GOVERNING RECOVERY: AN ANALYSIS OF
HOSPITAL LENGTH OF STAY

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This thesis is submitted in total fulfilment of the requirements of
the degree of Doctor of Philosophy

March 2002

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Statement of Authorship

This is to certify that

i) this thesis comprises my original work towards the PhD

ii) due acknowledgment has been made in the text to all other material used,

iii) the thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Signed:
Acknowledgements

To undertake and complete this thesis has been a privileged experience.

In addition to the nurses, patients and their family and friends, doctors and hospital administrators to whom I owe thanks for their willing involvement, I acknowledge the following people who have been very important to me in the successful conduct and completion of this study.

The scholarly and collaborative supervisory environment created and sustained by Professor Judith Parker and Associate Professor Trudy Rudge has been at all times respectful, challenging, unfailing supportive and (almost always) thoroughly enjoyable.

A welcome addition to this dynamic have been the contributions of Professor Sioban Nelson who at various stages read my work, participated in University of Melbourne Department of Postgraduate Nursing thesis review processes and offered insightful and encouraging comments.

For the quality of my life that has made possible the successful conduct of this study I thank most of all Paul, Daniel and Liam Flanagan.
Abstract

This research examines hospital length of stay as a feature of contemporary health care reforms. The ideas of Michel Foucault on governmentality enable length of stay to be studied, not as numerical values of hospital use, but rather as one of the social and political processes through which certain concepts are made susceptible to measurement and part of practice. In this study length of stay is examined as a programmatic rationality, evident in the reengineering of the modern hospital. However, the focus of analysis is not the ‘effect’ of this reengineering, as seen in the substantial changes to hospital treatments and the shifting burden of responsibility for health and ill-health care to individuals and communities. Rather, analysis is directed at understanding how such rationalities make possible reengineering or shifts in the local contexts of hospital care practices.

The thesis presents a discursive analysis of government and organisational policies and reports, professional literature and media reports, as well as texts generated through the conduct of fieldwork where ethnographic techniques of document analysis, interview and participant observation were used over a twelve month part time period in a Pre Admission Unit, Short Stay surgical ward and general surgical ward of a public acute care metropolitan hospital.

The thesis contends that through attention to length of hospital stay, the health care practices in this study have become founded on presumptions of patients as well and the necessity to restrict access to hospital beds. The successes of hospital programs designed to streamline surgical services are argued to be as dependent on particular forms of nursing and patient identity as they are on advances in surgical or managerialist techniques. In this study beds and recovery are conspicuous as objects of attention that become linked as objects of moral practice through the adoption or refusal by nurses and patients of certain ways of being. These self-constitutive practices are studied as they align with the accomplishment of decreases in the duration of hospital length of stay.
Restricting access to hospital beds is also associated with moves away from the bed as a therapeutic location of nursing practice. As nurses manage hospital time and space, in contemporary locations of pre admission and short stay wards, their role, compacted by the disappearance of time, is less available to fracture along lines or levels of skill. However, the ongoing contexts of shrinking social health care funding indicates that nursing practice continues to be at risk to a desensitisation to human suffering. The managerial responsibility to, at the very least, notice the duration of hospital stay and act in ways which actively seeks to decrease that period is being superseded by a moralisation of recovery, initiated in advance of hospitalisation and founded on self care resources.
Table Of Contents

<table>
<thead>
<tr>
<th>STATEMENT OF AUTHORSHIP</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>3</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>4</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>6</td>
</tr>
<tr>
<td><strong>CHAPTER 1. WHY STUDY HOSPITAL LENGTH OF STAY?</strong></td>
<td>9</td>
</tr>
<tr>
<td>Introduction</td>
<td>9</td>
</tr>
<tr>
<td>The demand for hospital services</td>
<td>11</td>
</tr>
<tr>
<td>Studying length of stay</td>
<td>15</td>
</tr>
<tr>
<td>Strengths and limitations of the study</td>
<td>23</td>
</tr>
<tr>
<td>Introduction to chapters</td>
<td>24</td>
</tr>
<tr>
<td>Summation</td>
<td>26</td>
</tr>
<tr>
<td><strong>CHAPTER 2. HOW IS IT POSSIBLE TO WRITE (ABOUT) LENGTH OF STAY?</strong></td>
<td>28</td>
</tr>
<tr>
<td>Introduction</td>
<td>28</td>
</tr>
<tr>
<td>Locating length of stay</td>
<td>29</td>
</tr>
<tr>
<td>Length of stay as represented in nursing literature</td>
<td>33</td>
</tr>
<tr>
<td>Length of stay and the hospital</td>
<td>41</td>
</tr>
<tr>
<td>Length of stay and government health care policy</td>
<td>42</td>
</tr>
<tr>
<td>Length of stay and policy implementation: Casemix</td>
<td>45</td>
</tr>
<tr>
<td>Length of stay as a poor surrogate for cost</td>
<td>49</td>
</tr>
<tr>
<td>The re-engineering of hospital services</td>
<td>51</td>
</tr>
<tr>
<td>An Alternative view</td>
<td>52</td>
</tr>
<tr>
<td>Length of stay and nursing practice</td>
<td>53</td>
</tr>
<tr>
<td>Summation</td>
<td>56</td>
</tr>
<tr>
<td><strong>CHAPTER 3. HOW MIGHT WE CONCEPTUALISE WRITING (ABOUT) LENGTH OF STAY?</strong></td>
<td>58</td>
</tr>
<tr>
<td>Introduction</td>
<td>58</td>
</tr>
<tr>
<td>Relevant aspects of the work of Michel Foucault</td>
<td>59</td>
</tr>
<tr>
<td>Rationality: Attention to thought</td>
<td>63</td>
</tr>
<tr>
<td>Government: Attention to power</td>
<td>68</td>
</tr>
<tr>
<td>Power and subjectivity</td>
<td>69</td>
</tr>
<tr>
<td>Governmentality</td>
<td>74</td>
</tr>
<tr>
<td>Freedom</td>
<td>77</td>
</tr>
<tr>
<td>An analytics of governmentality</td>
<td>81</td>
</tr>
<tr>
<td>Problematisation</td>
<td>83</td>
</tr>
</tbody>
</table>
CHAPTER 4. HOW MIGHT WE STUDY LENGTH OF STAY AS LOCAL PRACTICES?

Introduction 93
Recognising forms of data 94
Generating texts for analysis 97
Observation as contexts of social interaction 99
   Situational and negotiated identity 100
   Perceptions of power 101
   Contextualising meaning 102
   Criteria for validation 103
   Representation and reflexivity 104
Illustrations from fieldwork 106
Interviews 110
Analysing texts 113
The conduct of fieldwork 116
Ethics, recruitment and participation 118
The surgical pathway 120
Summation 125

CHAPTER 5. GOVERNING BY TIME: ADMINISTERING THE MOVES TO ENLARGE THE SPACE

Introduction 126
Making visible: Inscribing length of stay 129
Materialisation of time: Hospital beds 132
Bedsides and surgical nursing practice 136
Intellectualisation of space and time: The whiteboard 146
Disciplining 'the flow' 149
Discussion: The reconstitution of hospital beds 155
Summation 161

CHAPTER 6. GOVERNING BY RESPONSIBILITY: RECOVERY AS AN OBJECT AND ETHIC OF PRACTICE

Introduction 163
Pre admission, short stay and 'the perfect hospital'
   'They know / we know' 174
Resourcing and the resourced 178
   Pain free pain management: a resourcing strategy 185
Resistance and the risky 188
Resistance and the independent 190
Resistance and the resourceful 191
Discussion: Pre admission and pre recovery 196
Summation 202

CHAPTER 7. CONCLUSION AND (ANOTHER) TRANSLATION 203
Introduction 203
Rationalities and consequences 208
Pre-recovery and moral responsibility 213
Challenges and implications for nursing 217
Political rationality 224
A concluding proposal 227
Black boxes 229
Summation 234

REFERENCES 236

APPENDICES 260
A. Ethics: Approval and information 261
B. NDHP: 269
General principles for bed management
General principles for a preadmission service
C. Pre Admission: 272
Patient assessment and admission form
Patient health questionnaire
D. Pain video transcript 277
E. Ward length of stay /DRG data 281

LIST OF TABLES & ILLUSTRATIONS
Table 1. – Length of stay publications in Medline 31
Table 2. – Length of stay publications in CINAHL 32
Illustration 1. – Whiteboard layout 147
Illustration 2. – Newspaper sketch: Public health 170
Illustration 3. – Newspaper sketch: Hospital admissions and discharge 171
Chapter One: Why Study Hospital Length of Stay?

Introduction

Like most governments all over the world, the Australian government has over the last two decades implemented a number of specific changes to its national health system; changes that have begun to reshape the role and function of hospitals. In the main, these health care reforms have been responses to issues shared globally, such as changes in demographics, disease patterns, information technologies, increased and changing consumer demands, and the growing quest for efficiency (Leeder 1998). The global emphasis on efficiency and effectiveness of health service delivery, recognised in 1990 by the Organisation for Economic Cooperation and Development (Courtney 1997), has paved the way for international health care reforms to consistently target the restriction of hospital use for the purpose of gaining health care efficiencies (Sochalski, Aiken et al. 1997).

Resultant moves to re-engineer hospital clinical services and reduce hospital inpatient services have coincided with changes in funding models, as seen in the development and introduction of information-based classification of patient care episodes, such as 'casemix' and 'Diagnosis Related Groups' (DRGs) (Duckett 1998). With health care accounting for 8.3% of Australian GDP (Ross, Nixon et al. 1999), and hospitals accounting for one third of the total Australian health care expenditure (Duckett in Mooney and Scotton 1998), cost-driven health care reforms bring into view new aspects of health services.

Though these new perspectives are not necessarily limited to the organisation of the hospital, one such 'new aspect', the focus of this study is that of hospital length of stay. In this exploratory study length of stay is examined as a feature of contemporary hospital practice. Government and organisational policies and reports and media are joined with other texts generated through the use of ethnographic fieldwork techniques of observation, interviews and document
analysis in a number of areas of an acute hospital surgical division, to provide textual data through which a discourse analysis is conducted.

As a study of hospital length of stay, this thesis converges on what at first glance may appear to be a single, simple, even insignificant concept. Length of hospital stay is, after all, surely just numbers that managers worry about. However, since its 'capture' in the development of casemix policies and classifications of clinical diagnoses, length of hospital stay has dispersed widely throughout health care services. The dynamic of this study, both motivation and justification originates from a number of sources. Length of stay is evident not only as an outcome or independent variable, but also as a means to an end or goal, readily accessible in the workings of government, especially health policy, where it flourishes amid explanations for the current standardisation, (hence appearance) of modern hospital services. A second, more puzzling yet equally political challenge, can be found in the prolific publications by nurses, doctors and other health care practitioners, which illustrate an incremental, and quite substantial surge in use of this previously bureaucratic concept. A third source of motivation, serving correspondingly as justification for this study, has been prompted by experiences within the liminal space that exists between hospital and home that has been created by shorter hospital stays and early hospital discharge practices (Gardner 2000). In this conceptual space new facts about length of hospital stay stimulate questions (again inevitability political) about how it is that everyone has now come to be expected to manage hospital length of stay? How is it that length of hospital stay appears to be concurrently a bureaucratic construct, a health care fact and a goal amenable to self-regulation?

Measurement is the process by which numerical values are assigned to concepts under investigation. This is not a study about numerical values rather it is a study of the process by which certain concepts are made susceptible to measurement and therefore the process by which measurement becomes a process of itself. As a nurse and academic, my interests and approach to this study are targeted not at what the numbers of length of stay might represent but at the social and political
connections in how attention to length of hospital stay might produce the clinical practices of nurses in providing patient care.

Episodes of acute surgical services have been selected as both arbitrary and exemplary sites in which to examine not so much the effects of length of stay as 'the invention…operationalisation and transformation of more or less rationalised schemes, programmes, techniques and devices which seek to shape conduct so as to achieve certain ends' (Miller and Rose 1995:591). The aim is to identify within such schemes, programmes, techniques, devices and ends, new possibilities for understanding nursing and contemporary hospital services.

**The Demand For Hospital Services**

The hospital as 'curing machine' is now well recognised as a place of therapeutic action rather than one of care or assistance (Foucault 1980a). We have consequently come to accept modern experiences of illness, that critical area of human uncertainty (Berg and Mol 1998), as compartmentalised though techniques of diagnosis and intervention. We now also accept that diagnoses of acuity will demarcate illness experiences between the public (institutional) arenas of health care from those previously deemed private. Though the distance between the two is shrinking, along with the ways in which individuals experience health care provision. The growth in demand for health care services has been linked to expensive advances in diagnostic and surgical technologies that have reduced the invasive effect of some treatments (mainly surgical and pharmacological) thus making them more widely acceptable choices of treatment for both patients and doctors. This has also had the effect of increasing the volume of individuals for whom such intervention is possible, and in an ever-enlarging number of cases, has now come to be deemed medically necessary.

Over the last decade in Australia significant numbers have opted out of privately funded health schemes, meaning that the pool of individuals accessing and relying on public health, and therefore public hospitals, has greatly increased. Despite the recent government schemes which offered incentives to join private health insurance, (Baulderstone 1996) approximately 57.7% of the Australian population
in 2001 were identified as fully dependent on the public health system for their health care needs. Add to this an increasing aged population, with their more complex health care needs, and it is no surprise that the management of episodes of acute care (and with it the role of hospitals) has become a significant challenge for the Australian health care system, as it has for most other modern health care systems.

Health service demands are inseparable from the way that health, sickness and disease are understood. Along with the numerous debates about health as product, potential and/or processes (Cowley 1995), social theories constitute sickness and recovery as variously subjective, behavioural, and/or temporal responses to ill health, sometimes deserving of legitimate places in health care, and others times not (Morgan, Calnan et al. 1985:485; Strauss 1975; Gordon, 1976). Although Australia's health policies might be understood to still focus on disease and illness, rather than the more contemporary notions of health and health promotion, (Baume 1995:100) other agendas are now reshaping our health systems. The biophysical and social positions on health and health care are being reshaped quite significantly by health economics, with health becoming increasingly familiar as 'product' and health care as 'services' that demand emphases on price, volumes and quality (Mooney and Scotton 1998). The contemporary economic agenda of competition, with its emphasis on the market, is most evident in the health care reclassification of the patient to that of the health care consumer.

This analysis does not start from a fixed position of considering health care (therefore hospitals) as markets and therefore health or nursing as products. The notion of consumerism, seen optimistically by some as a strategy in 'demedicalisation', (Nair 1998) does, however, provide insight into how health care (therefore hospitals and length of stay) might regulate and manage conduct through the transformation of individuals to the collective of 'patient populations'. While consumerism assumes a symmetrical relationship between health care consumers, providers and administrators, (Draper 1997, Hancock 1998) it is in this very
'construction', of both the individual and the state, where hospital length of stay might be understood to function.

Evident in government policies and procedures, scientific discoveries and inventions, as well as in academic publications and media, length of stay is a visible characteristic of contemporary hospital services, a characteristic substantiated by even the most cursory search of published health care literature. While acknowledging that length of stay is only one node in the complex network of policies and practices that go to make up acute care hospital episodes, it is considered here as a form of ‘strategic arranging’ that is intentional (Foucault 1990/1978:95) within the networks of health care services, and therefore too potent to ignore.

It has been proposed that we are in the middle of a paradigmatic shift away from health systems that privilege the diagnosis and treatment of illness, to the mainstreaming of public and primary health care, with its attention to individuals, communities, health promotion and health education (Keleher 2000, Armentrout 1993). We have, however, little theoretical knowledge about how various factors impact on our newly defined and sought after health care outcomes (Mitchell, Heinrich, Moritz and Hindshaw 1997; Mooney 1998). Length of stay has become a commonly accepted way of naming and measuring aspects of hospital function, yet we have very limited empirical investigation of its dimensions other than economic or patient satisfaction effects.

Despite its proliferation in literature, as will be explored further in the next chapter, and beyond its easily recognised form as numbers measuring duration of hospital stay, we know very little about the forms that hospital length of stay may take. We do, however, know that hospital patient acuity and throughput have increased and time has become a critical component for nursing (Latimer 1993; Rudge 1997; Latimer 2000; Fagin 2001). We know that there are accumulating issues around sicker people leaving hospitals when they still need to be cared for outside of hospital environments (Purkis 1997; Gardner 2000; Purkis 2001). We also know
that difficult decisions about health care rationalisation are inevitable, global, complex (Coulter and Ham 2000), and not an area of nursing strength or representation (Borthwick and Galbally 2001).

Questions about how and in what way length of stay shapes, as well as how it might be shaped by hospital health care practices, are still very relevant in Australia, where we still strive to reform our national health agenda though a commitment to an economically efficient, yet equitable and sustainable health care system (Hancock 1999), while trying to avoid the recognised pitfalls of particular models of managed care.

The challenge then is for this study to examine length of stay and the re-engineering of hospital services as a compilation of strategies, technologies, and practices that are recognised as not occurring in a socio-political vacuum (Hancock 1999). Consequently, length of stay is studied as a form of social and political practice, that, it is argued, has emerged as part of contemporary hospital health care, and which now makes it possible to think in particular ways about hospitals, patients, nursing practice, and the provision of patient hospital care.

This study suggests that it is because of, rather than despite, the inevitability of ongoing problems such as health care rationing, that new forms of health care knowledge (and therefore health care research) are needed. Interested in multiple rather than single forms of knowledge and their emergence and 'movement', this study deliberately disrupts the idea that length of stay has continuity as only one form, and that one form is numerical information about how long patients spend

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1 Managed Care can be broadly understood as health care coordination processes. While in some ways it is seen as separate from health care funding in collaborative models focused on tools and systems for coordinating, sequencing and standardising care processes for specific patient types, (Scott & Scott 1997) it is more commonly associated with the stigmatised US cost-cutting efficiency models of health care funding where an agent assumes full responsibility for the provision of health services for its members (Richardson 1998). Acknowledging the variation in degrees of coordination of care recognised as managed care, the general view in Australia is that this style of health care model has to date been avoided here (Mooney and Scotton 1998). Doctors' rights to 'clinical freedom' (Richardson 1998:211) are protected in legislation, and health care budgets are seen as determined by policy rather than economics alone (Leeder 1998). However the pressure to trade-off such practices with allocative efficiency is increasingly being viewed in some quarters as 'a potential solution' to rising health care costs (Scotton 1995).
admitted to hospital. Hence this study questions whether length of hospital stay can be understood to have anything inherently to do with health care, and how people might be persuaded otherwise.

Other questions demand answers about how is it that hospitals have recently been able to achieve quite substantial and continued decline in the average length of patient stay, and how strategies for early discharge and the provision of hospital services in patients' homes have been so quickly and effectively implemented. Is it that hospital environments are so hostile, or are home environments so much better as sites for health care delivery? Perhaps it is that our modern techniques of intervention and cure are so successful that hospital stays are just not needed to be as long? Or is it that hospital services have become such a limited commodity that they require (and are amenable to) rationalisation according to carefully designed and financially managed criteria? If this is the case what do we know about how this rationalization occurs and what does this mean for nursing who has shared with medicine the fundamental responsibility of hospital health care provision?

There is no denying the evidence of the effects of worldwide economic rationalist policies on the way that hospitals in most western countries are now funded. However, what is less well understood is why or how the network of persons, policies, practices and relationships that make up hospital services are governed in ways that almost uniformly decrease the period of time that a patient, regardless of medical diagnosis, might spend in hospital. Analysis of the practices of calculation and regulation, such as would involve or produce length of stay, are now accessible through relatively recent approaches to social inquiry. These approaches are directed at understanding how forms of government articulate, as, and between the various practices and relations that silently produce our lives and identities.

**Studying Length of Stay**

Readily identifiable as a source of information, the knowledge and understanding about hospital length of stay will be examined in this study through publicly available literature. However, health care, hospitals and nursing are dynamic and social practices, so we need to be able think about length of stay as mobile and
strategic in and across these 'locales' so as to expand, rather than limit the opportunities for understanding.

Therefore this thesis describes the conduct of data generation and discursive analysis of a diversity of texts ranging from government and organisational policies and reports, professional literature and media reports, as well as various hospital documents, interview transcripts and fieldnotes generated through use of ethnographic techniques over a twelve month period in a Pre Admission Unit, Short Stay surgical ward and general surgical ward of a public acute care metropolitan hospital.

Poststructuralism challenges commonsense definitions through 'critique of metaphysics [such as] (the concepts of causality, of identity, of the subject, and of truth)' (Young 1981). Poststructuralism also emphasises the role of language in mediating between knowledge and power therefore the way that knowledge is produced. Discourse, which will be elaborated further through other sections of the thesis, provides a starting point in understanding length of stay as the representation or articulation of systems of knowledge and how these knowledges might form truths. In the often quoted section from Foucault, discourse is seen as 'a violence that we do to things, or in any case a practice that we impose on them' (Foucault 1981/1970:50). It is in this practice that the events of discourse find the principle of their regularity. Therefore these truths are not pre-given or coincidental, but can be understood as grounded in and interrelated to systems of knowledge, practices and institutions (Hancock 1999b). Discourse therefore provides a means through which to investigate forms, and most importantly, the differences in how length of stay might be simultaneously knowledge and language as well as social and political power relations. Nevertheless, to avoid the idea of discourse (thus length of stay) as fixed and stable, it is necessary to consider discourse as regimes, as effects of power and thus 'the principle of their regularity' (Foucault 1981/1970; Foucault 1990/1978:170-18).
These concepts along with Foucault’s later work on governmentality have been adopted over the last decade in numerous nursing studies. The works of Gastaldo (1997), Barnes (2000), Nelson (2000), Pryce (2001) and Holmes (2002) provide just some of the major examples (as doctoral theses) in nursing where attempts to govern human conduct are analysed through the domination and discipline, from the state through to government of self. The application of Foucault’s ideas across numerous disciplines and areas of social analysis is testimony to the depth and breadth of his work. However this provides a challenge as will be discussed further in Chapter 3 for how to use these ideas. One challenge is to distill those aspects of Foucault’s work that are deemed useful for the project at hand, whilst remaining consistent with the origins and intentions of their development (which quite deliberately avoided or moved across discipline boundaries), as well as locating the study as also relevant to the key associated (disciplinary) works in which the study, in this instance—a nursing study, is being conducted.

Gastaldo and Holmes (1999) provide a summative view of 27 publications from 1987 to 1998, written by nurses in what is proposed as a trend of Foucaultian interpretations of nursing. The literature reviewed employed Foucault’s concepts of power/knowledge, surveillance, discourse, discipline, resistance, docile bodies, clinical gaze and panopticon, with the authors concluding that one of the most significant outcomes of these works is the conceptualisation of nursing as a political event with nurses as 'professionals who exercise power over life in society' (Gastaldo and Holmes 1999: 231). While not exhaustive of the nursing literature using Foucault’s work (and in fact missing some key and substantial works such as those of Purkis and Latimer published well before 1998), the authors propose that, 'a Foucaultian reading of nursing enables nurses to move into a broader interdisciplinary and critical scholarship' (Gastaldo and Holmes 1999: 231).

Located quite clearly within this 'broader interdisciplinary and critical scholarship', this study also shares with the above and other substantial nursing research, an interest the various practices that constitute the conditions within which nurses and patients come into contact with each other. In particular, the works of Purkis (1993;
1996; 2001), Latimer (1993; 1999; 2000), Parker (1996; 1997) and Rudge (1997) provide points of reference for the outcomes of this study. However, these works are not summarised at the beginning of the thesis so as to 'benchmark' analysis and interpretation. Rather these nursing works are used to substantiate discussion at relevant points throughout the thesis, and more specifically in the conclusion, as they resonate with the particular conceptualisations that emerge in the processes of writing the final thesis.

Questions about how length of hospital stay has become a problem connect with the creation of particular truths about hospitals and health care. The relevance of these works to this study requires that length of hospital stay be recognised to simultaneously involve attention to the significance of time as it articulates with different knowledges, practices and spaces. Hence analysis of length of stay needs to be undertaken in a way that accommodates this 'mobility' or 'performance' in the various locations and practices of hospitals, health system, and perhaps even beyond, as well as accommodates the conceptualisation of length of stay as more than just forms of knowledge.

Length of stay is therefore analysed less through theories of power, than as an analysis of the modalities of power 'toward a definition of the specific domain formed by relations of power' (Foucault 1990/1978:82). Foucault’s analyses of power suggest that there has been a shift in the type of power exerted in society. In the Middle Ages power was exerted through sovereign power; however power is suggested now to be disciplinary, in that it acts on individuals to achieve certain ends through programs and tactics associated with the 'conduct of conduct' (Foucault 1991). No longer exerted through the state, but through institutions like the family, the school and the hospital, 'governmentality', encompasses the 'ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics, that allow the exercise of this specific albeit complex form of power' (Foucault 1991: 102).
The notion of technologies provides a way to study the 'differences and mobility' of length of stay as forms of social practices through which the social or physical world might be manipulated according to identifiable routines (O'Malley, 1996:205). Thus technologies (as technologies of power) enable understanding of the diverse and different means, mechanisms, and instruments through which attempts are made to rationally affect the conduct of others and ourselves (Dean 1999). The relationship between discourses and technologies is established here through use of Michel Foucault's notion of governmentality. This concept assists in conceptualising length of stay as an apparatus of power located in social practices across space and time, not restricted to particular institutions, but 'dispersed through a network of open circuits that are rhizomatic and not hierarchical' (Rose 1999a:234). Length of stay is therefore understood as a regime of practice that is not accessible through any one particular program, theory or practice, but requires analysis as various practices. The idea that knowledge simply reflects the world suggests an uncritical identification with rationality (Agger 1991). Hence this study examines length of stay as an example of where and how such rationalities can be seen to create 'grids of evaluation and judgement' that then function in multiple ways (Dean and Hindness 1998). The focus of the study is on the intersection of various 'authorities', such as government policy and scientific developments, with the 'local practices' (Rose 1999a) of hospital health care treatments, management of episodes of acute care, and as such practices articulate with contemporary forms of government in developing new understandings about health and health care.

Length of stay is of interest as it 'works' technically. This is not only in the analysis of complex systems of power and relationships that exist between state and non-state authorities, (Rose 1999a) as would provide understanding only about the applications of power where forms of governing directly intervenes. What characterises this study as a governmental analysis (to be explicated in chapter three) are the stories about knowing and acting, as 'the emergence of particular regimes of truth concerning the conduct of conduct, the ways of speaking truth, persons authorized to speak truth, ways of enacting truths and the costs of doings so' (Rose 1999a:19). Therefore, use of governmentality to frame this study is
motivated by its suitability to understand how length of stay moves between, links, coexists, transforms, and is transformed by and between the locations of government policy, the publicly available literature, and individual experiences.

For this reason this study seeks to understand not only how hospital length of stay might shape or produce, but how this shaping or production is accomplished, not only though constraint but also through liberation of different forms of practices for how 'individuals are recruited to take care of themselves but the techniques that are deployed by the 'experts' of human conduct must in turn invariably shape how individuals come to think of themselves' (Nettleton 1997).

The analytical style does not seek 'the truth' that shapes the modern hospital 'as an essential kernel or rationality' (Foucault 1994c:313). Rather, theory and method have been crafted as sufficiently malleable and mobile to include human and non-human, fragmented and diversified strategies and locations of a specific hospital services program, while at the same time accommodating its analytical value in making it possible to recognise intersection between length of hospital stay practices and the 'ethicalization of existence' (Rose 1999b:263). Discussion explores these strategies and ethics through which individuals are not only bound, as much as also accept responsibility to act in ways that accord with the management of length of hospital stay. It is in this way that governmentality enables length of stay to be studied across and between the various sections of health care systems, thus studied as a political, thus programmatic rationality. As a governmental analysis the focus is on particular strata of knowing and acting (Rose 1999a), hence where this approach differs from sociologies of order or rule.

It should be evident from this point that this approach to the study of length of hospital stay deliberately aims to disturb the idea of an unproblematic boundary between the realms of government calculation, policy formulation and decision-making, and the conditions under which humans construct their individual existence (Bauman 2001). The work of Callon and Latour, on the 'sociology of translation' adds a further dimension to this analysis by enabling interpretations to
be understood to emerge from networks, rather than assuming in advance that we know how networks are structured (Callon 1986; Latour 1993). In this context the formation of scientific truth, dispersed across time and space, is seen to require representation in forms that allow re-ordering and control (Callon 1986; Latour 1987). Thus length of stay, while it may appear solid, as numbers and calculation practices, is also 'compound realities' made up of sets of relations which are human as well as technical and textual (Callon and Law 1997).

The following questions about hospital services, patients and patient care, and nurses and nursing practice broadly shape analysis.

- How is length of stay visible and constituted as part of the delivery of hospital services?
- How does length of stay make it possible to think in particular ways about hospitals, patients, nursing practice and the provision of patient services?
- How do the strategies and knowledges that have become associated with length of stay create truths (which act as incentives) about hospitals, patients, nursing practice and the provision of patient services?
- How are these truths enacted or resisted, by whom, and at what cost?

This study may possibly look very different if located in another area of hospital practice, for example aged care or medical nursing. As will be discussed further in Chapter 4, the rationale for situating this study of hospital length of stay in surgical services was identified early during preliminary literature analysis and early fieldwork, where surgery was dismissed as a straightforward and unproblematic aspect of hospital care. Though the focus of this study within surgical services is somewhat arbitrary, as analysis of length of stay requires its circulation through various areas of this one hospital as well as other hospitals and government departments, as well as mediums of public information, such as media attention, it will be argued that the location of this study in surgical care is a particularly obvious place in which to study the governing of contemporary hospital services.
For many reasons the study privileges the nursing discourse. As researcher with professional roles as an academic and nurse, it is inevitable that my particular and individual experiences and familiarities shaped over twenty-eight years of providing individual nursing care, managing nursing care environments, and engaging in nursing teaching, learning and scholarship, are inseparable from the writing of this thesis. Also, though the concept of length of stay may seem to originate from locations remote to the interests of nursing, we know that the healthcare dollar is finite, and episodes of acute care are expensive. Though not restricted to hospitals, nursing has a long tradition of location within hospitals, hence changes to hospital health care services will impact on nursing and nursing knowledge and practice.

Length of stay has become an objective global measure that provides a 'seductive option' by which hospitals can track their resource use and target efficiency gains (Draper 1999). As a part of such measures or technologies it is argued that patient care, and therefore nursing, are increasingly being rendered as knowable, calculable, amenable to intervention, and therefore administrable. However, as will be explored further in this thesis, increasing attention to hospital length of stay creates particular contradictions and paradoxes for nursing, whose disciplinary emergence has been in part founded on the (very much time dependent) nurse–patient relationship. Though the stability and value of such relationships in environments of shorter hospital stay are questionable, additional challenges for nursing are created in the shifting power relations, such as through models of consumerism.

This thesis explores length of stay not only as a mode of classification of hospital time and space, through which the state might be seen to intervene in hospital services through policies of economic efficiency, but also as these certain ways of thinking start to become legitimate and ethical objectives. Subsequently this study situates length of stay as an intellectual and political technology through which certain forms of knowledge (such as the hospital patient as well as the restriction of access to hospital bed use) link with other practices (bed management, new surgical
techniques, discharge planning), knowledges (risk, quality, resources) and new locations of care (Pre-Admission units, short stay wards, homes). These ‘associations’ provide knowledge that is simultaneously employed (as techniques and forms of expertise) to manage or govern hospital services. Thus the governing of hospital services can be seen to occur not only through the economic allocation of resources, but also through the inculcation of particular modes of subjectification.

**Strengths And Limitations Of The Study**

This study does not trace the origins of length of stay from government policy in order to explore its rationalising effects on hospital services. Though achievable, such an approach would be of little benefit (or even interest). Rather, I am interested to understand how the idea of length of stay has gained prominence as part of hospital health care services, and therefore how it ‘works’ in producing such services. The brief contextualisation of length of hospital stay provided against a background of global developments in health care practices has been presented not as the focus of this study, but as a point of contrast by which to show that it is necessary to find a way to study length of stay, not in isolation from particular aspects of science or technology or social, political, or economic forms, but in connection with them. Hence this study examines length of stay as a way of 'flushing out that thought and trying to change it: to show that things are not as self evident as one believed' (Foucault in Sybylla 2001). This thesis attempts to study length of hospital stay so that multiple and particular forms can be equally accommodated; however, this is clearly only one quite small research project conducted by one person, at one point in time. Therefore while pragmatic choices have to be made, the aim has been to make them through the limitation of scope and method, rather than at the expense of theory.

Length of stay is studied here discursively and empirically in a manner not previously reported. It is studied as regimes of practices; that is, as patterns of thought and action that includes incompatible and contradictory elements, as unstable constructions given unity and viability by the rules under which they are assembled (Foucault 1972). It is argued that these ‘assemblies of practices’ not only
shape hospital services but include practices defined as intellectual techniques, that 'locate human beings in particular 'regimes of the person' (Rose 1998), thereby shaping particular subjectivities. In treating length of stay as an idealised conception, this study may be accused of confining analysis to totalising and rationalised configurations. This does not aim to 'fly in the face of sensibility' by proposing that longer (thus costly) hospital stays are affordable, necessary, or even desirable. Though it does seek to provide an alternative analysis to ideas of contemporary hospital services as solely shaped by 'economic determinism' or 'consumerism', a challenge perhaps only answerable with the passage of time and exchange with readers of this work.

The inevitability of rising health care costs and the finitude of health care dollars does not remove the requirement that health care professionals remain cognisant of the complexity and contingency of hospital services. Length of stay can be read as numbers in hospital records and government reports, offered as considerations in medical or nursing decision-making, or described as individual hospital-patient experience. While examples of length of stay could be studied singularly or comparatively within any of the above mentioned 'locations', significance of this study requires answering 'for what purpose should length of stay be investigated'? It is suggested therefore, that the value of this analysis lies not with 'correcting common sense' or 'legislating the true representation of human reality' (Bauman 2001), but rather in finding ways to better understand the changing health care milieu and its impact on patient care and nursing. Thus 'not to supply officials with policy to resolve the difficulties … but rather to analyze the costs of everyone's participation in maintaining it' (Rajchman in Sybylla 2001:80).

**Introduction To Chapters**

In meeting the requirement of thesis presentation, the sequencing of chapters adheres to traditional conventions of research reporting. Though it has become common practice in research theses using poststructural approaches to introduce methodology first, and incorporate literature later in the thesis, often in conjunction with other texts for analysis, this format has not been followed exclusively here. The thesis has commenced with the introduction, background and approach of the
study as presented in this first chapter. The specific theoretical framing of length of stay as one political and moral foundation for regulatory control of health care has been delayed until after an orientation to broader notions of length of hospital stay. This is not a playful attempt to disrupt linearity, but the result of much 'to-ing and fro-ing' in trying to simultaneously present both research topic and research approach to the reader.

Inevitably the thesis does not develop a tidy story about length of stay filled with 'precise or neat definitions of concepts' (Willis 2000). Rather, analysis is woven through each section of the thesis as it 'follows' the nuances of length of stay as objects, subjects, concepts, rationalities and technologies that both present themselves, and are presented in this analytical exercise. Hence all chapters, including this one, include description and interpretation, and might therefore be understood to perform analytically.

Chapter 2 presents critical and discursive discussion on the manner in which length of stay is written and is visible in publicly available literature. This is followed in Chapter 3 by an introduction to the aspects of Michel Foucault's work pivoting around his notion of governmentality and deemed useful to this study as a means to understand length of stay in contemporary hospital surgical services. This theoretical framework is adopted from a broad position of 'interdisciplinary and critical scholarship' (Gastaldo and Holmes 1999: 231). Chapter 4 describes the methodological and technical principles adhered to in conducting the empirical aspects of the study. The conduct of fieldwork involved the use of techniques of observation, interview, and document analysis to generate texts amenable to analysis from the contexts of a surgical division of an acute care city hospital. Chapter 5 examines how length of stay is both administrated and administers the temporo-spatial capacities of length of stay. Chapter 6 extends this discussion to include techniques for the administration not only of others but also of ourselves, thus how subjectivities are governed through length of stay as both disciplinary and self-constitutive practices. Chapter 7 summarises the key elements of the study, and aims without seeking to replace one rationality with another, to provide what might
be empirically-testable differences (Paley 2001) for nursing surgical practices. This chapter continues the analytical exercise of weaving theory with the key elements emerging through the conduct of this study along with core and associated nursing works relevant to contemporary understandings of nursing practice. The thesis concludes with summative discussions of these practices, and introduces an extended notion of the 'black box' as a useful conceptual way to understand the 'future' of length of stay in hospital services.

**Summation**

Though health and health care are no longer solely the domain of hospitals and medical bureaucracies, hospital care continues to consume the bulk of most government health care budgets. The direction of health care towards systems of efficiency suggests that length of hospital stay, perhaps regardless of its visibility, will continue to pose challenges to both health care consumers and to providers. These challenges are reflected in the language arguments that policy-makers and organisational stakeholders use when they talk about health care. As measurement of efficiency permeates further in organisational and global life, it becomes even more important to articulate the assumptions embedded in practices. The aim of this study is to clarify some of the views that are embodied in such systems, and as the assumptions themselves point to particular domains of discourse. As discourse sets up conventions and boundaries, it shapes what can or cannot be legitimately talked about, researched, addressed, or solved by the scope of health care efficiency.

It is in this context that this chapter has introduced length of stay as a feature of contemporary health care systems. Therefore, rather than accept hospital length of stay as a stable, passive or inevitably resultant phenomenon, Michel Foucault's notion of governmentality provides a means through which not to 'activate', but rather create a mode of inquiry which is susceptible to the nuances of hospital length of stay. This choice situates this study of hospital length of stay as more than measurement, but rather as part of various forms of rationality which are often more ethical and political than procedural. Hence length of stay will be explored both in the publicly available literature, as well as in day-to-day practices. The aim
is not to exaggerate these to achieve some overarching explanation, but rather, to understand the forms of length of stay and how such forms constitute a problem warranting government action.
Chapter 2:  
How is it possible to write (about) length of stay?

Introduction

Length of stay is not a material object. It can be attributed 'conceptual and linguistic' as well as 'factual and numerical' forms, as is evident in the numerous publications written by doctors and nurses, as well as in the various government and hospital documents and reports. The challenge of this chapter, as previously stipulated in chapter 1, is to consider these 'face value', seemingly neutral forms, as they represent length of stay as a feature of contemporary hospital health care. This is not at all to suggest that the literature on length of stay fits neatly together. Selected published literature is examined for, and as surfaces of emergence of the phenomenon that has become recognisable as length of stay; for those who appear to have been granted the authority to speak (or write about) length of stay; and for the grids through which particular relations and forms of length of stay are available for analysis (Foucault 1992a:41-42).

The aim is not to establish an 'a priori' definition of length of stay from which all other expected facts or figures can then be examined. Though length of stay may appear at times to consolidate in tangible forms as goals or outcomes, this chapter does not strive to 'transform documents into monuments' (Foucault 1992a:7) where history is made relevant and assembled into totalities of definition. Rather, this analysis is a relational act in the differentiation between understandings about length of stay, as this opens the way rather than limit possibilities for analysis of length of hospital stay in the practices of hospital surgical services.

This discussion is critical in its selection and examination of relevant public literature, but is not inclusive or exhaustive of all available literature. Published references to length of stay in medical and nursing journals and Australian government documents constitute the data for this chapter. They are explored as words and numbers so as to introduce as well as augment the larger task of analysis.
of length of stay as a productive practice, active in the regulation of hospital health care delivery, and most particularly nursing practice. It is important, however, to declare that where this analysis might be seen to define length of stay, it does so only, as suggested by Deleuze, in the sense that 'things and actions are already interpretations' (Rose 1999a:20). Therefore reading, thinking and writing about literature written by others is an exercise in 'interpreting interpretations'. However, length of stay is employed here as more than a mere background, because in examining what is written about length of stay, and also how length of stay is written about, such writing contributes to identifying 'intelligible contestations' (Rose 1999:28; Rose 1999a:28). These contestations are not 'an ideal type against which a non-ideal reality can be calibrated' (Rose 1999:275; Rose 1999a:275), but act as a mechanism that assists to conceptualise bounded processes and relations that inform and are therefore part of this (always incomplete) analysis.

As established in the previous chapter, the significant variation in length of stay literature is dealt with by the emphasis in this study being on the Australian context, with international literature included only as it assists in situating this inquiry. Discussion includes attention to characteristics and techniques of publication and literature retrieval, and analyses that have particular relevance to length of stay. Related, yet different, concepts of hospital separation or discharge, bed occupancy and throughput or the rate or speed of patient processing are discussed at relevant points in the chapter.

**Locating Length Of Stay**

Bibliometrics provides evidence that the term *length of stay* has gained significance in health care publications since the early 1970s. Contemporary literature-searching techniques via electronic databases provide access to published information from a large number of sources. Through refinement of search terms and dates, conventional literature-searching strategies aim to reduce the volume of literature in order to isolate the references most relevant to analysing the topic in question. This approach is used here in reviewing the considerable volume of publications that use the term *length of stay*. Though limited, it provides one way into analysing what might be understood as *length of stay practices in current health care*
Medline and CINAHL, as two of the major international medical, nursing and allied health databases were reviewed to illustrate the relatively recent arrival, yet significant and rapid rise, in length of stay as a form of health care language.

Medline is a major medical database which contains bibliographic and abstract coverage of literature from biomedicine, allied health, biological sciences, physical sciences, humanities and informational science as they relate to medicine, health care, communication disorders, population biology and reproductive biology. The database contains 9.5 million records from 3,900 journals and selected monographs from congresses and symposia. CINAHL (Cumulative Index to Nursing and Allied Health Literature) provides access to most English language nursing journals (500 in number), publications from the American Nurses Association and the National League for Nursing, as well as primary journals from 13 allied health disciplines. While there is some overlap with Medline in that it contains some of the Nursing index references included in CINAHL, it does not include them all. Additional journals, databases, web pages and electronic clearinghouses were accessed for other sources of relevant literature, in particular for Australian government policies and reports.

An index of the rapidity with which hospital care has become associated with length of stay can be seen in the number of articles published in the clinical research literature. Using length of stay both as a search term and keyword, the first English language references can be found in Medline in 1968 and in 1984 in CINAHL two years after the commencement of each database. While early references were few (2 or 3 per year in Medline and 10 to 20 per year in CINAHL), the references to length of stay can be seen to coincide with particular developments in health care policy and the introduction of hospital funding models. Searching Medline and CINAHL from 1991 to 2001 for the words length of stay anywhere in the citation identifies 25,423 references to length of stay in Medline and 2,865 references in CINAHL. Mapping of publication trends over a fifteen-year period in CINAHL and Medline where reference is made to length of stay show a quite significant rise. Mapped at various intervals during the life of this study, publications are represented as peaking with gradual indication of waning.
This thesis commences during the period of peak in publication numbers. Analysis of the downturn is commenced in this chapter, and extended theoretically throughout. The use of tables such as these can be understood to accord with styles of statistical thought, which make possible forms of 'probabilistic reasoning' which transform the evidential status of discrete and variable facts (Hacking 1991:181-95). Accordingly, these tables are included here not as a mirror or representation of truths about length of stay publications, but as empirical objects which, in the style of this thesis, are understood to stabilise as facts, given that they draw on mathematical (rather than artistic) sciences to support my claim regarding the increases in published references to length of stay. The fragility and transience of these 'facts' are acknowledged as inevitably partial.

**Table 1. Length of Stay Publications in Medline**

- 31 -
Increases in references to length of stay may in part be accounted for by an increase in the numbers of journals added to each database, thereby increasing opportunities for publication. This does not provide an effective explanation for how or why length of stay has become such a focus of attention for health care professionals. This chapter examines these publications in relation to increasing volume of publication. The downward trend in publication (evident when these tables were updated late in 2001, before completion of this document) is synthesised with a concluding analysis in the final chapter of the thesis.

In both databases length of stay is listed as a database subject heading. Subject headings are introduced by database-indexing staff when entering citations in the database in order to facilitate effective database searching. The subject heading 'length of stay' was added to the Medline database in 1972, and the CINAHL database in 1984. Indexing of citations referring to hospital stays had, in both databases, previously been clustered under the heading of 'hospitalisation'. The significance in this is the change in indexing of health care publications from the
subject heading of 'hospitalisation', defined as 'being admitted to' or 'in a hospital', to a new category that is length of stay. The introduction of length of stay as a subject heading illustrates a new 'periodisation' of hospital care, where emphasis (as evident in publication) became time, that is, the 'period of confinement of a patient to a hospital or other facility' (definition of a medical subject heading from the National Library of Medicine 2001), rather than the act of being admitted to, or being provided care in a hospital. Reflective of Derrida's emergence from a modest beginning of a code achieving its own 'distinctive vocabulary, its own sound, its own ideology' we can start to understand length of stay as the beginnings of a 'mental map of social order' (Fairclough 1992:83) where this seemingly simple and logical act of clustering articles under subject headings, designed to facilitate database searching of thousands of publications, captures a movement in an orientation towards time as a component of hospital function.

**Length Of Stay As Represented In Nursing Literature**

With limited variation or critique, medical, nursing and allied health publications frame length of stay as a dependent variable in the measurement of efficiency of hospital and health care outcomes. While the nature of what constitutes a health care or hospital outcome varies considerably, there is particular emphasis on cost, risk, quality and health. Overwhelmingly, the literature referring to length of stay focuses on the inevitability of achieving desirable, that is, shorter, hospitals stays as outcomes in regard to cost containment (Eckart 1992; Subramaniam, Gray et al. 1995; Beaver, Zhao et al. 1998; Draper 1999; Murphy, Noetscher et al. 1999; Dalton, Carlson et al. 2000; Langhorne 2000). Efficiency is understood here to be a measure of the quantity of resources used to generate a particular outcome (Scheiwe 1998). Patients represented through group characteristics, such as medical diagnosis, feature as variables against which length of stay is measured in many medical and nursing studies. For example, length of stay has been studied in relation to prediction of pre-operative stay for heart transplant patients (Grady and White-Williams 1999), ICU patients (Miller 1998) and geriatric and rehabilitation assessment (Subramaniam, Gray et al. 1995) and also as one of the means by which to identify 'problem patient groups', such as the aged or HIV/AIDS patients, deemed high hospital-resource users or 'bed blockers' (Latimer, 1993; Fahs, 1996).
Other variables against which length of stay has been tested are the economic efficiency of clinical practices, where the standardisation of clinical practices such as decision-making is sought not only internally within an organisation, but also in external comparison between doctors and hospitals (Murphy, Noetscher et al. 1999; Murphy and Noetscher 1999; Schultz, van Servellen et al. 1999). In contrast other studies indicate that length of stay is also recognised as being more dependent on hospital factors than on doctors' modes of practice (Sloan and Valvona 1986; Well 1995; Wells 1995; Schwarz and Iessoni 1996).

Decreasing length of stay in some states of America has been referred to as 'almost a religious principle' (Gordon and McCall 1999) and has even led to mandated hospital stays with legislation designed to ensure that patients with particular health care needs, such as birthing mothers and mastectomy patients, receive hospital stays of a set minimum time (Raube and Merrell 1999; Hadley 1997-1998; Canavan 1997). Seen as 'highly prized victories over managed care', (Gordon and McCall 1999) such changes in legislation have, however, prompted a number of new research studies questioning the economic efficacy (read validity) of such legislation (Raube and Merrell 1999).

Other non-patient factors that affect length of stay are staffing variances and difference in care-management approaches, such as clinical nurse specialists, or specific-care locations such as hospice units (Gilbar 1998; Lombness 1994; Hulen 1981). The capacity of hospitals to manage the volume of patients through hospital services means that length of stay is less visible at ward level, than the practices of patient throughput and hospital discharge. Latimer, in a study of nursing practices in relation to nursing assessment of hospitalised medical patients, found that the main medical and nursing work in this setting was 'the diagnosis and treatment of disease to enable timely disposal' (Latimer 1993:268)—an idea that resonates with the earlier work of Marc Berg on medical problem solving and the construction of hospital discharge for patients conceptualised by him as 'medical dispositions' (Berg 1992). Throughput is proposed by Latimer to relate to the speed with which patients can be moved through the hospital system, a strategy where managerialist strategies exploit medical authority to accomplish this speed (Latimer 1999). The
setting of Latimer’s study in medical aged care may account for this emphasis on speed as opposed to that of time. Though length of stay and throughput are mentioned in this work, analytical priority is given to the concept of throughput.

The influence of managerialist agendas in shaping medical decision making is well documented (Berg 1992; Clark and Mishler 1992) with fewer studies examining both medical and nursing decision making processes. The findings from Wells (1995) and May (1992) echo those of the medically focused studies where decision-making is shaped by institutional economic or resource imperatives, with clinical trajectories superseded by time controlled by achievement of efficient and prompt patient discharge.

In contrast to these broader studies about the effects of organisational influence on decision making about hospital stays, it has more recently been suggested that the cost-cutting potential of hospital stays has been exaggerated and that the effect of this particular cost on overall health care costs is not well known (Gordon and McCall 1999). Moreover, Clarke and Rosen, (2001) in a recent and extensive review of length of stay literature argue that there is a lack of any relationship between length of stay and health outcomes.

Recent reports, such as that from the Harvard School of Public Health, (Needleman, Buerhaus et al. 2001) investigate changes in hospital length of stay as associated with nursing practice. As part of a backlash against managed care and the restructuring of North American hospitals, as well as the public, media and Congressional concern over the reductions in quality nursing care, this study aimed to map the relationship between what they termed as 'outcomes potentially sensitive to nursing' (OPSN) and nurse staffing in in-patient units of acute care hospitals. This substantial, quantitative study of some 3,357 hospitals in the USA used regression analysis of patient discharge data, financial reports and hospital staffing surveys to suggest strong and consistent relationships between nurse staff levels and complications, such as infections, pneumonia, shock, upper gastrointestinal bleeding, as well as 'failure to rescue', or death from complications and length of stay.
The Needleman, Buerhaus et al study, in conjunction with others, recognised that not all that happens to patients, including clinical outcomes, patient reactions and records of the patient care provided, is charted in patient records (Berg 1992; Parker, Gardner et al. 1992; Cheek, Gibson et al. 1993; Heartfield 1996). Importantly, it was recognised that by using patient records as a key data source for analysis many nursing actions positive to patient outcomes were not detected. Examples of such outcomes are 'patient/family's being well cared for, ability to implement self-care activities and gain independence, emotional well-being, adjust/cope with illness or loss, satisfaction with personal and technical aspects of care, increased functional health status etc' (Needleman, Buerhaus et al. 2001:6). Therefore it was acknowledged that OPSONs were more than likely to be under-reported, since the documentation did not include all possible outcomes of interest, and were therefore biased towards adverse outcomes.

The impact of this on nursing is significant. These authors recommended that policies be introduced to enable systems for monitoring hospital patient care outcomes that are sensitive to nursing and nurse staffing. They recommended further research into how staffing levels and skill mix of nursing personnel are influenced by 'casemix, bed mix, physical layout of hospitals, nursing practice patterns, market and financial pressures and the availability of nursing personnel' (Needleman, Buerhaus et al. 2001). Length of stay was an outcome measure in this significant study, even though it was acknowledged that there was difficulty in interpreting variations in length of stay across states/markets and that significant questions existed about how length of stay was understood, and whether or not shorter length of stay was a desirable outcome from the patient perspective. Despite this, a justification for inclusion of length of stay was that it was 'unambiguously recorded in all patient discharge abstracts', (2001:40) with concession given to the need to compare expected length of stay with observed length of stay.

A broader consideration of nursing-outcomes research indicates that these reports are usually designed to demonstrate the effectiveness of nursing interventions in producing desirable outcomes (Sidani 1996). However, though approaches to
research design and definitions of outcomes vary between organisational, economic, personal or clinical incentives, cost is the common factor in most reported studies. The differentiation between outcomes relevant to an individual's health, and outcomes relevant to the provision of health sciences, is a fundamental issue rarely addressed in this literature. While the war on germs may previously have been understood to have been fought by nurses (Nelson 1998), the rise in social models of health and nursing have seen the rise of risk as now part of the biomedical model as 'a new form of germs' (Greenwood 1996:308). However the management of risk in most of these studies is actually financial risk to the organisation, rather than any other risk, such as to an individual's state of health. (Brooten, Brown et al. 1988; Schifalacqua, Hook et al. 2000).

Exceptions to this are to be found in mental health and aged care services, where shortened lengths of hospital stay are particularly contentious because of their potential for impact on cost-shifting to the community, and the potential to exacerbate individual health status (Pilette 1990; Dershewitz and Marshall 1995; Langhorne 2000). Where studies address clinical factors, they most commonly focus on adverse events rather than the real or potential benefit that nursing or other forms of care might provide. In the same sense, studies about quality of hospital care, though increasingly recognised as a central rather than discretionary function of health care systems, (Fletcher 2000) commonly employ length of stay in a manner that presupposes hospitals as less desirable locations for health care, than a person's home (King's Fund Centre 1989; Richards, Coast et al. 1998; Parkes and Sheppard 2000).

Therefore ideas about quality can be seen to vary between poles of professionalism and bureaucracy (Wright 1991) and reside with the particular interests and styles of government, health care organisations, health care professionals and consumers of health care services (Schultz, van Servellen et al. 1999) (Draper 1999). Issues of ethics (especially in environments of competition policy) and the existence of significant gaps in public health quality while well recognised, are less easily solved (Komesaroff 1999; Fletcher 2000). Clinton and Nelson (1998) suggest that the diversity in perceptions and programs of quality cannot be adequately
considered outside issues of power and examinations of practice. They argue that the main force of the current quality movement is derived from demands for organisational efficiency and reform, and describe key assumptions of this quality movement as the presumption that organisational processes and employee practices are resources through which improvements in cost and outcome efficiencies can be acquired, and that change in organisations needs to be accomplished by working on the way that various members of an organisation think. In exploring new approaches to understanding quality, they argue that the effect of modes of thought such as efficiency and reform is to 'deny the contingent nature of both organisations and the development and implementation of policy' (Clinton and Nelson 1998:146).

To a lesser degree, length of stay is commonly reported in published literature as a component of clinical decision-making. In these contexts, the language of length of stay is used to describe a factor taken into consideration in decision-making about patient care (Jackson 1994; Fahs and Wade 1996; Grimmer, Hedges et al. 1999). How length of stay varies between clinical decision-making about hospitalisation and care requirements, as well as care requirements beyond hospitalisation is a subtlety that is variable and inevitably unclear in the available literature. Decreased length of stay is understood as a factor that may exacerbate the quality of health outcomes, such as the early hospital discharge of the elderly (Johnstone and Zolese 2000). Or alternatively, decreased length of stay is a factor seen to contribute to better health outcomes, such as decreasing the potential for nosocomial infection (Chathas 1991; Nguyen-Van-Tam et al. 1999).

The length of hospital stay is readily accepted as highly correlated to clinical risks such as patient co-morbidity and severity, and therefore highly correlated to hospital costs and charges (Riordan, Engoren et al. 2000). However, the conversion of clinical events or process of decision making rarely separates clinical factors and cost factors. This issue is symptomatic of the pervasiveness of length of stay (as part of health care policy and procedures) in that as the differentiation between clinical processes and economic processes is difficult to achieve it is therefore not commonly sought. Considerations of policy and procedure as forms of practice (discourse), illustrates not so much the constraints imposed by policy (Ball 1993)
but how issues or problems might be constituted within the policy (Bacchi 1998). This may account for the consistency with which length of stay is used across a wide variety of studies as an indicator of how well (that is, economically efficient) various health-care strategies are implemented. Further evidence of this is seen where length of stay is employed as a strategy to identify discharge-planning designs most beneficial to nursing, yet with no critical discussion of what type of \textit{benefit} length of stay is presumed to be, and therefore whose interests might be served by these perceptions of benefit (Haddock 1988).

In contrast to nursing interests, patient participation has received considerable research attention and will be discussed later in this chapter aimed at evaluation of particular programs. The impact of these issues, such as the increasing acuity of hospital patients (without associated increase in nurse–patient staff ratios), is posed as relevant to the global problems impacting on recruitment and retention of hospital nursing staff, and therefore significant to the overall quality of hospital health services. In this sense the interests of nurses are juxtaposed with those of patients, as well as those of hospital managers, who are in many cases, nurses!

Despite this complexity, the frequency and consistency with which length of stay is employed in medical and nursing studies can be seen to imply a non-problematic acceptance of length of stay as a given, fixed concept, most useful in reporting health care research (‘a proxy for efficiency’) (Badham and Brandrup 2000) and as a means of realising 'undreamed of savings' (Johnson and McCargar 1999). While some studies acknowledge other contextual issues that may affect length of stay, the potency in how length of stay has been conceptualised, and how such conceptualisations impact on practice, tends to receive limited attention. An exception to this is the recent review of length of stay by staff from The London School of Hygiene and Tropical Medicine, who, in questioning the role of the hospital acknowledges the relative lack of technical limitations to reduction of length of stay. They suggest that while length of stay is relatively easy to measure, it is becoming increasingly difficult to identify \textit{the actual care} implied through the measurement of length of stay, though acknowledging that '[a]nxiety about the
Chapter 2: How is it possible to write (about) length of stay?

abrogation of this non-technical, caring function of hospital care is liable to raise moral or ethical dilemmas' (Clarke and Rosen 2001:169).

The relative consistency in characterising length of stay as an indicator of cost not only denies considerations of length of stay as anything other than an indication of cost, but also denies consideration of how or why length of stay has become a health care problem, given that answers appear so obviously to be economic. There is very little value in debating whether strategies to constrain hospital costs might abate, or how far the duration of hospital stays will shrink (Duckett 1998; Komesaroff 1999). However, the void that currently exists in the nursing and medical literature is not whether decreased length of stay has changed hospital care. The numerous studies on technological advances, increased acuity and re-engineering of hospital services already show us this (Caplan, Brown et al. 1998; Czaplinski and Diers 1998).

What is not visible is investigation of how this apparent and growing interest in hospital length of stay has become such a natural part of hospital care. To question how length of stay might participate, not only in classifying hospital patient health care, but how this classification might constitute hospital care, and therefore the way that doctors, nurses, patients, families and carers all perceive themselves in these experiences, assumes that length of stay is simply one thing, an outcome. This one thing is assumed as a natural and expected focus of health care, thus leaving unanswered questions about the declining length of hospital stay and the capacity for action, or multiple actions, acquired and required for accomplishment.

The representation and employment of length of stay as a stable dependent variable of cost analysis, aligns with a single picture of health professionals as rewarded for efficiency, technical skill and measurable results. This representation therefore implies that length of stay has a capacity to shape and fix the forms of human engagement that are hospital care. This has particular implications for both nursing, which has professionally aligned itself with human engagement as a feature of its therapeutic processes, and also for patients, whose duration of hospital stays has substantially diminished. In seeking answers to this interest in
length of stay, and in particular the capacity of length of stay, the chapter now turns to discussion of hospitals and health care policy as they highlight length of stay as part of a social problem warranting government action.

**Length Of Stay And The Hospital**

In contrast to length of stay as the 'universal metric for gauging the success of hospital efforts to contain and reduce costs', (Taheri, Butz and Greenfield 2000) length of stay is also understood by health care professionals as the period of time in which a patient is deemed to need the hospital resources of supervision and monitoring (Douglas, Vemuri et al 1996). Therefore, though relevant to all phases and locations of health care delivery, length of stay is an integral aspect of hospital care, as evident in recent changes to the Australian National Heath Act 1953 and the Health Insurance Act 1973, with the introduction of the Health Legislation Amendment Bill (No.1) (Health Industry and Investment Division Private Health Industry Branch 2001). These legislative changes have redefined hospital treatment so as to enable the health industry to fund alternative models of health care for privately insured patients, more or less as substitutes to in-hospital care for admitted patients.

Whether publicly or privately funded, hospitals have been recognisable within the modern world as the central component of health systems in bringing together people, resources, knowledge and expertise to deal collectively with health issues and challenges (Braithwaite and Hindle 1999). The modern hospital is a complex institution serviced by an expanding diversity of medical specialties with enormous technological and pharmacological resources on which to draw. From the basic church-established welfare shelters of the 3rd century AD, hospitals were transformed by 18th century industrialisation and urbanisation into a place for the medical treatment of the sick, and provision of bed-rest and convalescence (Lynaugh, 1992; Bauer, Fagin et al 1996; Hillman 1999). Bounded by the availability of large machinery for diagnostic purposes, the medical knowledge of surgery and anaesthetics, and the nursing knowledge of observation and hygiene, provision of modern health care has necessitated patients receiving care in the

Recent developments in hospital services suggest, however, that the role of the hospital has changed from that of a dormitory for bed-rest or convalescence, to a treatment centre, (Maddern and Maddern 2001) with practices of procedure or intervention now the sole, or overriding rationale for a patient's hospital stay (Draper 1992; Tonti-Filipini, 1995). Fifty years ago patients entering hospital would have stayed for between ten and fourteen days, whereas currently between 60–70% of all hospital surgery is day-surgery, where the patient does not even stay overnight (Maddern and Maddern 2001). Prolonged hospital care is no longer seen as desirable, and 'recovering under the watchful eyes of health professionals' a luxury no longer affordable to the community (Ruzicki 1989:629). This has significant implications for nursing, whose long history of association with hospital services has been commonly understood to involve monitoring patients' responses to medical treatment 'through the lenses of scientific knowledge such as anatomy, physiology, and mechanisms of disease, pharmacology and other therapeutic procedures' (Liaschenko 1998). Though nursing's primary audience has been medicine (Liaschenko 1998), nursing, like the rest of the 'health care sector, is rapidly being transformed in response to demand for identifiable, quantifiable indicators of cost effective quality outcomes' (Parker 2000). This emphasis on affordability is relatively new in public sector health care and is heavily influenced by contemporary neoliberal forms of government.

**Length Of Stay And Government Health Care Policy**

Associated with rationalised and relatively coherent mentalities of liberal democratic government, economic rationalism claims that market and prices are the only reliable means of setting values, and that markets and money deliver better outcomes than states and bureaucracies (Hancock 1999). Health is just one of the many social spheres that has become increasingly market dependent, with governments and policy-makers preoccupied with the overriding logic of one form of rationality, that is, the economic (Bauman 1987; Pusey 1991). Core assumptions of these neoliberal modes of government are a commitment to limited role for
government, the freedom of individuals from government coercion, and assumed benefits from unregulated voluntary market transactions (Hancock 1999b). These strategies are directed at

'quantifiable targets, performance indicators, outcomes measures and results, reduced costs and improved efficiencies, the separation of core business to differentiate those service delivery tasks suitable for contracting out or privatisations; the introduction of competition where possible; the changed basis of public sector employment with individually negotiated performance based contracts and the disaggregation of large monolithic organisations (such as … hospitals) into corporatised businesses' (Hancock 1998:51).

Therefore market strategies aim 'to create a distance between the decisions of formal political institutions and other social actors, conceive of these actors in new ways as subjects of responsibility, autonomy and choice and seek to act upon them through shaping and utilizing their freedom' (Rose, 1996:54). However, for market systems to be applied beyond the private and into the public sector, the reformulation or reduction of policy and programs and practices to that of systems, where exchange creates market forces of supply, and demand is required (Labour Resource Centre 1987) Callahan 1999). Market theory is consistent in accounting for human nature as marked by self interest, human behaviour as shaped and manipulated by incentives, (financial and otherwise) and has a political ideology in which the market is a critical ingredient of democracy (Callahan 1999:238). The overall ideal of the market is efficiency, understood to occur when 'individuals both on the demand side of the market and on the supply side, pursue their own interests through the market, and the price-mechanism results in all satisfying their desires or maximising their utility to the greatest possible extent with the resources available' (Mooney and Scotton 1998).

In health care, discussions on economic rationalism and privatisation as approaches to develop, distribute and manage health care resources are most evident in the policies of competition and contractualism (Hancock 1998). It is in this context that health has been constituted as a commodity (Seedhouse 1986) 'which can be bought (by investment in private health care) sold (via health food stores and health
Chapter 2: How is it possible to write (about) length of stay?

centers) given (by surgery and drugs) and lost (following accident or disease) (Aggleton 1990). However there has been overwhelming recognition of 'the improbability of a single, simple concept of market that can be adopted for use in the health system' (Saltman and Figuersa 1999:225). Significant public debate about the inability of markets to bring about efficient production where health care is the commodity, relates to differences in public and private sectors where the 'public sector is concerned about the public good based on beliefs in rights and a redistributive ethos, rather than being purely profit driven' (Hancock 1999a; Hancock 1999c:64), and economic approaches to individual autonomy and the role of utilities such as personal satisfaction, with non-utilities such as freedom and health (Mooney 1998).

The doctor-patient relationship is a complex one that has been extensively debated elsewhere. The health care risks that are an inevitable part of health care and the expertise that is invested in doctor–patient relationships, mean that choices about health care services are complex. Making decisions about the provision and payment for health services in ways that distinguish health care markets from competitive markets is particularly difficult (Scotton 1998). Though the market concept may be widely held to be an inadequate model for health-care delivery, (Deeble 2000; Leeder and McAuley 2000) its current prominence is accounted for because it provides a system where production and allocation of health-care resources are determined mainly by decisions in competitive markets, rather than in the less-preferred option of a centrally controlled government system, a state (Callahan 1999; Wildes 1999).

This principle is enacted in strategies such as competition policy, and seen as the economic and political strategy most commonly employed to ensure that market forces operate to regulate economic relations (Glaser 1993; Hilmer 1993). In Australia, a National Competition Policy with bilateral political support was introduced in 1995 (Hilmer 1993). The aim of this policy was to establish competition and cost considerations as the guiding principle of public policy at every level of government (Hilmer 1993). This aim is enforced through various legislation and statutory bodies, such as the Trade Practices Act 1973, the
Competition Policy Reform Act 1995, and the Prices Surveillance Act 1983, as well as through the Australian Competition and Consumer Commission and the National Competition Council as regulatory authorities (Fels 1996). The significance here lies in recognising that the current environment is one in which economic (thus competition) incentives dominate. In health care, the competitive model emphasises marketable health care services, with their emphasis on diagnosis and treatment so as to reinforce health services related to illness, to the detriment of wider concerns about what constitutes health care (Labour Resource Centre 1987:45). In this sense a competitive model of health is seen to confuse ends with means.

This discussion has proposed that the impetus for shifts in health policy can be found in broad socio-political movements, of economic rationalism, and competition policies. In this study of hospital length of stay, it is particularly pertinent to address how casemix, as a government policy, has changed the way hospitals are funded, and given length of stay a particular visibility.

**Length of stay and policy implementation—casemix**

Like in other major nations, most Australian hospitals are now funded through casemix schemes. Previous systems for funding hospital services had been based on traditional levels of reimbursement of reasonable costs incurred by hospitals in the delivery of health services (Lake 1992). A new system, designed around a set, fixed rate in advance of the provision of hospital services, was first introduced in October 1983 in the United States of America (Inglehart, 1982), and is now used in many parts of the world (Casemix Quarterly). Casemix is the number and types of patients treated by hospitals, and the mix of bundles of treatments, procedures and so on provided to patients. In general, it is predicated on the standardisation of resource use in treating patients, and therefore a measure of hospital output and activities. (Eagar and Hindle 1994). Casemix data facilitate the management, monitoring and planning of health services by supplying:

- information about the quality of care;
- a basis for funding, paying and charging for health care services;
- measures of hospital output; and
comparisons between different care options at national and local levels.

Hospital funding under casemix schemes does not occur in advance of actual care rather the rate setting of payment is prospective (Diers 1992). Funding is set by classifying populations of patient care episodes through Diagnosis Related Groups (DRGs). A DRG is a clinically and resource homogenous category that provides a means of grouping types of patients who are deemed similar through broad clinical diagnostic categories and resource use (Duckett 1998). Developed to define and measure the mix of cases treated in hospitals, casemix is proposed as a solution to the requirement to compare cost and quality among institutions or services (Diers 1992).

In Australia, DRGs are referred to as AN-DRGs and they are used by government to set rates for funding through standardising differences in the casemix of hospitals, which then allows comparisons of hospital efficiency, and facilitates the allocation of hospital funding (Duckett 1998). Casemix policies do not identify a reduction in length of stay as an aim. It is, however, in the formation of DRGs that length of stay is identified as the basis for clustering the same, or similar, diagnoses into the same group, therefore making it possible to allocate a cost or price to each classification (Diers 1992)141). Thus the price set for funding of a DRG is for an average of a cluster of same or similar diagnoses, calculated from the average length of hospital stay for a population of patients. At the end of this process, length of stay has been calculated as an average of an (averaged) group of patient classifications of hospital length of stays.

Consequently, length of stay features prominently along with diagnosis, treatment and patient volumes, in the numerical and graphic representations of hospital funding criteria, and performance in Australian Commonwealth and State casemix reports (Commonwealth Department of Health and Family Services 1996). In this capacity length of stay is a conceptualised calculation and classification of hospital care, which forms part of the techniques undertaken to contain costs and rationalise the micro-allocation of health care funding (Commonwealth Department of Health and Family Services 1996) Easily calculated and monitored through technical
means already available to hospital management systems, (Draper 1999) length of stay is designated as the period of time that a classification group (a DRG, not a person) spends in hospital, minus any days of leave (Eagar and Hindle 1994; Australian Institute of Health and Welfare 1997). Separation is understood to have occurred when an inpatient is discharged, is transferred to another institution, absconds, dies while in care, changes status (for example, from acute to nursing home) or leaves the hospital for a period of seven or more days (Health Care Statistics 1995).

Length of stay is readily visible in government and hospital documents, most commonly represented as a single column in large tables depicting numbers or fractions of days of hospital stays. Again, it is important to note that this is not for patients, but for groups or populations of patients clustered through and as AN-DRGs. The average length of stay is the mean number of days in hospital for a group of patients with a notion of 'bed days' calculated by subtracting the admission date of individual patients from the date of hospital separation (Eagar and Hindle 1994). Length of stay data are compiled at the hospital in the weeks following patient separation, using specially-designed software that assigns patient care episodes to set casemix classes or categories that are DRGs (Commonwealth, 1996).

All length of stay figures provided in such reports have been subject to a process referred to as trimming. This purposeful technique involves the removal of unusual cases prior to the production of statistics. For example, analysis of trimmed DRG data does not include patients who were in hospital for unusually short or long periods (Eagar and Hindle 1994). As a process of homogenisation, this accomplishes production of an 'actual' length of stay from the 'real' patient scenarios that are deemed to have deviated too far from the predetermined norm, and are hence removed. As techniques of difference and conformity, such technologies make very clear decisions about the population base to which DRGs are being applied. Those with very long or very short lengths of stay are deemed to belong to a different population. Despite strategies such as trimming, or perhaps because of these strategies, different emphases such as average length of stay or
bed days, or length of stay as represented in casemix reports, have a certain and perhaps strategic consistency. In designating DRGs, hospitals manage their work around the notion of classifications of groups of patients rather than individual patients, and providing for comparison of hospital performance, and therefore the efficiencies of both hospital staff and patients. In this way hospital patients and patient-care can be seen in new categories (length of stay) that are 'no mere reporting of developments' (Hacking 1986).

Casemix has not gained much popularity with health professionals (Byron and McCathie 1998; Degeling and Black et al, 1995; Diers 1999), writing about health care in the USA, suggests that there has been a sense in nursing that casemix would be responsible for the economic demise of nursing, and that nursing activity and patient acuity were beyond such measurement. Despite Australian nurses having some presence in national casemix cost modeling activities, (Vickerstaff 1994) similar concerns exist for the representation and future of nursing in Australia (Lawler 1999). As a numerical representation of the period of admission to hospital, length of stay is seen as limited to a single indicator of cost (Draper 1999). Length of stay does, however, provide a relatively easy option for Australian hospitals as an indicator of resource use and a means by which to identify where efficiencies might be gained.

Draper (1999) politicises length of stay in suggesting that the seduction of length of stay measurement lies in the very ease with which it can be measured, and thus the very ease with which it provides a ready means of responding to political or public pressures such as the controversy of hospital waiting lists. Such practices can therefore be understood as functions of policy that create, through definition, problems that can then be readily solved (Bacchi 1998).

Length of stay exists as a strategy formulated by policy-makers and health economists removed from clinical practice, and used in ways that are commonly rejected by clinicians as irrelevant or injurious to their practice. Yet clinicians variously adopt this same strategy, length of stay, as a technique through which to demonstrate outcomes of their practice. Therefore competing histories and
interpretations of length of stay seem to have been woven together, and therefore warrant closer investigation.

**Length of stay as a poor surrogate for cost**

The Australian Casemix Clinical Committee, the group vested by the Commonwealth government with the ongoing responsibility of refining AN-DRGs, recognised in 1992 that length of stay was not a good surrogate for cost (Australian Casemix Clinical Committee 1992). Despite previous use as a measurement of resource, it was acknowledged as highly variable, and therefore of limited predictive significance. This Committee recommended that analysis based on the length of stay should not be the sole tool for evaluating proposals for additional AN-DRG categories (Hickie 1994). Multiple factors cause variations in length of stay, including:

- patient characteristics—like age, sex or social background;
- the environment—such as geographical isolation, or the lack of available alternative accommodation or home care;
- administrative and organisational matters—such as availability of beds, staffing patterns, administrative efficiency and the characteristics of the medical staff—or clinical factors, such as the mode of treatment or admission or discharge policies (Australian Institute of Health and Welfare 1996):63].

Anticipated further development in the design of mechanisms to provide accurate cost data and cost weights include recognition that hospitals are now involved in episodes of care conducted outside the hospital boundaries (Australian Casemix Clinical Committee 1992). Despite this acknowledgment, publications in nursing and medical journals making reference to length of stay continue to grow as demonstrated in table 1 and 2. In contrast to the government recommendation that length of stay is a poor indicator of cost, this table creates an empirical representation of the upsurge in references to length of stay in health care publications, thus reflecting the suggestion from Bauman (1992) that statistically insignificant phenomena may prove to be decisive, and that their decisive role cannot be grasped in advance. Hence, assisted by policies like casemix, length of
stay maintains a representation in government and hospital publications as 'facts' available for the purposes of defining the classification of patient groups, thus shaping the way hospitals are thought about and managed.

In this literature analysis, length of stay has a numerical representation that is neutral, and with a fixed meaning that precedes its recording. There is little questioning of how attention to length of stay might characterise its very appearance. References to length of stay in publications are only just beginning to wane after a decade of substantial growth, during which health policy makers and health economists identified length of stay as only one element in the cost of hospital services. Little empirical information exists on how or where such 'facts' are established, or how they might act in shaping hospital health care practice. With shorter length of hospital stay acknowledged as not necessarily implying better forms of care, nor implying inferior forms of care, (Hirsch 1994; Duckett 1998; Draper and Silburn 1999) the growing recognition of length of stay as a hospital services' problem has coincided in Australia with sweeping changes to hospital services. This complicates attempts at single analysis of changes to the role of hospitals, as discrete from changes to health policy.

In an article entitled 'Healing in a Hurry: Hospitals in the Managed-Care Age', Suzanne Gordon provides an insightful commentary and critique of the United States of America's managed care mentality, where strategies directed at length of hospital stay have been studied in ways that are biased towards positive outcomes by small numbers, or with no control groups. These studies are accused of trivialising patient and family experiences and shifting costs to the patient and community (Gordon and McCall 1999). Directed at the aim of a universal health care program, Gordon mentions (unfortunately, as opposed to cites, as no references are included) leading USA economists as suggesting that in a period from 1980 to 1993, where inpatient days decreased by 36% per patient, the inpatient costs rose by nearly 53% per patient. Such statistics affirm that what has commonly been removed from hospital care are the periods of low intensity, therefore less expensive care even though it is recognised that an accurate method of measuring illness severity is not yet available (Long and Mann 1998). Despite a
lack of independent or verifiable evidence the contribution of Gordon’s overall argument to contemporary health care debate is that hospitalisation is not the most important health care factor, and that the 'cost cutting potential of shortened hospital stays has been greatly exaggerated, and the effect on overall health care costs is far from certain' (Gordon and McCall 1999:11).

**The re-engineering of hospital services**

Though hospitals in Australia account for most health resource expenditure and employ the majority of health professionals, (Duckett 1998) their traditions of health care are being redefined and relocated with reduction in duration of hospital stay and increases in the quantity and sophistication of care provided outside the hospital environment. Health care trends that are destined to continue are recognised as the compression of length of stay, increased outsourcing and privatisation, renewed efforts to manage quality of care, and greater use of care options such as ambulatory care, day-only hospitalisation, and home care (Braithwaite, 1999; Komesaroff, 1999; KPMG 1996). This transformation in hospital services is most evident in the rapid expansion of health-service delivery in modes other than through admission of an individual into hospital.

Stephen Duckett (1998), a Professor of Health Policy and Dean of Health Sciences at La Trobe University and a prolific commentator on the Australian hospital system, echoes the 'marketisation' of health care, in suggesting that the decline in length of stay forecasts a change in health product definition. He sees a critical factor in Australian hospital services as the changes in what hospital services are provided, and also, more importantly, in when hospital services are provided; that is, before or after discharge from hospital. He considers this shift in the timing of hospital services to be one of the key challenges currently facing Australian hospitals (Duckett 1998). Gardner describes the associated shift in locations of care, from the hospital into the home and community, as 'a new conceptual space where two different types of health services meet, bringing with them different cultural practices and expectations' (Gardner 2000).
Chapter 2: How is it possible to write (about) length of stay?

An Alternative View

Armstrong (1998), in a study of the decline of the hospital as part of the United Kingdom health services, poses an alternative explanation, to that of economics, for hospital reform. Hospital function has previously involved separation of potentially dangerous sick persons from their home and the rest of the population by containment as 'hazard' to the bed. This bed acted not only as a hygienic separation device, but also a 'therapeutic space' to enable nature's 'powers of repair' and to augment medical care (Armstrong 1998). Further, Armstrong suggests that identification of the dangers of cross-infection and iatrogenesis during the 1940s to 1960s, coincided with recognition of the debilitating effects of prolonged bed rest on a person's health and recovery, resulting in questioning the logic of bed rest. Armstrong proposes that research and development of germ theory and the diminished incidence of complications associated with early ambulating have decreased the demand for hospital beds and increased the search for alternative modes of health service delivery (Armstrong 1998). The risk of iatrogenic complications from hospital stays is used to justify changes to hospital stays with Caplan and Brown (1997) writing about the re-engineering of Australian hospitals, suggesting that if hospital care were a drug, its incidence of increasing complications would cause it to be banned.

Despite these analyses, in Australian there has recently been a significant increase in demand for hospital beds. Where overall hospital admissions rose by nearly 50% over the last twelve years, the number of persons admitted for overnight stays has remained unchanged (Deeble 2000). Perhaps the exponential rise in demand for hospital services may well be a demand for new forms of hospital services, such as 'same day surgery', enabled by technological and to a lesser degree pharmacological and home care innovations. This may be seen to concur with Armstrong's proposal that the decline of the hospital is 'the architectural and institutional manifestation of new social representations of the nature of illness' (Armstrong 1998). His summation that the hospital has been re-invented with access to the bed reduced, and the care package that surrounded the patient's bed transferred to the patient's home or the community, seems readily applicable to contemporary Australian hospital health care. The current proliferation of programs
that accomplish a reduction in length of hospital stay, such as day surgery, short stay surgery, early discharge, and home care, provide fertile ground in which to explore his proposal of new representations of illness.

**Length of Stay and Nursing Practice**

How then do we analyse the significance and implications for the reshaping of hospitals and the reduction of length of stay? What might new representations of illness mean for patients and the health workforce; and in particular for nurses, as the largest population of hospital health care providers? It is not only the location of care that is relevant, but also how this impacts on availability and type of health care, and consequently what is understood and experienced as health and illness and responsibilities for individual care.

Specifically in this context, attention is given to how health, thus health care, becomes a social and political issue warranting government action and increasingly defined by personal responsibility and capacity. As hospital funding and length of stay decreases, individuals are discharged earlier from hospital, usually requiring continued care within their homes, or in the homes of family or friends. This care involves increasingly sophisticated skills that need to be provided by the individual, their friends, or their family, with additional visits, backup, support and services from health-care workers usually nurses. This move, however, from institutional-based to community-based health (Baum, 1998), involves not only the capacity to care for oneself, but a differentiation within populations between those requiring care, and those with potential to provide care, that is, the individual or family members (Liaschenko 1994; Gregor 1997).

Purkis (1997) proposes that for governments and others to accomplish this differentiation between populations, they actively draw on the notion of family. This differentiation is also evident in current conceptualisations of quality health services, as underpinned by the proliferation of patient satisfaction studies that purport to consult patients and report patient preferences for shorter hospital stays (Draper and Hill 1994; Commonwealth Department of Health and Aged Care 1998; Draper 1999; Caplan, Ward et al. 1999; KPMG 1996). In this context, 'the success'
of contemporary hospital practices in reducing length of hospital stay needs to be considered in light of connections between the individual and the collective, the ethical and the political.

As identified earlier in this chapter, the implications of these changes for nursing are evident in the growing body of literature, emerging originally from the managed care environment of the USA, and rapidly reflected in Canadian, European and Australian nursing literature, signals dramatic changes in the nursing care-giving role. In striving to develop ideas about modern nursing, nurses have realised that conventional epistemologies founded on traditional sciences are inadequate, and have turned to concepts such as holism and care as socially valued vehicles for professional independence (Cheek, Gibson et al. 1993). Despite a brief period of popularity, holism was soon subject to critique as not only intrusive and unnecessary, (Lawler 1991) or inappropriately opposed to scientific requirements of care, (Parker 2000) but also as a form of rhetoric constrained by medical and institutional forces (Wells 1995) and as yet another sign of the ability of nursing to adapt to historical contingencies (Nelson 2000). Meanwhile, care, and in particular the practice of care giving, though the focus of numerous analyses, has survived into the 21st century as a fundamental tenet of nursing. Buchanan (1999) provides an effective analysis of how the hospital has been legitimised by the work of Foucault and many others, as the place of medicine, in ways that overlook the expanse of nursing hospital practice. However hospital nursing care is currently subject to what Gordon, Benner and Noddings (Gordon, Benner et al. 1996) describe as 'the market challenge'.

Conceptualisations of nursing practice as care-giving is seen as 'at risk' in the current contexts, with hospitals restructuring (as described in this chapter) where the quality and availability of public access to adequate nursing care is seen to be declining (Needleman, Buerhaus et al. 2001; Gordon 2000; Lawler 1999; Sochalski, Aiken et al. 1997; Aitken and Fagin 1997). What has traditionally been understood as hospital nursing care is changing, because of either a lack of available nurses, or else a lack of access to the available nurses, such as through decreased length of hospital stay by patients (Fagin, 2001; Gordon 1997). Though a
number of other rationales are proposed for the changes in hospital nursing, such as changes in the numbers and skill mix of nurses and others employed to provide nursing care, (Needleman, Buerhaus et al. 2001; Aitken and Fagin 1997) a link exists with length of stay in the aim to restrict hospital use and the accomplishment of greater efficiencies in inpatient settings.

New ways of organising hospital patients, such as pre-hospital and short stay units, mean that nurses practicing in hospitals are now required to care for a far more diversified patient population with greater variation in patient characteristics; and in particular, increased patient acuity (Hillman 1999). The variation of skill mix in nursing teams is also a very significant factor, not emphasized here only for the purposes of expediting this thesis. Perhaps the patient diversity or acuity mattered less in the times where hospital stays were longer. However, the current circumstances of patient acuity, new surgical and pharmacological interventions, and decreased length of hospital stay, mean that the periods of observation in which doctors and nurses provided care to patients, at the same time as developing medical and nursing knowledge about patient recovery and passing on knowledge to the patients and families or carers about their condition and how to manage its symptoms, no longer exists. Clarke and Rosen (2001) see this as the shift from focus on the place of care (that is the hospital or home) to the actual components of care. Investigation of the implications of this, or perhaps what might be more fittingly defined as the requirements of these shifts in the way that hospitals function in the delivery of health care, form part of this study.

Gordon describes this provision of quality health care in decreasing periods of face to face contact as a new challenge that forms a 'mission impossible' for nursing (Gordon 1997). One of the impacts of this situation will be seen in the way in which nursing continues in determining what is recognised as 'nursing knowledge' and the definitions of nursing outcomes. The current enthusiasm for an 'evidence base' for practice is but one example of the shaping of nursing outcomes. Liaschenko, writing in 1998 about shifts in nursing knowledge, suggested that nursing had moved from the previously popular notion of nursing advocacy as being able to speak on behalf of a patient, to that of nursing testimony as the idea of
'bearing witness to the event about which one speaks' (Liaschenko 1998). However, a concern emanating from this study, which foregrounds nursing in the contexts of increasing patient acuity and decreasing length of hospital stay, is that nursing may find itself much less able to testify, or at least quite limited in what can be testified about, as nurses increasingly witness (and provide) much less, or perhaps quite different, patient care.

**Summation**

This chapter has explored how length of stay emerges and is produced in literature, policies, procedures and reports as various nursing, medical, political, social, bureaucratic and economic discourses. Between these various locations and authorities what is of interest in understanding about length of stay in this literature, has been its procedural value as measurement. However the rationality and procedures of measurement are overshadowed by its potency as it takes shape as an incentive, or empirical definition, through which it seems possible to shape hospital services.

Though length of stay is apparent through the opening of health care to commercial interests and the promotion of economic competition, to limit considerations of it to a centralising or controlling state or government economic accomplishment diverts attention from how individuals engage with(in) the local practices associated with the currently declining length of hospital stay. It is as yet unclear as to how these forms of length of stay participate in the creation of the various objects and subjects in which it is involved in managing. Though directed at reducing the uncertainty of hospital funding, it is unclear how the various policies and practices associated with length of stay can be understood to 'work' empirically in decreasing hospital length of stay, particularly at the level of nursing and patient practices, not only as political processes, but as aspects of human experience. How does length of stay, and its measurement, shape the purchaser, the provider and the consumer of hospital services?

While clearly now recognised by government as no longer a statistically significant indicator of health care costs, the statistical significance of a phenomenon is,
however, but one consideration. Hospital health care (thus hospital nursing) are human services, therefore '[t]he kinds of action a human body is capable of will depend in part upon its physical constitution, in part upon the enduring social and institutional relations within which it lives, but also upon the frameworks of moral interpretation which define its acts.' (Patton 1998:74). Thus length of hospital stay presents itself as a both a problem and a solution, significant when judged by the volume of references by doctors, nurses, economists, managers and public health researchers in published medical and nursing journals, significant in defining certain objects and subjects of attention, significant in its impact on the diminishing access to nursing care, while contentious in its contribution to costing and facilitating quality health care.

In analysing length of stay, hospital services and nursing practice, the questions of significance are not so much about the effects or impact of particular programs or policies on practices, as means to achieve a decline in hospital length of stay. Though length of stay has been shown to articulate with managerialist interests evident as a totalising rationality of economic efficiency, the questions here are about the productive capacity of these sciences as part of contemporary hospital services. What are the links between rationalities of declining length of hospital stay and the requirements and capacities for being patients and nurses? How is it that patients are discharged from hospital quicker, and some say, sicker? How do nurses and patients articulate themselves and their practices and experiences in this context? To answer such questions, an approach is required that avoids polarising between policies, organisations and individuals, and facilitates analysis of how such entities might network with each other in shaping the very things that contemporary health care purports to encompass, things such as health, health care, hospitals, nurses, doctors, patients, and their carers. It is in this context that this study seeks to examine how our contemporary culture of attention to hospital length of stay might be understood as not only a political form of government, but how a political form of government might, though social connection take shape and shape the practice of nursing.
Chapter 3:
How might we conceptualise writing (about) length of stay?

Introduction

Episodes of hospital care involving decisions about individual experiences of hospitalisation, such as how long a patient stays in hospital and at what point a patient is fit to leave hospital, have resided with medical knowledge and been administered predominately through practices of medical expertise. However, as introduced in the previous chapter, the domains of hospital health care have as much been the business of statisticians, engineers, bureaucrats and even architects, as they have been the domain of doctors or other health care professionals (Osborne, 1996). To study length of hospital stay therefore requires not its abstraction from the networks of rationalities, policies, organisations and various individuals of which it forms part, but rather a conceptual style that is sensitive to the possibilities for connection between various elements and across various locations. This chapter presents such a conceptual style, not only as context for the remaining chapters of this thesis, but also as this folds back to include the contextualisation of length of stay presented in the previous chapter as theoretically consistent with the remainder of the thesis.

The work of Michel Foucault provides a number of theoretical positions applicable to this study. His analyses of concrete social apparatus (dispositifs) or regimes of practices (regimes of truth) illustrate a form of critique that 'does not consist in saying that things are not good as they are. It consists in seeing what kinds of self-evidences, (évidences) liberties, acquired, and non-reflective modes of thought the practices we accept rest on' (Foucault, 1981/1970:33). Accordingly, the approach adopted in this study examines how contemporary hospital surgical services are managed. The aim is to understand how the rationalities and technologies associated with the emergence, prediction and control of length of hospital stay are both constituted by, and constitute individuals and their health and health care practices. In using the work of Foucault, a particular interest is in examining how...
the self emerges, or is produced by precisely those techniques that supposedly only shape it (Prado, 2000). Accordingly, the concept of governmentality, with attention to discourses and technologies, enables analysis of texts available in public and institutional settings, with others generated from the conduct of fieldwork in an acute care hospital to explore what are, after all, abstract issues. It is this practice that Annemarie Mol terms 'the conduct of empirical philosophy' (Law, 1996).

Governmentality is introduced through primary discussion of the work by Foucault on power and the constitution of the self in modern society, since this enables length of hospital stay to be understood as a contemporary technique for managing people. The chapter provides a background against which length of stay can be interpreted as a political practice; practice through which individuals, specifically nurses and hospital patients, can be understood as both self-responsible 'agents', as well as those whose 'nurture and exploitation is essential to the might of the state and quality of life within it' (Dean 1994:185). It is important, therefore, to acknowledge that while this analysis may at first appear remote to the interests of nursing, the issues are grounded in local, daily and individual hospital practices, and are therefore grounded in the conduct of nursing practice.

**Relevant Aspects Of The Work Of Michel Foucault**

Despite numerous debates about the scope and periodisation of Foucault's work and its relationship to that of other 20th century social thinkers, his writing and interviews provide useful conceptualisations of truth, power and subjectivity, and their relationship to the government of conduct (Dumm1996). Foucault did not address health policy; (Osborne, 1997) however in his work there are any number of dimensions or possibilities available through which to explore the productive capacity of length of stay as a largely political project that 'makes up' contemporary episodes of acute hospital patient care. For this study his conceptualisations of power as questions of government, as 'the way in which the conduct of individuals or states might be directed' (Foucault 1982:221) provide a means to disturb length of stay as a growing rationality of modern hospital practices.
The word, *government*, is used by Foucault to convey activity that aims to shape, guide or affect the conduct of some person or persons (Gordon 1991). Therefore studies of *governmentality* are concerned with the kinds of knowledge that bring about problematisations and the strategies, tactics, and programs of government, along with the invention and assemblage of particular apparatus and devices for exercising power and intervening on particular problems. The key to governmentality is examination of the 'new forms of economic and social relations and new political structurations' (Foucault 1994d:68) as the means through which the 'self regulating capacities of subjects (are) shaped and normalised' (Miller 1990). Analyses of governmentality are concerned with the conditions of possibility and intelligibility for certain ways of seeking to act upon the conduct of others or oneself to achieve certain ends (Gordon 1991; Rose, 1999a).

In identifying with the work of Michel Foucault, this study does not however purport to undertake a 'Foucaultian analysis', in the sense of implying that there is a single consistent theory or method belonging to Foucault (Apperley 1997) and therefore applicable to this study. Accordingly, attempts will not be made here to summarise his considerable analyses of how, in modern society, responsibility has been taken for various life processes by those deemed most powerful, by way of illustrating such consistency. Although his ideas about power, truth and subjectivity may be seen to vary throughout his numerous analyses, Armstrong argues that the variation in how Foucault uses concepts differently in various analyses are not signs of inadequacy or a lack of rigour. Rather, they illustrate the deliberate and thoughtful nature of his studies by showing that the idea of a systematic and universally applicable method was the very thing that Foucault questioned (Armstrong 1991). Recognising that a number of foci are available, attention is directed to governmentality, as first used by Foucault in a series of lectures in 1978 and 1979 (Gordon 1991). Therefore, though this study aligns with the notion of a Foucaultian analysis, any claim to a 'Foucaultian method' not only contradicts Foucault's problematisation of the easy attachment of authorship to truth, suggesting that 'a name makes reading too easy', (Kritzman, 1990) but may confuse the conceptual framework that is assembled here, with the diversity, complexity and controversy of Foucault's extensive analyses.
Only those aspects of Foucault's analyses as presented here inform this study. Foucault referred to his books as '... little tool boxes ... if people want to open them, to use this sentence or that idea as a screwdriver or spanner to short circuit, discredit or smash systems of power ... so much the better' (Patton, 1990). Therefore, in contrast to some debates, it is proposed that there is a consistency to Foucault's notions of subjectivity. Evident in his later work, subjectivity is linked to global political matters, where governmentality, power and subjectivity enable a form of criticism directed at 'how men [sic] govern (themselves and others) by the production of truth' (Foucault, 1991:79). It is important to note, however, that for Foucault, like other poststructural theorists, the true has no universal nature (Deleuze, 1991). There are only truths, that is, truths of enunciation, truths of light and visibility, truths of power, and truths of subjectivation (Deleuze, 1991). Truth then, is the formation of domains in which the practice of defining true and false can be made at once ordered and pertinent (Foucault 1991b). Thus the problem of reconciling hospital length of stay and its management and how it shapes and produces knowledge and understanding about health care for hospital patients, hospital administrators, as well as health care professionals, is explored as one particular (inevitability incomplete) project which may well have taken other directions.

One of the mechanisms through which governmentality, or power as government, can be understood to occur is through discourse. As a significant element in Foucault's analyses, discourse varies in design and application, as evident in Foucault's explanation of his use of the word as:

'sometimes using the word to mean the general domain of all statements (énoncés), sometimes as an individualisable group of statements (énoncés), and sometimes as an ordered practice which takes account of a certain number of statements (énoncés)' (Foucault 1992a:16).

Foucault's focus is in the rules of formation through which groups of statements achieve a unity as a science, theory or text. Thus discourse can be understood to be 'a group of ideas or patterned ways of thinking which can be identified in textual and verbal communications while also located in wider social structures' (Lupton,
Chapter 3: How might we conceptualise writing (about) length of stay?

1992:146). However, it is significant to also note that ‘… we must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies' and ‘… whose tactical function is neither uniform nor stable' (Foucault 1990 /1978:100). Thus it is discourses as 'regimes or games of truth' that constitute both subjects and objects, not only under certain simultaneous conditions, but also as constantly modified in relation to each other, therefore modifying the field of experience itself (Florence, 1998). Chapter 2 presented various statements through which conditions have been established for length of hospital stay to be spoken about. Before casemix policies and DRG development, length of hospital stay (like clinical decision making) was limited to the treatment or care required during hospital stay, rather than the duration of stay, or attempts to decrease the duration of stay, or the association with funding for hospitals. It is recognition of the multiplicity and variability, as well as modification in discursive formations, which signals the need to extend analysis beyond the concept of discourse to include its modalities as relations of power.

Technologies refer to the diverse and heterogeneous means, mechanisms and instruments through which governing, the 'arts of government' (Foucault 1991a) thus power relations are accomplished (Dean 1999). Foucault identified two main technologies as those of domination of subjects, and those of self constitution. As will be discussed further, this is not to suggest the idea of a self governing subject (Prado 2000). The conceptualisation of government as power relations is particularly useful for understanding how ideas of a self are reasoned; for in order to work, governing involves the formation of the subjectivities through which it can work (Foucault 1982). It is to this task that an analytics of government is directed, and which Dean (1999) argues is not a study of politics or power, as much as a study of attempts to rationally affect the conduct of others and ourselves. However, rather than consider rationality as separate to power, it is this very relationship between reason and power that is visible as the focus of Foucault's writing (Gordon, 1980). For now, and as will be discussed further in this chapter, this affect is more complex than positivist notions of causality. Attention is given in this study to governmentality as it facilitates analysis of how the current decline in length of stay
is accomplished, and what this (or these) accomplishments(s) achieve.

Though the relative popularity of Foucault's approach to discourse analysis is evident in the proliferation of studies drawing on his work, his later work on governmentality has until recently received less attention. The tenets of governmentality, as will be expanded later in this chapter, are understood as the governing of individuals, at a distance from government, and by expertise and knowledge of populations. Rose (1999a) suggests that attention to governmentality enables movement from empirical descriptions of routines of government, to understanding how such routines are or can be thought. He argues that it is in forms of thought that attempts to unify and rationalise techniques and practices in relation to particular sets of objectives, diagnoses and schemata, can be found.

Therefore governmentality is not the representation of individual consciousness, but the bodies of knowledge, belief and opinion in which we are immersed (Dean, 1999). However, in order to understand political action it is necessary to understand how rationalities might be implicated in the exercise of governance (Dean, 1994). It is in this sense that a discussion of rationality foregrounds more detailed discussion of governmentality, power and subjectivity, since these concepts perform methodologically to inform analysis of hospitals, length of stay, and episodes of acute care.

**Rationality: Attention To Thought**

The ideas of Weber and Foucault as primary theorists of rationality are juxtaposed with those of Crozier to provide an introduction to understanding how the contexts of increasing rationality might be comprehended. Weber sought to explain the place of the modern individual in the rationalised world through discussion of modernity and rationalisation in the contexts of organisations (Weber, 1978). He was interested in theories of bureaucracy and rationalisation, and the historical development of the 'ideal type' (Crozier, 1964) as an organisational process by which the disciplined, disenchanted, and depersonalised modern world was produced through a universal compulsion to consistency, order and rigour, with the modern individual imprisoned in bureaucratic systems (Weber, 1978; Whimster,
1987). Through discussion of different forms of rationality, Weber argued that there was no single reason or universal standard by which to judge all forms of thought (Dean 1999). Weber claimed that modern bureaucracies achieved legitimate authority; that is, domination, through processes of legal–rational authority. He argued that all social action shared the feature of instrumental rationality, as goal-oriented strategic action (Kearney and Rainwater 1989:196). Bureaucratisation as the rationalisation of collective identities (Crozier, 1964) was accomplished through capitalistic economic activities, such as accounting, whereby 'the modern rational organisation of the capitalistic enterprise … develop[ed] in the separation of business from the household' (Weber, 1992 /1930:21-22).

The instrumental rationality of the Enlightenment's positivistic, technocratic and rationalistic identification with progress, absolute truths, ideal social orders, and standardisation of knowledge and production, (Sarup 1988) for Weber, leads not to universal freedom and happiness, but is bounded by an 'iron cage' of bureaucratic rationality (Weber 1978). He suggested that rationality is a phenomenon that permeates all major institutions of capitalist society, and refers to the extension of the calculative attitudes of a technical character, epitomised in scientific reason, and given substantive expression in the increasing role that science and technology play in modern life (Giddens and Held 1982:9). Hence technique is relevant to instrumental rational behaviours because it defines the means by which given ends can be achieved.

Consistent with Weber's structuralist beliefs, the increasing spread of bureaucracy is an inevitable accompaniment of the rationalised character of capitalist society, with technical rationalisation, requiring that behaviour be reproduced by others who follow rules laid down by such techniques; that is, the 'iron cage' (Giddens and Held 1982:9). In contrast to Marx's idea of bureaucracy as state apparatus, Weber sees bureaucracy as characterising all forms of large scale organisation, yet shares with Marx a view that bureaucracy is not accountable to the massed population affected by its decisions. For Weber there is no way of surpassing bureaucratic domination other than by avoiding the spread of bureaucracy. Weber's notion of rationality is based on types of social action or legitimate domination evident in the
value rational approach to the economic rationalisation of health care delivery. Not inconsistent with the ideas of Foucault, Weber describes different forms of rationality: the individual subject and its conduct, and the rationality of the capitalist economy, modern law and administration, with forms of rationality embodied in different institutional practices and techniques. His ideas and those of Crozier were based on a philosophy that assumes a unified individual subject capable of acting rationally by choosing ends and means of action according to the actor's own evaluation and assessment (Hindness, 1987).

Crozier's work on the 'the bureaucratic phenomenon' complements the idea that all dominance involves attempts to achieve freedom through strict impositions on others. However in contrast to Weber, Crozier focused his studies of bureaucracy at the operational level of specific cases where the 'frustrating complicated slowness of procedures' could be understood as the 'maladapted responses of "bureaucratic" organisations to the needs which they should satisfy' (Crozier, 1964:3). Interested in bureaucratic organisations as cultural and social systems of society, (Crozier, 1964:210) Crozier suggested that the ruling position belonged to those not trapped within the 'iron cage' of bureaucracy, but able to 'make their own situation opaque and their actions impenetrable for the outsiders, while keeping them clear to themselves' (Bauman, 1998:33). It is this uncertainty within Crozier’s verdict that Bauman suggests is still relevant. That the 'people who manage to keep their own actions unbound, norm free and so unpredictable, while normatively regulating (routinizing, and thereby rendering monotonous, repetitive and predictable) the actions of their protagonists, rule' (Bauman, 2000:119).

Foucault shares with Crozier an interest in the visibility of power and margins of liberty as the locations where changes can be effected (Crozier, 1964; Bauman 1998:33). However, his focus was not the organisation as much as practice, where 'means-to-ends rationality is temporally and culturally contextual' (Prado 2000:107). In this way Foucault reworks Weber's and Crozier's rationality as the legitimate (or otherwise) discursive structures of political order, to see it as governmental rationalities of particular practices. It is because Foucault opposes rationality and power, to force and violence, that he speaks of rationality rather
than rationalisation, of governmentality rather than government (Brown 1998). Hence it is his challenge to 'analyse specific rationalities rather than always invoking the progress of rationalization in general' (Foucault in Dreyfus and Rabinow 1982:210), which informs this study of hospital length of stay.

Though Turner (1997:xvii) argues that Foucault's studies of discipline, power and governmentality have an 'intellectual proximity' to Weber's instrumental rationality and bureaucracy, there is much literature that warns of the inability to argue for theoretical continuities between these two (Gordon 1987). Foucault does, however, inherit from Weber a concern for rationalisation and objectification as significant cultural trends and important problems of our time (Dreyfus, 1982:166). Following Weber's prophecy of the 'deadening' effects of bureaucratic, economic and cultural rationalisation, (Whimster 1987) Foucault makes apparent the implications of modern institutions for the autonomy of the person by reworking Weber's rationality as a legitimisation of violence. Weber considered that the state claims monopoly over the use of violence (Weber 1978) whereas for Foucault, governmental rationality is a mode of power that is precisely what releases governments from the need to use instrumental violence and therefore replaces violence as a mode of governance (Brown 1998).

Foucault argues for the historical nature of rationality, as 'the techniques and procedures accorded value in the acquisition of truth' (Foucault 1980c:131). As will be discussed later in this chapter, Foucault's analyses of 'policing' reconfigures an explicit mode of violence to the application of detailed knowledge to specific relationships, such as that of medicine (Foucault 1991a). The application of this 'detailed knowledge' can be seen in the forms of seduction and repression, which make the need for legitimation redundant (Seidman 1988:191).

Programs and technologies of government are therefore assemblages that may have rationality, but the rationality is not one of coherence or singular essence (Rose 1999a). Rationalities are discourses that address practical questions concerning how to conduct the conduct of the state and the population, which the state claims to rule (Hindess 1996). Foucault stated that he was not preoccupied with rationality
'as an anthropological invariant' (Foucault 1991b) and considered that the use of the word needs to be shifted away from intentions, and restricted to an instrumental and relative meaning. Thus practices do not exist without a certain regime of rationality. Attempts to unify and rationalise techniques and practices in relation to particular sets of objectives, diagnoses and schemata can be found in forms of thought (Rose 1999a). Thought is not what gives action its meaning, rather it is what can be understood to be the practice of freedom (Foucault 1997). 'The individual is an effect of power, and at the same time, or precisely to the extent to which it is that effect, it is the element of its articulation' (Foucault 1980b:98).

Definitions of rationality and the bureaucracy that governs individual behaviour and decision-making are limited in their application to understanding actual practices. Just as knowledge of the body is not limited to the "science of its functioning", (Prado 2000:55) so successful intervention in the social world enable rationalities to be understood as 'objectively' rational. Foucault's analyses of institutions provide evidence of where programs of government 'act as grids for the perception and evaluation of things', (Gordon 1991:8-11) with the constitution and complicity of subjects evident as internalising coordinated and value-laden understandings of the self as accomplished through political technology where:

[p]olitical rationalities conceptualise and justify goals as well as the means to achieve them, thus defining the proper parameters of political action and the institutional framework appropriate to those limits. They do so through discourses that makes it seem as if techniques are addressing a common problem through shared logic and principles. Political rationalities are purposively rational in that, by providing generalised principles they enable systematic pursuit of values, the determination of ends selected according to those values and effective planning of the application of means to achieve those given ends. The combination of technical and purposive rationality in political discourse renders it programmatic, inducing methodically rational conduct which is simultaneously rule governed, reproducible and principled (Simmons 1995:38).

Hence this study of length of stay challenges the idea of consistencies of length of hospital stay with an analytics of government, assuming that discourses on
government are an important part of government rather than simply a means of 'violence' or legitimation. Length of stay does not exist in a form that has sufficient power to operationalise itself in framing hospital services, thus government of hospital stay needs to be accomplished through multiple actors and agencies rather than as a set of state apparatus implementing an *a priori* distribution of power and authority (Latour and Woolgar 1986). Hence the challenge here is to discover 'how forms of rationalisation became embodied in practices, or systems of practices', (Foucault 1990/1978:47) such that this informs how hospital length of stay power-relations are rationalised, rather than simply the ways in which power is used (Kritzman 1990).

**Government: Attention To Power**

Power, an extensive yet problematic component of analyses of modern Western thought, has been a significant component of Foucault's work (Hindess 1996). Liberalist, pluralist and structuralist debates contest various definitions of power as the capacity to act, with the right to act (Hindess 1996). Modernist conceptions of power situate power in relation to its exercise, in sovereign forms of rule that exist as a result of a contract between two consenting parties. This conceptualisation assumes that both the sovereign and subject exist in a relationship *prior* to the exercise of power and that power is the result, rather than the productive cause, of this relationship. However, *degrees* of power, as the realisation of outcomes cannot simply be assumed from the capacities of those exercising power. As mentioned previously, power is a significant feature of Foucault's work, with his greatest contribution to social theory seen as his reconstitution of how power is understood. For Foucault, attention is needed not to theories of *power over*, as in forms of domination, but to power as the capacity to influence others (Foucault 1991a).

Power can thus be effectively understood not as a reified thing, but as a process and strategy that maintains a relation between what is 'sayable', and however indirect, what is visible (Kendall and Wickham 1999). Foucault proposes that power could never be possessed by an individual or appropriated as a commodity or piece of wealth. Rather, it is employed and exercised through netlike organisation (Foucault 1980b:98). However there could be no power relation without the correlative
constituent of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations (Foucault 1980c). Therefore what is analysed is not power, rather it is the relational tactics and strategies by which power is circulated. Foucault proposes that it is the different power relationships that existed between strategic games and liberties that needed to be analysed (Bernauer and Rasmussen 1994). Strategic games were what resulted in some people determining the conduct of others, whereas states of domination are what are more commonly recognised as power (Bernauer and Rasmussen 1994).

**Power And Subjectivity**

Focus on the issue of subjectivity provides this study with a way in which to examine length of hospital stay other than as the emergence (and perhaps passing) of a new phenomenon shaping hospital patient and nursing practices. Subjectivity provides a way to understand the success (or otherwise) of hospitals in accomplishing quite considerable decreases in the length of stay, by recognising that subjects are not only ruled, but also motivated to comply with what is presented as *shared* ideals of short hospital stay. While power is presumed to be inherent in all of Foucault's work, it is most apparent in his conceptualisation as a positive constitutive element that underlies all social relations from the institutional to the inter-subjective. Foucault's preoccupation was with how power relations were created and maintained through what were understood as humane and freely adopted social practices (Foucault 2000a). Thus Foucault declared that 'it is not power, but the subject, which is the general theme of my research' (Foucault 1982:209).

Consistent with other poststructural theorists the experience of being a person is captured, for Foucault, in the notion of subjectivity. He proposes that as histories of the present, his studies sought not 'solid identities of the past' but their 'unrealization'. Thus the purpose was not to 'discover the roots of our identity, but to commit itself to its dissipation' (Foucault 1994f:386). Subjectivity is therefore constituted through those (multiple) discourses in which the person is being positioned at any one time. Foucault used the word 'subject' to articulate a form of power that simultaneously 'subjugates and makes subject to' (Foucault 1983:212).
Therefore a subject is that which is amenable to the effects of power. However, to be amenable to power 'there has to be a "being" serving as an alibi if the process of subjectification is to be effective' (Racevskis 1994:23). Hence being is but an effect of discourse that naturalises the situation of individuals in the universe or collective destiny.

Foucault was concerned to emphasise the subject and its choices as largely determined by prevailing discourses, and specified three modes of objectification which transform human beings into subjects: objectivisation of the speaking subject, dividing practices, and the transformation of humans into subjects (Foucault 1982:208). The first mode is 'organised scientific discourse' where forms of knowledge with the status of sciences objectify speaking subjects through economies (orders) of discourse (Foucault 1980c; Foucault 1991c). In this type of analysis the discursive relations sought are characterised as a political economy of truth … centred on the form of scientific discourse and the institutions which produce it; it is subject to constant economic and political incitement (the demand for truth, as much for economic power as for political power); it is the object, under diverse forms, of immense diffusion and consumption (circulating through apparatuses of education and information whose extent is relatively broad in the social body, not withstanding certain strict limitations); it is not exclusive, of a few great political and economic apparatuses (university, army, writing, media); lastly, it is the issue of a whole political debate and social confrontation (ideological struggles) (1984:73).

Regimes of truth are the types of discourse that society accepts and makes function as true, through mechanisms which distinguish between true and false statements: the means by which each statement is sanctioned, the techniques and procedures accorded value in the acquisition of truth, and the status of those who are charged with saying what counts as true (Foucault 1980a). Foucault analysed how the emergence of modern juridical and the human sciences of medicine and psychiatry was simultaneous with the emergence of new technologies for governing people, (Simmons, 1995) illustrating Foucault's proposal that '… there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that
does not presuppose and constitute at the same time power relations' (Foucault 1995/1977:27).

Truth is therefore not discovered and accepted, but an ensemble of rules according to which the true and false are separated and specific effect of power attached to what is referred to as the truth (Foucault 1980a). The operations of such power therefore need to be studied at the point of the object and field of application, where powerful strategies are installed and produce real effects (Foucault 1980b). However, truth centered on forms of scientific discourse and the institutions that produce them, is also subject to constant economic and political demands (Foucault 1980b; Foucault 1980c).

In this study, this approach provides a position from which to analyse expertise and the role of expert knowledge and authority, which is particularly evident in this study within the juxtaposition of economic discourses with those of medicine. The aim is not to identify the truth in discourse, especially truth that presents as an individual's consciousness, but to detach the power of truth from forms of hegemony, be they social, economic and/or cultural (Foucault 1980a). Not that Foucault's analyses seek to liberate individuals from power, or suggest a better situation or practice (recognising that Foucault's work is said to be famous for failing to offer ideas about what 'should be') (Fraser 1989:56). Rather, a politics of truth seeks to change the production of truth, as truth 'isn't outside power, or lacking in power' (Foucault 1980a) but 'produced by multiple forms of constraint' (Foucault 1980c) that form the 'regimes of truth' or types of discourse accepted in a given society. The significance of this for Foucault, and also applicable here, is that 'people know what they do; they frequently know why they do what they do; but what they don't know, is what what they do, does' (Dreyfus and Rabinow 1982:187).

As an example, Foucault's studies of sexuality provide five ways in which confession was able to create sexuality as something that needed to be dealt with scientifically; that is, as 'a complex machinery for producing true discourses on sex' (Foucault 1990/1985:68). These 'techniques were the clinical codification of the
inducement to speak evident in the combination of examination with confession, the postulate of general and diffuse causality in which sex was endowed with "an inexhaustible and polymorphous causal power" (Foucault 1990/1985:65), the principle of latency intrinsic to sexuality which required the extraction of truths, the method of interpretation and the medicalisation of the effects of confession where the requirement for, and skill of the person being confessed to, involved interpretation or 'recodification' through processes of comparison.(Foucault 1990/1985).

The second mode through which subjects are 'made' is the 'normalising or dividing practices', as constituted through specific disciplinary techniques of 'hierarchical observation', 'normalizing judgement', and 'the examination', where one is either 'divided from himself [sic] or others' (Foucault 1982). It is here within heterogeneous practices that 'one would locate a description of the configurations of processes within which persons and populations were produced as objects of medical attention' (Rose 1994:51). The Panopticon is the commonly cited metaphor used to illustrate disciplinary technologies or technologies of domination which function by structuring visibility by those with authority, and the compilation of reports and dossiers to enable comparison of subjects (Foucault 1975). In these ways the notions of normalisation and surveillance are combined to constitute the 'all-seeing' power of a uni-directional and normalising gaze, which is orientated to producing 'regimented, isolated, and self-policing subjects' (Foucault, 1980d). Hence disciplinary technologies act on the body to control individuals through the production of 'docile bodies' via the uni-directionality and anonymity of the gaze, and linking within the institution a central 'observer' with a multiplicity of 'observed'.

Power/knowledge relations or techniques of power provided specific ways of understanding how the modern subject was a fabrication made available by the humans sciences (Rose 1994; Rose 1999b). The behaviour of individuals was also seen as able to be shaped or controlled, by these human sciences, however this fails to address 'the global issues of politics, namely the relations between society and the state' (Gordon, 1991:4). Though Foucault did not believe in an essential subject,
he did believe that humanity existed as a hallmark of modernity. Hence his work on the history of sexuality introduced a new form of power, bio-power (Foucault 1990), concerned not only with managing the processes of life in a disciplinary and 'anatomical' way, but also on a social level, biopower treated:

the body as a machine: its disciplining, the optimizing of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls, all ensured by the procedures of power that characterised the disciplines (Foucault, 1988/1986:139).

However, governing also concerned a new form of object, the population, and a new form of subject, the members of a population (Foucault 1991a:101; Moss, 1998:2; Gordon, 1991). Bio-power concentrates on life and the use of power to produce (that is, control or coerce) healthy individual bodies and populations based on a view of them as resources and manageable bodies (Dreyfus and Rabinow 1982:133). Rose argues that the two central axes through which medicine became meshed in this policing, were through the axes of statistics and administration (Rose 1994; Rose 1999a; Rose 1998). These axes are visible in this study in various diagnostic categories, such as types of surgery, beds, and classifications according to time through which short stay patients are constituted and managed, and organised through numerous spaces and technologies to ensure their participation in maintaining predictable length of hospital stays.

Foucault's third mode for studying subjects involved 'techniques or technologies of the self' (Foucault 1988b; Foucault 1988c). These technologies involve the employment of self discipline by human beings to develop a sense of self described by Foucault as an 'ethics' by which to transform themselves to attain certain states of happiness, wisdom, perfection or immortality (Foucault 1988b). Thereby through techniques of the self or 'arts of existence', individuals actively fashion their own identities in governing the self. However, in focusing on ethics, Foucault was not so much shifting attention from bodies or disciplines, to populations and the self, as adding attention to 'power over life' operating at the level of populations. Foucault asked that we 'see things both in terms of replacement of a society of sovereign by a disciplinary society and the subsequent replacement of a
disciplinary society by a society of government, in reality one has a triangle, sovereignty-discipline-government' (Foucault 1991a:102). In response to some of his critics, (Gordon 1991) this analytical development afforded him a way of understanding the continuity between the personal projects of citizens and images of social order (Miller and Rose 1988). That is, between the discipline of the self and the government of the state. Foucault encapsulated in the word governmentality, changes in the technologies of, and attitudes towards governing, developed in the eighteenth century in Europe (Danaher and Schirato et al 2000).

**Governmentality**

Foucault substituted the word 'government' for 'power' after the publication of Discipline and Punish, (1995/ 1977) to avoid an 'extremist denunciation' of power as a repressive model (Hindess 1996). However this use of government was not reflective of the liberal sense of a formal institution of government, but more loosely related to being governed by a power structure of some kind. Governmentality has since become a conceptual technique for analysing the political rationality of the modern state through new forms of economic and social (power) relations, what Foucault called 'the arts of government' (Foucault 1991a)

In operationalising his interest in 'the type of rationality implemented in the exercise of state power', (Foucault 1988b:73) Foucault proposed that the idea or art of government had broken with Machiavellian concerns of territorial links of ruler and state. Hence, he coined the complex and multidimensional term 'governmentality' to describe the 18th century emergence of an art of government organised to maximise the capacities of populations. It was the economic changes during the 18th century that demanded the means to ensure the 'circulation of effects of power through progressively finer channels, gaining access to individuals themselves, to their bodies, their gestures and all their daily actions' (Foucault 1991a:100). Foucault described this as a political economy, where the 'resources–population relationship' was recognised as no longer able to be controlled or managed through coercive regulatory system(s) (Foucault 1994d:69). Subsequently, access to individuals was necessary to gain the information deemed necessary to assist not so much the implementing act of governing, but rather to ensure the welfare or security of the population. Thus
the population came to represent more the end of government than the power
of the sovereign; the population is the subject of needs, of aspirations, but it
is also the object in the hands of the government, aware vis-à-vis the
government, of what it wants, but ignorant of what is being done to it
(Foucault 1991a:100).

Dean (1999:18) proposes that we govern according to various truths about our
existence and the ways in which we govern give rise to different ways of producing
truth; however, this conduct is not random. The arts of government are bound up
with not only the object of the population, but also the discovery of a new reality,
that is the economy defined as a set of relationships (Dean 1999:19). Thus the [arts
of] government conduct are directed at the accomplishment of a political economy,
such as where length of hospital stay can be understood to link with political
economies of efficiency, as political economy, as scientific knowledge which
forms, but is not solely, an art of government (Gordon 1991:16). Political economy
depends upon the wealth of the population, (Foucault 1991a) therefore issues of
sovereignty and territory are secondary to the efficient management of 'men [sic]
and things' (McNay 1994). As such, political economy

arises out of perception of new networks of continuous and multiple
relations between populations, territory and wealth; and this is accompanied
by the formation of a type of intervention characteristic of government,
namely intervention in the field of economy and population. (Foucault
1991a:101)

Thus analyses of the exercise of power extend beyond the individual to include the
management of populations relating to domains of ethics and politics; the 'practices
of self' and 'practices of government' where it is through such modes of power that
governmentality weaves as practices of self and government, without reduction of
one to the other. Government is thus a continuity in forms of rationality which do
not emerge from 'the state', but are all-pervasive as they are [re]constituted in the
'microphysics of power' (and the political technology of the body) and the concerns
of the government of nations, populations and societies' (Dean 1994:176).
Governmentality defines 'the contact between the technologies of domination of others and those of the self, (Foucault 1988:19) with government now the calculated administration of the life of the population for the purposes of economy (Rose 1998). Thus operations of governmentality are sought in this analysis of length of hospital stay, as 'programs of conduct which have prescriptive effects regarding what is to be done … and codifying effects regarding what is to be known' (Foucault 1991a:75). Length of stay is to be explored not only as forms of knowledge and power, but also as how such forms function as rationalities; that is, a set of knowledges, practices and interventions rationalized by the norm of the optimization of life of each individual and the population as a whole (Dean 1999). This aim also requires examination of power and authority in the sense of actors already being the result of some governmental action such as disciplinary, biopolitical, or ethical, that has produced certain shapes as citizens, consumers, communities or societies (Dean 2000:199).

In analysis of these new forms of government, subjects are guided to achieve these various ends, and learning how to guide the actions of individuals becomes the art of government which requires 'knowledge of the subjects "soul" and officials who could monitor and account for each and every individual' (Moss 1998:3). Thus the goal of governance is to persuade groups of individuals to behave in a certain way without provoking them into thinking critically about (and therefore potentially dissenting from) what they are being asked to do.

While there is inevitably an economic cost to the exercise of power, a political cost can also be paid where power is too violent and runs the risk of revolt (Foucault 1977). In governance, the already existing conscious motivations of the subject are steered in any number of directions. Once those motivations are known, rules are structured in such a way as to extract optimum kinds of behaviour (Rose 1999a:22). The object of discipline is not to manipulate the existing tendencies, but to create new, particular capacities. Hence the applicability of governmental analysis to understanding length of stay is that it styles the investigation to study how certain capacities of individuals, such as nurses and hospital patients, are
produced and shaped, and also, how length of stay and episodes of acute care are produced and shaped.

Therefore the notion of governmentality broadens the category of power by distinguishing between violence domination and the type of power relations that characterise the relations between individuals. Whereas disciplinary power suggests the inscriptions of power in one direction, such as on bodies, governmentality is less one-dimensional and allows social systems to be explained as 'an endless play of domination' (McNay 1994).

In Foucault's analyses of government, liberalism is seen to provide a paradigm of modern power, which makes certain techniques of government explicit (Gordon, 1991). Two substantive differences are proposed between the work of Foucault and liberal thought. The first is Foucault's assertion that power and freedom are inextricably linked rather than in opposition, the second, as discussed previously, is that the individual is an effect of power relations, or the 'vehicles of power rather than its point of application'. The concept of neoliberalism is linked to particular forms of rational self conduct as consciously contrived styles of conduct (Rose 1993; Burchell 1993; Gordon 1991) and therefore valuable as a theoretical attachment to some of Foucault's more general ideas about liberalism to facilitate analyses of contemporary health and social care (Bunton 1997). These contemporary forms of liberalism (neo or advanced liberalism) retain the liberal presumption that the real is programmable by authorities, and that the objects of government can be rendered thinkable in a way that their difficulties appear to be amendable to diagnosis, prescription and cure (Rose 1999). Neoliberalism, as a mentality of government aimed at managing problems of welfare and reducing costs, (Rose 1999:137–139) provides a way to understand how attention to, and government of hospital length of stay is not accomplished so much by a direct will to control or rule, as by strategies or incentives which involve subjects and the practices of freedom.

**Freedom**

Returning to Foucault's notion of subjectivity, power relations are understood to require power on both sides, therefore it is power relations that constitute freedom,
with games of truth indicating an ensemble of rules for the production of the truth (Bernauer and Rasmussen 1994:16). The games of truth are ensembles of rules or procedures for the production of truth, which equates to a certain style of outcome or results (Bernauer and Rasmussen 1994:16). Rose (1999a) draws on Foucault's ideas to suggest that there cannot be practices of freedom if there is not liberty, because otherwise there would not be a power relationship, it would just be domination. Thus '… if there were no possibility of resistance, of violent resistance of escape of ruse, of strategies that reverse the situation, there would be no relations of power' (Bernauer and Rasmussen 1994:12). The exercise of power as government, differs from domination through the capacity for action. To dominate is to prevent action, whereas to govern is to acknowledge and use the capacity for action, which of course presupposes a freedom of the governed (Rose 1999a:4). Thus power operates 'intra-individually' on a population of acts, gestures, bodily articulation, and mental classifications. The effect is to re-absorb as part of a general interpretive scheme the demographic population as well as 'gain a series of interpreting devices linking macro with micro explanations' (Pizzorno 1992:211).

Recognising an obvious relationship between rationalisation, the excesses of political power, and moral questions, (Foucault 1982:210) morality is seen as attempts to make oneself accountable for one's own actions, or as a practice where human beings take their own conduct to be subject to self-regulation (Dean 1999:11). Thus, for patients and nurses, and all others involved in health care, it is in government as linked to ethics that questions of freedom are raised; remembering that the freedom of the individual from oppressive aspects of modern society is not contingent on a meta-narrative of justice or morality grounded in an idea of transcendental rationality (McNay 1994:143). Where government gives shape to freedom it is not constitutive of freedom (Dean 1999). Government is based on the existence of a subject who is free as a living and thinking being, endowed with bodily and mental capacities (Patton 1998).

Hence those who are governed, are to some extent capable of acting and thinking otherwise; for example, where the governed are empowered by expertise or required to act as consumers in a market system (Dean 1999). Where certain modes
of governing are deemed liberal, this is accomplished by working through the freedom or capacities of the governed (Rose 1999; Rose 1998; Petersen 1997). Liberal ways of governing are therefore seen as 'technical means of securing the ends of government' (Dean 1999:15). This is accomplished by defining the nature, source, effects and possible utility of these capacities of acting and thinking, with the forms of governmental engagement providing a means of interrogating the form of 'indirect' or 'decentralised' government, described as 'liberal' (Osborne 1997; Goodwin 1996). Thus within this frame of liberal government, the strategies of regulation and forms of authority that participate in the systems of rule (in this instance the duration of hospital care) governing is understood to form a complex web of power relations. These power relations exist between the institutions and authorities (as 'political'), and the 'disciplinary' forces (as 'non-political') that (re)constitute individuals (and groups of individuals) in relation to a 'norm' (Foucault 1980d).

By taking the practice of power as his starting point, Foucault provides a parallel to Weber's studies of domination and rulership. Whereas for Weber the subject was on the receiving end of structures of power, Foucault proposes the individuating processes of power as facilitating subjugation. This needs to be remembered in the context that forms of identity promoted by various practices and programs of government should not be confused with a 'real subject' that exists outside of discursive formations and relations of power. Thus there is an ontological distinction in Foucault's work, as the difference between the field, which governs the acts of all persons, and the specific way in which each person acts (Dreyfus 1991).

While the subject as a unified, coherent reference point with free will and stable identity is disputed by poststructuralist theorists, (Rosenau 1992) Bauman (1995:81) who it is necessary to acknowledge does think there is a self, proposes that it is the stable and durable constructions of identity that position identity as a modern invention situated within a culture of 'identity building'. He suggests that explorations of postmodern identity aim to 'avoid fixation and keep the options open', (Bauman 1995:81) thus the subject is perhaps only ever presented in quite
Chapter 3: How might we conceptualise writing (about) length of stay?

particular games of truth, with such 'games' not imposed from outside according to a necessary causality or domination (Florence 1998).

Foucault claims that the imposition of a rationality that claims universal status, necessarily involves the institution of hierarchical power relations based on the derogation of an 'other' (McNay 1994:37). What Foucault was interested in, was 'how the subject constituted himself in such and such a determined form, as a mad subject, or as a normal subject through a certain number of practices which were games of truth, applications of power' (Foucault 1994a 281-282). Foucault believes that practices are always determined by social contexts, so he avoided defining autonomy in essentialist terms only. As indicated in the earlier discussion of governmental rationality, the agency of a person is no less an achievement of discipline, than an achievement of an organisation or social structure.

Therefore in constituting our subjectivity and in shaping and reproducing our practice, we contribute directly to governmentality (Gordon 1991), where practices '… work by working their authors …' through '… mundane acts of self authorisation which sustain the practitioner as compliant identity, a self policing individual' (Usher, Bryant et al. 1997). This is evident in the government of health care as practices that construct health care in particular ways, and therefore hospitals as well as health care professionals and health care recipients. Thus practice becomes governed by an ever-shifting agenda that one contributes to as author, yet there is no single author or authoritative source (Usher Bryant et al. 1997). Practices of translation are understood as where

one actor or force is able to require or count upon a particular way of thinking and acting from another, hence assembling them together into a network not because of legal or institutional ties or dependencies, but because they have come to construe their problems in allied ways and their fate as in some way bound up with one another (Miller and Rose 1990:10).

The ethics of the self is therefore an outcome of government at the level of individual relations; an 'agnostic and combative struggle' between free individuals who 'try to control, to determine, to delimit the liberty of others' (Foucault 1994a).
In contrast to the object of sovereign power as the exercise of authority over subjects of the state, the object of disciplinary power is the regulation of, and ordering of numbers of people within a territory where the object of government considers 'subjects and the forces and capacities of living individuals, as members of a population, as resources to be fostered, to be used and to be optimised' (Dean, 1999:20). With the fragmentation of the centralised state, power is spatialised along different dimensions, calling for new techniques for analysing regimes of government. Practices of government are deliberate attempts to shape conduct in certain ways in relation to certain objectives (Rose 1999a; Rose 1998). Hence governing is a heterogeneous dimension of thought and action that requires an understanding of what motivates the domains or entities to be governed so as to be able to capitalise on this to the facility for self action (Rose 1998). This, Rose (1999a) calls the practices of freedom as part of government.

This governing, or regulating of individuals, provides a basis from which resistance to government can be articulated. Resistance is understood to arise where power relations are the most intense. It is the replacement of docile bodies with a more active understanding of the subject, with resistance as part of techniques of the self, which renders the idea of resistance plausible. Examination of forms of identity is therefore not to discover what we are, 'but to refuse what we are—to refuse the kind of individuality, which has been imposed on us for several centuries' (Foucault 1988b). The resistance of the government of individualisation gives rise to the project of the self. The work on the self is analysable, not as a symptom of forces that break with ideas of tradition, but through questioning of aspects of conduct, the techniques it encourages, the 'practices of the self', the population it targets, the goals it seeks, and the struggles and hierarchies in which it occurs (Dean 1996).

**An Analytics Of Governmentality**

With the defining features of Foucault's governmentality as the object of population, government by individual capacities, apparatus of security and the 'governmentalization' of the state, length of hospital stay will be analysed as a new form of power; invented, applied and revised in local arenas. Analytical emphasis will be given to the immediacy, though admittedly contingent nature of social
practices, which are conceptualised as governmental, discursive and technological as they assist in the examination of local, rather than as linguistic practices of texts.

A governmental analysis is concerned with the conditions of possibility and intelligibility for certain ways of seeking to act upon the conduct of others or oneself to achieve certain ends (Gordon 1991; Rose 1999a). It is thus open to examination from any number of ethical and political perspectives that question government, authority and power (Dean 1999:40). Rose (1999a) suggests that studies of government address particular dimensions of our history made up of invented, contested, operationalised, transformed and rationalised schemes, programs, techniques and devices which seek to shape conduct so as to achieve certain ends. He argues for the significance of governmentality as an analytic strategy in exploring the relationships between modes of ruling, truth telling and expertise in the contemporary advanced liberal mode of government (Rose 1993).

Therefore as a mode of investigation, governmental analysis incorporates notions of power and subjectivity as they recognise the agency of subjects without falling back upon a notion of a fully autonomous individual (Patton 1994; Petersen 1997). Governmental analysis proposes a strategy for examining the mutually constitutive relationship between modes of government and political subjects (the governed) by focusing on local practices (Foucault 1978; Foucault 1980a:99) as a '… zone or space of governmental intervention' (Osborne 1997:176). The provision from this, is to investigate how certain bodies of expert knowledge, associated with techniques of monitoring and assessment of length of hospital stay, might be activated or mobilised in order to be thought, and through which they might 'act at a distance' upon problems that governmental discourses and rationales reveal in the field of society, entrepreneurship, or the individual citizen (Robson 1993:463).

Hence an analysis of this kind implies that 'the various and particular forms of 'government' of individuals were determinant in the different modes of objectification of the subject' (Florence 1998). The will to govern thus constitutes the self with interrelationships as a key object and resource (Rose 1998). Thus the self-constitution of the subject is not something the individual self invents, but are
patterns found in culture, proposed, suggested and imposed by culture, society and social group (Foucault 1984a)

**Problematisation**

A starting place for governmental analyses is the identification and examination of specific situations in which the activity of governing is called into question (Dean 1999). Problematisation is a study of where, how, and by whom aspects of human beings are rendered problematic. The appearance of problematisations can be seen to have definite social, institutional or professional locales, and can be assigned a time and a place (Dean 1998). Such a study is therefore concerned with analysis of the specific conditions under which particular entities emerge, exist, and change. Governmental analysis therefore attends to practices, not as ideal types, law-like necessities, or manifestations (Dean 1999:20) but aims to explore the regime of practices or regimes of intelligibility through which to govern is to act under a certain description (Rose 1999a:28).

The aim is to de-stabilise and de-naturalise the present, to maximise the capacity of individuals and collectivities to shape the knowledge, to contest the authorities and configure the practices that govern them in the name of their nature, their freedom and their identity (Rose 1999a:282). Hence the aim of such analyses is to provide conceptual tools to re-evaluate the values 'by which we are ruled or governed, showing the humble and mundane origins of the supposedly pure transcendent, revealing the lies, falsehoods, deceptions and self deceptions, the costs as well as benefits entailed' (Rose 1999a:282). Analysis therefore challenges the way we do things and how we think about them, questioning that they may not be as entirely evident or necessary, as we believe.

Discourse analytics aim to identify the emergence of a regime of practice or discourse, examine the multiple sources of elements that constitute it, and follow the diverse processes and relations by which these elements are assembled into relatively stable forms of organisation and institutional practice (Dean 1999:21). As an analytics of government, this is done without formulating a set of general principles with which to reformulate the conduct of conduct. In this sense, an
analytics of government acts as a form of criticism (Foucault in Kritzman 1990) which makes explicit the thought that is largely tacit material form, as well as in the language, practices and techniques in which we are governed and govern. Hence, the 'outcome' of an analytics of government is not recommendations for change, or declarations of right or wrong, as, an illustration of the rationalities of resistance and programs to which they give rise, and to make clear what is at stake and what the consequences of thinking and acting in such a way are (Dean 1999:37).

Practices of government are historically constituted assemblages that cannot be reduced to particular sets of relations, principles, problems or functions (Dean 1999:29). Though there is no straightforward translation for dispositif, Deleuze describes these social apparatuses as tangled, multilinear ensembles with knowledge, power and subjectivity as substituting variables (Deleuze 1991). In drawing on Deleuze's work, Dean (1999) identifies four 'reciprocally conditioning yet relatively autonomous' dimensions or spaces through which regimes of practices govern'. The dimensions are the fields or forms of visibility, concern for the technical, rational and thoughtful activity, and the formation of identities. These are not reducible to one another, thus transformations in any one dimension impacts on the others. In this way a governmental analysis requires the examination of the forms, or fields of visibility, that are necessary for the operation of regimes of government. Forms of visibility do not pre-exist, but are configured or illuminated by 'lines of light which form variable shapes inseparable from the apparatus in question' (Deleuze 1991:160). The light configures objects, which are therefore dependent on it for their existence. Like Foucault's notion of the gaze as a mode of enunciation, the questions are what kind of light illuminates and define certain objects while obscuring and hiding others (Dean 1999:30).

Although studies of governmentality are concerned less with language and texts than they are with regimes of truth, analytic attention needs to be given to language and texts in the first instance, so as to be able to recognise what regimes of truth might look like. Thus the notion of discourse and its internal rules of formation are as important as the social processes of its happening.
Discursive formations

Discourse, as previously suggested, is an ambiguous term that incorporates knowledge, practice, language, subjectivity and power (Foucault 1992a; Macdonell 1986). Though linked, it is the way in which these concepts are emphasised, and their acknowledgment of text and/or context, that signifies differences. Definitions of discourse develop in complexity, from all forms of talk, writing, and constructions of meaning, through to 'patterns of thought and action that includes compatible and contradictory elements that are unstable constructions, given unity and viability by the rules under which they are assembled' (Macdonell 1986:31).

Consistent with the theoretical grounding of this study, discourse is grounded in context with analysis directed at illustrating the hidden assumptions of knowledge that govern the way we live and the way we think (Barrett 1991). Though texts are the means through which to realise discourses, discourses are not only the patterned systems of texts, messages, talk, dialogue and conversation evident in the analysis of texts, but also as locatable in wider historical and social structures.

The discourse analytics literature is substantial and diverse in proposing how a discourse analysis might actually be conducted. Where methods for discourse analysis are specified, (Parker 1992; Fairclough 1992) their application demands theoretical framing. Most notably, Foucault's work illustrates that a method through which to conduct a discourse analysis needs to be framed by the circumstance of the study. This is evident in the shifts in discursive attention within Foucault's various studies, where discourse

... appears as an asset—finite, limited, desirable, useful—that has its own rules of appearance, but also its own conditions of appropriation and operation; an asset that consequently, from the moment of its existence (and not only in its 'practical applications'), poses the question of power; an asset that is, by nature, the object of a struggle, a political struggle (Foucault 1992a: 120).

Methodological disputes are evident as effects of power, demonstrated in Foucault's statement that 'the successes of history belong to those who are capable of seizing these rules' (Foucault 1984:86). With his emphasis on power relations...
Chapter 3: How might we conceptualise writing (about) length of stay?

irreducible to any single characteristic but able to be read in a number of ways, method gives no prior concern to theory or practice, but requires that the question of priority remain open. Foucault explicitly acknowledges 'between techniques of knowledge and strategies of power, there is no exteriority' (Foucault 1978 (1968) :98). Hence one cannot locate a position beyond power, but can potentially locate and therefore exploit the 'points of resistance within power in order to reconstitute the self and its environment' (Apperley 1997:22).

Though Foucault's writing demonstrates a diversity of actual method, (Dreyfus and Rabinow 1982:79-105; Flynn 1994) Gutting proposes that these differences or changes in Foucault's method were not incidental, related to a lack of rigour, nor a continuous development in style, but openness to method directly related to openness to the object that was under study (Gutting 1994). On a number of occasions, particularly in his three volume study of sexuality, Foucault alludes to method as 'points to consider' (Foucault 1998:28) or 'cautionary prescriptions', (Foucault 1990 /1978) always reinforcing that method evolves in the conduct of analysis, rather than as something given in advance (Apperley 1997:17).

Specification for discourse analysis is provided by Foucault, with discursive formation recognised as having systems of dispersion that define the field for a variety of different, even conflicting, sets of elements (Foucault 1992a:38). Analysis therefore involves attention to statements, best described as 'serious speech acts', (Foucault 1992a:83) and the relations between them. Statements are different to a sentence or proposition; however, are considered true and meaningful not only for those who express them, but also for those who read or hear them. The aim of analysis is to determine the unity of statements about length of hospital stay by virtue of the common object(s) of analysis, manner of reference or mode of statement, deployment of a system of concepts, and evidence of an identity and persistence of theoretical theme (Foucault 1992a). The unity of statements requires a clarification of key concepts and relations, as well as the relationship between statements, discourse and discursive formations, which address an audience in a particular way, are structured to persuade, (either benefit or suppress) reproduce power relations, have ideological effects, overlap in complex interrelations with
other discourses, and are historically located, therefore dynamic and changing (Parker 1992:3-17). Thus

[whenever one can describe, between a number of statements, such a system of dispersion, whenever, between objects, types of statement, concepts, or thematic choices, one can define a regularity (an order, correlations, positions and functioning, transformations), we will say … that we are dealing with a discursive formation) (Foucault 1992a:38).

Analysis of discourse is directed as questioning how is it that one particular statement appeared rather than another (Foucault 1992a). Thus it is from a group of statements that the rules that make possible the construction of other statements, therefore the rules that allow the unity of a discursive formation and the regularities of dispersion of statements in a discursive field, are evident (Barrett 1991; Foucault 1992a:116-117). Analysing discourse and the objects its statements are about, requires illustration of enunciative modalities, kinds of cognitive status, and the authority these statements have; the concepts in terms of which they are formulated, and the theoretical viewpoints they develop (Foucault 1992a).

Discussion in chapter 2 identified surfaces of emergence, not only within textual locations of literature and policy, but within the discursive locations of scientific authorities, such as economics, medicine and nursing. Various grids of specification were also indicated such as policies (for example, casemix), procedures (trimming of length of stay) and organisations (hospitals) as particular relations of objectification (Foucault 1992a:41–42). However, it is the relation between objects, established by discursive practice and relations, such as between the non-discursive; for example, social, institutional, political and economic events and practices (Foucault 1992a:162) that make it possible to pick out objects and give them a public reality (Dreyfus and Rabinow 1983:63). Discursive relations are therefore neither objective nor subjective; that is, they exist separately from primary relations, such as those of institutions or techniques, and secondary relations, such as the reflections of a subject (Foucault 1992a).
It is in this context that discursive analysis of length of hospital stay involves investigation of texts embedded as fields of intervention, where actual practices are accomplished through acknowledgment of language, not as representative of reality, but as a system of distinction, which conveys meaning (Smith 1999). The focus is language as it manifests the conditions for the existence of the world (Mahon 1992), where words are invested with multiple meanings which bare the traces of historical usage, and the social conditions and relations of the particular times and places (Comber 1996:159).

Hence this style of analysis enables an understanding of how 'what is said' fits into a network that has its own history and conditions of existence (Barrett 1991:126). In this way a discursive formation is not just the order of language, or representation of social entities and relations, it is a structuring principle, which governs belief and practices to produce a network of material relations. Discourses of length of stay construct or constitute key entities such as health care and hospital care, and position people as social subjects, such as the consumer, the 'well' patient or the surgical nurse.

However, in writing about or examining the discursive formation of length of stay I am examining the objects produced by the discursive formations and practices, rather than the discursive formation of length of hospital stay itself. Thus length of hospital stay is not a group of signs, but 'practices that systematically form the objects of which they speak' (Foucault 1992a:49). These relations are not present in the objects (such as time, beds, short stay patients) hence it is not these things, per se, but what enables them to appear, that constitutes a discourse (Dreyfus and Rabinow 1983:62). Understanding of a discourse therefore requires elaboration of the objects its statements are about; the enunciative modality, or kinds of cognitive status and authority these statements have; the concepts in terms of which statements are formulated and the theoretical viewpoints developed.

Though Foucault is accused of juxtaposing rather than interrelating the discursive with the non-discursive, (McNay 1994) this concern for the material or technical as well as the linguistic, enables discourse to function in governmental analysis.
through questions such as: by what means is certain authority constituted and particular rules accomplished? Laclau and Mouffe suggest that issues of differentiation between Foucault's discursive and non-discursive are overcome in his discursive formation as bypassing distinctions between the material and non-material, theory and practice, and related issues of determinism and priority (Marsh and Stoker 1995). An accomplishment particularly evident in the later use of Foucault's work by people such as Rose, Dean, Law, Latour and others associated, albeit briefly, with the development of actor network theory.

Further analytical development is apparent in Foucault's later work where his 'rule bound' analysis of discourses shifted to acknowledge and place far greater emphasis on power relations, though with discourses still as the inevitable sites of social struggle.

**Technologies**

As power relations are grounded in systems of social networks, (Foucault 1982) their analysis as technologies of power (discipline and self) requires establishment of systems of differentiation, types of objectives, means of bringing power relations into being, forms of institutionalisation and degrees of rationalisation (Foucault 1982:223). In this study of length of stay in the institution of a government-funded acute-care hospital, requires recognition of the differentiations and privileging of authority as invested overtly in disciplines of economics and medicine within that environment. However, the means of bringing power relations into being are also apparent in alternative discourses, such as that of consumerism, which invest individuals with authority to speak in new ways about hospital services. Therefore, attention is directed to not only the kinds of knowledge that bring about problematisations, but also to a concern for the *techne* of government. Techne is power as strategies, tactics, and programs of government, the invention and assemblage of particular apparatus, and the devices for exercising power and intervening on particular problems to be explored (Dean 1999). Technologies of power as government can be seen 'to cut experience in certain ways, … to bring new facets and forces, new intensities and relations into being' Rose (1999a:31).
Chapter 3: How might we conceptualise writing (about) length of stay?

The organisation of space as a tactic of power, evident in the Panopticon, provides a metaphor to explain disciplinary technologies (Foucault 1995/1977) where theoretical schema are not necessarily an imaginary utopia, but induce a whole series of effects in to the real; 'they crystallise into institutions, they inform individual behaviour, they act as grids for the perception and evaluation of things' (Foucault 1991b:81). As a technology of power the Panopticon combines notions of normalisation and surveillance, where rationality is self-contained and untheoretically geared to efficiency and productivity (Rabinow 1984:20). This mentality of government is particularly evident in the 'vast documentary apparatus' (as evident in the modern hospital) which becomes an essential part of normalising technologies (Rabinow 1984:22).

Accepting that 'what the apparatus and institutions operate is in a sense a microphysics of power whose field of validity is situated in a sense between the great functioning and the bodies themselves', (Gordon 1980:26) focus is given to the technologies of government. The technologies of interest are those evident in the various assemblages of different forms of practical knowledge, intellectual tools, calculative technologies, modes of perception, practices and vocabularies of calculation, authority, forms of judgement, architectural forms, human capacities, non human objects and devices and inscription techniques designed to achieve certain outcomes in terms of conduct of the governed (Rose 1999a:52). These forms of government also require certain forms of conduct on the part of those who would be governed, identifiable as techniques of the self that pattern an individual's relation to himself or herself that allows them to recognise themselves as subject (Martin and Gutman et al.1988).

Though Foucault's work provides fertile ground from which to ask any number of possible questions about hospital length of stay, governmentality is selected as a strategy to problematise the practices of length of hospital stay, rather than to answer specific questions. This study connects questions of government, politics and administration to the space of bodies, lives, selves and persons (Dean 1999:12). Questions about how length of hospital stay has become a problem linked the temporo spatial aspects of hospital services, connect with the creation of certain
truths about hospitals and health care. This raises further questions about how these truths contribute to the government/administration of the individual and the population. How have particular conceptions of human identity become intrinsic to attempts to govern, such as through expertise or consumer demand?

This thesis explores these questions through an analysis of texts available in the public domain of government, hospital and other health care policies, reports and literature. To augment this analysis and remain consistent with Foucault's raison d'être, it is important to explore answers to these questions as forms of practice. The necessary distinctions are therefore not between 'discourse/meaning' on one hand and 'power/domination' on the other', (Rose 1994:53) but rather, the focus of analysis requires investigation of 'the varied and complex ways in which practices of truth situate persons in particular relations of force' (Rose 1994:51). This is not to imply that such practices are what 'happens in reality'. The point, elucidated by Rose, (Rose 1999a) is that an analytics of government needs to be concurrently concerned with truth, power and subjectification, through 'analysing the way a word or book functions in connection with other things, what it makes possible, the surfaces, networks and circuits around which it flows, the affects and passions that it mobilizes and through which it mobilizes' (Rose 1999a:29).

Hence the following analysis returns to the proposal from chapter 2, that we might consider discursive fields as 'intelligible contestations' (Rose 1999a:28) that it is not so much as 'an ideal type against which a non-ideal reality can be calibrated (Rose 1999a:275) but as a mechanism that assists in conceptualising a set of bounded processes and relations. These processes and relations are employed because they are useful for the purposes of this analysis, while at the same time acknowledging that such boundaries are ever-mobile and shifting.

**Summation**

Following this discussion of Foucault with emphasis on core concepts of governmentality, discourse and technologies, the length of stay might be understood as the progress of knowledge towards particular objectivities that present 'a history which is not that of its growing perfection, but rather that of its
conditions of possibility' (Foucault 1970:xxii). One of the aims of discussion in chapter 2 has been to provide length of stay with a chronological threshold from which to explore new forms of knowledge and practice in hospital and nursing services. The challenge is now to move from the identification of length of hospital stay's general spaces of knowledge, as previously discussed to examine its configurations, its modes of being which define systems of simultaneity, as well as series of mutations, and analyse these governmentally, that is, technologically within the local practices of hospital care.

It has been argued that Foucault's theoretical perspectives facilitate a move beyond mere description of observed events, or interpretation of meaning of such events, to understand the development of techniques associated with the disciplining, interpretive, and subjectifying human sciences, which constitute the objects and subjects of analysis. The aim, or perhaps the best that such an analysis can do without dissolving into political ideology, is to seek conceptions that yield greatest insight into where we are now and what we have become (Allen 1998). Thus for the purposes of this study, the next chapter discusses how I took this research inquiry out into a new context of hospital surgical services, not in the sense of constructing a paradigm case, as much as an examination of a site of 'taken for grantedness'.
Chapter 4:

How might we study length of stay as local practices?

We must reverse the philosophical way of proceeding upward to the constituent subject that is asked to account for every possible object of knowledge in general. On the contrary, it is a matter of proceeding back down to the study of the concrete practices by which the subject is constituted in the immanence of a domain of knowledge (Florence 1998:462).

Introduction

The previous discussion of governmentality was directed at substantiating the study of length of stay as a program, a social practice, a regime of rationality (Foucault 1991a). The challenge is now to shift emphasis from the theoretical, so as to explicate how length of stay might actually be studied as practice. As the quote at the top of this page indicates, this thesis is theoretically oriented towards recognising the importance of concrete practices. It is therefore with the expectation that theory in the form of the previously presented ideas of Foucault will suffuse the generation and analysis of data, this chapter addresses what are understood as the technical matters that direct the forms the data took, how the data were generated, and how theory was used in the analysis of this data. This orientation precedes but does not imply predominance or aim to overshadow the discussion in the latter section of this chapter of the pragmatics of the research that are the description of the field and fieldwork practices in which ethnographic methods were used to generate a diversity of texts for analysis.

Dean (1999:2) suggests that studies of 'the means of directing how we behave and act' are characterised by their concreteness. In discussing studies of governmentality, he echoes Foucault in cautioning researchers that that there is no common way of using the intellectual tools produced in this analytical field. With discourse understood as a mechanism through which technologies constitute phenomena of concern, accordingly, primary analytical attention is given here to discourse, as it provides a vehicle, or techniques, for what is understood as destabilising the 'field' or moving outside the 'truth trap' (Jacobson and Jacques
Chapter 4: How might we study length of stay as local practices?

1997). Although not literally possible, the approach here proposes that the conduct and refinement of research is not so much the increasing acquisition of skills to reflect the objective and generalisability of truth of events, but rather 'the willingness to work within the apparent world as enacted in 'discourse'' (Jacobson and Jacques 1997:42). Hence this chapter describes how discourses were employed in examining not only how length of stay was conceptualised, but also to assist in understanding how the potency of such conceptualisations operated (in a Foucaultian sense) 'ethically' in shaping contemporary experiences and practices of hospital, and in particular, nursing care. It is the emphasis of this second component that accords with what has come to be understood as an analytics of governmentality (Rose 1993; Rose 1994; Rose 1998; Dean 1999; Rose 1999a; Rose 1999b; Foucault, 1997; Foucault 1991a).

Recognising Forms Of Data

The reading of selected publications about length of stay as presented in chapter 2, provides a number of ways in which length of stay can be understood. In seeking not so much to challenge, or support, these differing or complementary positions systematically, this study deliberately seeks out difference and contrast as points of departure from which to interpret the ostensible shift in understanding and use of length of stay in contemporary hospital care. To accomplish this analysis, texts were required through which to explore the

vulgar, pragmatic, quotidian and minor level [through which] … one can see the languages and techniques being invented that will reshape understandings of the subjects and objects of government, and hence will reshape the very presuppositions upon which government rests (Rose 1999a:31).

Thus in meeting the theoretical and technical requirements of an analytics of government, an identification of contexts was required in order to be able to conduct a style of fieldwork from which texts as data could be produced. Acknowledging that contexts are not only concrete spaces in which to study contemporary programs, practices and rationalities of length of stay, the context of this study included my interactions and reflections as researcher and was therefore 'constructed through the interpretation of discourses and practices made visible through the construction of multiple perspectives' (Latimer 1993:66).
The material forms of data in this study are texts as they 'reflect, are produced by, and help to create, a teeming world of entities' (Callon and Law 1997:170). Texts were generated through collection, compilation, and ongoing analysis of published journal articles, government documents and reports, as well as on the conduct of fieldwork using methods of interview, institutional document analysis and notes recording my observations and conversations. Texts provide for a study of language as 'things said' (Lupton 1999) and as embodied in discursive formations, across the group of texts, that provides evidence of historically created and recreated social relations of power (Foucault 1992a; Foucault 1997). In this study language is not seen to reflect social reality as such, but should be understood in terms of competing discourses; that is, competing ways of giving meaning to the world (Lather 1991:24). Language is how social organisation and power are defined and contested, and the place where our sense of ourselves, thus our subjectivity, is constructed as shifting and contradictory, rather than stable fixed and rigid (Richardson 1994). Research informed by poststructuralist theory directs researchers to understand themselves reflexively as persons writing from particular positions at specific times, thereby freeing them from trying to write a single text that says it all (Richardson 1994). Acknowledging that reports of research are always constructed and partial, (Atkinson 1990; Clifford and Marcus 1986) messy and imbued with human judgement, (Lupton 1999) with no single perspective able to claim exclusive privilege, (Marcus 1994) decisions as to where to look for data, which texts might be recognised as data, and when enough data had been 'collected', were each guided by the theoretical approach and pragmatic considerations, as will be further explicated in this chapter.

At the methodological level Foucault treated history in a very specific way, and wrote from the perspective of a future historian in order to defamiliarise present practices and categories, to make them seem less self-evident and necessary (Foucault 1992a:3–10). This analytical approach strives to disturb the taken-for-granted, and free a space for the invention of new forms of rationality and experience (Sawicki 1991:101). A 'history of the present', as termed by Foucault, is concerned with the 'ways discourse has constructed particular (mythical) truths in the realm of particular power relations and political struggles' (Smith 1999:30).
Chapter 4: How might we study length of stay as local practices?

History is used here to diagnose the present by making the present seem as strange as the past; (Kendall and Wickham 1999) thereby allowing questions as to the relevance of length of stay for hospital health care services. As a technique, rupture or discontinuity is directed away from causes and origins to seek contingencies (Kendall and Wickham 1999). Accordingly, this study is not an historical study of the emergence of length of hospital stay, nor is it isolated to the pragmatic analysis of observations about length of stay conducted during periods of fieldwork, or what Rose refers to as the 'valorization of experience with a denigration of theory' (1999a:55). Rupture or discontinuity is employed here in determining the 'corpus of texts' (Fairclough 1992) that are needed for analysis … in a manner that illustrates what this analysis is sensitive to, rather than as an expression of relativism.

While length of stay cannot be considered as a blank or empty 'object', it is explored here as a valuation of 'the moment of fieldwork in history, the moment when historical thought becomes inventive because it is linked to a practice on its object' (Rose 1999a: 55). Length of stay is examined as a site of juxtaposition in which there is contest and struggle, what Foucault calls a heterotopia, (Foucault 1970:xviii) where different spaces come into contact with other spaces that seem to bear no relation to them (Danaher and Schirato 2000). The periodisation of this study of length of stay does not infer that research is static, rather that the social is local and ongoing (Smith 1999). The social world is materially heterogeneous, with social processes able to be told, performed, embodied and represented within materials that are only partly social (Law 1994). Thus the dynamics of fieldwork situate data as discursive accounts, and the generation of textual data for analysis as an ongoing social process.

Discourses are deeply rooted in, and deeply dependent on elaborated evolved texts, with intertextuality taken for granted (Smith 1992:35). In asking how it is that certain statements appear rather than others, (Foucault 1992a) analysis of the conditions of existence of statements provides a means to question critically the historical, practical, and discursive embeddedness or conditions for existence, rather than what is directly being referred to. Thus in 'territorializing governmental thought', (Rose 1999a:34) it is the site from which the speaker speaks rather than
the speaker's subjectivity that is of interest. This site is not, however, only a matter of cutting up time in order to govern subjects, but is also the making up of governable spaces (Rose 1999a) in which 'thought …becomes real by harnessing itself to a practice of inscription, calculation and action' (Rose 1999a:31). In his work on the creation of systems which then close off other options, Bruno Latour argues that science, thus scientific knowledge, is accomplished through organisational processes of literary inscription which are accomplished by enrolling and controlling physical and social resources into networks of association (Reed and Hughes 1994). Therefore in seeking to balance accounts of practices, it is necessary to turn 'exclusive attention away from humans and look also at nonhumans' (Latour 1993:229). Documents analysed during the conduct of fieldwork included computerised and written patient medical case notes, fieldwork notes, hospital policy and procedures documents, hospital program reports and evaluations, patient information brochures, hospital promotion, and communication literature, such as the monthly hospital bulletins.

**Generating Texts For Analysis**

Good qualitative research is more than a description. It requires processes of synthesis, conceptualisations and abstraction. It involves an extensive knowledge of the topic, the setting and the social science literature (Morse 1998:443). Therefore the methods used in the conduct of this study involved techniques of observation, interview and document analysis to generate a collection of texts for analysis. However, the product of research is different from single descriptive accounts gleaned from single sources or provided by participants. Method choices, guided by poststructuralist ideas about language, subjectivity, social organisation and power, aimed not to devolve from abstract philosophical positions or individual researcher impulses, but to evolve through the considered and intersubjective involvement in the processes of the study. Contextualising data in the form of information about context was sought to provide beliefs, assumptions and values that comprised the participants' sense-making around observed practices, (Spradley 1979). However fieldwork was not used, nor is it reported in the conventional ethnographic anthropological traditions, for seeking analysis of culture or society (Atkinson 1990; Clifford and Marcus 1986). Rather, the conduct
and reporting of fieldwork acknowledges differences and contrasts, uncertainty and diversity, while attempting to remain sensitive to multiple perspectives as well as interest in the particular (Angrosino and Mays de Perez 2000) which in this case were 'practices related to length of stay'.

Conducted part time over a twelve-month period, fieldwork involved interactions between the researcher and doctors, nurses, patients, families, ancillary, clerical and management staff, as well as observation by the researcher of various nursing and medical practices. Acknowledging that fieldwork should be flexible, creative and responsive to what is happening, (Patton 1990) fieldwork in this study involved observations of patient care and nursing practice, with particular attention to ward rounds, handover, patient admissions, patient discharges, as well as the nursing staff interactions with patients, patient families and other hospital and health care staff.

With the joint aims of generating data that were both credible and susceptible to analysis, fieldwork is clearly recognised as having been shaped, selected and produced rather than occurring naturally (Smith 1999; Stanley and Wise 1993). Attention to data was directed to analysis of the productive capacity of language and texts, as this requires a reflexive rather than a 'realist ethnographic tale-telling' approach (Lather 1991:13–15), with texts for analysis crafted to provide 'depth, detail, emotionality, nuance and coherence that will permit a critical consciousness to be formed by the reader' (Denzin 1997:283).

The evolving strategies of interview, observation and social interaction included my writing of notes during and after each period of observation or interview. These notes took the forms of fairly detailed and accurate records about what I had seen and heard from observation, reflections about how I might change the way that I, as researcher was doing things, such as foreground or background my presence in the field, or noting particular persons that I should arrange to speak with in greater detail. Fieldnotes included recording of comments about what I saw as developing ideas of themes, and personal responses to what was going on. As with other forms of data, these notes were obviously not considered an 'objective description of the field, unaffected by the voice of the researcher', (Rudge 1996:146) rather, my notes
provided textual evidence of the multiple positions available within the conduct of fieldwork. Where possible, all data (including field-notes, literature, interview transcripts and documents) were either typed as word files, or scanned and entered into an N-Vivo \(^2\) (N-Vivo 1999) project. This project was not used for purposes of analysis but as a mode of formatting which offered effective storage, sorting and retrieval of various files.

**Observation as contexts of social interaction**

My (inter)actions in the conduct of fieldwork may well be accommodated by prescriptions of any number of contemporary fieldwork designs. Postmodern or poststructural ethnographies, participant observation, observation of participation and performance all evoke frames through which an understanding of how my fieldwork for this study was conducted. However, while not actively seeking to diminish either fieldwork traditions or the academic requirements of a thesis, my fieldwork practices are presented here without the coherence of any one approach. This is not an attempt to be innovative, or to avoid providing evidence of substantial methodological reading. Rather, this approach seeks to describe what was actually done. A description that aligns with Donna Haraway's notion of an 'ethnographic attitude' as a mode of practical and theoretical attention, a way of remaining mindful and accountable' (1997:191) while at the same time producing a number of textual analyses that articulate with scholarly interaction that is made up among living people in living situations.

Defeated by attempts to harmonise outside observer and insider perspectives to reach consensus on 'ethnographic truth', (Angrosino and Mays de Perez 2000) contemporary social research is said to have shifted from prescriptions of observation as method, to a greater emphasis on the techniques of social interaction. Described as a shift from method to context, this development is evident in attention to issues of membership and participation, rather than as researcher and subject roles (Smith 1999; Stanley and Wise 1993). The work of Angrosino and Mays de Pererez (Angrosino and Mays de Perez 2000) is presented here not to suggest that it is definitive in framing the conduct of contemporary

\(^2\) NVivo is a computer software program designed to assist qualitative data analysis
Chapter 2 of this thesis presents length of stay as not having a material form. Therefore, to study its various forms, to be sensitive to and understand its complexity, thereby its discursive construction, entrée was required to the contexts and practices of hospital health care delivery. My role as researcher and doctoral student in the conduct of this fieldwork intersects with my employment as an academic in a university school of nursing and midwifery. In conceptualising how I might undertake fieldwork, I was conscious of issues related to power and identity. Bauman (1992) argues that the existential modality of agent identity is neither given, nor authoritatively confirmed with construction consisting of successive trials and errors of learning and unlearning. Seeking to avoid identification as an academic familiar with this environment and known to some staff through my roles as a clinical facilitator, I sought a fieldwork experience as someone new to this study of length of stay, rather than as someone with a pre-established involvement in such matters. I anticipated that this design or desired presence would enable me to watch and talk with staff and patients in ways that were different than if I had been openly recognised as 'a university lecturer'.

Situational identity relates to the adoption, or more often, negotiations of identities based on how passive or active the researcher and participants chose, or are permitted to be. Angrosino and Mays de Pererz argue that research processes of social interaction are always tentative 'involving continuous testing by all
participants of the conceptions they have of the roles of others' (Angrosino and Mays de Perez 2000:683).

My fieldwork observation plan had been to adopt a participatory approach to observations, anticipating that direct observations would provide a better understanding of the context in which things, such as access to taken-for-granted understandings, issues not noticed by others, or matters knowingly not raised in interview occurred (Patton 1990:204). In enacting these observer and participant roles I did not have any other designated role other than that of researcher, however as the discussion of fieldwork later in this chapter illustrates, I was sometimes only able to observe whilst at other times able to participate in simple non specific roles such as making beds, helping patients to have a drink or find a nurse and helping nurses to locate patients or equipment.

Observation is proposed as a technique where perceptions other than those recalled or revealed at interview or document analysis become available (Angrosino and Mays de Perez 2000). It is acknowledged, however, that such 'observer' perceptions are derived from 'experiencing the setting', while at the same time trying to understand the setting through personal experience, observations, and speaking with other participants. The significance of the extent to which it is possible to become an 'insider to experience', while at the same time capable of understanding in a way that allows for 'description for others', creates an irreconcilable tension that has underpinned the last two decades of debate about research methods, particularly in regard to ethnography (Angrosino and Mays de Perez 2000; Patton 1990:207; Rudge 1996; Coffey and Holbrook et al 1996; Emden 1997).

**Perceptions of power**

A second principle of social interaction identified by Angrosino and Mays de Perez, involves perceptions of power. They propose that 'people access behavior not in terms of its conformity to social or cultural norms in the abstract, but in regard to its consistency, which is a perceived pattern that somehow makes sense to others in a given situation' (Angrosino and Mays de Perez 2000:680). Their ensuing discussion covers issues of the ideal and real, and negotiations of cooperation,
gender and boundaries. A position on power for this study has, however, already been established through the ideas of Michel Foucault.

For Foucault, methodological disputes can be seen as effects of power, demonstrated in his statement that 'the successes of history belong to those who are capable of seizing these rules' (Foucault 1984:86). With Foucault's emphasis on power relations irreducible to any single characteristic, but able to be read in a number of ways, method then gives no prior concern to theory or practice, but requires that the question of priority remain open. Foucault explicitly acknowledges '[b]etween techniques of knowledge and strategies of power, there is no exteriority' (Foucault 1990 /1978:98). Hence one cannot locate a position beyond power, but can potentially locate and therefore exploit the 'points of resistance within power in order to reconstitute the self and its environment' (Apperley 1997:22).

For Foucault, power 'brings into play relations between individuals (or between groups)' (Foucault 1982:217) and exists as power relations, entrenched in social networks. While he argues that it is necessary to distinguish between power relations and relationships of communication, he suggests that a society without power relations can only be an abstraction (Foucault 1982:223). Therefore the analysis of power relations requires establishing the systems of differentiation which permit one to act upon the actions of others, the types of objectives that are pursued by those who act on the actions of others, the means of bringing power relations into being, the forms and mix of institutionalisation through which power is given a social ensemble, and the degrees of rationalisation through which power relations act as a field of possibilities (Foucault 1982:223–24). Translated to this study, power was clearly a series of multidimensional relations continuously (re)negotiated within the individual and daily practices of fieldwork.

**Contextualised meaning**

Observation, whether participatory or not, allows impressions to be gathered through all relevant human faculties. However, research is not an absolute value of objectivity enshrined in the application of certain research procedures and
practices. As a social act, research and its reporting is inherently biased with all observations influenced by the historical, theoretical, and value predisposition of the observer. Thus there are no objective observations, only observations situated in the worlds of the observed and the observer. The situational and negotiated identities that people bring to context specific interactions either embrace self conceptions, or serve individual needs (Angrosino and Mays de Perez 2000). Thus what the fieldworker observes 'is conditioned by who he or she is' (Angrosino and Mays de Perez 2000:686) as much as those he or she may be seeking to study. As a nurse conducting research into nursing, as a previous (and most probably future) hospital patient researching hospital care, I was positioned and clearly positioned others and myself. These 'positionings' help trace power relations evident in the multiple and shifting positions.

**Criteria for validation**

Developments in fieldwork validation have focused on assessing the perceived ‘accuracy’ of understanding and representation of what is being investigated and involved numerous debates about how objectivity, subjectivity, validity and reliability are understood (Hammersley 1990; Hammersley 1992; Minichiello et al 1999; Lincoln and Guba 2000). Recognising the logical positivist orientations of these concepts later versions of the same arguments have resulted in new concepts of credibility, transferability, authenticity and confirmability (Denzin and Lincoln 1994; 2000) gaining recognition as more suited to emergent notions of rigour in qualitative research. Mays de Pererz suggest that internal criteria are those by which members check their behavior against prevailing group norms, whereas external criteria are those where group members check behavior in terms of supposedly prevailing universal standards (2000:686). Polkinghorne, however, provides more 'readerly'-focused criteria for validation, by suggesting that contemporary criteria for judging the validity of observation are the transformation of a 'list or sequence of disconnected research events into a unified story with a thematic point' (1997:14). Emphasis has shifted in regard to these concepts to that of hermeneutic processes through which to weave method and interpretation (Guba and Lincoln 1989), noting that any ‘claims’ of this study are made only in the context of this study and are therefore not generalisable everywhere.
Suggested techniques through which to enhance the quality of data collection and analysis processes include triangulation, testing rival, divergent or negative explanations (Patton 1999), use of ‘rich data negative cases (Maxwell 1996) and prolonged and persistent observation and engagement at the sites of fieldwork (Newman and Benz 1998; Grbich 1999) and peer debriefing (Guba and Lincoln 1989). Due to positivist implications, triangulation is usually now avoided as a means of credibility check (Guba and Lincoln 1989) however, as will be discussed further in a later section of this chapter, this study included texts generated through fieldwork conducted over a sustained period of time, involved different methods of data collection, including various types of interview, observation and various types of documents and data sources including different individuals as well as different groups of patients, family members and health professionals in a diversity of roles provide a purposeful mixed sample of participants.

Validity in qualitative research is well recognised as the 'reader being convinced that the researcher has accessed and accurately represented the social world under study' (Grbich 1999:59). In offering what is presented as a new way of judging writing as a method of inquiry or the accomplishment of the 'unified story', Richardson (2000:937) provides criteria relevant to notions of validity which require that reports of fieldwork need to offer the following:

- a substantive contribution to understanding about social life
- aesthetic merit in the shaping and complexity of design
- reflexive accountability to the standards of knowing and telling of the people that have been studied
- emotional and intellectual impact in expressing a credible account of 'the real'.

Representation and reflexivity

This study is situated in the intermediary of representation where the aim is to find a 'match between the constructed realities of respondents (or stakeholders) and those realities as represented by the evaluator and attributed to various stakeholders' (Guba and Lincoln 1989:237) and draws selectively from Soja's (1996) conceptual development of space, to argue that fieldwork is not only
conducted in the 'first space' of the real concrete place of geographical anthropological investigation, but includes a 'second' or social space as the imagined or mental place of social interpretive investigation. It is in working between these spaces that a third dynamic, and lived space, is created where the imagined (or interpreted) becomes the real, with the representation, or image, coming to define and order the reality (Soja 1996). Hence the conduct of fieldwork and the series of written representations that produce the practice reality of writing fieldwork into this thesis can be understood to become no different, with various degrees of representation inevitable. Space is thereby used in various ways as one technique in this analysis to make apparent both concrete and relational places and practices, as well as certain analytical positions.

Although no longer defensible as a tool through which to maintain objectivity in ethnographic method, (Marcus 1994) research is acknowledged by Steier (1991:3) as 'constituted by processes of social reflexivity and then, of self reflexivity as social processes'. For Fontana, (Fontana and Fry 2000) reflexivity requires the minimisation of the authorial bias and influence, illustrated in this thesis by inclusion of descriptions of settings and participant’s own language use. Reflexivity is situated here as a form of scrutiny of social responsibility in the conduct of this research, an approach is encapsulated in Donna Haraway's suggestion that '[v]ision is always a question of the power to see—and perhaps of the violence implicit in our visualizing practices' (Haraway 1991:192). This reflexivity can be understood as a complex form of self-awareness. However, this needs to be considered in regard to Foucault's efforts to show that rather than knowledge yielding power through description, 'power perpetually creates knowledge and conversely knowledge induces…power' (Foucault 1980a:27). Thus fieldwork consisted of 'being at risk in the face of the practices and discourses into which one inquires'. (Haraway 1997:190).

Related to the gap between the ideal and the real, one example from my study involved the extent to which participants were *told* that they were being observed and told the exact purpose of the study. Variations of this occur in all social research (Patton 1990:211). While observations were combined with the use of
Chapter 4: How might we study length of stay as local practices?

Interview and textual analysis, it is acknowledged that all representations are only ever partial. In the conduct of fieldwork, and subsequently in the writing of this thesis, examples that presented negative or alternative views were actively sought, and emphasis placed on the writing of this study to acknowledge complexity, difference and partiality. The aim was to illustrate complexity of simplicity and incorporate insights into what might be considered authentic for the social group under study, rather than for generalisation to a larger population. Hence the data extracts provided in the following chapters are sometimes representative of many and at other times indicative of particular less commonly held views.

Illustrations from Fieldwork

My practice of these 'principles' of identity, power and context, are presented through analysis of extracts from my fieldwork notes. These extracts are provided not as exclusive, but illustrative of some of the issues apparent in my attempts to move between 'outside researcher and inside nurse/researcher'.

As the medical round finished … Sarah (Clinical Unit Specialist) headed off down the corridor, saying to me as she left that she 'had to go and do a bed'. I followed her as she grabbed a linen bag and walked into a single room where a cleaner was cleaning the bathroom. There was no patient here or signs of patient belongings. Sarah stripped the bedding (sheets) from the bed and put them into the linen bag. I picked up a pillow from the bed and started to remove the pillowcase. She said, 'Oh you don't need to do that, it's bad enough in this day and age that I need to do it, but you must have better things to do'. I asked her what she meant. 'Well I know I am in charge, but this ward only works if we all get in and do things as they have to be done. I wouldn't normally do a bed, but the next patient is on the way up and I am free, but you don't need to do this' She proceeded to ask another nurse (who had come into the room and started to help in remaking the bed) whether a patient in the room next door was available for me to go and speak with. (Researcher Field-notes)

This situation occurred on the first morning of my 'observations' on this particular ward. This nurse and I had spoken on three previous occasions about my study and what I would be 'doing' during the periods of observation of her and others. She was a senior member of the nursing staff with research experience and had volunteered to allow me to observe her nursing practice over a period of several
weeks. On reading my notes, it is apparent that what I had perceived (and previously used) as a way of making myself less an outsider to the clinical area and more visible as a nurse, thus insider to clinical practice, clearly did not fit with her expectations of my role in the conduct of research.

Though increasingly recognised as a 'non-nursing duty' and delegated to patient support or domestic staff, bed-making (that is, changing the linen on hospital beds), is a very common hospital activity in which nurses frequently participate. Previous experiences in clinical settings, either in the conduct of clinical nursing practice or for the purposes of research, or teaching and supervision, had suggested to me that participating in simple, non patient-contact activities, such as bed-making, signified to other nurses a willingness to cooperate. What I had viewed as a routine and relatively meaningless activity in the conduct of my observations, watching her while at the same time indicating my familiarity with what nurses do and providing a sign of preparedness to 'fit in', had been rejected. My observation of her doing menial nursing work, and my attempts to be seen as both researcher and nurse, by participating in this menial work, had made her uncomfortable. What she had deemed as an appropriate use of her time (as evidenced in her justification that 'this ward only works if we all get in and do things') was clearly not seen as an appropriate use of my time. I was clearly not there to make this ward work, yet my intention had been very deliberately to not get in the way of making this ward work. In the context of collaborative research, this nurse was as much a part of this study as I was. Hence her request not to 'observe' her 'doing the bed', was respected, despite my notes of the event becoming data to be used in this study. Analysis of this example illuminates the shifting and fragmented processes of power and identity where the 'successes' of my interaction in the conduct of observation suggested that identities for the nurse and for me were situated and negotiated as very much separate things.

A further example of the success (or otherwise) of my efforts in interacting in the social environment of my research was evident in my involvement with a second level (enrolled) nurse working on one of the three hospital areas in which I conducted fieldwork. There were few second level nurses involved in these areas of
the hospital. This particular nurse had not formally expressed any desire to participate in my study (such as in an interview, or for me to observe her nursing practice) however as a permanent member of the nursing staff she was often present when I was with patients, or observing other nurses or doctors in the ward. Despite her friendly demeanour and regular conversational exchanges, I was aware that she was not comfortable discussing issues related to patient care or nursing practice. In this regard she remained wary of these topics over the four-month period in which I visited the ward on which she worked. As her involvement was not necessary to the success of my focused observations, and (perhaps coincidentally) she was never the nurse that I needed to speak with when inquiring about particular patients, her role in the success of my study was not an issue. I was, however, curious as to why she avoided any exchanges about nursing. I did not approach her about this; however in the last week of my visits to her ward she announced: ‘I might see you around uni[versity] sometime’. Responding to my inquiry about this, she explained that she was enrolled in the undergraduate nursing program at the university where I was employed. While not involved in the teaching of that particular program, my situated and non-negotiable identity as lecturer had created for this nurse a reason to keep her distance from me.

These two conflicting examples are balanced with numerous, quite different relationships developed during the period of fieldwork. Along with formal taped interviews and observations of nurses interacting with patients, doctors or others, considerable periods of time were also spent sitting in the ward office conversing with staff as they went about their work, or writing notes while seated in the nurses' tea room. These opportunities allowed for informal interactions and unplanned activities. Listening and talking with nurses as they spoke to each other and included me in discussions about patients was always informative. Following my initial introductions as a nurse doing further nursing studies that involved research, I became a regular face in my four-hour visits to the ward. From the beginning I was always welcomed and included into the natural flow of conversation. My ‘welcome’ was evident in the uninterrupted flow of shared conversation, using the language of medicine and nursing to discuss the events of the hospital, the patients, and nursing and medical staff.
Chapter 4: How might we study length of stay as local practices?

The tearoom in particular proved to be a valuable location and strategy to balance the more formal interactions of the ward. I was conscious of, and tried to remain sensitive to the privilege of this location and interaction, and attentive in avoiding asking too many direct questions, or assuming that I would always be welcomed in these discussions in this place. Patton (1990:226) suggests that using body cues provides a way of judging what might be going on in a conversation between others, and then later using informal chat to seek out what had occurred in the conversation. Acknowledging that everything that goes on, in or around a program is data, I was careful to tell any nursing staff that I had not previously met who may have entered the room that I was writing notes about my observation and discussions as part of a research study. When talking with staff I stopped writing. However, sometimes I would ask questions about their conversations and make notes afterwards about relevant things that had been said. The only notes I recorded in the main ward areas such as the ward office, were notes about patients, especially where I was reading from patient records.

When I interviewed nurses or doctors, or accompanied them in their provision of patient care, I openly took notes. In this sense I developed what might be seen as a triangulated a pattern of relating to staff in formal and informal ways (Patton 1990). Documentation is subject to a number of constraints, such as it is inevitably incomplete, inaccurate, or sensitive to only certain issues. Interviews are limited to the perceptions of the individuals, as well as the dynamics of interpersonal relationships. Therefore different sources of data provide a check on what has been reported in interview, (Patton 1990:245) rather than seeking to disprove one or the other to illustrate in more depth and detail the differing perspectives. These differences allowed me a continuity in which ideas that might be offered informally in the tearoom, could be looked for in how nurses acted in ward-room practices just as the tearoom provided the opportunity to sometimes learn more about what had gone on out in the patient care areas.

In generating information that needed to be useful for the end point of producing a thesis, there were considerations that may have been answered differently if the study had prioritised different outcomes. The very research question itself can be
considered the first point of clarification or compromise in defining what is desirable and useful to study. Choosing length of stay, and the surgical division as a technique, program or process of study served to remove the emphasis on, and increase stress for individual nurses being studied. Hospital discharge was used to facilitate recognition of a research purpose for hospital staff and patients. As a pragmatic strategy, the ethics application and access to the hospital site was framed as exploring length of stay through the contexts in which the accomplishment and management of hospital discharge occurred.

Attention to hospital discharge did create some access issues needing negotiation with senior hospital nursing staff, however its value lay in providing an easy research context from which to engage clinicians, and patients and their families, in exploring issues of interest to this study. This approach was not so much to conceal the true object of interest, rather than to accommodate shifting and development, as well as communication of a theoretical object of interest (regulation of length of stay, therefore hospital services and health care) in the context (of hospital discharge practices) in a way that would be meaningful to staff and therefore facilitate open engagement with participants. While full and complete disclosure is recommended, since anything other than this is not only morally questionable, but constrains the researcher in trying to participate and interpret (Patton 1990), my interest was more in the broader practices of length of stay than it was in the practices of hospital discharge. Discussion in chapters 5 and 6 of this thesis attests to discharge planning as just one of a number of frames that might be applied to the series of practices or programs implicit within this investigation.

**Interviews**

Interviews were conducted as either targeted interviews with specific individuals at predetermined times, where specific and predetermined issues were discussed, either in-depth or as less formal conversational interviews. This occurred with one or two individuals where and as issues arose from the contexts of participant observation (Patton 1990:280. Sometimes interviews with patients also included family members or friends, who were encouraged to join in the discussion, though discouraged from answering on behalf of the person who was identified as the
hospital patient. While these may appear as discrete approaches, in practice each interview was defined by who was involved, what was being discussed and how the interview had been organised.

Interviews did not adopt a rationalist approach in seeking to uncover an objective knowledge, nor seek consensus (Holstein and Gubrium 1995). Rather, they were conducted throughout the practice of fieldwork for various reasons. Akin to the style of ethnographic interview, (Fontana and Fry 2000) difference in interview design provided me with the flexibility to pursue issues where and as they were triggered by field work events, while also providing for more structured or more detailed discussion of questions and issues at a mutually agreed time, with persons whose opinions I was particularly interested in understanding. Eight taped interviews were conducted with registered nurses, five from the clinical area, and three with nurses in management positions with responsibility for multiple clinical areas. Numerous untaped interviews took place with nurses and doctors in clinical areas such as ward offices, corridors, elevators, as well as the previously discussed tearoom conversations.

The study did not set out to specifically include or exclude doctors, thus their inclusion in interviews and discussions was directed by the context of each observation. Eighteen patient interviews in the Pre-Admission unit were taped; however only fourteen of these patients continued in the study via a daily discussion about their progress and experiences while on the ward. These untaped interviews were conducted either at the patients' bedside, or in ward lounges. A telephone interview was conducted with each patient between two to three weeks after his or her discharge from hospital. The four patients who did not continue in the study either had their surgery cancelled, or suffered clinical complications preventing continued participation.

Interviews involved the use of questioning directed at generating discussion of opinions and experiences of hospital care and discharge planning, as related to the duration of hospital stay. Discharge planning provided a useful focus for interviews, allowing issues associated with length of stay to emerge from
Chapter 4: How might we study length of stay as local practices?

interviewee's local experiences, rather than by directed questioning. During the conduct of this fieldwork there were quite regular media reports of cuts to hospital funding, and this was raised by a number of interviewees either as an explanation for negative experiences, or as comparative evidence of how good their experience had been. Acknowledging the 'residue of ambiguity', (Fontana and Fry 2000:645) I framed my interview questions and discussion in a deliberate attempt to avoid interviewees assuming that I was interested in stories of good or bad hospital experiences. I avoided using the phrase 'length of stay' until others used it. I directed questions at how patients, doctors, nurses and carers thought about the issues of hospital care, surgery and surgical recovery, hospital discharge, early discharge and home care, rather than good or bad experiences. The interview approach was therefore directed at discussion of the local issues of their hospital stay, their surgery and their recovery.

These interviews might be considered guided conversations, (Patton 1990) with questions designed to elicit participants' experiences about surgery, nursing care and discharge planning. At the first interview the participants were asked about their expectations and knowledge about the impending surgery, and about previous hospital experiences and expectations on discharge from hospital. In the telephone interview held between two to three weeks after discharge, patients were asked about their experiences following discharge, how they managed post-operative symptoms, the need for and access to assistance from family or friends, medical community and allied health services, and their return to usual activities.

Individuals were encouraged to talk about their stories in the language most familiar to them, with all responses taken at face value. There was a greater degree of familiarity when patients were contacted at home. Discussion allowed conversation to flow naturally and to follow the individual thinking, acknowledging that this approach to interview (ethnographic interview) is an interactive event in identity formation (Spencer 1994). In this approach to interview, identities are not isolated phenomena but are presented and negotiated within the contexts of ongoing interactive events (Hewitt 1984, Spencer 1987). With the exception of the telephone interviews of discharged patients, a follow-up
discussion was held with participants in which my perceptions of what had been spoken about were discussed. This strategy was motivated by ethical sensitivity to ensure that participants were comfortable with the continued inclusion of their ideas and opinions as data in this study. Less overtly the strategy can be understood to serve as a means of establishing credibility (Guba and Lincoln 1989) as participants were able to continue engagement, however formal or informal in discussion about their practice and length of hospital stay.

**Analysing Texts**

Though attention is paid to the examination of 'discursive' and 'technological' practices, as opposed to texts, textual data is the mode through which what is a discourse analysis is conducted. Hence the ideas from the previous chapter are used as 'sensitising concepts' through which to explore the social world as it may approximate various conceptions, which are never more than provisional guides to a changing and complex reality (Willis 2000). In recognising the difficulty and artificiality of splitting the examination of knowledge or power from practice, or techniques such as those of domination and the self, the analytical focus is to use the texts generated through ethnographic techniques and

… experiment by bringing them into forcible contact with outside concepts, accidentally or inspirationally chosen, by trying to frame the whole with necessary complexity and to deliver analytic and illuminating points not wholly derivable from the field but vital to conceptualizing its relationships (Willis 2000:xi).

Thus to compensate for Foucault's neglect of a detailed textual analysis, the work of others such as Parker (1992), Fairclough (1992) and Lupton (1999) provide techniques for analysing instances of discourse without reduction to linguistic analysis. Hence analysis of text, analysis of discourse processes, of text production and interpretation, and social analysis of the discursive event in terms of its social conditions and effects, is undertaken at various levels. Analytically, discourse provides for an emphasis on accounts rather than micro-structural elements of conversation, such as turn-taking, interruptions, and pauses. At a macro level, texts were examined focusing on inter-textuality across the group of texts, and coherence of particular problematisation, followed by analysis of micro practices of text production, distribution, and consumption, as they make length of stay visible as a
social practice (Fairclough 1992:231). Drawing on Parker (1992), Fairclough (1992:56) and Lupton (1999) as well as on my own understandings of the contemporary contexts of hospital surgical services, the sorts of questions asked of the texts were:

- why are certain words or phrases used to describe length of stay?
- what (discursive) objects and subjects are being referred to by these words or phrases?
- what socio-cultural assumptions are conveyed by these words or phrases?
- whose interests (institutional or otherwise) are being served by these representations and connections?
- what sorts of moral judgments are being expressed in these texts?

Length of stay is therefore examined as a dispositif or 'assemblage of practices and discourse … which constitutes (length of stay) as an object of knowledge, a domain of governmentality, and a particular form of self-relation' (Dean 1994:203).

Foucault (1979) has highlighted the importance of technologies in modern forms of power, and it is clear that these are centrally instantiated in language (Fairclough 1992:6). The cohesion of texts, that is, how clauses and sentences are linked together, were sought, as this allows access into what Foucault calls 'the rhetorical schemata according to which groups of statements may be combined (how descriptions, deductions, definitions whose succession characterizes the architecture of the text, are linked together' (Fairclough 1992:77; Foucault 1992: 57). Analysis consisted of constant alteration between the different texts, looking for how features, patterns, and structures, which are typical of certain types of discourse, restructure tendencies in orders of discourse and ways of using conventional discourse that are specific to this sample (Fairclough 1992:231).

Orders of discourse were sought through consideration of the complex interdependent configuration of discursive formations as primacy over its parts and/or has properties which are not predictable from it parts (Fairclough 1992:68). Intertextuality is employed to indicate the ways in which certain discourses or texts can be seen to manifest each other. At its most obvious, this takes the form of
explicit referencing conventions, whereas at more subtle levels, intertextuality echoes other texts evident through, for example, the use of common structures, terminology and contrastive relationships, intersection of different strategies, material heterogeneity that produces relational effects of knowledge, power and subjectivities (Law 2001).

Language is treated in analysis as a form of social practice, shaped and constrained by social structure, while on the other hand, socially constitutive (Fairclough 1992; Foucault 1992a). Thus the three constructive effects of discourse are construction of social identities and subject positions, social relationships between people, and the constructions of systems of knowledge and belief as corresponding with the identity, relational and ideational functions of language (Fairclough 1992). Analysis is conducted at the same time as data generation, or collection, through cycling 'back and forth between thinking about the existing data and generating strategies for collecting new, often better quality, data' (Miles and Huberman 1984:49). Hence in this study, length of stay was considered as it intersects with other factors such as cost, throughput, nursing intensity measurement, recovery, cure, products (as defined by casemix) and quality.

Key questions to be addressed include who is speaking, and what position does the subject hold accordingly description will be provided of the sites from which discourse derives its legitimation and points of application (Foucault 1992a). Attention is therefore given not to the spoken or written words, but the act of speaking or writing them, as well as the context in which they are written, the status, sites and positions (Foucault 1992a). Therefore, which individuals (doctors, nurses, patients, carers and family members) spoke about length of stay was noted, accompanied by attention to what positions they occupied in speaking, such as nurse managers, or resident family members. To analyse the laws operating behind the formation of things requires the analysis of 'a field of regularity for the various positions of subjectivity' (Foucault 1992a:55). In this study texts were analysed by reading for similarities and differences, then the language, such as words and phrases used in documents, or by participants, to describe length of stay, were clustered into themes or categories. These themes or categories were then
examined across data sets to seek consistencies and differences in approaches to this phenomenon.

The 'pathway' of analysis in the next two chapters falls both within and outside of a number of (theoretically consistent) frameworks. Chapters 4 and 5 might present themselves as analysis of power as technologies of domination and the self; however discussion of practices of objectification and normalization, as separate from analysis of subjectivities, is difficult and poorly executed here. Chapters 4 and 5 also emphasise analysis of the practices of one clinical area over another, with chapter 4 focused on the surgical wards, the short stay surgical ward in particular, whereas analysis in chapter 5 foregrounds the Pre-Admission unit, with less emphasis on the surgical wards. Spatially, chapter 4 examines material and non material representations of space, while chapter 5 analyses the imagined spaces of representation through which nursing practice and recovery is stylised. There is no advantage to be found in delineating between these places, except as this may assist the reader seeking particular forms of structure. I propose that all of these ‘frames’ assist analysis through 'approximate conceptions encapsulating the scope and action of the creative cultural practices of agents, and approximate conceptions of that which, in situ, social agents are 'making sense of" (Willis 2000:xviii).

The Conduct Of Fieldwork

Fieldwork took place in a medium-sized metropolitan public hospital of approximately 350 beds, identified here for ethical reasons as City Hospital. The selection of this hospital was influenced by its Australian national recognition as a leader in the provision of innovative patient-care programs that provided me with access to a number of relatively recent patient-care programs that were specifically related to decreasing the duration of patient length of stay. Examples of such programs involved pre-hospital services, emergency department services and approaches to discharge planning, aged care, and a number of services provided for patients following discharge from hospital, such as home nursing and general medical practitioner liaison.
Access to the City Hospital was negotiated through approaches to the hospital human ethics committee and nursing administration. Initial access discussions with senior hospital nursing staff created some pressure for me to conduct fieldwork in a medical unit which had just implemented a discharge planning program as part of a national hospitals best practice scheme. For a number of reasons I was keen to avoid being seen to evaluate a new patient care program. While clearly acknowledging the significance of aged care for contemporary health care services management, my decision to conduct fieldwork in the hospital surgical division was directed at studying the dynamic changes to length of stay that had taken place in surgical care.

As discussed in chapter 2 of this thesis, many of these changes are accounted for by technological innovation. However, in contrast to the complexity and chronicity of aged care, I was interested in the 'taken-for-grantedness' of this seemingly straightforward practice of surgical care. Surgery also provided some elimination or constraint of the numerous factors, which might be understood as 'extraneous variables' impacting on the operations of the length of hospital stay.

I visited many different sites within the City Hospital, the surgical division where discussions with nursing staff snowballed, as staff suggested others involved in the various projects or programs relevant to changes in the hospital length of stay. While this was a time-consuming part of early fieldwork, this approach proved useful in establishing a wide area of access and recognition, whereby I could freely move between much of the hospital, approach staff for assistance, from nursing administration through to the wards, and spend regular periods of time in targeted areas of the surgical division. Another benefit of this early fieldwork activity was that it prompted the commencement of a style of 'cross checking' (Guba and Lincoln 1989:240-241) that continued throughout the conduct of fieldwork where emergent propositions could be 'tested' out in discussion with other participants as well as by focusing my observation on either particular participant groups or

3 Snowball is a form of sampling technique which takes advantage of social networks and seeks participants with characteristics in common (Beanland 1999). The characteristics in common in this study were where participants or locations were nominated as having significance to the topic of hospital length of stay.
locations or practices. Through this broad approach to the hospital I gained a good introduction to how surgical services operated at City Hospital, since I visited each of the major surgical areas and spoke with senior nursing staff about current surgical patient services.

Other forms for identifying participants for the study (that is, sampling) were purposely guided by my earlier experiences in clinical nursing practice, which also informed decisions about where and how I should undertake observations, and who it might be best to interview. I arranged and conducted all observations, interviews, case-note and document reviews in this study. While I initially chose the ward tearooms as a quiet, adequately furnished space to retire from the ward and make notes, I found that as nursing staff came out for their breaks they would often engage in conversation with me about what I was doing, thereby triggering useful discussion with me and between the nurses about relevant patient care issues. I overtly directed some of these discussions to topics about length of stay relevant to my study.

**Ethics, Recruitment And Participation**

Despite having organisational ethics and executive nursing administrative approval to conduct the project, several meetings with a senior nursing staff were necessary not only to initiate access, but as a strategy that would work within a hospital policy for the recruitment of participants. As a strategy to protect the rights of employees, non-hospital employees conducting nursing research were required to recruit volunteers for participation in research through the use of two strategies. Flyers advertising the project could be posted in the hospital dining room on a display board next to numerous advertisements for hospital and health care professional functions, as well as the usual notes about rental accommodation and things for sale. The research participant's recruitment policy had been designed to prevent direct approaches to individual nurses for research participation. Interestingly, no such procedure existed for medical or allied health research at the City Hospital.
The second strategy for recruitment of participants was to negotiate with ward unit managers to speak with nursing staff during the handover period. This strategy positioned research as a series of very direct and isolated activities, which required some deliberations about ethical conduct on my behalf. Recruiting individual nurses was not at that point my priority, as much as identifying relevant locations and practices through which to study length of stay. In adopting the second of the two recruitment strategies I found myself welcomed into discussion with numerous nurses working in clinical and managerial positions in the surgical division. Though these meetings had been established as preliminary discussions, it occurred to me five minutes into the first 'meeting' that there were issues being raised and comments made that were directly relevant to what I wanted to explore, thus these meetings were generating data. The conditions of my organisational ethical approval required individual signed consent for participation in both interview and observation.

Acknowledgment of the ethical principles of informed consent, deception, privacy and confidentiality and accuracy (Christians 2000) in my earlier application for ethical approval, included specific points about the ethical issues of ' incidental' observation that might occur where an individual was observed without their direct consent, notwithstanding the fact the ' incidental' interview had not been anticipated. There appeared to be a perception at the senior organisational level that my research would 'commence' at the point of clinical practice, despite my correspondence to the contrary. I resolved this by informing staff as early as possible in our 'meetings' that my research strategies included writing my own notes, and that their comments about length of stay may form part of the 'field-notes' I recorded during each visit to the hospital. No staff member asked me not to include his or her comments in this way. On two occasions after a 'meeting' I made arrangements with nurses to conduct a more formal interview to audiotape our discussion and their opinions. Where an interview was audio-taped, signed consent was always obtained. All patient interviews, whether audio-taped or not were preceded by full disclosure about the study, and signing of consent form.
The Surgical Pathway

Fieldwork was conducted in three phases through three linked areas of the surgical division. Described by some staff as part of the 'surgical pathway', the three areas were the Pre-Admission unit, a gastrological and colorectal surgical unit, and a short stay surgical unit. In the early phase of fieldwork I also interviewed three staff and spent three days with the nursing staff of the hospital at home program.

The Pre-Admission unit and the home care programs were relatively new programs in City Hospital, and my initial design was to select an information-rich sample of patients and use ethnographic techniques to 'follow them' through their episode of acute care. The home hospital program relied on referrals from hospital staff, and although quite busy in terms of the number of patients being cared for by this service, there was no specificity to the patients being seen other than they needed some attention by nurses after hospital discharge. Recognising that the majority of surgical patients leave City Hospital without referral to the services of this program, I decided not to pursue this home-care service but to focus on the 'in-hospital practices'. A decision was made to interview patients after discharge from hospital, rather than through the 'hospital at home' program.

Having decided on the surgical pathway, I approached the three nurses in charge in these three areas, who had indicated their enthusiasm to be involved in the study and had introduced me to their units and programs and nursing and medical staff. Following this, I arranged to speak about my study with all nurses in these units at various hand-over periods. At these sessions I informed staff that I would be spending time in the area speaking with patients as well as observing patient care, particularly admission and discharge decision-making. I sought voluntary participation from nurses for consent to follow them over a series of three- to four-hour periods as they went about their usual nursing practices. This would involve observing their patient care as well as participating in taped discussions (interviews). In the first instance I had 2–3 nurses in each area agree to participate in the study, which greatly assisted my becoming a regular sight in the wards. In the first instance I would attend the ward/unit at the beginning of either a morning or afternoon shift when the registered nurse who had agreed to participate in the study was on duty, and would spend time observing general routines.
In the Pre-Admission unit, this consisted of two meetings with the two nursing staff to discuss the unit and its operations, and three visits during the clinic periods where I noted the coming and going of medical, nursing and allied health staff, and patients and their families and carers, along with other visits to follow patients through the Pre-Admission experience. Although patient Pre-Admission interviews were conducted by nurses from the ward in which the patient was to be admitted, post-operatively, the Pre-Admission unit staff coordinated which appointments the patient needed, including scheduling specialist consultations, such as a specialist nurse to visit women scheduled for investigations for breast cancer. Therefore, while I spent much time in the Pre-Admission unit throughout the middle period of fieldwork, it was most often in the company of a nurse from the wards doing the Pre-Admission unit interviews. Being known to the Pre-Admission unit staff (administrative and nursing) prior to arriving with ward staff, assisted in making my presence uneventful. Later I sat in with patients during their interviews with nurses and doctors in the Pre-Admission unit. In the 'hospital at home' program, I interviewed nursing staff and spent time observing them visit new referees to the program before their discharge from hospital, and then travelling around the adjacent community to visit discharged patients in their homes. During these initial observations I confirmed my interest in primary practices of interest as those that occurred within the environs of the hospital, before the patient was discharged home.

Patients arrived at the Short stay ward at staggered intervals early each morning to correspond with the scheduled time for their surgery. Those patients who were having major surgery would be transferred after their surgery straight from the recovery suite to a different ward, so their 'admission' to Short stay ward was always temporary. This plan provided more time for the other wards to organise patient discharges, thereby vacating beds ready for the new patients to be admitted after their surgery. This system of admission to a surgical reception area separate from the ward worked well in terms of bed management; however it provided a disjointed system for patients and their families and friends to follow. Patients were left by family and friends in a different ward to the one that they would be in after
surgery, and were required to keep their belongings packed so that they could be transferred with the patients to the ward where they'd be staying after their surgery.

The surgical patient's reception admission paperwork had been done in the Pre-Admission unit during attendance there, sometimes up to a week beforehand. On arrival in the ward they were shown to the day-room to have their temperature, pulse, respiration rate and blood pressure measured and recorded. They then waited in the day-room until a nurse from the operating theatre rang to ask that they be prepared. At this time they were taken to a bed in order to deposit their belongings, shown to the nearby bathroom and asked to empty their bladder, change into operating theatre dress (patient gown) and then get into the bed. Following this, a pre-medications in the form of a tablet or injection was often, but not always administered, and patients waited (about half an hour) until the operating theatre staff arrived to take them, in their bed, to the operating theatre suites.

In City Hospital the Pre-Admission unit is in an area separate from the wards. It is designed to provide the services that a patient would usually have had done in the first few hours of hospital admission. Examples of such services are: medical examination, anesthetic examination, nursing assessment, electrocardiograms, x-rays and blood tests. The nursing staff from the ward scheduled to receive the patient after surgery attends the Pre-Admission unit to conduct the patient consultation. In some cases preoperative procedures, such as bowel preparation, that need to be commenced one to two days prior to surgery, are commenced at the Pre-Admission unit visit. The patient booked for admission to hospital for surgery is given an appointment to attend this unit approximately two weeks prior to being admitted to hospital. Patients, their family members and friends, as well as medical and nursing staff, viewed this unit as the first step in the process of hospital admission. The unit is located away from the ward area on the ground floor of the hospital, near other outpatient facilities. It consists of a main entrance, reception desk, two waiting rooms, four examination rooms and eight assessment rooms, with a bathroom and staff office. Patients were booked into the unit to coincide with the theatre-booking list. This computerised system allows a particular team of medical staff to have all patients scheduled for a morning or afternoon surgery list.
to attend the unit in the same session. There is little opportunity for patients to alter this booking time, since the Pre-Admission unit appointment usually coincides closely with the scheduled hospital admission date. On some occasions patients did come to the Pre-Admission unit on the same day as their admission, and after being seen by the various staff proceeded directly to the ward from the Pre-Admission unit.

Introduced in western health services since the 1970s (Armstrong 1998), the Pre-Admission unit in Australia has been one of a number of key strategies introduced through the first phase of the Australian National Demonstration Hospitals program (NDHP) as an essential part of improving the overall efficiency and effectiveness of managing planned admissions and discharges from hospital (Alexander and Kasap 1997). With the programs of attention for this study as those associated with the provision of surgical services the Pre-Admission unit, specific problems were identified as 'an unoptimised health status (for the surgical patient); unacceptable operating cancellation rates; fragmented patient care; and unnecessary investigations (Daffurn and Sutherland 1997). The designated principles of pre-admission care are recognised as:

- coordination of the patient's referral for elective surgery and admission to hospital
- optimisation of the patient's health status prior to admission, and facilitation of 'day of surgery' admission
- optimisation of the operating room schedules by reducing cancellations on the day of surgery
- education of the patient and family about the operation and hospital procedures and
- coordination of the episode of care through computerisation of patient data at this first visit to (Alexander and Kasap 1997). See also Appendix B for NDHP Pre Admission Service principles.

The Pre-Admission unit is a hospital initiative designed to limit the period of time that a patient spends admitted to hospital; that is, the amount of time spent occupying a hospital bed. As mentioned earlier, the implementation of these units
in several public Australian hospitals has been financially assisted though a national scheme called the National Hospitals Demonstration Program. In particular these projects target improvement of access to public hospitals, by moving away from models of patient throughput towards supporting management and clinical practice reforms that avoid compartmentalising care process (The National Demonstration Hospitals Program 1997).

Commencing in 1993, the National Demonstration Hospitals Program has distributed Commonwealth government funding for initiatives that have been pervasive in shaping many aspects of Australian hospital services. The projects funded under this scheme have been targeted particularly at improving access to public hospitals; however there has also been an agenda to move hospital services away from models directed at patient throughput, towards supporting management and clinical practice reforms that avoid compartmentalising the care process. Though the objective is population-based, the resultant programs all require the direct management of individuals to achieve the program aims.

Over a five year period, 39 Australian hospitals have participated in National Demonstration Hospitals Program projects involving the implementation of strategies related to bed management, Pre-Admission services, operating room management, discharge planning, and various models of post-acute care (Commonwealth Department of Health and Family Services 1997). The hospital in which fieldwork was conducted for this study has been successful in gaining National Demonstration Hospitals Program funding, and has subsequently developed a number of new programs, as well as overseeing the implementation of similar programs under the auspices of the National Demonstration Hospitals Program at other hospitals.

The General Practitioner Liaison program may be understood as one of the strategies through which patients are assumed as resourced. As part of a drive to accomplish integrated health services, seen as 'an important trend as Governments, clinicians, health service administrators and researchers work towards more innovative ways to assist patients' smooth journey through the continuum, in a way
which aids quality of care to the patient and lowers the cost of production' (Wilson and Popplewell 1999:13).

Funded under the National Demonstration Hospital Program, City Hospital undertook to develop a service agreement model for hospitals and Divisions of General Practice to formalise links between the different health services (Wilson and Popplewell 1999). While not legally binding, this agreement proposed that development be underpinned by extensive consultation and collaboration between these different health services, as well as by a number of expert committees, individuals and professional groups, and is described as based on intent and best practice principles (Wilson and Popplewell 1999). The need for this program was associated with increases in ambulatory care, increased day surgery, reduced length of stay, early (termed assisted) discharge practices, increasing aged population, and increase in community services. Seeking to overcome the delay in communication of information about patients between the hospital and the general practitioner, this program integrated communication technologies, such as email, fax, and links to pathology, databases and teleconferencing, with the establishment of the new nursing role of general practitioner liaison. Patients were all assumed to have a general practitioner.

**Summation**

This chapter has described the methodological and technical principles adhered to in the use of ethnographic techniques of observation, interview, and document analysis to generate texts for discursive analysis. Analysis of an extract from my fieldwork notes has provided insight into the application of these techniques. The following chapters examine the length of stay as it is evident in the local practices of episodes of acute surgical services. Analysis aims to understand how length of stay is thought about and practiced, what length of stay makes visible, and how such visibilities shape conduct.
Chapter 5:
Governing by time: administering the moves to enlarge the space

Introduction

The object common to an analytic of hospital length of stay is time. Like space, time is a basic category of human existence (Parker 1996; 1997). Though theorised in different ways, time and space are naturalised through commonsense everyday meanings (Harvey 1990:203). In this chapter it is proposed, in a pragmatic rather than philosophical way, that the privileging of time, from its origins in casemix policy, to the subsequent recording of hospital stay as hours and days, serves to enlarge, while simultaneously compressing, the spaces available for surgical care. This is not to suggest that space has a fixed pre-existing or universal form, but that a privileging of (hospital) time is discursively understood as 'practices that systematically form the objects of which they speak' (Foucault 1992a:49). Therefore while length of stay is recognisable as a temporal category in the (modern) classification of hospital services, an analytical value lies in the temporal ideas of postmodernity where time is 'a flattened sense of presentness' (Parker 1999:14) and how the emergence of new spaces reduces the need to govern (hospital) time.

In the same way as the organisation of space in Foucault's analysis of the Panopticon was understood as a tactic of power, (Foucault 1980d) attention to hospital length of stay is understood here as disciplinary, thus productive of a series of effects in the 'real' (Foucault 1991a). Thus spatial analysis is not limited to examination of the 'deadening effects of rationality', rather what is sought are 'the techniques and procedures accorded value in the acquisition of truth' (Foucault 1980c:131). The calculation and administration of the various and fragmented spaces of hospital care are proposed to form part of the assemblage and 'certainty of mapping' (Certeau 1984) that have now become contemporary episodes of hospital surgical care.

The representation of length of stay in government and hospital reports form certain truths about hospital efficiencies. This objectification of hospital services
through numerical representations of the time that patients spend in hospital, can be accomplished without sophisticated statistical processes or the complex judgements such as those required as part of medical diagnosis. When a patient goes home from hospital, the discharge or separation\(^4\) date is recorded in their medical records to be later compared with the date of admission to arrive at a designated number of days to indicate the length of stay. This numerical data is then collated with that of all patients (DRGs) in that population (be it DRGs, ward, hospital or state) and disseminated, sometimes back to the local sites from which the data was collected, and always onwards to other users of such information (hospital administration, medical and nursing administration, state and national government, insurance companies, developers of clinical guidelines etc). These numerical representations of hospital time and space are readily accessibility to potential consumers of such information. Thus length of stay is able to be 'constituted as an area of investigation … only because relations of power [including those exercised in the writing of this study] had established it as a possible object'; thus length of stay is only able to become a target or object for power relations 'because techniques of knowledge and procedures of discourse were capable of investing in it' (Foucault 1990/1978:98).

As norms of bureaucratisation, the calculation and administration of (hospital) time generates relatively stable physical forms of institutional and organisational practice. In these practices, patients, nurses, patient care and nursing practice are disciplined, as much through local administrative managerial discourses, as those of the previously single rule of biomedicine. Analysis indicates that nursing practices are particularly related to the specifics of administration, rather than to broader perceptions of organisational practice, in the sense that a 'science of organisation deals with markets, hybrids, hierarchies, bureaucracies, and the like, whereas the science of administration is preoccupied with internal organisation' (Williamson 1993:484). The association between economic rationalist government changes to hospital organisation, and the decreasing length of hospital stay has previously been established in this thesis. In seeking to generate new dimensions of

\(^4\) Separation is understood to have occurred when an impatient is discharged, is transferred to another institution, absconds, dies whilst in care, changes status eg from acute to nursing home or leaves the hospital for a period of seven or more days (Health Care Statistics 1995).
understanding, the approach in these next two chapters aims to 'tell the same story'—in terms of means of actions rather than effects (Bauman 2000:113). Hence this chapter examines the various means by which representations of length of stay are made visible in the ward-based practices of surgical nursing, so as to understand how these representations might form interconnecting truths, for '[w]hat is interesting is always interconnection, not the primacy of this over that, which never has any meaning' (Foucault, 2000a:362).

From my initial entry into the surgical division of City Hospital, analysis has been difficult to separate from my years of nursing experience, particularly as this informs perceptions of beds and the bedside as significant locations of and for nursing practice. Though the bed remains steadfastly materialised as a location of nursing practice, its temporo-spatial representation is far more contested as a location for the administration of the new nursing priorities of managing hospital length of stay. Hospital beds in this study are particularly visible as discursive objects that shape or produce nursing practices in certain ways. These practices, though related to physical beds, are also decentralised away from the single locations of individual beds through inscription, such as in documentation and on whiteboards. These forms of inscription provide ways in which actions of individuals are controlled to align as 'centers of calculation' (Latour 1987). Thus government acts at a distance in disciplining individual actions. In this discussion the actual practices may vary; however, the rationality is consistent with decreasing the length of hospital stay, hence increasing the volume of hospital patient throughput.

Bauman uses the concept of travel to suggest that acceleration can be understood to enlarge (travelled) space (Bauman 2000:113). In this study of contemporary surgical care, attempts to decrease the hospital length of stay are understood to accelerate the speed of surgical intervention and post-operative care, with an associated compression of the duration of hospital stay. The means by which this is accomplished is through the materialising of time (therefore space) through various modes of inscription in documentation, beds and whiteboards. Nursing practice is
no longer restricted to the physical space of the bed, but enlarged and fragmented across a number of spaces, such as patient information brochures and day rooms, all of which assist in accomplishing increased throughput of increased numbers of patients.

The metaphorical use of acceleration is also relevant to the discussion across the next chapter where hospital/health care spaces are understood to have 'enlarged' beyond the hospital or clinic to include the resources of self, home, family and community. The focus in this chapter is, however, on the paradoxes that are visible in nursing practices around the bed, and analysed as a contested temporo-spatial object, a disciplined, enlarging while also shrinking space of observation, calculation and therapeutic intervention.

**Making visible: inscription of length of stay**

As previously discussed, length of stay is a highly visible and functional part of the mapping of hospital resource use (as part of DRG definition) in reports such as those from the Australian Commonwealth and State health departments. However, length of stay is not visible at ward level. What is visible are the numerous procedures of calculation and administration through which length of hospital stay is arrived at externally, although not inseparably, from ward practices.

Procedures for the calculation of length of stay are most apparent on the wards in the multiple and varied documentation processes, such as the recording and display of patient admission and discharge dates, and the progress through various places between. Within the patient medical record there is a juxtaposition of clinical and managerialist discourses as health professionals construct the patient 'as case' through their own professional knowledge, (Foucault 1993) while at the same time the patient and their care is mapped against (hospital) time as an 'axis of police' (Rose 1994a:55). Rules about what a hospital patient needs are framed by clinical discourses about diagnosis. Rules about what a patient is entitled to (including length of stay) are framed by managerialist discourses of administration of resources.
In the patient medical records the date of admission is recorded at the start of each section; that is, the medical and nursing admission, examination and history notes, theatre notes, and electronic care plans. Like patient medical records, these various forms of documentation are significant in organising patient hospital stays. The patient medical records, patient lists, patient care plans, bed-cards, and the mapping of occupation and movement of actual beds all provide material evidence of the significance of time and space, evident as the bed in hospital care.

The objectification of patients through documentation, particularly through the knowledge of juridical and biomedical sciences, and the associated invisibility of nursing work, has been well documented elsewhere and will therefore not be discussed further here (Cheek and Rudge 1994; Cheek 1995; Heartfield 1996; Gibson and Heartfield 1996; Berg 1997). However, though emphasis will be given to how time serves to objectify patients, the following extract is included as it illustrates the embodiment of a patient though documentation in patient records, and how this form of embodiment becomes interchangeable with the physical body of the patient in medical decision-making. In the following event the medical and nursing staff conducting a ward round visit an elderly man who had surgery two days previously.

Patient not in his bed. Nurse quickly looks around the bay and into the corridor—no sign of the patient—doesn't say anything. One doctor takes the charts from the basket at the end of the bed and places them on the bed, second doctor drops the patients case notes on to the bed, next to the charts. Everyone is standing around the bed looking down at the charts—one doctor thumbs through them, 'They look OK'. Senior doctor looking up at bed card

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5 Computer printouts of standardised patient care plans identified as units of care relevant to the particular requirements of individual patients.

6 A card displayed on the wall above the bedhead with the patient's name, doctor and date of admission written in thick felt pen.

7 Patient records, kept confidential from the patient in the ward office include details about the patient admission, medical and nursing assessment, operation, anaesthetic records, surgical consent and clinical notes made during the period of hospitalisation. Patient charts were commonly kept in a basket hanging from the foot of the patient's bed. These included medication order forms, vital sign observation charts, intravenous fluid order charts and fluid balance charts.
asks, 'Well it's three days so what about home?—Is there a wife?' Junior doctor thumbing through case notes (as opposed to charts which another doctor is looking at) confirms that the patient has a 'wife' and the senior doctor asks 'can she manage?' The junior doctor recounts a discussion with a daughter from the previous day, where the daughter had said her 'mother can't manage him'. No discussion of what it is expected that needs to be managed. Medical staff look to the registered nurse and ask 'can we trial home with support services'? Before the nurse answers another doctors says, 'What about the convalescent ward? This suggestion is followed by conversation in lowered voices, which I cannot follow. I don't hear the decision. (Researcher Fieldnotes)

The ward round moves to leave the room, as they pass the bathroom an elderly man comes out. He walks slowly, but unaided by the nurse walking next to him. Doctors greet him, one asks 'good morning how's things'. Doctor doesn't wait for reply before saying 'we are going to send you to convalescence OK?' The patient nods, looking around at the various members of the ward round. No one else speaks, the doctors move to leave the room. The nurse walking at the back of the group approaches the patient and quietly says 'I'll come back later and tell you all about it'. (Researcher Fieldnotes)

After surgery, examination in the form of measurement of vital signs and inspection of the surgical incision as well as decision-making about further treatment and progress towards going home take place at the location of the bed, and are recorded in the patient records. In this situation the man (and his body), are superseded by the patient record as sources of information on which to make health-care decisions.

Other than individual patient records, documentation about length of hospital stay is visible on the ward in two main forms of patient list. The first list is a handwritten page, made out each day on which all patients in the ward are recorded with each patient's name, diagnosis, doctor, bed number and date of admission noted. Copies of this list are kept in the ward office with an updated version photocopied and distributed to each nurse at the commencement of each shift.
Nurses use these lists to make notes during nursing handovers, notes about patients or particular things that they need to do during the shift. The second patient list is written on a whiteboard attached to a prominent wall in the ward office. On this whiteboard the names of all patients either currently admitted to the ward or expected to be admitted that day were recorded, as well as the doctor’s name, the bed number and the date of admission. As the whiteboard was clearly visible to everyone entering the main area of the ward office, it did not include details of patient diagnoses. The recording of patients' expected dates of discharge were less visible, though stated in the computerised care-planning records, and where clinical pathways had been developed, these also included dates of anticipated progress and discharge.

**Materialisation Of Time And Space: Hospital Beds**

A second and highly visible space for the administration of time is the hospital bed. A principal location for the delivery of health care and the development of medical science over the twentieth century, the bed has also been a major focus of hospital policy and planning. Armstrong (1998:446) describes the hospitals 'very core' as the physical presence of the bed. However, the numbers of hospital beds in Australia are strictly controlled by government regulation, (Leeder 2000; National Health Strategy 1991). Considerable growth in the supply of hospital beds did occur in Australian during the 1970s, reaching a peak of 95,000 before diminishing to 50,851 during 1998-1990 (Financing and Analysis Branch 2000). This decrease in the numbers of hospital beds can be seen to reflect international trends in the economic rationalisation of health care systems, with the translation of this location of care, the bed, to a rationalised health care commodity (Zoloth-Dorfman and Rubin 1995).

Although health care statistics are based on separations from hospitals, references to beds are still common. This transformation is most evident in the diversification of language now used to refer to hospital beds. In current Australian government documents the transformation through managerialist discourses of beds to commodities is evident in different nomenclature related to types and mixes of beds, in ways that designate the bed as both specific locations of clinical care, and
the measurement of hospital resources. Examples of language used to refer to beds are: beds as indicators of clinical category that is acute beds, transition beds, medical beds, surgical beds or nursing-home type beds (Commonwealth Department of Health and Family Services 1997; Department of Human Services and Health 1994). Beds are also referred to in the classification of resources, such as bed norms (that is the bed to population ratio), global beds (total number of beds), average available beds (Statewide Division and Health Information Centre, 1999 #745) and associated with that other precious resource, time. These categories are 'total bed-days, elective bed-days, emergency bed-days, maternity bed-days, surgical bed-days and non-surgical bed-days (Commonwealth Department of Health and Aged Care 1999; Commonwealth Department of Health and Family Services 1997).

Hospitals have traditionally been an architectural manifestation of the separation of the sick or ill from the well, (Foucault 1993) with hospital admission synonymous with allocation to a bed for reasons of investigation, diagnosis, treatment and/or recovery. Despite contemporary developments in ambulatory hospital services and modern surgical techniques enabling minimal intervention and rapid recovery periods, this perception and practice continues. The hospital has provided a safe place in which to contain or 'house' the sick person away from unsanitary or unsafe environs, while at the same time removing the contagious patient from society. Armstrong describes this as the hospital being 'twice over a place of safety', in that it was both a sanitary place that separated the patient from the potential dangers in the home and environment, and a hygienic device that separated dangerous patients from vulnerable others within the hospital environs (Armstrong 1998:448).

As a therapeutic space, the bed provided a location for the practice and development of the art and science of medicine, where the therapeutics of medicine could be augmented by bed-rest for patients. Armstrong (1998) traces the shift from therapy to harm as discourses of danger, seen as iatrogenic illness, came to be associated with bed rest. Foucault's studies of knowledge and institutions focused attention on the economy of visibility and the formation of knowledge linked to
certain exercises of power (Foucault 1995 /1977:187). However, of relevance to the hospital is his analysis of the practices of the 'gaze' as a mode of perception and enunciation of medical practitioners through which statements about the body and disease could be made visible through forms of control of movement and of the timing and space of activities (Foucault 1995 /1977). Nevertheless, just as discipline for Foucault was more than just the coercion of bodies, but also included the place where a factory worker might be allocated, or the allocation of certain grades to a student, (Sarup 1996) so the bed is analysed as it contributes to 'making up' a disciplinary space of patient care practices.

The furthering of medical science as previously described by social theorists Foucault and Armstrong was not apparent in the activities in the City Hospital Short Stay ward. In fact, all surgical care was bluntly described by some medical and nursing staff as 'mundane' and 'not worthy of research attention'. One divisional nursing director described surgical nursing as 'straightforward and predictable, with the nurses just technicians who did wound dressings and medications'. In contrast to this, studies of nursing such as that by Latimer employs a quotation from Lentz about surgical nursing as having 'recognizable importance', (Latimer 1993:vi) to contrast her study of the invisibility of medical nursing as part of the medical gaze.

In this and subsequent publications Latimer expounds her thesis about nursing practice, derived from an ethnography of medical nursing, to suggest that nurses in the conduct of care 'act as conduits through which power effects are made possible' (Latimer 2000:116). She argues that this involves nurses aligning their work with the 'technical and heroic work of the clinical domain' (2000:116) so as to preserve their visibility and identity, which serves also to preserve the purity of medicine. Latimer suggests that nurses are the ones that 'drive the organisational need for movement and flow' (2000:117) and in doing so assist doctors to have clinical involvement only with those patients who can be easily processed through the hospital environment. Liaschenko provides further empirical support for the thesis that nursing extends the 'perceptual capabilities of the physician through space and
time', (Liaschenko 1994:20) and concludes that the price nursing has paid for a place at the bedside is the invisibility of nursing's knowledge.

Short stay surgery was not evident as a highly prized clinical medical domain. As will be further illustrated doctors paid little attention to these patients as the straightforwardness of their surgery suggested that they were of limited clinical significance. Decision-making was commonly delegated to junior doctors or initiated by nurses with the 'recognizable importance' in this study directed at ensuring the availability of hospital beds.

That surgical nursing might be considered mundane was also reflected in the conduct of ward rounds at City Hospital. The two surgical wards in which observations were conducted physically adjoined one another. However, the ward rounds, composed of ward-specific nursing staff, yet clinic-specific medical staff, were observed on many occasions to cease at the point where the two wards joined. Comments such as 'who's next door' were exchanged to ascertain which patients belonging to the particular surgical clinic were in the Short Stay ward. A doctor (usually of junior standing) was left to 'go and see how the short stays are getting on'. Unlike the surgeons in Fox's study, (1989) for whom the ward round and associated announcements of patient healing and readiness for discharge were exercises in medical power and authority, the patients in the Short Stay ward were already (or perhaps, as will be discussed further in the next chapter, always) deemed to be recovered. Consequently, the ward rounds on the Short Stay ward differed to the ward rounds conducted elsewhere in the surgical division. Where they did occur, they were less frequent that on other wards, short in duration, with limited discussion. This type of ward round was described by one surgeon as a 'business round' these ward rounds were

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\text{simply a ward round to check on patient care and make decisions regarding patient care, as distinct from a 'teaching round' during which discussions occur for student/trainee doctor teaching'. (Doctor Paul)}
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The Short stay surgical patients were seen as straightforward, as mundane, with postoperative decisions already made before surgery left to be enacted by the
nurses. Where changes might be made to these predetermined decisions, such as patients needing to stay longer, it was most often the nurses who first made these decisions then advised doctors of what they deemed to be necessary.

**Bedsides And Surgical Nursing Practice**

Nursing activities involved nurses in communication and generating information through observation, assessment and documentation of patient responses to surgical intervention. Nurses undertook what is well recognised as 'bodywork' (Lawler 1991; Lawler 1997) in the assessment and management of vital signs\(^8\), surgical incision sites, patient responses to surgical intervention, such as pain and nausea, and to a lesser degree mobility, hydration, nutrition and elimination needs. Patient admission periods, or 'stays', varied from hours to three–four days. Each nurse on a daytime shift was usually allocated to between six and eight patients. The staffing of wards included 'non bedside or supernumerary nurses' as those 'not allocated to the main care-giving for individual patients', although these nurses often assisted with observing, advising or delivering various aspects of direct care during a shift (Audit Commission for Local Authorities 1999:66). However this role was minimal, with only a team-leader not allocated to patients. The first three to six hours after a patient returned to the ward from surgery involved frequent observations, thus contact with the nurses, as this was the period of greatest variation in patient responses to surgery. It was during this time when recovery from anaesthetic was most pronounced, the potential for haemorrhage was high, and the need for accurate pain management important. As patient-responses stabilised, the frequency of these assessments reduced, and nurses had less direct contact with each patient. Nurses managed these observation responsibilities despite often needing to leave the ward to escort other patients back from the operating theatre.

The ideal of nurses as constant carers, always available for ward based hospital patients is well recognised in numerous nursing studies (Allen 2001) and is evident

\(^8\) Temperature, pulse, blood pressure and oxygen saturation
in participant comments such as the following from Natasha who was one of two clinical nurses on the surgical ward⁹:

'We are around the patients 24hrs a day; we are the ones who do for them' (Nurse Natasha).

This perception of nursing as essential and constant, even though mundane and marginal, is suggested by Andre to have a moral advantage for nurses through the extended and quiet shared presence that provides nurses with particular and attentive insights about patients (Andre 1998).

In contrast to the somewhat romantic notions from both Karen (the Clinical Nurse in this study) and Andre, (the medical sociologist) other nurses who participated in this study had different views about the availability of individual nurses to meet the needs of individual patients during their brief hospital stays.

'Most days it is just so busy here we can have up to three patients in the one bed with no extra staff.' (Nurse Jane).

I’m always conscious about what our bed situation is; I always know that there’s people waiting. ...The beds are there and you need to keep the people moving through so you can’t be with them very much, but sometimes it just doesn’t run like that. We would all like it to be black and white but there are sometimes when you just have to say no, this person needs to be here. (Nurse Meri)

The perpetuation of nurses as a single homogenous carer, always available to meet the holistic environmental needs of sick patients is less well supported by more recent studies of nursing (Latimer 2000; Nelson 2000; Parker 1996a; Purkis 1993).

In accordance with what were recognised as emerging discourses of managerialism, business and efficiency, the work of nurses in this study was directed by demands originating from both the pre-booked theatre list, as well as the predictability with which other patients could be discharged from the ward. Attention was given to the

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⁹ Clinical Nurses had additional ward responsibilities to other registered nurses, usually had additional qualifications or experience in a clinical speciality and were paid a higher salary rate.
efficient management of spaces and bodies, (Fox 1989) rather than extended periods of quiet, shared presence. A nurse who had worked on this ward for two and a half years described 'things on this ward' as 'too quick for nurses to really give care and for patients to get any care' (Nurse Mary).

While the next chapter addresses in more detail the relationship between nurses and patients, the inevitability of a relationship between nursing and care is suspended in this study of nursing practices in the accomplishment of the strategy of length of stay. With care not the focus of study, it is explored as instigated by participants. In the above quote the nurse spoke about care in a way that positioned it as additional to the functioning of the ward, the practice of nurses and the needs of patients. While still undeniably therapeutic, hospital services 'on this ward' were not dependant on notions of nursing care. Accordingly the following comments from another nurse indicate her ideas of nursing care as the availability of one nurse to each patient, again not achievable in the context of short stay surgery.

*Nurse Meri:* I don’t like it when a patient comes in and then goes straight off to theatre before I have had a chance to meet them. I am someone’s nurse. I am looking after them and I like to be able to do things for them, say to get them ready for theatre. It's not good for the patients, even though things do get done, that is, organised from a ward point of view.

*Researcher:* What is not good for patients?

*Nurse Meri:* It is not good for them to have lots of different people looking after them. They don’t know who is their nurse, who to speak to, who can help them. They all know who their doctor is. It's not good nursing care if they don’t know who their nurse is. But it is only as a team, you know with teamwork, that we get things done.

The requirements of contemporary managerialist strategies, such as bed management to achieve routinised and predictable hospital activity, (Commonwealth Department of Health and Family Services 1997) were always apparent in this ward. Nursing observations and assessments were focused on patient responses, with the 'overriding emphasis' on 'ensuring that beds are vacated
as efficiently as possible' (Hospital Bed Coordinator). Hence nursing practices indicated that rather than nursing or clinical decisions creating an emphasis on beds and length of stay, it was more likely that attention to length of stay and the availability of its material form, the bed, was what influenced nursing clinical decisions.

The bed also functioned as another type of hospital resource, as a means of transport used to move patients around the hospital, and as such, had the effect of transforming the supposedly inflexible physical ward spaces architecturally designed to accommodate each bed (in this case twenty-two). Movement of the bed out of the ward to the theatre with the patient, provided for flexibility in the number of beds, as well as in the bed 'occupants', able to be moved through these physical spaces. So despite being room in the ward for only twenty-two beds at a time, at any given moment there were a far greater number of beds (thus patients) allocated to the ward and moving around other areas of the hospital, while still being monitored or managed by the ward nurses.

While not seeking through historical comparison to authenticate a fixed or necessarily progressive idea of the bed as the location (or otherwise) of nursing, it is interesting to consider some of the protocols that have previously governed this rather high profile nursing domain. Nursing publications since the time of Nightingale's Notes on Nursing, (1859/1980) have until about the last thirty years affirmed the significance of the bed as a hygienic and therapeutic space for nursing practice. Nursing textbooks have included entire chapters dedicated to the techniques and standards of hygiene and comfort, with beds and bed-making skills proposed as necessary for effective, efficient and quality nursing care (Doherty, Sirl et al. 1944/1963).

Nightingale's original ideas and recommendations for bed-making derive from her concept of the bed as a source of 'feverishness'. Her recommendations on precise bed specifications have since disappeared in more recent nursing publications; however, nursing texts from the mid-twentieth century until now retain the
significance of the bed in statements such as 'A well made bed … is a great comfort to a sick person' and 'Bedmaking … must be carried out conscientiously and thoroughly at all times' (Doherty, Sirl et al. 1944/1963). Descriptions in one fifty-year-old nursing text provide instructions for making fifteen different styles of 'beds' ranging from the unoccupied or admission bed, through to the theatre, amputation or fracture bed. A review of current nursing textbooks affirms the bed as a significant location of nursing care; however hospital beds have become reframed away from the appearance of the bed itself, to its inclusion as part of patient management practices. Nursing textbooks reviewed as part of this study still include instruction on the physical requirements of bed-making (Berger and Brinkman Williams 1999; Crisp and Taylor 2000; Craven and Hirnle 1996). In such texts sections are dedicated to the problems of limited mobility associated with the bed through bed-rest, rather quaintly referred to by Berger and Brinkman Williams (Berger and Brinkman Williams 1999:1176) as 'disuse phenomena' or 'disuse syndrome'. Despite this formal and professional knowledge about beds in these texts for nurses and nursing, the bed is clearly situated in discourses of appearance and hygiene.

Notions of beds as aesthetic, therapeutic and hygienic spaces were evident in the Short Stay ward. The following extract from my observation notes of a man the day after his surgery, illustrates the bed as potential indicator of patient status. My fieldwork notes record observations of beds as 'dirty and untidy'. Barry, the patient, had undergone surgery the day before and was expected to go home on this day, so his bed was not prioritised or organised as a hygienic or necessarily therapeutic place.

Barry was lying in bed with the curtain drawn part way around his bed. There were two other men in beds in this four-bed room. Following his shoulder surgery yesterday he looked pale with the bedding untucked and the tell-tale stains of Betadine smeared over his pillowcases and sheets.

(Research Fieldnotes)

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10 Betadine is an antiseptic cleansing lotion commonly used before surgery to clean the skin around the site of the incision. While the lotion dries a few minutes after being applied to a person's skin, it can then rub off on fabric leaving a brownish discolouration.
This observation took place at 9am. The patient may have not felt well enough to move sufficiently for his bed to be made, the bed may have been perceived as comfortable as it was; the patient may have just been waiting to go home, and hence did not warrant clean linen (a considerable hospital expense). All of these are quite plausible explanations; however, in this situation this patient had during discussion with the nurse in the pre admission unit, made it quite clear that he lived alone and considered his shoulder surgery sufficiently incapacitating to require a second-night stay in hospital. This had been discussed with the nurse (who was a member of the staff of this ward) in the pre admission unit. In the context of this discussion the nurse had stated that 'only a one-night hospital stay would be necessary'.

Although the information was recorded in his medical records that he lived alone, no mention was made of the conversation between the nurse and patient during which he had expressed concerns about going home to an empty house the morning after his surgery. This situation has been included, as it illustrates particular visibilities of 'the bed' in administration processes. This will, however, be revisited in the next chapter where it will be analysed in regard to subjectivity.

The writing in medical records provided spatial and intellectual opportunities for those with the authority to participate (through the acts of writing) in the flows of population that have become the focus of health professionals' actions (Castel 1991). The absence from the medical records of information such as Barry's social circumstances and health-care preferences indicated that his request to not go home to an empty house the day after surgery was perhaps not a sufficiently valid one for the purposes of surgical care. The nurse's documentation of this interview may have been based on anticipation that the patient's clinical condition would not require the extra stay, however by not documenting Barry's concerns and expectations on this matter, the nurse aligned her practices with managerial discourses that require and ensure brief and predictable hospital stays. (Allen 2001; Dingwall 2001). Nurses described how patients were allocated to surgical diagnoses by medical staff in outpatient clinics, then allocated by clerical staff to
the Short Stay ward based on this diagnosis. This documentation contradicts the social process of individualisation as the patient becomes a category or population of patients through administrative framing other than as determined by specific individual needs (Dodier 1998). Though this documentation in patient medical records serves to legitimate actual patient needs, the individualisation of these needs will be discussed in the next chapter.

Observations of a patient's disheveled bed and Betadine-soiled bed linen may have been related to all of the possibilities listed previously; they were, however, also relevant to the situation where this patient was perceived by staff as no longer a 'bona fide patient', since he had recovered from his surgery and was considered by the nurses to be able to go home. He was saying that he needed to stay in hospital. Further analysis of this situation illustrates that the appearance of this bed is considered as perhaps more than an experience in ward economy, but also an indicator of this patient's somewhat ambiguous status as patient.

Arriving on the ward I checked the patient allocation book and asked the nurse nominated to look after Barry how he was getting on after his surgery.

_Nurse Tania: Oh he is Ok. He had his surgery yesterday, not as extensive as anticipated, he really only had a bit of bone shaving He had his (intravenous) infusion down just now and could go home, but he wants to stay so I guess he can._

_Researcher: Will he stay here on this ward, or will he be moved elsewhere?_

_Nurse Tania: No, it's not worth it really, after all he doesn't really need convalescence. The doctors has ordered him to have some physiotherapy], so that should free things up and get them moving._

_Barry was lying in bed with the curtain draw part way around his bed ...he had a large Elastoplast\(^1\) dressing over his shoulder with that arm in a sling. His eyes were half closed but he looked up as I greeted him and asked how he was feeling. He spoke slowly._

\(^1\)Elastoplast is a brand name of an adhesive elastic bandage

- 142 -
Barry: 'Oh hi, I feel pretty lousy, I've just had to get up to go to the toilet and the shoulder hurts quite a bit. I can't pass urine in bed. Feel really wonky'.

Researcher: 'Has the doctor been in to see you yet'?

Barry: 'Yes he said that I could go home today, but I said that I still feel pretty ordinary, really wonky—so he [the doctor] looked at Tania [nurse] and said to her, what about convalescence. She said 'he can stay', so I am not sure if that means I am to stay here or I have to go to another ward or what. They have convalescence here, don't they?'

The patient was confused as to whether he would move wards, and whether the announcement by the nurse that he could stay over-rode the authority or decision of the doctor. Barry was unsure as to whether he could stay in hospital, in this ward, or would be required to go home. He knew that he felt unwell and considered this, plus having no-one at home, constituted his status as patient, although the patient information brochures given to patients in the Pre-Admission unit before surgery provided information that postoperative symptoms of dizziness and nausea were common. This, however, did not diminish this patient's sensation of experiencing them.

The nurse looking after Barry commented about the situation as follows:

Nurse: I know he wants to stay—he told the doctor that he wanted to stay and the doctor just looked at me, so I said this is a short stay ward and we don't have the beds, he needs to go to convalescence—this is a short stay [sic] not a hotel.

Researcher: I have just been speaking with him and he seems unsure as to whether he is going or not.

Nurse: Oh he can stay I suppose, the doctors don't really care. ...[doctors name] just said to try and get a physio[therapist] to see him. In here it is our call really. They are all supposed to be patients that should go after one or two nights, but we [nurses] are the ones that make the call about whether they can stay or not. We just have to answer to ... [the Nurse Manager].

A short time later as I walked past Barry's room, he called out 'They have told me that I can stay until tomorrow, but then I have to go'.
He appeared pleased with this result. I noted that his bed had been made with clean linen. In focusing on the bed, a simplification of aims and outcomes is accomplished. The appearance of the bed act as 'an indicator of entitlement', whereby a patient is deemed sick enough to stay as hospital patient, or as recovered and no longer needing to stay. Bed condition, while previously uniform as an outward sign of certain nursing care and practice standards, is now tolerated by nurses as variable and a visible sign that a patient is not sick, is not staying in hospital, thus does not always require a clean or tidy bed, hence an unmade bed on these wards was a sign of economic efficiency.

Dodier (Dodier 1998) describes an administrative frame as a generic rule-bound process where all people are treated according to one category (such as risk) and are therefore treated the same. Alternatively, he suggested that a clinical frame provides for the decisions, such as those made by a doctor, to follow a course that leaves room for the unpredictable particulars of any individual (Dodier 1998). In this situation, Barry's social circumstances as living alone are configured as clinical; that is, related to his pain and restricted physical movement. Administratively, he had been allocated to a ward on the basis of an anticipated short stay, though in his case this stay means only one night, and a clinical reason must be found to justify the second night. The patient was referred to physiotherapy as an action in making visible a clinical reason for his continued stay.

The use, and equally significant, non-use, of the hospital bed is not only as an empirical object, but is conceptually active as a discursive formation, thus object of moral practice in the constitution of numerous hospital, health, and health care discourses. Latimer (2000) identifies the bed, along with admissions and discharges, as basic categories in the organisation of hospitals. In her study of nursing on a medical ward, the expression, bed, was representative of 'many resources: a space available to place someone in, the hospital's facilities, expertise, nurses, drinks, machines, cleaning, research, drugs, shelter, food, work' (Latimer, 2000:20). In her thesis Latimer suggests that length of stay was not visible at ward
level (1993), however her attention to patient throughput as a significant issue for nursing practice alludes to these practices. A subsequent publication by Latimer extends her analysis of the complexity of the bed and bedside, as metaphors for the movement or 'flow' of patients through the hospital, and locations in which nurses 'accomplish their multiple agendas, both by drawing on codes, rules traditions and procedures and by surpassing them' (Latimer 2000:6).

I think the Doctors make a lot of decisions but I guess it depends on who does the rounds, I mean someone like me or Jayne is probably quite confident in saying I think its time this person went home or to the convalescence unit, or I think this person needs this input or that, and usually they are quite receptive to us. They know we are around the patients 24hrs a day. The Doctors are usually pretty good, and sometimes you'll think they [the patients] are not ready, and they will say it's time to go, it's ready for them to go home, and if you say I don't think they are ready, they listen, and we don't ever fight about who needs to stay or who doesn't' (Nurse Natasha).

As [the ward] round walked away, the nurse spoke with that patient about a couple of things that needed to be organised (? discharge medications) and about what time she [the patient] could go [leave the hospital]. The nurse said 1pm would be good. The patient said that her husband was at work and maybe it [the time for hospital discharge] needed to be 2pm. The nurse replied 'we are a bit pushed for beds, we do have this transit lounge you can go to'. (Researcher Fieldnotes)

Nursing work in this study focused on mapping, thus administrative ordering of the flow of beds, and with them 'short stay patients'. Unlike the previous citations from early nursing texts that recommend the last activity in bed-making as checking that the bed is correctly aligned with the other beds in the room, (Doherty, 1944/1963 #703) for nurses, hospital beds are now aligned with the demand for short periods

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12 Transit lounge is a waiting room for inpatients from any area of the hospital, scheduled to leave the hospital either for discharge or transfer to another hospital or nursing home. Nursing staff are in attendance to supervise and assist patients. Patients in this areas could still be monitored for vital signs, have drugs administered, and be served meals as they waited for transport, dispensing of medications, or investigative results, before they leave the hospital.
of occupancy and increased throughput. The visibility and knowledge of nursing practice found less in the actual appearance of the bed, room or ward, than in the coming and going of beds and their occupancy. Castel uses the term 'flows of population' (Castel 1991) to describe the replacement of the subject as concrete individual with a combination of factors, in his case deemed to represent risk. It is in this sense that the appearance of the bed is less about the quality and efficacy of nursing, than as a sign of its duration of occupation. One of the locations for this bed management is the display on the ward office whiteboard13.

**Intellectualisation Of Space And Time: The Whiteboard**

In all hospital wards and clinics, including the Pre-Admission unit and the two surgical wards in which observations were conducted for this study, a large whiteboard was prominently displayed in the office space. The whiteboard on the Short Stay ward is an approximately 1x1.5 metre board divided up into sections that correspond to the spaces on the ward allocated for beds (note: not bed numbers but spaces on the ward designed to accommodate a bed). This whiteboard mapped a variety of information about the patients, the beds and the bed spaces. There was a place for listing the patient's name, the admitting doctor's name, the day of admission, and the day of surgery. Here I use the term 'bed space' for the concrete space, for as explained earlier, the actual physical beds were moved in and out of what was a material allocated bed space, designated by a numbered location.

While the whiteboard provided a temporary or transient textual record of patient's names and movements, the patient was effectively relegated to the margins as the whiteboard 'worked' by making visible, allowing everyone to see the movements and availability of the bed as a dominant discursive object. Each 'bed section', or 'bed space' on the whiteboard was divided into two categories so that the details of two different patients could be displayed as being located in the one space of each bed. This was to accommodate the admittance of a new patient to a bed where a previous patient may have left that allocated physical bed space to go to the operating theatre for surgery. The second bed space allowed for a second patient to

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13 A framed metal board with a white surface easily written on with felt tip pens and magnetic surface for labels.
be admitted and then leave for the operating theatres before the first patient returned. This system necessarily required that one of these two patients go to another ward after surgery. They may be expected to go home shortly after returning to the ward (this was uncommon, as there were separate day-surgery facilities for these patients) or transfer to another ward for their post-operative period. Each bed space in the ward could have up to four beds, hence patients move through in a day. Table 2 illustrates the whiteboard layout, while denying the complexity of additional names and the overlay of various magnetic labels.

<table>
<thead>
<tr>
<th>Bed</th>
<th>Patient name</th>
<th>Doctor</th>
<th>Date of Admission</th>
<th>Date of Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patient name</td>
<td>Doctor</td>
<td>Date of Admission</td>
<td>Date of Surgery</td>
</tr>
<tr>
<td>2</td>
<td>Patient name</td>
<td>Doctor</td>
<td>Date of Admission</td>
<td>Date of Surgery</td>
</tr>
</tbody>
</table>

The whiteboard provided an active account of patient/bed movements with updates or transitory information about patient movements in the form of colored magnetic labels, that could be placed across bed-sections to indicate pending patient movement, such as awaiting discharge from hospital, or transfer to another ward. On many occasions a third patient's name was written into one of the bed sections where one patient may have been admitted to that bed and gone to theatre, a second patient had been admitted and was waiting to go to theatre and a third patient was scheduled to arrive on the ward for admission to that bed after the second patient had gone to theatre.

The whiteboard was also a site for communication between health care staff that worked or visited the ward. Patients become featureless in their normalising as 'occupiers of beds'.

*Doctor walks in to the ward office, the nurse seated at the desk writing in patient notes looks up from her paperwork at him. He looks at the whiteboard as he says 'beds 3 & 7'. The nurse looks to the whiteboard, showing the patient names, bed numbers, doctors to whom the patient is assigned, as well numerous magnetic stickers with transfer, discharge or
Chapter 5: Governing by Time: Administering the moves to enlarge the space

With no other words spoken between the doctor and the nurse, the whiteboard provides a link between the doctor's plan to visit patients, and the nurse's role in this interaction. The whiteboard indicates a patient's whereabouts, the patient's address, which is as much, or perhaps even more the bed than the patient. In this sense the bed becomes a sort of shorthand for the patient, as well as an indicator of bed use and availability of (unoccupied) beds. The significance of the whiteboard, while not to be overstated, is as a map which enables surveillance of bed spaces, that is beds, patients and nurses.

The City Hospital Bed Management program was a formalised hospital-wide program developed as part of the National Demonstration Hospitals Program, and involved strategies such as designated patient admitting office, Pre-Admission unit, and a hospital Bed Management Coordinator. These various strategies all included visible bureaucratic processes directed at the centralised management of all patient admissions, stays, transfers, and discharges, through an integrated and coordinated process. See Appendix B for NDHP Bed Management principles.

While aspects of the formal Bed Management Program were visible on the ward, as the daily completion of Ward Bed Statements, and communication with the Booking Office about new admissions, the requirement to manage beds in particular ways was more subtle. The whiteboard represented the bed as a category of the classification of length of stay, and as such, participated in the surveillance of beds (their location and availability) by making visible to those present to read it, the capacity of the ward (therefore the nurses) to accept more patients.

Other than the display visible to the direct observer, the nurses were unclear about who, where, when, or exactly how the ward beds were accounted for, other than the fact that they were (ac)counted. A daily bed statement sheet was filled out by clerical staff in consultation with the nurses, was forwarded to the Bed Manager,
which stated which beds were anticipated to become vacant that day. It was a task seen as of little importance to the nurses, who knew that justifications could always be found for why the ward bed status was not as had been anticipated, for why someone was not going home as planned.

These practices about beds can be understood as disciplinary, with the bed (located very much within the hospital) likened to a disciplinary, carcereal space, 'in which are concentrated all the coercive technologies of behaviour', (Foucault, 1995/1977: 293) and conducted in rigidly delineated areas such as the bed, the day room, the Pre-Admission unit, and the whiteboard. In these areas, not only is the patient (like Barry) unsure as to who has what authority to control their movements in or out of hospital, who is monitoring what; but the nurses, unsure about exactly who or how bed use is monitored, do it themselves. Though not part of the formalised hospital bed management program, the whiteboard while just an immobile, material list, also acts a form of representation, or informational panopticon. Hence a foundational activity in the coordinating work distributed in time and space (Bowker and Star 1999:138:266 & 138), and in doing so, gives rise to nurses as 'docile bodies' (Foucault 1995/1977).

Disciplining 'The Flow'

Nursing staff made changes to the whiteboard as beds/patients moved in and out of the ward. The expectation of (and subsequent organisation for) short periods of admission and constant turnover of patients meant that the nurses on this twenty-two bed ward might actually provide care for up to forty-five patients in a day. It was perhaps no surprise that these nurses joked about how they were sometimes slow to rub out the details of a discharged patient from the whiteboard, as though this practice might slow or stem the flow of patients by 'pretending we have no beds'. They realised that this action only created the appearance of slowing 'the flow', as the beds were all pre-booked by the Admissions Office, and the Bed Managers as part of the hospital bed management processes which streamlined patient throughput. In the hospital surgical division, all information about scheduled surgery is circulated via the theatre list to all relevant locations, such as all surgical wards, the theatres, the surgeons, the nurse managers, the bed managers
and the admissions staff. The admissions office staff or Bed Managers (who were nurses) would regularly ring wards to negotiate patient movements and bed use. Phone inquiries would be made about whether 'anyone had gone home early', hence seeking information about 'what beds were available'. Admissions Office and Bed Management staff and the nurses on the wards were often engaged in attempts to renegotiate specific patient movements to meet contrasting needs.

The whiteboard and theatre list were two examples of the symbolic spaces of control through which nurses engage with length of stay management as a subcategory (or perhaps master category) of bed management. The following extract illustrates how nurses did not accept just any patient to the ward, but contested with others about which patients were suited to the ward and should thus be provided access. In this situation a Bed Manager rang the ward seeking a bed, any bed, for a new admission. However, the nurses on this ward were more interested in ensuring that patients for admission to their ward could be anticipated to meet certain criteria; that is, could be anticipated to have short hospital stays of one or two nights. Though the actual length of stay for the ward was variable and frequently extended beyond one night, this was the ward norm.

_Ward Clerk: ‘Sharon’s on the phone and wants to know if we can swap Mrs Sampson for a Mr Yeoman’s—he's due for cataract surgery today?’_

_Nurse Susan: ‘Who is it on the phone?_

_Ward Clerk ‘It’s Sharon’_

_Nurse and Ward Clerk checked the ward copy of the (operating) theatre list._

_Nurse: ‘No, no way, tell her we are quite happy with Mrs Sampson thank you’._

The ward clerk relayed this information to the person at the other end of the phone.

_Nurse Susan: (to me) ‘They wanted us to swap an admission that is booked here today—a woman having a cholecystectomy, for an bloke having eye surgery; both should be only be here overnight, chances are he is older and if they are looking for a bed for him there is something else going on. I would rather have the younger. I would rather have her (the chole[cystectomy] patient) who I know will get going—better than an oldie’._
This nurse referred to the Bed Coordinator as a 'they', in that both Admissions Office staff and the Bed Coordinator were seen to compete with the nurses in the ward, let alone the actual patients seeking admission for the beds in the ward. In this situation, with no attempt to seek out additional information about either patient, the decision-making by this nurse illustrates an overriding motivation for the nurses on this ward to ensure predictable patient turnover, hence patient admissions to this ward needed to be patients more likely to be ready for discharge in one or two days.

The telephone calls from Admissions Office also caused problems related to the pressures and volume of demand.

Nurse Loretta: 'Admissions can be a real problem. Yesterday they rang three times trying to get a patient in, and eventually we just agreed. We were so busy but they just kept ringing. They put more pressure on us than the other wards. There is no way they would ring three times to get a bed for another ward. They treat us differently. They think we are here to take the pressure so they really give it to us.

Researcher: 'So what can you do in those situations? What choices do you have?'

Nurse Loretta: 'You get the extras in by moving the discharged patients to the patient's day room. These are patients who are waiting for drugs or transport or whatever. The new admission gets put in their bed and then we can get extra beds from the old day surgery.'

Very little day surgery was practiced at this hospital, as it had been contracted out to a recently built adjacent private hospital. Bed bookings relied on predictable movements of patients through admission, surgery and discharge. When patients were deemed ready for discharge they were often asked to move to a 'day room' to await either drugs from the pharmacy department, or family members to arrive to take them home. Nurses would continue to 'do things' for patients in the day room. Sometimes nurses would take a final set of vital signs, explain to patients about prescribed medications, or how to manage their pain, movement, diet, surgical incision or drains, when to seek further assistance or advice, as well as when and
where to see the doctor next. All of these things regularly took place in the day room, where a number of patients and their families and friends waited, and where nursing activities continued beyond the location of the bed.

*Nurse Mary:* 'This morning Mr Chambers, the old bloke who had a hernia repair\(^{14}\) yesterday, I took him to the day lounge and he was literally sitting there swaying in the breeze. I said to him are you OK? He said sure. I mean, you really wonder sometimes 'cause there is so much to do and half the time here the next patient is already in their bed. I don't like it but what can I do? I can't stay in the day lounge and watch them. You just have to keep going back to check and hope they are OK. It's better if they are just waiting for drugs or something and their family has already arrived, but if they are waiting for transport and we have to watch them, its not easy sometimes'.

*Researcher:* 'Do you use the transit lounge when patients are waiting for their discharge to get organised or finalised?'

*Nurse Mary:* 'No not really, it's too far away from the ward and we need to keep a really close eye on our patients—right up until they are out of the door anyway. We have had to put quite a few back to bed, so we really can't use that area'.

The day room, although located within the ward area, was not (an official) place of observation; that was reserved for the bed. The nurses 'can't stay in the day lounge and watch them'. However in the day room sometimes up to six patients at any given time might be waiting for periods of up to half and hour before ready to leave the hospital. While the patients were deemed 'fit for discharge', the nurses knew they still needed to be monitored. It was not uncommon for them to need further attention by nurses in this place. This nursing supervision was more than enacting legal responsibility. These nurses knew from their previous experiences that many of these people were still experiencing the acute effects of surgery and needed care.

When patients were taken to the day room, this was not recorded on the whiteboard. Patients were taken to the day room, because the bed was imminently

\(^{14}\) Hernia Repair is surgical repair of a weakness in a muscle wall.
needed for another patient. The details of who was in the day room (their condition, and what they were waiting for) stayed with the nurse who was allocated to the patients. Although this room did not officially exist as a space of nursing practice, it was an active part in the disciplining of access to the bed.

The disciplining of the physical bed space could not always be maintained. Though hesitantly, patients were sometimes returned from the day room to a bed.

*Patients son to nurse 'Dad's not well, he's been sick'*

*Nurse Jane: 'Were you sick down there? (motioning her head in the direction of the day room). Patient nodded his head. 'Did you actually vomit?*

*Elderly man nodded his head. Nurse looked at son who explained that his Dad had vomited into a pot plant as they 'didn't know what else to do'.

*Nurse Jane: 'OK let's get you back to bed then and give you a lie down for a while, we'll just check your notes' To the clerk in the office 'are Mr Davidson's notes still here?'

*Nurse to Researcher: 'Lucky its Friday otherwise we wouldn't have a bed. They often feel sick but he has been sick'.*

Although the patient's bed had already been stripped, cleaned and remade with clean linen, that this patient 'had been sick' as opposed to 'felt sick' was an overt signal that justified a need for nursing attention. A sheet was laid over the bed and Mr Davidson was helped to lie on top. Following a check of his medication chart he was given an anti-emetic\(^{15}\), and spent a further hour resting on the bed before indicating that he felt well enough to go home. His son had waited without comment, as much emphasis in patient-information brochures was given to patients and their families and friends in the Pre-Admission unit, that they needed to be available to take patients home as early as possible on the day of discharge.

The Short Stay ward was always exposed to the potential for new admissions. While the whiteboard indicated *patients per bed*, this was not reflective of patients still requiring care. Therefore, part of a nurse's work in maintaining the accuracy of

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\(^{15}\) Antiemetic is a medication to relieve nausea and vomiting.
the whiteboard, was in maintaining the flow, and the correct flow required adherence to the predicted short length of stay. While direct observation of the whiteboard by hospital staff responsible for length of stay management (the nurse manager, the bed coordinator, the clinical resources staff) was infrequent, the effects of exposure to this 'gaze' were ever present. Through the whiteboard both the patients and nurses were made object and docile through either their occupancy of beds, or their subjection as *keepers of the accuracy* of the whiteboard.

However, nurses also needed to balance such requirements with what they perceived to be 'nursing', evident through attention to the patient.

'We manage through team work, though I don't like it when a patient comes in and then goes off to theatre before I have had a chance to meet them. I am each patient's nurse. I am the one looking after them on that day and if I am looking after them then I like to be able to do things, like to get them ready for theatre. I get really concerned about the patients because that is what we are here for. Even though things get done and organised, from a ward point of view it is not right, it is not what I call nursing if they don't even know who is looking after them, if I can't do some things for my patients'. (Nurse Natasha)

Osborne (1993:553) argues that the aim of advanced liberal mode of government is that it seeks to align medical technology with administrative technology, and that 'what is at stake is an attempt to make truth administratively and economically efficient'. Attempts to manage the increased costs and demand for health services have provided health economics with a powerful presence in current hospital practices. An illustration of this can be seen in government policies of efficiency and effectiveness, through which length of stay is made visible by its attachment to DRGs as an indicator of economic efficiency. Despite the Federal government no longer collecting length of stay data as part of its casemix data collection, a hospital casemix statistician observed that

*... even though length of stay is no longer statistically useful in the calculation of resource use, I am being inundated lately by different clinical staff, doctors and nurses in different positions, from the divisional through to the wards, wanting*
length of stay data for their areas. They seem to find it useful as a way of interpreting the productivity of their areas, but statistically, in relation to casemix, it's not you know. (Manager of Information Services, Casemix Research)

In addition to the external distribution of data to the Department of Human Services, reports are used widely within the hospital for purposes of which this person was unsure. She suggested that it was probably to do with audits, and discussed how she had been asked by the Department of Surgery to assist them with information related to clinical indicators required as a part of their accreditation with the College of Surgeons. As part of the growing field of 'experts' recognised for particular knowledge and skills, hence able to comment authoritatively on health resource allocation, she suggested that:

length of stay had been important in the development of DRGs, but that better indicators of cost management now exist. (Manager of Information Services, Casemix Research)

As further evidence of this growing practice, one unit manager explained that he kept records of length of stay as a way of mapping monthly budgets.

I keep my own statistics on the length of stay of patients in the ward and the monthly budget as I am interested if how much expenditure I can see as directly related to patient length of stay. (Clinical Unit Manager).

However, the nurses tended to see themselves as active in this process of directing patient's hospital length of stay.

I try to prompt the Doctors on the round to think about whether they might go home tomorrow or not so that we can start to get organised. (Nurse Natasha.

Discussion: The Reconstitution of Hospital Beds

Hospital patients are classified by clinical and administrative structures. Descriptions of length of stay enable its analysis as a classification strategy, through which categories of time and space make visible certain objects, such as beds, whiteboards, and documentation. These objects are also objects of discipline, and thus implicated in the exercise of power (Dean 1994:195). Bowker and Star suggest that we are
mostly ignorant of the 'social and moral order created by these invisible, potent entities. Their impact is indisputable, and as Foucault reminds us, inescapable.' (1999:3).

The hospital bed is visible as a physical location for the hospitalised individual; it constitutes a patient location within the organisation, and is also a means of transport. The bed can also be understood as a relational location of surveillance from which clinically relevant and accurate data can inform judgements about entitlement to 'patient' status and hospital services. It is through intellectual technologies, such as the whiteboard, that the bed is transformed into a resource-space in which nurses enact managerialist responsibilities to administer and ensure smooth, stable, predictable (meaning preferably brief) patient flows through the hospital system. Length of stay is therefore visible in 'the deployment of those intellectual and political technologies that render reality calculable as an object of administration (Clinton and Nelson 1998:145). Hospital beds for the surgical patients in this study were not therapeutic or hygienic spaces of nursing care. They were short stay beds, pre booked by the Admitting Office, and classified by the projected brevity of their occupancy, identifiable by the control associated with their access.

As has been discussed, hospital beds might also be understood as boundary objects that inhabit several communities of practice and satisfy the informational requirements of each of them (Bowker and Star 1999). Measurement and reporting of length of stay is clearly a strategy about beds rather than people; however, the bed is a new form of nursing responsibility. It is no longer the bed's appearance or cleanliness that matters. Rather, it is ordering strategies evident as processes of classification and calculation, which occur through negotiation and documentation (such as criteria for preferred patients and the whiteboard and other patient lists) and are directed at containing or minimizing difference, 'the prime negotiated entity in the construction of a classification system' (Bowker and Star 1999:231).

Through such strategies the bed becomes no longer a 'real' space, as much as a 'place without a place, that exists by itself, that is closed in on itself' (Foucault, 1986). It is in this place where nursing care has traditionally been enacted, where
the individual is visible (but only through allocation to the bed in the form of entitlement) as patient. The patient is visible in the bed locations of the ward or theatre, the patient is not visible in the day room, as either not yet admitted (even though present) or dischargeable (even though not yet discharged). Hence the day room, though a location that involves nursing involvement, was a non-place in terms of recognised (staffed) nursing work. It is the duration of occupancy of the bed, that is, the length of stay, with the addition of the invisibility of places such as the day room, that enable episodes of acute care to be managed. In this sense, the space of the bed became manageable only through the routinising, or 'taming of time' (Bauman 2000:115). However it was this taming of time which created the circumstances in which 'it is not what I call nursing if they don't even know who is looking after them, if I can't do some things for my patients'.(Nurse Natasha)

Length of stay therefore acts as a diagnostic device through which clinical practice can be scrutinised and measured through classification and calculation of objective performance, thus providing a new set of procedures for organising hospital stay that competes with clinical conditions or medical interventions. Through measures, economic efficiency becomes visible, as it also makes visible certain patients, the environment (including resources such as beds) and administrative and clinical judgments. Through attempts to predetermine length of stay such things are rendered knowable, calculable, administrable, and therefore amenable to intervention.

Bowker and Star (1999) suggest that to classify is human, and that classification is an invisible, potent entity, capable of crafting people's identities, aspirations and even dignity. Through attention to the calculation of length of hospital stay, the individual disappears as an object of knowledge. The patient as medical case is replaced by techniques to administer the anticipated length of stay, the bed, and the management of difference, is shifted from the patient and medical diagnosis, to that of the bed and its use. Patients become bed and beds become numbers.

Numbers are understood to achieve an unmistakable political power in technologies of government. Rose (1999a) argues that numbers determine who
Chapter 5: Governing by Time: Administering the moves to enlarge the space

holds power, by operating as diagnostic instruments of liberal political reason that align public authority with the 'values and belief of private citizens'. Numbers also make modern modes of government possible, by making up 'the object domains' or 'spaces of population' upon which government is required to operate, and they enable complex formulae to be applied to numbers claiming to represent states of affairs (1999a:197–198). They disclose aspects of society, while at the same time appearing to de-politicise whole areas of political judgment. Rose argues that 'The organisation of political life in the form of the modern 'governmental' state has been intrinsically linked to the composition of networks of numbers connecting those exercising political power with persons, processes and problems that they seek to govern' (1999a:199). As such, numbers form an important part of the 'calculating tools' necessary for the links within the networks, alliances and conduits through which power operates. However, numbers not only connect areas of calculation, but also enable 'centers of calculation' to function in governmental information relays, through re-presenting that which is distant and making it amenable to deliberation and decision (Latour 1987), a function applicable to the mapping of hospital beds.

Turning the objects of government into numericised inscriptions enables government to operate 'at a distance' from such centers of calculation (Rose 1999a:212). The power of the single figure renders invisible, and therefore incontestable, the judgments and decisions that go into measurement and numbers. Rose (Rose 1999a:208) suggests that 'the apparent facticity of the figure obscures the complex technical work that is required to produce objectivity'. However, for Haraway (1998) it is the numbers as instruments or tools that render things accessible to observation. She suggests that charts are examples of rhetorical instruments, a kind of argument, a technology of persuasion or a device to think with (Haraway 1998:232). An illustration of this is provided in the following comment from a nurse about standardising rates of intervention and modes of care that now allow hospitals to provide what is interpreted as a better quality of service because
ten patients can be given one night's care each as opposed to one patient receiving
ten nights care (Nurse Lynette).

Through such new modes of perception a governable space is produced. Within this space an extension of authority is made possible over what the modes of inscription, classification and calculation depict (Rose 1999a). The duration of stay for a collective of individual patients is (re)inscribed as single figures, or occupy single spaces that represent the length of stay for a diagnostic category or the space of a bed, and further 'along the line' represent an individual. This allows comparison, establishing of norms and standards, (and truths) and therefore evaluation and subsequent funding decisions. However, considerable cooperation is necessary to create common understandings, to ensure reliability across domains, and to gather information, which retains integrity across time, space and local contingencies while not presupposing a consensus (Fujimura 1992).

The numerical forms of length of stay are accorded a certain neutrality, and are thus able to act rhetorically in a mapping or charting, like 'a little machine for producing conviction in others' (Rose 1999b:37). The frequent references to patient throughput and length of stay in the health care literature privileges these technical and collective views of hospital activity. The challenge has been to identify empirically, how such views link with, or are translated into the delivery of hospital care. The monitoring and measurement of length of stay functions in the production of health care fact, by providing information about individual hospital stays as well information about patient groups. Length of stay is therefore implicit in the calculation and standardisation of hospital services.

Length of hospital stay can also be located within the therapeutic domain of the biomedical, where it participates in the performance of medical authority (Fox 1989) as well as the market domain, or discourses of patient experiences and consumer expectations. It is included in clinical decision-making about patient progress and preparedness for discharge. Hence, to limit considerations of length of stay to that of an outcome, particularly a technical or numerical one, obliterates the complexity of this phenomenon. To conceive of length of stay only as numerical
information about patient outcomes diverts attention from considering the strategic or contested dimension of length of stay, a dimension that articulates or networks with other interests in shaping hospital services and patient recovery.

Bowker and Star suggest that 'classifications hold a memory of what work has been done … and so permits the recommendation of reasonable due processes for future work' (Bowker and Star 1999:253). However, organisations can also be active in forgetting, not necessarily as a negative concept, but one sometimes useful, such as to change organisational identity (Bowker and Star 1999). Use of length of stay as a classification framework provides a certain efficiency of information that refines, or may even replace other details. The length of stay data associated with DRGs and clinical pathways are far more refined or privileged forms of memory (Bowker and Star 1999:257) in terms of prediction, than monitoring of individual patient progress by individual doctors and nurses. For the Short Stay ward to change the identity of the hospital (such that patients and nurses recognise this as a short stay environment) there needs to be new ways of doing things that are different from the previous ways, and for such change to be successful, group memory must not be mobilised against change. Hence doctors and nurses need to recognise this style of surgical services as correct and the acceleration of time as best.

It is proposed here that the whiteboard might be understood as an 'apparently humble and mundane mechanism, which appear[s] to make it possible to govern' (Miller and Rose 1990:8). Hence the acceleration of speed of time of hospital care means that the space available in which to provide care is enlarged to include the patient's home and community. This increases not the (in hospital) time available for care, but the capacity for the flow of volume of patients. So just as the focus is populations of patient flows, these populations are recognised as such by emphasis on particular characteristics. Characteristics or subjectivities for nurses are found in their performances as bed calculators and managers, except of course where nursing cannot be deferred to more suitable places or times such as where a patient might actually vomit rather than feel sick.
This discussion of subjectivities is extended in the next chapter, where continuing or new notions of patients subjectivities (and for that matter new or continuing nursing subjectivities) are referred to as 'those heterogeneous processes and practices by means of which human beings come to relate to themselves and others as subjects of a certain type' (Rose 1998:25).

**Summation**

Analysis in this chapter proposes that length of stay participates in the predetermination, hence administration and regulation, of episodes of acute hospital admission. Interest and investment in efficiency, evident in the numerous strategies to increase patient throughput, decrease the length of hospital stay and subsequently shift locations of health care outside of hospital boundaries. Hospital innovations such as Bed Management and Short Stay surgery programs, as well as development of 'non bed' spaces of hospital patient care, such as the Pre-Admission unit and home care, have been driven by aims to restrict, or compress bed access. However against the backdrop of efficiency nurses were engaged in managing an increase in the use of ‘non bed' that is, non measured spaces of nursing care.

Government is a matter of representation and intervention. Miller and Rose argue that the 'specificity of governmentality as it has taken shape in "the West" over the last two centuries, lies in this complex interweaving of procedures for representing and intervening' (cf Hacking 1983, in Miller & Rose 1990:7). However, a crisis is said to exist in our experiences of space and time, 'a crisis in which spatial categories come to dominate those of time, while themselves undergoing such a mutation that we cannot keep pace' (Harvey 1990:201). This chapter has explored the representations of length of stay as visible in the local practices of hospital surgical services, where changed understandings of time and space are visible.

Time and space are sources of social power, never neutral in social affairs, especially where they connect with money (Harvey 1990:239). All manner of conceptions of the bed as a hospital health care space and place exist. Examples of the bed as therapeutic, hygienic, classification, and patient location, coexist with the economic space of the hospital bed. Thus, the progressive monetisation of health care
relationships transforms the qualities of time and space, just as the pursuit of profit alters the way that time and space are used and defined (Harvey 1990:228–229).

As the innovative technologies of modern surgery all but obliterate the visibility of surgical intervention, so the space of the bed as a therapeutic nursing location, thus the role of the nursing in providing postoperative surgical care, has also been all but obliterated. The bed is an experienced, physical and material space of nursing and hospital care, spatially fixed through representations of its materiality, and available to perception through technologies such as the whiteboard. This representation of health care spaces, functions, along with the fixing of time, in forms of documentation such as patient records and bed cards to provide ways for the material space of the bed to be talked about, imagined, and thus understood. However, this is not only as represented health care spaces, but as spaces of representation, (Lefebvre 1997) where length of stay comes to function as a mental invention through which new meanings and possibilities for hospital services, nursing practices, and patient care become available.

Many people and technologies are enrolled in monitoring length of stay for accelerated patient throughput to be achieved, thus for the spaces of surgical care to be enlarged. However, as seen in the management of the nauseated, as opposed to actually vomiting patient, the disciplining of these 'spaces of the bed' is not always easily maintained. Patients are classified and scheduled for hospital admission, surgery, and discharge, in a manner reflective of contemporary post-Fordist management ideologies of 'just in time'. Bed management processes, though often remote to the ward, direct the means by which elective patients gain access to a bed (and a nurse), accelerate the duration of stay, and shrink or remove the bedside as a location for nursing practice. Further consideration of this in the next chapter, proposes that length of hospital stay is evident though techniques of contracting and responsibilisation, as techniques of moral responsibilisation.
Chapter 6: Governing by responsibility: recovery as an object and ethic of practice

Introduction

Following the administration of time and space as domains of power knowledge relations, analysis now turns to the spaces that discourse makes available 'for particular types of self to step in' (Parker 1992:9). Attention is not only directed at what is visible and expressible in seeking subjects as they may be products of discursive formations, but also in their relations to the technologies of government as social practices 'manipulating the social or physical world according to identifiable routines' (O'Malley, 1996:205). The empirical and normalised length of hospital stay, analysed previously in relation to published literature and hospital beds, is now examined for intellectual responsibility, as accessible through the axis of subjectivity (Bernauer, 1995).

Where Foucault's early work spawned the use of disciplinary techniques to effectively explain power relations and docility, governmental analyses propose that disciplinary technologies exist only for those who cannot be relied upon to govern themselves (Armstrong 1983; Armstrong 1984; Armstrong 1993; Foucault 1993; Foucault 1975; Dean 1999). Accepting that Foucault's concept of power is realised in and through 'the sense of capacity to do or become certain things', (Patton 1998:65) it is insufficient to propose that social or political change, such as the announced visibility given to length of stay in policy, 'causes' nurses (and others, including patients) to treat themselves (and others) differently. Change does not 'transform ways of being human by virtue of some 'experience'' , as this would require an assumed continuity of subjects (Rose 1998:25). Rather, what is of interest is how meaning is given to experience, through the various human experiences of behaving, being categorised and/or being dealt with in particular ways. Remembering that the theoretical framing of this study proposes that there is no experience and no knowing self other than that which is an effect of discursive practice.
Analytic attention to the governing of selves in the 'non bed' spaces of hospital care presupposes that episodes of surgical care are perhaps more complex than simply performances of control and making dependent surgical patients. Therefore, rather than strive to separate techniques of domination or freedom, this chapter explores the various devices by which to produce meaning as 'grids of visualisation, vocabularies, norms and systems of judgement' (Rose 1998; Rose 1999a:25). These 'devices' are examined as they govern certain population-based requirements of hospital services. This government is accomplished by giving meaning to individual experiences through adoption and enactment of certain characteristics and capacities with analysis directed at the micro-powers through which 'free' individuals are constituted and constitute themselves (Foucault 1990/1985:26). Therefore the focus is on how nurses and patients are disciplined to act as in ways which prescribe boundaries in relation to length of stay, as well as how they prescribe their own such boundaries.

In this chapter interactions between nurses and patients in the contexts of the Pre-Admission unit and the Short Stay ward focus on nursing identities as they surface in the constitution of those of 'the patient'. The first section of the chapter examines nursing practices as empirical, and instrumental attempts to control patients' episodes of acute surgical care. This informs the second half of the chapter where it is proposed that these disciplinary practices also participate in the production of various subject positions for nurses and patients which are not only as reactions to power but are also amenable to understanding as purposeful 'practices of liberty' (Foucault 1994). Understood as contractual arrangements, these practices are examined as they involve various modes of resourcing and resistance.

**Pre-Admission, Short Stay And 'The Perfect Hospital'**

The Pre-Admission unit and Short stay ward bring together (re)classified nurses and patients. For patients, this classification is according to an anticipated length of hospital stay rather than the previous classifications of medical or clinical diagnosis. For nurses, the new classification retains the emphasis of nurses as 'body workers' (Lawler 1991; Lawler 1997) while simultaneously requiring them to become skilled 'information workers'. As information workers, nurses become
skilled in identifying and processing not only the previously identified information about physical hospital spaces (beds) but also the 'non material' spaces that are generated to govern recovery.

New hospital patient-care locations, such as the Pre-Admission and Short stay, make it difficult to discriminate between clinical and managerial discourses in hospital health care services, and between the populations of hospital patients. The Pre-Admission unit and Short stay ward are conceptualised in this study as sites for the gathering of 'new knowledge of human individuality', (Rose 1994) valuable because patients are 'normal people in their own clothes with their friends and family' (Nurse Carol). Though knowledge is recognised as an essential part of government, (Foucault 1991a) it makes sense of human conduct only through creating expertise, thereby enabling the forms of 'truth' necessary for government (Rose 1999a).

The Pre-Admission unit and Short stay ward act as surfaces of emergence, for new ways of thinking about patients and the care that they receive.

*I think the Pre Admission Clinic is one of the best things. If every patient could come through there, probably the hospital would be perfect. (Nurse Karen).*

The perfect hospital is produced (for this nurse) in the pre-admission processes, or 'clinic', through which particular modes of perception and enunciation 'produce' patients. Thus the processes of 'come[ing] through here', as an entry point to the hospital, might shape the Pre-Admission unit as an instrumental 'ideal type', providing order and discipline as legitimate forms of domination in a bureaucratic system (Weber, 1978). The Pre-Admission unit and Short stay ward are therefore understood as part of 'explicit programmes: ... with sets of calculated, reasoned prescriptions in terms of which institutions are meant to be organised, spaces arranged, behaviours regulated.' (Foucault 1980b:80).

Remembering that the nurses conducting the patient assessment and interviews in the Pre-Admission unit, worked on the different surgical wards and were the same
nurses who would care for these patients when admitted to hospital and after surgery, the Pre-Admission unit processes were viewed as useful because …

\[
\text{we get to see them while they are still well, I mean I know they need surgery but in the Pre-Admission unit they are usually fit and well and this helps to know what they should be like after they have had their surgery. (Nurse Karen).}
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Thus individuals for admission were both patients requiring admission to hospital for surgery, while at the same time 'well' and 'fit'. Fox (1994) found that similar discursive contestations exist between surgeons and anaesthetists, who while sharing a biomedical discourse, require patients to need surgery at the same time as 'be fit' enough for anaesthesia. Nurses in this study are involved in the same way in thinking about, engaging with, and securing care for individual patients, while concurrently complying with organisational structures and processes consistent with 'a perfect hospital', which is understood as a hospital with a predictable patient length of stay. These discourses were not restricted to the patient's body, but inclusive of the patient's social life, evident in nursing practices as 'information work'.

In the Pre-Admission unit, nurses conducted assessments and interviews with the patient, and, where present, family and friends. The resulting documentation, although brief and restricted to the minimal space available on standardised forms, reported the patient's expectations of the scheduled surgery, social and home circumstances, and daily or regular activities such as lifestyle and occupation (see the example form in Appendix C). Nurses had limited contact with the patient's body measuring and recording each patient's vital signs\(^{16}\), sometimes examined the area of the patient's body that needed surgery, discussed the particular scheduled surgery, and described the hospital admission, operating theatre, postoperative and recovery processes. Patients were told in various ways that

\(^{16}\) Vital signs measured in the Pre-Admission unit include temperature, pulse, respirations, blood pressure, weight.
... to be ready for discharge we need the wound to look good, no temperature, have you eating and drinking and for you to be up and able to move around'.
(Nurse James)

However dependent the conditions for hospital discharge appeared to be on clinical or functional indicators, an anticipated length of stay was always mentioned. In accordance with this well-recognised requirement of quality consumer-responsive health care, (Draper 1997; Draper 1999) length of hospital stay was defined early in the Pre-Admission interview through statements such as:

this type of surgery needs two or three days (Nurse James)
this type of surgery only needs one or two nights (Nurse Gail)

Patient information brochures such as the Guide to the Hospital, Patients Rights, Pain Management, Short Stay Surgery and Hospital at Home were available in each of the Pre-Admission unit waiting rooms and handed to patients by nurses at the consultation. These documents affirmed the emphasis on length of hospital stay, with one Short stay ward brochure stipulating that, 'You will be expected to be ready for discharge at 7.30am so please have your transport arranged to accommodate this'. Many patients who participated in this study when asked about these brochures indicated that they had either not read them, or did not have a clear understanding of all the contents. While given out at the Pre-Admission unit appointment, the next opportunity for nurses to talk with patients about the content was in the few hours after the (already fasting and commonly anxious) patient arrived at the hospital before surgery.

On admission to hospital, nurses always asked patients whether they had any questions, and sometimes they did. A 69 year-old woman, scheduled for surgery to investigate a palpable lump in her breast, expressed disappointment about not being able to continue (after surgery) to sit in the sun, as this was something she loved to do. Further questioning revealed that this information had come from one of the number of brochures she had been given in the Pre-Admission unit. A specialist oncology nurse visited all women scheduled for investigations of breast neoplasm at the time of their Pre-Admission unit appointment and after surgery. The information about exposure to sunlight or more specifically sunburn while
receiving radiation and chemical therapies, and after surgery on auxiliary nodes\textsuperscript{17}, was included in a brochure on the management of breast cancer. This example provides evidence of the complexities of balancing when, where, and how much information to give to patients, along with the need for associated discussion with specialists. In this situation very detailed information was given to, and read by this woman before her surgery. Two weeks later, after discharge from hospital, and readmission (for a period of one and a half days for a complete mastectomy\textsuperscript{18}) she had many questions about where she might find support now that she was home from hospital. She was being cared for by one of her daughters who had come to temporarily stay with her.

Although relatively subtle, the mention of length of stay in the nursing Pre-Admission consultation and patient literature signalled to patients, and to those accompanying them, an instrumental significance to their categorisation.

\ldots short stay, long stay they are really quite different things. The whole process for these patients depends on how long we think, or I should say know, really, as these days we pretty well know exactly how long they will be here. (Nurse Pauline)

However, the following comments from Karen, a nurse from a 'long stay' surgical ward, shows how these classifications can be seen as something that are worked on or produced by nurses in the conduct of their daily work.

\textit{We've sort of like got a standard thing, like Day 1, when they have come back to the ward you let them rest, do their obs[servations] and things like that. The next day you get them out of bed, I mean it really all depends on what kind of operation it is, but most surgery, the sort we do, you think well, Day 1 they should sort of like get out of bed, shower things like that, really start increasing their mobility and things like that. But of course, like depending on the patient, you sort of keeping on thinking, well is this patient able to do it, or what, not as

\textsuperscript{17} Auxiliary Nodal Dissection—surgical excision of lymphatic nodes under the arm.

\textsuperscript{18} Mastectomy—surgical removal of breast tissue.
well. I mean, I always think if it's Day 2 they should be definitely be out of bed. If they haven't been out of bed before, well this should be the day and things like that. ...I think it's always sort of been the way, like we often have the care plans and things ... you know, when they case-manage patients' pathways, you actually have your list, and you think well, Day 1 whatever .... You always have that in your mind, and you think it is a surgical ward, in and out so to speak, but like you have surgery, 2 days and then go home sort of thing. So you always sort of like try to think, well its best to try and get them moving, and then also other things as well like, the chest physio[therapy], you don't want them to develop chest infections etc. So things like that, you're always sort of like thinking of mobility and things like that to get them moving. (Nurse Karen)

These extracts represent nurses, patients, their bodies and hospital surgical care as subjects and objects of calculation, not as subjects representing an individual with freely-chosen choices; rather, disciplinary powers are evident, the object of which is the subject, as the short or the long stay, or the Day 1,2 or 3 patient. Our caring for, and being cared for by others is inseparable from how power, in its modern form, operates. A difference between these examples, and the exercise of power in the constitution (disciplining and moralisation) of patients (and their bodies) is evident in a shift between these examples from individuals to a population. As a defining feature of governmentality, population encourages and makes possible the invention of an array of tactics and technologies deployed upon individuals and en masse (Foucault 1991a:17–18). This shift to a population focus is evident where nurses guide, and are guided by, individual recovery as a day to day process, as opposed to the perception of recovery which is associated with the patient who has been defined in advance, as 'long' or 'short' stay.

Further evidence of this flow between individual and population can be gleaned from the impact of certain media on patient expectations of hospital services. It is proposed that patient expectations were 'stylised' through exposure to the textual products of politicisation and/or entertainment evident in various daily media. During the period of fieldwork for this study newspaper reports commonly used the
bed metaphorically to represent entitlement to, and quality of public hospital health services, through headlines such as 'The Long Wait for a Bed' (The Advertiser, October 1999) and 'Extra Beds Reduce Pain' (The Advertiser, November 1999). In opposition to this demand, the incumbent Minister of Health was quoted as promoting an alternative to public hospital services in suggesting (in a manner reminiscent of The Wizard of Oz) that 'There is no bed like your own bed' (The Advertiser 2000). Newspaper cartoons published during this period provided evidence of similar views of the hospital as not an attractive or inviting health care location. One sketch portrayed the public health system as a dysfunctional (and somewhat sad looking) figure bleeding at the points where its hands and feet had been cut off.

Illustration 2: Newspaper Sketch: Public Health

Alternatively, the hospital was portrayed as a manufacturing assembly line, where in a Heath Robinson-style sketch, patients were admitted to hospital through a hole in a ceiling, through which they fall, onto a stretcher as conveyer belt, to then be tipped into a crowded 'bed'. From this 'bed' existing occupants / patients are displaced, with insitu intravenous infusion, and clutching the pole, from the bed and out through a hole in the floor, a hole labelled discharge.
Profoundly, the only identifiable nurses in this sketch (as evidenced by their frilly caps) are either seated at a desk reading from a long list and issuing the managerial decree of 'Next', or are shut outside, observing events only by peering through a small window in the door.

Illustration 3: Newspaper Sketch: Hospital Admission & Discharge

(TheAdvertiser 11/5/98)

During this same period, City Hospital featured in various media reports when nurses undertook three days of industrial action over the closure of a ward due to unpredicted budget shortfalls. For nurses on the surgical floor, 'this had nothing to do with us' (Nurse Mary), as the closed ward had been a cardiac assessment unit. Comments from patients indicated otherwise. For Mr McDonald and Mr Richards, their subjectification by the reduction of length of hospital stay, and the reduction in the numbers of hospital beds was directly related to their perception of hospital care.

'... lucky to get anything under the current funding crisis'

'... haven't had to wait long (for surgery) at all, all things considered'
Within this context of economic challenges for public hospital systems, nurses, like the Minister for Health, were observed to speak to patients in ways that affirmed the hospital as an unfavorable place to be:

>'the whole idea of this [Pre-Admission] clinic is to get all of the pre-operative care done before you're admitted. All the things we used to do after you came in to hospital we now do beforehand so you don't have to be here for as long. It's better as you get home quicker'. (Nurse Gail)

Such comments denied the experiences of patients, such as those of the woman who made a two-hour return bus journey to attend the clinic (for two and a half hours), the day before she was to repeat the bus journey for hospital admission. The view by nurses that the Pre-Admission unit was a 'good service' was not always consistent with the views of all medical staff:

>'The older ones' [surgeons/doctors] they like to keep their patients up on the ward and have more time with them up there. Some of them don't realise that the system has changed and they just can't justify the time with patients. We can do it just as well and much quicker down here. (Nurse Anne)

>'Some of them [Doctors] are just protective and still like to have their patients come in the day before, early, so that they know they are here for certain, to oversee their prep[aration]. Fortunately we have a Head of Division who believes that nurses are too soft and says that patients are better off having their bowel prep at home, because if you give a patient instructions on what to do then they will do it, whereas nurses are the ones who are too soft and change things'. (Nurse Pauline)

These nurses were discussing the pre-operative requirements of a woman scheduled for bowel surgery. Anne's comments about a change in the hospital system sought to justify a shift in medical surveillance of patient care through use of the Pre-Admission unit, by emphasising time and responsibility. Doctors desire to 'have more time' with patients on the ward could, according to Anne, be replaced with the Pre-Admission unit as 'much quicker'. Meanwhile her suggestion that '…we can do it just as well' disguises a comparison of quite different pre-operative
practices. On the ward, pre-operative patient care would include giving patients similar information to that provided in the Pre-Admission unit; however, pre-operative patient care could also include supervised administration of specific interventions, such as in the bowel preparation\textsuperscript{19} for this woman. In the Pre-Admission unit no interventions (other than diagnostics of vital signs and ECGs\textsuperscript{20}) were conducted. Hence the comment that 'we can do it just as well' is somewhat misleading, as ward pre-operative nursing included administration and monitoring of interventions, whereas in the Pre-Admission unit nurses only provide for patients the instruction about how to do such things for themselves. The nurse's comment that doctors 'just can't justify the time with patients' fills any discursive space that doctors might seek to generate between their clinical practice and the managerialist discourses of throughput. These nurses appear not to seek any discursive space between nursing practice and the gathering of patient information and calculating of (hospital) time as techniques through which to increase the independence of patients.

Pauline's comments also support the shift in hospital pre-operative services away from the ward, but for very different reasons. At first glance it may appear that she sees the patient as empowered by not having to be in hospital for the pre-operative care, hence free from both medical and nursing interference. However, in echoing the idea that it is fortunate to have a Head of the surgical division who thinks patients are better off having their pre-operative preparation at home, and by default, that the \textit{Pre-Admission unit is a good thing}, Pauline indicates agreement that 'nurses are too soft and change things'. Hence patients are presumed empowered by being individuated in relation to their particular surgical needs. However, through this very process in which patients can take up certain actions, they also are expected to, take up certain practices, hence govern themselves in the

\textsuperscript{19} Bowel preparation involves the cleansing of the colon—usually over a 2-day period—by restricting food intake, and oral administration of laxative or intestinal lavage agents. These agents have the potential side effects of nausea, fluid and electrolyte imbalances, and hypothermia (as the recommended administration is to take the fluid very chilled to make more palatable and ensure complete ingestion of a full dose).
conduct of their pre-operative care. These practices are those of responsible persons/patients, rather than as patients subject to nursing practice. Despite nurse's ongoing public recognition as one of the most trustworthy professions, this nurse's comments reflect the dominance of medical discourses such that nursing practice might be seen to 'interfere' with patients' compliance with medical instruction, hence the disciplining of patients by medicine's 'gaze' (Armstrong 1988; Armstrong 1995; Armstrong 1993).

This responsibilisation of patients is also apparent in recommendations from a National Demonstration Hospital project report on Pre-Admission units, which proposes '… customer focus … will improve patient satisfaction and ensure that the patient and their family are educated and prepared for their role in the use of the health care facility' (Daffurn and Sutherland 1997) [italics are mine]. The emphasis here is clearly on 'delimited and targeted domains for intervention' (Osborne 1997: 185), with the patient as an active participant, rather than recipient, which functions as 'a moving force throughout the whole [hospital/health] system, giving it coherence as its principle of functioning' (Osborne 1997:186).

'They know/ we know'

One of the key strategies in the Pre-Admission unit involved the exchange of information. This exchange between nurses, patients and doctors involved not only scrutiny of the patient's body for confirmation of disease or symptoms necessitating surgery, and their devised and enacted to reduce the duration of hospital stay, involved fitness for anaesthesia, but information for patients about their surgery and what they needed to do to prepare themselves. However, emphasis on gaining information from the patient was given equal importance. Gathering information about the patient and their personal or social circumstances made what was previously 'invisible', visible though 'the brightness of the gaze', (Foucault 1994:196). This visibility was only afforded to those with the authority to access the patients' medical records, nurses and doctors as well as the patient, and (where present) family and friends. In the Pre-Admission consultation, interview processes

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20 Electrocardiogram is a graphic record of the electrical activity of the heart muscle used as one form of diagnosis of cardiac function.
were a selective strategy to make visible only certain information of patient's lives. Nurses' information work was guided by patient factors such as anxiety, poor pain management or lack of home care help that might interfere with the prediction and reduction in hospital stays. The Pre-Admission consultation involved nurses and patients in subjection as ethical subjects of their own behaviour.

*The Pre-Admission patients are different, well, for one they know all about the operation, the doctors have gone down there, the nurse goes too but often it's the actual Consultant that goes down and speaks with the patient. They [the patient] understand the operation, they understand all the postoperative expectations of the nursing staff and medical staff and things like that, they know what has to be done, and we know all about them. We know their social situation and their home situation so there are no issues about them not being able to go home on time. (Nurse Carol)*

This constitution of the 'Pre-admission patient' aligns with a rationality of the perfect hospital, through processes of 'they know' and 'we know'. Through these processes the patient and the nurse are made visible through information strategies which accomplish 'they know … all the post-operative expectations' (that is, the patient knows what is required of them in the impending hospital surgical episode) and 'we know … all about them' (that is, the nurse has been able to learn (and document for others) the necessary details to assist with the prediction of discharge and movement of the patient through the surgical episode.

Along with hospital systems that measure or classify a patient's illness, the significance of what is known in this context is framed or measurable by the timing of hospital discharge, hence the management of length of stay. Carol's comments describe the expertise of medicine as having the responsibility of information-giving, as it is the Consultant who *speaks with the patient*. For nurses, the Pre-Admission practices are directed at information gathering. Before analysing what might be understood as the ontological significance of this, the purpose of these information-gathering practices is reinforced through examination of an alternative to the Pre-Admission unit patient.
The significance of information gathering was evident with patients admitted to hospital through the Emergency department. These patients were understood by nurses to be potential problems:

... chaotic [is what] it can be when we get people in through Emergency. We have never laid eyes on them before and you just don't know anything about them ... you have to start from scratch and work out what is going on and what they might need. It is no wonder that for these people their discharge gets delayed' (Nurse Natasha).

Perception of these individuals as 'potential problems' involved a perceived lack of the necessary or correct information. An audit of patient-records for randomly selected emergency admission patients, showed that they all arrived on the ward with some documented information. Three of the six patient records included a referral letter from a General Medical Practitioner, which in addition to the details of the patient's clinical condition, made reference to the patient's social situation, such as where and with whom they lived. The other three patients had all been seen in the Emergency department previously with the same complaint, therefore had hospital documentation of both clinical and some social information. Emergency department medical and nursing staff, as well as the surgeon who authorised the hospital admission, had all made comments in the patient records about the clinical condition and the social circumstances. While clinical information was necessary to initiate response to the patient's clinical needs, the nurses considered this inadequate to the conduct of their practice.

When we have the Pre-Admission chart you always look there when you get a patient. So you're able to start there and have that bit of chat and sort of find things out. Whereas the ones that come through Accident and Emergency often come in and aren't really willing to talk ... it's a lot harder to talk to them because they are unwell. I'm probably contradicting myself there saying elective surgery patients aren't sick, I suppose they are, it is just that the Emergency ones they're not quite as willing to talk as much as what the Pre-Admission ones do, I mean it's elective surgery most of the time and they are sort of well enough to communicate, it is just that whereas the Accident and Emergency ones say, 'oh we have been waiting down in A&E for so many hours, I just want to go to sleep or just want to
...do whatever'. So you always find out a lot less about them than the pre admitted patients. That just makes them harder to look after'. (Nurse Lynette)

May and Purkis (May, 1995 #789) suggest that 'ideas about what it means to be a nurse and to do nursing work involve for both the nurse and the patient, the productive work of establishing a sense of location' (284). These Emergency patients were 'not...willing to talk', they were not 'pre admitted'. For these nurses and patients, the necessary talk, about social circumstances external to the hospital, had not occurred. Hence, the patients admitted through the Emergency department were seen as problems in that they 'are not known' [about] and 'they do not know' [what is considered meaningful by nurses for patients to know]. Comments that this 'makes them harder to look after' do not apply to their clinical condition as much as to the management of their length of hospital stay.

These practices can be seen as empirical, and instrumental attempts to set or control the identifiable routines for patients' episodes of acute care. Nurses in this study idealised a perfect hospital, acted as information workers and intervened in medical authority. The following discussion proposes that the above techniques participate in the production of a number of subject positions for nurses and patients. However these 'subject positions' are not only as reactions to power (such as 'they know' and 'we know') but also as purposeful 'practices of liberty' (Foucault 1994).

Analysis now turns to examine these 'subject positions', as they may still be disciplinary, while also interwoven with and translated into practices that are ethical. These ethical practices are identifiable through a subject's ability to work on their own capacities to reject unwanted forms of identity (Moss 1999). Discussion explores how individuals are categorised, dealt with, and behave as expert, resourced or risky. Resistance is analysed as alternative forms of resourcefulness evident where patients actively draw on capacities to act in ways other than those proffered by nurses and other actors in the hospital system. Resistance to nursing identities, though difficult to identify in this data, are
suggested as evident where nurses describe making space in which 'to do' various styles of nursing.

**Resourcing And The Resourced**

Nursing practice in the Pre-Admission unit and Short Stay ward was directed at identification of real and/or potential patient-problems or needs. Surgery was understood to be traumatic, with surgical nursing defined as *the minimisation of trauma* (Nurse Pauline). To effect this minimisation the nurses in the Pre-Admission unit needed knowledge about the various types of surgery and potential postoperative patient responses. Nurses needed to know how to identify problems, needs and risks, and identify various ways of addressing them, not as discretionary authorities on those topics or subjects, but rather as authorities on how to 'shift responsibilities to users for their own condition and for the personal comportment and behaviour necessary to receive care' (Rose 1998:165). With finite health-care resources, the supplementation of health-care needs in this manner, binds patients to professional and expert norms in new ways.

Analysis of nurse’s practices in this study suggests that they limit the allocation of hospital resources through working on, and with patients, in the identification of (self-care) resources. Conceptualised here as acts of resourcing, these practices ameliorate identifiable problems through the nurse 'identifying' resources. As such nursing practice both provides for, and requires, patients to experience previously unidentified social networks as resources. Consistent with Rose's discussion of expertise in advanced liberalism, nurses and patients become 'experts, as knowledge workers, [who] no longer merely manage disciplinary individualisation. … They provide information, for example, risk assessment—that enables these quasi-autonomous entities to steer themselves' (Rose 1998:147). On a small number of occasions resourcing included arranging access to hospital home-care resources, and limited community medical, nursing, and support services.

These nurses were required to possess clinical knowledge about numerous diagnostic conditions and the anticipated postoperative recovery. However, there was little evidence of knowledge about resources available outside the hospital to
assist the patient after they go home. The necessary skills for these surgical nurses were described as being able to 'get them [patients] through [the hospital]' or to 'get them going'. Nursing competence was required by the previously discussed organisational processes the prediction and control of length of stay. However while the identification of patient circumstances, which might interrupt the quick and predictable hospital throughput hence avoid 'bed blockers' (Latimer 1993) the nursing competence most valued was the 'practices of resourcing' though these nursing consultations. The success of this process was significantly linked to individuals sharing certain meanings about expectations of surgery and post-operative recovery.

Establishing the presence of social networks (family members or friends), a 'taken for granted primary resource of care', (Heaton 1999:768) was a feature of the Pre-Admission nurse-interviews. As patients described with whom they lived, or people who they considered might help them after discharge from hospital, nurses framed these individuals as 'carers'. Examples of such carers in this study were a 10-year-old son, a partner with severe attention deficit disorder\textsuperscript{21} and a daughter with a 'bad back'. Nurses were sometimes quite direct in making family members responsible for patient care, with statements such as 'so when your wife comes home you'll be doing the vacuuming [or gardening] for a while, won't you?' At other times no direct discussion was entered into about the anticipated need or quality of available support, once it had been established that there was some. Similar approaches were used to explore patients' previous experiences with hospitals, or pain or surgery to find (self) 'resources' from which the patient might draw on to inform this experience.

The resourcing of patients was reinforced after surgery, where patients' responses, such as pain, nausea and vomiting were diminished, or re-framed as normal, thus self-manageable. The following example involves an elderly woman admitted for insertion of a plate and screws for her fractured elbow. The morning after her surgery Mrs Anuan was getting back into bed when a nurse came into the room.

\textsuperscript{21} Attention deficit disorder is a mental condition marked by inattention, impulsivity, and in most cases, hyperactivity.
Mrs Anuan was dressed in her clothes with a packed bag on the end of her bed. 
One arm was bandaged.

*Mrs Anuan: Dear, I feel terrible, this always happens to me after anaesthetics. I just feel a bit sick and as though I am going to faint.*
*Nurse Loretta: You're going home this morning, aren't you?*
*Mrs Anuan: Yes, yes my son in law is supposed to come and get me but I don't know when he can get here.*
*Nurse Loretta: just lie back on the bed, you're all packed so there is nothing to worry about. Just rest til he gets here. Nurse turning to me 'She's OK, she has done this before, she just gets sick after anaesthetics'*. Picking up Mrs Anuan's records, from the end of the bed. 'Does your arm hurt? We can give you something for the pain. Yes, you are due so I will get you something, OK?'
*Mrs Anuan: Nodded as she reached for the vomit bowl on the bedside table 'OK. I don't feel ready to go home. I am going to my daughter's, but think I should stay, stay one more night.*
*Nurse Loretta: 'You'll be right. You don't want to stay here, better to get home where your daughter can look after you, you'll feel better there'.
*Mrs Anuan: 'You nurses say I have to go and I'll be all right. I suppose that I can ask my daughter to help me. I would just feel better having nurses and the doctor around. They know what is going on, my daughter doesn't. She is a nurses' aid in an old people's home, but she is off work with a bad back so I don't think I should go to her. There isn't anyone else. I am 76 years of age and live by myself. I would just feel better with the nurses and doctor around'*

In this conversation the nurse and patient appear to speak at cross-purposes. Mrs Anuan attempts to negotiate a delay in her impending hospital discharge, create opportunities for the nurse to enact her expertise about the hospital, the value of home over hospital, and management of post-operative responses as she administers analgesics, at the same time as encouraging Mrs Anuan to accept that she will be better off at her daughter's place. Meanwhile Mrs Anuan searches though a number of options as she presents herself as:

- not well enough to leave hospital (she feels sick and faint)
• not organised enough to leave hospital (as her plans to leave the hospital are not yet finalised)
• not having access to adequate care/expertise/resources to leave the hospital, expressed as not wanting to go to her daughters because:
  ▪ her daughter, though acknowledged as having some expertise through working in an old persons' home, lacks that of the nurses and doctor
  ▪ her daughter has a bad back, thus should not or can not be expected to care for her mother, and
  ▪ she doesn't know when her son in law can get to the hospital.

The nurse reinterprets, or ignores, these comments as she searches out alternative ways for Mrs Anuan to experience her impending hospital discharge. 'Rest' and 'something for the pain' are suggested, but only after the symptoms are situated within a time frame of 'going home this morning'. Sharing in this ethic of 'getting the patient going', Mrs Anuan had packed her bags and (although not finalised) has arranged her transport home. The nurse speaks of the patients 'history with anaesthetics' in a way that positions it as normal, as 'OK'. Nausea and dizziness are common, therefore predictable, responses to anaesthetic drugs. The fact that these symptoms had occurred previously for Mrs Anuan was unlikely to diminish this particular experience for her; the nurse's responses to Mrs Anuan's symptoms are from an established context of such symptoms as 'normal'. This normalisation indicates to Mrs Anuan that her symptoms are not significant, 'manageable' through rest, and being pain-free, with the suggestion that they will be even better at home.

In shifting through her recommendation of analgesics (despite some analgesics commonly recognised as exacerbating the post-anaesthetic symptoms of nausea and dizziness) and affirming home as a better place than hospital, the nurse, without having to actually say so, made clear to Mrs Anuan that her symptoms would not require (or permit) a continuation of her hospital stay. Mrs Anuan offered a number of reasons for why her daughter's place was not where she felt she should be; however, for the nurse, to be not in hospital was to be 'at home'. In this situation nursing practice adhered to an administrative requirement for
predictable hospital discharge by normalising the patient's symptoms, at the same time as removing any differentiation between Mrs Anuan's home and her daughter's place.

In an interview with Mrs Anuan some weeks later she described City Hospital as 'a very good hospital' and the nurses as 'wonderful', however her comments about discharge from hospital were as follows:

Mrs Anuan: 'I never imagined that a broken arm would cause so much ...(notes unclear) .... I came from hospital to my daughter's ... for three weeks. I was just a dead loss when I got to my daughter's. I didn't really feel well enough to go home, I wasn't steady, I just felt sleepy. But they needed the bed and I understand you just can't stay. They need the bed for the new people to come in. They gave me lunch after I saw you, but I couldn't eat anything, the nurse took me down in a wheelchair, I was a bit groggy and still feeling faint when I caught a cab home—well to my daughter's actually—I got home and just went to bed'.

Identifying with a social responsibility for 'bed shortages', Mrs Anuan described how she 'just went to bed' as her act of self-care to lessening the demands on her carer/daughter. This woman did not live with her daughter and had described being uncomfortable in going to stay in her daughter's house after discharge from hospital. When asked in the Pre-Admission unit whether she had anyone to help her after discharge, she stated she had a daughter, but that her daughter 'had a bad back'. The nurse had commented at the time, 'you'll be right, she won't need to do anything for you really'. The record made in the patient records under 'discharge notes' records that the woman would 'go home to her daughter's'. Three weeks after surgery Mrs Anuan was seeing a physiotherapist weekly and still needed some assistance provided by her daughter, with hygiene, grooming, and dressing, as well as meal preparation.

Nurses described the shorter hospital stays as linked to quicker recovery times and the return of patient independence.
People used to have their convalescence in hospital. They could go home and not even need a wheelchair to get to the front door. But things have changed and we need to get the community to realise that. They need to find the support to recover at home. (Nurse Mary)

The complexity of various influences on the changes to hospital services and length of stay for patients and nurses are expressed in these comments from a senior nurse.

We just need to change community attitudes. People would rather be at home. Doctors sometimes say when we [nurses] say they [the patient] can go home and the doctors say you must be joking, but if you ask the elderly, they usually have a daughter that will take them or some other family that can help. Patients usually now expect to have their surgery on the day they come in to hospital. See the whole day of day of admission thing has come about through gynaecology patients who are usually young women who have families and would rather come in at the last minute than have to find extra childcare. The media is the problem. The newspapers write large headlines of ward closures and that is supposed to mean health system in crisis but it is often about better or improved health services. They also report some things and not others. We close wards some days and no-one says a thing, another time, or like last year it ends up in the papers. I suppose we did reallocate the beds this time, whereas before we lost them. People just don't see the better service. We used to have a patient in bed for ten days now we can have ten patients in a bed for one day each. (Nurse Lynette)

While this idea of better service may not have been apparent to Mrs Anuan we can see evidence here of the complex integration of contrasting power relations as the '… mode of polis, structured according to principles of universality, law, citizenship and the public life, and the mode of what Foucault calls "pastoral power" which instead accords an absolute priority to the exhaustive and individualised guidance of singular existences' (Gordon 1987).

As my observations continued, I watched nurses and doctors decide on numerous occasions that an elderly patient needed to stay in hospital longer than originally
anticipated. I wondered why Mrs Anuan's advanced age, nausea and dizziness resisted reclassification away from 'normal' and 'resourced', to elderly or aged, as these classifications inevitability entitled the bearer to longer hospital stays. For reasons alluded to in the following discussion, I considered Mrs Anuan's case too sensitive to raise directly with these nurses again, and was left to assume that with the resource of a daughter and a lack of other 'resources' (such as perhaps assertiveness) to demand otherwise, this woman was deemed not to need the hospital resource of a longer stay.

The demand on nurses to juxtapose managing patient hospital stays with individual needs was rarely easy. Nurses often talked about their patients and what they did for them during their meal breaks on the ward. This talk provided ways for them to examine their practices and seek affirmation from each other for their nursing actions. In the following example, a nurse recounts her dream about Mrs Anuan's discharge from hospital. Susan was in charge of the ward that day, and while not allocated to look after Mrs Anuan, had conducted the discharge proceedings. Although this account makes reference to a nurse's dream, analysis is restricted to the conversation.

Nurse Susan: 'I dreamt about Mrs Anuan last night—it was dreadful'
Other Nurse: 'Why who was she?
Nurse Susan: 'She was the elbow lady from yesterday (looking at me) you know her she was one the ladies you saw'.
Researcher: 'Was that the lady who fainted?'
Nurse Susan: 'She didn't faint. She was just dizzy,- but yes her. Her son-in-law rang me late yesterday furious that we had sent her home. There was absolutely no medical reason to keep her. I asked her if she wanted to stay on for lunch but she said she would go. They [her family] hadn't come to get her so we sent her home in a taxi. I felt dreadful about it but she wouldn't stay any longer'

The nurse went on to describe how in her dream the son-in-law had been very angry with her and had bought his mother-in-law back to the ward and demanded that she be readmitted (a Bed Manager's nightmare). Susan considered that she had undertaken Mrs Anuan's discharge consistent with good clinical (medical)
decision-making, as aligned with the requirement for predictable patient throughput. With 'no medical reason to keep her' Susan firmly discriminated between Mrs Anuan's symptoms of dizziness and nausea, as evident in her quick rejoinder to my suggestion that Mrs Anuan had fainted. The demarcation between symptoms of dizziness and fainting (like those of Mr Davidson's nausea and vomiting in the previous chapter), was clearly significant as the basis for decision-making. I had used the word 'faint' based on recall of the patient's words at the time, and as assisted by writing fieldnotes after the event. However, in legitimising her practices, and perhaps sensitised by having dreamt about this incident, this nurse was very clear that the patient had been dizzy rather than had fainted, in a way that seemed to be allied to justification for her actions. Her actions had been to send home from hospital an elderly woman who was experiencing some mild postoperative symptoms. Despite some disquiet on behalf of Susan for Mrs Anuan's situation, her (nursing) actions were consistent with the resourcing or pre-recovery conducted through information given to all patients before admission for surgery, that dizziness was not uncommon after the anaesthetic. For Susan, the frequency of this clinical situation aligned with administrative discourses to support her judgement and actions.

**Pain-free pain management: a resourcing technique**

Another area of significance for patients 'resourcing' was pain management. Despite twenty-first century promises of more humane surgical care, (Cowley and Springen 1997) pain is a still a significant issue in surgical care. The Pre-Admission unit information given by nurses to patients signalled the social variability of this biophysical event, with patients being told that: 'Now days we get people moving much faster after surgery, as we now know it is not moving that is bad for you. You need pain relief to get moving' (Nurse Gail). Patients were told by nurses to 'have a chat to the anaesthetist about your options for pain relief, because you need to be able to do the things we need you to do' (Nurse James).

Despite contemporary surgical techniques to reduce incisional pain, not all surgical patients had this type of surgery, and as patients go home earlier than in previous years, they often experience considerable pain. In this study the analgesic
medication given to most patients on discharge was a combination of Paracetamol and Codeine\textsuperscript{22}, considered by the national pharmaceutical board as too strong for over-the-counter purchase, thus only available with a doctor's prescription. A number of patients in this study went home from hospital without adequate analgesic medication, or even instructions on how to manage pain. Sometimes they left without waiting for their scripts to be filled by the hospital pharmacy; for example, one woman indicated she had analgesics at home, however in my post-discharge interview, they turned out not to be strong enough so twenty four hours later she needed to visit her General Medical Practitioner to get effective pain management.

For another patient there was confusion about her plans to get her analgesics from a chemist on the way home from hospital, resulting in her not moving from a sofa and not eating or drinking since she was in too much pain, and her spouse had gone to work on a twelve hour shift. Such errors in judgement had consequences only for the patients. Deemed to have either the resources, such as carers, or money, thus able to meet the costs of accessing additional health-care resources, none of these patients reported any complications sufficiently serious to require readmission to hospital during the period of fieldwork. Hence these patients were not only materially invisible to the hospital system after their discharge, but were also morally invisible, as no harm had been done to them by the system working in this way. The responsibility was theirs.

Patients in the Pre-Admission unit are not asked about perceptions or experiences of pain as much as \textit{told}, either through direct or indirect means, about how this would be managed in hospital. One indirect mode of instruction about management of post-operative pain, was a video played on a large television in each of the two Pre-Admission unit waiting rooms (see Appendix D for video script). While not suggesting that patients do not need information about how to manage post-operative pain, this video performed (textually) a range of complex functions,

\textsuperscript{22} Paracetamol and Codeine are analgesics publically available in low doses by over supermarket or pharmacist counter purchase, or more concentrated preparations are available only with a doctor's prescription.
including the articulation and synthesis of different discursive themes and ethical positions for pain management. Through the video, patients were informed about their responsibilities in the management of this aspect of surgical care, including the wrong way to care for themselves in regard to pain. The video featured comments from a surgeon and nurses, interspersed with a voice-over and series of scenes where patients are provided with various forms of pain management techniques, including infusions, pumps, and inhalation of analgesic gases, as they portray various forms of post-surgical activity, such as having dressings changed and getting out of bed. This information only focused on pain management while in hospital.

The video commences with pain situated as 'useful', as an indictor for self-limitation to prevent further injury, as illustrated through the example of participation in vigorous sport. In contrast, postoperative pain is situated as 'not useful' and 'doesn't do anybody and good' and 'slows...down' both 'recovery from the operation' and 'the healing process'. In these examples, pain is a warning sign to be acted in accordance with, and a problem to be overcome by various means. Post-operative pain suggested by the surgeon on the video is 'a commonly held concept' that 'is no longer true' because of the availability of 'excellent ways of relieving pain'. Complicity in using pain-relieving techniques is located within the surgeon's authority, through a statement that 'I want my patients to use them' (the excellent ways of relieving pain)’ and also for those patients 'who prefer to be in control', they are offered self medication through the Patient Controlled Infusion pump or to 'think of something nice and pleasant'.

Reliving pain requires patients to both control not only a pump and themselves, through controlling their thoughts, they are also asked also to give over their 'thoughts' and 'feelings' to the nurses. Though the surgeon is situated in this video as the expert who can speak about 'misconceptions about treatment options' and 'wants his patients to use pain relief', patients and nurses are also afforded areas of expertise. Patients are encouraged to accept effective post-operative pain relief as accomplished through their identification and confession of pain to nurses who act as diagnosticians and witnesses to the effectiveness of pain-relief techniques.
Nurses and patients participate with the patients only, as they act upon themselves by accepting responsibility to speak up about their pain (and thoughts and feelings).

The video of approximately 10 minutes duration was often left in the video player where it was replayed after it automatically rewound. The average time spent by patients in the Pre-Admission unit was between one and two hours with most of this time between consultations spent seated in one of the two waiting rooms. All patients in the Pre-Admission unit would watch or hear the video more than once, with many patients watching or hearing the video several times during their clinic attendance. This analysis of the video is provided here, as an example of where no single strand of power predicates cooperation and identities for patients, nurses and doctors, yet pain becomes as much the capacity to speak out, as a physiological process. This video sets the scene for a series of relationships for each patient to shape their surgical episode through their unique involvement in managing their pain, visible in references to 'those who prefer to be in control'. Viewed in advance of their surgery the video is 'a relationship of power … a mode of action which does not act directly and immediately on others. Instead it acts upon their actions, an action upon their actions, on existing actions or on those which may arise in the present or future' (Foucault 1986:220).

The pain video was a resourcing strategy through which patients and their family and friends were education about pain management techniques. However a presumption of having had this education is evident in the following example, where a postoperative patient on Short Stay ward was presumed by the nurse to understand why they would not want morphine for their pain.

> there is morphine there if you need it, but I'm sure you would rather not have it. We'll get some Panadeine written up. (Nurse Jane)

**Resistance And The Risky**

Despite the efficient identification of patient needs, education through techniques such as the pain video and commencement of discharge planning before or on

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23 Morphine is a powerful analgesic and respiratory depressant drug.
admission, the duration of hospital stays or patient 'careers' (Zussman 1993; May 1992; Dodier and Camus 1998) were not always controllable.

*Mr Hill is still here. He had a cyanotic episode this morning. He was all set to go to ... [local rehabilitation hospital]. I'd got everything done—just about got him out the bloody door and this happened.* (Nurse at handover)

The emerging thesis has been that hospital care is premised on the reconstitution of the hospital patient as well thus reduced access to the hospital bed. Accordingly aspects of nursing practice are visible because they align with certain dominant truths, in this case, truths about hospital length of stay. However multiple truths existed about institutional nursing practice. An example of nursing practices that disrupted the dominance of clinical or length of stay discourses was the allocation of care provided to (some) elderly persons deemed to be too risky to send home too soon.

The Australian Diagnosis Related Group (AN-DRG) schedule commonly includes discriminators for age (for example see Appendix E for Gastroenterology AN-DRGs for two surgical wards over the fieldwork period). Subsequently elderly patients were regularly offered, recommended or directed to have extended hospital stays. For one 81 year-old woman with an extensive incision on her face following exploratory surgery, the decision was made by nurses to keep her in hospital an extra day. This woman's daughter, standing in the room while the decision was being made, had indicated that she was willing to take her mother home. The doctor had indicated that he did not have a preference, however, the nurses decided that she should stay as she was 'elderly and frail' and the incision 'was nasty'.

In the previous discussion Mrs Anuan was not successful in her attempts to represent herself as at risk if sent home from hospital or un(der)resourced to be able to go home. Elderly patients were the group most often deemed by nurses to at risk if sent home too early, therefore 'risky' in relation to the (self) management of shorter hospital stays. This is supported by Latimer, who suggests that this negative linking of 'old people' with time and 'increased risk of failures over throughput', is
evidence of the elderly as a very distinct category from that of other categories of
patients (Latimer 1993:12-13).

**Resistance And The Independent**

The success of short stay nursing practice was also dependent upon rapid return of
a level of independence. Patients were required to be able to care for themselves
within hours of surgery. This was the 'type' of patient for whom the Short Stay
ward (and therefore nurses) was provided.

> I am pretty busy this morning. I've got Mr Jones. He needs full nursing-
home care. Later today he'll be transferred back [to the nursing home] but
this morning I have to fully feed and shower him. We're just not set up for
that. Four of my beds already have their second patient for the day in, and
by the time I go home some of them will have even a third. We just can't
care for people like that. (Nurse Jane)

Two hours into the morning shift these comments indicate that allocation of
patients to this ward needs to include more than only an *anticipated* length of stay.
Patients needed to be able to recover a degree of independence quickly. Nursing on
the Short Stay ward did not include 'full nursing-home care'. Mr Jones is an
example of how, despite a presumption of mutual dependence, *short stay* and
*independence*, do not always go hand in hand. Mr Jones had been scheduled
routinely to this ward because of this type of surgery and the anticipated duration
of stay. He was elderly, and had not been able to care for himself independently on
admission, and while having the identifiable resource of the nursing home to which
he would return, Mr Jones could not be presumed to be recovered in the same way
that other patients, especially short stay patients, might be.

Expectations of independence also included assumptions about the existence of
home and community resources, such as the existence and quality of relationship
between patients and a General Medical Practitioner. While previously deemed not
to have the public authority to make decisions with regard to their own condition
and treatment, discourses of consumerism now promote an environment where
patients choose or resist medical and managerial expertise. Patients adoption of
self-care practices on discharge from hospital, were often unbounded by the
expertise of doctors and nurses. Here Naomi describes how she dismissed or reinterpreted medical advice by making her own decisions about how to manage after hospital discharge.

They told me I would be up and about in 3 days. The doctor said that when I came home I could look after the kids (a 16-month-old and 3-year-old), pick them up straight away when I came home. But I didn't 'cause I knew that would be wrong. I just left it for a day or two as the kids are pretty heavy, and he was wrong about that' (Patient Naomi)

Another cholecystectomy patient, Louise, was one of two patients in my study who cancelled their post-operative appointments with the surgeon, which had been scheduled for 2 weeks after surgery. For Louise this was …

inconvenient. There really was no need to follow up with them. I am eating OK and my scar is fine. I just have some scars to show for this now but it is all over, like it never was.'

Louise had also declined to wait for the hospital pharmacy to delivery her analgesic medications before discharge stating that …

they told me what to take [for pain] and they were going to give me some but I wanted out. I wanted to go home and knew Mum would have some so I just said that I have some. My mother has chronic back pain so I understand about pain from helping her over the years, since I was a child.

**Resistance And The Resourceful**

'Techniques of relating to oneself as a subject of unique capacities worthy of respect, run up against practices of relating to oneself as the target of discipline, duty and docility' (Rose 1998:35). For Barry, a middle-aged man scheduled for midweek orthopedic surgery, the information that he would only 'need' an overnight stay illustrates this juxtaposition. Barry explained to the nurse in the Pre-Admission unit that he lived alone and was concerned that he would be ready to go home the day after his surgery. He spoke of knowing about the pressure on hospital beds, but considered that he needed to be sure that he was able to manage before he went home.
Barry: 'I don't have anyone to help me until the weekend. Then I will have people that can stay with me'
Nurse: 'This type of surgery only needs one night in hospital'.
Barry: 'I've had experience with having to come back and I don't think I can go home straight after this operation. The shoulder will be stiff and sore and I won't be able to do things for myself. .... The weekend will be OK, but I need help before then'.
Nurse: Isn't there someone? Do you have family or friends who could help?'
Barry: 'No, that is not the issue'
Nurse: 'This is only relatively minor [surgery] and due to the bed shortages it may not be possible for you to stay longer than two days.'

In this conversation the nurse uses a number of different strategies to convey to Barry the preferred modes of being a surgical patient, one as resourced and the other as socially responsive to bed shortages.

Barry's resolve not to be discharged earlier than what he considers appropriate was perhaps informed by his previous experiences of re-hospitalisation. To the nurse's question about family or friends he chose not to answer. By not giving details of whether he had friends and family he refused to engage in the nurse-led activity of 'resourcing himself'. His refusal also denied the nurse enough information to assist her to 'resource' him. Hence the nurse shifted emphasis away from ensuring prediction of length of stay through family and friends, to 'bed shortages'.

The nurse did not ask any questions about the patient's previous re-hospitalisation, and in what on one hand might be understood as the trained incapacity of the bureaucratic worker, (Crozier 1964) this nurse ignored much of this conversation with Barry to selectively document only that the patient 'lived alone'. In my interview with Barry after this observation, he described previous surgery unrelated to this health episode, where after hospital discharge he was found to have developed an infection and was readmitted to hospital. There appeared no opportunity for this nurse to devise in advance of his hospitalisation an alternative strategy for handling Barry's needs therefore they were simply ignored.
Consistent with what May and Purkis describe as nurses extending their gaze 'beyond the concrete condition of the body to intrude into the patient's private subjective sphere' (1995:591) the nurse in this situation can be seen to engage a number of strategies to both provide and seek to prescribe for Barry an acceptable identity or mode of being to ensure a predictable length of hospital stay. In the first instance the authenticity of scientific knowledge about 'this type of surgery' was employed to prescribe 'one night in hospital'. However, when Barry did not take up what was offered by the nurse as an ethos of 'resourced patient' by providing information about his family and friends, the nurse then attempted to create an ethos of 'responsible short stay patient', one for whom the term 'bed shortages' implied certain meanings and actions.

Barry resisted or rejected adoption of such ethics by declining to answer whether or not he had friends or family, or whether they might care for him in the way required. More specifically Barry asserted what might be understood as a different form of moral authority by indicating that this was 'not the issue here'. As an enactment of 'resourcefulness', Barry drew on his previous health care experiences to frame what he understood to be a hospital patient. The nurse did not, however, seek information about what Barry considered 'the issue here', but reiterated the medical and economic scientific 'games of truth' (Foucault 1997a), which informed classification of Barry's scheduled surgery as 'minor', hence needing limited hospital stay. The nurse added to this a further strategy by first describing the period of hospital stay in two different ways, one night and two days. The second expression of two days has the appearance of a longer stay, and secondly, by introducing the issue of the availability of resources. By reference to 'bed shortages' the nurse may be seen to appeal to an ethos of social responsibility for public and bureaucratic discourses, as well as perhaps indicate to Barry that decisions about length of stay were really not open to negotiation, but subject to other forces beyond the realm of the nurse and the patient's clinical condition.

For this patient, the issue was not about how his clinical condition might require the configuring of his friends and family as resources, or indeed, whether such an accomplishment might be possible. His expectations were that the necessary hospital
(thus nursing) services would be available and enacted to meet his needs. Enacting and ethos of consumption, Barry did not adopt the capacity to see his friends and family as resources. He had not engaged with the idea of the hospital as an undesirable place in which to be, nor with the bureaucratic or public problem of 'bed shortages' as his problem. In voicing the expectation that he would stay in hospital until there was a match between his clinical condition and his social resources, Barry also resisted the enactment of nursing practice as the capacities of the 'resourcing nurse'.

A re-reading of the relevant section in the previous chapter indicates how the nurses on the ward were not happy with Barry's behavior. The conditions for recovery as established in the Pre-Admission unit remained within the patient's control only as long as the authority of the nurse (in this context, the tacit contract about length of stay) was not questioned. The nurse's resistance to Barry's consumer approach contrasted with the nurses' requirement to act not only as bed managers, but as experts in resourcing, through the reconfiguration of patients' capacities to see their friends and families as resources. Resistance to Barry's consumer demands was evident in the doctor's configuring of Barry's request to stay as clinical, rather than social, as affirmed by the referral to physiotherapy 'to loosen his shoulder'. In this sense, Barry refused the normative regulation by which he might be transformed 'through nursing practice' to 'see' and 'use' what he had in the way of private resources. For him, the acute-surgical hospital episode was a resource to which he demanded his access to remain open for further consideration. For these nurses, their work in 'reproducing identities through intervention and imposition of meanings', in this case, the reconfiguring of patients' relationships with their family or friends (May 1992:288) had failed. Barry can be seen to resist a resourced or recovered identity, while adopting a position as an active, enterprising and self-caring subject capable of selectively consuming health products and selectively reading his or her own health messages (Bunton 1997).

The doctors observed in this study were rarely definitive in the information that they gave to patients about length of stay and the timing of discharge. Their discussions with patients demonstrated a closer orientation to physiology, which
afforded their discussions far greater opportunity to be influenced by clinical factors, what Cash (2001) proposes as the 'contractual space' for clinical autonomy. He suggests that the fundamental relationships of clinicians are contractual, hence 'the degree of contractual space is positively correlated with the degree of clinical autonomy, [thus] as the specification of the contract increases the degree of autonomy decreases'. (Cash 2001:41). Since doctors were not heard in this study to engage with patients directly about issues of length of stay; however, as discussed in relation to ward rounds in the previous chapter, doctors clearly differentiated between the clinical domains and those aspects of practice that were considered the 'business' of moving patients through the hospital.

This administrative orientation was evident in nurses' quite specific information to patients about the anticipated length of their hospital stay. For example, when Barry raised the issue with the doctor in the Pre-Admission unit (before his appointment with the nurse) of how long he would stay in hospital, the doctor demonstrated a much wider contractual space for his clinical autonomy, by simply stating, 'you should only need one night but we will see what happens'. Significantly, Barry, perhaps sensing space for his own autonomy, only nodded in response and did not engaged further in this discussion.

Other patients, such as the 74-year-old man who negotiated to leave early to care for his disabled wife, demonstrated this ethos of consumption. Mr Songon, a 36-year-old man admitted for an incisional hernia repair, following a partial colectomy and colostomy three months earlier, described how a delay in the scheduling of his surgery caused him to leave the hospital before his surgery.

...they told me to be in by 9am, yet come 3pm I still had not been to surgery. They were unable to give me any information other than there was an emergency. I was pretty frustrated that they told me to just wait. ... I was pretty anxious about this operation even though they told me it was a minor one, they had made so many mistakes last time, I was worried if they were telling me everything. The nurses knew that I was getting more and more agitated yet didn't do anything. ...after a while I just thought enough and left. All I really wanted was for someone to come and explain what
was happening and try to help me. I'm just sitting there waiting and waiting to get chopped and they don't even notice'.

Like Barry, the previous experiences of hospital and surgery for Mr Songon, act as resources or capacities that enable him to refuse the docility being asked of him by the hospital and nurses.

**Discussion: Pre-Admission and Pre-Recovery**

*Contracts* as written or spoken agreements or commitments, featured in this study as not only those formal legal, industrial and market relations of Federal to state, state to hospital, state or hospital to staff and other service providers, but also as the relational understandings that existed between hospital to wards, staff to staff, staff to patients, patients to hospital staff, and patients to their carers for variety of service provision. Empirical description has been provided of various contracts between patients, nurses and doctors, evident from the initial divulging of information and consent to enable medical diagnosis and associated provision of hospital and surgical services, through to some perhaps less visible contracts with nurses, themselves, carers and other community resources.

In particular, the Pre-Admission unit and surgical ward interactions between nurses, doctors and patients, provide examples of 'bureaucratic transfer', (Dodier 1998:61) where the individual is characterised by lists of variables, however these variables (resourced, risky, independent) do not always lead to the application of the same rules. It is here that the administration of 'other' intersects with techniques for the administration of ourselves (Rose 1999a:5). Hence it is here that 'procedures of contractual implication', (Burchell 1993:23) involve individuals in decision-making about actions that would have previously been the responsibility of doctors and hospitals as authorised governmental agencies.

The decision-making about surgical recovery is directed or constituted by length of stay, where information about the patient's social circumstances forms 'an obligatory point of passage' (Law 2001) through which nurses and patients (and videos and brochures) enact various resourcing practices. Through these practices, patients are both subjected to power, and become subjects in their own right. This
occurs though patient’s predetermination as an already-recovered surgical patient—that is, as a citizen 'free' to enact their recovery. However patients are also subject to the prescriptions from hospitals, thus as citizen-subjects, (Cruikshank 1999:24) patients are consulted on some aspects of their hospital and discharge care, not consulted on other aspects and all the while constituted as fit and well, while recognised as needing surgery. This moralisation of patients as fit and well did not always occur in the hospital after surgery on a daily basis, but in advance of these advents. Hence, alternatively fabricated identities of recovered, resourced, resistant or risky provide evidence of new forms of responsibilisation. In these forms of responsibilisation, the governed are encouraged to freely and rationally conduct themselves, (Rose 1999a), while at the same time regulated in ways that serve state needs for predictable population flows for expedient hospital throughput.

Hospital admission and discharge processes involve various codes of conduct for the commencement and end of an episode of acute care and the announcement medical authority. However, with sickness and patienthood no longer available, hence 'discontinued lines' in the market place of hospital care, recovery (and admission and discharge processes) has become a moral code through which the contraction of hospital resources is accomplished through contracting for various (self and other) resources. These resources are 'normalised' through various techniques as capacities for self care. Though, this self care is not to be confused with health care. Only certain modes of recovery are facilitated and accommodated as surrogate variables for health care (Osborne 1997). With the exception of some elderly, individuals, as patients in this study, were not given choices about hospital stay and were not instructed in how to manage their lives in ways to avoid further sickness or ill health. They received instruction only as it pertained to recovery from this surgical episode.

Recovery is a process of progressive or sequential return to normal, as defined by pre-illness comparative standards of physical, social and psychological well-being (Baker 1989). Recovery has, however, also been conceptualised in opposition to medical treatment as a time-dependent social process (Room, 1998, Borkman 1998,
Carroll 1997). In recognising that 'the meaning of a "healthy regime of life" does not stand still', (Bauman 2000:79) so the episodes of acute care in this study involved only recognised conditions requiring surgical intervention. Hence the 'reality' of a patient's hospital admission was constituted within biomedicine as a health breakdown. It was in this context that emphasis was given to recovery, rather than health, as the phenomena of moral interpretation and means for nurses and patients 'to act upon themselves and others' (Patton 1998:74). However, recovery, as evident in the following nurse's comments, is ambiguously associated with confidence and wellbeing, while at the same time concrete and measurable.

A patient can be physically ready to be recovering, but if they're not emotionally, they won't do anything, they won't get out of bed, they're not motivated, they sometimes play their sick role a lot more and sometimes it's families that think Mum's not ready yet, she's not coping, she can't go home, and you say well she is, but she is just not confident. She doesn't think she's well enough and I think often that wellbeing is the biggest problem. After their surgery they are OK, sometimes they just need to be convinced of it. You see they come into hospital sick. But its often an acute short term illness, it's not a long term thing like a long time standing COAD 24 or something like that. It's a short term something that can be fixed and they usually can see that in a few weeks' time they will be feeling pretty good and the effects of surgery won't bother them again. (Nurse Natasha).

These nursing practices aim to ensure that patients 'recover' and 'relinquish the sick role' (Beckingham 1995) through return to self-care or care of others. As the period of hospitalisation continues to shrink, health systems (and seemingly now nurses) cannot afford for patients to lose this capacity for action, for self care, for self responsibility as 'allegiance to a fixed and unquestionable moral code of right and wrong, seems to run counter to the contemporary ethos of personal choice and cultural ... pluralization' (Rose 1999b). Hospital systems are reliant on patient's adoption or continuation of an ethos of independence, free from external expertise or advice as they no longer stayed in hospital, as hospital patients long enough for

24 Chronic Obstructive Airways Disease involves a persistent obstruction of airflow to the lungs.
things to be done for them, and are only in hospital as long as it takes them to learn
the necessary 'new ways' of doing for themselves. Such doing is their self care, as
described by George, two weeks after his haemorrhoidectomy.25

'I thought the hospital was really proactive in getting me to use pain
killers. All the pamphlets they gave me pushed it. The video in the Pre-
Admission clinic and the written info pushed it. I think that made all the
difference. It was great to have all this information—it took away the
anxiety for me. I did run out of Capadex26 soon after I got home, so I went
to my GP. I had to explain what I had done and that I needed a script and
that I wanted a repeat as well. I went to the local surgery. I hadn't seen
that doctor before though she does work there and she gave just gave me
the scripts. I also got constipated and needed Fibergel27 but I just went to
the chemist to get that. ... I normally run a good six kilometres a couple
of times a week but tried to get back to doing six ks [sic] but it was a bit
uncomfortable. I bled a bit much so had to cut the running back a few ks
til the bleeding stopped or was only small.

Thus hospital patients were normalised and categorised through information
exchanges (they know/we know) that enacted the expertise of the nurse (to resource
them) and the patient (to resource themselves). Emergency patients enacted choices
in 'refusing to talk' to nurses in ways that exercised their freedom (capacities) as
sick rather than well. This choice (freedom) was not commonly available to the
elective surgical hospital patient. One of the functions of nursing in this study was
to ensure that patients were prevented from behaving in a dependent way, or as
sick, when as elective patients they had the 'freedom' to be well. This 'freedom' was
given particular definition by their classification as an elective patient, a freedom
that required a different set of capacities to that of the Emergency patient, when it
came to recovery and length of stay. The pre-admission unit and short stay patients
are resourced in ways which define what it is to be empirically recovered/fit for

25 Haemorrhoidectomy is a surgical excision of haemorrhoids
26 Capadex is a brand name for the generic Paracetamol preparation.
discharge/well, thus the proper routes to hospital care are seen as through practices directed at prediction and control of hospital length of stay.

It is, however, in the disciplining of length of stay that an ethics of responsibility is established. Recovery is given form in advance of the event, where the actuality of recovery is rendered thinkable in terms of (among other things) the anticipation of length of stay. Recovery therefore becomes an ethics of moral responsibility in recognising and adopting an ethos of the 'pre admitted or pre-recovered', so as to be able to speak about pain (and wound care, nausea, mobility etc) in hospital, as well as manage these symptoms when out of hospital. This ethos of responsibility is also evident in the requirement to acknowledge and accept a problematisation of hospital bed shortages. Surgical nursing is therefore not only the hands and eyes of medicine, (Liaschenko 1998) as much as interaction that produces the recovered patient through attention to length of stay. The role of the Pre-Admission unit and Short Stay ward practices are thus understood as a reformation of patient citizenship; not so much as an activation of the rights of the consumer in the marketplace, (Rose 1994), as in relation to the care of the self, as it requires knowing oneself, as well as knowledge of a number of rules or codes of acceptable conduct or principles that are both truths and prescriptions. Therefore, to take care of the self is to equip oneself with these truths, and it is here that ethics is linked to the game of truth (Foucault 1997a:285).

How nurses and patients become subjects in such games of truth are styled by techniques of citizenship, contracting and responsibilisation (Dean 1999:167–168; Rose 1999b). These games of truth, however, are as much about recovery and independence as they are length of stay. For as Rose suggests, individuals are most able to 'fulfil their political obligations in relation to the wealth, health and happiness of the nation when not bound into relations of dependency and obligation but when they seek to fulfil themselves as free individuals' (Foucault 1997a:166).

This chapter has proposed techniques through which patients assemble a style of recovery 'by choice from among a plurality of alternatives each of which is to be
legitimated in terms of personal choice', (Rose 1998:79) and as this assembly, acquires characteristics that accomplish a predictable length of stay. While acknowledging that human beings are not 'the unified subjects of some coherent regime of government that produces persons in the form in which it dreams', (Rose 1998:35) the previous discussion has proposed techniques through which patients recognise themselves. As legitimised health [care] spaces have moved beyond the hospital it is proposed that "time has committed suicide" (Bauman 2000:119). This means that for these nurses and surgical patients, issues of length of hospital stay have been about their reformulation as both citizens and as subjects, rather than promoting the interests of one or the other. Bauman does, however, question elsewhere whether expectations of health consumers as active, enterprising and self caring subjects, capable of selectively consuming health care, actually enables them to do anything more that merely own the responsibility for choice rather than enabling choice as action (Bauman 1998:81).

With the disappearing separation between time and distance, the very calculation of time can be seen to have lost its meaning. What has gained meaning is responsibilisation. The decline in length of hospital stay for surgical patients emphasises the moralisation of responsibility in ways that accomplish new forms of independence. Individuals are no longer transformed from individuals to patients, subject to the demands of hospital routines, as much as defined in advance of hospital care as citizens, resourced and recovered, hence able to act through simultaneous production of oneself (Foucault 1990/1985:26–27) the particular needs of their recovery. Hence this 'new found' independence also needs to be seen to be dependent, dependent on a self.

This chapter has described how patients and nurses engage in the processes of short stay surgery, in ways which 'do not determine forms of subjectivity' (Dean 1999) as much as prescribe a responsibility for length of stay, and for recovery, as objects of moral practice. Though attention to length of stay and recovery may appear through my emphasis in this writing overt or able to be understood as 'moral codes', that is, rules of conduct, (Foucault, 1990/1985) I have tried to show that there also exist 'arts of existence', understood as self stylisations or a 'style of comportment.
distinguished from morality' (Flynn 1994:114). Understood as an ethos, or way of being and behaviour (Foucault 1994) through which nurses and patients engage in the 'truth games' that accomplish short episodes of acute hospital stay.

**Summation**

This chapter has analysed nurse–patient interactions, primarily in the locations of the Pre-Admission unit and Short Stay surgical ward, with discussion of medical practices, community attitudes, and nursing and organisational ideals. As micro-strategies, these interactions between individuals and with each other are seen to perform episodes of acute surgical care through various technologies of contracting and responsibilisation, directed at recovery and independence as modes of self care.

The modes of subjection conceptualised as resourced, recovered, risky and resistant are proposed as constituting ethical work for nurses and patients, in both empirically defining length of stay, recovery, and independence as both the objects, as well as the ethics or ethos of moral practice. The next and final chapter, as closure of this thesis, does not dispute the value of these as 'moral object or goals', but proposes how we might remain sensitive to the challenge they pose as substitute forms of health care.
Chapter 7. Concluding Discussion and (another)

Translation

I can’t help but dream about a kind of criticism that would try not to judge but bring an oeuvre, a book, a sentence, an idea to life; it would light fires, watch the grass grow, listen to the wind, and catch the sea foam in the breeze and scatter it. It would multiply not judgements but signs of existence; it would summon them, drag them from their sleep. Perhaps it would invent them sometimes – all the better. All the better. Criticism that hands down sentences sends me to sleep; I’d like a criticism of scintillating leaps of the imagination. It would not be sovereign or dressed in red. It would bear the lightning of possible storms (Foucault 1997:323).

Introduction

One of the ways in which governments have chosen to manage the increasing demand for hospital services has been through the measurement of hospital use. Measurement involves making sense of something through a process of assigning numerical values to the concepts under investigation. The measurement, hence classification, of hospital use as a concept of investigation by health care government, has for the last decade involved clinical diagnoses and length of stay as key characteristics or variables. These characteristics have largely been operationalised though DRGs. Hence it is through the allocation of numbers to DRGs that hospital services have been made visible, and therefore susceptible, to modern modes of government. Grounded in nursing practice and the contemporary contexts of hospital care, this study has investigated length of stay, as it might be understood to be more than mere measurement, as a heterogeneous feature of contemporary hospital services, a social and political mode of modern government.

Mapped against the emergence, the peak, and now the waning of attention to length of stay, this study endorses the well-recognised role of hospital nursing as limited forms of bodywork and technical practice directed at disciplining the individual in the accomplishment of organisational outcomes. More importantly this analysis
challenges 'understanding' hospital length of stay and nursing practice, as simply 'the gradual encroachment of more efficient technology of power' (O'Malley 1996:193).

This thesis proposes that length of stay might be better understood as one aspect of the partial and irregular implementation of a political program through which nursing discourses, practice, and particularly expertise, is being rewritten. In sharing with recent studies such as those of Latimer (1993; 1999; 1999a; 2000), Purkis (1993; 1996), Nelson (2000; 2001) Parker (1996; 1996a; 1996b) and Rudge (1997) whose studies also address aspects of the developments in the administrative and organisational expertise of nurses, this study continues attention to hospital length of stay as one strategy through which time has become a characteristic, variable, or effect of nursing practice. In addition this study has illustrated the effects of classification through the allocation of numbers, as it makes up 'the object domains' or 'spaces of population' upon which government is required to operate (Rose 1999a:197–198). Though visible as socially constructed quantification in various tables and graphs, as well as in other miscellaneous attempts to document it, time, a key component of contemporary nursing, is not necessarily visible in the practices of hospital services.

The 'object domains' or 'spaces of population' that are visible are made so through the lens of classification and include various material spaces of hospital services, such as beds, and the expansion of material non-bed spaces of nursing care such as day-rooms and pre-admission units. These health care and nursing spaces also include forms of documentation and communication, such as the whiteboards and bed lists, and other non-material spaces. Formed in the spaces of nursing consultations, these non-material spaces, in both the immediacy of the nurse patient interview and the remoteness of watching videos and reading patient information brochures, act as representational spaces of nursing care through which a stylisation of individual responsibility occurs. In this was according with other Foucaultian nursing analyses that 'self–regulation is a dominant form of social control and that the therapeutic practice of nurses is currently based on principles of self-care that foster patients' self-regulation' Gastaldo and Holmes (1999:237).
Hospital services and nursing practice involve numerous techniques of calculation, classification and moralisation through which individual dependence on hospital services is decreased, and the potential for more people to be treated in hospitals is increased. These techniques not only align with decreasing the duration of hospital stay, but generate particular and individual responsibilities, which in turn produce certain styles of surgical recovery. These styles of recovery are understood to act on the individual by 'normalising' the surgical event along with individual responses to that event. They remove considerations of the surgical patient as sick or unwell, and produce certain forms of nursing practice, which regulate the surgical episode through patient self-management and nurses' management of beds and bodies.

The analyses of length of hospital stay in selected literature were not conducted to privilege one account, or make other accounts less 'sayable'. The choice, as presented in Chapter 2 of this thesis provided a beginning place, a preliminary orientation to *particular* discursive associations and formations of length of stay. Generation of additional texts through the conduct of fieldwork in the empirical contexts of contemporary hospital surgical services provided access to length of stay as localised, sometimes direct, and at other times incidental practices.

Theoretically, this study has been crafted so that *length of stay* can be thought about as *techniques of power*. It is for this reason that analysis may at times seem to have disappeared down various 'descriptive or theoretical rabbit holes'. However, this has only been to substantiate 'understanding how and why we hold some things true, how and why we deem some things knowledge, and how and why we consider some procedures rational and others not' (Prado 2000:10). Power, thus government, has not been studied as broad 'ideal' types, as much as political technologies through which authorities of various sorts pursue certain objectives and outcomes through certain strategies and techniques, in relation to problems defined in particular ways (Foucault 1988a). Analytical emphasis has been given to *saying*, rather than being, therefore this study has been directed at 'spaces within which human beings, being the kind of creatures they have become, can exercise their political responsibility' (Rose 1999a:35).
The emergence of acute hospitals in the 19th Century was to provide safe settings for persons requiring elective and emergency treatments that required bed rest. However, almost globally, the number of beds per head of population has decreased, with evidence now indicating that the previous declines in hospital length of stay and hospital bed-use are slowing (National Centre for Classification in Health 2000). Explanations for this suggest that the decrease in hospital length of stay has occurred because the increase in the number of hospital admissions has been more than balanced by growth in the provision of day-case treatments, and the already accomplished reductions in lengths of hospital stay. Although there is an increase in the number of patients receiving day care, the continued demand for hospital admission tends to be attributed to older people and emergency admissions (National Centre for Classification in Health 2000). This study indicates that the calculation of time is losing significance as attention shifts to responsibility (and perhaps its inevitable calculation).

Emphasis on the bed has been seen in the local bed management practices in this study as a 'space fixing process' (Bauman 1998:2) performed as one aspect of the increasingly mobile act of health care. Hence health care is no longer restricted to the static institutional locations of a hospital. Even where an individual is admitted to hospital, the health and surgical care are processes 'on the move', with orientation to what will happen in hospital and after hospital occurring before the actual event. In this way the '… shifting of bodies and rearrangement of bodies in physical space is less than ever necessary to reorder meanings and relationships' (Bauman 1998:18). The work done to organise hospitals along managerialist rather than medical specialist lines, such as the Pre-Admission unit and the Short Stay ward, lessens the need for clinical decision-making by individual nurses and doctors to include consideration of the actual timing of hospital discharge. In this way some of the uncertainty or perhaps unreliability of clinical decision-making might be seen to be reduced, as evident in the growth in decision making tools and protocols for medicine and nursing (Berg 1998; Barnes 2000).

While on one hand the practices (including nursing) in these programs and locations blurs the internal and external hospital environments through brief
lengths of stay and encouragement of individual responsibility, on the other hand, certain hospital, medical and nursing practices specifically target particular information as acts of 'taming, domestication, and familiarity of various fragments … of the surrounding world' (Bauman 1998:13). This information forms a key part of the configurations through which hospital services are able to manage time and space.

This study has attempted to avoid presenting yet another mapping of the instrumental rationality of modernity, with hospital practices well recognised as part of various scientific (thus coercive) games (Foucault 1994a). Accordingly legitimacy through which particular problems (like bed shortages, surgical recovery, pain) have been explained (economically, technologically, socially) with supposed solutions (decreased length of stay, recovery as surrogate health care, responsibility for self care) presented only in certain ways, is in this study situated as more productively understood as governmental, rather than instrumental.

At this point in a thesis, proposals might well be offered as to how practices might be different or better. However, to prescribe change in this way not only belies the complexities of practice, but would diminish the theoretical consistency of this work. In adhering to Foucault's principles of power as relational rather than as possessed, the outcomes of this study, as an analytics of government, makes neither recommendations for change, nor declarations of right or wrong. This chapter presents discussion of what is at stake through examination of the consequences of thinking and acting in particular ways, as illustrated in the rationalities of resistance (Dean 1999).

A growing number of quality studies now contribute to understanding nursing roles as they are re-inscribed in the provision of acute care in non-acute care hospital settings, such as private homes (Liaschenko 1994; Latimer 1993; 1999; 1999a; 2000; Rudge 1997; Gardner 2000; Purkis 2001). Hospitals are increasingly redefined as involving only episodes of acute biophysical care, with social and chronic illness being the problem of communities. However, like the tangled relationship between hospitals and the wider health care systems, social and
chronic conditions cannot be suspended during acute-care episodes and therefore pose particular problems for nursing, whose work aims to encompass this diversity.

**Rationalities And Consequences**

Casemix policy situates length of stay _discursively_, as part of a standard. However, in the context of governmentality, discourses as forms of standard are not simply representations or reflections of external events or problems, but create their own regimes of truth as acceptable formulation of problems, and solutions to those problems (Foucault 1980d). Just as a standard always transforms not only the thing that is being standardised, but also those that come into contact with it, length of stay performs economically as it comprises relations to oneself, and relations to forms of discourse and modes of thought that count as truth (Patton 1998).

It is in this context that recovery is given form in advance of the surgical event. What is accepted as true and false about patient recovery rests on particular knowledges. Thus rendered thinkable by attention to length of hospital stay (and knowledge of resources both self and other), surgical recovery is not limited to a single postoperative space. Surgical recovery occupies a transient space, that moves between the before and after, the public and the private, the hospital and the home, and the available and accessible. This is not just restricted to the _liminal_ space of hospital home care programs (Gardner 2000), rather it is an experienced space, not phenomenological, but stylised, created _before_ an individual is admitted to hospital, _before_ their surgery. It is a space where individuals are 'recast as rational, responsible, knowledgeable and calculative' (O'Malley 1996:203). Hence length of stay is visible in calculation and classification, as well as in forms of moral economy, which provide (through delimitation) definitions for how individuals might think and act. However, this stylisation is not that of health or health promotion, but of recovery as an imminent and adequate health care goal.

The emergent features or 'practicable objects' (O'Malley 1996:193) of this particular analysis of length of stay are suggested as _time and space as beds and responsibilities_. Hospital beds are familiar as fixed central places of hospital care, maintained in detailed and specific ways by nurses as the observable places of
patient care and nursing practice. However, hospital beds are understood in this study to be far more transitory objects. Economically expensive and therapeutically risky, or perhaps even dangerous, beds have become symbolic of systems of regulation that illustrate a dominance of spatial rather than temporal organisation.

On first glance it may appear that the duration of bed occupancy is the focus of competitive disciplinary (scientific) practices between nurses, doctors, administrators and patients. However, nursing practice is not restricted to the material bed for its disciplinary functions. Nurses are now also actively involved with the bed as an idealised form. Analysis of the locations of nursing practice indicates that the idealised therapeutic space of the bed has multiplied and broken loose from 'actual' beds. The spaces of hospital nursing are multiple and include day rooms, transit lounges, clinics, homes and communities, as well as new spaces of calculation and classification in documentation, bed lists, care plans and whiteboards and in patient education through videos and brochures.

Allocation to a bed, and movement into and out of a bed have been well recognised as indicators of patient health status (Latimer 2000). The privileging of science that positions biomedicine in relation to other discourses constructs patient-hood within a hierarchy of power relationships. Illness as 'visible in the enclosed but accessible volume of the body' (Rose 1994:68), has been a primary consideration in making decisions about hospital admission, thus allocation of individuals to a hospital bed. The medicalisation of the surgical patients' body, though increasingly temporary, is still an event where the success of hospital administration services requires complex organisation of paradoxical patient-care issues. Paradoxical, as patients are required to surrender to the health-care system, while simultaneously being required to remain independent as experts of their own recovery.

Though we are used to viewing moral choices as rational and individual dilemmas, (Bowker and Star 1999:6) this study proposes new moralities, where hospital interventions are no longer limited to the allocation of individuals to hospital beds in ways which involve classifications of sickness or illness. While health may be the silence of organs, and sickness their revolt, (Sontag 1979) admission to hospital
is no longer restricted to attachment of sickness or ill-health to the performance of surgery. Accepting that this study has been conducted in the very location seen as most necessary and amenable to streamlining length of hospital stay, people diagnosed as needing surgery are isolated and fragmented as dysfunctional body parts.

However, *surgical care* for the people in this study suggests another discrimination of the individual; not only on the basis of their clinical condition, since this necessitates judgements about the available health care 'spaces', thus anticipated length of hospital stay and available private resources. With debates about the value of this style of decision-making developing in the rationalisation of health care literature, this study affirms through empirical evidence, the power of managerialist discourses in (re)producing clinical discourses. In this way the causes of illness or disease are significantly less the focus of contemporary nursing and hospital services, than the classification, allocation, and associated regulation of the temporo-spatial (and other) resources of health care. It is the regulation of these spaces in which length of stay works to manage the 'resources-population relationship', not in coercive ways, but through 'changes of attitude, of ways of acting and living that can be obtained through "campaigns"' (Foucault 1994d:70).

Just as Foucault described the shift in judicial system attention from the crime to the criminal, thus from a concern with the criminal code and its infringement, to a concern with the rationality of the criminal act, (Foucault 1995/1977) so it is proposed here that nursing practice has shifted attention from hospital care and patient recover, to rationalities of length of stay and the availability of other resources. This emphasis is not restricted to the resources of the hospital but includes the resources of the individual. Hence, conceptualisations developed in this study of individuals as recovered, resourced, risky or resistant (to name just a few) produced through pre-admission and short stay practices, provide us with a way to understand the particular problematisation of length of hospital stay within the programs of hospital services.
As a political practice, the problematisation of length of stay works to reduce the complexity of health care and to provide a field of delimitation (Osborne 1997:174) towards which health policy and practices (include those of the individual) can be directed. The whole series of practices associated with length of stay serving to *delimit individual dependence on the hospital* is evident in regulation of hospital stays, accomplished through instruction on the requirement for, and skills necessary to monitor beds and bodies, identify and assert individual needs, and recognise self, family, friends and community as resources available for whatever is determined as recovery requirements. In this sense, the nurse–patient relationship is being rewritten as no longer requiring a close interpersonal relationship 'but to engage with service users within a tightly circumscribed time-frame in order to accomplish the purpose at hand' (Allen 2001:177).

Short-stay surgical patients subject to less observation (direct and indirect) are not understood as sick. They are subsequently rationed in their opportunities for expert help and support in dealing with their health situation, and must become expert themselves. As long as these certain 'relations of ruling' remain and constraints to equal access to resources are maintained, re-writing individuals as 'experts' may just be another form of control, and is unlikely to change the hegemonic relationships or the inequity in health and health-care (Smith 1987).

Just as knowledge about the bed was needed to manage length of hospital stay, so knowledge about patients and their social situation become part of the 'new moral contract' (Foucault 1997:186) through which solutions to the problem of length of stay are sought. Solutions existed in the reconfiguration of the social, as resources amenable to self-care and recovery. Actions to achieve this align (although not in a linear way) with the prediction of hospital length of stay and ongoing responsibility for continued recovery after hospital discharge. Patients become (self) constituted as autonomous citizens, conceptualised 'in a variety of private, corporate and quasi-public practices' (Rose 1999a:166) able to actively consume health care resources, rather than disciplined only through removal of control from episodes of acute care.
However, constitution as citizens does not cause patients to behave solely in one way or another, but 'structures the possible field of action' (Dreyfus and Rabinow 1982:221). Despite apparent diversity when reproduced in report form, the complexity of length of stay is rendered invisible and incontestable. Contained within numbers, the 'apparent facticity of the figure obscures the complex technical work that is required to produce objectivity' (Rose 1999a:208). Thus numbers produced from calculation of length of stay deny and obscure the complexity of its composition, and in particular, take on the appearance of working 'bureaucratically on categories rather than individuals', (O'Malley 1996) hence they are presumed to be technical, and therefore work amoralistically. That the re-engineering of surgical services simply produces new outcomes does not explain their effectiveness in homogenising surgical services for all those involved.

Length of stay is understood here as one means through which the territory of the hospital has been problematised in health policy. The health-economist inventors of length of stay realised soon after its introduction that it had limited value for economic efficiency. However, the 'damage', so to speak, had already been done. Hospital administrators, followed quickly by doctors and nurses and other health care professionals, had found in length of stay, not only a new language, but a temptingly easy way to define and measure (particular) outcomes. The translation of length of stay to beds also afforded others (particularly patients, politicians and media) with a means to join the debates about what constituted quality hospital services.

Structurally reified through architectural design and the allocation of spaces in pre-admission, short stay, transit lounges and day rooms, the calculation of length of stay became evident in bed management, early discharge and hospital 're-engineering' programs, as well as in patients' medical records, bed cards, computer care-planning and clinical pathways. This thesis contends that length of stay has also become involved in less obvious discursive activities through which economic and therapeutic efficiencies have joined to strengthen the social requirement for self-care. It is in this association that not only beds, but also recovery, have become the territory of health care policies and practices, with their 'success' understood as
a (re)governing through the production of new truths, truths that moralise individual recovery.

**Pre-Recovery And Moral Responsibility**

There are many 'recoveries' within an episode of acute care, from the regaining of consciousness after general anaesthesia, through to the return to pre-illness states. In this study, recovery has been understood as formed through what Foucault calls techniques of domination and the self. Analysis has proposed that the physiological trajectory of recovery, though significantly altered with new medical, pharmacological and technological advances, is also produced or 'made up' (Berg 1997; Berg and Mol 1998) through various administrative and managerial discourses. This thesis has argued that these various discourses promote the reconceptualisation of recovery and independence as particular forms and goals of citizenship.

The representation within health-care literature and government and organisational policy of medical and economic scientific knowledge about bodies and economies of scale, implies the existence of straightforward 'facts' that are required to be revealed only to enable appropriate decisions to be made. Just as disease shifted from being understood in terms of essences or species, to being organised by what was seen in a patient's body and classified through procedures of medical statements, (Rose 1994; Rose 1999a) so the diagnosis of recovery has shifted from changes witnessed in bodies over periods of time. The 'disappearance of the sick man' and the 'emergence of the patient' provided accounts for new institutional structures, therapeutic technologies and attention to the doctor–patient relationship. (Armstrong 1988; Armstrong 1993; Foucault 1993; Armstrong 1995; Armstrong 1997; Armstrong 1998). Further, medical diagnosis is now recognised as being much more arbitrary than previously thought, and understood to be rendered 'thinkable, describable, calculable, predictable', (Rose 1994:62) as much by material and conceptual means, such as styles of information-gathering from patients (Atkinson 1994; Atkinson 1995; Berg and Mol 1998). The variable processes though which information is obtained from patients, and by medical diagnoses, is understood as a molding process in which patient's and their situations
are reconstructed to render them manageable within existing agency routines (Rees 1991).

The theoretical orientation for this study of governmentality, as the governing of conduct, (Foucault 1991a) is reflective of a growing body of nursing literature which 'places nursing at the centre of the production of discourses of control and creation of subjectivities' (Gastaldo and Holmes 1999:238). In particular, the nursing research of Purkis (1993; 1996; 2001), Latimer (1993; 1999; 2000), Parker (1996; 1997) and Rudge (1997) provide nursing points of reference for this study. In these works the conditions of nursing practice are analysed through notions of time and space and constituted as social spaces of engagement, with Parker (1996; 1997) and Rudge (1997) adding metaphorical and psychoanalytical perspectives to that of the tempro-spatial. These accounts of nursing practice are significant in providing stimulus to reframe approaches to studying nursing and understandings of nursing knowledge and practice.

Latimer's interest in the elderly and nursing assessment frame her ethnography of an acute medical unit where she examines nursing practice and the (re)configurations of patient identities during their period of hospital stay (Latimer 1993). Inclusion in this study of analysis of nursing practice in the new locations of preadmission units provides an additional dimension (while closely reflecting) Latimer's analysis of the initiation of patients to the hospital and the way in which nursing practices move 'in between the bedside as a site of exclusion and the nurses’ station [or whiteboard] as a centre of calculation' (Latimer 2000:123). Purkis' conceptualisation of the practice-based discipline of nursing develops over a number of studies that include ethnographies in acute surgical and community health care settings (Purkis 1993; 1996). These studies examine nursing practice and the ongoing production of identity in the cultural performance of social actors (Latimer 1999) with nurse patient interactions conceptualised as the social spaces through which nursing gains meaning (Purkis 1996). These studies share with this study, a much greater emphasis on the contexts within which nurses practice and the role of this in shaping practice. Like the nurses in Purkis's and Latimer's studies, nursing practice in this study was a skillful demonstration of disciplining
the spaces of the bed hence managing bed and patient flows around certain conceptualisations.

In this research, surgical services (hence nursing practice) appear premised on the conceptualisation of the patient as well. Thus, recovery for individuals in this study involves 'thinking, description, calculation and prediction' about the details of the surgical event, against parameters of availability of public and private resources. Bed occupancy gained the most significant attention as a public resource, second only to the availability of carers. The use of privately available resources, limited only by the discretion of the individual, rarely featured as the responsibility of the hospital, nurses or doctors. The shift in diagnosis of illness has been described by Armstrong (1990) from the medical techniques of clinical examination to the typed pages of a morbidity survey conducted by socio-medical researchers. This study has described a shift in the diagnosis of recovery as less on what an individual patient is observed to do, but premised on the patient as well. Hence recovery is shifted (in advance of the actual surgery) from singular or isolated emphasis on somatic, or psyche responses, to the identification of these (and others) as individual projects achievable through the identification of available resources within the individual or their immediate social network.

Recovery has become an ethics of moral responsibility, where patients recognise and adopt (or sometimes refuse) an ethics of 'pre admitted or pre-recovered' through which they are able to speak out (about pain, wound-care, nausea, mobility etc) while in hospital, as well as manage these symptoms when discharged from hospital—reminiscent of Parker's use of the body as text, that is, a spatialised, colonized and commodified metaphor through which she examines nursing practice in the 'post institutional structures of health care as it shifts away from the hierarchies and medical dominance of modernity' (1997:28). In the mutually constitutive contexts of time, space and knowledge, Parker argues for the recognition of the 'body as living flesh', that is, an atextual body, where experiences through embodiment provide a means of gaining understandings about nurse's work (1997:27). Rudge (1997; 1998) extends this use of textual and metaphorical analysis through examination of identity for nurses and patients in her study of
wound care practices in a burns unit. Rudge (1997) theorises notions of cover, (re)cover and uncover to analyse how nurses and patients enact and resist effects of dominant discourses concluding that nursing practice is a spatio-temporal event in which time is a critical element. Rudge shares with Purkis a proposal that there be a 'reconceptualisation of the nurse-patient relationship, as a social relationship inhabiting a co-constituted space and time' (1997; 299).

In this study a co-constituted ethical space of responsibility is evident in the requirement for individuals to acknowledge and accept a problematisation of hospital bed shortages. In this context, surgical nursing is not only the hands and eyes of medicine (Liaschenko 1998), but becomes clearly the hands and eyes of (bed) management, and a strategy through which the object and subject of (pre) recovered patient is produced. The practices of pre-admission and short stay are thereby understood as a reformation of patient citizenship, not so much as an activation of the rights of the consumer in the marketplace, (Rose 1994) but rather as in relation to the care of the self, requiring 'knowing oneself', as well as knowledge of a number of rules or codes of acceptable conduct or principles, that are both truths and prescriptions. Therefore, to take care of the self is to equip oneself with these truths, since ethics is linked to games of truth (Foucault 1994a:285; Foucault, 1997a).

These new modes of hospital stay and post-operative recovery are not de-medicalised (Lupton 1997). They have been translated from something that was witnessed, carried out by, and instructed on through the advice of doctors and nurses as experts, and as required, with an individual's full cooperation, to something that is now self-conducted, responsibilised, within the space of individual 'freedom' as framed by anticipated hospital stay and personal circumstances outside the hospital. Bauman concludes from analysis of computer software processes that 'time–distance separating of the end from the beginning is shrinking or vanishing altogether, the two notions which were once used to plot the passing of time and therefore calculate the forfeited value of time, have lost much of their meaning' (Bauman 2000:118). In a similar manner hospital admission and discharge processes are proposed here to have collapsed together to produce a
'prerecovered' surgical space in which patients are defined by identifiable (self and other) resources.

Contemporary nursing proclaims much of its science as *body work*, (Lawler 1991; Lawler 1997) developed through active 'witnessing' of patient care and 'attuned to immediacy, and to the demands of the moment' (Parker 1997:16). However, the representations of length of stay proposed in this study align with health care as efficient, technical, information-based and measurable, and as such 'fix' the forms of human engagement that *are* hospital care. The implications of this for patients are that with idealised notions of health beyond the resources of contemporary hospital care, patients are deemed well enough in advance of their surgery for recovery to replace health(care). Hence patients are deemed *well* despite their simultaneous classification as patient, and it is in part, this 'wellbeing', that underpins the reduction in duration of hospital stays, and consequently, access to nursing services. For nursing, which has professionally aligned itself with human engagement as a feature of its therapeutic processes, continued and careful consideration needs to be given to the 'changes to the demands of the moment'.

**Challenges And Implications For Nursing**

Clarke and Rosen (2001) suggest that the attention to the decrease in hospital length of stay requires a shift from focus on the *place* of care (that is, the hospital or home) to the actual *components* of care. Though systematic research reviews tell us that with the exception of the very old and the very young, there are minimal bio-physiological problems with shorter hospital stays (Johnstone and Zolese 2000; Langhorne 2000; Parkes and Sheppard 2000), continuation of research into the rationalization of the bed as a health care commodity, care requirements (after hospital discharge) and the effects of shifting care delivery to carers and communities is still needed. The aim of such research is not to provide descriptions of how difficult things currently are for carers or communities nor substantiate a wistful desire on behalf of nurses for longer hospital stays in which to enact romanticised notions of nursing care. This and future studies will be useful as they directed better understanding of contemporary nursing practices as this information might assist patients.
Patients and surgeons (and no doubt hospital administrators) perceive positively the re-engineered surgical programs, such as early discharge and hospital-provided home care (Caplan and Brown 1998; Caplan, Brown et al, 1998; Caplan, Ward et al, 1999). However these programs create new discursive spaces for nursing such as in the moralization of recovery, not only as this serves managerialist interests of length of stay but also in protecting the patient from the risks of the hospital. The continued schemes to decrease the duration of hospital stay, especially for surgical patients, demands that nurses consider their role in the diagnosis and delivery of such 'components of care' (Clarke and Rosen 2001). Nurses in the contexts of shrinking length of hospital stay are not only busy managing the care requirements that come with increased hospital patient acuity, but are also actively involved in a closer scrutiny and diagnosis of the resources needed to enact a decreased length of stay. In periods of increasing brevity and risk of hospital stay (and configuration of home-care patient selection programs through tight managerialist frameworks) knowledge of the components of care and the human experiences of illness and recovery is at risk.

With nursing practice now understood as 'time limited interventions' (Purkis 2001:149) in periods of increasing demand for 'completed diagnostic episodes and clinical pathways' (Latimer 2000:125), nursing work includes the generation of clinical and social patient classes though which exclusion of the social provides for managerialist pressures for hospital throughput to be managed (Latimer 1993). Similarly for Purkis (2002:149) the home as it constitutes 'a politicised public work space and a private living space' is all 'too easily discounted as important'. Yet it is here, in the home that Purkis argues the exclusion of the social might be turned around by nurses with use of their local knowledge about patients as a means to reintegrate ethics into their practice. Local knowledge is deemed to be that which is 'much more minute, personal and detailed than that relied upon by their manager' (2001:148). Purkis proposes that nurses practice ethically through recognising the legitimacy of their local knowledge of patients and develop 'systems for recording this knowledge which resist managerialist demands for standardisation' (2001:149). However, knowledge about what happens after the patient goes home from hospital
is only part of the picture. In this study, nurses to sometimes argue for longer stays selectively used whatever 'local knowledge' they had about patients' lives. In Latimer’s study (1993; 2000) nurses used local knowledge most confidently where it aligned with the clinical domain, evident here where nurses negotiated for longer hospital stays on the basis of patient's being aged, yet as discussed previously in Chapter 6, there was little consistency to how or when such classifications were made.

The organisational and professional (nursing) consequences of the decreasing length of hospital stay are currently measurable only through re-admission to hospital for reasons specifically related to the same episode of care, such as for a wound infection. The presumption is that individual experiences after discharge from hospital are unimportant and inconsequential to health care efficiencies. Because of this, certain information disappears from the knowledge of the hospital system, and therefore from nursing, thereby changing both professional and organisational memory and identity (Bowker and Star 1999).

Further evidence of this reshaping of contemporary hospitals can be seen in the proliferation of specialised units. In these new hospital locations, specifically designed to achieve particular outcomes (such as decreasing length of stay) particular categories of patients are separated from others. The evisceration of broader hospital experiences from patient groups through their categorisation into sub-specialties is also evident in the increasing specialisation of nursing. This specialisation mirrors biomedical specialties, although not restricted to them, as evident in wound care, day surgery and convalescence as examples of growth in nursing specialisation. As the clinical specialties of medicine compete with the managerialist reframing of hospital spaces, specialisation of nursing expertise also becomes fragile. In environments of decreasing patient stay, nurses have become experts, not in clinical specialties of medicine, as much as organisers of patient throughput in roles such as Bed Manager, Discharge Liaison or Home Nurse. What might be seen as acclimatisation by nurses to managerialist environments, potentially risks ignoring the more difficult tasks of addressing the redistribution of
their particular (that is, nursing) health-care contributions through public policy development?

The reallocation out of the hospital of what are termed 'low intensity nursing care days' (Cordery 1995) acknowledges that organisational inefficiencies and the dynamics of medical authority results in hospital stays that are often longer than necessary. With this situation now past (National Health Service Executive 2000), self-help provides necessary solutions to what are, after all, political problems, yet not directly amenable to state action or social conformity (Cruickshank 1999:55). The move to self-care or self-help has been accomplished both through restricting the bed occupancy time (hence visibility) and the recognition by individuals (nurses, patients and their carers) of surgical recovery as mundane and predictable, with self-care capacities mobilised through techniques of responsibilisation. Despite the recognition of the impact of this cost-shifting to carers and communities, (Langhorne 2000; Parkes and Sheppard 2000; Purkis 2001) what is less visible, and of yet unknown significance, is how the current developments in surgical technique, and the associated changes to hospital surgical systems, shape health care knowledge (for both providers and consumers) in ways that presuppose that surgery is an isolated health event that occurs discreetly as though, in a vacuum from the rest of an individual's health.

Florence Nightingale suggested that 'a hospital should do the sick no harm' (Nightingale 1992). With nursing practice still predominately located within hospital structures, organisational changes have the potential for significant impact. Contemporary definitions of nursing still resonate with the significance of patient environments and the tasks 'of looking after people when they are too ill to look after themselves, and to wean them back to self care as they recover', (Nelson 2000:1) align with ideals of 'doing no harm' only where hospital patients can be conceptualised as not sick in the first place.

The requirement for nurses to 'look after' patients is, in this study, increasingly evident as forms of 'moral training' through which patients are instructed in advance of their admission to hospital. The notion of weaning a patient back to
self-care is accomplished through processes of resource creation, rather than resource referral. However, these interactions are somewhat contradictory where patients are expected to be both responsible and self-caring, while at the same time unquestioningly accept the direction of health experts. Purkis suggests that acknowledgment by nurses of 'the legitimacy of their local knowledge' of patients' everyday situations, and 'the development of systems for recording this knowledge' (Purkis 2001:149) may provide the means to resist managerialist demands for standardisation; however it is the often somewhat cursory assessment by nurses in this study of this very information (local knowledge) that currently serves in many cases as justification for regulating hospital throughput.

Gordon describes the provision of quality health care in decreasing periods of face to face contact as a new challenge that forms a 'mission impossible' for nursing (Gordon 1997). Liaschenko, writing in 1998 about shifts in nursing knowledge, suggests that nursing had moved from the previously popular notion of nursing advocacy as being able to speak on behalf of patients, to that of testimony where one now 'bears witness to the event about which one speaks' (Liaschenko 1998). The contexts described in this study of decreased length of hospital stay and increased patient acuity, mean that nursing may find itself with either far less, or at the very least, quite different things, to testify about. Hospital nursing is being changed by the removal of time. In this sense, the nurse–patient relationship is being rewritten as no longer requiring a close interpersonal relationship but is engagement 'with service users within a tightly circumscribed time-frame in order to accomplish the purpose at hand' (Allen 2001:177). This is not to imply that nurses had previously or traditionally spend prolonged periods of time with individual patients, but more broadly to challenge how current changes to hospitals are causing an overall diminished access to adequate nursing (Fagin 2001). This concurs with the growing body of evidence that nursing does make a significant difference to patient's hospital health care outcomes (Needleman, Buerhaus et al, 2001).

Nursing roles in this study have been reconfigured through involvement in the construction of possibilities of de-limited determinations of health (Osborne 1997). The 'baseline picture' (Latimer 1999:199) of patients as 'well' and 'fit' functions for
nurses as benchmarks through which the experiences and behaviours of the pre-operative and post-operative patient are normalised to meet expectations of length of stay and anticipated discharge, as these encompass ideas about recovery. Hence nursing, founded on knowledge about what happens in the first twenty-four to forty-eight hours after surgery, is now focused on the skills of working to configure individuals and social networks as health-care resources. These technical and embodied technologies aim to produce moral creatures capable of exercising responsible judgement and control over their own conduct (recovery/health). Nurses engage with patients in various ways, through which both nurses and patients are individuated and govern themselves. The sick, dependent patient is civilized and made amenable to a certain moral order (by their inculcation of self-management and self-control) resourced, and in recognition of being 'lucky to get a bed'—thereby aligning at the level of individual experience, the government of the self with practices for the government of others.

Length of stay has been shown to pervade numerous aspects of nursing practice. In calculating potential risks and available resources, nurses are encouraged to limit contractual or resource dependency. In this way nurses now practice economically, where forms of contracting do not oppose, but generate, particular forms of nursing care. Though 'institutional trust has the appearance of being non calculative … transactions are always organised with reference to the institutional context of which they are part. Calculativeness thus always reappears' (Williamson 1993:486).

This thesis has implied that length of stay is part of a calculative approach to economic organisation of hospital services. Inescapable by nursing or medicine, health-care provision has been reframed as 'objects of a certain regime of knowledge [where] human individuals become possible subjects for a certain system of power amenable to being calculated about, having things done to them and doing things to themselves' (Rose 1988:197). In this way it is argued that length of stay has provided a means to 'see' this calculativeness in hospital health care and nursing practice. These new practices afford nursing with challenges to participate in productive dialogue between organisation, medical, and economic sciences, while recognising how this reshapes or reproduces how we define our
practice, hence relationships with patients and their carers. Suffice to say that this study indicates that nurses are not so much involved in relationships of trust or care, rather that the relationships are calculated, contractual arrangements around risk and resources. I acknowledge that all four of these (trust, care, risk and resources) are the focus of extensive literature bases, which while not conceptually explored in this thesis are potential sites for further study for their implications for nursing.

More extensive and longitudinal studies across broader socio-demographic groups, particularly those patients for whom the hospital does not provide home care follow-up, provide scope for further study. As hospitals accelerate the speed and expand the spaces of services, perhaps the service is the same, just the space is different. In contrast to this, just as the bed is no longer fixed, nurses now work in very mobile spaces. The clinical spaces of medical, and more lately, nursing specialisation, are less stable.

The implications of this for nursing are interesting. They are under threat from managerialist demands for more efficient skill-mix, where nurses risk increasing fragmentation into 'products', amenable to divisions between body-work and information-work. However, the breaking down, or fragmentation, of clinical specialities also suggests a surfacing of more generic skill, such as those required to manage resources beyond the body.

'In the weakening of modernist temporality directed towards the future there is the opportunity for the nursing voice that articulates towards the concerns of the moment to be heard' (Parker 1997:16). However, nurses as a professional group, are currently at risk of being de-sensitised by environments of limited social health funding and shrinking hospital stays. They are increasingly limited in being able to witness patient needs and care, not only because of the short hospital patient stays, but also as part of a social de-sensitisation to sickness!

If concrete moral responses and relationships are commonly violated, if nurses frequently have to violate the integrity of particular clients due to a lack of time and resources, insensitivity to concrete personal destinies will increasingly become
a moral option. If one frequently has to violate the integrity of actual persons for the sake of maximising the well-being of distant and potential related persons, intuitions that are deeply rooted in the moral phenomenology of nursing are threatened (Nortvedt 2001:117).

Thus the challenge for nursing is to remain sensitised to rationalities and difference, and tolerant of the incommensurability of what they are required to do while engaging with individual experiences of health and sickness.

**Political Rationality**

Length of hospital stay has been suggested here to be as much the imposition of a new morality, as the calculation of hospital resources. Neo-liberal government provides a way to understand length of stay as the imposition of a morality (Rose 1999a: 137). Attention to length of stay can be understood as part of a network of strategies involving the systematic changing of variables of the environment, which count on the 'rational choice' of individuals (Lemke 2001). While cuts to public health-care funding may mean that aesthetics alone are sometimes sufficient reason to encourage preferences for home over hospital, the various forms of contractualising between hospitals, government, and individuals, includes the formation of certain self(ves) as part of the contracting (shrinking) of access to hospital (beds). Thus the increasing mangerialism of health care not only reduces the contractual space available for clinicians, but also shifts this space from professional to technical (Cash 2001). This is not so much the technical of body-work as the technical of economic rationalisation. Therefore the only visibility given to the social is that which can be territorialised, thus able to be transformed into a market relationship between individuals.

With health replacing salvation in our ethical systems, (Jones and Porter 1994:68) attention to length of stay indicates the replacement of health with recovery as the performance of daily tasks in the natural order of both the body and the life (Rose 1994:68) in contemporary health systems. Thus the medico-legal requirements of hospital care are less met through doctors and nurses doing to or for patients, than as through adjustment of truths, where medicine, and accordingly, nursing, enlightens individual decisions on how to live. This is not limited to telling us how
things should be, as it is to actively participating in practices which are directed at getting patients to master, improve, and regulate themselves.

Nurses and patients can therefore be understood as subjects in games of truth styled through techniques of citizenship, contracting, and responsibilisation (Dean 1999:167–168; Rose 1999a). These games of truth, in this study are as much about recovery and independence as they are length of stay. For individuals are most able to 'fulfil their political obligations in relation to the wealth, health and happiness of the nation when not bound into relations of dependency and obligation but when they seek to fulfil themselves as free individuals' (Foucault 1977:166). Contemporary human beings can be understood to '… inhabit a network of assemblages which presuppose, fabricate and stabilize particular versions of the self' (Rose 1999b:265). Patients come to the pre-admission unit as experts of their own existence, and where this aligns with the truths of hospital length of stay, nurses, in 'negotiating' length of stay, use this. Patients speak out in terms of family and others, reversing what has been thought about as the hospital as providers of health care, to self as health care provider. Patients speak in terms of themselves as resourced. As an 'ethicalisation of existence' this self government has 'intensified the demands that citizens do not devolve responsibilities for health, welfare, security and mutual care upon "the state", but take responsibility for their own conduct and its consequences in the name of their own self-realization' (Rose 1999a:264).

Significantly, in the contemporary hospital the expectation of not devolving responsibilities is such that surgical recovery is whatever you want, so long as you leave the hospital on time. The reasoning for why issues regarding how much a person might bleed when they jog post-haemorrhoidectomy, or for how long they lay immobile to avoid experiencing pain, or whether they visit the surgeon ever again or not are irrelevant, since they are invisible to the professional and organisational memory of the hospital.

Previous hospital and patient care studies have indicated problems with the disease, sickness, and institutional focus of hospital care. Although the Primary Health Care
movement that emerged with the Declaration of Alma-Ata (World Health Organisation 1978) and Ottawa Charter (World Health Organisation 1986) attempted to shift health services away from sickness towards prevention and self responsibility, the explosion in public health agendas now recognises that health is often beyond the scope of the individual and requires the addition of global ideals and actions for health and wellness (Baum 1995; Wass 2000). While this study does not seek to contradict what might be seen as the appropriate de-institutionalisation of sickness and health care, it has in some ways deliberately sought to ignore or disturb contemporary notions that hospitals are risky and unpleasant places, and that patients are far better off at home. The idealisation of 'home as best' is based on assumptions about availability of particular health resources, such as knowledge and skills, let alone economic resources of food or shelter. This is not to diminish recognition of the issues of iatrogenesis, or to idealistically aim for hospital services beyond the economic reach of any public health-care system.

Patient's social capital (such as their networks with other people) is enacted as resources through which to expedite hospital discharge and recovery. Evidence on how to encourage patients to manage early discharge confidently, as well as short-stay, exists in organisational discharge-planning policies and procedures, and reflects recognition of the requirement for carer involvement for discharge success (Carr 1993; Baum 1994; Jackson 1994; Armitage and Kavanagh 1996). Recognised as an emergent theme of liberal, democratic, and market-based societies, community is a 'space of semantic and programmatic concerns', (Rose 1999a:167) through which these practices form part of the substitution of economic hospital resources with the social resources from the communities in which people live (Baume 1999). Hence government here involves length of stay, nurses, patients and patients' families and friends in relations or assemblages of government, as they are made 'real' as specific and local objects and technical devices for the government of conduct (Rose 1999a:190).

Neo-liberalism provides explanations of the rational principles of regulation and limiting of governmental activity determined through reference to artificially
arranged and contrived forms of the free, entrepreneurial and competitive conduct of economic rational individuals. Hence rationality is pegged to a contrived style of conduct, an art of existence (Burchell 1993). Neo-liberal moralisation as the making of each individual as the entrepreneur of his or her own health (Osborne 1997) is evident in the weaving within hospital care of rights and duty. With neo-liberal or advanced liberal rule characterised by the politics of the contract, the subject of the contract is not a patient or a case, but a customer or consumer; however contracting provides a means through which citizens are made consumers, an active citizen as one who is an 'entrepreneur of him or herself' (Rose 1999a). Rose describes this as a form of enterprise where the individual seeks to 'enhance and capitalize on existence itself through calculated acts and investments' (Rose 1999a:164).

Although the hospital surgical patient may not be 'a consumer' because of their dependency on the opinions of experts, at their actual point of contact with episodes of acute hospital care they are seen to '... best fulfil their political obligations in relation to the wealth, health and happiness of the nation not when they are bound into relations of dependency and obligation but when they seek to fulfil themselves as free individuals' (Rose 1999a:166), with an independent nexus of ties and affinities.

**A Concluding Proposal**

The role of the hospital in future health-care provision is uncertain. Many experts believe that health care knowledge will most likely be centralised in the hospital, with service increasingly provided at its periphery (National Health Service Executive 2000). Hence this analysis of length of hospital stay has not examined forms of calculation of particular hospital goals, measures or variables, nor focused on the associations between medical diagnoses and bed occupancy. Rather, this study, as a study of the inadequacy of rationality, has examined length of stay as 'assemblages which may have a rationality, but this is not one of coherence of origin or singular essence' (Rose 1999a:276). This thesis has proposed that length of stay is contingent upon a number of elements, some of which do accommodate particular medical and nursing expertise with the demands of resource utilisation. However,
competency in resource management by nurses and other health professionals does not separate the social, political, and ethical, but rather, is understood to combine them and generate complexity.

In what has been, among other things, research into hospital resources, it is necessary to recognise that however important complexities might be, they will inevitably vanish in the processes of labelling associated with distribution and allocation (Callon and Law 1997). However the technical and allocative efficiencies afforded to numerical representations of length of stay are examples of how the single figure provided by calculative practices is commonly set apart from political interests (Miller 2001).

In nursing practice and patient care, length of stay has been observed to sets norms, not only as effects or numbers, but also for behaviour; that is, for behaviours of nursing practice and patient recovery. Length of stay has acted as a standard not only for government officials who enact hospital funding, and casemix coders who transmit information to enable these transactions, but also for patients, nurses, doctors and carers in hospital departments, units, wards and homes. In this way, length of stay has created new governable spaces, associated closely with certain modes of perception. These modes of perception are available through the material techniques of thought, as inscription and calculation. Thus they make possible the extension of authority over the very thing that such practices aim to depict (Rose 1999a:37). In this way length of stay is clearly part of the discursive classification and calculation of hospital (and bed) use. Although attempts by patients, nurses, doctors and others to reconcile their expertise with the various and competing clinical and managerial discourses, length of stay has shifted from numerical 'facts' to become also individual responsibilities.

Hence, length of stay is as aptly understood as an entity that does not have subjects or objects that are separate from the context of its calculation and responsibilisation. It is more than the solid practices and numbers of classification and calculation. It is also sets of relations, which as compound realities are human, technical and textual (Callon and Law 1997). This is how length of stay regulates
and is regulated in the management of surgical practices. It is as a hybrid collective, where rather than being a 'set of relationships between human actors … it is better understood as a collective association of human and nonhuman entities' (Callon and Law 1997).

The durability of this construct is increasingly under examination. Evidence is available of the growing recognition that length of stay is not as economically relevant as was once thought. This is apparent in the stabilisation in demand for and reduction of hospital bed use, and the redistribution of hospital funds to developing non-hospital inpatient services (Commonwealth of Australia 1998; National Health Services Executive 2000; National Centre for Classification in Health 2000; Clarke and Rosen 2001). The downward curve of the tables in chapter 2 of this thesis, traced throughout the years of my PhD candidature, clearly represent the move towards a decline in references to length of stay in health care publications. Who knows, perhaps the subheading of length of stay introduced in 1972 (Medline) and 1984 (CINAHL) may at some point in the near future disappear from bibliometric (as one form of truth-telling) practices?

'BBlack Boxes'

Various hypotheses as to why length of hospital stay is diminishing (both in time and its representations) have been proposed. As a point of closure to this thesis I turn to Latour’s idea of black boxes. Latour reworks the commonly used idea of a black box previously recognised as a way of describing the bounding of complex mechanistic functions so that all that needs to be known is the input and/or output (Latour 1987). As part of the early work in science, technology and the social, Latour and others propose that black boxes, while still focused on inputs and outputs, also include various heterogeneous interactions and socio-technological compromises as 'disorderly and unreliable allies' (Latour 1987):131). No matter how complex or contested their history, these elements can be concealed, defined, held in place, mobilised and stabilised in a single entity (Callon 1986; Law 1994; Callon and Law 1997). As such, a black box contains not only complex parts and knowledge, but also 'that which no longer needs to be considered, those things whose contents have become a matter of indifference', (Callon and Latour
Acts of comparison and the establishment of norms and standards, enable though the (re)inscription of individual patient care as single figures, the formation of a collective of all hospital patients. In this 'collective', length of stay as part of competent resource management represents a diagnostic category, or the space of a bed, or the responsibility of a nurse, patient or doctor, 'built' as facts about an individual, standardised as a particular DRG, or a medical diagnosis, or as a short-stay, or long-stay patient or nurse, or as pain or wound management. Through processes of enrolling and enrollment, black boxes involve actors or forces to require or count on particular ways of thinking and acting from each other. '[H]ence assembling them together into a network, not because of legal or institutional ties or dependencies, but because they have come to construe their problems in allied ways and their fate as in some way bound up with one another' (Miller and Rose 1990:10). The ease with which health professionals translate the phrase length of stay into a responsibility, which requires them to, at the very least, notice how long a patient has been in hospital or actively seek to decrease that period of stay, is evidence of this. These translations act as modes of forgetting, silencing, deletion or representation (Law 1994; Bowker and Star 1999) visible as issues of time and space in the ordering of contemporary hospital nursing practice.

However, in ordering practice across time and space, difficulties with 'fact building' surface (Latour 1987).

[T]hey have to enrol so many others so that they participate in the continuing construction of the fact …, they also have to control each of these people so that they pass the claim along without transforming it either into some other claim or into someone else's claim … Each of the potential helping hands, instead of being conductor may act in multifarious ways behaving as a 'multi-conductor'. They have no interest whatsoever in the claim, shunt it towards some unrelated topic, turn it into an artifact, transform it into something else, drop it
altogether, attribute it to some other author, pass it along as it is, confirm it and so on (Latour 1987:208-209).

There are implications of this for nursing as they might be understood to be conductors of hospital services. The re-engineering of hospital surgical services, particularly for elective surgery, around presumptions of well patients and restricted bed access, limits the spaces available for nursing practice, while reproducing these spaces as increasingly specialised. What is being termed here, as nursing specialisation is the subtle and largely invisible integration of 'body-work' with 'information-work' by nurses as the core hospital patient-care labour force.

Latimer (2000:115-118) proposes that nurses are conductors of care. Like the nurses in my study, the nurses she described discriminated between patient needs on the basis of medical or social needs. The nurses in her study managed the multiple agendas of the hospital by acting to protect a reified clinical domain— the purity of clinical practice, the hospital front of 'first class British medicine'. Nurses and others drew on imperatives for throughput to help accomplish the appearance of this clinical purity in subtle and implicit ways, with managerialist requirements for throughput pushed to the background. In contrast in the current study of a very different but also hospital based nursing practice, no such reification or back grounding was evident. Managerialist requirements for throughput were mainstreamed by nurses’ practices. This does not mean that nurses did not care— it is just that this was not what was sought. This study was directed at analysing how length of stay was visible and constituted as part of the delivery of hospital services. Chapters 6 and 7 in this thesis provide examples of where some nurses suggested that in short stay surgical areas they did not have enough time to care while clear that the hospital was not always the best place to be. Where these nurses acted in ways or facilitated what Rudge (1997) refers to as the 'gift of time' they did so through reclassifying patients who needed to stay in hospital because they were elderly or had no one at home. This appeared to be very different from the gift in Rudge's study where nurses gave of themselves in the form of one to one time with patients. For the nurses in this study their 'gift' was giving as conductors of hospital resources—a gift of time in the form of bed occupancy.
Hence, notions of nursing practice (rather than care) are proposed in this analysis as interwoven closely with the resources of hospital services (inclusive of medical, nursing and ancillary), such as are therapeutically necessary for surgical intervention. Other therapies, such as recuperation and recovery appear to have been reallocated for enactment elsewhere, in places and discourses of preadmission and home. The bed has ceased to be hygienic or therapeutic spaces where medical or nursing care was enacted but is reinscribed as a mobile and administrable space, of nursing responsibility with considerable nursing emphasis on the duration of occupancy. Nursing practice in this study involved ensuring that patients could find the resources to do for themselves without the hospital. A sentiment that coincides not only with managerialist agendas but also contemporary agendas of risk management and social responsibility.

Thus this compression of hospital time distills the responsibilities of nurses and patients for surgical recovery. Just as the hospital bed gains visibility as a prominent location of hospital care so nursing, increasingly compacted in shrinking hospital stays, becomes in some ways more susceptible to rationalisation through its visibility as the largest hospital labour force, while also less able to be discerned from the combined machinery of hospital services. In this way the move away from measuring time to measuring responsibility may mean that the nursing role is less available to fracture along lines of skill level. This has been evident in this study in the relative lack of second level nurses and complete absence of unregulated care-workers involved in providing patient care as well as the generic nursing skills of 'resourcing' surgical patients. However this is an issue of particular significance as the contribution of second level nurses and nurse assistants come under greater scrutiny here in Australia (Gibson and Heartfield 2000). The acceleration of hospital treatment times, while perhaps most conducive to some forms of specialisation, such as preadmission and discharge assessment and liaison, also prohibits dissection of nursing practice into separate body-work or information-work roles and the devolution of these to others, as proposed in the expansion of second-level nurses or unregulated care-workers in hospital care.
However, even professional recognition and industrial protection of integrated nursing roles will not remove the wholesale threat from rapid hospital change to the desensitisation of nurses to individual suffering and needs. This is a risk evident in some areas of the 'time deprived' contemporary hospital. The space to allow a patient 'nursing supervised' rest in bed, rather than on the top sheet or in the day room, and the sensitivity to see the difference, is symptomatic of what is currently at risk. The risk is to the nursing contribution to illness and hospital care in the current contexts of shrinking social health care funding. This is not an attempt to replace the rationalities or truths of mangerialism, with 'quality' nursing rationalities or truths, but rather to find ways to understand nursing practice in the contexts of changes to hospitals and the increasing shift of burden of responsibility for health and ill-health care, away from the 'experts' of doctors and nurses, toward the individual and community.

Hence the empirical exercise of this study indicates that length of stay is clearly not one single, calculated outcome produced in numerical form and unquestioningly accorded neutrality. It is an inconsistent, ambiguous, and even illogical actor, rhetorically producing conviction in others without entirely defining them; (Rose 1999a) a conviction which has the potential to narrow the range of possible nursing actions and practices.

This study proposes that length of stay has not really stabilised in the new hospital spaces, as much it has been reformulated or translated from classifications of hospital use by patient categories (DRGs), to measurement of bed occupancy and forms of moral responsibility. Programs such as those of the National Demonstration Hospitals Program might be understood as the 'new machines', which harness the reformulation or translation and dispersion of length of stay, so that larger numbers of people and techniques are involved. However, the risk is that [d]issent has been made unthinkable' (Latour 1987:133) as we forget that it is the obedient behaviour of people that turns claims into facts (Latour 1987).

The acceleration of the speed of the time of hospital care enlarges the space available in which to provide hospital care to include the patient's home and
community, the media, and the attention of politicians. Length of stay has become a boundary object, able to 'get the work done' of decreasing hospital length of stay and increasing the capacity for the flow of volume of patients. Nurses and others now accept considerations of hospital length of stay as necessary.

**Summation**

This study has generated empirical evidence about length of stay as part of a collective of practices—practices of government, hospital, health professionals and health system consumers or patients. It is suggested that in this collective of length of stay, the contributions of any single element from the whiteboard, the architecture of the pre-admission unit, to individuals as casemix coders, doctors, nurses, the newspaper headline or sketch, are all active in making decisions about length of stay. Thus power relations are evident in a way that changes how we have come to understand hospital functions.

With 'the touchstone of any position its empirical fruitfulness' (Callon 1992) this study proposes that length of stay has ceased to be a means to an end as it stabilises in consuming attention and resources within the programs of pre-admission and short-stay. These 'stabilisations' remove the need for health professionals to give length of stay independent attention in enacting the practices of hospital surgical services. Thus 'black boxed' within particular hospital programs, length of stay is forgotten about in ways that produce certain knowledge and responsibilities. As new knowledge, it is knowledge of resources, the resources of beds and the responsibilities of the patient as both 'case' and 'self'. This thesis has argued that the metaphor of 'black boxing' of length of stay might signal not the simplification of complex information so that it might be ignored, but the need to remain cognizant of the part that nursing plays in turning claims about what hospitals should provide, into facts. Length of hospital stay may look as if it is following the disappearance of the hospital patient. Alternatively, this disappearance might be understood as solidification or stabilisation of rationalities of increased responsibilisation.

The seduction of length of stay resides in its ability to avoid opposition through numerical, thus 'factual', representation of its decline as indications of efficiencies.
The growing recognition of the problematisation of length of stay as not only economically, but also morally inadequate to health services, is welcomed. The recasting, however, of length of stay in various programs purporting to meet a number of components of care rather than length of hospital stay, needs to be carefully reconsidered, not as an act of conspiracy, but as works of power. These works of power require that we be mindful, for 'that power has no face does not mean that it is monstrous, only that it could be' (Cruikshank 1999:124).

This responsibility is not restricted to nurses and nursing. As illustrated in this study, hospitals are the domains not only of nurses, doctors, patients and other health care professionals, but also of media, bureaucrats, and 'communities' to name just a few. In the same way that this thesis has aimed to demonstrate care, not the care of the endless nursing debates, but care as evoked by curiosity, 'as the care that one takes of what exists and what might exist; a sharpened sense of reality' (Foucault 1994b:325), we all need to remain mindful of 'what they do does' (Dreyfus and Rabinow 1982). For it is in this preferred definition of care, this sharpened care of what exists and what might exist, that the problematisation of particular health care resources (in this instance the duration of hospital stay) might be understood to form 'the lightning of possible storms'; storms for the futures of health care, both within and outside the hospital bounds.
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ETHICS: Approvals and Information

Hospital Ethics Approval Letter
University Ethics Approval letter
Patient Information Sheet
Hospital Staff Information Sheet
Family/Carer Information Sheet
Patient Consent Form
Hospital Staff Consent Form
Family/Carer Consent Form
Invitation to Participate and Information for Patients about the Research Project:

“A Study of Nursing Practices in the Accomplishment and Management of Hospital Discharge”

You are invited to participate in a study exploring nursing practices in the organisation of hospital care. The practices and experiences of patients, family, health care professionals and others who provide health care services associated with ‘early’ hospital discharge and the continuation of care provided by hospital staff within the patient’s home will be explored. A better understanding about discharge and how it is organised may assist in decision making about discharge and contribute to improving the quality of hospital discharge care.

If you agree to participate in this study it will involve you discussing your experiences of hospital care. It is anticipated that one or two discussions, which will be tape-recorded, will take place during your time in hospital with a further interview or telephone interview after you have been discharged. Participation will also mean the researcher will read your nursing and medical records and observe nurses providing care to you either in hospital or in your home, if hospital care is provided once you are back at home.

Information provided by you will only be used for the purposes of the study and you may alter or withdraw any information at any time during the period in which the study is conducted.

Any means by which you could be identified will be removed from the tapes or notes so there will be no way of individually identifying you as a participant in this study. All information that you provide will be kept in strict confidence. The information in the forms of notes, tapes and computer disks will be kept in locked storage at **** for a period of five years after which they will be destroyed.

Your involvement in this study is entirely voluntary and your non-participation will not affect your treatment at **** in any way. Should you decide to withdraw from the study you may do this freely and without prejudice to any future treatment at ****.

This study has been reviewed by the Clinical Investigations Committee at ****.

Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, information about the conduct of the study or your rights as a participant, or should you wish to make a confidential complaint, you may contact the Administrative Officer – Research, ****.
Name of Hospital (**** identifying information replaced)

Invitation to Participate and Information for Staff about the Research Project:

“A Study of Nursing Practices in the Accomplishment and Management of Hospital Discharge”

You are invited to participate in a study exploring nursing practices in the organisation of hospital care. The practices and experiences of patients, family, health care professionals and others who provide health care services associated with ‘early’ hospital discharge and the continuation of care provided by hospital staff within the patient’s home will be explored. A better understanding about discharge and how it is organised may assist in decision making about discharge and contribute to improving the quality of hospital discharge care.

If you agree to participate in this study it will involve you discussing your ideas, understandings and practices relevant to hospital care. If you are a nurse and agree to participate in this study it may involve the researcher observing you providing care to patients, particularly care related to discharge such as admission, discharge planning and wards rounds.

Information provided by you will only be used for the purposes of the study and you may alter or withdraw any information at any time during the period in which the study is conducted.

Any means by which you could be identified will be removed from the tapes or notes so there will be no way of individually identifying you as a participant in this study. All information that you provide will be kept in strict confidence. The information in the forms of notes, tapes and computer disks will be kept in locked storage at the University of South Australia for a period of five years after which they will be destroyed.

Your involvement in this study is entirely voluntary and you may decide to withdraw from the study freely and without prejudice to any time.

This study has been reviewed by the Clinical Investigations Committee at ****.

Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, information about the conduct of the study or your rights as a participant, or should you wish to make a confidential complaint, you may contact the Administrative Officer – Research ****.
Invitation to Participate and Information for Family and/or Carers about the Research Project:

“A Study of Nursing Practices in the Accomplishment and Management of Hospital Discharge”

You are invited to participate in a study exploring nursing practices in the organisation of hospital care. The practices and experiences of patients, family, health care professionals and others who provide health care services associated with ‘early’ hospital discharge and the continuation of care provided by hospital staff within the patient’s home will be explored. A better understanding about discharge and how it is organised may assist in decision making about discharge and contribute to improving the quality of hospital discharge care.

If you agree to participate in this study it will involve you discussing your understandings and experiences of having a relative, partner or friend have hospital provided care in their home after discharge from hospital. You may also be asked to answer some questions that the researcher may have about this practice.

Information provided by you will only be used for the purposes of the study and you may alter or withdraw any information at any time during the period in which the study is conducted.

Any means by which you may be identified will be removed from the tapes or notes so there will be no way of individually identifying you as a participant in this study. All information that you provide will be kept in strict confidence. The information in the forms of notes, tapes and computer disks will be kept in locked storage at the **** for a period of five years after which they will be destroyed.

Your involvement in this study is entirely voluntary and your non-participation will not affect the treatment of the person for whom you provide care at **** in any way. Should you decide to withdraw from the study you may do this freely and without prejudice.

This study has been reviewed by the Clinical Investigations Committee at ****. Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, information about the conduct of the study or your rights as a participant, or should you wish to make a confidential complaint, you may contact the Administrative Officer – Research, ****
I, …………………………………request and give consent to my involvement in the research project “A Study of Nursing Practices in the Accomplishment and Management of Hospital Discharge”.

I acknowledge that the nature, purpose and contemplated effects of the research project have been explained fully explained to my satisfaction by MARIE HEARTFIELD and my consent is given voluntarily.

I acknowledge that the details of the following involvement

- Interview participation
- Observation of nursing care being provided to me
- Reading of my nursing and medical records

have been explained to me, including indications of risks; any discomfort involved; anticipation of length of time and the frequency with which involvement will occur.

I have understood and am satisfied with the explanations that I have been given. I have been provided with a written information sheet. I understand that my involvement in this research project may not be of any direct benefit to me and that I may withdraw my consent at any stage without affecting my rights or the responsibilities of the researchers in any respect.

I declare that I am over 18 years of age.

Signature of research subject:………………………………………..Date……………….
Signature of Witness:……………………………………………………..
Printed Name of Witness:…………………………………………………………

I,…………………………………..have described to ………………….
the research project and the nature and effects of involvement. In my opinion he/she understands the explanation and has freely given his/her consent.

Signature………………………………………………………..Date………………………….
I, ………………………………………………….request and give consent to my involvement in the research project “A Study of Nursing Practices in the Accomplishment and Management of Hospital Discharge”.

I acknowledge that the nature, purpose and contemplated effects of the research project have been explained fully explained to my satisfaction by MARIE HEARTFIELD and my consent is given voluntarily.

I acknowledge that the details of the following involvement

- Interview participation
- Observation of activities related to patient care

has been explained to me, including indications of risks or discomfort; anticipation of length of time and the frequency with which involvement will occur.

I have understood and am satisfied with the explanations that I have been given. I have been provided with a written information sheet. I understand that my involvement in this research project may not be of any direct benefit to me and that I may withdraw my consent at any stage without affecting my rights or the responsibilities of the researchers in any respect. I declare that I am over 18 years of age.

Signature of research subject:……………………………………Date………………
Signature of Witness:………………………………………………………………
Printed Name of Witness:……………………………………………………………

I,……………………………………………….have described to …………………
the research project and the nature and effects of involvement. In my opinion he/she understands the explanation and has freely given his/her consent.

Signature………………………………………………Date…………………………
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<td>FAMILY and/or CARERS</td>
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**NAME**

**Contact Details**

I, ………………………………..…request and give consent to my involvement in the research project *“A Study of Nursing Practices in the Accomplishment and Management of Hospital Discharge”*. I acknowledge that the nature, purpose and contemplated effects of the research project have been explained fully explained to my satisfaction by MARIE HEARTFIELD and my consent is given voluntarily. I acknowledge that the details of involvement in interviews has been explained to me, including indications of risks; anticipation of length of time and the frequency with which involvement will occur. I have understood and am satisfied with the explanations that I have been given. I have been provided with a written information sheet. I understand that my involvement in this research project may not be of any direct benefit to me and that I may withdraw my consent at any stage without affecting my rights or the responsibilities of the researchers in any respect. I declare that I am over 18 years of age.

Signature of research subject:…………………………………Date………………..

Signature of Witness:……………………………………………………………………

Printed Name of Witness:………………………………………………………………

I,…………………………………have described to ………………………
the research project and the nature and effects of involvement. In my opinion he/she understands the explanation and has freely given his/her consent.

Signature……………………………………………..Date…………………………
APPENDIX B

NATIONAL DEMONSTRATION HOSPITALS PROGRAM:

General Principles for Bed Management
General Principles for a Pre Admission Service
GENERAL PRINCIPLES FOR BED MANAGEMENT

Principles of bed management are essential elements required to optimise the use of a hospital bed and manage the continuum of care. The principles held include:-

- There is an organisation led commitment to manage all hospital beds.
- There is a centralised point of authority and accountability for the allocation of all hospital beds.
- A bed management forum is established to identify and resolve bed management problems. The hospital executive supports this forum.
- A documented policy framework supports integrated bed management principles.
- The function of allocating all hospital beds is centralised.
- Bed allocation staff have appropriate authority to allocate beds.
- Integrated bed management occurs 24 hours per day, every day.
- Integrated bed management must be linked with the needs of inbound and outbound patient traffic.
- Allocation of hospital beds is based on agreed medical criteria.
- The allocation of beds to clinical units is notional.
- A flexible bed base is built into the operating requirements to meet fluctuating bed demands.
- Patients are admitted to their correct speciality ward/unit on admission or within 24 hours where appropriate.
- A patient’s episode of care is planned from pre-admissions/emergency, through admission and discharge back to the community. Patients and carers are partners in this process.
- An interdisciplinary team plans and coordinates care and support services for a patient’s episode of care.
- Integrated bed management is supported by accurate real time information. Data is continuously collected, audited, analysed and disseminated to guide resource management and optimise efficiency.

GENERAL PRINCIPLES FOR A PRE-ADMISSION SERVICE

- A pre-admission service is integrated into service delivery and is not an isolated component of care.
- Pre-admission assessment is conducted on an outpatient basis wherever possible.
- Pre-admission assessment aims to optimise a patient's health status before admission to hospital.
- At the pre-admission visit the patient and their carer’s are informed and educated about their medical condition, proposed treatment and hospital procedures.
- The patient’s general practitioner and community providers are to be involved in the pre-admission process as appropriate.
- The planning and coordination of the patient’s care for both admission and discharge is commenced at the pre-admission visit.
- Patient information is coordinated and made available to all relevant providers in an efficient and timely manner.
- Pre-admission planning facilitates day of surgery admission where appropriate.
- Patient’s data should be computerised at the first contact and throughout the coordinated episode of care.
- Pre-admission services are continually reviewed, evaluated and improved.

These key principles have been used by hospitals participating in NDHP-2, which included City Hospital.

APPENDIX C

PRE ADMISSION:

Patient Assessment and Admission Form
Patient Health Questionnaire
APPENDIX D

PAIN VIDEO SCRIPT
**PAIN VIDEO SCRIPT**

**BACKGROUND OPENING MUSIC**

**VISION 1: VISION OF PEOPLE PLAYING SPORT**

**VOICE OVER:** Pain is useful when it serves as a warning to prevent injury. Sometimes people accept pain as part of their activities. It is part of the larger experience especially in vigorous sport.

**VISION 2: VISION OF NURSE ATTENDING A PATIENT WHO IS IN A HOSPITAL BED**

**VOICE OVER:** This pain is not useful. It is making it hard for the woman to breath deeply to clear her lungs and it is stopping her from being able to cough – it is slowing down her recovery from the operation.

**PATIENT:** I’ll have to have something for the pain.

**NURSE:** I’ll get you something for pain but while I am gone if it is still hurting try and think of something nice and pleasant.

**VISION 3: SURGEON IN THEATRE ATTIRE SCRUBBING IN PREPARATION TO PERFORM SURGERY**

**SURGEON:** I am about to help with an operation and the patient concerned may be expecting to have pain after his surgery. It’s a commonly held concept but its no longer true. There are excellent ways of relieving pain after operations and people should be aware of them and make use of them. I want my patients to use them.

**VISION 4: NURSE IDENTIFIED BY SUBTITLE AS A PAIN MANAGER**

**PAIN MANAGER:** Quite often a patient knows that pain relief is only a step away but do not want to bother the nurses because nurses always seem so busy. Well the nurses wouldn’t agree with that we want to stop the patient’s pain. Pain slows the healing process and keeps them in hospital even longer. There are lots of different ways of giving pain relieving and drugs. For example sometimes you can give pills or for stronger pain, an injection. We are aware that some people don’t like injections or are fearful of them or that injections won’t even help some peoples pain. There’re other ways that we can give pain reliving drugs. All the patient needs to do it to tell us about their pain and to let us know their thoughts and their feelings. And there’s something else some patients don’t like to ask for pain relief because they’re afraid of becoming addicted – I’ve never seen that happen.
VISION 5: \textbf{SURGEON}

\textbf{SURGEON:} There is a fairly widely held misconception that treatment of postoperative pain with strong drugs could actually lead to addiction. However it seems that there isn’t a shred of scientific evidence to support that statement. Indeed failure to treat postoperative pain effectively can itself be harmful.

VISION 6: \textbf{VISION OF NURSE WITH A PATIENT WHO IS IN BED, SITTING UP TO LEAN OVER A VOMIT BOWL}

\textbf{NURSE:} That injection didn’t seem to have helped, I’ll get you to relax.

\textbf{VOICE OVER:} Some people do feel sick as a result of the pain itself or even the side effect of the pain relieving medication. So if there are unpleasant feelings tell someone about it so that they can do something about it.

\textbf{NURSE:} Where’s the pain now?

\textbf{PATIENT:} All up there.

\textbf{NURSE:} So its right up there?

\textbf{PATIENT:} Yes look I am feeling sick it must be the injection, its really painful here.

Nurse and Pain Manager watching over patient

\textbf{PAIN MANAGER:}

OK look I think that we will need to call the doctor and see if we can either change the drug or the way that we are giving you the drug cause I think that is what the problem is.

\textbf{PATIENT:} OK thank you.

VISION 7: \textbf{VISION OF PATIENT IN BED CONNECTED TO AN INTRAVENOUS INFUSION AND PUMP}

\textbf{VOICE OVER:} This pump is continually delivering drugs, as it is required. The delivery rate can be preset for a constant flow or pts can control the rate to give themselves the best pain relief. This is excellent for those who prefer to be in control and to look after their own medications.

Nurse enters patient’s room and asks “how you feeling”

\textbf{PATIENT:} Good thanks.

Nurse looks towards pile of magazines and asks “would you like me to get you one?”

\textbf{PATIENT:} Any on motorbikes?

\textbf{VOICE OVER:} This patient is getting pain relief and interestingly they actually use less of the medication this way.
Vision of patient pushing the button on his Patient Controlled Analgesia Pump

**VOICE OVER:** If you push the button too often the machine automatically limits the number of doses to a safe level. The user cannot over administer.

**VISION 8:** VISION OF A PATIENT IN BED WITH AN INFUSION AND AN EPIDURAL CATHETER

**VOICE OVER:** During the surgical procedure or soon afterwards the anaesthetist may have inserted an epidural and this also provides excellent pain relief.”

This is over background vision of and conversation between a nurse and patient about the patient getting up from bed to have a shower.

**VOICE OVER:** The epidural is topped up whenever necessary and the user of the epidural can help to get the dose just right by letting the staff know how it is feeling. Whether more or less pain relief is needed. In this way the patient as part of the pain relief team he or she can help to fine tune the system by feeding back information about how well the pain relief is working.

**VISION 9:** TWO NURSES AT A PATIENTS BEDSIDE DRESSING A WOUND

**NURSE:** I’m going to take the dressing off OK?

Patient winces

**NURSE:** Oh its really painful is it? OK I think we will give her a couple of breaths on the Entonox – take a deep breathe – that’s it.

**VOICE OVER:** There is no need for people to put up with pain it doesn’t do anybody any good and it slows down the healing process. The continuation of new advances in pain control allows us to offer quick and convenient techniques for pain relief, which are quite safe. So if it hurts please tell us.

*Background closing music*

**END OF VIDEO.**
APPENDIX E

Example Diagnosis Related Group Data
Author/s:
Heartfield, Marie

Title:
Governing recovery: a discourse analysis of hospital stay length

Date:
2002-12

Citation:

Publication Status:
Unpublished

Persistent Link:
http://hdl.handle.net/11343/39046

File Description:
Governing recovery: a discourse analysis of hospital stay length

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