(^5^2\). These abbreviations and acronyms differed from the former by being unique abbreviations of long or frequently used words. These unique short words could be hard to decipher outside the textual context. In addition, initials of the staff and institution were impossible to interpret correctly without previous knowledge. Further, there was fairly frequent use of symbols: ‘+’, ‘↑’, ‘→’ and ‘↓’ all have a function which varied according to the context in which they were used.

The nurses’ records had a recurrent structure: an initial specification of the patient and the date, a number of statements about activities related to the patient, and a conclusive signature. This structure can be seen in the first two extracts of data below:

*Extract 1: ‘Kathleen’ (Ward A)*

[1A During/at the end of day shift]:

(Date) Kathleen did some washing today. She says she does not feel well today. Has laid on the bed in her room a great deal of the day. Kathleen refuses to talk to anyone. Talking loudly in her room. Requested to have a cancellation phoned to the home support, but changed her mind, and stated that the home support is the only one she is interested in talking to. (Signature)

[1B During/at the end of evening shift]:

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\(^5^1\) Regarding, general practitioner (the abbreviation is not commonly used in Danish compared to English), physiotherapy/ist and pro necessitate [extra medication if needed].

\(^5^2\) Treatment conference, observational level, overnight leave and living room.
Kathleen is a little less distressed tonight. Left the ward for about ½ an hour – a walk without notice. Has been talking a lot inside her room but refuses assistance. Observed her diet tonight (÷ raw vegetables). (Signature)

[1C During/at the end of night shift]:
Early in the shift apparently auditory hallucinated – talked to imaginary persons, therefore got PRN [pro necessitate] T. Oxazepam 15 mg 12.30 WGE [with good effect]. (Signature)

Extract 2: ‘Peter’ (Ward B)

[2A During/at the end of day shift]:
(Date) Up for eating breakfast, eaten well. Went back to bed again afterwards. I brought morning medication down to Peter while he was still lying in bed. Was somewhat worried about what will happen to him. We talked about how it is important that he eats well and gets enough rest, agrees to this. Got up at dinner and ate well. Parents visit this afternoon. (No signature)

[2B During/at the end of evening shift]:
(Date) Has had a visit from the parents this afternoon, who have taken a trip home to look inside the apartment. (No signature). Has been happy about the visit from the parents. Says though, that it brings forward “bad memories”. Says he has promised things he is sorry about → does not go into detail about this. U.S [undersigned] has a talk with P. that “bad memories” can sometimes also be used for something positive. Has eaten supper + seen TV in the living room. Does not feel happy but knows that he needs to be here. (Signature)

[2C During/at the end of night shift]:
(Date) Slept. (Signature)

Statements were the most common mode of expression and the nurses typically use short main clauses with no, or just one level of, subordinate clauses. The syntax was unmarked (in Danish) and had the subject in the front position immediately before the infinite (auxiliary) verb, or exceptionally the inverted structure, with the subject immediately after the infinite (auxiliary) verb - typically, in order to emphasise a prepositional phrase in the front position (Allan, Holmes, & Lundskær-Nielsen 2003). This choice of syntax allowed the nurses to thematise the patient as the subject in the front position to the point where it becomes redundant. The typical ellipsis was of the subject in the front position but also frequently the finite (auxiliary) verb. This explains why local interpreters of Extract 2A had no doubt that it was Peter who “was somewhat worried” (and not the nurse), and who exactly “slept” in Extract 2C.

The function of using acronyms, abbreviations of words and syntax was to compress the length of the record as well as speeding up the process of recording. Thus, it had two
functions, concise information and speed, complying with institutional demands. The following extract was chosen to illustrate some of the above mentioned characteristics of institutional shorthand.

*Extract 3. ‘John’ (Ward A)*

[3A During/at the end of the day shift]:
(Date) Up at 9.30 good spirits. Had a visit from Ann James [a community mental health nurse], still disturbed by associations, can be corrected however. Has shaved on request. (Signature)

[3B During/at the end of the evening shift]:
(Date) Still very associating but has been more restrained today. Late in the shift, testier but still correctable. (Signature)

[3C During/at the end of the night shift]:
(Date) Slept from 00.20. (Signature)

Disregarding the proper names of medicine, there are only a very small number of formal technical terms which would only be understood by insiders. An example of a formal technical term was the thought disorder “disturbed by associations” in Extract 3A which originates from E. Bleuler’s classic definition of four basic symptoms of schizophrenia\(^{53}\). However, in Extract 3B, the same term was used more informally as a verb: “associating”. Differing from the formal technical terms, were a much larger number of informal terms which were everyday words used to fulfil technical purposes. Examples of this were “loud-voiced” and “distressed” as in Extract 1 and “more restrained”, “testier” and “correctable” from Extract 3. “Correctable” was a specialised word in the sense that was frequently used to indicate whether a patient’s excessive behaviour could be limited or stopped; insiders would know this meaning of the word. A further category of words did not have any technical connotations, for example the phrase “Does not feel happy [...]” in Extract 2. These categories of descriptive terms could best be described as being on a continuum from formal technical terms to technical use of common words to everyday use of everyday words.

A substantial part of the statements were accounting for what a patient has said or thought about something. In most of the reports, ‘indirect speech’ was used to report what was said or thought. Contrary to ‘direct speech’ indirect speech created ambivalence about

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53 The terminology is officially obsolete in Denmark and the continued use of it exemplifies how difficult it is to differentiate between formal and informal technical terms
whose actual ‘voice’ or words is heard, cf. the differences between Extract 1 and Extract 2. In these statements an experience-near vocabulary of the patient was used by the nurses, for example Kathleen’s statement about feeling unwell in 1A and Peter talking of “bad memories” in 2B. Only very rarely was a description using everyday vocabulary supplemented by a formal technical term summing up and/or explaining the description, for example Kathleen’s change of mind in Extract 1A could also have been reported as ‘ambivalence’, an abstracted description of a formal sign of mental disease.

The language used in the reports had several technical and institutional characteristics such as abbreviation of syntax and words and a use of specialised words only understandable for insiders as well as characteristics of everyday written language: a simple syntax emphasising the most important topic and a frequent use of everyday words. Nurses explained on several occasions that they mastered formal, technical terms but did not use them because the report should be intelligible for the patient if and when he or she should decide to read it. It is not possible to decide whether the nurses’ simply adopt the patients’ everyday language to a mental health nursing discourse; that is, that the nurses observe and create knowledge about the patient in a systematic and specialised way but use everyday language to convey this knowledge. Alternatively, there may be an unspecialised ‘domestic’, common sense discourse grounded in the concrete happenings and events of everyday institutional life which uses everyday language simply because it describes the happenings and events better than the formal, technical terms, as indicated by Chapman (Chapman 1988).

2. Cohesion and coherence: sense in unstructured reports

In the following part, an analysis of cohesion in the reports will show how characteristics of the genre of the reports were tailored to fit the institutional purpose of reporting and how linguistic ordering created certain images of the nurses’ practices. The nurses typically used two very characteristic and simple ways of creating meaningful statements about the patients: 1. A converse statement, and 2. A narrative. When nurses stated something about a patient, for example in Extract 3 where Peter was described as being in “good spirits” or that he “has shaved”, it would seem as haphazard information unless the interpreter already knew the context to which the statement was related, e.g. that Peter was known to be in a foul mood occasionally or that he had not shaved for several days. Relevant interpretations of these statements therefore rely on prior knowledge of the specific subject or patient. If an interpreter does not have contextual knowledge, the information may be regarded as superfluous and maybe utterly senseless. The point is that most lone standing (fragmented) statements would not be implicitly discursively framed by an abstract field of knowledge giving sense to single statements, rather, they were dependent on references to concrete contexts in
order to make sense. An exception was the structure of ‘problem and solution’ which was a very pervasive way of structuring nursing reports in some health care institutions (Crawford, Brown, & Nolan 1998). ‘Problem and solution’ was firmly held together by a discursive order, a causal link, but this structure was not widely used in the reports examined here; see, however, an example on extra medication in Extract 1C.

Statements would usually be paired; this minimises the uncertainty of interpretation. A *converse statement* was a double statement, where one or more statements about something was/were followed by a second statement which served as the contextualising frame of reference, expanding and qualifying the content of both statements. The statements were linked by an explicit or implicit conjunction, cf. (Halliday 1994). Examples of converse statements could be identified in all the presented extracts but a very clear example was in Extract 3B where both clause complexes consist of two clauses connected by the conjunction “but”. In these examples “but” should be read something like ‘conversely to this’ or ‘in spite of this’: ‘Peter was still very associating in spite of this he has been more restrained today’. Reading the clauses in reverse order alters what was stressed but not the basic meaning-creating relation between the clauses. This indicated that neither of the statements held a superior position. Only rarely, a set of statements would contain an explicit statement in a superior position. This can be identified in Extract 1A, just after the converse statement: ‘Kathleen did some washing ‘in spite of’ not feeling well’. The nurse used Kathleen’s experience-near expression of not feeling well, see above, and lists four observations of this: 1. she has lain in bed, 2. she does not want to speak to anyone, 3. she is loud-voiced in the room, and 4. she is indecisive about who to talk to. The nurse was thus creating an informal argument. In Toulmin’s terms she is making a claim ‘Kathleen is not well’ on four grounds each one connected to the claim primarily on the warrant of an everyday understanding of illness (Toulmin 1958), for instance if one does not want to talk to anyone, then one is not well; if one lies in bed, then one is not well etc.

To some extent the converse statement resembles Barrett’s description of ‘epigrammic appraisals’, which were defined as short, *spoken* descriptions of the patient ‘in a nutshell’ (Barrett 1996, 95-96). Both types of statements display the clinicians’ detailed knowledge of the patient through references to situations that were very telling about the specific patient.

Extract 4, below, is an example of a report with a high level of narrative cohesion.
Extract 4. ‘Ann’ (Ward B)

[4A During/at the end of the day shift]:
(Date) Had an anxiety attack just after the wake-up call, was shaking and crying when I entered the room. Got PRN tbl. Rivotril 0.5 mg just after morning medication, after I sat with her for a little while Ann began to talk about her anxiety about being discharged because she could not cope with more than one thing at a time. Morning assembly, ward rounds and a “daily duty” was too much for tomorrow. Calms down when I tell her that there are no current plans for discharge. (Signature)

[4B During/at the end of the evening shift]:
(Date) Did not feel well at suppertime. Felt dizzy and said that she could not move. Sat in her chair and rocked back and forth. Could laugh though. Had food served in the room and participated later in bingo. During the conversation A. found out that her earlier state was caused by drinking too little before going for a long walk. Talked hereafter a lot about her weight, diets and slimming and showed U.S. [undersigned] clothes she has bought which are too small. During this she is smiling and seems relaxed. (Signature)

[4C During/at the end of the night shift]:
(Date) Slept. (Signature)

A narrative differs from a converse statement by being a cohesive recount containing many locational references and temporal conjunctions and thereby organising events in time and place; it is a description of events unfolding around and involving the patient as well as the writer, cf. (Mattingly 1998). Extract 4A is an example of a narrative containing many references to time and place (“just after the wake-up call”), and to sequence (“when I entered, “after I sat down”) used by the writer to refer to a temporally situated sequence of events. Also characteristic is that the writer of the report appears as part of the report on several occasions, even though the objectifying “U.S.” is used in 2B and 4B. Further, the narratives in Extract 2 and 4 A and B have redeeming plots towards the end, where the patient in spite of distressful events during the shift is calm again. Structures of problem-solution and converse statements can fit into a narrative, for example the use of “Could laugh though” in Extract 4B.

A narrative orders the report into a coherent whole because of a number of cohesive features which are less conspicuous in a series of double statements or sequences of problem-solution. Interpreters of these latter statements must rely on situational and social knowledge in order to grasp the implicit coherence in these seemingly fragmented reports. In an analysis of written reports by veterinarians Schryer concluded, using the terms of Halliday and Hasan, that the informed insider will find the reports coherent but that they lack
textual cohesion (Schryer 1993). This was only partly the case with the nurses’ reports, as the more narrative extracts were in fact textually cohesive.

The structure of the reports was imposed through the processes of professional writing. The records’ entries referred almost exclusively backwards in time and the sense-making structures of the accounts were active in the re-construction of what happened. First, written language was ‘polished’ and the activities of reporting (writing, selecting what to report from the ongoing flow of happenings etc.) did not enter the description. The process of reporting deletes itself and presents post hoc certainty in the clinical practices, cf. (Berg 1996). Second, coherence was imposed through the writing. Cohesion created through the problem and solution sequence indicated a step-by-step decision making process; the narrative indicated a certain rounded off relation between persons and actions in past events. These coherences were imposed by writing reports and carried specific ideas of rational or successful clinical practice, common sense ideas of mental illness, and, notions of temporal orders in relation to the patients’ situation.

3. Ideational features of the reports

Fairclough adopted the term transitivity from the systemic functional linguistics. Here, transitivity denoted the grammatical patterns between processes (verbs), participants (nouns) and circumstances (adverbs and prepositions)\(^{54}\). The descriptions of the patient were very distinct as he or she would be the central participant (medium) in most statements. The patient was, as the medium, described as being involved in actions using a variety of processes which were sometimes directed towards a goal and sometimes not, in other words whether the verb took on object or not. However, there were only very few descriptions of the beneficiary of the actions. This means that the patient was described as a person who talked and acted etc., but not to or along with someone, which supports an image of a competent, but non-interacting, patient. Further supporting an image of non-interaction was that whenever one gives a statement a relationship is indicated between the person stating and that which is stated about. This relationship involves a choice between social interaction or not. In the third person, and almost all the statements were given in the third person singular, there would be no interaction between the actual stating and the person who the statement was about; the patient was never part of stating but the passive person about whom statements were given. Statements in the third person also leave the relationship between the stating person and the statement unclear; the level of ‘affinity’ expressed in the statements may be

\(^{54}\) Within the systemic functional linguistics one distinguishes between eight superior processes in English (Halliday 1994). This differs from Danish systemic functional linguistics, where there are only six processes (Andersen, Petersen, & Smedegaard 2001). The entire analysis has been made in Danish using Danish SFL.
between the person stating and the stated or between the textual participants. Opposite to descriptions of patients, the descriptions of the staff included a beneficiary: Staff members were described in the first person singular or plural and they talk with or to the patient. Especially in the narratives, staff members would appear as mediums taking action. They are, however, almost always omitted through the use of the marked passive voice in descriptions of authoritative actions towards the patient, e.g. “can be corrected however” (from Extract 3), or other examples such as: “The patient will be discharged tomorrow”, “Was restrained lying on his bed for 10 minutes” etc. These descriptions created an image of sanctions basically just happening to the patient. These three features of the reports – no beneficiary, non-interaction, and the use of passive – indicate the textual creation of a relationship between nurses and patient, where the patient was not fully socially interacting compared to the fully interacting nurse, who would be textually omitted when performing authoritative actions against the patient, resulting in a more objective and distanced tone. This means that the nurses used everyday language in describing the patient but they used it in a way which did not depict the patient as a fully competent social agent; the nurses were not described in the same way as the patients which reflected the significant social differences between the groups.

Even though there were different authors the reports on the same patient were very alike; a patient would be described using the same structures of transitivity which created a certain profile. Some patients were described using a high proportion of relational processes, which are processes that classify and/or identify participants. This was very evident in Extract 3, where John was described using attributes (adjectives) that concern interactions and social skills, but did not reveal him as actually performing them. On the contrary, narratives (see for instance Extract 2 and 4) have material, verbal, mental, and relational processes which support an image of a patient, who (inter)acts, thinks and expresses him or herself in certain ways. There were no records which contained shifts between narrative forms and the more fragmented series of statements. This suggests that different patients had certain ‘profiles’ and were described according to these. The nurses used the profiles to describe and accentuate the idiosyncrasies of the patient, and it has not been possible to identify links between specific categories of patients or categories of patients’ attributes with specific profiles, such as gender, behaviour or diagnosis.

The four extracts presented above were chosen to illustrate some general differences between the reports from the two wards as well as between day and evening shifts: The

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55 ‘Level of affinity’ is used by Fairclough as a property of modality which concerns the inter-personal effects of textual representation.

56 Further, there is no relation between diagnosis and profile, e.g. the patients represented in the four extracts have a diagnosis from the same overall diagnostic group F20-29.
nurses in Ward A, Extract 1 and 3, had a preference for using series of abbreviated statements rather than narratives, whereas the nurses in Ward B, Extract 2 and 4, had the opposite preference although there were no noticeable differences between the patients on the two wards. Night shifts in both wards were reported even further abbreviated, as illustrated above. The differences in the discursive practices were not only evident in the reports but were part of the culture on wards. Telling stories and anecdotes about the patients on the ward and the previously hospitalised during a shift happened notably more frequently and more flamboyantly in Ward B, indicating that narratives were used as way of socialising, including arguing a point of view, gossiping and having fun, as well as harmonising professional stances, in a more pervasive way in Ward B compared to Ward A\(^57\).

4. Writing practices on the wards

Nursing staff members called the written nursing records the ‘kardex’. A kardex was a ring binder containing a minimum standard of 11 sheets of paper separated by five dividers. The standard sheets of paper included ready printed forms on which to write down further information about the patient: demographic information, significant others, diseases and eventual diagnosis, the causes for admittance, a weekly timetable for therapeutic activities, and preparations for the discharge. Further, there were several instructions in every kardex on how to fill in the forms and what actions to take when admitting or discharging. A central part of the kardex was the continual report on the patient. The form for these daily reports had a ready printed headline “diary”, a place to write the patient’s name and civil registration number, lines for writing the report, and boxes for dating and signing the report. When a page was full another page was added, and occasionally it was necessary to file obsolete pages from the kardex of long-term admitted patients because their kardex became enormous.

Staff members wrote a report about a designated number of patients towards the end of each working shift. During the day staff used the kardex to get or update information related to a patient. Medical staff members did not use the kardex. The report was not formally structured to fulfil a formal goal and the nurses gave rather evasive answers when they were asked about what they chose to report; it seemed very hard for the nurses to verbalise and explain the principles of selection of information. When the researcher was introduced to writing kardex a nursing manager plainly stated: “One writes what has happened during the day”. The ready printed sheet for continuous reporting did not add to any considerable de-

\(^{57}\) A quantitative analysis of the length of the reports from the two wards also supports this observation. From Ward A there are a total of 219.5 pages describing 692 days of hospitalisation (mean: 0.32 page/day); from Ward B there are a total of 208.5 pages describing 372 days (mean: 0.56 page/day). Reports are significantly longer in Ward B: 19% on average.
gree to an ordering of what information to report or how to express and formulate this information. This informal ordering of what and how to write is indicated by the headline ‘diary’; a word which usually refers to writing personal (and sometimes confessional) stories about one’s personal life and experiences.

The goal and purpose of the reports was debated among staff members. Annoyances and opinions on what information was relevant to include in the reports frequently debated; they were prompted in particular when readers of a report thought that it contained an excess of irrelevant information: “Why do I have to know that Peter played table tennis for three hours? It’s completely irrelevant”, a nurse complained. Further complicating this threshold of relevancy was that the reports on the previous 16 hours were read aloud for the arriving shift and that the three shifts found different information relevant. For instance, the night shift would only under very special circumstances want to hear a ‘full’ report about the previous day and evening shift as the nurses’ simply did not feel the need for a lot of information to care for a sleeping person. Some experienced staff members would therefore sort out what they thought was relevant for the audience while reading the report aloud. Frequently reading a report was initiated with the question “When were you last here?” in order for the reader to be able to sample the most relevant and complete report for the listener. It seemed that the more recent knowledge one had of a patient’s situation the less information is provided.

Reporting about patients was a smaller part of writing practices on the wards. Order forms for meals, clothes, groceries, blood and urine samples are along with calendars, appointments for conversations and rounds, staff books, scrap notes and reports of assaults only a small number of places and forms staff regularly write, fill out or read. Mirroring these practices, the walls of the offices were partly covered with boxes containing ready printed sheets and forms and on every office table containers hold writing materials. Kardex reports were written according to staff’s pressure of work but usually one or two hours before the next shift arrive. If staff members had been occupied all day or something needed to be added to the report, writing was done in the final minutes of the shift or even during the shift report. Drafts were never made. Kardex reports were usually written in the office area behind an open or closed but not locked door. Interruptions of writing were common and even though staff members seemed completely occupied with writing part of their attention were always on the ward. Often, voices or sounds coming from the ward would be commented on. A member of staff, seemingly occupied with writing could for instance exclaim, “Oh Margaret, she’s busy, isn’t she?” referring to a quiet quarrel down the corridor. For the researcher as a newcomer on the wards, the constantly diverted attentions could be very confusing, as conversational topics could change according to things happening in adjacent
rooms; rooms and happenings the researcher had difficult learning to attend to. Often staff would be in doubt of what to write, either because there was nothing new to be added or because the writer had not seen the patient during the shift.

Turning towards the practices of selecting what information to report, there was a distinct discursive ordering of what topics were reported even though the nurses could not articulate the principles of their recording. A categorisation of the entries according to the types of verbal processes show that the entries were most frequently concerned with how and where the patient interacts, to a lesser degree with what the patient says and feels, and to a much lesser degree with staff and staff actions. The information included in the reports was chosen according to breaches of expectations in relation to the individual patient as well as general expectations of behaviour. The latter was very evident in the reports from the night shifts; ‘the night is for sleeping’ and disturbances of this rule get into the report as converse statements opposing the almost obligatory expectation: ‘slept’. As these expectations were firmly codified, it allowed for much abbreviated reports. During day and evening shifts expectations were looser and reports contained a greater variety of topics reflecting considerations about ‘what has happened’ to the patient at both a personal and a general level. This way of selecting information meant that general knowledge about types of behaviour and the specific genre of reporting was needed as well as previous knowledge about the specific patient. Further, the informally articulated and unstructured reports were not exact; “a little less distressed tonight” and ‘more restrained today’ would not describe the condition of the patient very clearly. Everyday language depends on context and could not be used for an abstraction of the patient’s behaviour. Statements like these did instead indicate a vague sense of direction: ‘things were improving’, but beyond that, a large amount of prior knowledge about the patient was presupposed in order to understand a more exact meaning with the report. Considering that substantial parts of everyday life on the wards was not technical but mundane domestic activities it is possible to assume that exact reports may not be needed by the staff; hints of direction and information about behaviour and interaction given in everyday language are sufficient. “The rest I can find out myself or look up later” as a nurse complained after listening to what he regarded as an utterly useless shift report. In this sense, the order of the selected information and the language and the structuring of the report reflect the fluctuations of everyday institutional life shared by patients and nurses. This observation of the characteristics of the genre must be understood as a result of the divisions of work at the hospital.

Writing the daily report was done individually. Sometimes the act of writing could serve as a reason to reflect on and discuss the patient with other staff members; on other oc-
The genre of mental health nurses’ written records

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Occasions writing seemed merely to transcribe thought. While writing was primarily solitary; reading and interpreting involved a team of nurses. The report was read aloud and the written account served as the information passed on at least for the teams at the two succeeding shift reports, where its significance could be negotiated or just noticed by the audience. Recordings were treated as evidence of events; staff consulted the kardex to know if certain events had happened in earlier shifts: was medication given, was the patient on leave etc. In one sense, an entry into the record soon lost its immediate importance because of the routine of only reading the latest two entries and because of the implicit need to relate the entry with additional situated knowledge of the situation. In another sense, the entries did not lose their social significance because the clinical knowledge became part of a more dynamic reservoir of observations where observations would be remembered, re-read, re-described, re-negotiated, and re-interpreted by staff members for a long time.

The record worked as a mediator of present and future work tasks; the nurses’ record had a different constitutive role compared with the medical journal, cf. (Berg 1996). Writing in the kardex meant adding to a pool of descriptive, negotiable clinical knowledge about the patients and, at the same time, adding to an implicit, mutual and situated understanding of mental health nursing practices.

**Discussion**

The following discussion will, first, focus on the mental health nurses’ written records as part of a set of institutionalised practices adding to the creation of abstracted, bureaucratic knowledge. Second, the records will be discussed in relation to the specific institutional divisions of labour at the mental health hospital. Third, the nurses’ reliance on prior knowledge will be discussed.

According to Dorothy Smith, *the rational administrative practices of record writing* are constitutive of an abstracted, institutionalised form of knowledge, which silences the particular actualities of everyday life (Smith 1987). The nurses’ records did – of course – mediate the nurses’ everyday experiences textually, but the records were not fully constitutive of abstracted, institutionalised knowledge because of their textual and discursive organisation. The vocabulary was unspecialised, consisting of everyday words based on local conventions for their scope of meaning, and the records were based on converse statements and narratives, which retained some of the particular actualities of the nurses’ experiences; correct interpretations of the record entries dependent on prior knowledge of the genre, including the local conventions for writing records, and the concrete situation described. Furthermore, there was no evidence of a formal, abstracted ‘mental health nursing discourse’ informing the reports. Discourses, formalised fields of knowledge, inform a substantial part of
recordings by medical practitioners where the relevancy of certain observations can be deduced from the anticipated medical condition (Berg 1996; Foucault 1997c [1963]). Stated differently, there was no formal, abstract discourse organising the kardexes across the sedimented layers of clinical knowledge into distinct patterns which reflect a specialised view on the patients’ condition and the related interventions offered by the nurses. Rather, the interests, relevancies, and perspectives inherent in the nurses’ records suggest that they to a large extent were contingent on happenings and events as they appeared for the nurses during everyday clinical life. Thus, the records did not fully fit Smith’s description of records as constitutive of an abstracted mode of knowledge. Instead, the records were a crossover between a fully abstracted bureaucratic discourse and more informal descriptions of everyday particulars conveyed in an everyday language and relying on prior knowledge of the described. Reminiscences of everyday life were continuously evident in the records, both in textual and discursive organisation, arguably because of the specific everyday character of the nurses’ work.

Smith suggested that that the gap between the abstracted mode of knowledge and the particular actualities, on which they necessarily are founded, should be theorised as a “bifurcation” of the (female) practitioner’s consciousness in the sense that the two realms involve a different organization of the practitioner’s memory, attention, relevancies and objectives (Smith 1987, 84). This observation was confirmed during the fieldwork: the mental health nursing staff did, as described above, express frustrating experiences about translating their everyday experiences into an institutional, abstracted discourse.

The crossover of everyday and abstract description and describing was related to the particular (gendered) divisions of labour at the institution. Garfinkel and Bittner stressed that records are written according to principles of relevancy which are contingent on the specific division of labour (Garfinkel & Bittner 1967). Nursing staff members spent a substantial part of their time engaged in observing and participating in everyday life activities on the wards, such as preparing meals, eating meals, watching television, going shopping etc. These ongoing activities are not conceptual modes of action that easily lend themselves to textual abstractions and the nurses found it difficult to select and abstract their concrete experiences. In a study of medical records, Berg found that physicians in part work up the patient’s trajectory through diagnostics and treatment through their practices of writing: from the initial jottings on the informal and unstructured scrap-pages in the record to the formal, fully abstracted and specialised, institutional and bureaucratic record (Berg 1996). According to Berg’s study, abstracted bureaucratic knowledge was produced through the practices of continuous record writing during – and after – standard clinical encounters purposely designed
for the work up of abstract clinical knowledge. In contrast, the mental health nurses’ clinical work was not organised into routines designed for the systematic construction of clinical knowledge and, therefore, everyday life ‘spilt’ into the records.

Writing records is part of professionals’ accomplishment of their everyday work (Garfinkel & Bittner 1967) and the mental health nurses’ professional accountability was warranted through descriptions of concrete everyday situations and not through descriptions using specialised psychiatric terms. Thus, the nurses’ professional accountability was closely linked to concrete situations and their implicit taken-for-granted details and not to a set of abstracted practices which would express the function of the institution; the local accomplishment of professional accountability was not related to formalised, abstracted academic or professional discourses. Furthermore, this particular feature of the nurses’ records points to the purpose of the record and the character of ‘knowing’ in mental health nursing. The records were used for providing descriptive ‘snapshots’ (Martin & Street 2003) of the patients’ situation which were primarily used in relation to the following two changes of working shifts. The descriptions were not very detailed and were used as an informal present state risk assessment to give the arriving nurses enough sense of the ward to run the ward efficiently and safely. Furthermore, much information had to be taken-for-granted by the nurses who worked in an organisational setting in which questions and interrogations of taken-for-granted assumptions were not common. In Hak’s case study of the construction of observational facts of a young woman’s paranoia, the nurses did not only interpret the patient’s behaviour in the light of previous documents about the patient, they also categorised the patient according to non-professional knowledge, leaving room for other ideological influences such as class and gender in the interpretation (Hak 1998). Interpretative frames were handed over and used by the professionals without systematic or institutionally sanctioned scrutiny. However, Hak’s study was made early in a formal (and informal) diagnostic process and that was a major difference compared to the interpretative processes in the wards studied, where patients stay for weeks on average and the majority have been admitted to the ward before. Patients are already known; they have a previous history on the ward. Having the sense of ‘knowing’ the patient already and having a primary interest in short-term risk assessments reduced a perceived need for extensive information. Given such a hypothesis, information was not relevant because the nurses already ‘know’, could explain a high threshold of relevance for information in the records.

The result of the present analysis was limited by the particular focus on nurses’ records and the practices of writing them. A more comprehensive understanding of the nurses’ discourses and discursive practices must include an analysis of, first, the discursive properties of all the recording systems in the institution, and, second, an analysis of the conventional-
ised practices for distributing, sharing, and transforming clinical knowledge in both speech and writing.

**Conclusion: no context – no meaning**

The study shows that even though it would take a mental health nurse to read a nurses’ record correctly, the nurses did not fully abstract their particular and situated experiences to administrative, bureaucratic discourse. This feature of the nurses’ record should not lead attention away from the records as part of the ruling apparatus, including the particular semantic and social differences between nurses and patients. The records were a central part of working up clinical knowledge – working across time and space – which was available both for further abstraction in other parts of the institution and for working up informal, and sometimes common-sense, categorisations of clinical experiences. As these categorisations were open for, and often supported by, non-psychiatric personal beliefs, the processes were less conspicuous and harder to identify compared with the more abstract processes of categorisation ‘higher up’ in the institutional hierarchy. The conceptualising of these processes of categorisation in the everyday institutional realm continues to be a challenge for the sociologists of health and illness.

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Chapter 5. Mental health nurses handing over information about patients

Abstract

Mental health hospital nurses take care of patients 24 hrs a day and are continuously producing clinical knowledge about patients. This knowledge is shared by, worked up, and handed over between nurses several times a day. In this paper it is argued that the linguistic and social conventions for handing over information about the patients at handovers have a significant influence on the amount and character of the information handed over. Transcripts of audio recordings of naturally occurring handovers were analysed using Fairclough’s outline for analysing discourse. The handovers are highly conventionalised and informal social positioning is negotiated according to the conventions. The organisation of clinical knowledge is suited the general characteristics of mental health nursing practice and the nurses are occasionally exposed as ignorant of detailed and explicit knowledge, these situations call for rhetorical deflections.

Keywords: discourse analysis, mental health, negotiation, nurses, professional talk, shift reports.

Introduction

Handovers between nursing shifts happen routinely two or three times a day at health care institutions open 24 hours and they are central for creating continuity in the care and treatment of patients. Handovers among nurses have a variety of important social and organisational functions such as handing over clinical knowledge about patients; confirming the solidarity of the nursing team; and as time for emotional labour (Parker & Wiltshire 1995; Wiltshire & Parker 1996). Further, nurses’ handovers are central everyday events in the negotiated production of clinical knowledge. There are different organisational types of handovers (Hays 2003; Manias & Street 2000) and this paper deals with verbal handovers: nurses reading out the patients’ nursing records for the nurses working the subsequent shift. They take place parallel with, but are mostly segregated from, other organisational events for negotiating and producing clinical knowledge, such as doctors’ rounds, interdisciplinary conferences etc.

Within the sociology of health care, talk among health professionals, in particular among non-physicians, has not previously been subjected to extensive or detailed examination (Anspach 1988; Atkinson 1995; Hak 1999; Have 1995). Communication among health
professionals is important to study as the discursive distribution of diseases and the related divisions of work among the professionals accentuate interpretative negotiations of the patient’s disease and treatment without the active participation of the patient.

Nurses’ handovers are part of an overall production of clinical knowledge within health care institutions but they have not been given attention within the sociology of health care, where most studies are concerned with the physicians’ institutionalised production of clinical knowledge. Handing over, negotiating and producing clinical knowledge about the patients in speech and in writing borders on several strands of sociological health care inquiry, in particular medical case presentations and record keeping. First, *studies of medical case presentations* focus on the features of linguistic conventions for how medical staff members present patients at different occasions, spoken and written (Anspach 1988; Atkinson 1999; Hunter 1991; Lingard et al. 2003). These studies describe case presentation as a very conventionalised genre that constructs an account of a patient’s trajectory through the treatment at the hospital; as a site for collegial inquiry and questioning; as a simultaneous self-presentation which accentuates a need for special rhetorical competencies in order to save face and handle insecurity; and, finally, as a significant event for apprentices to learn the genre of professional case presentation. However, being limited to the examination of communities of physicians these descriptions of genre may not be generalised to include other communities of clinicians in institutional settings where the purpose of producing clinical knowledge is different.

Second, *studies of records and recordkeeping* analyse records and the social processes in which they are produced, circulated and interpreted within an institutional community, cf. (Hak 1998; Rees 1981). Schryer analyses records *per se*: the textual organisation of veterinarian records and interprets these features of genre according to characteristics of the community using the records (Schryer 1993). Berg conceptualises records as technological artefacts being constitutive parts of medical practices. In this sense any recording is part of the process of turning the patient into a manageable case and in turn creating an image of a clear-cut trajectory through treatment at the institution, diminishing or deleting all traces of previous clinical uncertainty or ambiguity (Berg 1996). Therefore, records – their physical appearance and content – have social consequences far beyond their immediate production. However, these studies focus mainly on ‘medical’ records which do not automatically include the less visible recordings by other clinicians in the everyday administration of patients. An example of this blind spot is Hunter’s study of medical narratives (Hunter 1991): the diagnostic plot is designated a superior status in the analysis, which subordinates the recordings and chartings made by non-physicians: the coherencies in and the genre of these recordings are treated as insignificant.
In the case of mental health settings, the most substantial and detailed study of mental health professionals reading out, paraphrasing and negotiating documents in their mutual talk is made by Griffiths (Griffiths 1997; Griffiths 2001). Griffiths’ study shows how two mental health teams – one without a medical consultant – interpret written requests for referrals by negotiating the patient’s condition into local categories. These local categories allow the teams to accept, decline or postpone a referral. Griffiths concludes on the interpretative courses drawn on by the teams: “Case presentations tap into a rich descriptive repertoire which draws inter alia on the categories of expert psychiatric diagnosis, the more morally loaded slang of backstage medical talk, the social-psychological terms of social work discourse, and labels linked to practical perceptions of workload (“he’d be a long-term patient”).” (Griffiths 2001, 684). The informal process of negotiating cases by using this discursive repertoire and by using interactional moves blurs the distinction between formal/technical evaluations and common-sense evaluations and ‘facts’ from moral evaluations. Griffiths’ analysis shows, how formal and informal verbal registers are interspersed in the negotiations in mental health teams and how this has direct consequences for the patients through the teams’ formal function as gatekeepers. Therefore, it is important to examine communicational conventions for negotiating, legitimising or disputing clinical knowledge about the patients.

There is a substantial body of literature concerning mental health nurses’ communication in different institutional contexts, but mental health nurses’ intra-professional communication is rarely reported. Exceptions are found in ethnographies on mental health institutions, such as (Barrett 1996; Rhodes 1995), but these analyses rarely present detailed analyses of the communicative interactions between the nurses or within the mental health teams.

The analysis presented in this paper concerns the negotiated production of clinical knowledge at inter-shift handovers between mental health hospital nurses; the handovers may to some extent resemble the medical case presentation and the writing of medical records as the nurses read out their records. The analysis draws on data from an observational fieldwork study focusing on patterns of communicational interactions among nursing staff at a Danish mental health hospital. The objective of the present analysis is to gain knowledge of routine nursing practices through a description of the local social and linguistic conventions for handing over clinical knowledge, and, further, how the conventions have a direct influence on the clinical knowledge explicitly worked up and shared by the nurses.

Method

This analysis draws on one year’s ethnographic fieldwork at two adjacent Danish adult mental health hospital wards. Both wards were general, adult ‘special observation’ wards. The
wards had a similar capacity for admissions, 16 single bed rooms, and similar characteristics of staff and patients. The nursing staff members included general nurses, auxiliary nurses, occupational therapists, and nursing students. In this analysis there has not been made any distinction between the groups of trained/qualified nursing staff members as they all fulfilled the same functions on the wards and reported this work in identical ways.

Data used in the analysis comprised of a selection of audio recordings of nursing staff handovers from 2 x 3 successive handovers at both wards, photocopies of the written report accompanying these handovers, and fieldnotes written during the entire fieldwork. A modified conversation analysis transcription system designed to capture the ‘dynamics of turn-taking’ and the ‘characteristics of speech delivery’ was used consistently (Hutchby & Wooffitt 1998; Psathas & Anderson 1990).

Fairclough’s outline for studying discourse was used for analysing the social and linguistic conventions for handing over information about patients (Fairclough 1992). Fairclough’s eclectic approach to discourse seeks to combine text analysis with the analysis of micro-social interactions among participants, and the analysis of larger scale social and linguistic structures. In the interactional part of the discourse analysis Fairclough draws on conversation analysis, and, therefore, formal conversation analytical techniques were applied to describe how the nurses oriented to the institutional context. This included the formal analysis of talk-in-interaction: turn-take organisation, the overall structural organisation of the interaction, turn-constructions, topic-organisation, repair-organisation and wording (Drew & Heritage 1992; Heritage 1997; Sacks, Schegloff, & Jefferson 1974; Schegloff, Jefferson, & Sacks 1977). Further, comparisons between the spoken and the written reports were made to analyse how ‘reading’ out could be an interpretation through paraphrasing or selective readings.

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58 The selected recordings are made on two Tuesdays. The recordings were selected from 2 x 21 recordings because of the quality of the recordings and because Tuesdays are relatively ‘ordinary’ days compared to Mondays and Fridays (getting started after and looking forward to weekends) and Wednesdays (the interdisciplinary conference-day).
59 The conventions were further modified for this article:
( ) indicates doubt in transcription
::: indicates sound stretch
INCREASED VOLUME
emph
>increased speed<
<decreased speed>
(.) indicates pause > 1 second
(x.0) indicates pause in x seconds
= indicates latching between parts of talk
[ indicates beginning of overlapping talk and ] end simultaneous talk
(( )) indicates extra linguistic observations
After the initial technical analysis of the participants’ own understanding of the conversational context the succeeding analysis violated a conversation analytic tenet on the inclusion of extra-conversational categories in the process of interpretation (Schegloff 1997): ethnographic descriptions and interpretations of the wider social context for the talk-in-interaction at handovers were included in the discourse analysis as outlined by Fairclough (Fairclough 1992).

The audio recordings were made towards the end of the fieldwork at both wards. This timing was chosen deliberately as trust slowly increased between the informants and the researcher and because a continuous presence and use of the recording equipment reduced the informants’ discomfort with it. A trusting relationship was evident in the recordings by the informal and relaxed tone between the informants and the researcher as well as through statements like: “I forgot it [the microphone] was there” etc. The presence of the microphone was occasionally included in conversations for instance by making funny sounds over the microphone or by commenting to the microphone: “did you get that huh?” Occasionally, the researcher’s voice is part of the recordings either as part of small talk or answering specific questions during the handovers: “did you see what time Jim left for home?” These influences produced by the researcher obviously spoil the image of the data as being ‘naturally occurring’. However, the playful responses to the microphone and the interactions where staff position the researcher as a fellow staff member could also be regarded as reflexive and ‘natural’ responses to the research setting. Regarding the conversational topics during the audio recorded handovers, staff members may have been cautious about gossip and slander but typically these activities would take place outside handovers. Alternatively, a nonsense and non-participative approach by the researcher would probably have strained interactions in the setting.

Access to the wards was initially negotiated through the hospital management and later with staff at the individual wards. The empirical material has been handled in agreement with the legislative rules set out by The Danish Data Protection Agency. The National Health Service of Denmark gave permission to access relevant information about the patients and the researcher was subjected to the same professional secrecy as the staff. Information about the study: objective, methods, consent etc. was given to patients and staffs. One patient and two staff members declined to take part in the study and subsequently no material about or originating from these persons has been analysed. All proper names in the transcripts presented here have been changed.
Chapter 5

Results

The results are summarised and presented in three sections in line with the overall aim of the analysis. The first and second are concerned with the description and analysis of the structural organisation of the handovers: their conventionalised phases and sequences. The third section is concerned with the verbal interactions during the handovers and how they influence the knowledge jointly produced and shared.60

1. Exchanging information between shifts: the phases of handovers

In this section the three distinct phases of a handover are outlined. There were three daily nursing handovers on the wards. A handover is here defined as the period of time where members of a departing shift spend time with members of an arriving shift and therefore recordings in the ward office started as soon as arriving staff entered the ward. The period is characterised by two distinct levels of interactional formality (Atkinson 1982) and the definition is designed to include the more informal parts of handovers rather than focusing exclusively on the more formal part of the event. The handovers began at approximately 7 AM, 3 PM and 11 PM. The periods of overlapping time between the shifts were not the same. At 7 AM and 11 PM the overlapping period was 15 minutes and at 3 PM the overlapping period was 45 minutes. These temporal differences influenced the amount of information exchanged: the 3 PM handover was longer and had a higher proportion of turn-takes compared to the other two.

When staff members arrived they sought and/or received information about the ward and patients from the moment that they entered the ward. For instance, staff members would make impressions of the ward atmosphere on their way to the office and would often probe their observations to colleagues by stating: ‘it’s really quiet today huh?’, ‘Henry is in a good mood today?’, ‘has Brian F. been readmitted?’ etc. and start short verbal exchanges about the ward atmosphere or particular patients. Departing staff would frequently give concise, task-related information about unfinished work or things to give particular attention in the following shift: for instance, ‘I’ve just given John a shaver, remember to get it back’. The verbal interactions were informal and conversational: there were no pre-allocated turns or turn-takes, there were stepwise moves between topics, varied conversational styles, there could be several parallel conversations, and the floor could be taken by everyone.

60 The extracts presented here are translated from Danish. The translation is primarily aimed at preserving the interactional moves from the original recordings and secondarily at the exact word-meaning. This means for instance that a Danish joke is translated into an English joke situated in the same intercational exchange: however, the content and punch line of the jokes may differ.
Much attention was given to a big whiteboard in the office. The whiteboard listed names of patients, which room they occupied, which nurses were the primary carers, which medical doctor was responsible for treatment, the formal levels of observation, and the patient’s whereabouts if he or she was out of the ward. The whiteboard functioned as a ‘control panel’ giving an overview of the ward. Using their understanding of practice and their knowledge of previous and current patients, the nurses could estimate the workload and figure out who had been discharged or (re)admitted at a glance. One of several fieldnote recordings described the use of the whiteboard in the following way:

Extract 1 (field notes from Ward B)

“3:00 PM. The handover begins with a rambling conversation about things happening during the day and tasks that the evening shift must attend to. Tom, an evening nurse, asks if the name ‘Roger’ on the whiteboard refers to Roger Sawking [an infamous previous patient]. Henry, a day-shift nurse, denies and starts telling about a new admission of Roger, a man from Northern Jutland who is imprisoned for violence and who has cut himself. He has no current plans for repeating [a suicidal attempt]. He has been allowed to keep his belt because otherwise his trousers fall down.”

This was not the proper report on Roger but an informal sketch of the problems that might occur in the near future: that he was technically still in prison and that he had made an attempt on his own life. However, Roger claimed not to plan a new suicide attempt and he was trusted to the extent where he could keep a prime apparatus for hanging: a belt. With the statement about the belt and the falling trousers Henry recognised the (potentially) funny side of the otherwise grave situation. This ability to formulate and time concise and humorous descriptions was regarded as a sign of professional competency, cf. (Barrett 1996). Further, Tom’s probing question was, even though he was not right about Roger Sawking, also a sign of professional competency as it displayed his knowledge of a prior admitted patient and an informed reading of the whiteboard. The ability to probe and address clinical topics and the use of a professional jargon were locally recognised professional abilities. Therefore, even though the conversations were informal in this part of the handover, access to sharing clinical knowledge was constrained by social conventions: a nurse must be clinically able to produce clinical knowledge and have the social position to present and/or to probe for it. The particular group of nurses present would shape the scope of the informal part of the handover: very professionally competent nurses had a preference for informal talk with other very competent nurses, and the informally conveyed knowledge was negotiated between a limited number of nurses, thus reproducing the existing divisions between the informed nurses and the uninformed.

The informal part of the handover had a variety of functions for the nurses, such as confirming solidarity, relaxing, and harmonising the local professional standards. Regarding
the production of clinical knowledge, the goal and purpose of the informal handover was to hint or directly anticipate problems on the wards, in particular the patients’ actions; for example, Extract 1 is concerned with a new suicide attempt.

The initial informal period was succeeded by a formal period, where a nurse working on the ending shift read out the written records for the arriving staff. The records were mainly authored by the nurse allocated the responsibility for a specific patient during the shift; this nurse may not be same nurse reading the recording. The beginning of the period was usually marked by a verbal context marker, for instance: ‘right now (.) we’d better get started’, signifying the initiation of the formal report meeting. Interactions were formalised through a pre-allocated turn-take system where the reporting nurse was the primary speaker who introduced topics. There was a predictable and reoccurring introduction and closure of topics: a report about each patient. This formal order was partly negotiable, but serious deviations were explicitly sanctioned by the reporting nurse or by parts of the audience, see section 2 below.

The formal period was closed with a context-marker, for instance “that’s all folks”. After closing the formalised meeting the handover shared the same informal conversational characteristics and the same topic organisation as before the formal period. Topics were, however, often more oriented towards institutional goals such as organising the daily routines. The introduction of institutional or private topics or a combination of these depended on the nurse’s perception of the immediate workload. The analysis of the organisation of the handover continues in the next section on the sequences in the formal part of the handovers.

2. The sequential organisation of the formal part of a handover

The formal part of a handover consists of a series of recurrent interactional sequences and in this section these sequences are described. The participants orientated to a conventionalised structure, where the reporting nurse was the pre-allocated speaker, who introduced topics; a topic is mainly a patient. These topics could be controlled by the reporting nurse alone, but also through interactive turn-takes with the other participants.

Most frequently a topic was opened by the reporting nurse, who stated the name of a patient, while simultaneous producing and opening that patient’s nursing record from a briefcase-carrier. The name or the whole opening utterance could be stressed by means of its sequential placing or its intonation. Most often, the topic/name was emphasised by placing it the front position of an utterance. The name was alternatively given as part of a short meta-communicational preface, ‘next we’ve got Allison’, which underscored the sequential character of the handover. The closings of the topic could be done by the reporting nurse alone.
but occasionally also through interactive negotiations. In the following sequence, the topic is both opened and closed by the reporting nurse.

Extract 2 (audio-recording from Ward B, morning handover)

Karen […] (9.0) Mette (3.0) she felt bad at dinnertime felt dizzy and said that she could not
move (.) she sat in her chair and rocked back and forth (.) she could laugh though (.)
had dinner served in her room and participated later in bingo during conversation
Mette found out that the condition earlier was caused by not drinking enough fluids
after a long walk (.) afterwards she spoke a lot about her weight and diets and
showed the signer clothes she bought which are too small (.) here she was smiling
and seemingly at ease (.) and I’ve only written a date “but she has slept” ((writing is
added and the record is put aside)) (8.0) and now Mr. Udsted has appeared (1.0) […]

In this example, the participants oriented to the same formalised turn-take system: there
was a pre-allocated speaker and an audience. The speaker opened and closed the topic. There
were several long gaps in the report, but there was no change of speakers in spite of these
potential transition-relevant places. In this example the topic elicitor lay in the initial stress-
ing of “Mette”. The report was given in a narrative form with several ‘converse statements’
adding and qualifying previous statements. For instance, the severity of Mette’s state of feel-
ing dizzy was qualified by a second statement informing that it was not worse than that she
could laugh, see Chapter 4

Karens gave a meta-communicational statement about having
forgotten to record anything other than the date and continued to state under her breath that
Mette had slept while adding it in writing to the record. The closing of the topic was visually
apparent through the actual closing of the record, the nurse picking up the next record and
introducing the next topic: “Mr. Udsted”. This was an explicit example, albeit small, of the
record’s constitutive effect on writing as Berg pointed out (Berg 1996); Karen interacted
with the record and her actual recording was contingent on this interaction.

Records were read aloud by a nurse who may or may not be the author of the record. In
general, reading a record aloud involved unfolding institutional shorthand (symbols, acro-
nyms, initials and abbreviations) into full length words, phrases, clauses and names. As the
particular shorthand often omitted the subject and the finite verb these were often put into
words. Further, tempus in the record was read to fit a superior tense of the report. Often, the
reader would add small meta-communicative statements about the record or the reading of it,
for instance: ‘next we’ve got’, ‘I would guess there is noting new about Jane’ or ‘this is

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61 The description portrays Mette as suffering of dizziness and that she sits and rocks forth and back. Later,
through a conversation with the nurse, Mette recognises the causes of her problem. Finally, she is smiling. This
creates an image of a transformation of Mette’s condition from bad to good through the therapeutic influence of
the recording nurse. The report is an account of Mette’s accounts of her perceived distress as well as the di-
rectly observable distress. However, it is also an implicit account, conveyed in particular by the narrative plot,
of successful nursing interventions.
really hard to read’. The most elaborative reading of a record occurred when read by the actual writer; here the record was used to structure the content of an extended report. A reading out of a record without any explicit interactions between the reader and the audience did not add to the content of the record, rather, the report retained the characteristics of written records like for instance grammatical simplicity and a textual omission of clinical doubt. Paradoxically, reading out introduced, firstly, doubt about precisely what was written in the record: some nurses’ handwriting was a pain to read for other nurses, and sometimes a reader would ask for help deciphering the record. Second, doubt related to the meaning of what was read out: sometimes a reader would spell his or her way though a recording reading it staccato or in long stretches without extra pauses between the formal sentences, this phenomenon is exemplified through the ‘missing’ pauses in Extract 2.

The nurses’ orientation to a conventional structure was also evident in the organisation of repair (Schegloff, Jefferson, & Sacks 1977). Self-initiated repair occurs continuously: self-repair following a slip of the tongue or other-repair when needing help to read the handwritten record. Other-initiated repair, including questions about a specific patient, occurred immediately after the record had been read aloud. Other-initiated repair ‘too early’ in the report was ignored or sanctioned explicitly, for instance ‘if you’d just listen a bit more you just might find out’. The patterns of repair (re)enacted social positioning: many and early other-initiated repairs were made by staff members with recognised high social position or knowledge within the group of nurses, cf. (Atkinson 1999).

In this section, the non-interactive reading aloud of record was described. In one sense, the conventions allocate the reading nurse the formal role of speaking without interruption and thereby designating the other nurses the role as a passive audience. In another sense, the conventions allowed the written record to speak for itself without, an inquiry into the clinical knowledge presented or challenging the images of nursing inherent to the generic conventions for record writing; see for instance how Extract 2 carries particular scripts of nursing through the narrative structure and plot. The next session is concerned with the interactional dynamics associated with requests for repair of the content of the report.

3. Verbal interaction at handovers

In spite of the conventions at the handover, a reading often became part of interactional exchanges between the nurses. These interactions could be initiated by both reader and the audience and display their orientation to the possibilities for interactional moves in the context. The following extract contains both a sequence from a nursing record and a sequence from the subsequent 3 PM handover. Here, an occupational therapist, Liz, reads out her own recording about a patient, Mark, who is admitted to a mental health hospital for the second time. Present at the report are: Tina, an apprentice nurse who has worked the day shift, and
the evening shift nurses Moe, Rob and Mary. Rob and Mary have heard about and met Mark during the previous days; Moe has only heard Mark’s name mentioned once 15 minutes earlier in the informal part of the handover.

Extract 3 (Ward B, 3 PM handover)
The written record:
[night] (date) Slept. (signature).
[day] (date) Joined morning exercises. Been on a trip to the shopping centre (one hour). Bought sandals, shoes, socks, and swimming trunks + a little wallet (all in all about £ 45). Had a good overview. Good at choosing and not choosing. Managed to do all the services himself (signature).

The interactive reading of the record:

1 Liz [...] well Mark he also joined the morning exercises and then he came along to the shopping centre where he spent (.) 45 pounds he bought a pair of shoes and a pair of sandals socks swimming trunks (.) [and he:] 45 pounds (.) but we do not really have=
2 Rob [45 pounds]
3 Liz = any idea about how much money he’s got I tried carefully <to ask about>(.)
4 Moe would you mind telling me what he’s like (.)
5 Tina [he looks like ] a little mouse
6 Liz [he is:: ]
7 Liz year
8 ? yes
9 (Tina) yes
10 Liz he’s a little quiet >thirty eight year young man brought in< by the emergency team (.) is poorly has not eaten lately (.) has he has drunk (.) has intense thought disturbances (.) distressed (.) and Mary she knows a lot of stories about about the first day [ 
11 Moe [yes but is she insane >sorry< is he insane ]
12 Mary [yes he is ]
13 Liz [he is (.) e he has=]
14 =at any rate (.) [ 
15 Moe [year year but [(.) everybody isn’t [( )] 
16 Liz [really [sss [extremely ambivalent (.) but actually I think [he he that he e: had a good overview when we were= 
17 Mary [( )]
18 Liz =out shopping and he could easily overview that >he had a little difficulty< in taking in the shopping centre (.) there are many with that problem the first time (1.0) when you know one comes to a new ( ) actually he could manage paying n::: he knew what he wanted and didn’t want (3.0) Maria ((the next patient))

The reporting occupational therapist reads the recording about the trip to the shopping centre. At a transition relevant place (line 3), Rob interrupts with a request for repair by partially repeating Liz’s turn: “45 pounds”. Rob’s turn overlaps Liz’s turn and she repairs by
giving the floor to Rob. Rob’s turn is replied by Liz who stresses the amount by repeating it and thereby showing her understanding his interruption as a confirming question or a surprise. Liz, thereafter, accounts for her reflections on how much money Mark has to spend, which is not part of the written record. It is not evident within the conversational context to decide if these reflections are relevant for Rob; if it is ‘what he asked for’. However, Moe interrupts the elaboration (line 6) with a request for repair, when Liz’s talk slows down. Moe asks for further clarifying information about Mark. Tina and Liz start to answer the request simultaneously (line 7-8). Once again Liz repairs the overlap, this time by leaving the floor to Tina, who describes Mark metaphorically as a little mouse; a description which is acknowledged by several others. Liz elaborates on the mouse description through the wording of the description of Mark: “he’s a little quiet’. The description is speeded up when she starts to read fast from the front page of the record (which is not presented here). She ends the description by referring to Mary for more information about his arrival (line 14).

Moe re-phrases (and repairs her own error in the process) in line 14-15 and accentuates her first request for repair of the information: “is he insane”. Mary acknowledges this by giving a straight answer: “yes”. Liz also starts answering (line 18) but is interrupted by Moe, who interprets Liz’s turn as a questioning of the relevancy of asking about insanity and therefore a misunderstanding of her question (Schegloff 1987). Liz continues to answer the original question using a more formal phrasing: “extremely ambivalent”. This overlaps Moe’s turn and she stops talking. Liz continues to answer the question drawing on information written in the record and on general professional reflections on buying and overviewing at the shopping centre (lines 21-27).

Through the interactions the nurses negotiate a shared understanding of Mark and work him up as a recognisable case, ‘an insane’, which can be used to infer about and predict certain behaviour. However, the organisation of repair points to several places of uncertainty in the mutual understanding of the presentation. An interpretation of the reasons for the other-initiated repair, where Moe requests further information, is that she questions the explanation because she has no background knowledge of Mark to contextualise the observations from the shopping centre within. In this sense the report becomes a source of trouble. The first response to Moe’s request for further information is an informal metaphor of a little mouse. Here, however, Liz recognises that a different answer is requested and she turns to the more formalised descriptions available in the record; she also refers to Mary’s personal experiences from the admission as a further source on information. Moe is not, however, satisfied with these two answers and offers the term “insane” in order to fit Mark in to a recognisable local category. Mary recognises this request immediately and answers “yes”; but Liz chooses the semi-formal description “extremely ambivalent” before returning to observations from and reflections on the trip to the shopping centre.
These shifts show that handing over information and sharing understanding, firstly, involved an adaptation to different linguistic registers, cf. (Griffiths 2001): in particular, on the one hand, common sense notions of mental disease working particularly through the mouse-metaphor and the description of Mark in everyday-situations and, on the other hand, semi-formal technical mental health vocabulary. Secondly, the descriptive terms must serve to work Mark into a recognisable local category; otherwise they appeared as idiosyncratic descriptions: Moe warrants a local category, not detailed clinical knowledge.

Moe’s requests for repair were also breaches of the conventional structure of the handover; the request for repair of the handover’s content was a token of power and only a small number of nurses would make such requests. In this sense, powerful nurses, who could interrupt less powerful nurses and request them to be more explicit, used the local conventions of the handover. The power to ask others to be more explicit could expose the nurses as not having detailed knowledge of the patient; the conventions at the handover protect the reporting nurse from challenging questions. In Extract 3, Liz, who had worked with Mark during the shift, was struggling to provide Moe with the ‘right’ answer to her question. However, in the end Liz saved face by turning to her first-hand information: she was able to provide information about Mark and the participating nurses did not explicitly question this move or the relevancy of the information. In other words, Liz solved her struggles answering with a rhetorical move that allowed her to talk of that of which she had personal and professional knowledge. ‘Not providing the answer to a direct question’ was a common phenomenon on the wards and the nurses possessed a variety of face-saving strategies in these situations. These strategies could be accomplished single-handedly, as Liz did, or as a joint achievement where several nurses for instance agreed on the difficulty of having answers.

The analysis above indicates that the nurses’ handover is structured by social conventions, which create a social order during the handover, that determines the nurses’ access to clinical knowledge; and further, that this order is negotiated by the staff members re-enacting their mutual social positioning. In the next session, the content and conventions for handing over are further explored and compared to ‘the medical case presentation’ and recordkeeping.

Discussion

A central characteristic of the medical case presentation, spoken and written, was the building up of an overall trajectory of the patient’s disease and treatment (Berg 1996; Hunter 1991). The nurses’ handovers did not explicitly add to an overall trajectory, as they were mostly concerned with present state descriptions of the patient; in this sense, the nurses constructed trajectories across the previous one or two shifts without fitting them into an overall
trajectory. Another central characteristic of the medical case presentation was its definition in terms of a medical diagnosis. The nurses rarely referred to diagnosis or other specialised psychiatric terms and their accounts did not follow a formal psychiatric logic of observation for specific psychiatric symptoms. The nurses mainly used an everyday register and the content of their observations were mostly ad hoc descriptions of the patient’s behaviour. The use of an everyday register and the focus on behavioural problems was conditioned by the institutional divisions of labour: nurses, compared to other mental health professional groups, are engaged in continuous and mundane activities on the wards (Barrett 1996) as well as maintaining social control through the continuous surveillance of the patients’ behaviour (Rhodes 1995). Psychiatric nursing is in general not characterised by specialised, technical interventions and the skills of the mental health nurse are often described as personal capacities based on common sense, e.g. (May & Kelly 1982). The low level of technical specialisation and a large amount of everyday actions in the proximity of the patient supported a specialised clinical discourse, which resembled everyday language through being experience-near, very dependent on context, and having a shallow taxonomy of concepts.

Many medical case presentations, in particular the most formal, were through the professional, educational and institutional organisation of physicians given from junior staff members to senior (Anspach 1988). According to Atkinson, a central feature of the medical case presentation is the interrogation of a junior physician by a more senior physician through sequences of questions and answers (Atkinson 1999). A senior physician has the formal status and power to interrupt a junior physician’s presentation and demand further explicitness if the presentation of the case is found in need of repair; in the wake of demands for explicating knowledge uncertainty may surface. Uncertainty is rhetorically deflected differently by the seasoned physician and the student (Lingard, Garwood, Schryer, & Spafford 2003). The nurses’ handovers were not organised as happens where senior staff could interrogate the clinical knowledge and skills of junior staff; reading out the report was a task taken by turn and delegated to the nurses on a monthly roster. The nurses’ presentations were in this sense not enactments and reifications of a formal professional hierarchy, but events for enacting the informal hierarchy between the nurses. Moreover, the task of reporting rotates and only one nurse from each working shift read out the record, therefore, this nurse may have very little or no further knowledge of some of the patients described. Thus, the reporting nurse often had no further answers to give if she was questioned. However, the lack of explicit and detailed knowledge was not only linked to this organisational feature and a record with no overall trajectory; taking care of a mentally ill person does usually not presuppose explicit and detailed clinical knowledge, therefore, the nurses did not rely on or demand such knowledge in their everyday clinical work: they knew how to get on with their work having the experience and knowledge for all practical necessities.
The staff members had face-saving strategies that rhetorically downgraded signs of uncertainty or ignorance, which were prompted by different requests for repair of the report’s content. This discussion calls attention to the relationship between, on the one hand, the demands on staff for being linguistically explicit and precise about their clinical knowledge, and on the other hand, the silence and gaps that in different ways appeared in relation to handing over clinical knowledge.

A substantial part of the clinical knowledge produced by the nurses was not explicit or precise. A fundamental ethnomethodological tenet is that accounts are fundamentally indexical. This means that the reference of an account is dependent on how it is occasioned in the specific context of use. Therefore, the correct understanding of an account presupposes prior knowledge of the context of accounting. The subtle interaction between prior knowledge and an appearance is summed up by the notion of ‘the documentary model of interpretation’, which underscores that there is a self-perpetuating confirmative process between an appearance and an underlying set of expectations: appearances document peoples’ expectations (Garfinkel 1984 [1967];Heritage 1984;Potter 1996). The nurses’ production and interpretation of clinical knowledge depend on their common sense expectations about its (indexical) meaning: formal gaps in the written accounts were filled and meaning is found between disperse accounts. The common practical understanding of the clinical work allows nurses to give short accounts of their work, which are interpreted as concise and telling by other nurses. This common sense and practical ‘knowing’ was evident as formal ‘gaps’ in substantial parts of the nurses’ clinical discourse.

In clinical negotiations the nurses draw on both recorded present state information about the patient and on informing notions of already ‘knowing the patient’ based on the nurses’ memory and experience. This meant that the continuous production of knowledge about the patient changed according to the staff members present. An overall image of the patient’s condition would not be described explicitly or preserved in the recordings but be continuously re-created in each shift through the sharing of the new and old information drawn on, negotiated, and produced by the nurses present. The nurses interpreted records and brought together different interpretative frames of already ‘knowing’ about the patient and they possessed different rhetorical abilities and social status for bringing their points forward in the group.

The central claim in this paper is that the nurses’ production and interpretation of clinical knowledge relied on a common sense practical understanding of this knowledge, which was not interrogated during daily clinical practice; however, the nurses’ clinical knowledge was continuously questioned as a result of institutional requirements: they must give an explicit documentation of their work. This demand could expose the nurses as ignorant, and
they often expressed frustration in relation to this demand, because of the nurses’ inability to give adequate descriptions and still preserve an image of professionalism. In this sense the handovers exposed the nurses as strung up between different rationalities: the everyday practical understanding and a managerial discourse rendering nurses work visible, cf. (Traynor 1999).

**Conclusion**

The genre of handing over clinical knowledge among mental health hospital nurses has brought forward certain kinds of clinical knowledge fulfilling the overall purposes of predicting the patients’ behaviour and the getting a sense of ‘knowing’. Access to information, and in particular the interactional creation of ‘knowing’, was not evenly distributed: some nurses interrupted more by initiating other-repair, which reflected an informal hierarchy of who ‘knows’ about a patient and who holds local authority. The teams had no formal hierarchy of clinical authority related to the handovers and the handovers were not governed by a formally structured clinical logic. This meant that informally structured information about a patient’s daily doings would be given, and eventually elaborated on or ‘closed down’ according to who was present at the handover and to what degree the patient was recognised as ‘known’ in advance.

The most elaborative reports were given when the handovers were interactive: when nurses engaged in question-and answer sequences. These sequences were only initiated by a smaller number of nurses who, so to speak, overrode the conventions by requesting repairs of the report. The most detailed clinical knowledge about the patient was produced in interactions initiated by the most powerful nurses: the ones who dared ask for more; the catch was, however, that power and experience were often identical and the experienced nurses did not often question the report; they already had a sense of ‘knowing’ what was going on.

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Chapter 6. Interdisciplinary conferences

Introduction

In mental health settings a distinction between symptoms, the patient’s subjective complaints, and signs, the observable pathology, is not very useful. This is because many obvious pathological mental health phenomena cannot be observed directly. This means that the process of diagnosing in these settings rely on clinicians’ interpretations of patients’ appearance. However, the process of interpreting the patient’s complaints and appearance in relation to a classification of mental disease and disorder is not limited to the actual encounters between the clinician and the patient, cf. (Atkinson 1995; Berg 1992). The interpretative process also takes place away from the patient in a range of formal and informal encounters between mental health professionals (Barrett 1996). Here, professionals share and work up accounts of their observations and produce clinical knowledge about the patient through negotiation and discussion of the accounts available. Inter-disciplinary conferences are formal team-meetings between representatives from different professional groups involved in the treatment of a patient. These conferences have a central position in the institutional, knowledge-producing mechanisms away from the patient. It is important to examine the social conventions for the negotiated production of clinical knowledge at the conferences, because the knowledge produced is a central component of the clinical decision making processes. This introduction is concerned first with studies of clinical psychiatric knowledge as socially mediated and, second, with studies of interdisciplinary conferences as sites for the production of clinical knowledge and as sites for interprofessional struggle.

Within the sociology of mental health, the study of clinical knowledge as socially mediated has been studied along several strands of inquiry. Here, studies of mental health diagnosis and of classification are highlighted. Clinical knowledge in the form of mental health diagnosis has been given considerable sociological attention. First, a number of studies have indicated that concepts of mental health disease come into existence contingent on social and cultural forces rather than by the discovery of essential unites of disease, cf., (Busfield 1988; Szasz 1994). Second, ‘labelling-theories’ have been focused on the social effects of receiving a diagnosis: the effect on the patient’s identity and (deviant) social role after internalising a diagnosis, cf. (Schiff 1975). Third, studies of the influence of social forces’ on mental health practices have indicated that diagnoses and diagnostic criteria are part of creating professional legitimacy (Harper 1994; Manning 2000). Further, studies of the everyday use of diagnoses in clinical settings indicate that, on the one hand, formal diagnoses serve a number of formal institutional purposes and contribute to decisions about treatment; and
that, on the other hand, diagnoses are malleable and ambiguous: they can be used locally as strategies for e.g. gate-keeping or avoidance of psychiatric ‘dirty work’ (Brown 1990; Rhodes 1995). Moreover, mental health professionals draw informally on mental health diagnostic terms such as ‘neurotic’ and ‘depressed’, which to a larger extent conveys moral evaluation compared to the formal diagnosis and at the same time veils this evaluation through the linguistic resemblance to the formal diagnosis (Griffiths 2001; Tilley 1995). Thus, clinical knowledge, such as diagnoses, is negotiable and contingent on the situated mental health practices.

Studies of classification within health care organisations seek to explain how and why clinicians implicitly perceive certain patients as being of a certain type. Studies vary in their conceptions of which variables influence clinicians’ categorisations: it is debated to what extent categorisations are determined by organisational structures or, alternatively, by the interacting agents, but most studies mediate these classic positions (Latimer 1997). In a review of themes in the literature on nurses’ perception of ‘good’ and ‘bad’ patients, Kelly and May suggest following groups of variables: the patient’s disease, institutional rule-breaking, non-clinical social variables, the patient’s attitude towards treatment, and, clinicians’ evaluation of the patients’ (Kelly & May 1982). In an empirical analysis of categorisations of mental health patients, May and Kelly studied mental health nurses’ perceptions of patients and how perceptions led to certain behaviour towards the patient. May and Kelly argued that categorisations of ‘problematic patients’ could not only be explained with reference to staff members’ perception of the patient’s responsibility in ‘the patient role’ but rather that patients were perceived as problematic if the patient rejected the nursing offered (May & Kelly 1982, 287-289). This meant that the professional identity of the mental health nurses, who allegedly held only a limited number of identifiable professional skills and were expected not to dislike the patient, influenced the perception of and attitude towards the patient.

The processes of classification can be traced in people’s accounts of their experiences. In the seminal paper, ‘K is mentally ill’, Smith analysed how a young woman, K, was recognised by her friends as mentally ill (Smith 1978). The analysis showed how K’s friend Angela retrospectively constructed an account of K’s behaviour by classifying a series of events according to a lay conceptualisation of mental illness. Smith’s analysis accentuated how language influenced social life by demonstrating how the narrative structure of the accounts created objective facts mainly through the creation of a contrast between K’s behaviour and normal behaviour.

There is an absence of research literature on the benefits of teamwork in health care settings (Colombo et al. 2003; Opie 1997b). Studies of mental health interdisciplinary team meetings have demonstrated the interactional and negotiated character of the clinical knowl-
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edge produced at the meetings. Opie analysed a team working with committed psychiatric patients on a medium secure unit (Opie 1997a). Opie described the outcome of the interdisciplinary meetings as ‘team narratives’ built on a series of discussions and shaped for clinical action. These discussions were contributed to by different team members and were often provisional and inconclusive. Simpson’s multiple case study of inter-disciplinary mental health teams indicated that the inter-professional tensions and organisational defensiveness contributed to an erosion of the management of care and treatment (Simpson 2004).

Buckholdt and Gubrium described a situation at a treatment centre for disturbed children where a child’s situation was initially described as in progress (Buckholdt & Gubrium 1979). Through the discussion this interpretation was abandoned because it was argued that ‘progress’ was a mistaken observation because staff had allegedly seen less of the child lately. Another study was reported by Griffiths who analysed interdisciplinary meetings in a community mental health setting (Griffiths 1998; Griffiths 2001). Griffiths analysed conversational interactions in detail and showed how the formal hierarchy between the participants at the meeting was subverted by the use of humour and how historical information and loosely founded personal anticipations were used in the negotiations leading to decisions about the treatment of the patient.

The objective of this paper is to contribute to our understanding of interprofessional collaboration at mental health hospitals. The analysis is focused on the social conventions for language use at interdisciplinary conferences and how they influence the social processes of categorising patients through the production, negotiation and sharing of clinical knowledge. The analysis draws on data from fieldwork for a broader study, the aim of which was to analyse how communicational patterns among mental health nursing staff influence the shared images of the patients.

Method

Setting

The study was conducted at two adjacent ‘special observation’ wards at a Danish university mental health hospital, Ward A and Ward B. The official policy at these wards was that distressed patients should be given close and perhaps constant observation rather than imposing more drastic sanctions such as locking the entrance door or medical, physical and/or mechanical restraint. The wards had a similar capacity for admissions, 16 single bedded rooms, and on average the patients hospitalised during the fieldwork had similar diagnoses. On average, nursing staff at Ward A had almost twice as much mental health nursing experience as staff at Ward B (13.2 years vs. 7.5 years) and they were better educated as a result of formal
basic health care education and postgraduate courses. At both Wards the medical staff consisted of a consultant and two registrars.

Subjects
The weekly interdisciplinary treatment conference at the two wards was the subject of study. The conferences were held every Wednesday and were scheduled to last approximately two hours. The conference was referred to as the ‘treatment conference’ and the participants were the hospital staff: nurses, physicians, physiotherapist, occupational therapist, social worker, and psychologist. Further, community mental health nurses would participate and take part in discussions on patients relevant to their work in the community. Members of the clinical nursing staff did not usually participate at successive conferences because of irregular shift work; conversely, the other participants would attend most conferences. Sometimes conferences were split in two and the clinical nursing staff members would rotate and participate only in the debate on the patients they had an overall, daily responsibility for.

Data collection and data management
For the broader study, fieldwork at the wards lasted six months at Ward A and four months at Ward B. The empirical material included: audio recording of staff meetings; text documents produced by the nursing staff; participant observations and fieldnote recordings of staff interactions; background interviewing of staff members; and ward occupancy rates and lengths of stay.

Field observations were made of twenty conferences: Eleven conferences at Ward A and nine at Ward B. 13 of these conferences were audio recorded: Six conferences at Ward A and seven at Ward B. The recordings were summarised and recordings of two successive conferences at both wards were chosen for detailed analysis; they were selected at random because the recorded conferences at the wards were homogeneous and none differed significantly from the rest. The recordings were transcribed according to a modified conversation analysis transcription system designed to capture the ‘dynamics of turn-taking’ and selected ‘characteristics of speech delivery’ (Psathas & Anderson 1990). In order to make the transcript presented here fairly readable the use of transcription symbols has been minimised62.

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62 The conventions are:
( ) indicates doubt in transcription
::: indicates sound stretch
( .) indicates pause < 1 second
(x.0) indicates pause in x seconds
[ indicates beginning of overlapping talk and ] end simultaneous talk
( ( )) indicates extra linguistic observations
Data analysis

Fairclough’s outline for studying discourse was used for analysing the social and linguistic conventions for handling over information about patients (Fairclough 1992). Fairclough’s eclectic approach to discourse seeks to combine text analysis with the analysis of micro-social interactions among participants, and the analysis of larger scale social and linguistic structures. In the interactional part of the discourse analysis Fairclough draws on conversation analysis, and, therefore, formal conversation analytical techniques were applied to describe how the participants oriented to the institutional context. This included the formal analysis of talk-in-interaction: turn-take organisation, the overall structural organisation of the interaction, turn-constructions, topic-organisation, repair-organisation and wording (Drew & Heritage 1992; Heritage 1997; Sacks, Schegloff, & Jefferson 1974; Schegloff, Jefferson, & Sacks 1977). After the initial ‘technical’ analysis of the participants own understanding of the conversational context the succeeding analysis violated a conversation analytic tenet on the inclusion of extra-conversational categories in the process of interpretation (Schegloff 1997; Wetherell 1998): Ethnographic descriptions and interpretations of the wider social context for the talk-in-interaction at handovers were included in this analysis (Fairclough 1992).

Ethics

The National Health Service of Denmark permitted the researcher access to relevant health care data about the patients. Information about the study: aim, methods, the right to abstain from providing health data to the study, and the right to withdraw a previously given consent at any time without reprisal was given to all patients and staff. One patient and two nurses abstained from participating and no data originating from these persons were analysed. All proper names have been changed in the transcript presented in this paper to preserve the fullest anonymity. Even though the tenor at the conferences was sometimes sarcastic, but only in a couple of situations did the participants ask for particularly derogatory utterances to be disregarded in the further analysis.

Data extract

The linguistic conventions used at the two wards are exemplified with an extensive data extract taken from a debate of a patient at a conference at Ward A. The extract is not typical for discussions at Ward A but it is presented here as it contains distinct examples of common ways of using language at the conferences at both wards. The debate is about Bill: a young man diagnosed as schizophrenic. The discussion was the 7th out of 15 and present at the conference were: a consultant (C), a senior psychiatric registrar (SR), 4 nurses (N 1-4), a nursing student, and an occupational therapist (OT). Further; there were some ‘externals’ to the
ward: a community mental health nurse (CN), a psychologist, a social worker (SW), a physiotherapist, and the researcher.

At both wards the consultant and the registrars had permanent seats next to one another, which allowed them easy access to the medical journal and to talk together during the conference without involving the other participants. The participants would not arrive at the same time: Nursing staff would arrive last as the conference was held in a room in the wards and the nursing staff members tried to leave their clinical duties at the last possible moment. These late arrivals also meant that their seating would be more crammed and more peripheral to the table compared to non-nursing staff. Thus, the physical organisation of the conferences added to the creation and maintenance of the hierarchy between the professional groups.

1 C then there’s Bill
2 (3.0)
3 N3 well things are progressing
4 (1.0)
5 C congratulations
6 OT thanks
7 ((laughter))
8 SW new signals
9 N3 i:t yes it is [he gets up for the breakfast meeting [(.) he gets up and goes to well to [computer
10 SW [yes C [m: CN [yes
11 (. ) also beginning to have a completely different relationship to his home support [(1.0) was
12 C [hm
13 home yesterday to tidy up [and m:: took the initiative to get tidied up and called here (. )
14 C [yes
15 and said that he stayed a little longer because he hadn’t quite finished tidying up yet he just had
16 to organise the last few things (. ) and that is so to speak is (. ) [a major step in the right
17 C [m:
18 direction [you know (. ) so (. ) all of a sudden
19 C [m:
20 (1.0)
21 C m:: I had noticed y’know (. ) about a week ago that his look was (. ) a lot clearer [e::m when
22 N3 [yes
23 I talked with him but then (. ) the other day when I spoke to him about something that didn’t
24 suit him [ (. ) then the blinds came down again (1.0) then there was that distance again [   
25 N3 [((giggles)) CN [right
26 (3.0)
27 SW m: what is it you are saying he’s going to (. ) electronic data processing or what was it you
28 said
29 OT that well [go (. ) I take him over to the computer em:: one hour every day (. ) from nine
30 C [it’s Carol ] [(directs SW’s attention from N3 to OT)]
31 to ten
32 SW o.k.
33 ((several questions and confirmations at the same time))
Interdisciplinary conferences

34 SW he gets up and eats breakfast and goes with you
35 OT yes (.) he just drinks coffee
36 SW yes o.k. but [anyway ]
37 OT [well he ](.) gets up for the morning meeting generally speaking and then: (.) we
drink coffee and then we go over (.) and then we work with some (.) well: educational stuff
38 from the school n: (.) a few games (.) ‘n’ stuff like that
39 N1 yes at least he at least gets dinner
40 OT yes (.) he does
41 C he gets a daily routine [that the rest of us approve of (.) so he can (.) feel more normal (.)
42 Several [yes
43 y’know
44 SW and John you said something about the relationship to the Street Team what was that
45 N3 w: they were here yesterday and [and they were surprised at em:: (.) [ SW [yes
46 SW they could also sense
47 N3 [that something had happened  ] [(.)] yes because he took the
48 SR he becomes less autistic right
49 C m: [(.)] year it’s it’s::
50 N3 [yearh
51 N3 come on out n::
52 SR year
53 C you feel it when you (.) it’s that it’s those blinds y’ know (.) so (.) that he has [in his look
54 SR [m:
55 CN yes
56 SR and I also think that it is such an good example on that that when the very schizophrenic and
57 negative symptoms (.) then he lies there in his ambivalence should he get up and what should
58 (.) when it sometimes turns out (.) to go in and say you do not take the decision to get up (.)
you just must up (.) we simply take control (.) then we must take the conflict (.) and now he’s
59 quite pleased about it ‘cause [(.)] well it was actually quite nice to get up (.) and he doesn’t
60 N3 [yes absolutely
61 SR have to speculate any longer because (.) it’s an he perceives it as an order [and he follows
62 C [m::
63 an order (1.0) right
64 N1 but it is probably also because he has an interest in what you do with him Carol
65 because we have tried before to say you must get up[.0] but (.) he does not want
66 SR [yes
67 N1 to [he has jammed [ CN [m:  CN [m::
68 N3 he is currently anticipating that he (can go to The Mall today)
69 ((inaudible interactions))
70 OT well yes and no ‘cause he also says that it is uninteresting to sit and[learn some word
71 N3 [really
72 OT processing y’ know [((laughs))
73 Several [((laughing))
that is also what I said well:: I understand you have begun to work with a computer (.) word processing ((alters voice dramatically))
((general laughter))
(4.0)

The debate continued for approximately another 5 minutes with a discussion of how to get Bill to have a haircut and whether the application for a pension had been written. The overall patterns in the turn take systems did not change in this remaining part of the debate.

Results

Results are presented in two overall sections, both concerning the social and linguistic conventions of the interprofessional teams’ production of knowledge during the conferences. First, an analysis of the sequential organisation of the interdisciplinary conferences, both as it is represented in the data extract and in more general terms at the two wards. Second, an analysis of the language used for describing and categorising patients, focused on the use of narratives, metaphors, speech reports, and conceptions of mental disease.

1. The sequential organisation of the discussions

The overall structure of the conferences was characterised by distinct changes in the level of formality (Atkinson 1982). Both the beginning and the closing of the main part of the conference were marked explicitly by the consultants: informal talk and topics would cease during this period and conversations parallel with the central discussion were limited, brief and whispered.

At both wards, the first long turn-take in a discussion about a patient was an account of the patient’s present situation and/or recent changes in views on treatment or plans for discharge etc. These ‘first-accounts’ would fall on a continuum between, on the one extreme, the descriptive and ‘factual’ (what medicine has been given or how does the patient behave) and, on the other extreme, problem-oriented debates (problems or challenges in relation to treatment perceived by the staff or the patient). However, the structure of the discussions at the two wards was different63.

With regard to the data extract from Ward A, the consultant introduces Bill as the topic and leaves the floor (lines 1-4). After a prolonged period of silence, Nurse 3 appropriately self-selects and attributes a general predicate to Bill’s situation: it is ‘progressing’. Next

63 The order of topics (the patients) was not formalised, but certain patients would be discussed first or last at request according to the specific needs of someone at the meeting. Only rarely would the debates return to a patient already discussed, but in cases of late arrivals at the meeting or if a patient was described in interaction with other patients the patient could be discussed with invigorated energy. At one of the recorded meetings the debate of a patient was missed out by the participants.
there is a social, relaxed and humoristic interim (lines 5-7) which reflects a common sense of relief (and maybe surprise) that Bill, finally, is somewhat recovering. The consultant links progress with the work made by the occupational therapist and congratulates her on the progress. This unusual gesture is acknowledged by the occupational therapist and by several others through their laughter. Nurse 3’s following first-account (lines 9-18) is an abridged statement, assuming that the listeners have a prior understanding and knowledge of the case. The statement is a paraphrasing of the entries of Bill’s nursing record from the previous week; however, only the entries from the day before suggest a change in Bill’s behaviour, all other entries describe literally ‘no change’. Nurse 3’s highlighting of substantial changes seems to be based on a very selective reading of the record, he ‘cuts out events’ (Smith 1978) to warrant his initial claim about progress; however, Nurse 3 modifies the statement by adding “all of a sudden” which could indicate that ‘progress’ is not stable.

The discussion in the extract is structured by the social worker’s requests for repair of Nurse 3’s statement about progress. The requests for repair are accomplished by a series of probing statements and questions (lines 8, 27, 34 and 45). Answers are in turn given by Nurse 3, the consultant and the occupational therapist. Further, the consultant takes a turn in relation to all the questions and the social worker states her next question after the consultant’s turn related to the previous question. The consultant’s answers are summarising in the sense that the previous, concrete descriptions are translated into more abstract terms (lines 21-24, 42, 58 and 81-82), e.g. the description of what Bill does is translated into ‘daily routine’. Further, the senior registrar self-selects (line 61-69) and maintains that Bill’s situation is a good example of some general problems related to having schizophrenia and problems in trying to care for them. Medical staff members have through their conversational interactions transformed and interpreted the concrete accounts provided by the non-medical staff and translated them into more general notions of disease and treatment.

1.1 The general sequential organisation at the wards

At Ward A the debates were always initiated by the consultant who would close the previous topic and introduce the next. He would, by take the first turn himself, or by different means, allocate the next turn to a specific next speaker, typically a registrar. The formal responsibility for the treatment of a patient was allocated to an individual medical staff member and the registrar with the formal responsibility for a specific patient would be allocated the next turn if he or she were present. Only in rare instances would non-medical staff members be allocated the next turn or self-select. These turn-takes always happened in relation to patients about whom the medical staff had no news regarding the patient’s situation (as in the data extract). After the first longer turn-take the external staff members would request repair of the accounts given and ask for clarifications which often led to longer sequences of questions
and answers. The clinical nursing staff members only rarely participated in these ‘treatment and plan’ talks and would only give short accounts of eventual observations when specifically asked. The interactional exchanges were almost always interpreted and closed by summarising re-formulations by the medical staff members who controlled interactions and the process of interpretation.

At Ward B the nursing staff members were pre-allocated first-speakers. The topics were initiated by a member of the clinical nursing staff who was formally chosen to chair the conference. However, the actions taken by the formal chairman were under pressure from the consultant, who would signal by pointing at her watch when she wanted the next patient introduced, or deliberately ignored the nurse’s attempts to close a topic if she did not find it exhaustedly debated. After opening the topic, the chairman self-selected or allocated the next turn to another nurse. This turn was a first-account of the patient’s situation. The clinical nursing staff at Ward B had started preparing a written account of the patient’s present situation, which was read aloud at the conference, resulting in staccato readings of shorthand descriptions. This change of practice came forth because the nurses felt that their contribution to the conference hitherto had been too vague: a common consequence of shift work was that no nurses with up-to-date knowledge about specific patients were present at the conferences. After the ‘first account’ the medical staff would either initiate question and answer sequences on the basis of the introductory account or give an account of the treatment resembling the one given by the medical staff at Ward A. External staff would also request repairs. The question and answer sequences at Ward B were often impoverished and the nursing staff members often had to search the nursing records before answering or evading direct answers.

During the nurses’ first-accounts, the medical staff at Ward B would often start reading the latest entries of the medical journal or whisper between themselves, not displaying full attention to the nurses’ accounts. Debates would close when a member of the medical staff, in particular the consultant, would summarise the discussion. In contrast to practices at Ward A, the small and continuous summarising/re-formulating statements by the medical staff were relatively less frequent, sometimes only made at the close of a debate of a patient. In this sense, medical staff at Ward A continuously controlled interactions and discussions by means of turn-takes and concluding summaries, where only the latter was used at Ward B. Generally speaking, the question and answer sequences, central to the structuring of the debates, had opposing directions at the two wards: at Ward A questions were directed towards the medical staff; at Ward B questions were directed towards the nursing staff. However, in terms of interprofessional teamwork both turn take systems sustained the medical psychiatric interpretative dominance and hence the re-enactment of a professional hierarchy.
2. Language use and representations of the patient in discussions

The conferences were formal meetings. They were characterised by turn-take systems where physicians possessed interational control and control of the interpretations. This resulted in an unequal access to speaking and voicing opinion, which reflected and maintained the professional hierarchy between the professionals. Paradoxically, the language used was characterised by an informal tenor hinting egalitarian relations among the professionals: the register was mainly colloquial with an occasional use of technical terminology\(^\text{64}\).

With regard to the data extract from Ward A, the consultant gives a firsthand account of his experiences with Bill (lines 21-24) after listening to nurse 3’s concrete and descriptive account and giving five conversational continuers (lines 10, 12, 14, 17 and 19). The consultant’s account has a narrative structure and a metaphorical plot about autism and the suggestion that Bill can decide when to be attentive. This suggestion – a moral evaluation – is subtle as there is no reference to an agent ‘pulling’ down the blinds; however, because the blinds come down in a situation that does not please Bill it could easily be inferred that he ‘pulls’ them to avoid the unpleasant situation. Further, the narrative point about autism is supported by the use of metaphors: the look was clearer, the blinds came down, and there was distance. Moreover, the description is made with a wording and intonation that displays the consultant’s firsthand knowledge of Bill’s appearance with such accuracy that it makes Nurse 3 laugh.

Later in the discussion, Nurse 3 describes Bill’s relationship with the Street Team by means of direct speech reportage ‘hello there you are’ (lines 49-50) which is probably not an authentic quote but rather a rhetorical move. Nurse 3’s description is summarised by the senior registrar, who uses the formal technical term ‘autistic’ (line 53), which in turn is confirmed by Nurse 3, who designs a hypothetical stretch of direct speech to the virtual patient: ‘come on out’ (line 56), elaborating on the consultant’s ‘distance and hiding’ metaphor. The consultant picks up on this and repeats her blinds-description (line 58). Next, the senior registrar interprets Bill’s situation as an exemplar of a more general case (lines 61-69). The outset is the formal descriptive terms ‘schizophrenic’, ‘negative symptoms’, and ‘ambivalence’. However, formality is subverted by the actual use of these terms: Bill is ‘very’ schizophrenic and metaphorically he ‘lies’ in his ambivalence. Further, the registrar creates a hypothetical stretch of direct speech similar to Nurse 3’s ‘you do not take the decision to get up (.) you

\(^{64}\) Certain individual professionals had a preference for weaving in technical terminology more than others. Among the nurses it was regarded as a cheap way of latching on to the status of medicine or psychology. Technical terminology was in general compelled by official duties, such as referrals etc.
must up (. we simply take control’ (lines 56-57)65. The account is concluded with a point about Bill being happy about being commanded, which in effect links the hypothetic-theoretical account with realities: Bill gets up. The registrar’s account is a rhetorical mix of formal and informal language; of an explicit theoretically informed argument and a common sense argument; of the hypothetical and real life; and of description and giving advice.

In the data extract Nurse 1 adds an extra hypothesis to the registrar’s theoretical account of Bill’s ‘progress’: that Bill gets up because he finds the work with the occupational therapist interesting (lines 70-73). Nurse 1 objects to the senior registrar’s account: that a firm nursing approach towards Bill had not been tried hard enough, which implies that the nurses’ professional responsibility has not been fulfilled. May and Kelly suggest that mental health nurses’ categorisation of patients as ‘problematic’ was related to situations where the patient did not legitimise the nurses therapeutic aspirations (May & Kelly 1982). At the conferences these categorisations were negotiated away from the patient and notions of ‘bad’ patients were here related to negotiations of professional accountability and not to the legitimisation of nursing through the reciprocal nurse-patient relationship. A description of Bill as irresponsible gives the nurses the full responsibility for caring for Bill and a lack of success exposes the nurses to criticism. Conversely, a categorisation of Bill as responsible relieves the nurses for part of their professional responsibility for therapeutic success because Bill wilfully resists treatment: he is a proper ‘bad patient’ who does not conform to the patient role and acknowledge his disease, cf. Parsons (Parsons 1951).

The occupational therapist answers Nurse 1’s objection by agreeing and disagreeing at the same time (lines 77-79). She points out that Bill does not always find word processing interesting66: this is said in a tone of voice and with a wording slightly resembling Bill’s. She and others laugh at this. The intonation and wording is used as a remedy for the tension and creates solidarity through the implicit reference to Bill and his way of talking. The consultant acknowledges this interpretation by repeating the point of the joke upgrading the comical way Bill says ‘word processing’. The use of humour, in particular by the consultant, is used to circumvent the point raised by nurse 1 and the discussion of the reasons for Bill’s ‘progress’ is not resumed.

The discussion sets out as an interpretation of the descriptive accounts provided by Nurse 3 fitting and negotiating them into a moral evaluation of Bill’s responsibility towards treatment and care. This triggers Nurse 1 and the discussion changes focus towards being

65 There is ambivalence associated with the registrar’s use of the pronoun ‘we’. It could refer to the whole team, but the whole team would not be involved in getting Bill up in the morning. Thus, “we” is probably a rhetorical move to create an image of solidarity in the group.

66 In an entry in the nursing record the day before, the occupational therapist wrote that Bill lacked interest in working with computers and that Bill had difficulties in pointing out what else to do. This entry was, however, not read out by Nurse 3 in his reading of the record, which was focused on progress.
negotiation of the nurses’ professional accountability. The general point is that the negotiations of the patient were often shaped by forces external to the patient’s situation and that descriptions could be related to several categorising distinctions simultaneously.

2.1 The general language use and representations of the patient on the wards

There was a socially significant difference between the uses of language at the two wards: this difference was in particular related to the use of narratives, metaphors, speech reports and the references made to conceptions of mental disease. The language used at Ward A was less distancing and objectifying compared with Ward B. A narrative format was used at both wards. At Ward A both medical and non-medical staff would account for the patient’s and their own actions using narratives. At Ward B this was only done by the non-medical staff. Medical staff would describe the patients’ as cases, which would rhetorically accentuate a distanced objectivity towards the described and reduce human agency, cf. (Anspach 1988; Good 1994). The use of metaphors was more pervasive at Ward A compared to Ward B. Metaphors were in general used to describe the treatment, in particular giving it ‘direction’, or to describe some patients according to staff members’ perception of problems. Not all patients were described using language rich on metaphors; recurring metaphors were related to ‘weight’, ‘hidden/hiding’, ‘fragility’ and ‘container’. A patient could initially be described as autistic by means of hiding-metaphors, and weeks later, when staff experienced problems motivating the patient to participate in ward activities, he or she could be described as dead weight, hard to move in any direction. Metaphors were used to convey an experience-near understanding of the patient’s problem and imply the set of actions needed to counter this problem or to acknowledge the frustrations related to the problem, cf. (Rhodes 1984). The patient’s speech and thoughts were reported by means of indirect speech representation at both wards. Indirect speech creates a fundamental uncertainty about whose voice is reported. At the wards (extra-linguistic) ‘account markers’, such as copying the patient’s tone of voice, would frame the voice heard as the patients subjective voice but this did not resolve the fundamental uncertainty. The use of direct speech was common at Ward A but almost non-existent at Ward B. The use of direct speech rendered the impression of authentic representations and made the linguistic performance livelier because the patient’s voice was marked mostly by a shift in the tone of voice. Morally loaded conceptions of mental disease were very frequent at both wards: they were conveyed through an informal use of technical terms, ‘as he surely is PD [personality disorder] we should not expect to cure him here’, which to a certain extent disguises the informal evaluation inherent in the statements. At Ward A there were also frequently informal evaluations drawing on lay conceptions of mental illness, ‘her Mum is also a crazy’.
The differences between the uses of rhetorical devices at the two wards were probably contingent on the general tenor set out by the consultants. The informal use of language was a way of creating common ground for discussion and confirming solidarity across professional boundaries, cf. (Barrett 1996). Thus, the informal language use was contrary to the hierarchical differences between the professions (re)-enacted through the turn take systems.

**Discussion**

The predominantly silent clinical nursing staff at Ward A and the seemingly disinterested medical staff at Ward B can be interpreted as related to the same ‘discursive disorder’. Wodak describes ‘disorders of discourse’ as a lack of understanding caused by differences between actors’ cognitive worlds reflecting different social practices (Wodak 1996). The division of labour at the mental health hospital creates distinctly different experiences of mental health practice (Barrett 1996). Clinical mental health nursing practice is mostly situated in face-to-face interaction in everyday situations. In their clinical practice, nursing staff would mostly contribute with accounts of everyday events and concerns. Representatives of the formally more specialised treatment regimes usually experience patients in conversations segregated from everyday life at the wards, for shorter durations of time, and often with specific institutional purposes, such as diagnosing or evaluating treatment. This meant that the team members had different thresholds of relevancy concerning what to account for and what problems to discuss: This problem was expressed by many participants at the conferences, everybody seemed bored because they did not get the kind of information they felt they needed, cf. (Opie 1997a).

The analysis of the turn-take structure of the conferences shows how medical staff members dominate the discussions through their interactions and the process of interpretation at the conferences, and the result does not resemble a ‘team narrative’ as identified by Opie (Opie 1997a). According to Opie team narratives are characterised as being the sum of all of the team-members’ attempts to create an account of the patients’ situation. Quantitatively, the larger part of the discussions at the conferences was medical staff members accounting for the patients’ situation in mutual discussion or in discussions with the non-clinical nursing staff. Medical staff members translated the accounts of clinical observations with and into an overall medical model of an anticipated trajectory from clinical appearance via diagnosis to treatment plan (Hunter 1991). Descriptions of events, actions and plans were (re)classified through the interactions to fit into this overall anticipated trajectory of the patient’s situation, which is a less collaborative type of sharing and negotiating clinical knowledge than Opie observed.
Barrett interprets the continuous medical workup of common sense accounts as part of an institutional refinement of common sense ideas about mental health illness and their transformation into scientific concepts (Barrett 1996). This observation is to a large extent supported in this study but Barrett’s analytical focus is on showing the interdependency between psychiatry and cultural notions of mental disease. Thus Barrett does not sufficiently acknowledge the professional skills inherent in the transformation of commonsensical observations. Barrett’s argument could suggest that the informal and colloquial use of language reflects common sense notions of mental disease and that these notions are nothing more than re-phrased in the construction of the patient as an institutional ‘case’.

At the conferences, the anticipated trajectory of the patient’s overall medical situation served as the implicit interpretative framework and therefore for the transformation of observations accounted for in plain language into psychiatric, scientific concepts. The anticipated trajectory framed the topics and purpose of the discussions in the sense that the medical staff would discuss specific problems relevant to this trajectory and dismiss others. In this sense the turn-take systems re-produced discussions promoting medical interpretations. Therefore, in order to understand the structure and content of the discussions, prior knowledge of medical trajectories was needed and, further, knowledge about the patient was needed in order to grasp implicit and obvious clinical knowledge. However, the trajectory was predominantly implicit and the discussions were mostly without explicit conclusions, cf. (Atkinson 1999; Opie 1997b), and, further, informal descriptions of the patient’s idiosyncrasies would make it hard for the neophyte participant at the conferences to distinguish between, on the one hand, sharing lay, common sense observations and, on the other hand, specifically adding and fitting clinical knowledge to the trajectory. Thus, the implicit trajectory was a central constituent in the disorder of discourse.

The relationship between the anticipated trajectory and the images created was one of mutual confirmation. The anticipated trajectory introduced and accentuated certain classificatory distinctions creating specific images of the patients which could serve a range of different purposes: as an argument for giving a certain treatment, as an argument for discharge, as disclaiming professional responsibility, etc. During a conference, patients were classified along a number of classificatory distinctions according to the purpose of the discussion. The wards had a low turn over and a high proportion of re-admittances. This meant that most patients were already classified as specific mental health hospital cases, and their situation and appearance well known to the team. A lot of the fact-construction concerned fitting patients into a previously documented trajectory rather than categorising them for the first time.

This analysis showed how descriptions of patients are contingent on the organisational structure of the interdisciplinary team conferences by analysing differences and similarities
between the conventions for language use identified at the two wards. Conventions for language use at these wards may differ from other interdisciplinary conferences at mental health institutions. Differences may be influenced by factors such as: the division of work, the structure of the institutional hierarchy, the purpose of the conference, the type of patients, dominant personalities, etc. However, the impaired understanding between different professional groups caused by different everyday practices is potentially present in all interprofessional conferences and, as it has been indicated, the negotiation of the patient’s situation occurs along these lines of conflict. Further, there were differences between the conferences at each of the wards related to who was present. The ward nursing managers at both wards were only present at one of the transcribed conferences. At Ward B the junior registrar responsible for treating several patients was not present at either transcribed conference, which resulted in a lot of questions by the consultant trying to reconstruct the cases, of which she had no firm knowledge of. However, these absences were not unusual at the wards and they did not influence the overall structures as they are described in this paper.

In order to enrich the exemplary value of the study, a longer data extract was included in the paper demonstrating in detail how the analysis took the contextual, sequential and interactional dimensions of fact-construction into account. The data extract allows the reader access to a limited part of the researcher’s grounds for interpreting the production of clinical facts at the conferences, which in turn was the ground for arguing that clinical facts and trajectories are mutually constitutive. Parts of the premises for the interpretation of the presented texts could not be accounted for explicitly here, because many contextual insights, such as intonations and their private references, are part of the researcher’s experience during the fieldwork.

**Conclusion**

The analysis shows that the construction of clinical knowledge at the treatment conferences was highly conventionalised and controlled by an overall medical approach to mental disease. The clinical knowledge worked up was produced in line with an overall medical trajectory but at the same time categorisations would be contingent on smaller interactional exchanges during the conferences. The interactional exchanges at the wards did not lead to the production of collaborative team narratives consisting of synergetic insights from the different professional groups; rather, the conferences re-enacted the professional hierarchy at the wards.
Chapter 7. Mental health nurses negotiating clinical knowledge

Introduction

Mental health nurses are in their everyday practices continuously engaged in verbalising their clinical experiences. The nurses’ accounts are important to study as they are part of the overall institutional production of clinical knowledge and because the accounts externalise and objectify the nurses’ consciousness about their practices and warrant their professional accountability.

The bureaucratic administrative practices in mental health institutions produce abstract, textually mediated knowledge about their inmates (Smith 1974); and the overall institutional production of clinical knowledge is contingent on the gendered division of labour at a given institution, as the different professional groups contribute differently to the institutional production of clinical knowledge (Barrett 1996). Mental health nurses’ work is mostly concerned with activities that resemble everyday life, such as preparing and participating at a meal, watching and discussing the news on TV, going to a shop with someone. Such activities involve the ability to be frequently disrupted and to multitask by paying attention to and acting towards several things at the same time. These practices are concrete and mental health nurses struggle to translate their experiences of them into a fully abstracted bureaucratic administrative discourse; mental health nurses’ descriptions of clinical experiences reported in speech and writing retain many of the particularities of daily life (Chapter 4 and Chapter 5). Through practices of interprofessional collaboration some of the nurses’ descriptions are made available for further negotiation and abstraction among medical staff members whose practices are positioned ‘higher’ in the institutional organisation (Chapter 6). Compared to the mental health nurses’ work, the organisation of medical work, including scheduled meetings and already partially textually abstracted cases, ease the translation of everyday experiences into a conceptual mode of organisation, cf. (Smith 1987). Thus, even though mental health nurses do not produce abstracted clinical knowledge their descriptions will add to the overall construction of the patient as an abstracted “case” (Barrett 1996).

In addition to the division of labour, mental health nurses’ production of clinical knowledge is conditioned by a number of influences. First, several frames of understanding mental illness, ranging from formal, ‘textbook’ discourses on mental health to informal, lay conceptions, privilege certain observations and experiences of the clinic; these frames of understanding intersect and overlap in everyday clinical practices (Chapter 4, Chapter 5, and
Chapter 7

Chapter 6). Second, clinical practices are influenced by technologies, such as the recording system (Chapter 4), whiteboards (Heartfield 2005), and models for documentation (Latimer 1995). Technologies inform clinical practices, and, thus, the production of clinical knowledge, through their material and social constraints. Third, representations of clinical knowledge are constrained by the local conventions for appearing professionally accountable. Professional accountability is accomplished when the nurses actively link clinical knowledge to abstract conceptual systems (Smith 1987, 161), but also, and foremost, when the nurses, be their actions, continuously display the coherence and practical rationality of the concrete production and negotiation of clinical knowledge, cf. (Garfinkel 1984 [1967]). This means that the nurses must represent their clinical knowledge according to the locally situated conventions for what to represent, when to represent, and how to represent their clinical experiences. The production of clinical knowledge is, therefore, always informed by the organisation of social processes constraining which representations of the nurses’ clinical experiences can be regarded as conventional clinical knowledge.

Empirical research into mental health nurses’ contribution to the overall institutional production of clinical knowledge is limited, arguably because these practices belong to the informal and everyday realm of the mental health institutions. However, a related research topic is the study of clinical decision making which is typically related to specific areas of conflict, such as aggression (Lowe 1992), restraint (Marangos-Frost & Wells 2000), or ethics (Lützen 1993). Nurses are often, in this line of research, asked to account for their actions post hoc and studies are therefore indirectly adding to an understanding of the limits of mental health nurses’ professional accountability and the related production of clinical knowledge. Conversely, the study of the production of clinical knowledge would shed light over the ways in which decisions are accounted for.

The objective of this chapter is to create a synthesised understanding of the interrelationship between the social organisation of the mental health nurses’ daily practices and the nurses’ production and distribution of clinical knowledge. The first part of the chapter is concerned with ‘the game of clinical knowledge’: an analytical concept construed to describe clinical knowledge as a central currency in the social organisation of the wards. The second part of the chapter is concerned with the continuous communication at the wards. These communicational activities were not described thoroughly in the detailed analysis in the previous three chapters; however, the descriptions of continuous communication were important elements in pulling together the analyses of the field. The third part of the chapter pulls the analysis together round the theoretical concepts presented in Chapter 2, notably Fairclough’s concept of ‘order of discourse’. The fourth part of the chapter is concerned with an evaluation of the credibility and validity of the study.
Part One: The game of clinical knowledge

This analysis was a further interpretation of findings from Chapter 5 in which it was indicated, that the shared knowledge about the patient was dependent on the informal status of the speaker rather than on the most updated information available, and that the nurses often did not possess explicit and concise knowledge about the patient.

The analysis drew on data from the entire fieldwork: collected documents, audio recordings of meetings, informal interviews, and fieldnotes written in relation to participant observation. The previous three chapters emphasised detailed analyses of documents and audio recordings; they were supplements to this chapter’s qualitative analysis of the fieldnotes (the specific strategies for participant observation and for writing fieldnotes are described in Chapter 2 above).

The analysis was organised round the metaphor: ‘the game of clinical knowledge’. Miles and Huberman point out that metaphors – used for working up meaning in a data set – can, if they are not the informants’ or are formulated too early in the analytical process, open up theoretical perspectives and pull together diverse bits of information (Miles & Huberman 1994, 250-252); and that the ‘game’ metaphor stimulated an analysis of the characteristic dynamics of the situated practices of producing and distributing clinical knowledge among the nurses.67

Theoretically, ‘the game of clinical knowledge’ combined a constructionist emphasis on the situated and locally negotiated character of knowledge (Gergen 1985) with interactionist notions of how this production and negotiation of knowledge is socially managed in face-to-face interactions by the participants (Goffman 1990 [1956]). Thus, the analysis of clinical knowledge was concerned with how the nurses – through interactions – display having clinical knowledge or being in the know. Thus, in the analysis of the game of knowledge, an analytical distinction was drawn between ‘having knowledge’ and ‘knowing’; to have knowledge was to express concise knowledge of a present clinical situation; to know was to express knowledge of previous or general clinical situations resembling the present situation. The analysis will be summarised below as four facets of the game of knowledge.

Facets of the game of clinical knowledge

The first facet of the game of clinical knowledge arose from an analysis of the field research diary and was concerned with the fieldworker’s experiences of physical positioning in relation to the production and distribution of knowledge. First, a substantial part of the research

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67 The actual phrasing of the concept was inspired by Rhodes’ ‘’The game of hot shit’’, which was used to describe an admitted patient as a ‘hot potato’ which the different parts of the psychiatric health services would ‘gamble’ over in an effort to avoid that the patient was admitted to their unit (Rhodes 1995, Chapter Three).
took place in the ward offices, because the majority of the nurses’ mutual communication took place there. I would position myself centrally at a table in the office and try to blend in by writing in the same manner as nurses writing records. However, even though I sat right next to nurses engaged in talking I had difficulty hearing what they said. This observation was confirmed by other newcomers at the wards: it was very hard to eavesdrop even if one was clearly within earshot. The problem of hearing vanished later in the fieldwork when I became a participant in the conversations. Second, being situated in the office created a certain coherent picture of the ongoing discussion among the staff. As soon as I started to follow individual nurses during a shift this picture was challenged by a different image of debates at the office as more fragmented because each specific nurse would only intermittently take part in the ongoing debate. Third, I would arrive at the wards at different times during a shift and I experienced difficulties in getting a grasp of ‘what was going on’ if I was not given an up-date from the nurses or could listen in on a handover.

The analyses of these three sets of experiences led to the general observation that the communicational exchanges at the wards followed certain ‘channels’. Understanding the communication conveyed along the channels presupposed knowledge of the specific genre of clinical talk as well as knowledge of the specific clinical object being discussed. The debates were only coherent to the informed participant, and in the beginning I regarded the debates as incoherent listings of idiosyncratic knowledge, see Chapter 4 about cohesion and coherence in the written texts. The channels were also very much directed towards the specific participants; voices at debates were adjusted to the specific audience. It took skilled practical knowledge to create and form the communicational channels through which clinical knowledge was produced, distributed and negotiated. There were only a small number of formal forums for the exchange of knowledge and therefore the nurses had to interactively negotiate the beginning or continuation of informal discussion. Therefore, the observations during the fieldwork were focused on when and how people got in and out of conversations about the clinic, cf. (Sacks 1995).

The skilled practical knowledge of engaging in the production, negotiation and distribution of clinical knowledge was the first facet of the game of knowledge. In every shift specific members of the nursing staff had a particular responsibility for a certain group of the patients. However, nurses were continuously engaged in working with patients for whom they were not directly responsible for: sometimes because they had spontaneous contact with the patient, other times because they had an opinion about the patient that they wished to share. The nurses would continuously link up in different groups in the offices and share and negotiate clinical knowledge. These small interactional exchanges were pursued actively by the nurses, who would engage in the debate of certain clinical issues; they understood how to multi-task by being engaged in practical patient-related work as well as initiating, seeking,
and/or participating in intermitting discussions with other nurses. There were different roles for participating in these debates: one role was to actively initiate and engage in an (intermitting) clinical issue; a second role, often taken by some of the relatively experienced nurses, was a more passive pursuit of the discussions. These nurses were, however, continuously updated and involved by others when significant changes happened in the clinical situation or when explicit decisions were taken. A third role was not to participate actively in the debates and only to be involved in decisions on a need to know basis.

Influencing the overall decision making processes and having access to clinical knowledge was a sign of experience and status. The informal hierarchy was in part negotiated along these lines of exchanging and producing knowledge and the positioning was in part dependent on the individual nurse’s skilled ability to engage in the processes of negotiating and producing knowledge.

Access to clinical knowledge and an active participation in the clinical production of knowledge was a sign of status on the wards. However, the second facet of the game of knowledge was related to displaying prior knowledge of clinical situations and this type of ‘knowing’ could be used to reverse the status related to having knowledge of the present, clinical situation. The nurses frequently told stories and anecdotes about the patients in relation to prior admissions, about common (comical or dangerous) experiences, about the hospital, and about one another. Depending on the social context, a description would be told for amusement, mutual devotion, confirming notions of good clinical practice, etc. Some of the nurses had taken care of some patients during repeated admissions for decades and often since the patient was hospitalised the first time. An exchange summing these points up in a nutshell was given in relation to an informal handover between two nurses:

Nurse 1: Tim Olson has been re-admitted
Nurse 2: is he psychotic or has he attempted suicide
Nurse 1: he’s psychotic
Nurse 2: o.k.

This short verbal exchange is the handover given to ‘Nurse 2’ and it is an example of a powerful display of already knowing. A further general characteristic related to ‘knowing’ was the reduction of clinical knowledge given; in the exchange, Nurse 2’s display of already knowing closed the conversational topic. In effect, ‘knowing’ often meant ‘knowing sufficiently’.

Nurses who had worked at the hospital for many years would occasionally tell experience-near stories about the first admissions or about the patient’s family; what was more,

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68 Nurses would refer to ‘old’ (an old hand at the job) and ‘new’ nurses and in some situations explicitly ask for an ‘old’ nurse to discuss difficult situations with or complain if there was only one ‘old’ nurse working in a difficult shift.
this knowledge was often not even available in the medical record. In many situations the experienced nurses had knowledge of treatments that had been unsuccessful and they would be reluctant when such treatments were planned again. Anecdotal knowledge would be pre-faced by statements pointing to the past, for example: ‘before you started here William made friends with another patient who took her own life’, ‘one of the first times William was here in the early 80s we saw his mother (.) she was a fine looking woman’. Displaying such knowledge had a very high status and was part of the continuous negotiations of the informal hierarchy. This aspect of the negotiation of knowledge subverted the formal professional boundaries within the group of nurses: status was not just related to formal education or having clinical expertise, but also to ‘knowing’ the history of the ward and the clinic. This second aspect of the game of clinical knowledge supported notions of mental health nursing as relying on personal qualities that take many years to work up.

The third facet of the game of knowledge was related to the re-distribution of knowledge or when ‘knowing’ was displayed as ‘knowledge’. As described in Chapter 5 nurses with a relatively high position in the informal hierarchy could repeat truisms about a patient they had had no news about for several days. This observation was evident in relation to two full weeks of field observation on the wards, which allowed me to follow a certain group of staff members’ verbal negotiations of their experiences with the patients, including their written recordings, and to observe how these nurses’ concerns could become non-existent in the following shift in which the nurses could explicitly conclude that nothing special had happened to the patient and that there was nothing to be concerned about. Occasionally, such statements were given by nurses who did not even read the record. In Chapter 5 this facet of the game was linked to the nurses’ descriptions of the patients’ situation, which were related to present experiences rather than longer trajectories through illness and disease. A forceful member of staff was able to repeat a description simply by fitting it to his or her latest experiences. Often the re-distribution of clinical knowledge emerged because the latest available knowledge was short and ritualised statements (see Chapter 4). In these situations the nurses chose to draw on previous personal experiences to describe the patient’s supposed present situation, such as: [Monday morning] ‘well he’s had a good weekend (.) Friday we had a long talk about visiting his flat (.) and he went home Saturday’. This facet of the negotiation sometimes evolved into almost ironic situations:

The display of ‘knowing’ and the negotiation of informal positioning would not always concern knowledge about patients. Stories and anecdotes would also display knowledge of each other: ‘once when Jack was still a student nurse here [seven years earlier] his mother called us to find out where he was’. Stories and anecdotes would not only re-enact the hierarchical positions among the nurses. Stories also confirmed the nurses’ care for one another and often the stories were about difficult situations they had gone through together. Furthermore, displaying clinical knowledge in stories and anecdotes would also function as interprofessional boundary-work: problems in the collaboration with physicians or external collaborators would confirm the nurses’ unity against ‘the insensitive others’.
At a handover in the afternoon the reporting nurse (RepN) found out that nothing had been written about the patient and she ‘knowingly’ framed the patient’s situation as ‘progressing’, and explains about physiotherapy and a surprising goodwill from the patient in relation to seeing a community mental health nurse after discharge. An ‘evening’ nurse (EN1) asks the reporting nurse to write this information in the record which was soon questioned by another evening nurse (EN2):

EN1 could you write something about that  
RepN I can write it just after (.) year (3.0) well  
EN2 its already there (.) I’m not playing you (1.0) for a fool but I wrote that (.) a week ago  
RepN did you  
EN2 yes  
RepN well done Sue  
EN2 yes (3.0)  
RepN was that (.) when you sat and talked with her and made some arrangements  
EN2 yes  
RepN yes  
EN2 exactly

This small exchange illustrates how old knowledge is re-distributed and only by a mere coincidence questioned by the audience. In spite of being exposed as repeating week old knowledge as if it were new, the reporting nurse tried to save face by displaying her clinical knowledge of the patient’s situation by referring to the concrete episode, where the evening nurse and the patient made arrangements. In other words, she knew how to manage the social uncertainty and embarrassment in the game of negotiating knowledge appropriately.

The fourth facet of negotiating knowledge and knowing was related to not-knowing. The previous three facets of the game were concerned with the practices of producing, distributing and displaying knowledge to position oneself; the opposite of these practices, the thing to be avoided, is not to have knowledge and, thus, to loose ‘face’. The analysis of interdisciplinary conferences (Chapter 6) showed how the nurses were often unable to answer direct questions about the clinic posed by the physicians. The initial interpretation of this inability was that they were the result of disorder of discourse: that the nurses did not know answers because the questions were posed in line with a medical discourse. However, the continuous analysis showed that the nurses used the same evasive strategies in their mutual communication and that there were only very rarely interrogative debates about the validity of the knowledge produced and distributed. It was a difficult task to perform an empirical analysis of a non-existing object and the non-existing was mostly identified through inferences from evasive answers as the following demonstration of an analysis of a data extract will exemplify. The following extract is from an afternoon handover, where Kim was hand-
ing over a report on Sue to Jack and Jenny. Kim, Jack and Jenny were nurses and they all had previous knowledge of Sue and her situation.

Kim  [...] then there’s Sue ((yawns)) Kurtz (2.0) well she’s has all her duties today (.) ((sighs)) (.) she has vacuumed down there >I can’t find her< there she is yeah she has hovered and then she’s been to her classes (.) examined in (.) Dickens (7.0) yes (.) has followed her plan German cleaning and electronic data processing she has done a little EDP before at the Fellows School (.) from where she remembers bits and pieces (.) she’s tried using a program for drawing before (.) and then Sue tried patience ‘n’ stuff (.) it was hard for her not so much to control the mouse but you know understanding [ (.) and=

Jack

Kim = finding out what the game was all about [(1.0) so:: (.) but she’s been active today she=

Jenny [yes

Kim = is really devoted when she hovers down there n such >anyway< I think its smashing its wonderful she’s doing all those things [ ]

Jenny [it’s good she’s got something for=

Kim = sure [ ]

Kim [yes [ ]

Jack [what about her m:: hallucinations

Kim her what [ ]

Jack [her voices(1.0)

Kim really there’s been nothing today [ ]

Jack [no (1.0)

Jack [there was a period last week where ]

Kim [I also think it changes (.) a bit some times you know she can have some evenings where she screams and is completely >don’t you remember< when we had an evening shift [ and she (.) and then: sometimes during the day where she seems you=

Jack [m::

Kim = know (.). as if she’s not so harassed

Jenny she cages herself in a lot so it’s hard to know[(.) e: [ ] [ ] [ what’s hidden (3.0)

Jack [m:: [ ]

Kim [yes [ ] [yes

Jack [yes

Kim starts the report with an introduction about Sues doings while she searches for the record, hence the meta-communicational remark “can’t find her”. The actual reading of the record begins after the long break (7.0) in line 3 and stops at the discourse marker “so::” (line 9) which indicates a shift. The shift includes a repetition of the account about Sue cleaning but also informal and personal evaluations of this through the adjectives “smashing” and “wonderful” (lines 11-12). These assessments are agreed on by Jenny, who downgrades the adjectives to “good” in the second assessment. At this point, line 16, Jack asks about “hallucinations”, which is a formal and technical word. Jenny’s answer is a repair initiator; where Jack repairs by re-wording the question from “hallucinations” to the less technical word “voices”. After a small delay Kim denies that Sue has had problems with
‘voices’. Jack’s answer “no” (line 20) is interpreted as a request for repair by Kim; the delay after “no” is interpreted by Jack as a request for repair: a qualification of the reasons for his initial question. They start to talk at the same time and Jack repairs the overlap by leaving the floor to Kim. Kim states that Sue’s condition varies and refers to some common experiences with Jack (line 22-23), which Jack acknowledges (line 25). The sequence ends with Kim giving an explanation for ‘not knowing’ by proposing a metaphor of Sue as a lockup area into which the nurses have no access (line 27). This metaphor is agreed on by the others, creating a unifying solidarity, and the topic is closed.

The interactions performed in the extract followed the conventional pattern of handovers: the floor was pre-allocated to the nurse handing over and she read the written record aloud without interruptions, cf. Chapter 5. Jack posed his question about hallucinations after the reading had ended. However, Jack’s question for information projected a straightforward answer, but this is not given. The answer was prefaced by an initial repair initiator “her what” and a small delay – approximately one second - before denying voices. These are typical features of giving a ‘dispreferred answer’ (Heritage 1984;Pomerantz 1984). Further, Kim turned to Jack with a question projecting an affirmation about remembering a common experience, which he acknowledged, and reflections on Sue’s general behaviour. The design of the answer protected the face of Kim through an answer which involved the accountability of Jack and the presentation of general knowledge about Sue. The presentation by Kim thereby diminished signs of explicit doubt about the observations, Kim saves face. Further, solidarity in the group was confirmed through the reference to common experience and through agreeing on the metaphor on Sue as “hiding”, provided by Jenny. The successful management of the dispreferred and an achievement of solidarity were orchestrated jointly by all three nurses.

Kim played the game of knowledge very well, saved face, and succeeded in talking about the general difficulties and experiences about Sue. It is not possible to decide whether Sue has hallucinations or not, or whether Kim has present clinical knowledge about Sue’s mental condition; however, the pattern related to Kim’s answer was interpreted as indications that she did not possess the exact knowledge to give a straight answer to Jack’s question. Situations like the one described here were common at the wards but only rarely did they lead to a loss of face or dangerous situations.

The general conclusion in relation to ‘the game of clinical knowledge’ was that a central part of the production of knowledge was contingent on social interactions of ‘knowing’. Both the access to the channels of production and negotiation of knowledge and the negotiation of knowing were practical skills, and, further, that negotiations of knowing were central parts of displaying solidarity and positioning within the informal hierarchy. Thus, the con-
clusion supports a rejection of a realistic view on mental health nursing knowledge as passively reflecting reality and, further, places an emphasis on the contingencies between clinical knowledge and the nurses’ practical interaction rather than on the individual nurse’s ability to represent and make sense of his or her clinical experiences.

‘The game of clinical knowledge’ was influenced and sustained by the particular social organisation on the wards. *First*, the nurses’ interactions with the patients were continuous during a shift and therefore the need for mutual negotiations and production of knowledge would arise continually. *Second*, the nurses worked in (changing) shifts which meant that no one would work through for longer periods of time. *Third*, the records would add permanence to the knowledge described there, this permanence would further be accentuated by the organisation of the handover. *Fourth*, the knowledge needed to provide good care for most psychiatric patients need not be exact or extensive. These four characteristics about the social organisation on the ward mean that the negotiation and production of clinical knowledge would be influenced by clinical knowledge with different ‘ages’ and different ‘speed’. Therefore, the production of knowledge would not follow a pattern of continuously adding to the most up-dated knowledge, but rather be united and dispersed through the particular social organisation, including the social dynamics of ‘the game of clinical knowledge’.

The next section is concerned with the continuous daily communication among the mental health nurses; this part of the nurses’ communication is an important element in the overall analysis of the nurses’ communicational practices.

**Part Two: Continuous clinical talk among the mental health nurses**

This part of the synthesising chapter of mental health nursing practices is concerned with the nurses’ production of clinical knowledge in their everyday communicational practices. The analyses presented in the previous three chapters were mainly made on the basis of data from recurring and formalised happenings. A common denominator of the studies was that, when access to the contexts was negotiated and granted, it was possible to collect and construct very detailed data of the language use through photocopying the written records or transcribing audio-recordings from the meetings. However, a central aspect of the nurses’ communicational practices was the continuous, everyday talk among the nurses outside the more recurring and formalised events; these communicative practices could only rarely be captured in audio-recordings, because the nurses’ discussions were fragmented in time and space: debates could be intermittent and take place in different parts of the ward. This part of the nurses’ communicational practices will be referred to as ‘continuous’. The following descriptions and analyses of the nurses’ mutual continuous talk in the wards are primarily based on the relatively less detailed data from the fieldnote-recordings and secondarily on
data from the detailed data from the audio-recordings of the informal parts of the handovers. Because of this specific character of the data it was not possible to deploy all the analyses of language use suggested by Fairclough; it is not reasonable, for instance, to analyse the grammar of spoken language after a transcription by means of fieldnotes because the linguistic complexities were not described well enough.

Conditioned by the overall research question data was divided according to whether or not the data described nurses engaged in the production of clinical knowledge. Therefore, the following analysis disregards the parts of the nurses’ talk that did not directly or indirectly refer to the clinic. Examples of non-clinical talk would include nurses talking about their children, how annoying it would be to bicycle home in the rain, how many minutes the tea should draw in order to be perfect, etc. The distinction between clinical and non-clinical topics is not discrete, as many references to the clinic only appear implicitly or as part of non-clinical discussions. A mundane example of this was a couple of nurses who teased a male colleague because he accidentally happened to record a clinical encounter between himself and a patient as a situation where the patient mistook the nurse for “a man” rather than for ‘her husband’, “everybody could make that mistake” the nurses jokingly remarked. Here, even though teasing is at the forefront of the social interaction between the nurses, knowledge about the patient was redistributed. The clinic was continuously described through the staff members’ communicative interactions, which were not specifically concerned with producing or distributing clinical knowledge.

In general, an informal everyday language was used for the continuous clinical talk: the words were words ‘everybody’ would understand, however, some words held specialised connotations, see Chapter 4. Continuous clinical talk was experience-near and referred mostly to everyday situations: the situations were situations everybody would understand, for instance debating, joking, telling stories, gossiping, sounding alarms etc. The nurses’ informal talk could relevantly be categorised using a range of theoretically informed, linguistic and social parameters such as the structural organisation of the statements, the turn-take systems, different linguistic registers etc. The following four categories of continuous clinical communication in the clinic were identified by analysing and comparing the coherency and cohesiveness of the nurses’ expression of clinical knowledge, cf. the analysis of records in Chapter 4. The four categories – one-liners, converse statements, narratives and affirmative debates – are not mutually exclusive as a converse statement can be part of a narrative and a narrative part of an affirmative debate.

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70 “The clinic” was conceptualised in the widest sense as whenever any object related to the clinic appeared directly or indirectly as a topic in the nurses’ talk.
The first category was the one-liner which resembles the written ‘single statement’, see Chapter 4. A one-liner was characterised by a short and telling expression about a clinical experience. An example was a nurse, who entered the ward-office and exclaimed “there are spiders on the ceiling in room four”. After a short pause a second nurse sitting at the table writing replied in a dry tone of voice: “We’ll have to find a broom then”. Nothing else was said and the first nurse left the office shortly after a quick glance into a medical record. A correct interpretation of the statement relies on the interpreter’s ability to ‘fill the indexicality’ (Garfinkel 1984 [1967]): the spiders are not real but part of the patient in room four’s hallucinations. In this sense, the ability to link the statement with a prior knowledge of the patient’s particular situation allows the second nurse to interpret the description as a metaphor for hallucinations which is acknowledged in the ironic tone of voice and the concrete interpretation of the metaphorical statement. The nurses therefore display and confirm a mutual knowledge and understanding of the severity of the patient’s situation.

An explicit confirmation of a one-liner was not always given and it was impossible for the researcher to infer anything about the nurses’ more or less correct understanding of the very abridged statements. There were, however, examples of obvious misinterpretations among the nurses. Such an instance occurred when an experienced nurse on her way home entered the ward office during a handover. She took a piece of paper hanging on the whiteboard, waved it at the evening staff nurses without saying anything, before leaving with the paper in her hand. After the handover, the nurses had several physical struggles with a newly admitted patient who ran back and forth in the corridor trying to get out the front door whenever anyone tried to enter or leave the ward. The patient’s aggressive and “door-seeking” behaviour came as a surprise for the evening nurses and they had to raise the general alarm during a struggle at the door. It later turned out that the piece of paper that the experience nurse waved was a pre-printed notice for the entrance door telling all arriving people to use the doorbell and wait for assistance before entering; the experienced nurse explained the next day that she regarded waving the sign as an unequivocal message to the evening nurses about the patient’s behaviour in the corridor. None of the nurses the day before interpreted her waving this way and they lost control over the situation.

The examples of one-liners point to a more general feature about continuous clinical talk. The communicational situations were definitely everyday situations, such as telling a one-liner or signalling by waving a sign, but a correct understanding of the one-liners and signals presupposed prior knowledge of the particular situation. Obvious misunderstandings were signs of nurses’ inability to fill in the indexicality correctly, but mostly it was not pos-
sible to decide to what degree one-liners were generally correctly understood, because there were no verbal exchanges or actions unambiguously displaying such understanding.\footnote{Further, confirmations of one-liners could also be interpreted as the participants’ confirmations of the situation they were told in rather than the one-liner itself. For instance, a patient was jokingly described as: “he’s a one off” [“ham går der ikke 12 af på et dusin’] and everybody present laughed; however, when the nurses were asked afterwards they could not explicate the actual point of the one-liner (because the Danish expression is not very common): their laughter confirmed the situation rather than the literal or metaphorical meaning of the one-liner.}

The second category was \textit{the converse statement}, see chapter 4 for further definitions. A converse statement was, like the one-liner, not necessarily part of longer conversational exchanges. It differs from a one-liner by linking two statements qualifying one another which make the intended meaning of the statement more concise: ‘Henry was a pain to get out of bed this morning but I succeeded by shaking the bed’. Using one-liners or using converse statements was often associated with clinical status. This was because it displayed the practical ability to sum up clinical knowledge in a short and telling expression. Further adding to a sense of shared clinical understanding was that interpreters understood the meaning of these short expressions.

The third category of clinical communication was telling stories about clinical events. Stories were organised by a turn-take system that allowed the story-teller to tell the story without being interrupted. These clinical stories always worked at two levels of social significance: First, the story organised the storyteller’s experience into a sensible narrative order, and, second, the telling of the story had a social significance among the nurses, such as entertaining, gossiping, arguing, as part of social positioning or interprofessional boundary-work, etc. Stories could be re-told by different story-tellers, told by several storytellers, or told among nurses who all already know the story. The longest stories took more than 15 minutes to tell and the shortest were clinical anecdotes. The following situation was recorded by means of fieldnotes.

In the ward office all the nurses are gathered round a table for the morning coffee break where a couple of them talk about a patient, Tom. Tom was a schizophrenic patient, who had just been discharged. “Lisa, couldn’t you tell us the one about you and Tom?” Lisa tries to avoid telling the story but begins to tell about a day where Tom approached her and asked: “Excuse me, can I ask you a question?” “Yes of course.” “Are you a herring?” Everybody laughs and Samantha starts to tell a story about a psychotic patient, Lynn. The patient had recently had extensive plastic surgery done in connection with treatment for a serious cancer disease. Samantha says that Lynn looked at Samantha’s name badge and asked if she was Samantha Fox. Samantha answered that she wasn’t and Samantha had laid her hands on her own breasts and explained that it was possible to have them made bigger. Everybody laughs loudly (Samantha does not have a bosom comparable to Fox’s). A student, George, starts to
tell a story about Lynn in the same humoristic tone as Samantha. George had walked with Lynn and she had referred to her body and body parts as artificial. George quotes Lynn several times for saying “I have an artificial body” laughing more loudly after each turn. George is the only one laughing and eventually there is a complete silence at the table. The silence is broken by Lisa who asks about the prospects of discharging a patient before noon.

This event is informally structured and the mundane story-telling round the table begins with a suggestion to Lisa about repeating an old, amusing happening on the ward. The story is known by most of the nurses present but it is socially significant as it is very telling about Tom and socially appropriate to repeat at this specific moment as the situation is relaxed and humoristic. The humoristic tone is succeeded in the following story about Lynn and Samantha. The student nurse has a good understanding of the communicational activity (because it is an everyday situation) and he tries to continue the humoristic story-telling. However, the student nurse does not create an acceptable plot and the humoristic situation ends abruptly in a period of silence. This silence can be interpreted in relation to the embarrassment created by the student’s misjudgement of what could be humorous in the situation as well as in relation to the unspeakable severity of Lynn’s cancer-disease.

The fourth category of clinical communication was affirmative debates. The affirmative debates had several turn-takes related to the same clinical topic or experience but without interrogating or seriously contradicting the previous statements. An illustrative example was when a group of four nurses sat in the ward office relaxing and joking. A story is told about one of the nurses, Lisa, who during dinner was told five times to count to ten slowly by one of the other nurses, John, because Lisa was annoyed with a patient, William, who despite serious loss of weight did not concentrate much on eating. The nurses talk very loudly and discuss that very long legs are needed in order to kick someone at the opposite side of the table. Lisa remarks that she and John were a good fit at the table because John has very long legs and Lisa just doesn’t use the space under her chair. Lisa continues to tell about William, who had complained that Lisa was after him; she had replied that she was employed to be after people – and more, that she enjoyed it. The nurses continue to talk about how difficult it was to get William to sit and eat: William had “on top of everything” only eaten one potato. “How many spoonfuls of gravy was it he needed to swallow the potato?” Lisa tells about how many times she had to drag William back into the chair and that she finally thought “bloody hell mate”. Another nurse interferes: “You didn’t say that”. “Oh no, I was just thinking, and thinking is allowed here (. ) init”. They talk about the situation where John just knows that Lisa is “exploding”. John thinks that counting to ten really helps. Lisa regards this remark as a kind of teasing and starts a friendly complaint about John being cheeky.
They begin to talk about the William in turn. “He is probably not used to having food served”. Another nurse agrees and says that his wife does not look after him unless it is in order to get new customers. “She is not at home very much because she goes to a club during the daytime”. Someone says that William had complained that the wife did not ask before going out with other men. When asked by staff, William had said that he would allow it, but that it was upsetting that she did it without permission. Someone says that William had been upset about hearing another man in the background when he had phoned home. Someone else says that William had once had been asked to take the dog for a walk when a friend visited, and when he came back the wife and the friend were dressing. After this statement there is a pause (3-5 seconds) after which one says: “Had it been a child it would have been compulsorily removed from home.” Nobody comments on this conclusive statement and all four nurses start working at something else.

‘An affirmative debate’ was characterised by an informal, everyday conversational turn-take system allowing the nurses to voice their opinion about the patient, which created a series of statements about the patient that were neither mutually exclusive nor with overall ‘pulling together’ or an obvious decision made at the end of a debate. These turns were part of the production of clinical knowledge, displaying and confirming a mutual understanding of the debated topic.

As described above, the nurses’ continuous talk was everyday language: the register was everyday and the turn-take systems were informal and conversational. Barrett also observed this socio-linguistic phenomenon and describes mental health staff as “[…] a group of sophisticates deftly using simple language.” (Barrett 1996, 96). In relation to a description of the informal communication at team meetings Barrett stated: “The lack of formal designation suggests that these important elements of clinical decision making were taken for granted and lay in the domain of common-sense reasoning.” (Barrett 1996, 95-96). However, Barrett’s argument linked and confused an everyday use of language with an informal everyday reasoning about mental disease, and it is not reasonable to infer directly from language use to modes of informal reasoning. The argument advanced in this section was relatively less ambitious: the nurses’ continuous clinical talk comprised of informal language use and this informality was used in a specialised way governed by local conventions for language use. Almost paradoxically, it took practical local knowledge to understand the everyday language use correctly and to participate appropriately in the discussions. Further, the informal structuring of the continuous talk meant that the common production of clinical knowledge was not explicitly questioned among the nurses but rather comprised of continuous listings of clinical knowledge. For the researcher it was impossible to point out instances of explicit decision making because opinions were formed and practice-related decisions taken on the
basis of these listings that had no explicit conclusions attached; however, to some extent the nurses’ clinical practice was guided on the basis of these debates.

The continuous clinical talk was a central element in the everyday production of clinical knowledge. In the next section, the practices of continuous clinical talk are compared to other linguistic and social practices by conceptualising them as part of an institutional order of discourse.

**Part Three: An institutional order of discourse**

As described in Chapter 2, Fairclough’s concept of an *order of discourse* was construed to account for the reproduction of social order through social and linguistic conventions for language use. Fairclough suggested that such conventions should be analysed as a configuration of genre, activity style, style and discourse (Fairclough 1992). The concept of order of discourse will serve as an outset for describing the nurses’ distinctively different use of language on the wards and for identifying the social practices that account for ‘the mental health hospital nursing order of discourse’.

The nurses’ clinical communication was associated with certain genres of communicating about the clinic: the practices of putting clinical experiences into words and of sharing and interpreting these. These genres could be differentiated because they are associated with different social practices for negotiating and distributing text. The stylistic and generic differences are at a further level of abstraction related to different discourses operating through the linguistic and social practices on the wards. Furthermore, the mental health nurses’ discursive practices on the ward will be interpreted as part of a set of institutional practices through which clinical knowledge is worked up; these institutional practices are contingent on the specific divisions of labour.
The figure illustrates the institutional organisation on which the order of discourse is contingent. In the following three sections three distinct parts of the order of discourse will be described: Everyday communication in the clinic, handing over clinical knowledge, and ‘the disorder of discourse’ between medical staff and nursing staff members.

**The nurses’ continuous everyday communication**

The continuous talk among the nurses was distributed through informal communicational practices, as described above. These practices were structurally organised as different informal activity types: informing, gossiping, entertaining, small talk, confirming and exchanging opinions, etc. These activities among the nurses had the same stylistic characteristics: participants with relatively equal formal social positions and the use of everyday registers. The majority of the nurses’ production of explicit clinical knowledge was related to the continuous everyday communication on the wards. Clinical knowledge was in most instances produced when a clinical experience became part of communicational events without the production of knowledge as the goal for the activity: for instance telling a funny story among colleagues about a clinical experience would produce clinical knowledge. The following data extract is from the fieldnotes and is presented here as a means to further the analysis of the nurses’ clinical practices.

“I am sitting in the ward office. There is the sound of breaking glass. Shortly after, a staff member comes into the office and says that it was Tina who deliberately broke a glass.
Later, a nurse says that a patient had said that Tina took two pieces of glass when she was clearing up the broken glass and that Tina was upset about a snitch. The nurse explains that she had tried to cover for the snitch by stating that she herself had seen Tina taking the glass.

It turns out that Tina took four pieces of glass. A nurse, Margaret, exclaims: “I’ll just threaten her with something. What was it I used when I got the phone?” (The phone was confiscated the day before because Tina continually called the police in an effort to get them to take the voices out of her head). Shortly after, Tina comes to the office and says that she has taken a knife and wants to trade it for the phone. Margaret says that she is not employed in trading, that she wants the knife back immediately, and that they can talk about calling afterwards. Shortly after the knife is returned and Margaret asks Tina for the last two pieces of glass as well. Tina cannot find the glass. She manages to find one more piece during the afternoon but cannot find the last one. The nurses express mutually sympathy for Tina’s situation: Tina is so confused that she cannot remember where she laid the glass even though she really made an effort to find it.”

The data extract describes two different categories of activity types related to nurses’ communication in the clinic: first, the continuous everyday clinical talk among the nurses, and, second, the communicational interactions between the nurses and the patient. The latter types of activities were also linguistically organised as everyday activities, such as telling ‘white’ lies and ‘blackmailing’, etc., in order to gently force through a certain ‘correct’ and unproblematic behaviour on the ward. These activities were structured as everyday activities and they would often re-enact certain social relations between the participants, notably the relationship between a grown-up and an infant as seen in the blackmailing and dealing in the extract. Thus, everydayness was inherent in the clinical language use and was related to both the mutual discussion and to communication with the patients.

Contingent on the institutional divisions of labour the majority of the mental health nurses’ activities were non-technical and deployed in everyday situations, such as informally sharing one’s experiences, sitting at a dining table, waking someone in the morning, asking someone to get ready repeatedly, etc. The nurses’ practical sense (Bourdieu 2000) of getting on in everyday situations informed their actions and gave even the neophyte nurse a sense of how to get on in the hospital setting.

This is not the claim that anyone could start working as mental health nurses or would know how to get along appropriately among mental health nurses. First, because communication among the nurses was structured as everyday conversation but the specific social conventions for speaking appropriately were negotiated locally. Further, as indicated above, the situated meaning of some of the everyday words was specialised, and some conversational exchanges had relatively little coherence for the uninformed listener. Second, because

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72 During the fieldwork I was introduced to the little black book at one of the wards. It was a book with mis-spellings and other faults from the records which were collected by the nurses. Everybody laughed when someone read it aloud. I decided to add a little to the book by pointing out a few ‘funny’ mistakes that I found in records, however, no-one found my jokes funny. Eventually, weeks later, after having several suggestions for
communication between nurses and patients had tacit dimensions. The vast majority of the communicational interaction between nurses and patients was everyday communicational activities. In spite of the everyday character of the communicational exchanges between nurses and patients some assumed practical knowledge frequently and obviously informed the interactions. It was not possible during the fieldwork to pinpoint these tacit dimensions with precision. For instance, for weeks a patient literally left whenever nurses were present for more than about a minute; an experienced nurse managed to sit next to the patient and cut Christmas decorations for an hour. The ability to be trustworthy and arrange everyday activities that would not scare the patient away was most probably based on experience with communication with the mentally ill, and thus it is a paradox: ‘a specialised everyday activity’, which may explain why nurses have great difficulty in describing their work, cf. Introduction. The dataset did not support further claims about the paradoxical character of most nursing practices, the ‘specialised common sense’, because substantial parts of nursing practices were not observed systematically.

**Practices of writing and handing over**

The practices of writing in the records were associated with a tight genre with the stylistic characteristics of writing, such as correct sentences, the omission of doubt, etc., and the use of formal and semi-formal terms as well as terms with specific local meanings (see Chapter 4). This specific genre of writing was linked to an institutional demand for rendering clinical experiences visible – displaying professional accountability – and can be interpreted as caused by a powerful managerial discourse (Traynor 1999). The genre of writing records was in terms of style distinctively different from everyday writing produced on the wards to make practices run smoothly, such as: shorter jottings, for instance in calendars, notes, and shopping lists, etc. The managerial discourse was in contrast to the everyday practices on the wards: The threshold for producing explicit clinical knowledge in response to the managerial demand for visibility was different to what was needed in the everyday practices. Therefore, the nurses often were frustrated about what to put into writing because their experiences with the patient were not regarded as relevant enough to record; the relatively frequent use of ritualised statements was a way of sidestepping the demand for visibility. Further, in a couple of instances on Ward B the nurses would not record their experiences about specific pa-

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the book turned down by the nurses, I suggested an entry almost identical to one already in the book. The suggestion was turned down, and a nurse told me that the entry I wanted in the book was written by a new member of staff, and they did not know if she was dyslectic, “and one shouldn’t make fun of someone who cannot help making mistakes”. I was embarrassed as I realised that I had understood how to joke but misunderstood the local conventions for joking. Traynor describes managerialism as a powerful discourse which colonises professional activities through bureaucratic rationalisations (Traynor 1999, chapter 1).
tients because they were afraid of retaliations from the patient. Thus, the demand for visibility was explicitly circumvented by the necessities of making everyday life run smoothly.

The records were informed by a managerial discourse but the practical use of the records and the content of the records indicated that the nurses used the records to make everyday practices work; it was a reference in which to look up mundane details about the clinic in the same manner as asking another nurse, cf. Chapter 4. Only in rare instances was the lack of specific knowledge explicitly debated by nurses searching for exact knowledge in order to make an acute clinical decision. Further, some nurses would in some instances try to hand over clinical knowledge informally and only look up the formal ‘facts’ in the record to see if anything was missed out. The general point is that the use of the nursing record – a technology informed by managerial discourse – was to a certain extent incorporated in the informal everyday practices at the wards.

The written record served as the backbone of the formal verbal handover, in which much of the stylistic characteristics of writing was brought into the reading aloud. The conventions at the handovers inhibited the linguistic feedback mechanisms, including other-initiated requests for repair, and often reading aloud would be the only information about the patient handed over. Further, the conventionalised structure of the handovers contained a mixture of activity types: an informal part resembling the continuous communication as well as a relatively more formalised reading aloud from the written records (see Chapter 5). This mixture was a hybrid; first, between written and spoken language use, second, between formal and informal social organisation, and, third, between a managerial discourse and the necessity of getting on in everyday life.

**Treatment conferences and the re-enactment of a professional hierarchy**

The nurses’ contribution during the interdisciplinary conferences was limited and dominated by the interactions of medical staff members. The interactional structure of this specific activity type was medically defined and did not resemble the nurses’ communication elsewhere, mainly because it re-enacted formal differences in the institutional professional hierarchy. Mostly there were no stylistic differences between the nurses’ and the physicians’ use of language in terms of register and the use of commonsensical, informal descriptions of clinical experiences. The actual, informal, use of language can be interpreted as preserving a notion of solidarity among the participants at the conference (see Chapter 6). The ‘disorder of discourse’ (Wodak 1996) at the conferences was both the result of a lack of understanding between the professional groups, because of the particular divisions of labour and the forceful re-enacting of hierarchical positions by a professional group.
The ‘disorder of discourse’ between the cognitive and practical worlds of mental health nurses and physicians was partial analysis, because the physicians’ clinical practices were not systematically explored during the fieldwork. A further analysis and discussion related to nurse-physician communication would be concerned with the technologies and practices re-enacting of the particular clinical division of labour, of which the turn-take systems at the conferences was just one example.

**Conclusion: An institutional order of discourse**

‘The mental health hospital nursing order of discourse’ was related to the division of labour that influenced the practices for production and distribution of clinical knowledge. Furthermore, practices sustaining institutional hierarchies among the professions and the discourse and technologies of managerialism influenced the order of discourse. These different practices were directly observable as well as the frustration and difficulties expressed by the nurses when trying to translate clinical experiences into an expressional style relevant within the different practices. To some extent the discursive struggles were absorbed into the everyday practices at the wards: the records were full of narratives; the interprofessional tenor was everyday, etc.

The analyses indicate how clinical experiences are worked into clinical knowledge through a number of social and institutional processes: ‘the game of clinical knowledge’ underscores how clinical knowledge is contingent on social processes; and ‘the institutional order of discourse’ maps out a terrain of different linguistic and social practices which transforms the production and negotiation of clinical knowledge.

Fairclough conceptualises discourse as a part of ideological struggles and suggests analysing conventionalised and naturalised discursive actions as ideologically invested, see Chapter 2. The ideology present among the nurses was *a commonsensical everyday world*. The dataset clearly indicates that the nurses were engaged in everyday linguistic practices and that the experiences they shared were related to the everyday world. This observation is also made by Bunch and Barrett among others: Barrett plainly states: “The nurses’ particular version of reality was a practical, commonsense one” (Barrett 1996, 57); Bunch more indirectly talks of a ‘noisiness scale’ to describe how nurses’ react to the patients’ socially disruptive behaviour rather than the content of the patients’ speech (Bunch 1983, 83). The nurses described the patients by means of a case-by-case informal logic according to how patients here-and-now breached the commonsensical social norms and expectations of everyday life.

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74 A re-occurring problem of using appropriate language, which was not analysed above, was related to the practical education of nursing students at BNsc level: the nurses struggled to translate their everyday experiences into the appropriate textbook-like discourse.
The majority of the mental health nurses’ activities were non-technical and deployed in everyday situations, such as informally sharing one’s experiences, sitting at a dining table, waking someone in the morning, asking someone to get ready repeatedly, etc. Interpreting Bourdieu’s concept of habitus (Bourdieu 1998), Eriksen argues that what she identifies as an everyday nursing-habitus consists of certain dispositions for caring for others, which for instance included an ability to care by multitasking in an environment of continuous and unstructured demands for action, cf. (Eriksen 1992). The argument forwarded here is in line with Eriksen’s: that the character of the nurses’ practices may be better explained as externalisations of social structure rather than specialised actions rationally derived from an identifiable nursing perspective. Bourdieu’s theory of the practical sense can explain the nurses’ interpretative background in the clinic, which was focused on the everyday world; fundamentally, the nurses had an everyday understanding of insane and deviant behaviour.

Fairclough stated that the practices of production and interpretation of text were doubly constrained, see Chapter 2. The nurses’ internalisation of social structures endows them with a certain habitus, which naturalises a certain worldview – including frames of understanding mental illness – and certain practices. Further, nurses are constraint by the conventionalised institutional practices, ‘the institutional order of discourse’, which imposes certain constraints on the production of clinical knowledge. The analysis of mental health nurses’ production of clinical knowledge must include both sets of constraint.

**Part Four: Limitations of the study: credibility and validity**

This section is concerned with an assessment and evaluation of the scientific credibility of the findings in relation to the overall study design and the practical completion of the study. Questions of validity are related to the whole study process and therefore some of the reflections in this section will refer to topics already touched on during the thesis.

A constructionist position is founded on relativistic notions of knowledge: knowledge is contingent on the situated practices of producing, negotiating, and distributing knowledge. The position therefore inherently holds a paradox because the practices of studying ‘the nurses’ production of knowledge’ are also contingent on social variables. The paradox seriously questions the criteria for evaluating research findings, cf. (Smith & Deemer 2000), further, the leading international literature is ambiguous and contradictory regarding how to conceptualise the scientific credibility and rigour of qualitative research, cf. (Lincoln & Guba 2000; Olsen 2002). In a review of the Danish and international literature on the qualitative research interview, Olsen suggests a catalogue of issues that the interview researcher must account for in a study in order to ensure validity and quality (Olsen 2002, chapter 8). Olsen is concerned with interview studies, but the eight overall aspects are appropriated to
the present research approach combining fieldwork and discourse analysis by referring to the research literature specific for theses analyses. Olsen’s overall approach is chosen as the framework for evaluation because it questions the research process thoroughly to make it as transparent as possible and thereby make the results as reasonable as possible.

1. The general crafts of researching

This aspect is concerned with the general consistency of the study: in particular the internal coherence between the choice of theme, methods, and the epistemological foundation. The study is on everyday mental health nursing practices with a particular focus on the construction of clinical knowledge among the nurses. Insights into the everyday practices warranted a field study in which the researcher was a participative observer for a prolonged period of time. Discourse analysis was used to reflectively study the construction of clinical knowledge in detail. The study was appropriately framed within a constructionist epistemology, in which clinical knowledge was seen as mediated by social processes and practices constrained by social structures.

As noted above, the fieldwork would most probably have gained if the focus of inquiry had been widened to include a systematic analysis of the communicational practices between mental health professionals and patients as well as the communicational practices among members of other professional groups. This would have allowed a more comprehensive analysis of the overall institutional production of clinical knowledge as well as the mental health nurses’ position in the overall institutional practices.

2. Theme

Thematisation is concerned with the clarity of the research theme. The overall aim of the study was to generate an advanced understanding of mental health nursing practices. The study was, on the one hand, designed to generate detailed descriptions and interpretations of clinical mental health nursing practice, on the other hand, the interpretations of clinical practice were related to the theoretical debate on how to conceptualise such practices, see Introduction. Regarding the latter aim, the study was planned as a deductive analysis assuming that theoretical conceptions would to some extent be recognisable in clinical practices75. This

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75 After the first week of fieldwork it became clear that such a study would have to rely on a deductive approach inferring between interpretations of nurses’ accounts and social happenings and a number of distinct formal models of mental disorder, such as: the medical (organic) model, the social model, the cognitive-behavioural model, the psychotherapeutic model, the family model, and the conspiratorial model (Colombo, Bendelow, Fulford, & Williams 2003). Siegler and Osmond define a model as “an arrangement of an ideology, theory, point of view, etc., in such a manner that it can be compared with other ideologies, theories, points of view, etc.” (Siegler & Osmond 1974, 15). It was also clear that the deductive approach would not be appropri-
preconception proved unfit for describing and explaining everyday practices; and the original study was succeeded by a study with naturalistic aspirations for analysing data that were not external to the daily practices, such as interview data, cf. (Silverman 2001). The aim was both to minimise the influence of informants’ reflective accounts of their experiences and to minimise the researcher’s conceptual influence on the informants. In this sense, the study was critical towards accepting professional and ideological preconceptions and models of mental health nursing practice from the outset. To what extent this critical stance towards professional preconceptions influenced the research process is not clear but open to critical debate.

A systematic literature review was made and the difficulties related to working in a field of research cutting across the health sciences, sociology and linguistics were outlined. Throughout the field study separate fields of investigation were outlined and the general review was supplemented with reviews fitting each particular paper. The papers were not written for nursing journals and each of these ‘small’ reviews had to be fitted to the particular canon of research within the sociology of health. This work was substantial and the review for ‘interprofessional collaboration’ in Chapter 6 was selective rather than systematic because of the size of the field.

The existing body of empirical studies on mental health nursing practices and mental health nurses’ production of clinical knowledge was limited; unfortunately this meant that it was occasionally necessary to compare the findings with findings from studies only peripherally aimed at the same focus as the present study.

3. Design

This aspect is concerned with the arguments for the particular study design. The overall design of the study was defined before the field study began; however, the particular foci on the central and recurring practices of the production of clinical knowledge were first definitively decided on during the fieldwork in order to select the most relevant areas of study. Further, Fairclough’s model for interpreting discourse was at the outset one of several possible approaches. In time, however, Fairclough’s theory was decided on as the overall approach because it integrates several approaches to discourse analysis and thereby allows the researcher to emphasise certain aspects of the analysis in relation to the characteristics of the specific data-material.

There is no single way of analysing discourse, and justifying the chosen analysis is a question of validating it (Fairclough 1992, 238). Fairclough’s analysis suggests a number of
analytical approaches, but only a limited number of them are relevant in relation to a specific text, and other analyses may prove to yield significant results. Theses challenging problems have been dealt with via two strategies: first, Fairclough’s analysis has not been regarded as exhaustive, and alternative or more comprehensive analyses were allowed into the analysis; second, throughout the analyses, extensive data extracts were presented to give readers the opportunity to challenge the analysis and the interpretations of the data. Further, the choice of extracts has been aimed at displaying the ordinary data rather than the spectacular data, and the grounds for selecting the particular extracts were given.

4. Making data

‘Making data’ is concerned with the collection of data. The overall research unit were the general, adult mental health hospital ward and the wards were, in a metaphorical sense, enclaves in the middle of a large institution. A number of professionals and patients would visit the enclaves but also have professional duties and private interests outside the walls of the wards. Therefore, defining the field of research as ‘a ward’ was in effect an arbitrary delineation of a field of research. However, the wards were chosen because of the overall interest in mental health hospital nursing practice and the nurses would mostly be engaged in activities inside the walls of the ward. The limitations of the particular delineation of the field were that an overall and coherent interpretation of the institution and the practices maintaining it was not pursued and such an analysis might bring forwards alternative interpretations of the nurses’ practices.

The criteria for selecting recordings for transcription and for further and detailed analysis were that they were relatively typical, which meant that they were observed several times in the data-set. This strategy was pursued to avoid anecdotalism (Silverman 2001, 222-223); anecdotal evidence can be interpreted as a drawback to qualitative researchers’ focus on rich descriptions of small instances of social events. Conversely, anecdotalism must be countered by checking for how representative a finding may be in relation to more general phenomena (Miles & Huberman 1994, 262-277). The strength of the data set was weighted: the fieldwork took place over an extended period of time and in both formal and informal situations. Situations in which nurses produced accounts were often observed first hand. I had the opportunity to observe and talk with nurses one-to-one as well as in groups, and the key informants were very cooperative and placed in very different positions on the wards. The danger of going native – when the site biases the researcher – was counteracted by several measures, such as: regular pauses in the fieldwork; a major part of data was produced with a very little influence of the researcher and analysed in detail after the fieldwork had ended; an insistence on thinking conceptually; a reluctance to depend exclusively on only a few data sources, etc.
5. Working up data

This aspect is concerned with the further refinement of data. The transcriptions were regarded as interpretations and the question or validity is related to the choice of system for transcription and reliability related to precision, cf. (Kvale 1997, 165-67). 1. The specific parts of the records chosen for analysis were transcribed into typed writing in extenso and the transcription followed a predefined set of rules and symbols. The transcription was controlled by an assistant-researcher and discrepancies were discussed. 2. The audio recordings were listened to and summarised by the researcher. The recordings chosen for detailed analysis were transcribed in extenso using a predefined convention for transcription which was designed to capture the ‘dynamics of turn-taking’ and the ‘characteristics of speech delivery’ (Hutchby & Wooffitt 1998; Psathas & Anderson 1990). The reliability of the transcriptions was controlled by continuously working with the audio recording and the transcript which lead to a continuous refinement of the transcription. 3. The original Danish versions of the transcripts are available in Appendix 1 for readers to compare. 4. The fieldnotes were written by using a system for recognising direct speech reportage, indirect speech reportage and theoretical reflections and scrap notes were written in extenso as soon as possible after the event had happened.

6. Analysis

Drawing on Fairclough’s methods (Fairclough 1992), the interpretations were made on different parts of the data. The data was analysed as text, which meant that the linguistic text was the interpretative context; the data representing spoken interaction was analysed with the conversation as the interpretative context, which meant that the participants’ orientation was analysed; the data was interpreted with the background knowledge stemming from the fieldwork, finally, reflective questions were continuously asked by the researcher: “why am I reading this passage this way?” (Potter & Wetherell 1987, 168). This totality of different interpretative strands made interpretations comprehensive and they captured the dynamics of everyday practices with a minimum of data originating from the nurses’ experiences of their practices.

The interpretations were ‘inductive’ creating the ethnographic interpretation of ‘the game of clinical knowledge, and ‘deductive’ utilising Fairclough’s concept of ‘orders of discourse’ to organise an interpretation of the dataset, and theoretical in the discussion on how to conceptualise mental health nursing practices.

The researcher had previously worked as a mental health nurse. This could on one hand be interpreted as a disadvantage in the sense that the researcher’s prejudice would make him see what he already knew; it could also be interpreted as an advantage, as the researcher
would have some sense of ‘what was going on’ and which events were the socially most significant. The actual situation, where the researcher had two years of clinical experience four years earlier, was interpreted as an overall advantage, because the clinic was no longer a familiar place: it felt enlighteningly strange yet still not too strange, cf. (Hansen 1994; Wadel 1991).

7. Control of the analysis

Both Fairclough and Potter & Wetherell suggest enhancing the dataset by interviewing people who are somehow involved with the object of research (Fairclough 1992; Potter & Wetherell 1987). Such an approach allows the researcher to pose questions about the same issues and gives a more coherent picture of the linguistic practices in relation to a given discursive object. In the present study, systematic interviewing and analysis of interview data was rejected because it would increase the complexity of the analysis unnecessarily, as the interviews would have to be interpreted as reflective responses to the interview situation; and further, the analysis was focused on everyday practices, of which the interview situation was not part.

The gain of combining an analysis of ‘naturally occurring’ text with the analysis of interview data is that the totality they form is useful for validating the interpretations in both analyses. In the present study, the advantage of a ‘binocularly’ (Bateson 1979) interpretative approach was linked to the combination of discourse analysis and fieldwork; interpretations from the discourse analysis fed in to the interpretations of observations and experiences from the fieldwork, and vice versa. For instance, interpreting a ritualised recording about a patient correctly, see Chapter 1, was contingent on an understanding of the varied practices which presupposed fieldwork; conversely, a reflective interpretation of the nurses’ practices presupposed a detailed study of the negotiated construction of clinical knowledge.

“The outlier is your friend”; Miles and Huberman suggested a set of related strategies for controlling the patterns identified in a qualitative data set: checking for outliers, using extreme cases, following up surprises, and looking for negative evidence (Miles & Huberman 1994, 269-277). These controlling strategies were continuously used during the fieldwork and during the subsequent analysis. During the fieldwork, surprising and extreme events were used to formulate alternative hypotheses and ad hoc hypotheses about the social organisation on the ward which were afterwards tested for significance. For instance, references to formal psychiatric terminology were very unusual except in proper educational situations. Therefore, I was relatively surprised to hear a male nurse referring to formal theoretical concepts on several occasions. On closer inspection it turned out that the nurse was newly qualified (in spite of being middle aged) and had had a previous job where voicing
opinions was both needed and expected. Thus, I assumed that the nurse’s use of formal terms came forth because of his particular communicative (male) competencies and an education fresh in his memory. The fieldwork was therefore directed towards situations where the specific nurse used descriptive terms in order to observe how an unusual use of concepts was received in the setting; it was also directed towards other newly qualified nurses in order to observe how they used descriptive terms. During the analysis, where the analytical concepts and their relations were relatively well ordered, outliers were easy to identify. They were used to test the consistency of the analytical categories: the analytical challenge was here to weight eventual negative evidence. I found, for instance, that written descriptions of patients were ‘profiles’: they were consistently written in the same manner and length. However, occasionally there were entries that differed in length and style and I had to explain these empirical variations or reformulate ‘the rule of profiling’. If a patient was on leave, or if a nurse reported from an extraordinary treatment conference, the profile may be ‘screwed’. Put simply, the analysis of outliers was concerned with deciding whether an ‘outlier’ was a proper outlier that challenged the analytical concept, or, alternatively, evidence of something else.

8. Communicating results

The thesis was written in English for an international scientific community. It was condensed because of the article-format which forced points to be aimed at an explicit purpose in an exact and concise manner. In spite of the article format the long data extracts were prioritised to ensure analytical transparency for the readers.

Regarding the external validity (or in the qualitative jargon: transferability or fittingness), the grounds for selecting the wards and the general characteristics of the wards, the nursing staff members and the patients were provided in Chapter 2. However, a consequence of this non-probability based selection meant that claims about generalisation of the findings could not be founded on statistical induction but must be founded theoretically or as a case-by-case transfer. Per Schultz Jørgensen proposed the analytical generalisation of qualitative studies (Jørgensen 1996). This approach meant to select theoretical concepts and identify links between the concepts and the dataset with the purpose of challenging the existing conceptions of a given research topic. If the research process was valid (fine correspondences between concepts and data, and coherent relations between concepts) generalisation would be linked to the improved force of the theoretical conception of the research topic.

Analytical generalisation is an interpretation of data which influences our theoretical conception of a research topic. However, Jørgensen does not discuss the demands on the dataset in any detail and it remains unclear if Jørgensen presupposed a certain sample size or
that the sample should be representative of something specific? The claim is, here, that the analytical conceptions analysed and worked up throughout the thesis, ‘the game of knowledge’, ‘the institutional order of discourse’ and the interpretation of habitus as the most coherent explanation of mental health practices are conceptions that add to the previous conceptions of mental health nursing practices and therefore have wider resonance. The above-mentioned problem of size and representation was countered by the claim that no data suggested that the wards were not typical and a number of descriptions have been presented to warrant this claim\textsuperscript{76}.

\textsuperscript{76} Jørgensen explains ‘analytical validity’ with the concepts: ‘correspondence’, ‘coherence’ and ‘improved conceptual force’ ["fornyet udsigelseskraft"] and with them, he draws on three classic conceptions of truth. However, Jørgensen’s use of the term correspondence is not the classic link between reality and a concept, but the quantitative appearance of a concept in the dataset (to avoid anecdotism). ‘Analytical validity’ is therefore, in spite of the terminology, in agreement with the overall constructivist methodology with a focus on analytical coherence and the pragmatic “fruitfulness” of the study, cf. (Potter & Wetherell 1987).
Conclusion and recommendations

The conclusion of this study concerns the outline of the main results throughout the thesis and the formulation of recommendations for future research and development of clinical practices.

The purpose of the study was to gain further insight into mental health nursing practices by studying the production of clinical knowledge away from the patient. A systematic search for literature revealed only few studies of mental health nurses’ mutual communication and of clinical knowledge as worked up in clinical settings. An analysis of the literature indicated: 1. that it was very difficult to abstract descriptions of mental health nursing practices from their social context without missing out the sense of the situation, and 2. that the conceptualisation of practice is a site of professional struggle.

In order to answer the research aim and to preserve an authentic and situated understanding of mental health nursing practices, a fieldwork study was combined with a detailed discourse analysis. Data were collected during the fieldwork with particular emphasis on the nurses’ records, the inter-shift handovers, and the interdisciplinary conferences, as well as the most mundane everyday practices in the clinic.

The major results were:

1. In their mutual communication, the nurses used everyday language with the occasional use of technical words or words with special local connotations. For outsiders, this language use was difficult to understand, because it lacked textual cohesion and descriptions seemed idiosyncratic. However, the language use appeared perfectly coherent for the nurses, because they both mastered the particular genre and had prior knowledge of the conversational topics. Most of the linguistic activity types on the wards were everyday activities, such as telling stories, debating, persuading, etc.

2. Clinical knowledge was mediated by social processes; explicit knowledge of the clinic was produced, negotiated, and interpreted among the nurses in the clinic. This production of clinical knowledge was particularly influenced by hierarchical positioning among the nurses. The nurses needed social skills for participating in the processes of producing and negotiating clinical knowledge and these skills had to be learned by newcomers on the wards.

The everyday language was well suited to the everyday practices on the wards. Many assumptions remained implicit in the nurses’ communication and only rarely did the relatively low level of explicit and concise clinical knowledge lead to obvious misunderstandings among the nurses. The ability to sum up clinical experiences in telling expressions was
a sign of status; the opposite situation, to be found ignorant by peers, was avoided by the nurses.

3. The nurses’ daily language use was constrained by an ‘institutional order of discourse’ which comprised a managerial discourse and a medical-psychiatric discourse. The managerial discourse demanded visibility and control of the nurses’ activities, and it forced the nurses to put their experiences into writing. The genre of recording was tight, using simple and effective means for short and concise linguistic expression. The medical-psychiatric discourse was evident in the collaboration between the professional groups at the interdisciplinary treatment conferences. Through the turn take system a medical reading of the clinic dominated and the interactions re-enacted the hierarchical differences between the professions.

4. The nurses’ production of clinical knowledge did not follow a particular discursive format. The nurses described everyday happenings and events using an informal logic which reflected their engagement in the commonsensical everyday world. The everyday world’s unstructured demands for action were evident in the nurses’ communication. Further, the analysis of communication between the nurses indicated that the interpretative frame for producing clinical knowledge about the patient was the commonsensical everyday world. In this sense, the nurses’ production of clinical knowledge was not just constrained by an institutional order of discourse, but also by the internalisations of social structure that gave the nurses their commonsensical orientation to the clinic.

Mental health nursing practices were conceptualised as paradoxical because they were constrained by the nurses’ everyday life practices and by institutional practices. A topic for future research would be to describe and explain how mental health nurses’ practical sense for everyday life activities influences on mental health hospital practices. An aspect of this research would be to take the trivialities of everyday nursing seriously; this means describing and evaluating everyday clinical happenings, such as creating a socially ‘smooth’ atmosphere round a dinner table, and, further, to standardise these practices and evaluate if they have a lasting therapeutic effect on the patients and their conditions.

The study examined mental health nurses’ language use in naturally occurring contexts and there were only very few explicit references to nursing theory of formal psychiatric theory. This finding indicated that studies relying on interviews may accentuate an image of the nurse as rationally acting according to applied theory because the interview context brings out certain professional rhetorical constructs for the accomplishment of professional accountability.

Future studies should not uncritically embrace the nurses’ practical sense, as it will be ideologically invested with certain naturalised notions of deviance and mental illness. In the
present study, nurse-patient interactions were not systematically explored, but a more systematic and detailed approach to studies of nurse-patient interaction would be an outset for a more complete understanding of the paradoxical ideology of mental health nurses and an explanation of how these ideological practices affect the patients during an admission.

The final recommendation for practice is to further educate the different professional groups at the hospital. In particular the nurses were poorly educated in professional mental health nursing, and this lack of education could explain why the nurses relied almost completely on the contingences of everyday life in their observations of the patients, rather than adopting more systematic clinical approaches, such as the psychiatric. There will probably not be a synergetic effect in the inter-disciplinary work before the different professional groups become able to understand the (practical) logic inherent in the collaborating disciplines’ perspectives.
English summary

This Ph.D. thesis was aimed at gaining insight into mental health nursing practices by focusing particularly on nurses’ communication with each others. Starting from a general concern for the complex ways in which mental health institutions create ideas and facts about patients, different areas of mental health nurses’ mutual communication was examined in detail: nursing records, nurses’ shift reports, interdisciplinary conferences, and the continuous everyday interactions.

The analysis was based on a social constructionist tenet: knowledge is a receptor of social meaning rather than a passive reflector of reality. Therefore, the analysis was focused on social and linguistic conventions in the everyday practices that mediated the production of clinical knowledge, such as: decision making; recording; gossiping; informal debates; formal meetings, etc.

The empirical analysis combined an anthropological fieldwork study with a detailed discourse analysis. Fieldwork took place at two Danish mental health hospital ‘special observation’ wards for six and four months respectively. Data were systematically construed by means of continuous fieldnote writing, by transcribing audio-recordings of recurring meetings, by photocopying material written by the nurses and, finally, by continuously back-ground-interviewing the nurses. The analysis followed the outline for discourse analysis set by N. Fairclough who had developed an integrated analysis of the textual organisation of written texts, of interactional dynamics of verbal communication, and social practices.

The major results were:

1. In their mutual communication, the nurses used everyday language with the occasional use of technical words or words with special local connotations. For outsiders, this language use was difficult to understand, because it lacked textual cohesion and descriptions seemed idiosyncratic. However, the language use appeared perfectly coherent for the nurses, because they both mastered the particular genre and had prior knowledge of the conversational topics. Most of the linguistic activity types at the wards were everyday activities, such as telling stories, debating, persuading, etc.

   2. Clinical knowledge was mediated by social processes; explicit knowledge of the clinic was produced, negotiated, and interpreted among the nurses in the clinic. This production of clinical knowledge was particularly influenced by hierarchical positioning among the nurses. The nurses needed social skills for participating in the processes of producing and negotiating clinical knowledge and these skills had to be learned by newcomers at the wards.
The everyday language was well suited to the everyday practices on the wards. Many assumptions remained implicit in the nurses’ communication and only rarely did the relatively low level of explicit and concise clinical knowledge lead to obvious misunderstandings among the nurses. The ability to sum up clinical experiences in telling expressions was a sign of status; the opposite situation, to be found ignorant by peers, was avoided by the nurses.

3. The nurses’ daily language use was constrained by an ‘institutional order of discourse’ which comprised a managerial discourse and a medical-psychiatric discourse. The managerial discourse demanded visibility and control of the nurses’ activities, and it forced the nurses to put their experiences into writing. The genre of recording was tight, using simple and effective means for short and concise linguistic expression. The medical-psychiatric discourse was evident in the collaboration between the professional groups at the interdisciplinary treatment conferences. Through the turn take system a medical reading of the clinic dominated and the interactions re-enacted the hierarchical differences between the professions.

4. The nurses’ production of clinical knowledge did not follow a particular discursive format. The nurses described everyday happenings and events using an informal logic which reflected their engagement in the commonsensical everyday world. The everyday world’s unstructured demands for action were evident in the nurses’ communication. Further, the analysis of communication between the nurses indicated that the interpretative frame for producing clinical knowledge about the patient was the commonsensical everyday world. In this sense, the nurses’ production of clinical knowledge was not just constrained by an institutional order of discourse, but also by the internalisations of social structure that gave the nurses their commonsensical orientation to the clinic.

The results were used to recommend an outline for future research and clinical changes.
Danish summary

Formålet med dette ph.d. studie var at få dybere indsigt i psykiatriske sygeplejepraksis ved at fokusere særligt på plejepersonalets indbydelse kommunikation. Med udgangspunkt i en generel interesse i de komplekse mekanismer, hvormed psykiatriske institutioner producerer faktabladet viden om de indlagte, blev forskellige områder af en gruppe sygeplejepersonalemedlemmers indbyrdes kommunikation analyseret: sygepleje kardeks, rapporter mellem vakt-skifte, interdisciplinære konferencer, og de fortsatte, dagligdags interaktioner.

Studiet var funderet på en konstruktionistisk social epistemologi: viden er en receptor for mening og ikke blot en passiv reflektør af virkeligheden. Studiet var fokuseret på de sociale og lingvistiske konventioner for de hverdagspraktikker, der medtager produktionen af social viden, for eksempel: klinisk beslutningstagen, journal optag, sladder, uformelle drøftelser, formelle møder, osv.

Det empiriske studie kombinerede antropologisk feltarbejde og detaljeret diskursanalyse. Feltarbejdet foregik på to danske ‘skærmde’ psykiatriske hospitalsafdelinger, i hhv. seks og fire måneder. Data blev systematisk genereret ved kontinuerligt at tage feltnoter, gennem transskriptioner af lydoptagelser fra forskellige genkomne møder, ved at fotokopiere materiale skrevet af plejepersonalet, samt ved fortsat at deltage i hverdagens praksis og ad hoc interviewe personalet. Analysen fulgte N. Faircloughs diskursanalyse. Denne analyse integrerer tekstanalyse, mikro-analyser af social interaktion og makro-analyser af social praksis.

De vigtigste fund omfatter:

1. I deres indbyrdes kommunikation brugte plejepersonalet erfaringssproget, hvori der af og til optrådte tekniske termer samt termer med særlige, lokale konnotationer. For udefra-kommende var sprogbrugen svær at forstå, idet den ofte manglende tekstuel sammenhæng, og fordi beskrivelser virkede idiosynkratiske. Sprogbrugen var imidlertid sammenhængende for personalet, fordi de både beherskede genren og havde forhåndskendskab til samtaleemnerne. Hovedparten af de lingvistiske aktivitetstyper var hverdagsaktiviteter, som for eksempel at fortælle historier, debattere, overtale, osv.

2. Klinisk viden blev medieret af sociale processer; eksplicit klinisk viden blev kontinuerligt produceret, forhandlet og fortolket i klinikken. Disse processer blev i særdeleshed påvirket af den hierarkiske positionering mellem plejepersonalet. Det krævede særlige sociale færdigheder at deltage i produktionen og forhandlingen af klinisk viden, og disse færdigheder må læres i klinikken.

Erfaringssproget var velegnet til hverdagens praktikker i afdelingerne. Mange antagelser forblev imidlertid implicitte i personalets kommunikation, men kun sjældent førte det
lave niveau af eksplicit og prægnant klinisk viden til misforståelser mellem personalet. Evnem til at opsummere en patients situation kort og præcist var et udtryk for ekspertise; modsat var det pinligt at blive udstillet som ignorant og denne situation blev aktivt undveget af plejepersonalet.


Fundene blev slutteligt brugt til at foreslå fremtidig forskning og forandringer i klinisk praksis.
Appendix 1

Supplementary details about the patients

Gender: Ward A: 33 women and 42 men (1.27 man/woman). Ward B: 48 women and 53 men (1.10 man/woman). Total for both wards: 81 women and 95 men (1.17 man/woman)

Age:
Total for Ward A: mean: 41.8 years. SD: +/- 13.5.
Ward B: Women: mean: 42.4 years SD: +/- 14.3. Men: mean: 37.0 years. SD: +/- 10.7.
Total for Ward B: mean: 39.6 years. SD: +/- 12.8.
Average age at both wards: Mean: 40.2 years. SD: +/- 13.1.

Supplementary details about the staff members

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Table 2. Data on staff members in Ward A\(^1\).

\(^1\) Two staff members from Ward A did not wish to participate in the study.
### Table 3. Data on staff members in Ward B.

**Staff members’ age:** Ward A: Mean: 43.7 years; SD: +/- 10.38. Ward B: Mean: 39.2 years; SD: +/- 8.33.

**Staff members’ gender:** Ward A 15 women (79 %) and 4 men (21 %). Ward B 16 women (73 %) and 6 men (27 %).

**Experience in mental health:** Ward A: Mean 13.2 years; SD: +/- 11.72. Ward B: Mean 7.5 years; SD: +/- 8.87.

**Basic health care education:** At Ward A 12 (63 %) had short educations and 7 (37 %) longer. At Ward B 15 (68 %) had short education and 7 (32 %) longer.

**Courses:** At Ward A 1 (5 %) had none, 12 (63 %) had short courses and 6 (32 %) long courses. At Ward B 8 (36 %) had none, 10 (45 %) had short courses and 4 (18 %) long courses.

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Appendix 2

This appendix contains both the original Danish data extracts and the English translations of the extracts in order to validate the process of translation.

From Chapter 4

Extract 1: ‘Kathleen’ (Ward A)
[1A During/at the end of day shift]
(Date) Kathleen did some washing today. She says she does not feel well today. Has laid on the bed in her room a great deal of the day. Kathleen refuses to talk to anyone. Talking loudly in her room. Requested to have a cancellation ‘phoned to the home support, but changed her mind, and stated that the home support is the only one she is interested in talking to. (Signature)

[1B During/at the end of evening shift]
Kathleen is a little less distressed tonight. Left the ward for about ½ an hour – a walk without notice. Has been talking a lot inside her room but refuses assistance. Observed her diet tonight (÷ raw vegetables). (Signature)

[1C During/at the end of night shift]
Early in the shift apparently auditory hallucinated – talked to imaginary persons, therefore got PRN [pro necessitate] T. Oxazepam 15 mg 12.30 WGE [with good effect]. (Signature)


[1nat] 2/1 Først på vagten tilsyneladende hørehallucineret – talte med imaginære personer, fik derfor PN T. Oxazepam 15 mg kl. 0.30. MGV. xx.

Extract 2: ‘Peter’ (Ward B)
[2A During/at the end of day shift]
(Date) Up for eating breakfast, eaten well. Went back to bed again afterwards. I brought morning medication down to Peter while he was still lying in bed. Was somewhat worried about what will happen to him. We talked about how it is important that he eats well and gets enough rest, agrees to this. Got up at dinner and ate well. Parents visit this afternoon. (No signature)

[2B During/at the end of evening shift]
(Date) Has had a visit from the parents this afternoon, who have taken a trip home to look inside the apartment. (No signature). Has been happy about the visit from the parents. Says though, that it brings forward “bad memories”. Says he has promised things he is sorry about → does not go into detail about this. U.S [undersigned] has a talk with P. that “bad memories” can sometimes also be used for something positive. Has eaten supper + seen TV in the living room. Does not feel happy but knows that he needs to be here. (Signature)

[2C During/at the end of night shift]
(Date) Slept. (Signature)
Jeg går ned med morgenmedicin til Benny hvor han fortsat ligger i sengen. Er noget bekymret for hvordan det skal gå med ham.

Vi snakker om at det er vigtigt at han spiser godt og får hvilet sig, er enig i dette. Står op og spiser godt til middag. Får besøg af forældrene i eftermiddag. [-]

[aften?] Har fået besøg i eftermiddag af forældrene, som er taget en tur hjem for at kigge i lejligheden. [-]

[afven] 4/1 Har været glad for besøget af forældre.

Siger dog, at det bringer ”dårlige minder” frem. Siger han har lovet ting han har fortrudt. → uddyber ikke disse. U.T har en snak med B. om at ”dårlige minder” også nogen gange kan bruges til noget positivt. Har spist til aften + set TV i i opholdsstuen. Føler sig ikke glad men ved at han har brug for at være her. xx.

Extract 3. ‘John’ (Ward A)

[3A During/at the end of the day shift]
(Date) Up at 9.30 good spirits. Had a visit from Ann James [a community mental health nurse], still disturbed by associations, can be corrected however. Has shaved on request. (Signature)

[3B During/at the end of the evening shift]
(Date) Still very associating but has been more restrained today. Late in the shift, testier but still correctable. (Signature)

[3C During/at the end of the night shift]
(Date) Slept from 00.20. (Signature)


[nat] 2/1 Sovet fra kl. 0.20. xx.

Extract 4. ‘Ann’ (Ward B)

[4A During/at the end of the day shift] (Date) Had an anxiety attack just after the wake-up call was shaking and crying when I entered the room. Got PRN tbl. Rivotril 0.5 mg just after morning medication, after I sat with her for a little while Ann began to talk about her anxiety about being discharged because she could not cope with more than one thing at a time. Morning assembly, ward rounds and a “daily duty” was too much for tomorrow. Calms down when I tell her that there are no current plans for discharge. (Signature)

[4B During/at the end of the evening shift] (Date) Did not feel well at suppertime. Felt dizzy and said that she could not move. Sat in her chair and rocked back and forth. Could laugh though. Had food served in the room and participated later in bingo. During the conversation A. found out that her earlier state was caused by drinking too little before going for a long walk. Talked hereafter a lot about her weight, diets and slimming and showed U.S. [undersigned] clothes she has bought which are too small. During this she is smiling and seems relaxed. (Signature)

[4C During/at the end of the night shift] (Date) Slept. (Signature)

[dag] 6/1 Fik et angstanfalde lige efter morgenvækningen var rystende og grædende da jeg kom ned på stuen. Fik p.n. tbl Rivotril 0.5 mg lige efter morgenmedicinen, efter jeg havde siddet hos Randi lidt begyndte Randi at fortælle om hendes angst for at blive udskrevet da hun ikke kunne overskue

From Chapter 5

Extract 2 (audio-recording from Ward B, morning handover)
Karen […] (9.0) Mette (3.0) she felt bad at dinnertime felt dizzy and said that she could not move (.) she sat in her chair and rocked back and forth (.) she could laugh though (.) had dinner served in her room and participated later in bingo during conversation Mette found out that the condition earlier was caused by not drinking enough fluids after a long walk (.) afterwards she spoke a lot about her weight and diets and showed the signers clothes she bought which are too small (.) here she was smiling and seemingly at ease (.) and I’ve only written a date “but she has slept” ((writing is added and the record is put aside)) (8.0) and now Mr. Udsted has appeared (1.0) […]

Extract 3 (Ward B, 3 PM handover)
The written record:
[night] (date) Slept. (signature).
[day] (date) Joined morning exercises. Been on a trip to the shopping centre (one hour). Bought sandals, shoes, socks, and swimming trunks + a little wallet (all in all about £ 45). Had a good overview. Good at choosing and not choosing. Managed to do all the services himself (signature).

The interactive reading of the record:
Liz […] well Mark he also joined the morning exercises and then he came along to the shopping centre where he spent (.) 45 pounds he bought a pair of shoes and a pair of sandals socks swimming trunks (. ) [and he: ] 45 pounds (.) but we do not really have=
Rob [45 pounds]
Liz = any idea about how much money he’s got I tried carefully <to ask about>(.)
Moe would you mind telling me what he’s like (.)
Tina [he looks like ] a little mouse
Liz [he is:: ]
Liz year?
Tina yes
Liz he’s a little quiet >thirty eight year young man brought in< by the emergency team (. is poorly has not eaten lately (. has he has drunk (. has intense thought disturbances (. distressed (. and Mary she knows a lot of stories about the first day [Moe [yes but is she insane >sorry< is he insane [Mary [yes he is ] [Liz [he is (. e he has=
=at any rate (. [Moe [year year but (. everybody isn’t [( ] [Liz [really [sss [extremely ambivalent (. but actually I think [he he that he e:: had a good overview when we were=
Mary [( ]
Liz =out shopping and he could easily overview that >he had a little difficulty< in taking in the shopping centre (. there are many with that problem the first time (1.0) when you know one comes to a new ( ) actually he could manage paying n::: he knew what he wanted and didn’t want (3.0) Maria ((the next patient))

ET1 […] ae:: nå Mark han har oss været med i morgengymnastikken og så var han med i Storcenteret hvor han har købt for 450 kroner han har købt et par sko og et par sandaler strømper badebuks essentially extremly pensful (3.0) Maria ((the next patient))
AS2 [for 450 kroner ]
ET1 =men vi har ikke rigtig nogen ide om hvor mange penge han har jeg prøvede sårn at spørge lidt ind til
AS1 gider du at fortælle mig hvad han er for en (.)
DS6 [han ligner ] en lille mus
ET1 [han er: ]
ET1 jah
Tina ja
(DS6) ja
ET1 han er sårn lille stille >ottegødtrævåig ung mand kommer< med udrykningsteamet (. har det skidt har ikke spist i den sidste tid har han har drukket e er voldsom tankeforstyrret (. og forpint (. og Ea hun kan en helt masse historier om om den første dag [AS1 [ja men er hun sindssyg >eller< er han sindssyg [
AS3 [ja det er han ] [ET1 [det er han (. e han har i =
= hver fald (. [AS1 [ja ja men (. der er jo ikke alle sammen [(uhørligt) [
ET1 [altså [sss [ekstrem= =ambivalent (. men faktisk syg jeg [han han at han snø havde et godt overblik da vi var=
AS3 [(uhørligt)
From Chapter 6

Data Extract
C then there’s Bill
(3.0)
N3 well things are progressing
(1.0)
C congratulations
OT thanks
((laughter))
SW new signals
N3 i:t yes it is [he gets up for the breakfast meeting [(.)] he gets up and goes to well to [computer
SW [yes
(.) also beginning to have a completely different relationship to his home support
CN [yes
[(1.0] was
C [hm
home yesterday to tidy up[and m:: took the initiative to get tidied up and called here (.)]
C [yes
and said that he stayed a little longer because he hadn’t quite finished tidying up yet he just
had to organise the last few things (. ) and that is so to speak is (. ) [a major step in the right
C [m:
direction [you know (. ) so (. ) all of a sudden
C [m:
(1.0)
C m:: I had noticed y’know (. ) about a week ago that his look was (. ) a lot clearer
[N3 [yes
I talked with him but then (. ) the other day when I spoke to him about something that didn’t
suit him [(.)] then the blinds came down again (1.0) then there was that distance again [.
N3 [((giggles))
CN [right
(3.0)
SW m: what is it you are saying he’s going to (. ) electronic data processing or what was it you
said
OT that well [go (. ) ] I take him over to the computer em:: one hour every day (. ) from nine
C [it’s Carol ] ((directs SW’s attention from N3 to OT))
to ten
SW o.k.
((several questions and confirmations at the same time))
SW he gets up and eats breakfast and goes with you
OT yes (. ) he just drinks coffee
SW yes o.k. but [anyway ]
OT [well he (. ) gets up for the morning meeting generally speaking and then: (. ) we
drink coffee and then we go over (. ) and then we work with some (. ) well: educational stuff
from the school n: (. ) a few games (. ) ‘n’ stuff like that
N1 yes at least he at least gets dinner  
OT yes (.) he does  
C he gets a daily routine [that the rest of us approve of (.) so he can (.) feel more normal (.)  
Several [yes  
y’know  
SW and John you said something about the relationship to the Street Team what was that  
N3 w: they were here yesterday and [and they were surprised at em:: (.) [  
SW [yes SW [they could also sense  
[that something had happened ]  
N3 [ (. ) yes because he took the ] initiative right (.) now (.) that it was just that well hello there  
you are ((alters voice dramatically)) (. ) y’ know that it was so:: (.) positive that it that they  
came right (.) and was accommodating to their (.) suggestion (.) so it was y’know (.) a  
completely different relationship they had  
SR he becomes less autistic right  
C m: [ (. ) year it’s it’s::  
N3 [yeah  
N3 come on out n::  
SR year  
C you feel it when you (.) it’s that that it’s those blinds y’ know (.) so (.) that he has [in his look  
SR [m:  
CN yes  
SR and I also think that it is such an good example on that that when the very schizophrenic and  
negative symptoms (.) then he lies there in his ambivalence should he get up and what should  
( .) when it sometimes turns out ( .) to go in and say you do not take the decision to get up ( .)  
you just must up ( .) we simply take control ( .) then we must take the conflict ( .) and now he’s  
quite pleased about it ‘cause ((. ) well it was actually quite nice to get up ( .) and he doesn’t  
N3 [yes absolutely  
SR have to speculate any longer because ( .) it’s an he perceives it as an order [and he follows  
C [m::  
an order (1.0) right  
N1 but it is probably also because he has an interest in what you do with him Carol  
because we have tried before to say you must get up[( .) but ( .) he does not want  
SR [yes  
N1 to [he has jammed [  
CN [m: CN [m:  
N3 he is currently anticipating that he (can go to The Mall today)  
((inaudible interactions))  
OT well yes and no ‘cause he also says that it is uninteresting to sit and[learn some word  
N3 [really  
OT processing y’ know [[[laughs))  
Several [[[laughing))  
C that is also what I said well:: I understand you have begun to work with a computer ( .) word  
processing ((alters voice dramatically))  
((general laughter))  
(4.0)
Så er der Egon

L1

S3, ja det går fremad (1.0) [

L1

Tillykke [tak [((griner))]

Flere

SR1 nye toner[

S3 [det, ja, det er [han kommer op til morgenmøde [() han kommer op af sted til 1 ja til=]

L1 [m:]

S3 [ja [m:]

L1 [hm]

S3 =går åbø: (.) for at rydde op [tøg øm: tog initiativ til at få ryddet op og ringet ud til hertil (.)=]

L1 [ja]

S3 =og sagde han blev lidt længere fordi han var ikke helt færdig med at rydde op endnu han sku lige ordne de sidste ting (.) så det må man sige er er jo (.) [store skridt fremad [ikk (.) altså=]

L1 [m:]

S3 =(_, lige pludselig (1.0)

L1 altså jeg havde bemærket altså (.) her for en uges tid siden at han var (.) meget klarere i= bløkket [ø: når jeg snakked med ham men så (.) forleden dag da jeg lige snakkede med=

S3 [ja]

L1 =ham om noget der ikk passed ham [() så røg det der gardin ned igen (1.0) så der var lidt=

S3 [((fnis))]

L1 [m:]

S3 =_[_]

L1 =længere ind

(3.0)

SR1 m hvad er:d I sir han går til (.) edb eller hva vared du sagde [

ET1 [det ja [tar (.)] jeg tager=]

L1 [det er Inge ]

ET1 =ham med over til computeren ø:: en time hver dag (.) der fra 9 til 10 (.) [o.k.

((flere spørgsmål og konfirmationer oven i hinanden))

L1 [jamen det er rigtig fint

SR1 [han står op og spiser morgenmad og går med dig [

ET1 [jah (.) han drikker kun kaffe []

SR1 [ja o.k.=]

SR1 =men [alligevel

ET1 [altså han (.) kommer op til morgenmad s mødet sådan stort set og så: (.) drikker vi kaffe og så går vi over (.) og så arbejder vi med noget (.) sn: undervisning fra Skolen á: (.) lidt spil (.) å sn noget []

S1 [ja nu får han da middagsmad i det mindste [

ET1 [ja (.) det gør han []

L1 [han får en døgnrøget [som vi andre ka li (.) som han ka (.) selv ka føle sig mere normal (.) ikk

Flere [ja

SR1 og Poul sagde du noget med kontakten til Midtbyen hva vared du sagde []
S3 jm de var her i går og [og de var forundret over ø:: (.)] ja (.). ja fordi han han selv tog initiativ=
SR1 [ja] [de ku oss mærke [der var sket noget S3 =til det ikk (.). altså (.) at det var bare det der nå hej er i der (.). altså med det var sn:: (.) positivt at dev at de kom ikk (.). og var imødekommende overfor deres (.).forslag (.). så det=
=var sn:: (.). en helt anden kontakt de havde fået [ han blir mindre autistisk ikk å [ L2 ] L1 [m: [(.). jo= S3 [jo L1 =det de:t [ [det det man mærker når man (.). det er oss de:t a det det=
S3 [kom med ud ikk [ L2 [jow [ L1 =der gardin ikk (.). så (.). som han har [(1.0) i blikket [ L2 [m: [ja []
? L2 [og så syns jeg oss at det er sårn et eksempel på at at når de der meget skizofrene og negative symptomer (.). så ligger han jo der i sin ambivalens ska han nu stå op og hva ska (.). hva ska han lave hvo (.). hvordan nogen gange (.). hvor det viser sig (.). det gå ind og sige du skal ikke tage stilling til om du skal op (.). du skal bare op (.). vi tager simpelthen kontrollen (.). så må vi ta den konflikt (.). og nu er han jo faktisk glad nok for [(.) jamm det var jo egentlig rart at komme op (.). han skal ikk spekulere længere=
S3 [ja absolut L2 =fordi (.). det er en op han opfatter det som en ordre [(.) og han følger en ordre (1.0) ikkoss L1 [m:: S1 jamm det er så nok oss fordi han har interesse for det som du laver med ham Inge fordi det har vi har forsøgt før oss det å sige du skal op [(.) men (.) det vil han ikk [han er gået i baglås [ L2 [ja [ m:: [ja [ m:
? S3 han regner jo konkret at han (kan komme i Føtex i dag) ((uhørlige interaktioner))
ET1 jamen både og for han sir da oss at det er dybt uinteressant at sidde og [lære noget= S3 [nå ET1 =tekstbehandling altså([(griner)) Flere [([(griner))]
L1 [det sagde jeg oss nå:: jeg kan forstå du jo er begyndt å arbejde med computer (.). tekstbehandling ((karikerer stemmen))]
Flere [([(griner))]
(4.0)
Appendix 3

Forskningsprojekt på XX

Mit navn er Niels Buus. Jeg er uddannet sygeplejerske og i gang med en treårig forskeruddannelse. Som et led i uddannelsen gennemfører jeg et forskningsprojekt i XX.

Projektet handler om bedre at forstå plejepersonalets arbejde i hverdagen. Det gør jeg ved at tagtagepersonalet i hverdagen, ved for eksempel at observere deres handlinger og lytte til, hvad de siger til hinanden og til indlagte.

Jeg vil være på afdelingen på forskellige tidspunkter på døgnet cirka 15 timer om ugen i måned XX til måned XX 200X.


Derfor er der visse regler, jeg skal overholde:

- Jeg har samme tavshedspligt som resten af personalet. Jeg må ikke dele min viden om dig med nogen uden for behandlergruppen.
- Datatilsynet har givet tilladelse til, at jeg må opbevare den anonymiserede viden. Mine noter skal være låst forsvarligt inde og må ikke gives videre til andre.

Med mindre du siger fra, vil viden om din indlæggelse automatisk kunne være med i projektet. Du kan sige fra ved at give mundtlig eller skriftlig besked til mig. Det vil ingen konsekvenser have for din indlæggelse at sige fra.

Med venlig hilsen,

Niels Buus

Hvis du vil vide mere om projektet kan du kontakte mig personligt eller surfe på nettet:
Datatilsynets tilladelse kan du se på: www.datatilsynet.dk/fortegnelse/index.html, hvor du skal søge på ”Buus” i feltet, hvor der står dataansvarlig.
Tavshedspligt og patientrettigheder kan du læse mere om på: www.danmark.dk, hvor du skal søge på ”tavshedspligt” og ”lov om patienters retsstilling”. Personalet har også pjecer om emnet.
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