harm must come to the mother or baby because a disease is being inadequately treated. The aim of this series is to provide the information on which a clinical decision can be made.

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Personal Paper

Observations on the management of mood in a neurological hospital

ROGER HOMAN

I present my interpretation of aspects of organisation observed during a period as an inpatient, initially in a general hospital but for the most part in a specialist neurological unit, in which some seven weeks were spent in the men's surgical ward interrupted by a brief spell in the intensive care unit. My condition was diagnosed as myelitis, a disease of the spinal cord that causes paralysis and which in my case affected my legs and all functions below the ribs. It gets worse before it gets better, and though recovery was always in prospect, the medical staff were unable or unwilling to predict its rate or degree. All that was certain was that my stay in hospital would be a matter of weeks if not months, and I therefore sought a sociological theme as a way of passing the time.

In a study of religious behaviour I had incurred the wrath of fellow sociologists for my use of covert methods of observation, so I was keen to secure the informed consent of all those whom I observed in the hospital. Even as I lay in intensive care I recalled between moments of self pity that one of my severest critics had been the medical sociologist Robert Dingwall, in whose stamping ground I was now reposing.¹ Accordingly, I made my research purpose explicit at all times, was ostentatious in note taking and questioning, wrote this paper in the hospital, and circulated copies of it within the hospital before submitting it for publication.

In this account I consider mood management under three headings. Morale refers to the attitude of patients towards their

condition and the likelihood of recovery. The treatment of dignity refers to a tension between the cure of the body and respect for the person within it. (Other patient observers^{2,3} have complained of depersonalisation or dehumanisation, and I have taken the opportunity to reassess this process.) The section on discontent examines the satisfaction of patients as consumers, whether of goods, such as food, or of services, such as the responses of nurses to patients' calls.

Morale

My medical mentor believed that neurology was inherently less "gloomy" than other branches of medicine, such as chest medicine. The expectation of recovery was supported not only by the vague notions of statistics with which patients cheered themselves but in the systematic practice and policy of the nursing and medical staff.

My bed was in a bay of five which were reserved for patients who were likely to need closer attention than others. The bay adjoined the day room where ambulant patients came for their meals, received their guests, and watched television. While still obliged to lie in bed for my meals, therefore, I was able to observe the celebration of recovery and the daily improvement of those who had been more severely affected than I. The sequence from bed rest to sitting up to wheelchair to walking frame to crutches to sticks was a recognised progression, as were the exercises prescribed by the physiotherapist. I could see new patients going through the motions by which I had been introduced as well as more progressed patients practising the skills that I would rehearse. The visibility of recovery is important to patients receiving treatment for myelitis and related conditions such as the Guillain-Barré syndrome⁴; it affirms the doctors' assurance that deterioration is a normal first stage and that tangible improvement will follow.

Confidence in one's doctors and in the prognosis of improvement is enhanced rather than diminished by a full appraisal of possible consequences. My recovery, I was told, might take two years; that seemed a long

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time but at least it convinced me that the doctor was not softening the message. Similarly, he did not exclude the possibility that multiple sclerosis might be the cause of my condition and that therefore it might recur.

By contrast, nursing staff and physiotherapists contributed to the positive ethos of the hospital in a much more effective way. Physiotherapists behave like teachers and heavily reinforce progress and achievement, while nurses visibly rejoice in favourable changes in patients' conditions.

Possibly the most apparent threat to patients' morale is the death of a fellow patient, which is likely to be perceived as a failure. Death was the fate of a man in the bed next to mine in the intensive care unit. The close family who had kept watch left the unit. The curtain was drawn round my bed. I heard the squeak of the trolley as it came and went. The curtains were opened again. Death was kept a private matter and the nurses cleverly parried inquiries about patients who had left the ward for operations. Some nurses preferred to refer to the intensive care unit euphemistically as the recovery ward, with which it was also accommodated.

There was, then, a studied ambivalence among professionals within the hospital. On the one hand, candour was used in medical consultations to induce trust and confidence. On the other, physiotherapists employed an infectious optimism, which was shared by nursing staff, who went a stage further in protecting patients from potential sources of discouragement.

Dignity

In his essays on mental patients and other inmates, the American social scientist Erving Goffman recognised a systematic programme of induction into hospital life, in the course of which patients are estranged from the identities they enjoy in the outside world.⁵ Goffman attached a negative value to this process and talked of it as a betrayal. The effect is to detach the patient from the experiences for which he or she would normally feel responsible. There are plaintiff references to this process in the patient accounts of Eileen Fairhurst, who thought that the procedure adopted for her lumbar puncture left her "depersonalised,"⁶ and of Rosemary Firth, who noticed that a group of students discussed a patient Mrs A "in an astoundingly impersonal fashion" and judged the lecturer's bedside manner as "execrable."⁷

I recognise in my own experience a programme of depersonalisation but attach to it a positive rather than negative value. My ordeal as a patient was certainly happier than that of either Fairhurst or Firth, and several factors may have contributed. Firstly, possibly as a man or because of my personality I was less sensitive of examination, exposure, and unbecoming postures. Secondly, such was my immobility in the formative stages of my relationship with the institution and such my incapacity to wander out of bounds and so absolute my dependence on medical and nursing care that I became much more compliant to authority than my professional colleagues would have thought possible: by comparison, most patients attending for tests or observation and so on are free to be restless. Thirdly, it was apparent that the institutional arrangements were more consultative and awareness of patients' anxieties greater than in the hospital experienced by Rosemary Firth: happily, the reported procedure and execution of her lumbar puncture were not adopted for my own.

There were, however, several instances during my stay that had the potential for indignity. For the lumbar puncture and myelogram I was dressed in a short white buttonless gown, white stockings, and paper pants: the sartorial style was that of the Sugar Plum Fairy. I was placed on a table seven inches too short for me, injected, and tilted upside down until the dye ran from my lumbar to my dorsal region. I lay in bed and was wheeled around with catheter dangling and urine bag alongside, visible to the visiting world. I was four times dropped on the floor. When the time came for me to be taken from the bed and put into a wheelchair my legs hung pathetically like wet spaghetti. I quivered and squawked for all to hear when, after a day of attempts to force water through my bladder, I was recatheterised. Often I would be sitting on the loo and somebody would come in to empty the waste paper bin or collect the hoist. After a fortnight without bowel motions they undertook the desperate remedy of aperients and suppositories. And when a motion did come naturally it occurred while I was in the bath.

VALUE OF THE IMPERSONAL

Had I foreseen these experiences that which I should have feared most would have been the bowel action in the bath. Yet the significant point is that none of the experiences was as horrendous in the context of a patient career as it would seem to someone in the world outside. Something happens to neutralise the experience and to render it less embarrassing. Even with the bowel action in the bath I found it appropriate as ever to thank the nurses who came to my help but inappropriate to apologise. Their explanation that no embarrassment was incurred was in terms of the absence of previous

acquaintance: "It is not as though you really know us." This was the orthodox interpretation, which apparently accorded with their training, and there were attempts to sustain professional distance, as by the use of formal styles of address, though these lapsed early in my case. I could not discern in nurses' interaction with patients anything as systematic as the defences which Joan Emerson observed in her study of gynaecological consultations,⁸ but it was a small hospital and some relaxation of the norms of professional behaviour was afforded.

My own interpretation of the episode in the bath, however, is in terms not of professional distancing but of conditioning to routine. In response to my call "There's a bowel action, nurse" there arrived together a staff nurse and an auxiliary. On reflection, my words suggest to me that I had already internalised the spirit of depersonalisation, which I am shortly to commend. Staff nurse then turned to the auxiliary and said, "Okay, can you get a bedpan, and I'll lift the hoist. Just keep your hands out of the water, Roger." Thereby, within seconds of my call responsibilities had been allocated to each of the three participants. That there was a standard procedure which did not have to be planned in my hearing signified to me that this was a routine occurrence and that I had somehow been prepared for it by having been seen on the loo before by routine visitors. My emotional unease was alleviated by the promptness with which the trauma was managed. The situation was under control, even if I was not. I felt no need to apologise because I did not feel responsible. They had been working on my bowel and now it had become capricious: that was not my fault but the bowel's fault. Hence the very detachment of soul and body which is viewed with disapproval as the process of depersonalisation had been the means of sustaining my dignity.

It is as a vital if unintended part of this process that we may interpret the detached behaviour of lecturers and consultants which so offended Rosemary Firth. The consultant's visit is depicted faithfully in Rembrandt's painting *The Anatomy of Dr Tulp*, in which the focus is on an undraped corpse. Dr Tulp is distinguished by his demonstrative gestures, and his junior colleagues or students look on in awe and deference. The one passive party is the patient, who can eavesdrop if he wishes but is unlikely to understand. In my time I have found it easier to develop rapport with the sentries who guard Lenin's tomb than I have with hospital consultants. In the hospital from which I was referred students were chided for arriving late and missing "a very interesting forty one year old gentleman," but it was not until some time later that I learnt what was interesting about me. To complain that this style is impersonal, however, is to miss the point that it was a valuable function in inducting the patient in a domain in which depersonalised relationships are the means of his survival in the vicissitudes of hospital life. The consultant's ward round, with all its celebration of hierarchy and taboos on personal interaction, is, as Joan Emerson observed in her study of gynaecological consultations, governed by clinical definitions of the relationship.

The deference which medical subordinates show to the consultant on the basis of his experience and standing and the authoritarian style in which medicine is practised are in contrast with more democratically organised spheres of knowledge such as the social sciences, in which consensus is not so much sought as avoided and in which deference is thought unhealthy. It is the conflict of epistemological disciplines that is perhaps signified by the antagonism towards hospital systems evident in the work of Fairhurst and Firth.

Discontent

There were two principal items of potential dissatisfaction for patients as consumers; these were the quality and variety of food and the responsiveness of nursing staff and auxiliaries to the expressed needs of patients. In neither sphere was dissatisfaction expressed by more than a small minority. Customer satisfaction was a matter of tension between two communities of patients, the "contents" and the "not contents." Both groups had fluctuating memberships; seldom would the attendance at one meal table be the same at the next. A newcomer to ward or table would be introduced not only to the routine but also to what was considered to be the appropriate attitude towards the arrangements. The night I was brought in I was settled into bed, given a cup of tea, and curtains were drawn, other patients kept a distance, and the registrar and nurses came to see me with tendon hammer and routine questions, respectively. When the coast was clear two of the more conscious and mobile patients came to introduce themselves and the ward. I was told that we were all well looked after, the nurses were informal and kind, the medical staff were great professionals, and so on.

At the meal table, too, normative attitudes were rehearsed before newcomers. If the particular meal was below par reference was made to the two roast meals provided each week. There were comments intended for the hearing of new patients, such as "I always enjoy the soup" and "These celery hearts are tasty." There were in my time two patients who were in the habit

of leaving much of their food and in both cases other patients would notice and either plead with or reprimand them. One of the most dramatic instances of the power of the majority group at the meal table concerned a man who rejected his meal with, "I told them no fish. No fish I told them." There persisted from others at the table a chorus of approving noises about the meal until he too ate his fish; and at the end of the course he commented, "Well, that's the best bit of cod I've had for a long time." So it was also that one patient who announced that she was going to write a letter of complaint about the meals found no supporters and the letter was never written.

Similar consensual norms prevailed in respect of what constituted a sufficient cause to press the bedside button and call a nurse. It was common for patients to announce to others their needs before pressing the button; for example, a patient might say, "I think I'm going to need a commode" or "I wonder if they'll give me another painkiller yet." These would then be informally screened. If it was only a case of a water jug that needed filling another patient might say, "They'll be round in a minute with tea." It was the general view that nurses were conscientiously responsive to calls and that this standard could be jeopardised only by abuse. So powerful was the influence of the patient group that embryonic complaints seldom survived gestation.

Conclusion

There are three observations running through this account which are worth pointing up by way of conclusions having a bearing on medical sociology. Firstly, there is an antipathy between sociological and medical norms regarding the status and prestige of experienced professionals. The most fleeting observation of a consultant's ward round shows medicine to be the more hierarchical and authoritarian. Observers accustomed to more democratic relationships are adversely disposed to this practice and to the

regulation of the system which it symbolises. Sociological observation not grounded in the rationale of medical practice tends to be negative in its evaluation. I suggest that medical practice should not be judged by its failure to conform to norms prevailing among social scientists.

Secondly, I believe that there is a case for the depersonalisation of patients as part of a coping strategy. It is achieved systematically and serves the disabled patient in settings that would otherwise be perceived as compromising or embarrassing.

Thirdly, the role of the patient population as an agency of social control is important. The patient group operates most effectively in the control of dissent and in the marginalisation of potential dissidents. The effect of this is to purify the role of the nursing staff, whose responsibility for care is unadulterated by conducting public relations with patients as consumers.

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Clinical Algorithms

Urinary frequency and urgency

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Definitions

Diurnal frequency is the passage of urine every two hours, or more than seven times during the day.

Nocturia is the interruption of sleep more than once each night because of the need to micturate. It is common to void during the night when sleep is disturbed for other reasons—for example, insomnia or lactation—but this does not constitute nocturia.

Urgency is a strong and sudden desire to void which, if not relieved immediately, may lead to urge incontinence.

Incidence and causes

Frequency and urgency are common symptoms which often coexist and may occur with other symptoms, especially incontinence or dysuria. It is unusual for urgency to occur alone because

once it is present it almost invariably leads to frequency to avoid urge incontinence and to relieve the unpleasant symptom.

About 20% of adult women suffer from frequency of micturition and 15% have urgency. There is a slight increase in the incidence of these symptoms around the time of the menopause.¹ The incidence of nocturia increases with age, and women over the age of 70 normally have to void during the night.

The table shows the more common causes of frequency and urgency of micturition.

Common causes of frequency and urgency of micturition

Excessive drinking	Genital warts
Habit	Bladder mucosal lesion (eg papilloma or neoplasm)
Anxiety	Bladder calculus
Urinary tract infection	Urethral caruncle
Urethral syndrome	Urethral diverticulum
Detrusor instability	Radiation cystitis or fibrosis
Pregnancy	Upper motor neurone lesion
Cystocele	Impaired renal function
Pelvic mass (eg fibroids)	Diabetes mellitus
Small bladder capacity	Diabetes insipidus
Urethritis	Hypothyroidism
Chronic retention of urine	Congestive cardiac failure (nocturia)
Diuretic treatment	
Previous pelvic surgery	

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