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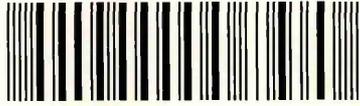
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RISK AS THE KEY CRITERION FOR INTERVENTION? A STUDY OF FOUR PSYCHIATRIC SETTINGS

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Viewing 'risk' in a Foucauldian sense makes 'risk' like 'power' productive. Its attempted eradication multiplies it: as we evade it, it encounters us at every turn. We live with it and within it. Our bodies carry its mark(ings) as we become 'always at risk'. In these processes, as we attempt to evade risk we learn to doubt such possibility. Doubt, rather than knowledge, becomes the discourse of the 'self' as subject. (Calas 1999p.692)



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ABSTRACT

Risk management has become one of the major issues facing nurses. Its role in healthcare organisations has gained increased recognition as the consequences of risky decisions have become more visible. The project was primarily concerned with exploring issues that confront one particularly group of professionals – psychiatric nurses – as they experience a particular approach to risk management. The study used the advancement of the risk management agenda as an opportunity to examine the nature of risk management and consider what nurses understood to be the nature of a proficient risk management. Case studies analyses were provided of four psychiatric units. Data were collected over four years through observation, interviews and documents. It used an integrated approach to examine the development of risk management processes in its social, environmental and clinical contexts. Drawing on sociological theories of risk, it introduced the theoretical framework of arena concept and explained how this concept affect the decision making process. It was suggested that the decision making process is a social process in which regulative, normative and institutional effects influence the perceptions and management of risk. The processes were shown to involve a dynamic interweaving of certain structured interests mixing with both clinical and societal considerations inside and outside the healthcare settings. Risk was considered to be the outcome of a complex process of social construction comprising of cultural and political elements in which both the influence of institutions and individual evaluation can be discerned. The findings showed that psychiatric nurses presented a creative and critical understanding to the issues involved in risk management by adopting and absorbing new approaches to risk

management in order to advance their professional work. This study formulates a new conceptual framework of understanding risk management in organisational context and contributes by drawing together previously unrelated research and shows how it provides the basis for a theoretical model risk management that is more complete.

CHAPTER ONE

INTRODUCTION

We have seen the emergence of a notion of risk as way of making intelligible and manageable a whole series of difficulties in our contemporary experience, from those of organisational management, through loss of work, ill-health or criminal victimhood. The language of risk is indicative of a shift towards a logic in which the possibility of incurring misfortune or loss in the future is neither to be left to fate, nor to be managed by a providential state. Problems previously understood in other ways are recorded in the language of risk. New zones of intervention become visible and 'risk management' is added to the responsibility of individuals and authorities. Understood in this sense, the notion of risk enables us to highlight a number of related features of the contemporary vacation of psychiatry. (Rose N 1996 p.13)

Mental health professionals increasingly are required to justify risk management strategies and to ensure that standards, procedures and protocols have been carefully followed and documented (Dent 1997; NHS Executive 1994; NHS Health Advisory Service 1994; Royal College of Psychiatrists 1996). The Nursing and Midwifery Council (NMC) -the new regulatory body that has replaced the UKCC (United Kingdom Central Council for Nursing, Midwifery and Health Visiting) - is contemplating including a new clause on indemnity insurance in the Code of professional conduct that provides financial compensation in respect of a practitioner's failures and/or omissions. In a piece "Indemnity insurance: a matter of trust or a compulsory requirement?" (MNC News Summer 2002 p8) it declares that: "Under this option, a practitioner could not register or re-register with the NMC unless they had professional indemnity insurance cover or could prove that their employer provided vicarious liability for them. The simplest way to effect this option would be for practitioners to self declare that they had indemnity insurance and to provide proof of this cover if required to do so." Prominence is being given to actuarial or statistical techniques to risk management as a response to the

evidence of the limitations of the predictive ability of clinicians (Monahan 1997; Monahan & Steadmann 1988). Risk decision making approach within psychiatric nursing is not a recent development. There is a long history of using risk technologies in psychiatric nursing interventions for example, the use of devices such as a strait waistcoat and restraining chair to control patients. So in many instances, what are portrayed as new risk technologies mainly entail new labels for established technologies and practices. Notwithstanding this lineage, there are new and fundamentally changing dimensions of contemporary society to argue that risk has become the key decisive factor for nursing intervention.

Risk assessment and risk management are central to patient care with front-line professionals increasingly aware of their accountability for, mistakes in, assessing and managing patients. Described as a “vogue” both clinically and politically (Vinstock 1996), Davison (1997) notes that risk assessment is an important, integral and unavoidable part of clinical practice whilst Webster et al (1994) point out that it as an expanding responsibility for mental health professionals. Thus, there is expectation that health professionals should be able to assess risk and take the appropriate action (Duggan 1997). Rose (1996 p.15 emphasis added) echoes this observation by his assertion that risk management “is a challenge to each individual professional rather than to the abstract rational qualities of some overarching system. Risk management – the identification, assessment, elimination, or reduction of the possibility of incurring misfortune or loss – is to become an integral part of the professional responsibility of each expert: government of risk is to take place through *a transformation of the subjectivity of each professional*”.

What is the significance of the concept of risk in the organisation of mental health professionals? Do the system-wide procedures, driven by management-based reforms that demands efficiency, control, standardisation and codification of knowledge erode the need for discretion and the deployment of tacit knowledge and specialist expertise or are they going to be accommodated by professionals? Has the phenomenal spread of risk management permeated the social life of psychiatric nurses?

The study explores how nurses construct understandings of risk analysis as it affects their lives as individuals, professionals and organisational members (McAuley et al 2000). It probes how psychiatric nurses make sense – that is, understand and share understandings about assessing and managing risk, what issues and problems their organisations face and how these problems and issues are resolved. This approach to sensemaking refers to the processes of interpretation and meaning production where actors reflect on and interpret risk analysis and produce intersubjective accounts (Weick 1995). Rooted in the interpretivist concept, sensemaking sees risk analysis not as an objective phenomenon, but instead enacted through the social construction and interaction of information processes of actors (Berger & Luckmann 1966). This is in line with the interactionist perspective which emphasises the central place of interpretation in social life and argues that social problems cannot be understood in terms of “objective” social factors rather such problems are rooted in the “processes of collective definition” (Blummer 1971 p.298). From this stance, I argue that responses to risk management strategies are shaped and reshaped as a result of ongoing activity by different professionals groups. An interactionist approach, which will be developed in chapter four, implies seeing risk management strategies as problematic where risk management

interventions emerge out of a set of negotiations among relevant actors and are always subject to further negotiations.

Such a paradigm contrasts sharply with the rational and calculative view of risk analysis, which has dominated social science research. Risk analysis is driven by scientific and technical consideration and combines risk assessment and risk management (Short 1984); where risk assessment is the process of estimating a risk to determine whether current risk strategies are appropriate and adequate and risk management as the process of ensuring that risks are managed in the most efficient and effective way (Waring & Glendon 1998). Risk analysis has been presented as a technical procedure which can be undertaken through simple sequence of steps – that is through rational calculation of ends and means (Department of Environment 1995). Within such a situation, all risk could be predicted so that accidents are minimised or prevented (Johnstone-Bryden 1995). With little research, standards have been offered of how risk can be identified and managed. In the words of Norman (1997 p.87), “The standards set for nurses are existing tools which should be integral in any risk management strategy. Their utilisation cannot wait for research findings.” Thus without knowing the relative value of risk management (whether indeed it controls or reduce risk) nurses are being asked to adopt these standards which contradicts the call for evidence-based practice. In a word, much of the literature makes the assessment and management of risk non-problematic. My quarrel, then, with most mainstream approaches to risk management is that little attention is given to the social, political and economic contexts leaving us with a somewhat flat one-dimensional view of the concept that fails to grasp the richness and complexity of healthcare organisations in the current period.

Indeed, literature on investigating the effect of guidelines on the practice of clinicians suggests that compliance is often low (Grill & Lomas 1992; Glynn et al 1997; Mayor & Eaton 1992). Caper (1988) found an unsatisfactory response to implementation of protocols by American doctors because they resented the imposition into their clinical autonomy. This observation echoes UK's Department of Health report on the use of chemicals in food which questioned the routine use of quantitative risk assessment for chemical carcinogens and concluded that "This is because the present models are not validated, are often based on incomplete or inappropriate data, are derived more from mathematical assumptions than from a knowledge of biological mechanisms and at least at present demonstrate a disturbingly wide variation in risk estimates depending on the model adopted." Difficulties in deploying risk assessment have been noted by a number of studies. Clinical assessment of risk of violence has been criticised for its poor accuracy (Litwack et al 1993; Monahan 1981, 1988). McNeil and Binder (1991) found that there was over prediction in overall rates of assaults. Mullen (1997) noted that whilst risk prediction is reasonably reliable in the medium term, it is less so in the long term.

So whilst clinical risk assessment has facilitated much debate within psychiatric nursing and has become one of the major issue facing nurses (Hollin 1997 Monahan 1997) there are differing viewpoints. Thus although Woods et al (1999) portray a therapeutic approach to risk, Rose (1998) argues that the language of risk is more about control than care. Crighton (2000) points out the lack of structure in the approaches to both risk assessment and risk management. Moreover, empirical data on the performance of professional risk assessors does not inspire confidence. Monahan's (1981) review of five major studies noted that psychiatrists

and psychologists were accurate in no more than one out of three predictions of violent behaviour. Kettles et al (2000) in a study to identify the nature and extent of current risk assessments in use within forensic psychiatric settings revealed the variety of instruments in use. Though every organisation was attempting to use some form of clinical risk assessment, there was little uniformity. Many of the organisations have or were developing their own forms of risk assessment that have some basis in research evidence. Others were using some form of tool or instruments that did not have a research background. The implication of the study was that there was lack of consistency of views for inclusion in the types of risk reviewed. This evidence has shown that there is much work to be done on how clinical risk management is utilised to the best advantage for both patients and staff. Given that risk assessment is prevalent within psychiatric nursing, it is appropriate to ask what might impinge upon risk management that are currently in use. This growing recognition of the shortcomings of risk assessment techniques has not been accompanied by a sociological research concerned with how psychiatric nurses both as individuals and in groups, used various tools and techniques. We have relatively little understanding of the ways in which clinical practice guidelines are used within the developing course of practical activities; still less of the ways in which they feature in interaction and collaboration between professionals. This analysis suggests a need for a rigorous, empirically based approach to risk management in the area of mental health.

This study rather than focusing on how the choice of particular risk strategies leads to more or less optimal performance explores the process of risk management by analysing how in one environment - a management technology - risk management was received and made to perform in four psychiatric settings. The

emphasis is on studying the process's construction and investigating how meaning emerges and changes in organisational settings (Czarniawska 1997). The contention is that people make sense of organisational events and organisation by inventing new meaning for occurring organising processes so creating "frames of reference" (Weick 1995), or "patterns of meaning" (Porac et al 1996). The research focuses on organisational actors and the meanings they construe as they interact with their environments. The interpretative sensemaking process seeks to identify theories of action that guide nurses' decisions and behaviours (Hedberg 1991). The approach embraces Weick's (1995) ideas of interpretive constructivism. First, that maintaining and establishing identity is the most important property of sensemaking because definitions of what is self and what is "out there" is constituted in social interaction with others. So that identities are continually defined and re-defined in social encounters displaying situational elements in the representation of self. Second, sensemaking is on-going acts of communication in which individuals continually re-negotiate what is the organisational reality in social interaction. Past experience embedded in frames of reference meets with present experience, triggered by "cues" extracted from on-going organisational events to produce inventions and interpretations of reality. Therefore, collective sensemaking and the development of shared meaning are processes exemplified by actors trying to make sense of common experience, interpreting the importance and contents of cues differently because they may not necessarily share the same frame of reference.

The study follows the approach that addresses the socially constructed and historically specific character of the conceptualisation of risk and its management. A cautionary warning must be made in advance. In following social constructionism I am not advocating idealism of which more in chapter three. I am claiming that

there is room for variety of interpretations and meanings and that behind risk knowledge are social processes and that such processes involve negotiations and conflict, both overt and implicit. Here the material world is constantly shaped and interpreted through human actions and consciousness. Indeed, it has been argued that experts, policymakers and individuals operate in a social context that influences how they construct their views of risk issues (Douglas 1992; Schwarz & Thompson 1990; Wildavsky & Dake 1991). Others also argue that the public and expert values inevitably influence risk assessment (Jassnoff 1986; Wynne 1991). Worldviews and interests can influence how issues are framed and how risks are perceived. The context of risk entails more than just expert assessments of the probability and the harm of an activity: work on risk perception shows that risks are multidimensional and that the public perceptions are related to among other factors whether risk is voluntary or controllable (Slovic 1987). Moreover the public has become acquainted with rights, standards and expectations from healthcare as part of the Patients Charter Initiative. Additionally the changing public perception recognises that professionals are not infallible in their decision making processes and is more likely to seek litigation as a source of redress against untoward clinical incidents. Nurses therefore may be in a complex, ambiguous, shifting and contradictory field of risk management in relation to other actors - theoretical argument about risk issues will be developed in the next chapter. This shows that the context within which nurses think and act is determined not only by administrative, informal rules of professional culture, but also by the risk decision rules, formats, and technologies by external influence. In other words, the external risk decision criteria, limits the discretion and autonomy of nurses. I argue further that the role of nurses as risk managers may change the way in which they provide care to patients; the traditional

focus on welfare is supplanted in favour of a focus on risk surveillance and security. I do not however, see nurses as passive but active individuals who have the choice when positioning themselves in relation to various discourses.

The study opens up the possibility for re-conceptualising taken-for-granted aspects of practice of risk management and the taken-for-granted understandings of risk. It has three potential contributions, first, the stress on subjective meaning of risk decision making to all categories of participants, the many negotiations which transpires within and around interventions, the ever changing nature of services has the potential to deepen our understanding of the face-to-face encounters between relevant actors within risk management context and offers a framework with which to make sense of these observations. It may also enable us to think harder about processes and interactions that are regarded as unproblematic. Finally, in a more macro-sociological sense, the project can enrich our understanding of the larger social role played by other actors in the decision making process. Seemingly disparate events can be seen as part of a larger pattern in clinical practice.

The chapter is organised as follows. The first section briefly reflects on the various issues and theoretical perceptions/perceptives within contemporary debates on risk and provides a rationale for the particular stance taken in the studies. This sets the stage for the next section recounting the reasons for the recent interest and responses in risk management in mental health services. In the discussion that follows it highlights how risk management strategies may contribute to the reconstruction of identity and plays into the existing modes of psychiatric nursing.

Background of the Study

It is virtually impossible to move around healthcare settings without hearing nurses talking about risk. It is argued that in the world of mental health

professionals, risk analysis (combination of risk assessment and risk management) has become or rather becoming the organising concept that gives meaning and direction to clinical practice; with the language of risk taking over from that of need or welfare, in which risk analysis and monitoring of risk and risk taking are becoming the rationale and the organising principle of mental health organisations (Rose 1996). Risk related discourses and strategies are seen to have taken key roles in the decision making about patient care (Dean 1997). As Castel (1991 p.289) reminds us the “modern technologies of prevention are overarched by a grandiose technocratic rationalising dream of absolute control of the accidental, understood irruption of the unpredictable.”

The category of “at risk” currently underpins crucial aspect of health policy documents. The notion of “risk” has become woven into the fabric of patient care, where patients can now be measured against graded and cumulative sets of *factors*. The effective practitioner is supposed to identify, assess, calculate and reduce risk. The domain of the “risky” and “at risk” becomes the space for the multitude of professionals organisations, in which the notion of risk reshapes the obligations of psychiatric professions. Rose (1996) argues that risk management and risk reduction as logics for professional action, have come to supplement or replace other forms of professional action and judgement. This can be seen in situations where the management of everyday life of the patient has taken prominence over clinical judgement and the logic of prediction has taken over patients’ likely future conduct. For example, under the draft Mental Health Bill currently out for consultation, people with severe personality disorders should be placed in secure mental health hospitals to prevent them from committing crimes. This is an invention of a psychiatric diagnosis “dangerous and severe personality disorder” referring to

people with severe personality disorders who pose a serious risk to the public without a research base. There is therefore the defining of mental illnesses by the effects that an individual has on our society rather than the problems of the patient. It seems patient care within this rationale has reconfigured the organisational form of psychiatry to containment for the “risky” until their risk can be fully assessed and controlled. Psychiatric care from this stance, attempts to address administrative questions about what is to be done with patients and how decisions are to be made in response. This observation indicates a shift in the rationalities underpinning the government of mental pathology and mental health and it is reasonable to argue that this may lead to a subordination of the clinical to the administrative function of expertise. Ericson and Haggerty (1997) in the “Policing the Risk Society” suggest that orientation to risk alters the structure and practice of police organisation. In particular, that orientation led to a preoccupation with the collation, collection and dissemination of information for the purpose of risk management. Perhaps we can argue that the functions of social protection previously associated with psychiatry may be reconfigured in somewhat similar terms. This development is illustrated in the increasing emphasis on keeping records, sharing information, making plans, establishing networks for the surveillance of patients, case conferences and multidisciplinary teams.

Psychiatric nursing contexts have changed dramatically in recent years as social, cultural, and economic factors have modified the resources tools in their lives. The experience of organisational life for nurses and most professionals is characterised by monitoring of tasks, extensive use of financial targets and controls, standardised packages, audits and assessments. Thus nurses cannot possibly remain untouched by their contexts. Just as their contexts are shaped by their presence,

nurses and their contexts mutually constitute each other. To portray the richness of nurses lives across the many contexts in which nurses find themselves require a careful analysis of the relationship between the local and the larger societal contexts, power/knowledge relations and the contemporary circumstances in which they are embedded. My emphasis of attending to the process of doing interpretation in a cultural-historical framework requires attention to the fit between the local situation within which I was immersed and the larger picture. This means that in addition to the systematic observing and listening that constitute fieldworks it will be useful to focus on the broader contexts that comprise the lived experience of nurses.

The contextual perspectives taken in this study suggest that a setting is best thought of as a complex web of personal and temporal interactions that make up everyday life. Settings are not static entities to be captured by a sense of descriptive variables but instead are fluid and dynamic, constantly reconstituting themselves within activity and are inherently social, reflecting and framing interaction. Geertz (1973 p.360) encapsulates this observation neatly. "Human thought is consummately social – social in its origins, social in its functions, social in its forms, social in its applications." Therefore as we begin with a unit of analysis that includes the individual and his/her culturally defined environment we must remember that individual action is generated out of social interactions and the meanings they create. As noted by Geoffrey et al (1994 p. 277): "These patterns of interaction become recursively recreated over time and ultimately become shared knowledge. This shared knowledge is then used by organisational members to make sense of past experiences and provides a framework for interpreting situations and deciding present and future actions. In other words, whilst the interplay between

individual sense-making and group discourse is complex, it is also critical to an understanding of how reciprocal patterns of influence are formed and reconstructed within organisations.” This means that individual action is generated out of the social interactions and the meanings they create.

The discussion so far suggests the need for studies to locate nurses’ experience in specific cultural and historical contexts. Implicit in such an approach is the understanding of caring practices through narratives about real life experience in meaningful contexts (Benner 1984). This provides a locally grounded perspective on the experiences of particular individuals that can then be linked to other descriptions. The consequence of this perspective can be a rich narrative that is at once general and particularistic, broadly focused while thickly descriptive (Geertz 1973). Getting at what it means to be a nurse in today’s society requires that we explore how clinical practice is viewed both by nurses and by the larger culture. Societal views of clinical practice are part of the cultural-historical context within which nurses exist. What does it mean to be a nurse in a culture with many competing and contradictory views of who nurses should be? Because nursing is a continual construction, it must be viewed from many angles to be understood. However in traditional research on nurses, little attention is paid to the social, political, and economic contexts of health and healthcare.

In this study, I make the case for orientation to caring practices that are particular, historical, contextual and societal in nursing inquiry. If it is important to study in context, it is particularly important to study psychiatric nurses in context. Frequently psychiatric nurses are placed into contexts over which they have no control, are constantly challenged to develop competences in settings and are continuously under watchful eye of society. As mentioned above, it is not to say that

nurses are powerless. Clearly, they resist directives, are able to invent within environmental-created contexts, their own contexts.

Risk discourse has gained a dominant focus on contemporary life as the consequences of risk decisions by organisations have become more visible. Giddens (1991; 1994) concept of 'reflexivity' of modern social life notes how our lives have been enveloped by constant monitoring of risk that pervades our sense of how to manage ourselves in the world. Luchmann (1993) observes how our world is obsessed with risk and for Beck (1992), the 'risk society' is a new and different modernity in transition from the industrial society where people are constantly aware of and anxious about environmental risks to human health. Douglas (1990 p2) has characterised the idea of risk as a "central cultural construct" of our time where "health risks seem to loom around every corner, posing a constant threat to the public" which continually make headlines in the media and increasingly the topic of public communication campaigns. Indeed this fascination with risk is reflected through the media reporting of and public and professionals' response to cases such as; bovine spongiform encephalopathy (BSE or mad cow disease), the threats from ebola virus, climate change of the ozone layer, E.coli contamination of meat, cases involving water quality and toxic waste, the release of known paedophiles into the community, the failings in paediatric cardiac surgery in Bristol and failings in cervical screening programme. In this context, risk has been conceptualised as a social state engendered by an increasing lack of trust in both the project of modernity and expert knowledge (Beck 1992; Giddens 1991; 1994).

Mental health organisations are faced with unique set of problems when dealing with issues of risk given that they are often both regulator and risk generator, and the fact that no other organisation is organised so centrally around

the issue of safety. When patients encounter the psychiatric system, clinicians intervene using technologies, which may carry with them their own inherent dangers, which unlike general medicine, may result in suffering of the general public and staff. The mental health profession currently faces some of the greatest challenges to its credibility it has ever encountered. Until the past few years, when patients were kept in large remote institutions, the institution was the focus of formal inquiry when mistakes were made. Changes in society as noted above have resulted in a dramatic development of public awareness and expectation in terms of clinical practice. The public now has a far deeper insight into errors in treatment or clinical judgement through the media and as a result come to expect rather more of their clinicians than has been in the past. Consequently, there is now a requirement that a formal external inquiry (there were around 40 such inquiries by early 1996) is held in any situation in which a patient with psychiatric disorder commits a homicide focusing on decision making by individual clinicians. A cursory look at those patients who have killed illustrates this observation; Christopher Clunis killing Jonathan Zito, Dennis Archer who axed his wife to death and then killed himself, Rodney Rollins killing his father and Andrew Robinson killing Georgina Robinson (no relation) after being taken in and out of community care. These unfortunate cases have led to demands that practitioners are more vigorous and methodological in their decision-making, which is especially true for patients who pose risk to themselves and others.

It is now assumed that improvements in practice and therefore outcomes for patients could possibly be achieved if research evidence (the development of clinical practice guidelines to assist practitioners) on health care interventions from well-conducted studies was carefully identified and utilised by practitioners

(Grimshaw & Russell 1993). This focus towards evidence-based practice could change our understanding of clinical risk because it challenges the traditional legal definition of clinical negligence as specified in the Bolam test (Bolam v Friern Hospital HMC 1957). In the Bolam test, a practitioner is not guilty of negligence if his/her intervention was based on accepted practice in the field. Such a normative definition of negligence placed reliance in court on the testimony of respected clinicians acting as expert witness. This is however problematic. In cases where two sets of expert witnesses (plaintiff v defendant) have different clinical opinions, it may be difficult to prove negligence as each apparently represents a legitimate body of clinical opinion. The changing nature of legal definition of clinical negligence is illustrated in one recent case (Bolitho v City & Hackney HA 1997) where the House of Lords ruled that courts had to be satisfied that exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. Therefore in the future, we can expect point of views about clinical negligence to turn more on evidence and less on opinion. Without a doubt moving from a normative to an empirical definition of negligence may widen the scope for such actions considerably. For instance, where evidence on the effectiveness of health care interventions is at odds with common clinical practice, successful legal actions could be, launched by patients. In other words, the move towards evidence-based practice may redefine negligence and risk in healthcare in much broader terms that may require a new approach to risk management.

The phenomenal rise of risk management discourse can be seen as the latest of many management fashions used for constructing realities (Brunsson & Olsen 1993) or schemes for “sensemaking” (Weick 1995) by mental health nurses. Discourse is used here as a set of language patterns, including rhetoric, making sense of practice,

thoughts and actions which are forms of life for practitioners. The way that discourse is used impacts on the thoughts and actions of individual actors and groups and is self-generating in directing perception, concepts of what is admissible fact. Actors within the discourse are both caused to think and act in certain ways because of it, and also contribute to the ongoing construction of the discourse. As a result language and action cannot be regarded separately but are intertwined and mutually causing (Bakhtin 1981; Fairclough 1992). It is important to note that a discourse does not constitute a single coherent knowledge of practice, but rather, is formed by many acting often in conflicting ways (Foucault 1972). The same discourses in different places may have contrasting effects. Therefore risk discourse may be dominant in policy deliberations and clinical arena, but such discursive dominance will produce different problems and practices for nurses in different locations. Nurses' lifeworlds and histories will mean that they heed the essence of risk management discourses in different ways and apply them differently in their clinical practice. Within this particular analysis, transformations in risk management practice are seen as the outcome of the interplay of various socially and historically situated discourses and practices which may have had, and continue to have, unforeseen and unintended consequences. This means that a discourse can be regarded as located within a broader milieu of social-cultural and historical meaning and so extend beyond its context.

Following Watson (1995) risk management can be regarded as a "discursive resource" because it is a linguistic pattern, which is used to make sense of identity and activities and a set of processes in which meanings, and interpretations are made and socially negotiated. This suggests that rhetorical strategies and linguistic conventions play a formative role in guiding how people interpret situations and

construct versions of experiences. Thus it is contended that discourse is the essence of the change process since it is through patterns of discourse that relational bonds are formed and structures are created and maintained. Through discourse, individuals co-create and form their social reality in a sense where utterances are practical forces in determining and negotiating of meaning within organisations. In this sense, it may be useful to think of the concepts risk assessment and risk management as steering devices that allow organisation members to coordinate ongoing relations with one another, where meaning making is shared (Wittgenstein 1968). A vital premise of this argument is the unfixed position of meaning. The conventional meaning of a concept does not determine how it will be applied; meaning is never final but always postponed in relation to other terms that are evolving themselves, and developing meaning through new applications that transform the structure of interpretive assumptions thus repeatedly extending the confines of their existing applications (Derrida 1978; Wittgenstein 1968). But why is this discourse risk attaining prominence?

The Emergence of Risk Management

The impetus for introducing risk management techniques in the NHS is consistent with the 'hegemonic' ideological changes that began in the 1980's. Risk management has been a key element in the introduction of what has become known as the "new managerialism" or "new public management (NPM). The focus on NPM approaches includes establishing performance measures, classifying objectives, standardising practices through mechanisms such as clinical pathways, guidelines and protocols, formalising accountabilities via markets and formal purchasing contracts, providing financial incentives and consumer empowerment, and application of private-sector management styles (Dunleavy & Hood 1996;

Ferlie et al 1996; Hunter 1993). Rise in health care costs and demand for health services from the mid 1970s coupled with cash limits led to the emergence of NPM in the NHS. Thus NPM is concerned with cutting costs and doing more for less as a result of management techniques and structural changes. The NHS is facing unparalleled expectations for high quality, safe and timely care. Patients now have more effective mechanisms for registering complaints if these expectations are not met. The changing public perception recognises that professionals are not infallible in their decision making processes and are more likely to seek litigation as a source of redress against untoward clinical incidents. The management of risk is now synonymous with reduced monetary costs to trusts and it has become imperative that change is effected to reduce the likelihood of error and the associated costs to the health service. The concept of risk management has been characterised as a reduction of risk in juxtaposition with a desire to increase client satisfaction and care (Macdonald 1994; East 1995; Wilson 1995). Within this environment nurses are professionally accountable for their practice and risk management strategies (UKCC 1992). These challenges to the NHS are due to developments such as The Clinical Negligence for Trusts (CNST 1996), Working for Patients (DOH 1989), The patient's Charter (1991) and The 1997 White Paper The New NHS.

The removal of Crown Immunity meant that NHS Trusts were subject to fines and other penalties from the Health and Executive instead of by the District Health Authorities. Survey data suggests that the cost of clinical negligence litigation rose from around: £1M in 1975, £50M in 1990, and £200M in 1996 (Dingwall & Fenn 1995; Evans 1998). The transfer of financial burden led to the formation of Clinical Negligence Scheme for Trusts (CNST 1996) with the aim at providing individual trusts with financial support in cases of litigation. Medical negligence claims were

increasing by 5% per annum above inflation, which was identified as an increase in real terms from £53 million in 1990/1991 to £175 million in 1995/1996 (McCaghy et al 1997). The National Audit Office recently reported (National Audit Office 1995-1997) that there was an average of 0.5 patient incidents per 1000 in-patient days. It has been estimated that trusts are losing almost about £1300 million per annum in financial resources in direct and indirect costs as a result of inadequate or ineffectual risk management strategies (Lloyds 1995). There also has been a dramatic rise in the number of legal actions being taken against General Practitioners – up some 100% from 1993-1995 (Hale 1997). The response of the financial pressures from litigation for clinical negligence has been to introduce a series of new standards and preventive measures, which sought to identify and reduce the risk exposures patients' have (NHS Executive 1996). Each Trust developed risk management structures and procedures to undertake risk assessments in a proactive way.

The Working for Patients (DOH 1989) set out plans to create an internal market. The focus was designation of some groups as purchasers of health services (health authorities and fund-holding general practitioners) and other groups as providers of services (hospital trusts, most general practices, community services, voluntary and private health care agencies). The purchaser-provider split enabled purchasers to set out through contracts, the types of services they required and agree with the provider on the level of cost of services. The logic was that purchasers would commission the most efficient and economic providers, thus improving efficiency, treating more patients and decreasing costs in the process. To integrate users into the quality process, The Patient's Charter (1991) was launched. It gave performance targets and required the publication of data about actual outcomes

which: could be used to measure and check professional performance and consumers could use to make choices about their treatment. Both of these measures increased imperative of higher standards and care with increased pressure on reducing costs.

The 1997 White Paper *The New NHS – Modern and Dependable* placed a statutory duty for quality on all health organisations. At the heart of the changes is a local responsibility for *clinical governance*. Clinical governance as part of a new approach for assuring quality health care is a framework intended to ensure that all NHS organisations have in place proper processes for monitoring and improving clinical quality. For the first time it makes the executives of NHS trusts legally responsible for clinical quality. Before this new approach, hospitals and trust boards have been responsible for balancing the books with responsibility for patient care being with individual clinicians. High-profile cases such as the inquiry into heart operations on babies at the Bristol Royal Infirmary (Smith 1998), and the failings in the cervical screening programme at a hospital in Kent (National Audit Office 1998) have raised questions about clinical responsibility. Why had no one noticed? How could such poor performances be allowed to continue for so long?

Underpinning clinical governance is an emphasis on an organisation-wide transformation, which includes effective leadership; working as teams; dealing with poor performance; evidence and good practice and professional development.

Effective Leadership: While clinical governance is the responsibility of clinicians, strong leadership, commitment and direction will be needed to ensure successful outcomes. The challenge for leaders will be the active creation of cultures of working environment, which are open and participative, where ideas and good practice are shared, where education and research are valued and where blame

is used exceptionally. Successful clinical governance will depend upon the strength of the working relationship between leaders and health professionals.

Working as Teams: Clinical governance is seen as multidisciplinary activity in which the quality of care a patient receives depends upon a whole chain of people. Thus there should be encouragement for both multidisciplinary and interdisciplinary collaboration, where quality is viewed from the patient perspective and not as separate compartments for separate disciplines.

Dealing with poor performance: Involves the development of performance procedures where cases of deficiencies are dealt with in a sympathetic manner.

Evidence and Good Practice: Support for, and application of evidence-based practice is a key feature within clinical governance. Processes for evidence-based care involve: identifying relevant evidence, critically appraising the evidence for validity and clinical usefulness, implementing and incorporating relevant findings into practice and continual measurement of performance against expected outcomes.

Professional Development: Staff within the health organisation is key to meeting the challenges of the new approach. Thus the recruitment, retention and development of staff are essential. Equally important are, supporting and training in modern information technology, access to evidence, participation in developing quality strategies and encouragement to look critically at existing processes of care and improve them.

Clinical governance requires health care providers to ensure that:

- clinical audit is in place;
- there are clinical risk management systems;
- practice are changed through evidence;
- continuing health needs assessments are held;

- leadership skills are developed at clinical level;
- untoward events are detected openly investigated and lessons learned;
- continuing education is in place;
- high quality data are collected to monitor clinical care.

The strengthening of professional self-regulation is to run parallel to managerial systems of quality control. A *National Institute of Clinical Excellence* (NICE) will promote and maintain higher standards of professional practice by overseeing the development of National Service Frameworks to ensure clear standards of clinical practice and the *Commission for Health Improvement* (CHI), using the national framework, will monitor the implementation of the service frameworks and supporting quality plus participation in clinical audit and review of how poor clinical performance is dealt with locally.

Policy Driven Structures for Risk Management

In mental health, high profile incidents and subsequent inquiries (eg Bloom-Cooper et al 1995; Heginbotham et al 1994; Sherperd 1995) have raised public concern over the safety of people with mental health problems. Each enquiry highlights specific deficits in the care and treatment provided with recurring themes: paucity of actuarial systems to measure risk, limited psychometric assessments risk, inadequate multidisciplinary input to the assessment of risk, lack of effective collaboration and sharing of information between differing agencies and limited implementation and audit risk factors (O'Rourke et al 1997). This has led to demands that practitioners are more rigorous in their decision-making for caring for the mentally ill. In response a number of guideline documents have been issued:

The Care Programme Approach (CPA)

The most important policy initiative in recent years has been the Care Programme Approach (CPA) (DOH 1990). The CPA was introduced to provide a framework for the care of the mentally ill in the community. It requires health and social service departments to devise and implement care packages for all patients in contact with the mental health services. The CPA has four main elements:

- assessments of the health and social care needs of the individual including *assessment of risk*
- production of a plan of care which incorporates the identified health and social care needs of the individual
- nomination of a key worker to maintain contact with the individual and to monitor implementation of the agreed care plan
- regular review and monitoring of care plan.

Other underlying principles are that, mental health professionals should work as part of a multidisciplinary team and involvement of patients and their carers in drawing up, agreeing and reviewing the agreed plan of care. A central theme of the guidelines was the need to encourage patients and their families, or carers, to participate in all stages of the CPA process. This is to commit health and social workers to the concept of joint working in which the patient is placed at the forefront of care. The nomination of a designated professional as a key worker created a range of responsibilities and accountability. These are the use of skills and knowledge in assessing the patient and maintaining contact, act as a consistent point of contact for patients and their carers as well as other professionals, ensuring that documentation is completed, signed by the patient and circulated to all members of the care team, providing support and arranging regular reviews of the treatment plan

with the patient and care team. There were subsequent guidelines on supervision registers, those on the discharge of mentally ill patients from hospital and supervised discharge:

The Supervision Register

Supervision registers were introduced in an attempt to identify people who are considered to be at a significant risk of committing serious violence, suicide or serious self-neglect as a result of mental illness (DOH 1994). An important feature of the register is the formalisation of multidisciplinary and multi-agency risk assessment. The registers has been designed to keep close scrutiny on people who have difficulty in maintaining contact with services ensuring that those most at risk do not become lost to follow up.

Discharge Guidance

The discharge guidance document (NHS Executive 1994) called for a risk assessment on discharge ensuring that the relevant information is available including: past history of the patient, information from others and accurate information about past behaviour. It also involves defining future circumstances likely to present increased risk, proposing how these changes might be brought about, seeking expert advice when necessary and recording the risk management strategy and deciding the review date.

Supervised Discharge

The purpose of supervised discharge (HMSO 1995) is to ensure that a patient who has been detained in hospital for treatment receives aftercare services. The decision to apply the guideline depends on the level of risk to the health and safety of the patient, the safety of other people or to the patient due to serious exploitation. The guidelines potentially extend the boundaries of duty of care because they go

beyond the boundaries of the mental hospitals. With CPA duty of care follows the patient into the community setting in which the mental health professional feels a unique weight of responsibility for the safety and care of his/her patients regardless of other professionals. The introduction of supervision registers, also extend duty of care beyond the patients consent. Mental health professionals are responsible for taking all reasonable steps to remain in contact with a patient who has been judged to be at risk regardless of their consent. This duty extends until the patient becomes detainable or until the risk is no longer present, but given that a particular risk factor will always remain in the patient's history, it is difficult to know how long the duty to supervise should be. This development has an important civil right element because the patient ability to discharge him/herself unless detained under the Mental Health Act is removed. In addition, the guidelines create a climate of expectation regarding standards of care and obligations of mental health professionals in protecting the public from untoward incidents.

The Mental Health Act

Legalism has been a central component of social reform in the area of mental health since the nineteenth century; the 1890 Lunacy Act governed admissions, treatment, control, and supervision of patients. Historically legalism has been used to counteract what was viewed as the shortfall of professional management. In the twentieth century the 1983 Mental Health Act and the Mental Health (Patients in the Community) Act are the regulation for the care and treatment of mentally ill in England and Wales. Most of the treatment under the Mental Health Act takes place on hospital wards, involving a range of essential activities such as dealing with documentation of people who are detained and the holding power of nurses (detaining of people who are hospital and not already detained). Under the Mental

Health (Patients in Community) Act, a patient subject to supervised discharge is required to abide by the care plan. The appointed key worker has powers to require the patient to reside in a particular place, and the patient to attend for medical treatment and rehabilitation. Non-compliance by patients leads to a review with a possibility of compulsory admission. The Human Rights Act, which became effective in October 2000 throughout the United Kingdom, would affect the above Acts. Mental health professionals will need to strike a balance between rights of the individual, the demands of the family and the local community and the social requirement that mentally ill are treated. How far has the introduction of standards, protocols, legislation and social factors triggered new work practices and responsibilities of nurses?

Transformation of Psychiatric Nursing?

Castel's (1991) observation of a vital strategic shift from dangerousness to risk within the care professions appears to encapsulate the contemporary preventive strategies. He suggests that the original justification for intervention was always around the notion of dangerousness namely, detecting, diagnosing and treating/confining dangerous individuals. Dangerousness was seen as a quality inherent to a given individual who was deemed capable of dangerous actions. In contrast, the notion of risk is more selective but at the same time applies to a larger group of people than the notion of dangerousness, where the category "at risk" is placed within a system of factors drawn from observations of others. The above view suggests innovative strategies in clinical practice, in that, the prominence of combination of factors affect how intervention is carried out. Intervention is no longer "the direct face-to-face relationship between the carer and the cared, the helper and the helped, the professional and the client. It comes instead to reside in

the establishing of flows of population based on the collation of a range of abstract factors deemed liable to produce risk in general” (Castel 1991 p. 281). Identifying a person as posing a risk no longer means observing him/her for signs of dangerousness. It is now sufficient to identify a person as a member of a “risky population”, based on a “risk profile.”

Patient behaviour has been a key focus of violence research. The Violence Risk Assessment Study (Monahan & Steadman 1994) designed to improve the validity of clinical risk assessment offers one of the most comprehensive set of factors that could be used in risk assessment. There are four domains within which risk factors for violence are conceptualised, namely, dispositional, clinical, historical, and contextual factors. Individual dispositional tendencies include demographic, personality and cognitive variables; clinical factors refer to diagnostic or mental state aspects of patients; historical factors refer to biographical events; and contextual factors refer to the contemporary social networks and social support of patients as illustrated in Fig. 1a.

Figure 1a: Factors in Clinical Risk Assessment

Dispositional Factors	<i>Demographic</i> – age, race, gender; <i>Personality</i> – anger, impulsiveness and psychopathy or personality disorder; <i>Cognitive</i> – intelligence.
Clinical Factors	<i>Symptoms</i> – delusions, hallucinations, violent fantasies; <i>Functioning</i> – substance abuse, alcohol and other drugs.
Historical Factors	<i>Social history</i> – family history, child rearing, child abuse, family deviance, work history, employment, job perceptions, educational history. <i>Hospitalisation history</i> – prior hospitalisation, treatment compliance. <i>History of crime and violence</i> – arrests, incarcerations, self-reported violence, violence towards self.
Contextual Factors	<i>Perceived stress</i> – social support, living arrangements, activities of daily living, perceived support, social networks.

The category of 'at risk' patients deemed to be a danger to themselves or others has had a high profile in social policy debates and has been the recurrent focus of legislative deliberations. Douglas (1990) characterises the idea of risk as a central cultural construct and argues that its use rather than 'danger' or 'hazard' has the rhetorical effect of creating an aura of neutrality and of cloaking the concept in scientific legitimacy. Danger reworded as risk, is removed from the sphere of the unpredictable and placed at the feet of individuals. Risk becomes, in Douglas words a 'forensic resource' where individuals can be held accountable. Similarly, Ewald (1991) notes that the notion of risk incorporates a secularised approach to life, where God is removed from the scene, leaving the control of events entirely in human hands.

An approach based upon inherency of danger posed a problem for professionals in its limitation of the possibility of establishing and maintaining an effective prevention, which could lead to criticisms over lack of consistency. Snowden (1997) believes that risk is a more attractive term than dangerousness, as it does not contain pejorative connotations. Dangerousness however continues to be a major consideration of practitioners when deciding, for example, whether to detain or release a patient. This is illustrated in the guidelines on the discharge of the mentally disordered and their continuing care in the community with a section on assessing potentially violent patients (NHS Executive 1994). The importance of dangerousness is also obvious in the supervised discharge proposals (DOH 1993) and the supervision registers proposals (DOH 1993). Owen's (1992 p. 239) observation that "the spectre of dangerousness both defines the function of psychiatry and legitimates its operation" is apposite. In any discussion of risk assessment, there seem to be the presence of the concept "dangerousness" and this

has a particular significance for the perception of a person as “dangerous” in two related issues. The concept of dangerousness can be seen as a fixed personality trait which is questionable because a person may pose a risk at certain times and response to certain situations but not in others (Gostin 1986). In addition, the absence of “objective” criteria for recognising dangerousness may lead to assessment based on myths or ordinary “common sense” and misconceptions.

This new approach to interventions, as signalled by the shift from dangerousness to risk may have three important implications for the care of patients. First, preventative policies associated with risk are constituted in terms of factors rather than individuals. Future problems such as risk of violence to others risk of self-harm and risk of serious self-neglect are now to be found within recognisable constellations of risk factors and not within individuals. In attempting to make a risk prediction, the practitioner has to take account of factors which correlate with a particular harmful behaviour and which are therefore associated with the increased likelihood of a particular risk occurring. Secondly, intervention is no longer primarily based upon professional expertise but rather around the notion of risk. The dependency on abstract factors deemed likely to produce risk raise an interesting point about the role of the practitioner being indistinguishable in many ways from that of the administrator. That is, the therapeutic task of the practitioner takes second place to administrative knowledge. The final implication of the general shift away from “dangerousness” is that the employment of risk brings with it a new powerful form of surveillance. In the words of Castel (1991 p.288 emphasis added) “it is no longer necessary to manifest symptoms of dangerousness or abnormality, it is enough to display whatever characteristics the specialists

responsible for the definition of preventative policy have constituted as *risk factors*.”

Whilst the factors do not guarantee the accuracy of any prediction, the suggestion is that they provide a starting point for professionals. It is argued that predictions can be made more accurately when practitioners take into account interactive factors such as gender, prior history and use of drugs (Meloy 1987). For example, Monahan (1981,1984) identified prior convictions and prior violent incidents as consistent predictors of further violence and homicide. Taking an implicit positivist stance, it is assumed that the relationships between risk factors and outcomes are given, with the prediction of future events seen as technical ones that can be overcome with the use of more detailed data bases and more complex statistical analyses, and more accurate measures of risk. The success of using such an approach, it appears, depends upon the ability of risk factors to accurately predict future outcomes and the ability of practitioners to measure risk factors and evaluate them appropriately. Such a standpoint does not however address the ontological and epistemological questions about the nature of prediction and uncertainty.

Research in clinical decision-making (Benner 1984; Harbison 1991 Schon 1983) identifies three major models for prediction: the linear/rational model, the hypothetico-deductive model, and the risk assessment model (Gottfredson & Gottfredson 1988).

Linear Model

In the rational model, the practitioner follows a problem solving approach (for example, decision tree or critical pathway) with some notion of probability and weighs outcomes according to factors or guidelines. Decision in the rational model

is determined by a formula to be followed. For example, Towl and Crighton (1997)

propose five steps to follow when conducting risk assessments:

- Step 1: Specification of target behaviour
- Step 2: Examine relevant knowledge base by exploring and examining; client's account, accounts by significant others and relevant documentation. Identify factors, which may increase/decrease the risk of target behaviour.
- Step 3: Estimate probability of target behaviour occurrence. Assess consequences of target behaviour occurrence.
- Step 4: Assess the acceptability of the estimated risk, given the consequence of target behaviour occurrence.
- Step 5: Specify appropriate management, monitoring and review arrangements.

The model does not offer actual factors to consider by the practitioner. Implicit in the guidelines however, is the need to establish the events, use functional analysis, actuarial and statistical evidence while identifying specific factors related to the identified 'risk' behaviour. The strength of the linear model is that it provides relatively clear direction for the practitioner, as well as a "logical" argument for the decision. The weakness is that decision is determined by a formula to be followed without consideration of contextually relevant information.

Hypothetico-Deductive Model

The hypothetico-deductive model considers different factors in the specific context. Past experiences with similar situations provide the practitioner with patterns of cues to the risk behaviour. Such cues are developed into theoretical position, which is then tested against previous experience and existing knowledge as regards the person being assessed and others previously assessed. Monahan & Steadmann (1994) suggest that three aspects are considered during risk assessment:

first is the relationship between cues or risk factors (for example, anger, age, past history) and clinical judgement and prediction; second, the relationship between clinical judgement and prediction and the criterion of risk behaviour; and third, the relationship between the cues or risk factors and the criterion of risk behaviour. The weakness of this model is that the accuracy and validity of prediction may be limited by the practitioner's favoured methods of intervention and previous experiences.

Risk Assessment Model

The final model incorporates environmental and personal factors in any given situation. The practitioner considers types of harm possible across a multitude of variables, (for example alcohol, drug use, and prior history might influence the likelihood of harm), and provide risk factors that may contribute to risk behaviour. Thus it allows the practitioner to weigh both environmental factors and personal factors present in any given situation. While practitioners are encouraged to rely on their clinical judgement in risk assessment (Reed 1997), there has been an increase in the range and diversity of formal, standardised and actuarial measures. Distinction is made between clinical risk assessment and actuarial risk assessment. The former is defined as the process that occurs when information about risk factors is collated and interpreted through personal judgement of the practitioner, the latter is the process by which human judgement is eliminated and deductions rest exclusively on empirically established data and the event of interest (Davison 1997). Davison (1997) review of the literature, observes that actuarial approaches to predicting behaviour are more accurate than clinical judgements and Monahan (1997) describes it as an exciting and promising development in the mental health law. However, it is argued that actuarial approaches are seldom used in practice

because clinicians may be hesitant to the use of actuarial methods due to the calculations required (Gardner et al 1996), and Davison (1997) noted that actuarial approach could not fully replace clinical assessment.

Depending on the goal of assessment, the practitioner may use aspects of one or more of these models. A general, purpose patient dynamic risk assessment and risk management strategy is the Risk Assessment Management and Audit Scheme (RAMAS). RAMAS, a standardised schedule for measuring, monitoring and managing risk addresses four areas of risk, namely, dangerousness, mental instability, self-harm/suicide risk and vulnerability. RAMAS requires clinicians to collect information from a variety of sources; historical, dispositional, clinical and contextual data (see Fig. 1a). The framework allows professionals to move from a process of often subjective and individualised risk assessment to a more comprehensive, systematic, actuarial, multidisciplinary risk assessment and strategy (O'Rourke et al 1997).

The clinical decision-making model assumes processes of human reasoning and behaviour that are based on rationality, with practitioners weighing up the cost and benefits of various actions and making decisions based on these assessments. As noted above decisions need not necessarily take place on a conscious or 'rational' basis. A distinction can be made between reflexive actions against habitual conduct that does not require conscious problem solving activities. Such actions may be products of acculturation that do not involve step-by-step problem solving approach but rather acquire as an outcome of habits. Risk related practices, therefore may include both activities that may need high levels of statistical reasoning but also those practices that do not involve such deliberation, but rather are experienced regarded as second nature. Bourdieu's (1984) notion of 'habitus'

which may be interpreted as a set of dispositions and techniques that become organising principles by which practice are maintained is useful in exploring the habitual acculturated nature of risk-related actions. A reflexive behaviour, the feeling that a considered action is the right one, is often a vital element in risk analysis but as indicated, promblematisation also has its role in this context, sometimes as an important starting point, and sometimes mainly for checking the plausibility of the preferred action alternative.

While the three clinical decision-making models appear distinct, they are not necessarily exclusive means for deciding on interventions. Because decisions in the clinical arena are rarely precise, practitioners are supposed to approach their decisions from multiple perspectives. It is possible to detect the development of the three models as following a sort of progression driven by the attempt to be more contextual. An important characteristic of the three models is the dominance of science illustrated in the distinction between 'objective risk' and 'perceived risk'. The former is regarded as 'true' risk estimated by risk assessment procedures; the latter, the uninformed view of risk often held by the public or others not exposed to 'good' risk assessment analysis. A number of critics of these approaches have began to articulate an alternative perspective which is based on the idea that technical risk assessment alone cannot account for the full range of risk consequences (Douglas 1985; Kasperson et al 1988; Kasperson & Kasperson 1996). Bingley (1997) suggests that professionals cannot follow a recipe or formula in the arena of risk assessment, and must constantly re-evaluate his/her own role in relation to each individual case. Furthermore, Taylor et al (1997) assert that in risk assessment the practitioner is confronted with a person with unique constellation of characteristics, environmental issues and the nature of the mental disorder. They propose that

professionals interpret research findings and act differently in risk assessment and management, since they are influenced by personal and professional experience. Consequently their judgement will be shaped by their own temperament, experiences and professional backgrounds. As will be outlined in more detail later, research has identified that individual factors such as risk preferences, risk perceptions, risk propensity and organisational characteristics namely group behaviour, cultural risk values and organisational control systems affect the decision making process. From this context, risk is conceptualised partly as a social construct and partly as an objective property (Short 1989).

There are some key points to emphasise from our analysis. First, within the risk approach, the reach of “risk” is endless and nothing remains outside its territory, and nothing remains beyond intervention. Since ‘risk’ can be legitimately found anywhere there is no patient who is not at risk of something. The entire category of the mentally ill may be considered to be at risk. As Ewald (1991 p.199) observes “...anything can be a risk. It all depends upon how one analyses the danger.” By turning risk into a self-directed ubiquitous force in this way, every human experience may be transformed into a safety situation with the presumption that quantifiable and generalised risk factors are straightforward. But what does it mean for a patient to be ‘at risk’? A category such as history of mental illness, may sound well defined enough, but in practice they may be interpreted much more broadly. The term ‘risk’ is also open to the widest of interpretations. Thus a patient’s history can stretch over many years going back as far as childhood. So that there is no real way of assessing how much, for example, a patient is ‘at risk’ of self-injury or suicide apart from plunging into the patient’s history to look for patterns of behaviour, which may repeat itself. In other words, anybody with a past

blemish on their records should be considered as a permanent risk to themselves and others. It is clear that all kinds of mental health patients with a huge variety of illness may be lumped together with the expectation that successful strategies may be identified for various outcomes.

Secondly, one of the profound and ethical challenges faced by practitioners and society at large lies in the definition of risk (an issue which we shall return to later on) that leads to intervention and the accuracy of the prediction of that risk. Predictions of the future can go wrong in two ways. For any group at risk, there will be some predicted to be at risk who are not (false positives), and some predicted as not being at risk who in fact are (false negatives) as illustrated in Fig 1b. Prediction also involves the possibility that a practitioner's own biases will influence his/her own judgement. In clinical assessment there is a danger of hindsight bias (Pollock et al 1989).

Figure 1b: Outcomes of risk Prediction

True Positive <i>Correctly predicting that an event will occur</i>	True Negative <i>Correctly predicting that an event will not occur</i>
False Positive <i>Predicting an event that does not occur</i>	False Negative <i>Predicting an event will not take place that subsequently occurs</i>

This observation is important in the context of a public inquiry, where reflection after tragedies is focus selectively on the factors that appear to have contributed to the outcome. As a consequence, it heightens expectation that untoward incidents can and should have been avoided.

Finally, there may be an emphasis on defensive practice where professionals may become cautious in order to limit their liability. Here, Menzies (1960) concept of 'social defence' is useful in showing how features of risk assessment and

management techniques can be used to reinforce the individual psychological defensive needs of practitioners. Her research concerns the powerful anxieties stimulated in the course of fulfilling the nursing role. To prevent painful anxieties arising from intimate contact with patients (issues of life, death and sickness) practices and policies arose more to help nurses evade such anxieties than care for patients. For our purpose, prediction of risk based on factors may diminish nurses' awareness of responsibility for patients as whole people, and instead becomes, for example, 'the dangerous', or 'the violent'. As a result practitioners may adopt a protective ideology that all patients are dangerous or violent which defensively simplified their complex realities and therefore avoid making troubling and painful judgements on an individual basis. This might lead to an improvement in safety issues, but it might equally well have other consequences. For example, patients who are deemed to pose a higher than manageable risk may be excluded from services; furthermore professionals may tend to over-predict dangerousness in order to insure themselves against making mistakes.

We may note en route that assessing and managing risk is not an exact science (Bingley 1997). Front-line practitioners are daily making risk decisions, often of great complexity, in an inherently, uncertain situations. Most risk assessments are based on contingent knowledge (Jasanoff 1996) because it is impossible to know the complexities of every situation and all future possibilities and impacts which can result from any situation of risk. In addition, as risk decisions are about the prediction and control of the future (Kemshall et al 1997), it is an attempt to predict the unpredictable. Schon's (1983; 1987) concepts of "technical rational view" and "artistry view" of professionalism capture the situations facing professionals. The former, which seems to be in vogue currently, views professional practice as the

assessing of risk through a pre-determined set of clear-cut routines and behaviours. By contrast, the latter views clinical practice as complex and less certain where professionals make complex risk decisions, relying on a mixture of professional judgement, intuition and common-sense which cannot be set down in absolute routines or measured. Practitioners from this standpoint, are confronted with “messy,” indeterminate situations which often do not fit existing theories or available bodies of knowledge. In these situations, practitioners without clear guidance have to frame and resolve the problem, which is particularly so in the uncertain world of risk.

Indeed Carson (1996) argues that risk assessment is highly fallible exercise with the unlikelihood that any method could be found which will provide perfect safety. Under the impact of reforms in the 1990's, Annandale (1996) found how nurses and midwives developed strategies to protect themselves in the “risk culture” of the new NHS. Clearly, a risk management procedures, with its controlled step-by-step procedures, strict monitoring and inspection with well prescribed rules covering every eventuality of risk is difficult to achieve in practice. Wynne (1988) suggested that when such procedures are translated in practice it presents ambiguities and complexities. Clearly, how risks are defined, measured and assessed depends on the values, interests, priorities and epistemologies of those who have been charged with the task of risk assessment (Wayne 1996). This is done within the context of broader organisational factors such as culture, power and professional practices (Clarke & Short 1993; Kaperson & Kaperson 1996). In light of this, it is important to explore the ways in which psychiatric nurses make sense of risk assessment and management within clinical decision-making. It is clear that sense making (Weick 1995) is an integral part of effective management of risk, for

how can practitioners frame problems and comprehend the nature of risk if they cannot make sense of the concept?

The requirement of intensive interaction with patients as co-producers of care means that professional control and legitimacy over “specialised knowledge” seem to be changing (MacStarvic 1988). Indeed, contemporary social theories emphasise that we are living an age of uncertainty and draw our attention to the instability of knowledge. This suggests that the status of expert knowledge is becoming increasingly contested (Carter 1995). This calls into question the reliance on rational analytical approaches, where practitioners will ultimately be expected to know and be responsible for any decisions and interventions. There are also doubts about whether practitioners do or even can operate in purely rational way. Scholars have suggested that in practice people do not actually operate in this rational way as other types of motivations for doing analysis are common. For example, Meyer (1984) noted that a great deal of formal analysis is more concerned with the justification of decisions already made and Brewer (1981) described how analysis may be used to deflect attention away from issues by giving the impression of action and Meyer and Rowan (1977) gave us insight into the symbolic and ritualistic uses of language.

Uncertainty in decision making

The dominant view of clinical decision making as a precise, certain and scientific practice is questionable. When clinicians make decisions they take a lot of clinical “facts” from variety of sources about individual patient and often depend more on their sense of the situation than on general medical knowledge (Fogel 1980). This indicates that clinicians often compensate for uncertainty by drawing on commonsense understandings of the situation. Thus instead of following guidelines to explain clinical phenomenon, clinicians frequently renegotiate these guidelines.

There is immense diversity among varying circumstances in which judgements may be required and as significant are the logistics limitations in making these judgements within a clinical or organisational context. As pointed out by Borum (1996 p.953) "Different settings may require information about different types of decisions of risk, or they may have varying time frames for prediction of relevant behaviour. Different risk assessment tasks require different types of decisions and vary in their critical action thresholds." Indeed, Shotter (1993) suggests that following a model is inadequate because in following rules people create, challenge, change, check and correct them as well. Similarly Berg (1992) in introducing the concept of "routines" observes that the decisions clinicians make routinely embody the safety norm and suggests that clinical practice does not always adhere to universal rules. To make a decision clinicians need a lot of different types of information in order to build up a sufficient clinical picture; which leads to a degree of uncertainty about how to combine all the information available.

The prominence of risk analysis may bring with it the potential to redefine the boundaries and relations between professionals and service users. Pressures to be more efficient coexist with standardising procedures and professional judgements that challenge notions of professional accountability and regulation (Pollit 1993). Furthermore there is likely to be blurring of role distinctions and demands for multi-professional collaboration and therefore rise in complex ethical issues that require interdisciplinary collaboration. The theme running through our analysis has been that clinical uncertainty characterise the experience of mental health professionals from several directions. Clinical uncertainty arises from the fact that professionals have limited and varying capacity to deal with information in other words, they are subject to bounded rationality - the assumption that all rational humans would take

decisions to maximise their profit, or preferred advantage (Simon 1979). In practice perception would intervene between the decision maker and the 'objective' environment. Human perception is therefore a filter through which risks are viewed. Since not all the alternatives are known or reliably assessed, the decision maker would aim for a satisfactory rather than a maximum outcome when faced with a complex situation. This suggests that imperfect knowledge compels the decision maker to construct a simpler and more personalised model on which to act. Here the choice from a range of alternatives would be based on individual knowledge/experience; an experience which determines perceptions upon which the assessor respond to risk. Also there may be differences in the capacity of professionals due to varying competencies, resources and positions. The way professionals experience various kinds of uncertainty (risk aversion) may vary, as does their evaluation of different combinations of stakes and probabilities. There is another ambiguity linked to risk analysis, that is, uncertainty concerning the evaluation of risk factors: how do practitioners know whether the outcome of their assessment and management of risk will be successful?

At this stage it is important to mention that the role of expertise is not being underestimated. In arguing that the role of professionals may be changing as a result of new statistical and administrative techniques of knowledge acquisition and dissemination, I am not suggesting that professional expertise is now less important or that professionals are inflexibly captivated by risk discourse, preventing them from imaginatively modifying the specific discourses which informed their practice. To suppose that clinical practice is colonised by risk discourse, denies the actions of professionals to negotiate actively the application of risk analysis in their daily work. My suggestion is that the effects in practice may be both complex and

unpredictable, for example, the possibility that such initiatives may result in unintended consequences and destroy some elements of professional work. Having outlined what I think might be happening to psychiatric nurses with the prominence of risk discourse, the next section briefly presents the likely impacts on mental health professionals.

Impact on Mental Health Professionals?

How would such vast bodies of sophisticated quantitative tools, ideas, tools, strategies, policies and methods aimed at enhancing clinical decision-making affect practitioners? There might be a danger that the tools or techniques of risk management are treated as magical solution, with practitioners investing their hope in the technique or approach as if it, by itself, will help resolve complex situations. Such a stance refers to care which divorces the techniques of risk management from any appreciation of, integration with, or accountability for the whole patient, or consideration with the substantive questions of the field of psychiatry. In Bion's (1961) terms risk management ideology represent basic assumptions dependency functioning in which the profession evades anxieties stemming from confrontation with its tasks by creating a magical investment of hope and expectation in some invincible object. Such an argument centres around, the emergence of a type of social defence, which is that, by focussing its hopes on methods instead of sophisticated attention to its primary task; the profession relieves itself of painful awareness of its challenges and responsibilities.

In the shift from 'dangerousness' to 'risk' demands are being made on the profession to innovative in profound ways that diffuse deeply into practitioner's ways of thinking and relating to patients. Such adjustments, which can be understood from Argyris & Schon's (1975) concept of type 11 learning, involve

changes in the values, orientations, assumptions and basic frameworks of practitioners. This observation is similar to the concept 'frame-breaking' changes, which by the intensity, depth, breath and complexity of their impacts, cause organisations to rethink completely their purposes, structures, processes and cultures. It can be hypothesised that practitioners are likely to be affected in their experience to their ways of caring which may stimulate severe uncertainty. For example, the conventions governing the professional life and behaviour are going through profound transformation. This means that the historic norm of professional autonomy and practice orientation of technical rationality are giving way to vastly different professionals' roles. The presences of array of tools the practitioner must contend with heighten complexity within as well as without. There is, also an increasing number of stakeholders making a greater number of demands on professionals. The goals and purposes of interventions are called into question as groups claim knowledge of risk management. These developments create massive uncertainty about clinical care. Given the observations about the conditions under which anxiety is stimulated (Menzies 1979; Hirschhorn 1983), it is reasonable to argue that the current demands for change being made on professionals could elicit deep and painful anxieties and a conflict between professional ideology and management ideology.

From the above observation, we can argue that there are diverse ideologies, values, historical events and frames of reference influencing nursing practice. Based on a research in a hospital, Meyer (1982) concluded that ideologies wield strong forces in guiding the adaptation of organisation. Other scholars have highlighted the importance of ideology in the structure and functioning of organisations, emphasising the influence of ideological beliefs on organisational-level action

(Alveson 1992; Beyer 1981; Czarniawska-Joerges 1988; Dunbar et al 1982). Therefore healthcare organisations like any other social organisations reflect the ideologies of the greater society in their cultures and actions; the management ideologies of hospitals in turn affect beliefs, values and behaviour at all levels of the organisation. In this way, ideologies of the greater environment influences extend to organisational, professional and individual entities affecting their decisions, behaviour and conduct. Accordingly, the impact of risk management may be seen as outcomes of the complex influences of organisational, political, and economic structures and ideologies in the health care environment. In a related vein, Chua and Clegg (1990) observed how the nursing profession in the United Kingdom has used different discourses in their pursuit of professional identity at different historical periods reflected in views held about the professions, their relationships with peers, patients, other professions with whom they interacted, and with society at large. Professional knowledge is therefore constructed within a societal, historical, political, philosophical and the environment context.

If we accept the above premise then, how does the dominant ideology of British nursing that encompasses concepts of humanism, holism and empowerment centred on nurse-patient relationship fit in with the dominant perception of the risk attributable to mental disorder in society and the increasing use of risk management technology? Risk management techniques are seen as rational systems in which professionals behave in a logical, purposeful and coordinated approach. This ideology of rationality lays emphasis on efficiency, predictability and calculability of outcomes, with control over uncertainty. Does this meet the criteria of ideologies of nursing? The central ideology of nursing, the holistic approach, refers to the patient as a complex human being within a specific social context. It is the total

social situation of the person that is of importance, not the single problem that the patient first presents or is identified as having by others. In practice, holism refers to the notion of regarding information as more than a collection of factors but instead interpreted within its context and never in isolation. Holism espouses the idea that people are multiple, interacting, open sub-systems, that are greater than the sum of their parts. Moreover, professionalism is among the strongest of ideologies; with claims for ownership of special knowledge, definitions of what tasks make up a profession, possession of rigorously attained systematic body of knowledge, a norm of autonomy and control of work (Abbott 1988; Freidson 1994). However, within the pure risk management framework, taking an individual and holistic caring perspective to patient care is impractical because assessment is tailored to group approaches that are uniform and formulaic to the care of patients. From this angle it can be argued that, the nursing ideology holism makes an uneasy fit with the dominant ideology of the corporate culture.

This chapter set the scene by critically looking at risk management technologies in relation to mental health nurses. It discussed how existing literature points to the fact that psychiatric nursing operates in terms of rules, formats and technologies of risk decisions systems which connects with the features of the “risk” society within which nursing now takes place.

Chapter 2 presents a review of various epistemological and methodological approaches to analysis. Using the arena metaphor, it provides a conceptual framework for conducting the research.

Chapter 3 provides theoretical and methodological framework for understanding autobiographies and argues that autobiographies of researchers are useful research tools for clarifying the assumptions underlying the project. It

provides a short account of how the research was developed. The stance taken is that the traditional researcher/subject distinction is inappropriate. Here research involves a process of self-engagement and change for the researcher as well as for the subjects, the researcher and the researched is seen as part of the whole. Who am I as a researcher? Why do I study the phenomena I study? How have my experiences as a person shaped my research questions? My argument is that the development of a research interest is a personal experience and then delineation of a focus of concern, is affected by both the practical and theoretical aspects of one's research. In a hermeneutic or interpretive approach, the researcher's bias, existing pre-understandings and interpretive framework is necessary ingredient in evolving an understanding of phenomenon under study. It highlights methodological issues that arise in the field research among peers. This intellectual account is intended to supplement the methodological analysis in chapter 4.

Chapter 4 describes the theoretical background to my research methodology and discusses the methods used. It presents the philosophical and methodological approach of the project. Symbolic interactionism provided the epistemological background. Given this stance, the research methods used were qualitative, intended to capture the rich array of subjective experiences of organisation members. Research activities on the sites proceeded along similar lines. The predominant method of data collection was extensive observations at the four sites over a period of four years. Attempts were made to stagger my observation in order to witness the units at each time of the day. There were attendances at unit handovers, risk decision making reviews and multidisciplinary meetings – events relevant to decision making. The purpose of the participant observation was to provide ethnographic data concerning formal and informal activities that constitute the

decision making process. Under optimal circumstances, it was possible to follow a particular decision as it was discussed informally on the units, presented at handovers and debated in formal patient's reviews. Participant observation was supplemented by interviews. Three major goals of the interviews were first to draw more thorough conclusions about perceptions of organisation members than could be obtained by observations. Second, to explore in detail the values, beliefs and reasoning used by participants in risk decision making and third, to pursue theoretical leads that were suggested in the course of observations. The interviews also served as a validity check, to ascertain whether observations were consistent with the perceptions of participants. Self-scrutiny was aided by critical incident analysis, for instance, why certain events are regarded as important and what participants learn from incidents. Other information was obtained from documents.

Chapter 5 offers an ethnographic analysis of how nurses assess and manage risk. It provides descriptions of four case studies. It provides an empirical analysis of how nurses participate in decision making and how nurses make sense and handle decisions. Following the logic of theoretical sampling, the cases were drawn from diverse environments so that common themes could be developed across a variety of settings and build a stronger and more consistent understanding. I selected three settings from the National Health Service and one setting from the independent sector. The four units differ from each other in their clientele and their clinical dynamics. My interest was not in their distinctive dynamics but the social processes that link all units.

Chapter 6 provides an empirical analysis of how nurses participate in risk decision systems and examines how nurses make sense and handle risk decisions. It extrapolates from the case studies conclusions about risk decision making in

psychiatric settings and shows how the professional knowledge of risk becomes embedded in communication rules, formats and technologies.

CHAPTER TWO

RISK AND SOCIAL KNOWLEDGE

Risk analysis is a unique field in that it has no academic boundaries. It admits all creeds. Whereas traditional disciplines tend to specialise, we seek to integrate across disciplines. Our role, viewed broadly, is to draw upon the best available scientific knowledge in pursuit of societal goals – health, safety, and environmental protection. (Fiksel 1990 p.195)

Discourse on “risk” today occupies a prominent place in a variety of intellectual disciplines within contemporary social sciences. Obtaining a precise common definition of the concept has proven to be extremely difficult, however, not only because of its interdisciplinary applications but also due to its varied approaches. In the social scientific domain, a distinction has been drawn between “objective risk” and “subjective risk” as illustrated in the Royal Society’s (1992) report. In what was thought to be a bridging of gap between supposedly objective risk, derived by scientists from statistics and admittedly subjective risk as perceived by the public the Royal Society’s report resulted in two sections written from different viewpoints (natural scientists versus social scientists), which completely contradict one another. The natural scientists took the view that objective and perceived risk are distinct and that the public’s perception of risk is flawed. This technico-scientific perspective (Lupton 1999) that has tended to dictate governmental and scientific discussions of risk promotes a positivist (or realist) theory and rationalistic policy orientation. The social scientists in contrast suggested that disparate groups view risk in different ways and react to it differently. This social constructionist approach looks upon risk as a “social construct” and argues that risks do not directly reflect natural reality but are played out in every society

through lenses shaped by history, politics and culture (Douglas 1992). All knowledge about risk (from experts and lay people) from this stance is bound to the socio-cultural contexts in which this knowledge is generated. Thus scientific knowledge is never value-free but rather is always the product of seeing, not a static objective phenomenon, but is constantly constructed and negotiated as part of the network of social interaction and the formation of meaning. The lack of conceptual coherence in the analyses of risk is reflected in the ambiguity and the language use.

This difficulty of achieving “a single uniformly understood language for the risk analysis community” led to the contention for abandoning risk, when after four years the Society for Risk Analysis failed to define the concept “risk” “...saying in its final report that maybe its better not to define risk. Let each author define it in his own way, only please each should explain clearly what that way is (Kaplan 1997 p.407). Jardine and Hrudey (1997) note the difficulties of multiple and imprecise meanings of words on risk communication and put forward a bundle of recommendations to reduce the problems so created; and Calman and Royston (1997) attempt to devise a standard classification of risk levels with a plea for a standardisation of “the language of risk” in order to improve “risk communication” are all part of the doomed attempts to define the word risk. For Dowie (1999 p.69), the solution is to abandon the concept risk in decision making: “In any of these situations we need to remove “risk”, not try to understand it better or to treat its symptoms by attempts at “clarification”. It is simply not needed. We do not need a category of “risk decisions” or “risk management decisions”. They are just decisions. They are just factors.Nothing of importance will be lost with “risk”, except by those who rely on fudge and confusion as instruments of political persuasion and social lubrication”.

Within the background of the failure of attempts to clarify and standardise the language of risk is the increased recognition of the role of risk in organisations as the consequences of “risky” decisions have become more evident. The concentration of the public, media and regulators spotlight upon the risks associated with high technology systems illustrated in the concerns expressed over Three Mile Island, the Space Shuttle Challenger, Union carbide in Bhopal, Chernobyl, bovine spongiform encephalopathy (BSE) and genetically modified (GM) crops has resulted in a need for organisations to deal with a variety of fundamental safety decisions. This new phase of attention of the negative aspects of risk departs from the old notion of “no progress without risk, no benefits without leaping into the unknown (Halfmann 1999 p.177). In the above cases the public has been outraged and attributed the risks to the influence of organisations and possible negligence on part of the controlling authorities. In contemporary societies risks are not seen as mere externalities or unintended consequences, but a key question around which politics and social debates are increasingly organised (Shrivastava 1995).

Disasters such those mentioned above are said to have helped to alert the public to the dangers around us. Sociological accounts of risk believe that an awareness of the destructive consequences of technology and science provides the basis for the widespread concern with safety today. The assertion is that disasters in recent years have helped to alert the public to the dangers around us heightening public concern for safety in the process (Beck 1992). But if we accept the argument that disasters and catastrophes have happened throughout history, what account for the public’s anxieties today? The different public reaction to the Clapham Junction railway accident in 1988 and of the Hatfield rail crash in 2000 is enlightening in this respect. In the former case many people perished, the public was shocked however

rail travel was not put to serious questions. In contrast the response to the Hatfield turned into a full-scale panic. For the public this disaster was confirmation that rail travel was out of control. In psychiatric care recent reactions to “dangerous” patients as compared to past reactions illustrated in Clunis case mentioned in chapter one (of which more later) is instructive. The trigger of anxiety and fear from technological and scientific developments has extended to an intense response of risk-aversion now prevalent in every domain of human activity. Thus disastrous incidents, which in the past would have been waved off as bad luck, are now interpreted as indications of a major danger. But what counts for the discontinuity between premodern and modern risks?

Scholars have attempted to analyse the differences between premodern and modern risks. First, Douglas and Aaron (1982) suggest that modern societies are confronted with increased awareness of risk because more decisions are now taken in an atmosphere of uncertainty. This approach interprets the meaning of risk as a “social construct”: relating to the current subjective consciousness of society, rather than a reflection of increased real dangers. Second, it is argued that risks in premodern times were personal and not global as they are today - the effects of acid rain, global warming and nuclear fallout are borne by those who do not contribute to their origins (Jamieson 1992). Third, is the assertion that risks facing late modernity are not natural (occurrences such as earthquake and floods) but manufactured (the results of human intervention) (Beck 1992; Fredenburg 1996; Giddens 1990; Jamieson 1996). Related to this, is the notion that risks in the past were usually noticeable, while they are not generally today (e.g. contamination induced by radioactivity and toxins in foodstuffs). Fourth, is the crucial role that the media plays in late modernity. For instance, Thompson’s (1995) notion of the processes of

discursive elaboration and “extended mediazation” (the ongoing process of communication and debate of media messages) has led to the social amplification and attenuation of risks in late modern societies Kasperson and Kasperson (1996). As will become clear in the next section, disputes over clinical issues normally involve references to scientific reports that are summarised by the communication media. The media reports then become an object of discussion for commentators and experts whose comments are further commented upon by other commentators. These media messages could then lead to recipients taking responsive action to events. From this stance, the media in late modernity both report and shape what is going on; thus news organisations are significant actors involved in the social construction of risk (Short 1984). In the words of Stallings (1990 p.80); “By selecting events to report, by interviewing and quoting experts who interpret these events and by assembling and distributing news products, news organisations create an important component of public discourse.”

The chapter is organised as follows. The first section presents three organisational events concerning risk issues. It shows risk how risk is no longer seen as the probability of harm arising from determinable physical, biological or social causes but instead as the embodiment of deeply held cultural values and beliefs. The word risk has changed its meanings over the centuries. The next section provides an abbreviated review of three major traditions that have emerged from social and political analysis and examines how this played out in assessment and management of risk in psychiatric settings. The final section reconceptualises the determinants of risk behaviour and presents framework in risk management based on the arena concept.

Event analysis in organisations

The current MMR debate in the United Kingdom provides a graphic illustration of a clash between two kinds of rationality namely instrumental reductionist rationality (the head) of the expert and the common-sense rationality (the heart) of the lay public. Anxiety over controversial research by Dr Andrew Wakefield and colleagues at the Royal Free hospital published in 1998 in one of the world's leading scientific journal the Lancet raising the possibility of a link between the MMR vaccination and bowel disease and autism and media coverage has made many parents reluctant to have their children vaccinated. The main plank of the thesis is that MMR can trigger a form of bowel disease, which can in turn affect development. The Royal Free team found measles virus in the gut, but most scientists who tried to replicate the experiment failed. In the first week of February 2002 a long-awaited paper by a Dublin pathologist Professor John O'Leary published on the website of the journal Molecular Pathology found fragments of measles virus of the gut and tissue of the autistic children with bowel disease who were patients at the Royal Free. But Professor O'Leary and other commentators from Warwick University agree that this does not prove a link to MMR. A large study involving nearly 500 autistic children in the north Thames region of London carried out by community paediatricians at the Royal Free, together with scientists from the public health laboratory service and the Open University published in the Lancet in 1999 found no increase risk of autism after MMR jab and no difference in the age at which children were diagnosed as autistic (between those who were vaccinated with MMR at 18 months and those vaccinated later) concluding that the rise in autism had begun before MMR was introduced in 1988. Papers written on the experience of MMR vaccination in Sweden and Finland have found that there was

no connection between the jab and autism. In addition, it is known that MMR has been used in the US for nearly 30 years, nearly 20 years in Scandinavia and in Britain since 1988 with relatively few side effects.

However it is argued by scientists that there may be a theoretical possibility that MMR could trigger problems in a number of children. Also for parents, because there is no proven link between MMR and autism or other conditions, does not prove there is no link. In the “Defiant parents stand by decision” (The Guardian, Thursday February 7 2002 p.3): a parent said, “I think people are worried about the situation at the moment but the general impression is that although measles can kill, there is more to fear from the MMR vaccine. Since thalidomide, the medical establishment and government departments have shown they are not wholly reliable on these matters.” Another says, “People have trusted the government on thalidomide and BSE. Just because it is the voice of authority, that does not mean it is convincing. In light of other scares, it is simply not enough for them to say that we have got to believe they are right.” Yet another parent added, “My feeling is that there needs to be a lot more research and that Andrew Wakefield is not the pariah everyone thinks he is. The government needs to wake up and listen to the public because we are in the end the ones who are having to make the decisions.” The government would not let children have single measles vaccination as requested by parents, doctors and some politicians because its scientific advisers say the time lapse between the three jabs leaves children exposed to infection, and that some parents might not bring in the child for three separate visits. The scientific uncertainty surrounding the MMR debate like the BSE issue has made risk issue immensely complex; namely a trade-off of the possibility that some children may become autistic against public health benefits (illustrated in the

measles epidemic in south London) in the face of highly uncertain knowledge of effects and processes and the parents demands for the elimination of any risk, however small.

In health care organisations patient safety, the avoidance, prevention and amelioration of adverse outcomes or injuries from clinical interventions, has now become a significant issue at the highest levels. Disasters and accidents in popular accounts are often described as human error, which can be rectified by improved training, changes in group dynamics and better communication and decision making skills to prevent similar decision failures. The emphasis on the individual as a rational decision maker has the potential of leading to embracement of a universal assumption about risk assessment, irrespective of the specific organisation's political, economic and institutional environment. It is becoming increasingly obvious that it is restrictive to regard failures in organisations only in individual terms; but rather should be seen as a range of problems of behaviour which might have their origins in failure at the level of, for instance, managerial activity, institutionalised information systems inter/intra group communication patterns, as well as individual blunders (Perrow 1984; Turner 1978). Accidents and disasters are therefore the result of complex, human and organisational factors, which may be difficult to detect in foresight. Indeed, past organisational research has shown that accidents and disasters are due to the action and interaction of human, organisational and technological factors (Shrivasta 1987). For example research has highlighted factors that propel organisations toward disasters: the operation of micro-level cognitive process (Weick 1988), employee beliefs about risks and failures (Starbuck & Milliken 1988), intra-organisational technological failures (Morone & Woodhouse 1986; Perrow 1984), the intra and inter-organisational

failures of communication (Turner 1978) and internal organisational characteristics (Gephart & Pitter 1993).

The above observation underscores the urgent need for nursing theory, research and practice to address the social, political and economic contexts of health and healthcare as illustrated in the Bristol inquiry report. Between 30 and 35 children undergoing heart surgery at Bristol Royal Infirmary died between 1991 and 1995 who, would have survived if treated elsewhere. The inquiry report revealed that the failings and flaws were not just those of the surgeons but also the hospital, its organisation and culture, and within the wider NHS as it was at the time. There was a mindset of “professional hubris” that as a teaching hospital Bristol had to be at the leading edge. But with hindsight, it was doubtful that Bristol should ever have been designated as a specialist centre for open-heart surgery on children since the hospital never did enough operations on children for the surgeons, trained and experienced in adult heart surgery, to become really skilled. Thus although clinicians were actively collecting data, there were denial of any adverse inferences drawn from the data. There was evidence of under funding which was typical of the whole NHS with the conclusion that the flaws were not caused by lack of resources. The report identified poor teamwork and management, inadequate leadership, a closed “club culture” (with insiders and outsiders) and absence of systems to listen to concerns. The physical set-up was “dangerous” with surgeons on one site at the Royal Infirmary and paediatric cardiologists several hundred metres away at the children’s hospital. The operating theatre and intensive care unit were on different floors, and children had to be transported by lift that could be called at any time by others. An expert review of 80 cases carried out for the inquiry showed inadequacies at every point from referral to diagnosis, surgery and intensive care.

Another important message from the report is that the NHS has failed to respond adequately to the special needs of children, which might equally have been about the mentally ill. Among the almost 200 recommendations are calls for a new culture of openness, with non-punitive system for reporting serious incidents, abolition of clinical negligence litigation, which is part of the culture of blame and secrecy, replacing it with administrative scheme for avoiding compensation, a call for a council for the quality of healthcare independent of government to include the new bodies set up to oversee standards of healthcare that the National Institute for Clinical Excellence, the Commission for Health Improvement and the planned National Patient Safety Agency.

These post-disaster activities namely a public investigation, identification of flaws and errors leading to the tragedy, a set of recommendations to prevent similar incidents was also evident in the Christopher Clunis case. In 1992 Christopher a young African/Caribbean stabbed Jonathan Zito to death on an underground station with a screwdriver. The investigation of the mental health service response to Clunis brought to light features which were similar to the Bristol case. The inquiry report painted a picture of a flawed system of care with poor teamwork between professionals, poor communication and evidence of a fragmented and under resourced system. Although Clunis has a long history of psychiatric illness there was a lack of continuity of care due to poor communication by professionals; notes and files were mislaid, messages between different professional groups were lost or misunderstood. The inquiry also noted the failure of professionals to assess dangerousness with the consequent neglect of exclusion of personal and social support for Clunis and his family. No discharge plans were made for his care in the community under Section 117 of the Mental Health Act and was often out of touch

with services and relatives. Between 1987 and 1992 Clunis had been admitted to four major psychiatric units, but each of them lost contact with him. He was at one point transferred from a secure unit to a general psychiatric bed to save money. Despite Clunis making threatening and violent attacks on two consecutive days in the week before the killing of Jonathan Zito the police failed to make an arrest following report from the public. The main lessons from the Clunis case were that professional liaison within the NHS and between it and other agencies were inadequate, that Section 117 of the 1983 Mental Health Act and other policies, such as Care programme Approach were not being put into practice properly and that even when services have procedures in place delivery of long-term support after or between crises were inadequate.

The significance of the MMR debate, the Bristol and the Clunis cases show the importance of other actors within healthcare. The MMR debate is no longer a question of calculating risk on all the available evidence, of which there a large quantity from more than 90 countries that use MMR; it has become a test for the government and experts about how to handle a crises of public confidence. The legacy of collapse of confidence in scientists and their relationship to government because of the BSE affair means that what is crucial is not presenting scientific evidence, but tackling the more complex task of calming the fears of parents. The Bristol case led to widespread demands for closer regulation of the medical profession which led to the announcement of hospital league tables based on surgical survival rates and other indicators of medical performance. The introduction of league tables following the new framework of clinical governance, involving a National Institute for Clinical Excellence and Commission for Health Improvement, is seen as marking the decline of deference to medical mystique and

the advance of patient empowerment leading to breakdown of trust between the medical profession and public. In the Clunis case Mrs Zito, knowledgeable and experienced in the field of mental healthcare, argued for more funds for community care, more emergency beds in hospitals and more effective planning of discharges. Doctors used the case to protest the lack of resources. A pressure group SANE called for more hospital beds, more incarceration and introduction of tighter restrictions on discharge. This led to the introduction of Supervised Discharge Orders, compelling patients to take their medication and comply with their aftercare plan under sanction of recall to hospital. Analysis of the cases demonstrates that the field of healthcare is contested and complex and made up of diverse and contradictory logics, that mistakes cannot be accounted for by reductionist explanations that direct attention only to individual actors and that mistakes are indigenous, systemic, normal by-products of the work processes (Paget 1995; Bosk 1979). In addition, the possibility of a mistake is intensified by the complexity of healthcare (risky work). In a sense the more complex the technology and the organisation as it is the case in healthcare, the greater the possibility of the kinds of failure which Turner (1976) identifies as “failures of foresight”. Risk management therefore does not occur in a vacuum but rather linked to environmental contingency, politics and structures of power. As Adams (1995 p.1) observes “Everyone is a true risk “expert” in the original sense of the word; we have all been trained by practice and experience in the management of risk. Everyone has a valid contribution to make to a discussion of the subject.” But what is risk?

What is risk? A concept in search of meaning

Since risk assessment and management have become major themes in scientific and public policy one might assume, that the term ‘risk’ would be easy to

define. However, the meaning of 'risk' has always been fraught with confusion and disagreement. Yates and Stone (1992) observe that risk is the most abused concepts in social science. The lack of conceptual coherence in the analyses of risk is reflected in the ambiguity and imprecision of terms used in the language of risk. In everyday popular usage the term 'risk' has many meanings, for example, the terms 'threat', 'hazard', 'danger', or 'harm' are frequently used as synonyms. Researchers also differ considerably in their constructs of risk. While risk is now widely studied, the concept is highly contested. Beck (1994 p.9) reminds us that "In risk issues, no one is an expert, or everyone is an expert, because all the experts presume what they are supposed to make possible and produce: cultural acceptance." The basic idea of risk as possible loss has been interpreted differently in different disciplines. Psychologists define risk in terms of perceptions people exposed to potential loss by using psychometric measures of risk perception to measure risk (Slovic 1987). Economists define risk as uncertainty about economic gains and losses by using statistical probability models to measure this uncertainty. In strategic management, because it is not possible to know all possible decisions consequences and their probabilities, scholars use the probability of event times the impact of the event as a measure of risk (Lave 1987; Shrivastava 1995) and thus regard risk as uncertainty or unpredictable consequences (Baird & Thomas 1983). The concept of risk has typically been seen as the probability of a negative event or threat occurring and the possible consequences. As a result the objective for policy has been to manage risk "rationally" by "experts". Over the years, organisational sociologists have observed the complex ways in which the physical and human elements of technological systems interact to produce risky conditions and periodical disasters (Clarke 1989; Krimsky & Golding 1992; Perrow 1984; Turner 1978). Slovic (1999) argues that

that risks are multidimensional and that public perceptions are related to among other factors, whether the risk is voluntary, controllable, familiar, potentially catastrophic and known to science. Differences among experts, individuals and groups about varied perception of risk are seen as a result of different worldviews (Douglas 1992). It is also argued that public and expert values inevitably influence risk assessment, and therefore the notion of separating scientific risk analysis is dubious (Jasanoff 1990; Wynne 1991). By focusing on cultural effects such as varying goals, assumptions of rationality and motivations and the regulative and legislative environment which guide clinical decision-making, the sociological perspective enables us to perceive the decision making process as social process in which normative and cognitive orientations are involved.

Changing Concepts of Risk

Risk appears to be the prevailing metaphor for describing and analysing changes in contemporary societies (e.g. Beck 1997, 1996, 1992; Castel 1991; Douglas 1985, 1992; Douglas & Wildavsky 1982; Ewald 1991 Giddens 1991). Calas (1999 p.684) sees risk both “as a new epistemological and political space for analysing changes in contemporary industrial capitalist societies” and “as metaphor of choice for productive life in the coming century, since it allows for both on-going construction and deconstruction of possible worlds within the uncertainties that new capitalisms might bring about.” Considering risk as a conceptual framework for analysing changes in contemporary capitalism can be illustrated in Beck’s (1992) concept of the “risk society” the process of modernisation - which deals with hazards and insecurities induced and introduced by modernisation itself. In describing this trend as ‘risk epidemic’, Skolbekken (1995) argues that it reflects the social constructions of a particular time in history. The historical development of

'risk' concept is characterised by scientific theorising and experimentation (Gephart 1996). Various means have been suggested for the proliferation of the concept and language of risk in expert discourses over the past decades. These include developments in probability statistics, establishment of institutions and regulatory agencies to deal with such phenomena conceptualised as highly risky, and an increasing value placed on scientific rationality as a basis of certainty (Douglas 1985; Short 1988). In a sense, the distinguishing feature, of modern risks as opposed to traditional ones are noticeable largely through application of scientific models. Discourses on, and practices of risk assessment and management reveal a number of changes over the centuries. For nurses, there are fundamental transformations, not only in risk management techniques, but also in the underlying rationale of nursing thought and practice. Douglas (1990) has observed that the connotation of the word 'risk' has changed over the centuries and Lupton (1999) argues that the increase of the concept and language of risk has its origin in the changes inherent in the transformation of societies from pre-modern to modern and then to late modern (postmodern). Each period problematises risk in a different way and therefore proposes new technologies for the management of mental health patients. It is worth briefly identifying the distinguishing features of pre-modern to late modernity in order to understand the current rationalities, techniques and management of psychiatric nursing.

I contend that the contemporary forms of risk management theory and practice may be better understood by situating them historically. In addition I share the view that discourses on risk management are not self-contained entities, but rather, correlate with other discourses and therefore should be examined within the context of a wider set of discourses. The assumption is that a historical assessment of the

social cultural conditions and the institutional arenas in which particular forms of risk management thought and practice emerge and take shape, may challenge current notions of nursing craft and shed different light on the understanding of nursing practice today. The historical approach proposed in this analysis draws upon the work of Foucault (1977; 1981) and others to provide a genealogy and archaeology of the conditions of possibility for particular conceptualisations and practices of psychiatric nursing to emerge. It locates traces of the present in the past, not in order to reconstruct the past, but with a deep commitment to understand the present. In Foucauldian terms, genealogy is an attempt to outline, how ideas, concepts and beliefs have both shifted and continued into the present while archaeology provides the systematic and analytical description of particular discourses. Thus the analysis is not a linear history of the development of risk management ideas over time but an attempt to understand historical periods and events in their own terms. It is important to note that Foucault's work on history of madness has both been endorsed and criticised. It has been acknowledged for occupying a special and central place in the historiography of psychiatry (Goldstein J 1987), for both its empirical content and powerful theoretical perspectives, as the most penetrating work ever written on the history of madness (Porter R 1990) and as the "new cultural history" (O'Brein P 1989). Here Foucault's notion of madness as a variable social construct and not an ahistorical scientific given is recognised. But his work has also been criticised for lack of empirical evidence and for its generalisations and oversimplifications (Midelfort H C E 1989; Sedgwick P 1982; Hacking I 1986). Foucault's work has been found wanting in terms of specific historical facts and interpretations even by historians who are favourably disposed to his work. Thus Scull (1990 p.57) whose work shares much of the general spirit of

Foucault's says his work rest on the "shakiest of scholarly foundations and riddled with errors of fact and interpretation." Similarly O'Brien (1989 p.31) an enthusiast finds Foucault's work "too general, too unsubstantiated, too mechanistic." Porter (1990) also raises important questions about Foucault's work. For example, Porter challenges Foucault's claims about the way the Classical Age conceived madness (as varieties of unreason) as dubious in light of English experience and questioned Confinement (confinement was relatively uncommon in England) as a practice definitive of the era's attitude toward madness.

Whilst some of the critique of Foucault's central views for example on confinement raises an important empirical challenge it does not, in itself, undermine the interpretative power of his work. Foucault's work was not primarily a history of events and institutions but the experience of madness in which he strived for a comprehensive unifying interpretation that tried to give intelligible order to a hotchpotch of individual historical truths. Thus my justification for sharing the sentiments of Foucault's historical construction is his hermeneutic approach – making sense of the experience of mental illness – that is examining the various threads and themes that contributed to the shift in thinking rather than its connection with empirical "facts". Facts are not a given with their meaning readily visible, but need to be interpreted; there is therefore a close relationship between fact and interpretation. We cannot present facts in a way that is free of theoretical baggage; facts are social constructs where certain theoretical positions will inevitably prefer certain facts. Following Carr (1987 p.23) I likened facts to "fish swimming about in a vast and sometimes inaccessible ocean; ... what the historian catches will depend partly on what partly on chance, but mainly on what part of the ocean he chooses to

fish in and what tackle he chooses to use – these two factors being, of course, determined by the kind of fish he wants to catch.”

Foucault’s work gives an extensive and subtle interpretative framework that raises provocative questions. In criticising the dominant ideology of psychiatry – the triumph of reason over witchcraft – Foucault reveals how psychiatry involved various forms of “governmentality” to regulate individuals whose behaviour was in many ways “deviant.” In social construction terms, such an approach points us to the function of concepts of disease and illness as components of a larger system of social regulation. Foucault’s argument that there is no unity to the concept of madness means that madness does not refer to any coherent form of behaviour but rather a discourse within the medical profession itself, which creates and constitutes unity that are then termed sane or insane. From this stance, scientific concepts are not neutral descriptions of patterns of behaviour but are rather produced through discursive activity. This supports the argument that it is impossible to separate out value judgements from social and scientific accounts of illness behaviour (Turner 1999). While Foucault’s approach is different in its suppositions and methods, there are some similarities with Szasz’s (1961; 1970) questioning of the role of psychiatry in eroding individual and human rights. Szasz argues that madness is artificially created concept which is used to control those who think differently from the majority of the population and that the notion of mental health enables the majority to victimise and dehumanise the minority. The value of such critiques in the social sciences of medicine raises vital questions about supposed neutrality and reliability of scientific methods and concepts in the management of human affairs. It uncovers the problems of the positivist views of madness, which underlie the medical model of psychiatric deviance. This implies that psychiatric judgements reflect the norms

and expectations of society. In taking the social constructionist ways I am not suggesting that mental illness (e.g. depression, schizophrenia) does not exist but to recognise that definition of a condition is dependent upon social conventions as well as clinical grounds (Campbell 2000).

In advocating a marriage between mental illness and culture, I am following scholars who argue for the importance of cultural influences upon health and illness (e.g. Dubios 1952; Foucault 1961; Gilman 1988; Kleiman 1988; Lindenbaum & Lock 1993; Porter 1995; Waitzkin 1983). In *The Origins of Human Disease*, McKeown (1988) observes that most common causes of sickness in every era are determined by conditions that prevail at the time and Gadamer's (1993) *Enigma of Health* notes that illness involves cultural practices and shared meanings. This new understanding of illness is illustrated extremely well in Morris' (1998 p5) contention that "Illness ... is not strictly speaking an object. It is not something we can know inside and out, through an inventory of its material properties, like a moon rock. Even when caused by a toxin, by a microbe, or by the dysfunction of an organ, illness is a fluid process that changes as we change, enigmatic, insubordinate, subjective. It captures bodies, minds, and emotions, remains at its deepest level inaccessible to language, and alters under the influence of non-medical events from divorce to climate change." I believe that tracing a historically new way of understanding illness (convergence between mental illness and non-medical events) questions various viewpoints basic to the mechanistic model and that such an exploration may add to our knowledge of mental illness.

Foucault's conceptualisations of power through the exploration of surveillance and control of the body and sexuality (Foucault 1981) and the body's subjugation through the mediation of science and the practice of exclusion both in a

spatial and social sense (as with mental patients, prisoners and slaves); through scientific classification namely the categorisation and partitioning of people (e.g. the category of the “normal” and sociological classification by race, gender, ethnicity and roles) (Rabinow 1984) and finally the concerns of self-control or “subjectification” on individuals’ own bodies, souls, thoughts and conduct (Foucault 1984) have encouraged interest in the body. This is illustrated in recent scholarships in organisation theory, sociology, anthropology, philosophy and history of the human body (Dale 2001; Douglas 1966; Elias 1978; Good 1994; Grosz 1994; Leder 1992; Shilling 1993; Turner 1996). From the body being “ontologically” absent – not being aware of our bodies - (Leder 1990), “under-research” and “under-theorised” (McKie & Watson 2000), there is currently an expanding field of sociology of the body (Turner 1999). Interpreting the symbolic significance of the body as a metaphor (for example phrases such as anatomy of Britain, the health of the company, with bodily symptoms and signs of social distress) is one of the areas that the social theory of the body is developing. Douglas’ (1966) book *Purity and Danger*, which shows the problems of uncertainty and risk in relation to the orifices is an example. Other developments in sociology of the body are debates about: patriarchy, sex, gender, sexuality and identity (Butler 1990; Grosz 1996; Haraway 1989; Lindemann 1997; Martin 1987) the social construction of medical conditions (Annandale 1998; Fox 1993; Turner 1993), issues in organisations as illustrated in Dale’s (2001) *Anatomising Embodiment and Organisation Theory*, which explores the relationship between the human body and the development of social theory about organisations and organising.

Risk and Otherness

Theorisations of the links between ideas of the body and anxieties about risk and Otherness (Lupton 1999a; 1999b), is useful in mapping out the epistemologies of risk. Foucault's notion of a clinical "gaze," that transforms the body into an object of scientific scrutiny shows how bodies can be understood as prone to disorder and therefore need caring, managing, controlling, excluding and isolating. Douglas' (1961) influential work in *Purity and Danger* suggests that dirt, filth and pollution stand as the image of disorder, anomaly, ambiguity, danger and threats to human survival. Douglas describes how taboos - prohibitions that if not observed are believed to result in instant or unavoidable harm - act in cultures to protect them from behaviours that cause danger to them. The idea of taboo fit in with the belief that in addition to ferocious animals and devastating storms, nature was enveloped with harmful, threatening, uncontrollable forces and hostile demons ready to attack at the slightest provocation. The notions of pollution and taboos however were not about hygiene, because concepts about scientific hygiene did not exist; they represented images of disorder and indirect sign of social cohesion. Taboo with its links to dirt and pollution is here seen as conceptual mechanisms for giving the world structure and meaning. Rituals of pollution (e.g. rites and ceremonies) represent a strategy of control over a world that appears out of control and deeply threatening. According to Douglas pollution rituals and taboos – coherent belief systems provided by culture - are vital means of imposing order on a world that at any moment threatens to give way to chaos. Crucial to Douglas' concepts about the symbolic nature of purity and pollution strategies is her observation that the human body is a conceptual microcosm for the body politic or society of which it is part. This is illustrated in the relation to how the flow of fluid in and out bodies' openings

is symbolically conceptualised and controlled. Notions of the body and its openings and boundaries address a major preoccupation of human societies namely how to deal with threats.

Douglas' insight shows that bodily control is an expression of social control. So that ideas about what substances should be incorporated in the body in terms of what is pure and therefore safe to ingest, reflects notions about the body politic and how the boundaries of societies are maintained, regulating the entry of certain types of people "in" and keeping some others "outside" the body politic. Douglas' observations underpin her understanding of cultural role and importance of risk in contemporary western societies, particularly the use of risk as a concept for marginalizing and blaming an Other who is placed as posing as a threat and thus a risk. Risk for Douglas is a strategy for dealing with danger and Otherness. The other conceptualised as different from Self is the subject of anxiety and concern, particularly if it threatens to blur boundaries. For our purpose mental illness (abnormal bodily state) is a source of social pollution that challenges notions about bodily margins stirring the meanings of fear, danger and potential contamination and therefore societal demands for patients to be managed, supervised and controlled.

Douglas' notion of the Other position as contaminated and polluting have echoes in postcolonial theorisations (e.g. Bhabba 1986; Radharrishana 1996; Said 1989; Spivak 1988) with the claim that Western modern knowledge - that is that the Enlightenment notion of knowledge have silenced the voices of the marginal Others. The argument is that non-Western societies and cultures are represented only in terms of the categories of Western thought in which Western society acts as a standard against which all other societies are judged. This predictably leads to the

silencing of other voices. The result has been the acquisition of an aura of superiority for Western cultures and the imposition of the sense of inferiority upon non-Western cultures. In the colonial era, black people were portrayed as savage, uncivilised, uncontrolled, irrational, dirty and therefore threatening to white people. The black body was regarded as porous, odorous and so as potentially contaminating to that of the white body – clean, contained and controlled (Camaroff 1993). Depicting social groups such as non-whites, the disabled, women, Gypsies the Irish as “dirty” has served to represent them as the dangerous Other (Sibley 1995). Bauman (1991) reminds us how the Jews represented in Nazi writings as dirty, unhygienic, pathological, contaminating and consequently requiring extermination in the interests of cleanliness and hygiene gave us the Holocaust.

The above observation is demonstrated in Foucault’s identification of the creation of a discourse that defines sanity and thus marginalizes the insane. In his *Madness and Civilisation*, lepers (prime source of contamination) were the Others of medieval society, whose exclusion from everyday life helped provide society with a sense of its normality. Foucault contends that a new Other (e. g. non-productive, the criminal, the homeless and especially the mad) was born, as leprosy became less common and thus was less able to play its previous symbolic role. The Other, then is that which lies outside a particular culture or society epistemological boundaries. Not only does society treat everything beyond its boundary as the Other, but it also requires an Other without which there can be no sense of Self. Mossman (1997) points out how encounters with homeless people confronts society with deeply felt anxieties about rational ordering and Thomson (1997) explains how people with disability, because they fail to conform to standards of normality are also often treated as sub-human and subjected to fear, anger and abuse. Following

Douglas, social groups who are seen as abnormal and extraordinary can be conceptualised as “dirt” lying outside the normative ordering system of society. Like dirt, people categorised as mentally ill has been dealt with through policies of regulation, exclusion and avoidance in an effort to re-establish sociocultural order.

An additional viewpoint on Otherness is expressed in psychoanalytic theory, which centres on the projection of unconsciousness, emotions and fantasises upon the Other; as part of individual’s continuing attempts to maintain a coherent subjectivity and to construct and maintain conceptual borders. Based on Douglas’ notion of defilement, Kristeva (1982) has developed the notion of abjection. The abject is viewed as dirty, filthy, contaminating waste, which confounds boundaries. Following Douglas, Kristeva maintains that the abject matches the attempt to clearly define borders. To delineate borders, a line must be drawn between the inside and outside, between the clean and the proper self and the abject Other. That which threatens identity must be discarded from the borders and placed outside. In a similar vein Williamson (1989) used psychoanalytic approach to theorise the popular response to HIV/AIDS. She argues that the horror expressed on issues surrounding HIV/AIDS (regarded as monster) is result of the splitting off and projection of repressed anxieties and fascination about “unacceptable” or “perverted” sexualities. The monstrous characteristics of HIV/AIDS lie in wait to break down the boundaries between Self and Other - dissolving categories between the “contaminated” and the “pure”. Accordingly, people believed to be “at risk” of HIV infection have been routinely considered as contaminated and polluting, the repository of fears and anxieties about death, illness, chaos, lack of control and the incipient permeability of the social and fleshy body.

With a particular focus on gender implications, Grosz (1994) in *Volatile Bodies* has build on Douglas and Kristeva's discussion to analyse the sexual bodily fluids. Grosz argues that anxieties about bodies are projected onto female bodies – where female bodies leak but male bodies do not. The female body is conceptualised as marginal, indeterminate, fluid, borderline and liminal as seeping sexual fluids such as menstrual blood that are considered to be particularly “dirty” because of the mysterious uterus and hidden female genitals. The female body tends therefore to be viewed as more dangerous, defiling than the male body. For instance, semen is exempt from the category of dangerous fluids because it is suppose to be purified by the heat of the male body. According to Oliver (1998 p.142), “The physical purification process corresponds to the male's cathartic purification of passions and lusts from his clean and proper self. The separation of the male body from the mess of reproduction, the separation of masculine identity from the male body's role in reproduction, allows masculine identity to be constituted by abjecting everything messy about reproduction and associating it with the female body. In this way, males maintain their own clean and proper selves.”

Conceptually, we have seen how the term ‘body image’ has been used to illustrate the ways in which we think about our health namely, our understanding and experiencing of health, illness and healthcare. The individual body image which is dynamic and continually transforming determines the distinctions between its outside or skin and its inside or inner organs. Lupton identifies a variety of bodily practices that have been established to deal with risk over historical periods – pre-modern, modern and contemporary era – postmodern or late modernity era. Drawing on the work of other scholars, Lupton (1999a; 1999b) argues that over the

centuries, changing concepts of the body in western societies “have been accompanied by changes in ways in which risk has been conceptualised and dealt with” (Lupton 1999a p 124). The notion of the ‘open body’ perceived as unrestrained, unstable and sumptuous during the middle age was replaced by the ‘closed body’ (independent, controlled, organized, individuated and closed off from other bodies) as the ideal in early modernity and late modernity.

Figure 2a: Epistemological Approaches to Risk

Period	Classification of Rationality Context	Risk management Strategies/Location of Services
Pre-Modern	Religious Authority	Practice based on wisdom/ Ships of fools
Modernisms	Rational, truth-finding, objectivity	Practiced based on scientific knowledge/madhouses, asylums, psychiatric hospitals.
Late Modernity	Social construction of risk; social circumstances	Practice based on openness, transparency and trust / community care, crisis intervention centres

The Pre-modern Era

The periods pre-modern and traditional refer to the types of societies, largely rural, agricultural, religious and relatively small in population that preceded modernity. The early cultures saw the world as an interrelated whole in which man, nature, a diversity of mythological characters and many types of unavoidable forces worked together to create the world. During the pre-religious period the gods were an essential part of the universe and therefore played an active role in human affairs. Nature’s extremes (risk, dangers) were seen as expressions of divine anger toward people. Myths represented the earliest cosmologies about how the world works. Christianity, which initially faced resistance and contempt from the first century A.D. in the Roman Empire, began to be tolerated towards the end of the fourth

century. Although there were a great deal of variety among the early churches depending on geographic location and culture, its earliest followers and their pre-Christian beliefs about the nature of man, God and the universe, the world was ordered according to God's will. The Church adopted Aristotle's concept of the universe, with the Earth at the centre because it supported the Church's view of itself as the centre of society. Religion and its rituals were an essential part of the social system where threats were regarded as acts of God. This category includes the type of threats that are generally considered inescapable. Their occurrence was beyond the control of humans, though, it did not mean that the consequences cannot be minimised or provisions made for recovery when an act of god strikes. Society found itself subordinate to the impulse of nature with the belief that all things work or change according to their basic natures.

Philosophy of nature, which asked new types of questions designed to help thinkers understand the fundamental nature of the universe began to emerge in the fourth century. Socrates changed the focus of philosophy away from cosmology toward politics and ethics in the fourth century. In the late fifth century BC atomists believed that the world was made up of tiny constantly moving particles, which came in a variety of shapes and sizes out of which everything in the material world was constructed. Their view was that life and all its forms are made up of those particles and life itself was a well-constructed machine. For Pythagoreans, numbers came first, then matter; their tool of choice for investigating the world was mathematics. Plato disagreed with earlier philosophical views which, attributed order to the inherent nature of things. In his view, creation was the result of various combinations of triangles. Plato also believed in various non-interfering gods whose role was to ensure stability and order support the universe. Aristotle, Plato's

student disagreed with his teacher's beliefs and engendered worldviews, which would dominate philosophical and scientific thought for almost two thousand years. Aristotle developed a formal system of logic and a set of principles, which he applied to a wide range of disciplines, including biology, cosmology, meteorology and astrology. Following earlier thinkers, Aristotle believed that natural objects, as opposed to man-made objects, behave in certain ways according to their natures. He believed that one could understand the basic nature of things through observation and experience (empirical knowledge) and also the use of inductive and deductive reasoning. Other forms of natural philosophy – Renaissance Naturalism- emerged in the sixteenth century in which nature was believed to possess a living spirit filled with mysterious unknowable to man's intellect. While different in many ways, Aristotelian natural philosophy and Renaissance naturalism shared a belief in nature's active participation in the world through interconnectedness of mind, matter and spirit.

This period saw European renaissance, with the thriving of mercantilism and earliest beginnings of capitalism. The emergence of the word and concept risk in the pre-modern period (mid sixteenth century) is linked to early maritime ventures (Ewald 1991, 1993; Luhmann 1993). The notion of risk was related to maritime insurance and used to designate the perils that could compromise a voyage. In this era risk designated an objective danger, an act of God that could not be imputed to wrongful conduct. This concept, excluded the idea of human fault and responsibility. Risk was perceived to be a natural event such as storm, flood or epidemic rather than man-made one. As such humans could do little but attempt to estimate roughly, the likelihood of such events happening and taking steps to reduce their impact. Risk was a neutral concept taking account of both gains

and loses. A system of strategies including beliefs and offerings to Gods, avoidance of tabooed places, were developed in an attempt to deal with, contain and prevent danger. Magic combined with touch of Christianity, served as a belief system by which threats and danger were dealt with conceptually allowing people to have a sense of control over their world.

The historical development of mental health as identified by Foucault (1971) shows evolutionary progress. Madness as the notion of 'folie' or foolishness in the pre-modern era was associated with divine insight and creativity. Madness was valued as a different way of being and knowing, perhaps a privileged way with a more direct access to heaven. Thus the patient – *the endangered body* - represented a number of fantasies, which vaguely veered between fascination and fear, desire and danger, attraction and repulsion. The period's ambivalence towards the mentally ill was illustrated in the exorcising madness by sending its 'loonies' away. The mentally ill were objects of fear and repulsion and were isolated for separation from society. In risk management terms, the mentally ill (open body) in the pre-modern period were managed by expulsion, being cast on the 'ships of fools' (Foucault 1971). The mad were isolated from society during this period particularly when they posed a threat (risk) to others or themselves (Midelfort 1989). The "at risk" with the consent of societal preference were seen as externalities to be confined and controlled. In terms of psychodynamics of constructing and maintaining boundaries of selfhood discussed above, the Other (patient) was invested with emotion, both positive and negative and conceptualised as different from Self (body politic or community).

Modernism Era

Modernism from the seventeenth century was not an event but rather a period of transition in which attempts were made to resolve questions from the past and radical new ideas began to take shape. Some ideas were discarded, while others were adopted and still adorn the scientific landscape today. The source of modernity the Enlightenment codified major developments in early modern European thought and provided a milieu for future cultural and political struggles. Although the Enlightenment project does not have a distinctive set of principles, it is still possible to isolate some of its general characteristics, particularly its rationality, humanism and universalism. For philosophers of the period, the key to human nature was its intrinsic rationality. Reason enabled us to discover the intricate abstract truths of mathematics and to apply these to our understanding of the universe. Reason allowed us to ask and answer questions of nature through carefully planned observations and experiments. Leading thinkers developed a range of naturalistic theories of human nature of man as a machine d'Holback of the mind as a microcosm Hume. They believed that the world had become a human world determined by human aspirations rather than by nature and that universal rational moral principles are binding on all rational beings everywhere. According to David Hume, human nature was the same in all nations.

The period featured rationalism, rational planning, totalising views of the world, standardisation of knowledge and a belief in linear progress, particularly the progress of reason and freedom. The machine metaphor for Descartes and others became a powerful tool for understanding nature. The basis of the Cartesian notion was the separation of mind from matter. In separating mind from matter, knowledge was depersonalised and a chasm was created between one's experience of reality

and reality as interpreted by science – the separation of objective reality from experience of reality. This dualistic approach wiped out every trace of intelligence and life from nature and was viewed instead as passive lifeless matter to be acted upon by outside forces. It was believed that all matter, including the *human body* operate like machine. The world was seen as a huge machine that operates with order and precision and whose understanding was accessible only to scientists through the power of mathematics. This notion of the world that operates like a machine with clockwork precision through a code of rules and consequences created a world of sameness, predictable, controlled and known: where acts of nature, plagues, social upheaval and other forms of disorder were seen as aberrations in a world order. This thinking can be seen in the complex organisational forms and processes (modern bureaucracy), which developed during the period. The essential characteristics and principles of modern bureaucracy are based on rationality, universal standards, division of labour, rule-governed behaviour and clear hierarchical structure (Weber 1947).

Enlightenment rationality acquired greater depth from ideals about truth through science. It was assumed that it was possible to control reason through the coding and structuring of human thought, and through the regulation of human action. Changes in the meanings and use of risk are associated with the emergence of modernity with the notion that the key to human progress and social order is objective knowledge of the world through scientific exploration and rational thinking. It assumes that the social and natural worlds follow laws that may be measured, calculated and therefore predicted. The science of probability and statistics was developed as a means of calculating the norm and identifying deviations from the norm and identifying deviations from the norm, with the belief

that rationality, counting and ordering would bring disorder under control (Hacking 1990). These themes were to become important to the modernist technical notion of risk. During the eighteenth century, the concept of risk had begun to be scientised (the development of statistical calculations of risk), drawing upon new ideas in mathematics relating to probability. The notion of risk was extended in the nineteenth century, as risk was located in the conduct of human beings and their interactions in society and not exclusively in nature (Ewald 1993). Thus the modernist concept of risk represented a new way of viewing the world and its chaotic manifestations, its contingencies and uncertainties. It assumed that unanticipated outcomes might be the result of human action rather than the hidden meanings of nature or the inevitable intentions of God (Giddens 1990). The notions of chance or probability and loss and damage as associated with insurance resulted in the idea of risk as a neutral concept; denoting the probability of something happening, combined with the magnitude of associated losses or gains. This means that modernist notions of risk also included the idea that risk could be both good and bad (Douglas 1992). This meaning of risk dominated until the beginning of the nineteenth century (Ewald 1991).

The discourse of madness during the modern era was based upon the splitting of reason from unreason in the quest for order and predictability (Foucault 1965). This development can be seen in the organisation of mental health services. The period witnessed a dramatic move away from unregulated unplanned local arrangements to a system that was increasingly rational, managed, centralised and segregative as exemplified in the creation of public asylums. The period also saw the development and acceptance of a medical model of insanity, in the construction of a theory that defined madness as a medical category with a biological basis. The

beginning of the nineteenth century saw an increase of medical categories with specified symptoms and aetiology and saw the dawn and spread of asylums in Europe and North America. Asylums were seen as schemes for the transformation of subjects into citizens who would regulate their own conduct according to norms of good sense, order, restraint, continence and responsibility. The mad, in the second half of the nineteenth century represented social danger and the asylum, whose rationale was the production of citizens who could be free to the extent that they had taken the obligations of moral, prudent and self-responsible conduct into themselves became the machine of morality. Thus confinement in asylums resolved a social demand – the containment of socially scandalous behaviour that was not yet criminal - in spite of a range of legal and constitutional rights, which prohibited confinement except for a breach of the law. The mad depicted as disgusting, dirty and lacking the most fundamental powers of self-restraint was chained up in madhouses where the general public could pay an admission fee to watch and jeer. Other strategies such as psycho-medical technologies such as bloodletting, immersion in water (hydrotherapy) and various mechanical restraints were utilised (Collin 1999).

In the period of early modernity, the mad (grotesque open bodies) were seen to lack the capacity for adequate regulation of their bodily boundaries and were regarded as 'at risk'. Madness became a disease and lost the dignity of being seen as meaningful unreason. Regarded as objects of fear and repulsion, they were isolated in houses designed more for separation from society than cures. The mad person represented social danger and their confinement in asylums was the response to social demand for mechanism for the containment of socially outrageous behaviour. Controversy regarding preferred location for services saw the movement of

institutionalisation from madhouses to asylums, mental hospitals to the community. The emergency of the mental hygiene movement in the 1920s and 1930s resulted in the setting out of preventative strategies for the population prior to surfacing of social danger so as to minimise the likelihood of the danger arising. In this context, the remit of intervention, widen to address not only madness but also social inefficiency and unhappiness. Here almost every infringement of institutional and social norms of behaviour (e.g. truancy, lying, tantrums, inefficiency at work) was given a psychological connotation and thus needful of investigation, assessment, prescription and treatment. The main emphasis was the creation and maintenance of social normality and competence (Rose 1985). So psychiatry performs a regulatory function for society by alleviating the personal distress of the emotional distressed and expanding its own spheres of influence vis-à-vis the definition and treatment of madness (Handy 1991).

We can draw on Foucault's insights to argue that during this period attempts were made to make invisible and control the presence and spatial distribution of the mad in the body politic: because the mad were seen as dangerous and risky to society's progress. Strategies of exclusion that were directed at the mentally ill were explicitly concerned with maintaining a body within certain geographical limits ((Sibley 1995). The mad are constructed as posing a risk to the dominant group through behaviour that is deemed to be different or potentially polluting and therefore confronting. Simultaneously, the mentally ill are constructed as being vulnerable and "at risk" from the greater power of the dominant group and therefore requiring regulation or exclusion for their own safety. The dominant ideal notion of the body is that of the body as controlled, its boundaries policed and regulated and kept separate from other bodies and the outside world.

It is important however to note that the nineteenth century also saw a fundamental attack on the legitimacy of the activities of asylums in which the standing of mental medicine as knowledge was ridiculed, the integrity of its practitioners criticised, and its capacity to cure questioned (Castel 1988). Nonetheless, psychiatrists made a general claim as to the significance of their science for the administration of the population as a whole in the interests of national well-being. A whole series of people (the idiots, imbeciles, criminals, gamblers, syphilitics, paupers, mad, drunkards among others) regarded as a threat to social order were amenable to prevention and control. Here the pathologies of individuals were not solely medical significance but were symptomatic of a wider social malaise. The boundary between the “sane” and the “insane” became blurred and the confined space of the asylum was no longer seen as the ideal solution. It was in this context that the mental hygiene movement arose in an attempt to devise a more positive approach in the form of preventive strategies for acting upon the population before the appearance of social danger. Psychoanalysis and a range of psychologies and therapies provided the mechanisms in addressing a variety of new problems (social inefficiency and unhappiness) such as the problem of shell shock during after the First World War, the issue of juvenile delinquency, truancy and absenteeism. It was here that the new programmes (the maintenance of social normality and competence) envisaged a non-custodial project. Inefficiencies of conduct of almost any sort were seen as results of minor mental disturbance which if not treated would get worse and lead to insanity, with all the consequent danger, misery and social cost. To tackle stigma demands were made for the establishment of clinics and hospitals where voluntary admission could lead to treatment. This line of thinking was embodied in the shift in terminology from lunacy to mental illness

and from asylum to mental hospital. In effect these were attempts to bring mental medicine into contact with general medicine and apply the same principles of treatment (namely investigation, assessment, prescription and treatment). It was against this background that interventions in psychiatric care could be understood in late modernity.

Late Modernity

Most observers locate the advent of late modernity or postmodern era sometime after World War Two in the advanced capitalist countries. However, there is disagreement about whether this constitutes a decisive break or some sort of continuity with the modernist era. For instance, Baudrillard (1983) sees postmodernism as an indication of destruction of meaning, therefore depicting all previous social theories obsolete, Bell (1976) perceives postmodernism as the continuation cultural trends originating in modernism. Lyotard (1984) rejects the modernism-postmodernism conceptualisation while Foucault (1973) resists any characterisation of his intellectual project as postmodernist. Despite the multiple ways in which the term is used there are common threads that ties together the diverse elements. In its many guises late modernity is concern with the excesses of capitalism, industrialisation and rationalism (Turner 1992), rejects the Enlightenment argument that human nature is always and everywhere the same and argues for the need for new theoretical and methodological strategies. Seen in this light, late modernity perspectives exhibit striking similarities with the work of Durkheim, Marx, Weber and others in the classical sociological traditions that made great effort to find new ways to understand the dramatic changes in social structure.

The late modernity era which questions established thought (objectivity of rational discourse) is characterised by uncertainty and ambivalence related to

constant change, cultural fragmentation and breakdown of norms and traditions (Giddens 1990; Lash & Urry 1994). Emotion, intuition, as well as rationality play important part in guiding action. Traditions associated with order where individuals have few rights and governed by church and nobility in the pre-modern era are replaced with individuals' rights and autonomy. Such changes are perceived as causal to a particular way of understanding the world that differs radically from earlier eras. For the individual, these changes are linked with an increasing sense of uncertainty, complexity, ambivalence and disorder, a growing distrust of social institutions and traditional authorities and an escalating awareness of the threats intrinsic in everyday life. The firm deterministic view (the linear clockwork view) of the world promoted in earlier eras began to shift to the acknowledgment that the world is made up nonlinear dynamical systems. In terms of illness this observation articulated the fact that much of the practice of medicine is outside the ambit of the modernist reductionist model of science.

The late modernity era is identified by its appreciation of the complex linkage between biology and social forces in terms of illness termed the "biopsychosocial" model (Schaffner 1992). This approach embraces the social construction of reality – a notion that refers to the ways in which the world is structured and in large part created by forces of human culture (i.e. language, myth, ideology). This new thinking suggests that illnesses while always biological are in addition cultural artefacts and therefore rejects the continuing dominant biomedical model that views disease as the result of biological and chemical mechanisms in the body; in other words a denunciation of a single theory that will explain every illness (Lyotard 1984). Kleinman and Good (1985) challenged the emergent consensus that the contemporary criteria of depression are universal and biologically grounded disease

and reminded us of cultural influences on the experience of depression. Such an approach has an intellectual lineage in the premodern and modern eras. In advocating a rational, empirical and biological medicine as different from magic and religion, environmental forces such as diet and work were seen as causes of disease by Hypocrites. Aristotle investigated various non-natural (non-biological) causes of illness including climate. There were suggestions by Renaissance theorists that personal habits like excessive study could cause illness by distorting bodily fluids and eighteenth century doctors located specific illnesses to the influence of lifestyle (Morris 1998).

What is unique of mental illness today? How does mental illness in the late modernity era differ from mental illness as it was understood and experienced? Reactions to the traditional approach to psychiatric diagnosis, which set rigid standards of behaviour from which it was considered abnormal to deviate, is leading to increasingly loose definitions of mental illness. Mental illness is now not only to be “cured” or to be contained but also to be managed as patients across diverse specialist institutions and professionals (hospitals, clinics, homes, mental health centres, crisis centres, psychiatrists, general practitioners, clinical psychologists etc) (Rose 1996). In the late modernity era the centrality of risk discourse in relation to patient care can be linked methods of to “biopolitics” (Foucault 1984); that is, attempts on the part of the society to discipline and normalise citizens. Such normalisation involves gathering information about populations and subjecting it to statistical analysis. As observed in chapter one, individuals are compared to others by assessing their attributes to ascertain whether they fall within the norm or outside it. If found to fall outside the norm, people are encouraged or sometimes coerced to engage in practices that bring them closer to the norm as illustrated in introduction

of the supervision register. The risk to the public might be negligible, but there is still a consensus that patients, nonetheless, need to be controlled.

The contemporary preoccupation with playing safe and avoiding risks has been accompanied by increase in new psychological conditions or syndromes. A search for a representative mental illness quickly turns up a number of interesting candidates. For example, a growing number of children are diagnosed as suffering from attention deficit hyperactivity disorder and dyslexia, adults suffering from eating disorder, adjustment disorder (difficulties negotiating relationships), post-traumatic stress, social phobia, sexual addiction and food addiction. At the time of writing the chief medical officer of the United Kingdom, Professor Sir Liam Donaldson announced that Myalgic Encephalomyelitis (ME) also known as chronic fatigue syndrome (CFS) must be recognised as a genuine illness and insisted that doctors must provide prompt, authoritative diagnosis, appropriate advice and early access to treatment. The endorsement of the biomedical model extends the advance in the medicalisation of the problems of individuals in society and retreats from any attempt to confront such problems in social terms. It upholds dualism of mind and body, which was prevalent during the Enlightenment and implicitly, supports the stigmatisation of mental illness, by dogmatically repudiating any recognition of the role of psychological factors in the origins of physical symptoms.

Campaigners concerned with challenging oppressive and discriminating practices have drawn attention to the extent to which mainstream psychiatry has been affected by political social and cultural factors. Attitudes within this mental health project are that there is no clear boundary between reason and unreason, health and illness; abnormal behaviour becomes normal variance and equally valid aspect of life's rich tapestry. Thus conditions like CFS, Gulf War Syndrome and

other conditions that defy diagnoses and amplified by popular media debates have caused campaigners to demand treatment. For Showalter (1997), these disputed conditions are contemporary “hysterias.” At the extreme end, a conflation of insanity with oppression has caused some activists to emphasise the positive elements of madness where psychotic symptoms are seen as a source of enrichment rather than disabling; an organising Mad Pride along similar lines to Gay Pride. There are similarities in the activities of Disability Movement and Grey Power, the former celebrating and valuing disability by challenging the idea of the able-bodied and the later organising against a traditional definition of biological age.

It is important not to exaggerate the significance of social forces or to ignore relevant distinctions. There are dangers that the rigid conceptions of “normal” and “abnormal” behaviour (which may lead to a closure of any standard of “normal” or “mentally well” behaviour) and the portraying increasing numbers of people as pathologically or psychologically impaired (which may lead to self-fulfilling prophecy) may relativise away those aspects of the traditional approach that were positive and progressive. This perspective parallels the premodern era that relied on divine theory where God’s will was beyond dispute and in sense rejects the rational view of unreason of the Enlightenment period. A biopsychosocial view of mental illness however does not require abandoning all views based on the biomedical model. The Enlightenment views of mental illness, based on biomedical model were at least open to challenge unlike the divine theories that went before. The value of the rational, scientific approach to psychiatry was that as a minimum it saw insanity as a problem to be “cured”, rather than a divine intervention about which nothing could be done. Furthermore even within the biomedical model the practice of

psychiatry is not monolithic. Various disciplines within the multidisciplinary team have distinctive outlooks and conflicts about dimensions of mental illness.

The new terrain of psychiatry, the presentation of mental illness as just another normal part of life, has turned madness into inability to cope with everyday life. Professionals are therefore required not so much to cure as to teach skills of coping; namely encouraging the responsibility to cope, isolating failures of coping and reinstating to the individual the capacity to cope. These developments can be perceived in what Rose (1996 p. 12) following Foucault describes as “advanced liberal strategies of government” that involves “extending market rationalities – contracts, consumers, competition – to domains where previously social, bureaucratic or professional logic reigned; governing ‘at a distance’ by formally separating activities of welfare professionals from apparatuses of central and local state, and governing them by budgets, laws, audits, targets, standards, code of practice and the logic of consumer demands; making individuals and ‘communities’ themselves ‘interested’ in their own government in the sense that they should take responsibility for their own present and future welfare and for the relations which they have with experts and institutions.” A vital feature of such logic is the idealised body of the independent, self-regulated patient who seeks to maximise his/her life opportunities and minimise the risk to which he/she is exposed. In addition, the patient is deemed to need guidance and advice from expert knowledge to minimise risk. Risk management is thus becomes the responsibilities of patients and professionals.

The above observation allows us to bring to light some of the related characteristics of the contemporary profession of psychiatry. The first points to the way in which psychiatric patients are defined - the “new prudentialism” (O’Malley

1996): that is a way patients are increasingly held responsible for the management of their own fate through calculation about the future consequences of present actions - bringing of the future into the present and making it calculable. Failures of management of the self, for instance, lack of skills of coping with work, money and family are now criteria for qualification as a psychiatric patient. These responsibilities of self-management also provide new divisions within patients; the divide between the "ideal bodies," those who take their medication, keep appointments, able to cope in a way that parallel the assessment of the professionals and "porous bodies" who are not able to cope. Another feature is the way risk management and risk reduction as logics for professional action have to a certain extent reshape professional judgements. Such a shift is illustrated in the Clunis case (mentioned above) where the questions asked of professionals were where he should have been sent, decisions made in terms of his likely future conduct, his riskiness to the community and the necessary steps taken to manage his conduct. The demand on professionals was to predict rather than to diagnose (Rose 1996). Here, human action is motivated not so much by the desire to achieve positive changes but rather by the pressure to prevent certain events happening (Beck 1992; Giddens 1994). In the words of Beck (1992 p.34) "we became active today in order to prevent, alleviate or take precautions against the problems and crisis of tomorrow and the day after tomorrow - ". Another aspect of this development is the reflexive monitoring of action (Beck 1992; Giddens 1990; Lash & Urry 1994) in which organisations are under increasing pressure to explain their policies and be accountable to society. Thus risks in late modernity stem not so much from nature but from human interventions.

Our brief sociological look at the historical look of the concept of risk reveals the emergence of plurality of risk definition definitions. The idea of technological progress, central to the Enlightenment commitment to constant human improvement (public benefits and the common good), suffered erosion in the wake of several catastrophic technological accidents. The notion of progress as it is developed during the seventeenth century was based on trust in human reason to improve constantly the state of human affairs in the future. Thus in terms of modern decision theory there was a belief in the human capacity to guarantee positive outcomes with the expectation that an increasing body of scientific knowledge could provide the necessary insights about future developments that would finally render unnecessary past dependence on religion. Progress has however, been viewed much more ambivalently since the nineteenth century because the growth of knowledge through science did not prevent unwanted outcomes of technological innovations. The notion of contemporary risk originated from this development. The uncertainty of outcomes of decisions brought a link between risk and decisions – risk being a manifestation of possible future unwanted outcomes of present decisions. Here decision makers become involved in the negotiation of possible harmful future states against known and accepted present ones (Luhmann 1993). This prompted modification in the different meanings of the treatment of progress – progress is no longer certain but becomes a probabilistic outcome of application of instrumental rationality to political, economical and technological problems. As observed by Perrow (1984) risk is no longer associated mainly with the enhancement of humanity, but is now often connected to fear and disasters. The lost of a positive risk image has brought about conflicting views of risk assessment and risk management.

Risk and Sociocultural Theory

The ways in which western societies gave meaning and dealt with risk can be located in specific socio-cultural and historical contexts. The rationale that has tended to dominate debates on risk adopts a positivist or realist theory of knowledge and a rationalistic policy orientation. Risk, from this stance is a tangible spin-off of actually occurring natural processes. It is assumed that, risk can be measured by well-informed experts, and within limits controlled. People's judgements on risk are typically depicted as 'biased' or ill-informed compared with 'experts' more accurate and scientific assessments. However, research on risk perception argues that lay people have a rich conception of risk and that their views should be integrated in risk decision-making (Slovic 1992). The notion that risk, as a phenomenon can be isolated from social, cultural and historical contexts as advocated by exponents of the traditional approach has been challenged. Risk research has shown that contextual factors shape individual risk estimations and evaluations (Renn 1990; Slovic 1987). Three major critical approaches – cultural/symbolic, risk society, and governmental perspectives (Lupton 1999) have identified important factors such as, how risks are conceptualised, the position played by experts, and dominance of risk in contemporary society. It will be useful to present an abbreviated overview of the three perspectives.

The cultural theory claims that risk perception, is a social construct and suggest a pluralistic solution to the problem of interlocking knowledge with action (Douglas 1985; 1990; Douglas & Wildavsky 1982). Society, according this view, is composed of groups of people with different views of risks shaped by history, politics and culture. This affect how risks are perceived and what is considered as legitimate risk management solutions. Douglas and Wildavsky (1990) suggest four

different cultural archetypes: individualists, hierarchists, egalitarians, fatalists, and autonomy. *Individualists* appreciate decisions that come from personal judgement (self-regulation) rather than collective control and favour deregulation as a rational risk management strategy. *Hierarchists* favour a social organisation where the preservation of authority within a structure is paramount. In this worldview, there is trust in information from sources that are seen to support authority structures. *Egalitarians* prefer approaches to risk policies that foster equality of outcomes and therefore critical of the procedural rationality associated with hierarchy. They perceived dangers associated with most technologies as great, and their attendant benefits as small. *Fatalists* perceive societal and technological changes to be independent of any socially derived perspectives. The assumption is that individuals who are high in fatalism are excluded, or see themselves, excluded from any formal organisation of social life.

The implication of groups having different world views, means that they will differ in their definitions of what risks are worthy of society's attention and also over how these are to be resolved. It may be argued that unless there is societal consensus of one world-view over risk, distrust and conflict is inevitable. The cultural theory emphasis on a socio-cultural context in which individuals are located and through which they make judgements about risk, shows the importance of the individual's psychological and cognitive response to risk. However the models of risk responses have been criticised for their rigidity. For example, individuals' social groups or institutions can have more than one bias, and therefore making predictions concerning risk perception derived from membership of one group problematic (Lofstedt & Frewer 1998).

The 'risk society' theorists focus their analysis on macro-structural factors influencing what they see as to be intensification of concern in late modernity societies about risks. They argue that the risks produced under the conditions of late modernity have increased in magnitude and become globalized, and therefore more difficult than in the past eras to calculate and therefore difficult than in past eras to calculate and therefore manage or avoid. Central to the writings on risk society is the concept of reflexive modernity (Beck 1992; Giddens 1991). This concept incorporates the reflexive monitoring of action in an ongoing process implicated in every act of human behaviour. The risk concept has therefore become fundamental to the way people organise their world. As a result of our growing ability to collate and to reflect upon larger bodies of knowledge about risk, changing pattern of risk assessments and judgements develop. In the kind of 'colonisation' of the future, risk calculation turns the essentially unknowable into a new terrain of possibility (Giddens 1991). While the 'risk society' theories have contributed considerably to the development of a new paradigm for sociological research it has been seen to have limitations, in relation to their adherence to conventional modernist views on self, science and society. The models have been criticised for their lack of attention to a cognitive bias in their idea of reflexivity whereby the body is an object to be monitored by the ego or subject. The theorists are also criticised for espousing to positivist ego psychology, which is hostile to any notion that the self is complexly structured and differentiated (Lash & Urry 1994).

The third, 'governmentality', which I have drawn upon extensively, focuses its analysis on the ways in which the concept of risk mediates between knowledge and power. Risk analysis according to this approach, is primarily a specialised language and a set of practices – in formal terms a discourse (Foucault 1980). For example,

Foucault identifies the stages of the creation of a discourse that defines sanity and thus marginalizes the insane. Discourses embody divisions in language, defining marginality and making those defined as marginal, or outside of discursive norms (e.g. the mad), as specimens for those who control the discourse (e.g. professionals). The decision to frame mental health interventions in terms of the concept of risk, for instance, rules out other possible ways of talking about harms to patients. Risk discourse implicitly empowers some people as experts and excludes others as irrelevant or incompetent. A central feature of governmentality is normalisation: the method by which norms of behaviour are identified in populations and by which individuals are then compared to determine how best they fit the norm. Individuals determined to deviate from the norm considerably are usually identified as being “at risk”. To be categorised “at risk” compared with others meant being single out as requiring expert advice, surveillance and self-regulation. As noted above, writers espousing the governmentality approach have argued that within psychiatry, we are witnessing a shift from dangerousness to risk (e.g. Castell 1991; Kendall & Wickham 1992). Thus while “risk” in the past meant danger embodied in the mentally ill person capable of unpredictable action and violent, it is now based on abstract factors.

All the three theoretical perspectives highlight the social, cultural and political nature of risk, but they each offer a fine distinction in their approach to risk. Lupton (1999) (provides a detailed model of risk continuum) categorises the approaches at different points along a continuum, at which the realist approach of the kind offered in the traditional approaches is at one end of the pole and highly relativist constructionist approach at the other. The ‘risk society’ approach veers between a realist and a weak social constructionist position on risk. The ‘cultural’ perspective

is more towards the relativist position. The 'governmentality' perspective, which offers the most relativist position on risk, concentrates on the forms of knowledge, the dominant discourses and expert techniques and institutions that serve to make risk calculable and knowable. Better understanding is needed of how risk logics are produced and operated at the level of situated experience. What sorts of information then, do professionals trust and draw upon in developing their logic of risk?

From the realist stance, solving bureaucratic failures have, been met with bringing uniformity and rationality to decision making. Here, risk assessment depends for its success on the traditional bureaucratic virtues of rationality, expertise, insulation and authority. Studies of risk as a social construct give a different view of why risk management fails. Risk in the modern world, does not flow deterministically from conditions fixed by nature. How does the preceding discussion bear on the risks issues that are now confronting psychiatric nurses? We have tried to show thus far that risk concepts are not simply neutral descriptions of nature, but are culturally and politically conditioned ways of interpreting both our relationship to the world around us, and our obligations to others. What conclusion can we draw from what we have learned about socially embedded character of the risk concepts that are currently being developed to deal with the care of the mentally ill? How can we gain a continuous understanding of these complex changes in understanding psychiatric nurses in organisational context?

The intriguing debate within the three traditions has been anticipated in Turner's (Turner 1978) model, the Man made Disasters (MMD). The model, which is descriptive and analytic, seeks to understand the causes of disasters by focusing on the dynamic and complex nature on the organisational dimension of disasters

(man-made as well as organisation-made disasters). A proposal of the model is based upon a better understanding of the ways that knowledge and information were distributed before a disaster struck: “many disasters arise solely from administrative causes, or from a combination of technical and administrative causes. Those in positions of power, those concerned with management and decision-making and those who control administrative machinery may well find that some of their actions contribute inadvertently to the causes of a disaster” (1978 p.3-4). In his investigation of accidents and social disasters, Turner found that many disasters had long incubation periods characterised by a number of discrepant events indicating danger which were ignored or misinterpreted during the incubation period, and hence accumulate unnoticed. The implication for risk management is that long incubation periods can include dormant and exist unnoticed in organisations for long periods of time. The longer they go unnoticed, the more difficult it becomes to rectify. Such “failures of foresight” (Turner 1978 p. 31): which encompass complacency, poor communications, inadequate information handling in complex situations, failures to comply with existing regulations set up to ensure safety and incoherent norms and culturally accepted beliefs about hazards were evident in most major disasters in healthcare organisations.

Turner’s qualitative analysis of 84 official reports into accidents reveals a pattern of similarities in healthcare organisations noted above. We saw rigidities in perception and beliefs in organisational settings that prevented accurate insight of the likelihood of the disaster. There was evidence of what has been termed “the decoy problem”, namely that when some hazard was perceived, the action taken to deal with the problem, distracted attention from that which ultimately caused the disaster. There was an organisational tendency to deny remote dangers that enabled

administrators to dismiss as cranks those who disagreed with the organisation's policy. The organisations had information difficulties, where there were completely unknown prior information, prior information noted but not fully appreciated, prior information noted but not combined with other information appropriate at the time and prior information available but ignored, because there was no place for it within existing ways of understanding. In addition we observed the involvement of people without the proper training, the minimising of emergent danger that took the form of an underestimation of possible hazards. Finally, recommendations were designed to deal with the well-structured problem defined and revealed by the disaster, rather than with the ill-structured problem that existed before it.

In sum, Turner reminds us that disasters rarely come about for any singular reason rather it is typical to find that a number of undesirable events contribute to an "incubation period" often measured in years. The MMD model directs us, particularly to informational difficulties associated with attempts of individuals and organisations to deal with uncertain and ill-defined safety problems. The complex and multiple interactive nature of the model, presents the issue of the potential incompleteness of risk assessment models. His insights are clearly relevant to those who manage and operate in healthcare organisations. Health care institutions are complex organisations with multiple personnel, departments and technologies that are brought to bear on patients; interfaces which have been identified as the source of key gaps in patient care, corresponding to holes in defensive barriers (Cook et al 2000). Like most organisations in the hazard industry, health care organisations are organised centrally around the issue of safety arising from the rationale; to bring no harm. Risk is an inescapable part of the issue of health care. When patients encounter the health care system clinicians intervene to tackle those diseases, using

technologies, which carry with them their own inherent dangers. For instance, diagnostic tests, surgical procedures and drugs all have potential complications and side effects as well as benefits. Thus both the clinical products (diagnostic and interventions procedures) and professionals, the providers of care are sometimes potential sources of hazards for patients. The organisation of work tasks, must always take safety work –assessing, monitoring, preventing and rectifying potential hazards.

Another source of complexity is the therapeutic technologies (e. g. drugs) involved in modern health care. In psychiatric settings, part of the complexity arises from the unfeasibility of working with madness, “a phenomenon that defies clear definition” (Willshire 1999 p.775). Efforts to define madness have resulted in debates between a “disease of the brain” approach to madness typified by organic psychiatrists, and a “disordered mind” approach typified by psychotherapists” (Willshire 1999 p.779). Indeed, Gaba (2000 p.87) reminds us of one important source of complexity arising from health care “One is the human body itself. Human beings do not design or build human bodies (nor do we get an “instruction manual”). Clinicians and scientists face a “black box” whose functions are (even now) poorly understood relative to what we understand about airplanes or unclear reactors. This relative impenetrability produces an intrinsic “uncertainty complexity” that is greater than in systems that are designed and built by human beings.

The basic premise of the approach of the study is that humans are fallible and that errors are to be expected even in the best of organisations. Errors or mistakes are seen as consequences rather than causes that have their source in systems factors rather than the perversity of human nature. The assumption is that the various

performance aspects of a system are based on a complex interaction of man, technology and organisation. Following Reason's (2000) concept of system defences, I argue that psychiatric nursing systems, like high technology systems, have barriers and safeguards (e.g. procedures and administrative controls) that protect potential harm to patients. Such defences have been compared to slices of Swiss cheese with many holes that continually open, shut and shift their location. According to Reason (2000) the existence of holes in any one slice does not usually cause a bad outcome but happen only when the holes in many layers temporarily line up to permit a path of accident opportunity. Accidents (the holes in the defences) happen as a result of *active* and *latent* errors. Active errors, which take a variety of forms, procedures violations, lapses, slips mistakes are the unsafe acts committed in our case by nurses in direct contact with patients. Latent errors may arise from social policy, decisions made by management, procedures and as the term implies may lie inactive within the system for many years before they combine with active failures and local triggers to create an accident opportunity. Latent conditions, unlike active failures can be recognised and resolved before adverse events occur. Understanding latent conditions therefore may lead to proactive rather than reactive risk management.

Framework for Analysing Risk in Psychiatric Nursing

Risk Dimensions and Definitions

Our analysis shows the changing forms of contemporary capitalist industrial society which signal the constant loitering of dangers that are both volatile and unmanageable. We are also reminded of the impossibilities that come into view when attempts to control and calculate the dangers become caught up in bringing about the opposite. The changing semantic field of risk demonstrates how little we

still know about the social construction of safety and about reliability. The social dimensions of risk illustrates that risk is not something out there in an organisation's environment, but that it is repeatedly being constructed and negotiated by people when they make decisions in relation to external situation and events. Vaughan (1996 quoted in Gaba 2000 p.88) encapsulates this in her remark that "Risk is not a fixed attribute of some object, but constructed by individuals from past experience and present circumstance and conferred upon the object on situation. Individuals assess risk as they assess everything else – through the filtering lens of individual worldview." If we accept that perceptions and attitude towards risk are socially constructed, then what constitutes risk may be socially selected with both the process of calculation and the decision based on being context-dependent and therefore socially variable.

Risk in the clinical sense is defined here as the degree to which there is doubt about whether potentially significant and/or unsatisfactory outcomes of decisions will be achieved. The definition encapsulates three key dimensions in outcomes of decisions, which are essential for understanding of 'risk'. First, the doubt in outcomes explains what options are included in the set of potential outcomes and how likely it is that various outcomes will be realised. Without such knowledge, expectancies cannot be calculated and preferences may be unclear. Second, expectancies represent the conceptualisation of risk to include a full range of outcomes, both positive and negative. This is because it is not the expected outcome itself that constitutes a risk but the degree to which that outcome would be disappointing to the decision maker or other key stakeholders. Third, is the potential outcome, this dimension of risk deals with the potential consequences of choice

perceived to be of sufficient magnitude for decision makers to attend to and the potential threat or opportunity inherent in a given situation.

Factors that Influence clinical Practice

There are three main factors that may influence a decision maker in risk situations: characteristics of the professional and the patient, characteristics of the organisational context (internal and external) and the characteristics of the problem. Figure 2b shows the basic framework.

Figure 2b: Factors that Influence Clinical Practice

<p>Individual Characteristics <i>Patients Characteristics</i> – Condition (complexity and seriousness); Language and communication; Personality and social factors.</p> <p><i>Professional Characteristics</i> – Knowledge and skills; Risk preferences; Risk perceptions; Risk propensity.</p> <p>Organisational Characteristics <i>Inner Context</i> – Organisational structures; Decision-making; Organisational culture; Power relations; Control systems. <i>Outer Context</i> – Government policy and legislation; Regulatory enforcement; Courts; Professional regulation; Standards.</p> <p>Problem Characteristics – Decision maker's experience.</p>

Individual Characteristics (professional and patient)

The condition from which the patient suffers is the most powerful predictor of clinical outcome. Such an observation has added significance with the psychiatric patient who has a severe disturbance of emotional and cognitive functioning, which may influence communication with staff, and thus the likelihood of an adverse event. A number of staff factors, such as personality, experience and training may be influential. Risk preferences (Brokhaus 1980) have been suggested as one individual characteristic that influences individual actions. Professionals who enjoy

the challenge that risk entail may be more likely to undertake risky actions than those individuals who do not. Risk perceptions, define, as a decision maker's assessment of the risk inherent in a situation, is another determinant; namely, the decision maker's labelling of situations (Douglas 1985), denying uncertainty, overestimating or underestimating risk, and to exhibiting unwarranted confidence in his/her judgement (Bazerman 1986; Slovic 1972). Risk propensity conceptualised, as an individual's risk taking tendencies is another feature that influence behaviour. Here risk propensity is defined as the tendency of a decision maker's either to take or to avoid risks

Organisation Characteristics

The composition of the group, within which risk-related decisions may occur, may be an important influence on risk behaviour. Each staff member is part of a team, both within their hospital and the environment. The way individuals practice and their impact on the patient may be constrained and influenced by other members of the team and the way the team members communicate with, support, and supervise each other. The team may be affected in turn by management actions and decisions made at higher level in the organisation. The team's environment is partly controlled by factors such as staffing structures, and education and training. The organisation is affected by external environment, namely commercial environment, financial constraints, external regulatory bodies and the broader economic and political climate. In addition group contexts tend to influence individuals to take positions with regard to risk. The culture of an organisation may reflect the tendency to prefer certain values instead of others. Organisational tendencies to prefer certainty against uncertainty and risk avoidance as opposed to risk seeking

may be defined as an organisation's cultural risk values (Dougalas & Wildavsky 1982). These values and management's risk orientation represent additional organisational characteristics that impact on individual risk behaviour. The organisation's control systems may influence decision maker's behaviour (March & Shapira 1987). When the outcomes of risky decisions are punished, or the willingness to take risks is encouraged or discouraged as part of an effective decision making process, the organisation is seen as channelling the decision maker's risk behaviour by monitoring, evaluating, and rewarding the outcomes achieved and process used when risks are involved.

Problem Characteristics The experience of the decision maker's experience or familiarity with the situation is an important determinate of risk behaviour. When decision makers are more experienced, they may begin to focus selectively on the evidence of their past ability to overcome obstacles (March & Shapira 1987) and, therefore, may be willing to undertake risks that less experienced individuals would avoid.

The Social Arena Concept of Risk Management

Contexts play an important part of risk management decisions in that consequences are always mediated through social interpretation that is linked with group values and interests. Thus responsive risk management needs to incorporate societal values into the decision making process. The incorporation of value judgements in risk management decisions can be identified on three levels. The first set of value judgements are concerned with the criteria on which acceptability or tolerability of risks should be judged. The second deals with the trade-offs between criteria and the third help risk managers in designing resilient strategies for coping with remaining uncertainties (Fischhoff 1996; Keeney 1996). For nurses this means

that as much as the best available expertise is needed in care practices, societal input is equally important because it offers a basis for shaping the objectives of risk strategies and for assessing the numerous criteria that have to be applied when evaluating different options of care. How do nurses integrate clinical expertise, regulatory considerations and societal values in risk management decisions? Clearly risk management decisions involve social-psychological, organisational, political, cultural process. Knowledge of risk by professionals and social groups, the social and cultural meanings of risk, as well as structural and organisational factors shape the social experience of risk.

Following interactionist writers I argue that risk management issues cannot be understood in terms of objective social factors; rather such issues are rooted in the “processes of collective definition” (Blummer 1971 p.298). As noted in chapter one, the social construction perspective suggests that risk should be regarded as lodged in the process of definition, rather than some objective characteristic of a patient or an act. This view guides us to look at the process of which society constructs definitions of risk and applies them to specific groups. Such a model recognises that professional responses to risk management issues are shaped and reshaped as a result of ongoing activity by different social groups, competing for space in the public *arena* (Hilgarthner & Bosk 1988). An interactionist approach implies seeing most aspects of risk assessment and management as problematic. Policies of risk management have emerged out of a set of negotiations among relevant actors and are always subject to further negotiations. Indeed, in their study of two mental hospitals, Strauss et al (1964) conceptualised a dynamic model of intricate social arrangements and relationships in complex organisations where work is accomplished through *negotiation*. In what is known as *negotiated order*, their

findings showed how members of various occupational groups (e.g. doctors, nurses, patients, lay workers) negotiate the meanings, routines and tacit agreements of work against the background of beliefs about the 'appropriate' nature, goals and methods of psychiatry. Interaction and negotiation depended on the types of employees, professional ideology – particularly the intersection and contradictions between competing ideologies-, and the organisation's relationship with the wider environment. The heterogeneous mix of professional and non-professional means they may be an endless cycle of negotiation over intervention. Therefore risk management techniques could never explain about how risk is managed and likely to be tacit expectations of behaviour than explicit formulas for decision-making. The concept of negotiation, counters the view of rational decision-making.

The relevance of the arena model is that a psychiatric setting cannot avoid the resistances in its attempt to achieve integrated therapeutic purpose. Using the arena metaphor model as a starting point (Figure 2b) allows us to see particular facets of risk management in a richer way. It deepens our understanding of the internal life of organisations. Here the symbolic interaction tradition encourages us to examine the face to face encounters between relevant actors in the organisations and offers a framework with which to make sense of these observations. The view of professional/client relationships as conflicting is in my opinion one of the most important contributions of interactionists: a view that differs sharply from views in which professionals and clients are seen to exist harmoniously in a system of unambiguous roles and expectations. A static view does not do present the adequate picture to the various events now transpiring within mental health services: the extraordinary rise in client "consumerism" in which not only professional autonomy, but also professional expertise is profoundly challenged. The

interactionist position does offer a meaningful explanatory framework for risk management events. Apparently disparate events can be seen as part of a larger pattern and we can start to move toward a unified conception of contemporary service institutions. Finally, in a more macro-sociological sense, the interactionist emphasis on meaning and the negotiation of meaning can enrich our understanding of society's role in risk management decision making.

In terms of professional expertise for example, recent sociological studies have suggested that trust or rather lack of it is often a key factor in explaining why a non-expert may be inclined to disbelieve in an expert (Earle & Cvetkovich 1995; Gidens 1990; Kasperson et al 1998; Leiss 1996; Renn & Levine 1991; Slovic 1993). Kasperson et al (1992) described trust as an individual's expectation that other individuals in a social relationship can be relied upon to act in ways that are competent, predictable and caring. Faced with a public which appears sceptical of expert reassurances, many scientists have been inclined to look to public ignorance as the most likely explanation (Leiss 1996). This has resulted in further distrust of experts by the public. An explanation as observed above is that experts and the public work from different value systems. Experts are used to uncertain world where knowledge is always flawed. They can handle risk judgements more easily and seem impatient of those who cannot. The public see this as arrogance resulting in further distrust. Ruckelshaus (1996 p.2) caution us that: "mistrust engenders a vicious descending spiral. This interpretation is supported by studies such as nuclear waste dump (Rosa et al 1993), the attempted decommissioning of Brent Spar (Lofstedt & Renn 1998) and difficulties to site and build installations – hazards waste-disposal facilities and waste incinerators (Lofstedt 1997; Petts 1995) and organised public lobbies against mental health centres (Sheffield Star 1993) which

show that in areas of potential risk consumer and environmental organisations may command higher levels of public confidence than scientific organisations.

The acknowledgment that public concerns about risk are legitimate has led scholars to urge their incorporation in risk-related decision making (Pildes & Sunstein 1995; Slovic 1992). It has been argued that recurrent failures in risk management stem from a failure to recognise the more general requirements of the need for social trust (Kasperson et al 1999). Risk management from this position has gone wrong due to lack of openness and transparency, the failure to consult or involve actors and lack of responsiveness to public concerns. Accordingly commitment to democratic procedures and attention to issues of trust have become essential elements of any successful management of risk. To deal with democratic issues demands that we ask how fair and accountable our risk management strategies are. Questions such as these take us to the political stage. This demonstrates why the sequence of reasoning about risk is really a cycle namely beginning with a *scientific risk analysis* and returning to it via the *public domain*. Taking the public dimensions of risk management seriously means that there is a need to change the character of the scientific risk analysis and management processes. If the scientific evidence itself is uncertain or contested as is often is in psychiatry, then professional action alone may not be sufficient. Following such a perspective (the embracement of both expert and lay contributions for effective risk management strategies) suggests that risk management is more than merely technical.

The institutionalisation of risk management emerges from the resolution of the many problematic aspects of risk management strategies such as those mentioned above. A strategy for making sense of these resolutions, suggested by interactionist

theory, would be first to note the relevant actors in risk management situations and determine what meaning risk management has for them. For example, in risk management intervention, we would identify such actors as doctors, nurses, social workers, government agencies, potential patients and particular interest groups (Mental Health Right Groups). In assessing the meaning that risk management has to each group or individual within it, we would probably find that in some cases the meaning may be precise, but in some cases the meanings held will be ambiguous. A nurse may be personally opposed to risk management strategies but feels an obligation as an employee to perform them. Professionals may approve risk management strategies, but worry about the consequences to patient care; a patient may be “at risk” yet feeling unable or unwilling to comply with intervention.

These ambiguities support the usefulness of distinguishing among different kinds of “meaning” in the risk management context. We can differentiate between legal, ethical and experiential aspects of risk management. The legal meanings would include both the rights and formal constraints facing each actor: the obligation of organisations for safe care, the procedures to be followed in risk management interventions, the rights of patients among others. Legal meanings offer a framework that at least partly limits the movements and perceptions of relevant actors. An ethical meaning shows us how various participants conceptually feel about risk management. Here the range of meanings might be expected to range from those who think risk management is synonymous with control, to those who see it as infringement to patient’s rights, to those who think it unfortunate but necessary. The various positions taken toward risk management will not only vary from group to group, but within each group as well. Therefore negotiation of meaning has to be explored both internally and across various groups. Experiential

meaning refers to the consequences for several of different of intervention choices being made. The choice of particular method for interventions has different consequences for professionals and clients. This suggests that complete “meaning” of risk management cannot be understood without taking into account the activities that various actors called upon to perform.

From our discussion so far, an important way of conceptualising and understanding the social experience of risk is the concept of the arena metaphor (Haligartner 1988; Lowi 1964; Renn 1998). According to the theory, social groups in a political arena attempt to exploit their prospects to affect the result of the group decision process by organising social resources (e.g. power, social influence, value commitment). To be successful in the social arena, it is essential to mobilise social resources. Such social resources can be used to gain attention and support of the general public to influence the arena rules, and to score in the arena in competition with other actors. Actors will enter risk arenas if they expect this would provide them with a chance to gain more resources (Renn 1998). The more resources a group can mobilise in an arena, the more likely it is that it controls the conflict resolution process by getting its opinion included in the final decision. Risk management decisions by psychiatric nurses function under similar structural rules and constraints as presented by the model. Risk management decisions focus on two issues: what is an acceptable level of risk and how are risks distributed in society. All social groups that believe their interests and values are affected by a specific risk might be compelled to enter the arena, where success in the risk arena relies on the social actors ability to mobilise resources. The arena metaphor attempts to include social factors that are influential for the social experience of risk. Among them are the symbolic and moral content of issues, the possibility of using risk as a

substitute for other issues, the influence of media and social network, importance of values, the structure and design of political regulatory system and the dynamics of social interactions among major actors. The concept proceeds from the thesis that risk conflicts may not be about risks but rather about symbolic issues associated with risk debates where various negotiate their understandings of risk.

The notion of the arena metaphor model presents us with the main shapers of risk management decision-making. These range from societal influences through to individual professionals of an organisation. Within Figure 2c, societal arena is taken to refer to norms, beliefs, values, contemporary lifestyles and social expectation of members of society at large. This arena is a dynamic process of competition among the population with claims on risk decisions. This shapes elements of cultural knowledge available to organisational members to employ in organising their relations with each other and with outsiders. The institutional arena is the organisational environment (market environment) where risk decisions compete for attention. It is influenced by policy, shared cultural preoccupations, political biases and problem definitions.

Figure 2c: Conceptual Framework for Understanding Social Experience of Risk

SOCIETAL ARENA	Norms; Beliefs; Contemporary lifestyles; Claims on risk definitions; Opinion leaders; News media.
INSTITUTIONAL ARENA	Organisational environment; Policy (e.g. Legislation); Political and social action; Problem definitions; Regulatory actions; Legislation.
SERVICE ARENA	Organisational characteristics (structure, technology; individual risk behaviour; etc); Cultural system; Influence of multidisciplinary teams.

The service arena refers to organisational characteristics which include the organisation's structure, technology, with a cultural system in the formation of beliefs, perceived values, ceremonies, stories, practices shared by members of the organisation. The composition of a group within which risk related decisions are made influence professionals risk behaviour. Risk behaviour which may be characterised by the degree of risk associated with decision-making, has three determinants. First, risk preferences a characteristic that influences individual professional actions. Here, the suggestion is that professionals who enjoy the challenge that risks give rise to will be more likely to undertake risky decisions than professionals who do not. Second, are risk perceptions that is, a professional's assessment of the risk inherent in a situation. This is defined in terms of his/her labelling of the situation (Douglas 1985), probabilistic estimates of the extent and controllability of risks and confidence in those estimates. Risk perceptions may also impact on professionals' behaviour leading them to deny uncertainty, to overestimate risks and to exhibit unwarranted confidence in their judgements (Slovic 1972), knowledge and ability to perform under risky conditions. The third individual characteristic suggested to influence risk behaviour is risk propensity, namely the tendency of a professional either to take or to avoid risks.

The societal arena refers to the constructions of risk management meaning that involve influential individuals and groups (interest groups) drawing on their resources to influence how risk management strategies shape up. Actors use their energy and resources to change social definitions and create norms and rules through a multistage process. Such actors engender awareness of a problem through a process of making claims in which they point to the dangerousness of a given issue. They then use these messages to create an impression that certain conditions

are problematic and pose a present or future danger to society by drawing on experts to disseminate their message through the media. An example in an individual case is Mrs Clunis' influence in shifting the boundaries community care described above. Another example is the activities of the media. In each of the three health scandals noted above and many others, the mass media emerged as a major interest group by evoking and sustaining intense emotional responses, eliciting feelings that something must be done. Once a powerful and vocal group has influenced the public viewpoint, participants in the institutional arena respond to demands by enforcing norms and rules through policies, legislation, and political, social, and regulatory actions. In each health scandals and the subsequent inquiry that follows, various actors – including law enforcing agencies, scientists, health professionals, patients, former patients, voluntary organisations - have contended over the ownership of the solutions to the issues; the ability to create and influence the public definition of a problem and thus to define what should be done about it. By virtue of their specialist knowledge, such groups claim legitimacy and authority to identify what is wrong and to recommend solutions acquiring resources in the process.

Therefore risk decision-making is the result of a complex and intricate work by the various actors constituting an arena. One very salient problem resulting from the different loci of power and perceptions and definitions of risk represented by different arenas is the disparate and sometimes competing goals. Multidisciplinary teams provide a good example of this in the service arena. People from different professionals disciplines bring different views of mental illness, its cause and most effective treatments. The institutional goals of mental health organisations are contradictory because they are supported by conflicting societal preferences and ideologies in terms of whether to provide therapy psychiatric or medical perspective

control (control or social reaction models) of the mentally ill (Horwitz 1982; Perruci 1974). These types of conflicts, for the most part, are not addressed by traditional risk decision-making. It is important from this stance to suggest that risk decision-making should be oriented toward helping professionals confront conflicts, and recognise that they are inherent in the system and that uniform goals are unlikely.

Another problem related to that mentioned is the sheer complexity of mental health service organisations which is that they are characterised by an almost incomprehensible mix of clients, programmes and state guidelines and constraints. In mental health organisations therefore the problem is not so much eliminating or resolving conflict, but rather developing strategies that enable actors to function within these conflict-producing situations.

From the above discussion, it would seem that risk decisions are the outcome of the complex processes of social construction comprising societal, cultural and political elements in which both the influence of institutions and individual professionals can be discerned (Douglas 1985; Douglas & Wildavsky 1982). Thus the idea of the existence of single and shared technologies for risk decision-making may be a misleading way to address the issue given that everyday activity within the arena concept is constituted by plurality and conflict rather than by consensus and sharing of ideas and values (Martin 1992). From this perspective, attitudes to risk are jointly determined by processes of perception relating to individual professionals cognition and by the cultural dynamics typical of social contexts (Gherardi & Nicolini 2000). Each arena develops its own definition and culture of risk decision-making, definition on which choices concerning risks are made rather than on a set of probability calculations or rational judgements. It would seem that basic criterion for effectiveness of risk decision-making of an organisation within

the context of the arena model is the extent to which the overall functioning of the system (characterised by a set of norms, beliefs, attitudes and practices) can be mobilised.

Furthermore, a basic proposition within the arena concept is that the various subsystems exist with conflicting goals and orientations. So, the distinguishing features of “successful” or “unsuccessful” risk decision are the integration and coordination of these arenas to the role and quality of expert knowledge; how probabilities of uncertain events ensure that conflicts are identified and power transferred to solve problems and implement solutions. Central to the arena concept is the notion of conflict in which risk decisions are the result of complex and intricate work by the various actors. Since each arena is defined by a specific set of ideology, which must be identified locally, each may present technological artefacts of varying degree of safety, have unique risk assessment and management discourses and specific interpretations of reports, policy statements among others. This has a potential for what has been termed “social amplification of risk” (Kasperson et al 1998), which can lead to increased distrust between the various actors: conflict, cultural differences, ongoing tensions may generate widespread media coverage, societal attention, public concern and protests. Using the social amplification of risk notion, I share the observation that risk cannot be viewed as a single problem or challenge but rather that it comes in different forms and levels of complexity.

It is important to note that the limitations on negotiations that are imposed by social structure is real, and the point of an interactionist analysis is not to indiscriminately see every risk issue as subject to negotiation (Maines 1977). Rather, the strength of the approach taken is to show that certain features of

institutional life apparently obligated by hierarchy and rules are in fact more flexible than conventional organisational analysis would suggest. Internal sources of power within institutions and the problematic nature of rules governing them are two of the creative contributions of interactionists studying institutions. From the interactionist viewpoint, a vital feature of rule is whether or not they can be broken, without sanction by various actors. Nurses, for instance, are subject to a vast number of rules and guidelines. Some of these rules, for example, that patients risk management must be performed within days of admission are never deliberately broken –if they were the individual professional will be in trouble. Other rules, such as the policy that junior staff must be supervised when assessing risk are more laxly monitored and enforced. The insights presented above, has been developed to stimulate an enhanced understanding of the relationships between factors internal and external to the settings. The discussion represents an attempt to formulate a structure that will serve as basis for the examination of risk decision-making in the settings. The next chapter reflects on the evolution of my research interests and methods of inquiry.

CHAPTER THREE

THE PATHWAYS OF MY RESEARCH

The reason often put forward for the habit of ethnographic of effacement – the removal of the ethnographer of the scene of writing – is that without it ethnographer will descend into subjectivity and autobiography. This is indeed a danger, but the alternative, the denial of ethnographic presence and the specificity of ethnographic experience, is equally dangerous: it substitutes an unchallengeable subjectivity for a challengeable subjectivity. (Spencer 1989 p. 154)

For the most part, we are led to believe that given appropriate training and sufficient diligence, one should be able to produce a competent ethnography that authentically represents the subjective everyday worlds of the people we study (Meyers 1988). Within this tradition, the task of the researcher is viewed as relatively unproblematic: being the description of a self-evident reality (Denzin & Lincoln 1994). Ethnography in this approach often assumes a close correspondence between what the ethnographer observes and reports and the culture of the community studied: in other words, the style of reporting is that of an impersonal observer. Here, Van Maanen's (1988 p. 46), observation that: "Ironically, by taking the "I" (the observer) out of the ethnographic report, the narrator's authority is apparently enhanced, and audience worries over personal subjectivity become moot." is apposite. Personal accounts and influences, from this stance, seems to threaten legitimacy that encourages the explanation to be framed in positivist language so as to create and maintain the commonly accepted pretence of accuracy, precision, relevance, and rigor. In fieldwork, this involves ignoring the relationship aspects of data collection phase when it comes to the time to write in which: "The good feelings that we expect to have toward our participants during data collection must now turn to stone as we write our analysis. We think our physical distance

from the field will foster analytic distance and thus help us to produce an “objective analysis.” (Kleimman & Copp, 1993 p.26) Others have warned about the dangers of “going native” and the need to not only maintain distance but to “manufacture distance” (McCracken 1988) in the relationship with participants. The self of the social researcher is treated as a “contaminant” that should be separated out, neutralised, minimised, standardised, and controlled (Krieger 1991). Within this approach, theories that include personal experience are suspect: reflexivity or autobiography is regarded as navel gazing and has been labelled as “narcissism” (Llobera 1987) with researchers who write about their own emotions being termed as “emotional exhibitionists” (Ellis & Flaherty 1992).

Contemporary trends in anthropology have questioned these assumptions, suggesting that the act of ethnography itself is entrenched in a complex institutional web of power. The focal point of such critiques, are located in ethnographic dilemmas, particularly the act of ethnographic translation. Accordingly, translation itself can never be pure or without an element of the author/researcher’s voice in it. Clifford and Marcus (1986) have helped us to understand that ethnography has never been the detached objective description of cultures, or societies, or the explanation of human behaviour purely in terms of self-sufficient theories. Rather the roles of context, of social experience, of interest have been shown to shape ethnographic style and content. Personal values, social positions, and political interests are part of all aspects of the research process including theory. What is needed therefore is the unpacking of the many dimensions of the “self” – cultural baggage, personality traits, values, and psychological defences among others. Ethnography from this angle is located in time and space, and reflects ideas, interests, and organisation of the ethnographer. The research product is in the end

that of the researcher who tells or authors a text, and so doing, offers a document that is structured by the researcher's purposes, offering the researcher's interpretations (Stacey 1988). Such an observation supports the positionality or standpoint epistemology, which argues that texts are always partial, incomplete, and socially located, and require the author to "come clean" about stance and position (Lincoln 1995). It is also consistent with the issue of power as reflected in feminist theory and epistemology. Here, power is evident in three interconnected dimensions, namely the power differences stemming from different positionalities of the researcher and the researched (e.g. class, race, nationality, life chances), power wielded during the research process, such as defining the research relationship and power exerted in writing and representing (Wolf 1996).

Thus the ethnographer, as a positioned subject, constructs interpretations of experiences rather than simply reporting on the "facts" discovered during fieldwork (Rabinow 1986). Bruner (1986 p.5) comments that ethnographic stories represent the "imposition of meaning on the flow of memory, in that we highlight some causes and discount others; that is, every telling is interpretive." Charmaz (2002 p318) reminds us that "As social scientists, we start with research participants' stories but we tell them in another way. Which stories we tell, how we tell them, and how our audiences, including research participants, receive them all differ from the stories we heard. Sometimes we relate facts; often we provide fragments of stories, and, frequently, analytic stories." The ethnographer from a reflexive perspective becomes active in the writing of ethnography. This awareness that all ethnographies are interpretations of experience means that ethnographers have to monitor how their biographies intersect with their interpretation of the field experiences. Reflexivity, in this sense, constitutes continuous internal dialogue about how

biography influences the assignment of meaning to the words and actions of the informants. This observation challenges the splitting of the researcher and the researched and encourages the researcher to put him/herself into the research and writing as part of the experience. Reinharz (1979) characterises this relationship between researcher and research as a continual process of socialisation in which researchers are engaged in a search for their own identities and project their conflicts into their professional work.

The issues raised in our discussion is illustrated in recent years by some major changes in ethnographic style, namely ethnographic memoir and narrative ethnography (Tedlock 1991) and confessional tales (Van Maanem 1988), in which relationships and dynamics between researcher and subjects, as well as the emotional dilemmas faced by the researcher are documented in the ethnographic text itself (Rabinow 1986). Narrative ethnographies purposefully locate the ethnographic account within a complex web of epistemological reflections, personal experiences and cultural hegemonies that shape the production of knowledge. Where does all this lead us in relation to the place of the “self” in social science? For me it raises some vital issues. If research is indeed a process of self-engagement, then who am I as a researcher? Why do I study the phenomena I study? How have my experiences as person shaped my research questions? Following Crick (1996 p.175) I would argue that “....we need to understand our ethnographic products in terms of the producers and the production process, that is to say in terms of ourselves, our informants and the specific contexts in which encounters have taken place.....If much that we call ‘method’ has characteristics of a ‘reaction formation’ designed to protect the investigator from anxiety in the face of social phenomena, then clearly a most important kind of ethnographic data is

what is going on inside the researcher.....We require that our 'selves' become objects for scrutiny in the same way our research has rendered 'objects' those other selves with whom we have interacted in the field.”

The chapter is organised as follows. The first section provides a theoretical and methodological framework for understanding autobiographies and argues that autobiographies of researchers are useful research tools, particularly for clarifying the presuppositions underlying research. I shall provide a short account of how my research was developed. This biographical and intellectual account, the story of who, I am and how I came to do the research, is intended to supplement the methodological analysis in this chapter. The section is organised historically. I begin with a brief description of some early experiences that have shaped my professional life. I then explore my introduction to organisational behaviour and applied behavioural science and some of my early experiences of research and consultation as a graduate student. I then describe the theoretical background to my research methodology.

The Background to the Research: My Intellectual Autobiography

It is my contention that social scientists must be challenged to reveal and explain how their personas influence their scientific work since such a journey can help us gain better insight and understanding into their lives and work. To traditional methodologists what follows may seem irrelevant and self-indulgent as well as narcissistic and solipsistic. Indeed, such accounts of autobiographies are seen to have methodological flaws, to serve as basis of scientifically valid knowledge. Autobiographical data is subject to incompleteness, personal bias, and selective recall in the process by which the narrative is constructed. The fallibility of memory, repression, the shaping of stories according to dispositions, internal

idealisation, and nostalgia all present the possibility of biased data. Looking back at a particular moment in time might provide a view that is coloured by our current context, mood, or interest. There might also be our predisposition to construct masks through which we not only wish to see ourselves but also masks through which we wish others to see us. There is a possibility that what we can disclose to others is incomplete and thus open to the portrayal of being “crafty tellers” of stories (Grumet 1987; Handel 1987; Ross et al 1981). Revealing our intimate selves to unknown audience make us vulnerable and may evoke unanticipated reactions. For example, it is difficult to avoid expedient descriptions and interpretations and to refrain from exercises in “image management” and positive self-presentation. Indeed, those who assume that an objective reality exists apart from the world as defined by human agents might argue that the accounts of autobiographies are mere rationalisations (self-justification) we use to create meaning for our lives.

Despite the implied limitations of autobiographies I contend that we cannot dismiss their potential contributions to social science inquiry. Following C Wright Mills (1959) suggestion that sociologist’s primary subject matter is the study of the intersection of biography and history, I argue that the autobiography is a powerful vehicle for theoretical usefulness and methodological value. Autobiographical accounts provide us with insights into the nature of research that cannot be covered with any other methodological tools. Clearly, social scientists as observed above play important roles in the research process. Autobiographies reveal basic links between subjects’ personal lives and how they have chosen to carry out research activities. Bruner’s (1983) work illustrates how an autobiography can reveal the role of the researcher in structuring the overall research design. Examples that bring theoretical implications of autobiographies into sharper focus is Bettelheim’s (1960)

and Frankl's (1962) reference to their personal experiences in Nazi concentration camps to address theoretical issues regarding human personality. Thus our theoretical concerns are interwoven with our analysis of the methodological issues - the nexus between theory and research procedures including data collection and analysis.

From this stance, research is seen as a social process with the researcher a variable in the research design (Sjoberg & Nett 1968). The researcher's position in the social structure affects the selection of the problem under investigation. In addition, the researcher actively shapes the manner in which data are collected, analysed and constructed for publication. Autobiographies of researchers are useful in revealing how researchers' assumptions have been shaped by their life histories - including their education experiences. The researcher's assumptions regarding analysis, the nature of reality, the nature of rationality or otherwise in human action as well as the researcher's fundamental moral commitment, are directly and indirectly shaped by his/her social experiences and integration into the complex web of power relationships in modern society. Consequently, autobiographical accounts enable us to acquire a deeper understanding of important theoretical and methodological issues, which in turn provide us with fuller appreciation of the nature of research. The accounts draw attention to what it means to be a researcher by pointing out the variety and significance of such a venture. Autobiographies define the shape and the content of the field endeavour and in the process show the liveliness of research in a complex and diverse social order. I believe that the contributions of autobiographies lend a special legitimacy to the research process.

This means that my social change orientations are the result of a powerful interplay between my psychosocial development and critical life events. These have

shaped my scientific socialisation and professional development. Such developments are illustrated in the life cycle process (Levinson et al 1978; Schlossberg 1981) in which through one's interaction with significant others (e.g. parents, spouse, friends, mentors), one develops one's sense of personal competence, ability to engage in relationship among others. The process also influences one's scientific socialisation with respect to values and norms and influences the professional choices one makes. Throughout the life cycle people experience critical life events that compel them to re-evaluate and perhaps reconstruct their identities, values and roles: this requires a major reassessment of one's inner self and relations to others, and thus alter one's life cycle trajectory. In the words of Schlossberg (1981 p.5) it is "an event or non-event that results in change in assumptions about oneself and the world, and thus requires a corresponding change in one's behaviour and relationship." For me, the interaction between my psychosocial development and critical life events have, greatly influenced my continuing socialisation and professional development. This model is interactive and suggests that my orientations themselves are subject to change. My scientific orientations and my stance to research are products of these processes. Through a personal and intellectual journey, I have tried to understand the forces that have shaped the ways that I have conducted the research. The very development of social science knowledge intertwines latent values, assumptions, and personal experiences that, if made explicit, can enhance significantly my ability to appreciate and comprehend theory and research. This required me to conduct self-analysis and insightful introspection. A vital part of this is the writing of a semi intellectual autobiography, which lays out my pre-existing values and experience in relation to the research.

Most social science in its quest for generality imposes order and rationality upon experiences and worlds that are more ambiguous, more problematic and more chaotic in reality. The reality of life however involves experiencing contrast, managing discontent and disinterest. If we check our own experiences, for example, we know that our lives are often flooded with amounts of indecision, turning points, confusions, contradictions and ironies. A lot of social science glosses over this essential but central arena of life. Researchers seek consistency in subjects' responses when subjects' lives are often inconsistent. Autobiographies are suited to discovering the confusions and ambiguities that are played in everyday experiences. It threads through personal definitions of the situation, and historical change both in one's own life and in the world outside. I would argue that it is mistaken to see autobiographical account as thoroughly individualistic because lives move persistently through history and structure. As such as a method it allows us to grasp a sense of the totality of life. As Bogdan (1974 p. 4) says: "The autobiography is unique in allowing us to view an individual in the context of his whole life, from birth to the point of which we encounter him. Because of this it can lead us to further understanding of the stages and critical periods in the processes of his development. It enables us to look at subjects as they have a past with successes as well as failures, and a future with hopes and fears"

In taking this stance I am integrating my body into the process and production of knowledge in following Conquergood (1991 p.180) who "privileges the body as a site of knowing". The body in social science generally has been an "absence presence" (Davis 1997). "When the body is erased in the processing of scholarship, knowledge situated within the body is unavailable. Enfleshed knowledge is restricted by linguistic patterns of positivism dualism – mind/body,

objective/subjective – that fix the body as an entity incapable of literacy” (Spry 2001 p.725). For that reason, there is a need for an embodied research because: “Ideologies and experiences are made manifest through performance by replacing the rigor mortis of the written with fully embodied social critique. Such flesh to flesh scholarship motivates the labour of critical self-reflexivity and invigorates the concept and process(ing) of knowledge” (Spry 2001 p.726). In the words of Madison (1999 p.107), this is a “felt-sensing meeting between theory, writing, and performing”.

Realism versus idealism

It is important to note that I am not arguing that scientific practice is arbitrary or inappropriate, and that interpretation alone is possible - as captured by the subjectivity and objectivity continuum. I am not advocating methodological anarchism (Feyerabend 1975) but rather to argue that scientific knowledge has legitimate claim to truth, in a way that relates to external reality, recognising as argued above, that reality is subject to a multitude of social, pragmatic and sometimes irrational influences, and that scientific truth is not something separate from human concerns. I see scientific knowledge as the product of the activities of scientists acting as social beings working within disciplinary framework into which they are socialised. Scientific knowledge plays an important part in politics and other matters and is not independent of them. Scientific experiments are more ambiguous than most people imagine and no longer has unquestioned authority as illustrated in the BSE saga and the row over MMR vaccine (see chapter 2). In defending my position it will be useful to briefly discuss the debate between realism and idealism. This debate which is an ancient one, has seen the struggle between the assumptions that objectivity is desirable as the goal of science inquiry rather than

subjectivist assumptions asserting that understanding lived experience, the researcher's and those he/she studies is the legitimate project of inquiry. A version of the objective-subjective debate is the recent argument in the UK, over biology curricula in schools, between those who support creationism (a literal interpretation of the Bible's seven-day creation story) and those who accept the theory of evolution.

Realism (the view of truth and science that has been held by great scholars such as Darwin, Einstein Harvey, and Newton) argues that knowledge corresponds to reality. It assumes that reality consists of facts, which are reflected, in observation statements, in addition to logical connections between them. That is reality exists independent of human cognition and that the work of science is to discover important facts and processes that constitute that reality. In other words, the processes are out there, waiting to be discovered. Thus for the objectivists, there are truths about particular circumstances that can be determined (Popper 1972). Essential for the realism project is the design of a new unambiguous language to which facts can be stated in a purely observational fashion. Ordinary language is too messy, imprecise and ambiguous to indicate observations. Language reflects reality in mirror-like fashion like a picture. The common view of truth in realism is correspondence; theories are true if they correspond with nature. The correspondence theory states that truth consists of the degree of correspondence between an object and its description. It assumes that under normal conditions the human mind is able to gain knowledge of objects by means of observation and its experimental refinement. This observational knowledge can then be used to test beliefs and theories. The epistemological premise is that objects are able to cause our senses to form more or less correct observations of them as they actually are.

These observations can be sufficiently independent of theories held by observers concerning their objects that theories can be objectively tested. Ontologically it assumes that minds are part of nature.

From our discussion so far there are some problems with realism. Namely that there are no neutral data, which we reproduce, neither will it do to suggest that we receive neutral data from the world, after which we switch to the interpretation mode. Our judgements about what there is and what we see are theory laden from the outset and are coloured by experiences, beliefs and practices. In addition there are no unquestionable foundations for knowledge. In other words we are not presented with free-floating truths to take hold of, nor knowledge we have to pull from the air. What we think and say, as well as what we know about the world, is known by us. Such knowledge is not part of the objective world, of itself, but is the set of beliefs about the world shaped by participants in cultures, sharing worldviews, theories, and expectations and reflecting a rich template of intersubjective relations. This leads us to the observation that no theory is immune to alteration and even complete rejection in the course of time. Scientific theories are not absolute truths; they are just descriptions of the world, some of which fit better than others. The history of science is littered with distinguished names who made mistakes. Einstein's theory of relativity that the speed of light in a vacuum is an absolute constant is currently being challenged. Historically the study of light alone reveals a rich catalogue of misconception: Kepler's notion that light travelled with infinite velocity was a mistake and Newton's claims that light speeded up when it passed through a denser medium was found to be the exact opposite.

The alternative, idealism, (adherents Feyerabend, Habermas, Kuhn and Putnam) assumes that the world as we know it is somehow a creation of the mind.

Our knowledge is a subjective product and does not necessarily correspond to an outside world. We construct understandings of reality through our perceptual and interpretative faculties. Idealism sees knowledge as subjective construction and therefore there is no different rational, objective way to choose between different points of view. Social processes from this angle are created by human interpretation – they do not constitute reality as such but are concepts that describe it. For subjectivists, the very notion of “truth” is problematic; their argument is that except from certain principles about the physical world, there are few truths that constitute universal knowledge; rather there are multiple perspectives about the world. There is no reality other than that seen through and created by the paradigm (Kuhn 1962). Truth is seen as some sort of ideal coherence of beliefs with each other and with our experiences (Putnam 1981). Thus there may be more than one true description of the world. Epistemologically, it assumes that our ways of thinking and perceiving inevitably condition what we observe. Facts are theory-bound, never theory-independent. The ontological idea is that mind constitutes nature.

This thinking leads to relativism, which sees all knowledge as subjective; there is no rational, objective ways to choose between different points of view. The knowing subject is not the passive observer. On the contrary, the things we see and come to know are incorporated in a theory, or even more, they are part of worldview or of a long-established lifeworld with roots in history and culture. Theory is considered as part of a whole structure of methods, frameworks, concepts, professional habits and tradition. This structure determines the general approach to research. The social nature of science and the contextual nature of knowledge claims (that knowledge depends on prejudices and pre-reflexive practices) introduce more human and conceptual elements in philosophy of science. This development in

the philosophy of science seems to converge with hermeneutics – an important element in hermeneutics is the sensitivity to history. Gadamer (1975) develops this thesis and explains the essence of understanding and interpretation in the human sciences by analysing how we should understand text. He argues that any attempt to understand meaning requires an orientation to the subject matter and therefore rest on certain assumptions. We pre-judge a text, for example, even before we read it. If we know a text is by Shakespeare, we bring certain expectations to our reading of it. If we suspect another text to be a science fiction, we anticipate a certain plot structure. The book may not sustain our assumptions, in which case we may have to revise our expectations and reinterpret the chapters we have already read and substitute a new expectation of the book and rely on this in our subsequent reading.

This process is one, which is conceived as “hermeneutic circle”. We approach a text with a vague anticipation of its meaning and go on revising this expectation until a self-consistent meaning has emerged. Gadamer claims that any attempt to understand meaning involves a similar process and points out that the literal meaning of prejudice is simply prejudgement. In other words, an initial idea about a book or subject matter can be retained or dismissed on further experience. Prejudices then are not assumptions that blind one to real meaning of what one is studying; rather they offer an initial direction for further investigation. For example, before reading Shakespeare, we already assume high level of brilliance, we expect that it will deal with certain human problems and that Shakespeare will use the English language beautifully. Where a work attributed to Shakespeare does not meet these expectations, we often doubt that it is really Shakespeare’s work. Thus we understand a text not by objectifying it, ourselves being detached and disinterested spectators. On the contrary, in understanding it we are involved in and participate in

the work of art, starting from our own situation and prejudices. In this way interpretation brings with it sensitivity to history. To understand the meaning of a text in general, we should become conscious of our own situatedness and resist the naïve temptation of objectivism and the belief that there is a stable pre-given object as a secure truth on its own. Between subject and object there is that historical hermeneutic interactivity. Therefore in understanding a text we cannot possibly remain neutral or “objective observers” on the contrary we should search for our own prejudices.

Like realism, idealism presents us with some problems. The relativist claim that individuals provide the criteria for what is true or false, what is rational or irrational is problematic. For how do we define the relevant subject who is responsible for a particular viewpoint? To assert that no statement can be true because it is a product of the one who utters it is self-defeating. If what I think is true, is true for me, and what you think is true, is true for you, where do we end in terms of communication? Newton-Smith (1982) reminds us that the idea that what is true for one group might not be true for another is incoherent. In a sense the notion of “anything goes” undermines science. We seem therefore to have two equally unattractive options. The mind makes up the world maybe totally confabulates it, or we must assume that the world as it is in itself, independent of human exploration and theorising is accessible to us. Are risks factual statements or are they not factual statements? The extreme points – the objective-subjective dimension - form fundamentally different conceptions of what risk is. From the objectivity viewpoint risk is an objective hazard, threat or danger that exists and can be measured independently of social and cultural processes. In contrast the

subjectivity perspective assumes that nothing is risk in itself that is that what we understand to be risk depends on psychosocial processes.

Following Dryfus (1980) and Rorty (1980), my stance in the realism-idealism dichotomy is that knowledge is interactive, because we can never escape the hermeneutic circle. Our communication and actions develop against a shared cultural background of social practices of know-how and skills, which cannot be made entirely explicit because it is presupposed. My position embraces the idea that knowledge is a kind of interaction of subject and object. In other words, it is an intermediate position between realism and idealism, between subjectivism and objectivism. Therefore risk statements are neither purely factual claim nor exclusively value claims; instead, they are both at the same time or something in between (Adam B et al 2000). Going along with Beck (2000 p211 emphasis in original), "I consider realism and constructivism to be neither and either-or option nor a mere matter of belief. We should not have to swear allegiance to any particular view or theoretical perspective. The decision whether to take a realist or a constructivist approach is for me a rather *pragmatic* one, a matter of choosing the appropriate means for a desired goal".

My argument is that "subjective" and "objective" are relative terms. All our perceptions, thoughts, verbal and physical expressions are filtered through and formed by our senses, knowledge culturally formed tropes and a host private perversions. Objectivity in the study of human affairs is limited because we cannot, for instance, directly observe our family's thoughts, motives or emotions; but we can deduce what their private thoughts are from their public words and deeds (the data of an empirical social science). We can use these empirical data to construct and then check our inferences about subjective or otherwise unobservable aspects of

human affairs. Checking and making these deductions is parallel to the logical method of hypothesis formation and testing that physical scientists use to infer, for example the existence of gravity and other unobservable aspects of the physical world. We build blocks of secondary inferences once we are satisfied that our primary inferences are correct. For example, using knowledge gain from past experience, we might infer from a patient's facial expressions, utterances and other actions that the patient is angry (risk of aggression) and then use the emotion anger as part of our explanation for the patient's subsequent behaviour. The limits of objectivity (when we search for knowledge) are characteristic of human beings as observers, rather than the things we observe; and therefore the recognised limits to objectivity do not require separate methods of inquiry into physical and social phenomena as some critics conclude. The scientific method is a two-part process alternating continually between the formations and testing of hypotheses, it is thus similar to the hermeneutic circle.

In essence all research methods were primarily developed to answer specific types of questioning a specific research context. Even when a method is used and interpreted in the context for which it was designed; they all have limitations. Consequently, a method is not intrinsically valid or good; instead, it is relatively valid for a specific purpose, to answer a specific question in a specific research context. Bearing this caveat in mind, I argue that an objective or subjective approach is not better intrinsically than the other: they have different purposes and are ideally suited for tackling different questions in different contexts. Each approach from this stance should not be preferred over another because the two approaches may address different questions. What is required is to obtain the best

available data about a phenomenon and interpret it in the context of the limitations of its methodological categories.

So how do we resolve the argument that an objective world exists that can be known through the methods of science and science as a subjective construction? Our discussion shows that there is subjective element in both physical and social sciences (requirement in every case the informed judgement of individuals) it follows that all science is practised within a social, historical, and psychological matrix. What is needed therefore is a marriage between the logical approach and non-logical intuition. As noted in the last chapter, all facts are “theory driven”, thus following Wilson (1998) I argue for what he terms “consilience” – the interlocking of perspectives – between the domains of knowledge. Therefore in my attempt to advocate for interpretivism I am not taking the “romantic rebellion” stance (Shweder 1986) namely rejecting the empirical basis, logical methods and explanatory goals of the natural sciences as being inappropriate for the study of human affairs, and therefore a swing too far to the direction of subjectivity but to nudge the pendulum to a focal point. Here risk is seen as an objective hazard; threat or danger that is inevitably mediated through social and cultural processes and can never be known in isolation from these processes (Lupton 1999a).

Socialisation, Life Events and professional Development

I was born in Ghana, and came along as the fourth of six children. My parents cared a great deal for us and had our welfare almost constantly in mind. I grasped as soon as I could understand such matters that my father was very successful in his profession as an accountant, and also that his abilities were reinforced by self-discipline. My mother had a successful small business and combined this with looking after children of her brothers and sisters. My parents supported social

justice, particularly with respect to improving the lot of those with less. I learned quite early that fairness, justice and companionship are important. In our family completing school and attending college was assumed, and highly valued. Some of my greatest joys were presents from my father when I did well in my examinations. I had a set back when my father died suddenly during my first year in secondary school. My mother pledged to see me through university education, to achieve my ambition as an accountant. But by this time it was highly important to me that I obtained a job to help support the family. I got a job as a teacher in a primary school. Looking back it was this experience that initiated my interest in working with people. I got the opportunity to train as an Aeronautical Communication officer but found that un-stimulating. I was to have a second blow when my mother died after a short illness.

I wanted to do something different and useful, to see the world. Luckily, I got opportunity to train as a psychiatric nurse in England. Coming to England was a change for me. I became attuned to some additional facts regarding my identity. Heightened cultural awareness ensued and I became more realistically keyed into the fact that different cultures were going on at the same time my Ghanaian culture was happening. This was a new type of feeling for me because; up until then I have always been within the shores of Ghana. The concept of individualism that enveloped me seemed blessed with something novel and stimulating while at the same time it was cursed with loneliness and isolation, stemming from longing for community spirit. I became conscious of my experience as a minority group member and felt excluded. This was a period of an intense debate not just in the United Kingdom, but also throughout the western world about the impact of immigration on western cultures. Plurality was seen as the cause of national decline

and disintegration with calls for a coherent national identity and culture. The riots mainly by black youths in Brixton, Bradford, and Hansworth, Toxteth among others were defined by the mass media as a threat about which “something must be done”. They also serve as the media’s and some politicians’ primary source of sound bites on the dangers of blacks in the UK. Scapegoating was abundant in each of the riots and to listen to commentators, one might have believed that without blacks, the UK would be a land of infinite economic progress, with no crime and poverty. What struck me was the adoption of a generalised attitude toward natives of “third world” origins. This generalisation strategy according to JanMohamed (1985 p.64) is a “commodifi(cation)” of the native, “so that he is now perceived as generic being that can be exchanged for any other native (they all look alike, act alike, and so on)”. Such a strategy of generalisation that eradicates cultural differences between peoples of various non-white cultures lead into a monolithic image of the third world as passive, inferior, backward and uncivilised – categories that are interchangeable for a generic Other. Here the West is presented as superior and the third world as inferior.

For instance, the claim of natural superiority was evident in the September the 11th terrorists attack in New York. Muslims and different cultures were depicted as uncivilised, immoral and always inclined toward barbaric activities. The problems of Moslems were portrayed as specific products of their culture. Similar discussions ensued during the Rwandan tragedy –the war between the majority Hutu and the majority Tutsi populations- where Rwanda became a symbol of bestiality, terror and evil. Blacks were seen as lacking the “white moral capacities” and described as beasts with the tendency to violence. There was, then, a division between white and non-white and a tendency to treat non-white not simply as different but as less than

fully human. My point here is not necessarily to condone the activities of any of these groups but rather to point out the notion of identity as recognition of Self through abjection of Other as noted in chapter two. I saw as simplistic the “anti – white” sentiments following any criticism of non-white and felt that we do ourselves disservice if we cry “racism” with the same stridency of those who criticise blacks. Thus identity is possible only by the abjection of the other. But as we saw earlier the notion of abjection is complex in that it describes both fascination and repulsion with another.

Abjection theory helped me to understand why I experienced both inclusion (the fascination of my cultural coding as different from white bodies and more primitive and closer to nature) and exclusion because of being inferior and uncivilised. Drawing on the theorisations of bodies, risk and danger, blacks were seen as an issue that has brought the nation to brink. For example the quest for multiculturalism and minority rights were perceived as a threat to the social cohesion of British society; here, minority rights were seen as a risk to the nation (the body politic). Notions of risk danger as we have noted above, implicitly construct an imagined “normal” state of affairs that should be defended from the perceived danger in this case a healthy nation endangered by outsiders. Pursuing questions about my own identity as black, I soon came to identify with “vulnerable” groups and became increasingly aware of their plight. My marginality enabled me to examine society in ways that cannot be conceived of by those who are centrally located in social structures and my desire to help rectify social injustice. This sense of marginality is necessary forerunner, for one must question the social order if one wants to study it. Thus I internalised the concern with social

development and social justice, particularly with respect to improving the plight of vulnerable people.

I trained as a psychiatric nurse at St. Crispin Hospital, Northampton. Early experiences helped me understand more fully the concept of context, namely that no illness ever happens in isolation. That there is a bigger picture, like a family, a community and a set of circumstances that force a person to seek medical attention. On reflection, it was the relationship between patients' experiences, emotionally and physically, and the larger environment around their experience that interested me. This underlying theme drew my attention to the importance of a multiple level of analysis for understanding complex systems. I was trained to understand group dynamics and interpersonal relations, but I needed to understand organisational and wider social forces to explain the problems I encountered. I began to read everything I could find about organisation behaviour and change. I found a lot of interesting material that pushed my thinking forward, but something was always missing. I never felt satisfied that the picture I had was adequate or the depth of knowledge deep enough to answer my questions. I considered my only logical option was to return to college. I began to pursue a course in business studies, which offered interdisciplinary programme. Studying business studies gave me appreciation of the importance of economic and sociological factors in shaping social systems. The disciplines inculcated in me a strong appreciation of theory building and the importance of rigorous empirical research. It also gave me insight into the social scientific venture as a process of model building and created in me an inner intellectual tension between action and science.

I carried out a project examining the factors that make task group decision-making possible. I wanted to know the range of freedom available to professionals'

decision-making and the options available to them. In other words how does the professional environment frame the professionals' work? My earlier initiation in the social sciences and my search for a coherent theory to guide my professional activities proved unsatisfactory. I could not accept the profession's idealised form of clinical decision-making. It contradicted my psychosocial development and scientific socialisation. I was of the opinion that clinical judgement does not operate in idealised form: rather it is drastically limited by the influence of other non-clinical such as social, economic, political factors. I saw the healthcare system as consisting of pluralistic political processes, where risk decisions are being contested, renegotiated and redefined on a regular basis. I was of the opinion that the risk decision making environment was complicated both by the variety of players involved and by the seriousness of the consequences of poor decisions. Thus the solution to the problem of clinical judgement is to address issues that are both political and professional.

During this period, I learned that feeling hurt is being a "crybaby", that what you think is right or wrong doesn't count, and that one must always show a good face, never show them what I feel, in a sense I learned to be a "good nurse". I learned that what I thought was good and right was too personal. These in my opinion contributed to the trivialisation of human experience. Emotions and feelings were reduced to numbers and I felt we lost a feel for people in that much of what we do was narrow and method driven – humanity was forsaken for method. I was enveloped with double messages, dammed if you do dammed if you don't. Messages that generally considered, to represent positive values in an organisational and managerial context (espoused theories) are confronted with what counts. So the messages to take initiative meant do not break the rules; and give immediate notice

when mistakes occur (e.g. giving the wrong drug) is met with punishment if you make mistakes. The message of integration between science and nursing in reality was confronted with clinical practice that was essentially ritualistic. Argyris and Schon (1978) explain these phenomena through the model of how organisational learning systems develop and are sustained through derived and connected inhibiting circles: the lack of agreement between organisations' theories in use and their prevailing espoused theories. So that causes and intentions are given other than that which actually is the basis for organisational practices. Bateson's (1971) theory about double bind contributes an even more illuminating explanation to these phenomena. Members of organisations are exposed to conflicting management signals and caught in double bind situations; double bind connotes a situation where conflicting messages occur, but where the individual is unable to comment upon the ambiguity.

The Search for "Meaning" in Practice

My need to explore and theorise the ambiguity and frustration resulted in a return once more to formal education, Organisation Development (OD) programme, at Sheffield Business School, a highly experiential programme that stresses personal as well as group development and organisational change. Thus like bell Hooks (1991 p. 59), "I come to theory because I was hurting - the pain within me was so intense that I could not go on living. I came to theory desperate, wanting to comprehend to grasp what was happening around me. Most importantly, I wanted to make the hurt go away. I saw in theory then a location for healing." Sheffield Business School provided an exciting and challenging learning environment and my apprenticeship as OD practitioner took on a deeper, and complex dimensions for me. The OD programme was intensely stimulating and liberating. It was

commitment to systematic questioning of one's own practice as a basis for self-development and the concern to question and test theory in practice. Research was self-critical enquiry, centred on curiosity and a desire to understand and require the researcher to become involved in the organisational context he/she is studying. The underlying theme was the hermeneutic approach to understanding organisational life. McAuley (1985 p.295) puts it thus "...to undertake the hermeneutic process requires an ability, in the research situation, to strip away the accretions of the self's form of life in exposing the self to the other. Thus it requires a high degree of development of self-knowledge, an ability to identify in the self and momentarily hold still personal judgements and cultural signposts."

The hermeneutic tradition sees social inquiry in a dialogical form, always incomplete and uncertain, responding to new questions and problems in the quest for subjective understanding. This process of continual critique and counter-critique makes us aware that in interpreting a text or social group we can only plea to interpretations that refer to other interpretations usually referred to as the "hermeneutic circle." The understanding of a researcher, approaching a particular social issue will inevitably and unavoidably be conditioned by the social, historical, political, cultural tradition of which he/she is a part and by individual particularity – personal and intellectual history. And the way it functions is easy to understand. If all observations are necessarily impregnated with certain symbols and point of view, it might seem as though a researcher is in the grip of a theory in the sense in which an individual wearing coloured glasses is in the grip of the colour of those glasses. If the glasses are blue then everything will get a blue nuance. The world's perceived colour does not depend on the world but on the individual's glasses. In the same way, what a researcher says about the world seems to be determined by his/her

theoretical presuppositions. Thus in a hermeneutic approach, the researcher's bias, existing pre-understandings and interpretative framework are necessary ingredients in evolving and understanding of the phenomenon under study. By being conscious of his/her "prejudice" then, the researcher can place his/herself outside it, analyse the subjective realities, the webs of meanings and common understanding of others.

Many philosophers, Berstein (1983) and Rorty (1979) among them take the hermeneutics insight to be the most effective weapon against epistemological objectivism. The hermeneutic circle takes the form of attempting an initial holistic understanding as a basis for interpreting the parts of the system. Knowledge is gained dialectically by proceeding from the whole to the parts and then back again. Each time an incongruence occurs between parts and whole, a re-conceptualisation takes place. The frequency of re-conceptualisation decreases as the match improves between the researcher's conception of the social system and that held by its members. Ellen (1984 p. 30) notes "It is a methodology where the notion of success replaces truth as criterion of validity and where the participation of the researcher becomes the main means of verifying his account. If able to interact successfully with and towards subjects, i.e. if able to pass for a member, the anthropologist's understanding of their culture is right. And it is, of course, the group which defines the terms of acceptance and rejection of new members." The hermeneutic tradition strengthens the researcher's methodological position by forewarning his/her that his/her interpretation will never be exactly the same as participants. This tells us of the uncertain nature of our interpretations due to their inevitably provisional nature. There is then, no set of laws to ensure a correct interpretation but a reminder that we may as researchers change our minds or participants may find our conclusions absurd.

Sheffield Business School provided an exciting and challenging learning environment. The notion that during inquiry the observer is not independent and distinct from the object being observed proved much more satisfying to me. Following the existential-phenomenology trend that knowledge is perspectival - what is called knowledge is relative to the perspectives of those making knowledge claims (Rorty 1998; Wittgenstein 1953) became for me both the evidence and the affirmation of my existence. As part of the OD programme I undertook a project in a Mental Health Centre. Individuals involved with the Centre were criticised both from within and without. It was felt that the Centre was not establishing the appropriate and effective treatments to meet the community's needs. The formation of a hostile and suspicious cliques and factions resulted in tendency to personalise issues and scapegoat individuals as the cause of the problems. Centre employees in many respects turned inward, forever criticising their actions and reactions. There was a high staff turnover, a constant crisis orientation and a feeling of hostility and suspicion surrounding group interactions and a considerable amount of psychological labelling. My initial assessment from participants' seemingly endless concern over what the goals of the Centre represented fundamentally different and incompatible views about the nature of what the organisation was about.

While undertaking the project the organisational client seemed to assume that I have the knowledge and skills in prescribing a course of action rather than to help the client system learn to better solve its own problems. Ability, expertise and effectiveness were assumed. But I have not been a professional with all the rights, responsibilities and obligations implicit by that status. In my first few days at the Centre, I felt completely out of touch with my inner voice and was in search of my professional identity. It was a time of great insecurity and confusion and suffered

from inexperience in coping with the challenges presented (Wax 1957). This pattern of reality shock enveloped me with feelings of guilt, embarrassment and inability to meet other's expectations. I encountered the problem of what Hughes (1958) called "marginal man" having to play the role before one feels completely identified with it or competent to carry it out. Berg (1980) maintains that the apprenticeship period is the time, which provokes identity questions for the student as he/she learns to negotiate his or her role in the field. The questions "Who am I?" and "What am I doing here?" were ever present within me. According to Van Gannep (1965 p. 11) an apprentice who has not mastered fully the control of his power, or has developed the correct style is still in the state of "liminality" which is that a student finds him/herself in a limbo between the state of ordinary man and sorcerer yet properly neither. My situation exemplified the comments of Bailey's (1977 p. 184) that "People or objects which will not fit into a known category are likely to be regarded with fear, with contempt or even with loathing".

Finding myself placed in new and uncertain conditions, I underwent a period of concern about what my role is to be within the context of the situation. This role ambiguity was compounded by information overload creating even deeper internal chaos. This situational uncertainty was mirrored by emotional insecurity. The identity confusion coupled with the dilemmas of performance anxiety increased the stress. Expectations about my performance were perceived as being artificially high and of colossal significance. As a result, each incident relating to my performance became greatly magnified in retrospect, assuming a level of importance of the most critical proportions. As the project progressed, the issues that surface shifted from concerns about my performance to concerns about the viability of the field of OD and my anger with the client organisation. According to Berg (1980) questions,

concerning the field in which one is involved is a common theme for many apprentices learning their craft. My disillusionment lies in the fact that the romanticism, which comes from learning on the course, provided me with unrealistic standards, which were dashed. My high standards and expectations were brought in sharp focus with the reality of the experience itself. I expressed concerns about the adequacy of theory to explain organisational life and wondered whether OD as field has begun to capture the essence of what goes on in organisations. My personal fears of professional incompetence and lack of faith in what I had to contribute were mirrored by similar concerns about participants in the project. I felt they were incapable of applying the techniques that OD had to offer. The shift from and anxiety to frustration about my performance, resentment and anger of participants were due to my naïve and idealistic expectations. What I learned on the OD course did not prepare me for the dilemmas that arose in the field.

Feedback from my supervisor about my concerns enabled me to realise that OD techniques have much in common with psychiatric nursing (psychodynamic therapies). The OD practitioner or psychiatric nurse is a co-learner who helps by facilitating the client's learning rather than by dictating changes through the collection of data, testing hypotheses and developing solutions. The long-term collaborative relationship needed to explore sensitive issues, in both fields, are likely to be emotionally intense. The similarities between research relationships and psychotherapeutic relationships suggest that transference and counter-transference are likely to occur in both situations. The former refers to displacement of emotions from earlier situations, usually childhood experiences with the parents to the therapist. For example, superior-subordinate relationships, which entail the subordinate's dependence on an authority figure, often trigger unresolved feelings

about one's parents. During my project I had the feeling on a number occasions in which members of the organisation's anger and fear of senior managers were displaced onto me who represented an easier and more understanding target. The latter is the mirror image of the former. The therapist may respond on the basis of his/her own unresolved emotional conflicts to the client's feelings of helplessness, rage or fear. For example, I was critical about the ability of members of the organisation's ability to apply OD techniques, in order to defend against unconscious feelings aroused by my relationship with them.

This observation exemplifies the awareness of the researcher as a variable in the research process. As a researcher becomes immersed in the field, he/she develops different kinds of relationships with research subjects. The close bonds that emerge in the relationship between the researcher and the informant are particularly favourable to the mobilisation of transference. Dervereux (1967 p.xix) observes that the data of behavioural science are derived not only from "the behaviour of the subject," but also from "the behaviour of the observer," including "his attribution of a meaning to his observations." He suggests that the observer's reactions to his/her subjects may arouse anxieties that can distort the data being elicited and interpreted. When the observer is aware of these anxieties, rather than taking a refuge in "pseudo-objective" methodology, the research-subject relations, the role the researcher plays in the field and the effect on data gathering would be recognised. The acknowledgement of affective dimensions of the researcher-subject relationship (Hunt 1989; Rabinow 1977; Reinharz 1984) regards the assumption of a dichotomy between researcher and subjects as problematic and recognises that the research process is far less orderly. Proceedings in the field are frequently

unexpected, irrational and spontaneous. Researchers as well as subjects act on basis of situated feelings and moods (Adler & Alder 1987; Van Maanen 1988).

If we translate the stages of the research field experience to the process that occurs for the newly emerging OD practitioner on his or her first assignment, several parallels surface in psychiatric nursing, OD and ethnography. All the disciplines are based on humanitarian democratic philosophy regarding human nature and the helping relationship and believe in the inherent value and dignity of the individual right to personal development. Both disciplines jointly value the right of individuals to purposeful expressions of feelings, to unconditional acceptance from others, to genuine emphatic, non-judgemental response by the practitioner, and to a guaranteed confidentiality in the practitioner-client relationship (Beer 1980; Cummings & Worley 1997; French & Bell 1999; Omery et al 1995; Reed & Ground 1997; Rogers 1980; Spradley & McCurdy 1972). In all the disciplines, use of oneself as a tool is basic: where understanding the informant and client's interpretation of the world is the defining characteristics. To perform effectively, professionals in all disciplines must demonstrate personal awareness and self-understanding vis-à-vis their relationships with their clients. They must have the sensitivity and empathy necessary to take the position of the other (Geertz 1975). Through an interpretive mode of inquiry, practitioners seek to decipher what events mean to the client and significant others. By drawing the parallels in at three disciplines some key issues are identified. Namely that they all have theoretical interest in human interpretational process and concerned with the study of socially situated human action. In addition they all use human investigators as the primary research instruments and all involve the application of reflexive analysis.

The OD programme required deep self-disclosure and emotional vulnerability and gave me a sense of meaning, by providing an opportunity to disclose my “true” feelings and the permission to reflect on those feelings and how they were affecting my decisions. The programme requires the OD practitioner look briefly inward and become aware of his/her feelings as they relate to his/her experience of organisation. In doing this, the practitioner recognises the emotional impact on him/herself and can begin to question the emotional impact on others. Schutz (1994) proposes that being in touch with one’s feelings is important to effective problem solving and decision –making. Related to this is the importance of reflection – the feeding back of feelings by the practitioner to the client in order for the client to be aware of the practitioner’s feelings, thus creating a climate of recognition and validation. This is similar to the therapeutic process termed “focusing” where the therapist encourages a client to perceive and experience the feeling and then asks questions that allow the client to form images from the feeling (Gendin 1969). Going back and forth between experience and images helps the client create meaning related to the feeling. Through this path, I learned to value qualitative research methods, which very much fit who I am and how I relate to others. Being with people, spending long periods of hearing others’ stories, immersing myself in the richness of a situation was the kind of research that made sense to me and wanted to do.

My search for meaning in practice revealed that in many ways psychodynamic and psychotherapeutic perspectives have been represented in the organisational literature. For example, approaches to planned organisational changes were influenced by clinical research and practice. The group dynamics approach was influenced by psychoanalytic thinking as well as the work of such clinicians as Carl Rogers, Fritz Perls and Eric Berne (Benne 1976). The socio-technical systems

perspective was influenced in part by the work of W Bion on group dynamics and Melanie Klein on object relations. Kets de Vries and Miller (1984) based their descriptions of neurotic organisational cultures on psychotherapeutic literature. Zaleznick and Kets de Vries (1975) have borrowed from the psychoanalytic literature in investigating the exercise of organisational power. Clinical perspective has paid attention from the different stages by which individual change takes place, by drawing parallels between individual and organisational change processes (Kets de Vries 1991, 1996; Levinson 1972; Zaleznick 1989). Thus organisational behaviour and research methodology took on deeper and more complex dimension for me in paying attention to sociological and psychoanalytical phenomena. Experience taught me that change interventions based on oversimplified models of human behaviour usually failed because they do not pay attention to deep-seated underlying processes. Taking account, for example, of the rich underlying of individual change by accepting that conscious and unconscious resistances are unavoidable responses can turn the change process into a more realistic venture (Kets de Vries & Balazs 1999). I am therefore attracted by values that call for the interpretations about an individual's or group of individuals' inner dynamics in the light of structures and processes within subsystems, organisations and their environments and vice versa (Menzies 1975; Trist & Murray 1993).

Social Science as a Transformative Process

I recognise that in doing social science within organisations, my experience has shaped the nature of my work in several ways. First, critical life events (social background, political orientation and professional socialisation) have determined which issues interest me. My concern with social justice has shaped much of my work. This concern was laid by my parents' emphasis on the values of fairness and

equality of opportunity. My professional socialisation has had considerable impact on the social science theories I have adopted. My introduction to action research (Agyris et al 1985) which recognises the importance of the subjective nature of one's observations and one's participation in the research experience fitted with my democratic orientation developed in early life. Action research offers me opportunities for theory building, chances to make a practical difference with respect to problems and a potential for a creative exchanges between the worlds of research and action. This evolution in my perspective has been driven by my concern with practice outcomes and need to understand multiple levels and multiple aspects of social problems to solve them successfully. I am interested in both interpersonal, group dynamics and inter-group and organisational issues in a way that integrates psychodynamic and organisation theory (Neumann & Hirschhorn 1999). The former provides social scientific depth by reminding us of sources of energy and motivational forces experienced *within* individuals, small groups and leaders and the linkages between them and the latter offers scientific breath by bringing into focus the structures and processes within organisations, their environments and the linkages among them. Such a stance enhances the hermeneutic methodologies by its view that fieldwork is an inter-subjective process; which in turn adds an additional dimension to the sociological understanding of fieldwork thus providing richness and depth (Hunt 1989).

Second, my experience has influenced my choice of theoretical perspectives. I have been strongly attracted by the phenomenological view of reality, which highlights that we understand social reality only through subjective interpretation (Schutz 1967). The work Berger and Luckmann (1967) and of others on the social construction of reality has also greatly influenced me. This orientation is

underpinned by a set of values that include a commitment to self-scrutiny as part of the research process and a dialogue between theory and method during the research process (Berg & Smith 1985). It is simply impossible for the researcher to understand the “subject” unless he/she enters into a dialogue with the “subject” aimed at mutual understanding. In a sense, this is the locating of the researcher on the same critical plane as the researched. Based on an epistemology that considers all knowledge to be socially constructed, it begins with the acknowledgement that the identity of the researcher matters. The researcher is unavoidably present in the research process, and his/her work is shaped by his/her social location and personal experiences. According to Stanley and Wise (1983 p.162) “Because the basis of all research is a relationship, this necessarily involves the presence of the researcher as a person. Personhood cannot be left behind, cannot be left out of the research process. And so we insist it must be capitalised upon, it must be made full use of.” To this end researchers are encouraged to explore their intellectual autobiographies and the role of emotions and feelings in the research process (Reinharz 1997; Stanley 1984). I am attracted by the guidelines set for clinical research described by Berg and Smith (1985 p.25):

- direct involvement with people in social systems
- researcher commitment to a process of self-scrutiny
- willingness to change theory or method during the research, in response to the research experience
- description of the system favouring depth over breadth
- participation of system members in the research.

Third, concerns the specific questions I select to study. My inner world structured my choice of setting, experience the stages of the fieldwork and the

research roles I assumed. The reactions I encountered from research subjects have implications for the questions I asked, the feedback they got, and the materials I observed. My motivation for the research arose from aspects of my training and education as a psychiatric nurse, educator and a researcher, and from issues encountered during practice in a number of differing organisations. My move from the position of 'actor' to 'investigator' was the result of unease at the context and boundaries of the role of a psychiatric nurse within a complex organisation in contemporary society. My interest in developing the research was the ways in which managerial discourses impact on what nurses can do and say in their clinical practice. These discourses produce new questions for me to grapple with, as I work with nurses in the professional development contexts and do research in psychiatric settings. How does the new urgency and anxiety about safety, as a matter for government concern, intersect with professional nursing discourses about care? What effects do the implementation of risk management initiatives have on professionals? I was interested in these questions not only as a researcher, but also because as a nurse and as a writer of educational materials for nurses, I was concerned about the effects of my own discursive practices and in particular how such practices in particular how such professional knowledge effects impact on patients from contemporary nursing practices. I was curious to see if other nurses had similar experiences and was keen to examine the numerous political, social, legal, health, and nursing practice issues surrounding risk management. It seemed a natural progression is to undertake a PhD.

Fourth, I recognise that my experience also influences the way I interpret my finding. The development of a research interest is a personal experience and the description of a focus of concern, is affected by both the practical and theoretical

aspects of one's research. The researcher's relationship to the phenomenon under study is neither static nor given and continues throughout the research process. In the course of interpreting data, the transcripts of the participants in the study may be said to set a range of possible interpretations to which the researcher brings collection of intentions and meanings. As a result there will be conflict between the meaning structures brought to the research process by the researcher and the meaning structures that exist as part of the common sense world that they are seeking to understand when researchers develop theories. In a hermeneutic or interpretative approach then researchers observe and interpret the experiences of participants who are themselves interpreting the worlds they experience – double hermeneutic. This tension is described as “first- and second-order constructs that we encounter the irreducible dilemma of reconciling two spheres of meanings. When we focus on this nexus, we can gain insight into the way that persons generate theory. As part of this, the inevitable question arises about “Whose theory is it? (Schutz 1971 p.6). In the course of interpreting the data for the present study, I would have to bring my own thoughts and experience to bear on the data and to use inference to arrive at an understanding of the experiences of participants.

I conceptualise the research process as self-engagement and change for the researcher as well as for the subjects (Morgan 1983), in which any theoretical account involves “understanding the other through self-reflection” (Kleinman & Copp 1993 p.55), thus accounting for the self as thinking, imposing, reflecting and participating member of the social reality being presented. Such an observation is an acknowledgement of the importance the “self” plays in the research process, namely that the individual characteristics – personal history, biography, gender, social class and ethnicity - of the researcher shapes the way theoretical meaning is imposed on

everyday experience (Denzin & Lincoln 1994). The researcher cannot detach him/herself from his/her own participation in this experiential world: social science entails studying value-laden phenomena of which the researcher is a part. The way we conceptualise and write about issues do not simply mirror external reality, existing independent of our conceptions and writings about it. In everyday life, as in social research, people use culturally dominant meanings as a point of departure as well as the resources for thinking, getting data and writing. From this stance, theory is a way of seeing and thinking about the world rather than an abstract representation of it. Theory then is seen as the “lens” a researcher uses in observation than a “mirror” of nature. The “lens” metaphor helps us to think productively about theory choice. The researcher is able to carry out his/her research only in the context of his/her interests, world-view, preconceptions and values. In a word, all observations are theory-driven, with every theory carrying the values of the researcher.

In addition, it is accepted that values are omnipresent in inquiry. In the decisions, of what to study and how to study it, in the paradigms used, in the belief systems of those participating in the research, and in the theory which frames the work. Here, the trick is for researchers to acknowledge values openly and make sure that their research problems, paradigms, methods and context are value-resonant (Guba & Lincoln 1982). Values and thus various ideals and criteria of how social life should be formed, must guide research. Social science involves studying value-laden phenomena of which the researcher is part. The way we conceptualise and write about issues such as risk management do not simply mirror external reality existing independent of our conceptions and writing about it. This means that value-free interpretive research is impossible. This is the case because every researcher

brings preconceptions and interpretations to the problem being studied (Gadamer 1975). Hermeneutical circle, a concept noted above, refers to this basic fact of research, that all researchers are caught in the circle of interpretation. The researcher is not separated from his/her prejudgements and/or prejudices. There is no difference between understanding and interpretation as all understanding involves interpretation and all interpretation involves understanding; thus understanding will vary in relation to a person's self-understanding and the different questions that are asked (Bernstein 1983; Gadamer 1972).

In this chapter, we have seen that the personal biography of the researcher and the roles he/she takes influence the research in two ways, the sense the researcher makes of the setting and how participants make sense of the researcher. As a researcher observes or interviews, he/she reacts to the participant's words and actions these reactions prompt judgments, feelings, working hypotheses, understandings of the setting and participants. According to Hammersley and Atkinson (1983 p. 15) "There is no way in which we can escape the social world in order to study it" Alvesson and Skoldberg (2000 p.39) observe that "There is no one-way street between the researcher and the object of study; rather, the two affect each other mutually and continually in the course of the research process." This relationship and the researcher's reflections on it, a phenomenon termed reflexivity, is central to this piece of work. The next chapter details how the project was designed.

CHAPTER FOUR

METHODOLOGICAL APPROACH

Methods are mere instruments designed to identify and analyse the obdurate character of the empirical world, and as such, their value exists only in their suitability in enabling this task to be done. [The choices made] in each part of the act of scientific inquiry should and must be assessed in terms of whether they respect the nature and empirical world under study. (Blumer 1969 p.27-58)

As we observed in the previous chapter social researcher's choice of methods is related not only to the type of problem studied but also to his/her overall approach to social science research. All social research takes place from a set of ontological and epistemological assumptions that provide taken-for granted understandings of the nature of the world and preferred methods for discovering what is worth knowing. The philosophical commitments guiding the project, is centred on interpretivism that holds subjectivist assumptions about the world. Here, interpretation "implies that there are no self-evident, simple or unambiguous rules or procedures, and that crucial ingredients are the researcher's judgement, intuition, ability to 'see and point something out,' as well as the consideration of a more or less explicit dialogue – with the research subject, with aspects of the research herself that are not entrenched behind a research position, and with the reader (Maranhao 1991 quoted in Alvesson & Skoldberg 2000 p.248). This viewpoint presupposes the researcher's reflection as a essential component of his/her role. In terms of reflexivity this is an interactive and cyclical phenomenon rather than a linear one. The researcher is open to the interaction of what is considered fact and opinion. So the researcher both asks what sense he/she makes of what is going on (etic perspective) and the sense participants make about what they are doing (emic perspective). While the researcher cannot actually get into participants' mind,

he/she can search for evidence of their worldviews. Superimposed on these ongoing processes is the set of questions about what I am doing, my actions and how I perceived them.

Objectivists see reflexivity as something that can be controlled – that is the quest for objectivity by the researcher. The researcher from this angle is supposed to eliminate all bias and to remain disinterested. Acknowledging that reflexivity is present in social interactions, I argue that objectivity is elusive. I share Delamont (1992 p.8) recommendation that that qualitative researcher to be “constantly self-conscious about ...role, interactions, and theoretical and empirical material as it accumulates. As long as qualitative researchers are reflexive, making all their purposes explicit, then issues of reliability and validity are served.” I do not therefore find the quantitative/qualitative distinction useful (Alvesson & Deetz 2000; Silverman 2000), but am rather attracted to Hammersley (1992 p.163) assertion that “We are not faced, then, with a stark choice between words and numbers, or even between precise and imprecise data; Furthermore, our decisions about what level of precision is appropriate in relation to any particular claim should depend on the nature of what we are trying to describe, on the likely accuracy of our descriptions, on our purposes, and on the resources available to us; not on ideological commitment to one methodological paradigm or another.”

Introduction of risk management strategy implies the creation of meanings about patient care, organisational arrangements and interaction processes. These new meanings are being negotiated and agreed upon among actors in a continuous course of events. In a sense the application of risk management strategy is produced out of everyday interpretations and negotiations for local organisational actors (Strauss et al 1963). From these insights, it is useful to look at how risk management

is constituted in the local workplace situations instead of being considered as a pre-specified set of actions. This means that risk management is likely to be enacted in very different ways in different work context. In taking this stance, the suggestion is that risk management application emerges out of a complex interplay between individual and collective action and interpretation on the wards. There are different discourses between for example, care of the elderly, acute care, forensic care and so on. Here discourse refers to the use of language that places actors own positions and relationships within it (Fairclough 1995; Foucault 1972). The approach taken here sees knowledge or knowing as a process going on among people. By interacting, people make meaning for each other and the relationship is the carrier of meaning in the making (Austin 1962). Thus language is no longer considered as a practice mirroring reality; language is regarded as a practice of making meaning in ongoing relationships (Gergen 1994). Risk management is therefore best understood as local social production involving the discursive participation of different organisation members. My interest is to understand this process by looking at both the kinds of action that are discursively constituted as risk management, and ways in which this constitution takes place.

The discursive focus is theoretically compatible with a symbolic interactionist position; which provide a general theoretical backdrop of this study (Blummer1969; Fine 1996; Prasad 1993). Symbolic interaction is primarily concerned with the study of meaning with the belief that objects and events have no intrinsic meaning separate from the meanings people assign to them in the course of everyday social interaction. As a framework it offers both a way of conceptualising the social world and methodology for conducting research. Emerging elements of symbolic interarctionism is the growing interest in language as a primary shaper of meaning

itself (Cossette 1999; Fine 1992). Following this trend language can only be understood in the context of interactive situation in which it is produced. Accordingly, language is the carrier of ongoing co-ordination in which meaning emerges during interaction and always evolving. Making meaning is a very dynamic and open process, thus language in organisations must be analysed on the basis of the experience of the actors in the interactive situation. Cossette notes that (1999 p.1363 author's emphasis), "from the symbolic interactionist stance, the object of interest is not really the *word or phrase*, nor even the subject, but the interactive situation as it is *constructed subjectively by the actors concerned*."

Symbolic interaction is a particularly appropriate way to gain understanding of the kinds of actions that are discursively constituted as assessment and management of risk, and the ways in which this constitution takes place. Adopting a symbolic view of risk management may accomplish several ends. It may help researchers enter the cognitive worlds of organisational participants, help explain what risk management represents to people and how those representations can influence their interactions. The interactionist approach, go beyond explaining risk management in solely rational and economic terms and help reveal the expressive world of organisation members (Sims & Gioia 1986). It also rests on the assumption that every organisational situation may be enveloped in multiple and often conflicting interpretations and meanings. The perspective therefore emphasizes the need to present a many-sided picture of organisational life and encourages the use of more than one research method to capture complexity and problematical data. In addition, symbolic interaction reminds us that the relationship between meaning and action is dialectical and dynamic. Symbols from this view, are not static artefacts but are constantly produced and reproduced through meaningful social interaction. The key

to the symbolic interactionist position is the concept of “enactment” the process whereby symbolism in organisations shapes and influences everyday organisational practices. In studying the discourse of risk management, my interest is in how the symbolism of the concept influences the process of implementation and related areas of organisation-level action. In sum, symbolic interaction presents a methodological framework for understanding the symbolic process involved in risk management technology and offers an angle from which the researcher can look for various local meanings and to understand how those meanings become crystallised and influence action.

Contemporary strands of symbolic interaction have shown a growing interest in the affective dimension of the researcher namely that researchers experience emotional reactions such as feelings of insecurity, anxiety, loneliness, frustrations and confusions during fieldwork (Hunt 1989). Such an observation shares the psychoanalytic viewpoint of the interpretative nature, the intra-physic dimensions and inter-subjectivity of the fieldwork process. The researcher in attempting to decipher what is happening in the world needs to interpret the way that stories unfold, to find out hidden meanings, consequences and motives behind acts and social behaviour in order to assemble them into a coherent whole. In his concept of “thick description” Geertz (1973) encourages us to search for deep underlying structures while remaining firmly in touch with reality. Such an interpretive approach according to Geertz’s (1973 p.20) involves “guessing at meanings, assessing the guesses and drawing explanatory conclusions from the better guesses”. As suggested by scholars like Geertz (1973; 1983), Levi Strauss (1969), and proponents of hermeneutic, such an approach suggests that much surface complexity can be explained by an underlying organising theme that serves to

organise the surface phenomena. There is also a need to search for elements that have not only logical centrality, but also deep, perhaps unconscious, emotional significance (Freud 1920; Greenson 1967). In using psychoanalytical perspective, Gabriel (1999 p. 251-252) suggests that the “researcher looks for clues. The odd, out of place, the significant exception provide far more insight than large volumes of uniform and unidirectional data....researchers must be aware of instant conclusions. They must be especially suspicious of ‘innocent’, straightforward explanations, of undisturbed terrains, of dogs that do not bark. At times, an off-the-cuff remark at the end of a long interview may be of greater value...” There must therefore be a focus on discovery rather than a single stab at explanation. Initial interpretation must be tested against reality as perceived by others. Here, interpretation is a dynamic iterative and interactive phenomenon that may bring insights but rarely provides any final solution.

The researcher must focus on a specific group or question that is manageable. Given the time resources and desired output of the study, the area selected usually reflects the interest and expertise of the researcher. The project required an approach, which focused on the processes involved in assessing and managing risk. It was important to consider the use and development of risk management strategies, not only in context of managerial support for them, but more important, in the context of individual units within which they were developed. To provide the required level of detail and look at risk assessment and its management holistically within the organisation, a case-study approach was adopted, which enabled me to spend time on units, working with nurses and patients, observing and where possible, participating in activities relating to the process of risk assessment and risk management. In this study the question of how sites should be identified and on

what criteria they should be selected narrowed from looking at a range of hospitals to one organisation, a psychiatric hospital in the NHS where four units were selected. The criteria for the selection were based on the degree to which the units have been exposed to, and developed risk management strategies prior to the start of the project. In order to provide a comparative vantage point from which I could assess the generality of my observations, I conducted one year of research in an Old People's Home in the independent sector. The selection of more than one setting was designed to enable me to distinguish aspects of risk management activities which are unique to each unit from those which are common to both (Eisenhardt 1999).

Criteria of Selection

The project required an approach that focused on the processes involved in assessing and managing risk. To this end, it was important to view the use and development of risk management techniques, not only in the general support for them but more important, in the context of the individual units, within which they are being developed. In order to provide the required level of detail and to look at risk assessment and management technologies holistically within a unit, a case study approach was adopted, which enabled me to spend time on each unit, working with nurses, patients, observing and where possible, participating in activities relating to risk assessment and risk management processes. The problem of selection had two related aspects. First, there was the question of how to identify the sites and second, on what criteria should they be selected. I decided to choose my research sites from the health and independent sectors, both because of the degree to which they have been exposed to, or had developed risk assessment and management technologies. In addition, the organisations in these two sectors, as

illustrated in the four units ultimately examined, often manifest important differences in organisational structures, cultures, and management practices. For example, an argument has been advanced that suggest there is basic difference between public and private sector with regard to risk taking (Bozeman & Kingsley 1998). This variation may permit the development of assumptions regarding the effects of organisational forms and belief systems on nurses' judgements on risk decision-making.

Two conditions governed the selection of the sectors to be investigated to enhance the possibility that generalisations about the nature of sector-based cultural assumptions and comparisons and contrasts of sector-specific findings could be made at the study conclusion. Of primary importance were that the sectors exhibit some degree of between-sector heterogeneity by seeking organisations from contrasting environments in this case the public sector/independent sector. This would ensure that comparisons, contrasts and generalisations might be made from and sector-specific findings that did emerge. In addition the sectors display a strong degree of within-sector homogeneity namely high rate of interaction with regulatory agencies, high degree of uncertainty and social ambiguity and high degree of professionalisation. This would increase the likelihood that commonalities in organisational culture might be more observable. Other criteria were accessibility plus the fact that the sites were interesting to me, a criterion necessary to sustain the long-term intensive investigation required.

Following Pettigrew's (1988) caution of "death by data asphyxiation" I adopted within-case analysis, which involves detailed case study write-ups for each site; which were central to generation of insight (Gersick 1988; Pettigrew 1988). This helped me cope early in the analysis process with enormous volume of data. I

became intimately familiar with each case as a stand-alone entity and allowed the unique patterns of each case to emerge before I moved to generalise patterns across cases. To minimise the danger of premature and false conclusions as a result of information processing biases, within-case analysis was coupled with cross-case search for patterns (Nisbett & Ross 1980). I selected categories/dimensions and then look for within-group similarities coupled with inter-group differences. This approach compelled me to look for the subtle similarities and differences between cases. In the words of Eisenhardt (1999 p.541): “The juxtaposition of seemingly similar cases by a researcher looking for differences can break simplistic frames. In the same way, the search for similarity in a seemingly different pair also can lead to more sophisticated understanding. The result of these forced comparisons can be new categories and concepts which the investigators did not anticipate.” This enabled me to go beyond initial impressions, through the use of structured and diverse lenses on the data; and improved the likelihood of accurate and reliable theory. Additionally cross-case searching methods enhance the probability that I will capture the novel findings, which may exist in the data.

Gaining Entry

My efforts at researching and team development programmes in a variety of healthcare organisations have demonstrated that getting in has been difficult. Research is seen as an extra burden with reservations about ability to incorporate the researcher’s presence in an already busy environment. Access has been difficult because of nurses’ prior unpleasant experience with researchers. Although, the need for research was seen as important by many professionals in the health systems with which I have worked, difficulty in gaining entry seemed to revolve around the particular task that health systems perform, and their internal resources. Let us take

this in turn. First, within a healthcare organisation there is a set of forces directly connected to the characteristics of its primary task that acts as a potential barrier to the successful initiation of a research effort. The task (the delivery of healthcare) is inherently vague and ambiguous, making it difficult to set meaningful and measurable goals. In view of such uncertainty, a healthcare organisation often demands tangible proof that research will be useful. Second, are the attitudes of those who work in healthcare organisations, the attitudes and values of professionals dominate and often pose problems for the researcher. One such attitude follows from a principle “first do no harm” thus any act, which implies “judgement” on their standards is frowned upon.

I have learned to anticipate that there are several entry dilemmas in the entry stage that demand generating support within an organisation and obtaining individuals (daily gatekeepers) agreements to participate. Due to the complexity of the system, my entry was forced upon participants without regard to their views. The research was approved by senior management who were often viewed by “front-line” staff as out of touch with reality on the units. Following the organisation development tradition (Alderfer 1980; Beer 1980), I developed a number of liaison relationships with groups early on in the fieldwork in all sites. In my initial presentations to the groups I sketched out my research objectives and the primary issue areas I would cover. There was a lively exchange of views about the research proposals and anxiety was expressed about my being present in the sites for such a long time. Fear was also expressed that I might take on an evaluator’s role. The fate of data collected and confidentially and anonymity were of concern. By virtue of the research contracts, I had the right, - although limited - to enter and move about each unit and to talk to participants. Different sites established different

rules and protocols regarding mobility of access. In some units I was able to enter and move about virtually at will, to contact participants, to set up interviews appointments and participate in activities. In other sites mobility were greatly restricted. Some days I did not get in at all due to activities on some of the units. Some of the sites were dominated by concerns for security. Patients must be prevented from escaping or breaking the units' rules and patients and staff must be protected from harm. Visitors and other outsiders on two sites were carefully screened before being allowed to enter. The ability to engage in observation and to undertake interviews was affected by these concerns. I became anxious of getting in the way as an observer because of the concerns expressed. This obstacle reduced as time progressed and my presence on the sites became more commonplace. A further concern is related to participant's perceptions of my role as an evaluator. I needed to spend considerable time reassuring participants that I was not there to judge their standards of practice. Again this obstacle did reduce with time.

The study of healthcare settings needs establishment of an appropriate balance between social science and research paradigms in addition to building and managing relations with research participants. Gaining access is one thing but maintaining it requires continual attention. It is easy to lose sight of the particular design decisions when one is immersed in the field; for example changes views about how much organisational time one is tying up, changes in perceived value of the research means that access has to be worked for. The challenge concerning entry is the establishment of a negotiating relationship that is sensitive to the feelings, worldviews and the interests of participants and ethical given the fluidity of the research process.

Research Methods

The research methods were intended to capture the rich array of subjective experiences of organisation members during a process of risk management interventions. Following the growing acceptance of using multiple methods in organisational research (Alvesson & Deetz 2000; Alderfer & Brown 1975; Martin 1984), I use a triangulation of research methods - participation observation, unstructured interviews (informal conversation), unstructured observation (hanging out), semi-structured interviews and collection of relevant documentation (information brochures, policy and procedure document, memos, information booklets, and print based media). A development model of relationships was used to increase the validity of the data (Alderfer 1980) at all four sites. Data collection began with less-structured and less-structured methods and then moved toward more structured techniques as organisation members grew to trust me. There was enough structure to insure that data would be comparable across the three sites that is open to rigorous analysis, and at the same time, enough flexibility to cater for the special situation presented by each site.

Participant Observation. Participant observation which lay emphasis on the importance of human meanings, interpretations and interactions (Jorgensen 1989), provided insight into the everyday realities in the study. In the words of Cunningham (1993 p. 132), “participant observation allows the observer to take on, to some extent, the role of a member of the group and participate in its functioning. The observer is asked to experience the problem practically and personally. This is an opportunity to see the conflicts and miscommunication which might never have been recognised by asking questions in an interview.” In this study, I used the approach in which the researcher maintains an identity

close to the group being observed but separate from it. Here participation involves sharing assumptions, expectations, and emotions of the groups being studied (Ashworth 1995; Gabriel 1999). Indeed, in rejecting the duality of participation and observation Adler and Adler (1987 p.35) advise us to think of the researcher's involvements in terms of "committed membership" so that "researchers participate in the core activities in much the same way as members, yet hold back from committing themselves to the goals and values of members." The conception of research roles often developed into typologies, for example, Gold's (1958) topology of the four roles complete participant, participant-as-observer, observer-as-participant, and complete observer suggests the idea of a research role. However, I had many roles depending on the situation; there was a constant interplay between observer and participant because of the combination of the roles of field researcher, psychiatric nurse and as an "insider." For example, my clinical experience as a psychiatric nurse meant that on occasions, patients approached me for support and I helped staff in certain emerging situations which exemplifies how as a researcher, with no intention of affecting patient-nurse intervention I did so. My obligations then, in those situations, were not those of a researcher with control on how my presence affected the interactions, but rather my responsibilities were clinical ones with the outcome of a therapeutic situation.

Thus my role varied over time. Initially I might be "complete" observer (Silverman 1993) not verbally engaging in for instance, team meetings. However it was not possible for me to maintain this stance because the members wanted me to participant more actively. I changed my behaviour slightly engaging with comments when asked. The study offered the researcher's partial

enmeshment within the sites studied. The distance provided by the partial involvement contributed to balancing the postures of the observer and observed. I made systematic records of several matters on the sites over a period of time. Throughout the study, I made extensive notes from each meeting of what and how things were said and verbal reports at the change of shifts. My research activities in the four settings proceeded along similar lines. I observed and took part in clinical events at different times of the day and night. Clinical events included occurrences of unexpected systems state with negative and positive consequences. As soon as possible after an event has occurred, I noted what happened and why it happened. I spent time on units with nurses, doctors, and social workers when doing their work, and attended case conferences, unit rounds, and multidisciplinary team meetings. Participant observation provided data concerning a range of formal and informal activities that constituted risk decision-making process. Under optimal circumstances it was possible to follow a particular risk management decisions as they were discussed. This gave me opportunity to listen to talk about patients and the practical solutions suggested. I took notes during such meetings and wrote those notes into fuller account later on the same day.

Unstructured techniques. The early time in the field, the discovery phase, can be regarded as collection of stories about major relationships, key events and organisational complaints. Scholars including Bruner (1990) and Tenkasi & Boland (1993) suggest that stories are a fundamental way through which we understand the world. By understanding the stories of organisations we can claim partial understanding of the reasoning behind the visible behaviour of organisations (Boje 1995; Gephart 1991). This provides a valuable viewpoint to the study of

organisations in offering us ways of developing meaning from what is said or left unsaid, adding to our understanding of organisational behaviour. However, since members in organisations can tell different stories on the same story, including statements about past, present, or future events (Boje 1991), multiple interpretations are inevitable. In this study, a story is described as explanations offered by respondents to explain organisation behaviours, processes, or relationships; which are not necessarily consistent across, up, or down hierarchical levels because any given organisational behaviour can have more than one explanation. Stories reflect individual sense making (Weick 1995), and similar stories may coexist or compete for domination (Boje 1991).

Unstructured techniques involved listening and comparing different accounts; that is investigating how narratives are constructed around specific events and examining their importance. This included such things as sitting at lunch listening to various conversations, talking informally with members on specific problems, listening to complaints about various things and people, sitting around the sites observing interaction among staff and patients. I was able to gain glimpses and insights that were not often repeated in the course of routine interaction (e.g. collegial criticism). The collections of “off the cuff” remarks and observation involved a degree of “betrayal.” As Loland notes (1971 p.108) “it happens that participants everywhere do and say things they would prefer to forget or prefer not to have known. In the process of writing up his notes, the observer necessarily violates these participants’ preferences.” Schatzman and Strauss (1973 p.95) make the same point in their discussion of fieldwork technique that: “a single word, even one merely descriptive of the dress of a person, or a particular word uttered by

someone usually is enough to ‘trip off’ a string of images that afford substantial reconstruction of the observed scene.”

I used unstructured observation throughout the fieldwork to gather data and test interpretations of behaviours. It was unstructured in the sense that I did not initiate the topic for discussion nor did I try to structure it by placing research subjects under cross-examination. But rather acted like a travel companion on the “narrative, engaging with it emotionally, displaying interest, empathy and pleasure in the storytelling process (Gabriel 1999 p.271).” For example, individual and organisational critical incidents lead to discussions about emotions generated by the crisis and its aftermath. The stories revealed how wider organisational issues were viewed, commented and worked upon by organisation members and enabled me to gain insights to organisational politics, culture, change and other organisational phenomena in uniquely illuminating ways. Generally I did not record the conversation at the time but recorded afterwards. In the spirit of the clinical model, I used my own experience as data about the sites’ culture (Berg & Smith 1985). This approach recognises that a researcher is acted on by the system he/she enters. Understanding this influence through self-scrutiny gives access to the system’s meanings as well as that of the researcher’s. Devereux (1967) views the effect of the researcher’s presence in the system as an opportunity to gather formal valid information rather than a source of distortion in the data.

In this project, self-scrutiny was aided by the use of a journal, a tool increasingly adopted by other researchers; Lincoln and Guba (1985) make a strong case for a “reflexive journal” to record a diversity of information about self and method. Reinharz (1984) found that her journal-like field notes were powerful tool for understanding a situation through what she calls “experiential analysis.”

According to Sanjek (1990 p.108) “journals provide a key to the information in field notes and records: diaries record the ethnographer’s personal reactions, frustrations, and assessments of life and work in the field.” Journal writing is a channel for turbulent emotions, doubts, private prejudices and other mediations. It can be a powerful means to explore practice, to document fieldwork as it unfolds and in the words of Ferucci (1982 p. 41) “stimulates the interchange [between the conscious and unconscious] and allows us to observe, direct and understand it.” Writing also taps tacit knowledge, it brings into awareness that which we sensed but could not explain. What researchers implicitly grasp is much more than they can say, or know. This element of the study offered me the opportunity to delve into my personal interaction with participants and the research, and flesh out opinions and reactions that might affect the findings. Keeping the journal enabled me to develop an archive for gaining understanding and insights and to explore the multiple realities that only time and different perspectives made possible. In addition it enables us to come to know ourselves through the multiple voices our experiences take.

Semi-structured Interviews. The participant observation was supplemented by interviews. A basic principle of qualitative research is to try and move beyond the taken-for-granted and uncover the varied and often contradictory meanings that people use to interpret the area of life under study. This is both an individual and a social process as such interpretations are continuously tested out and reformulated in everyday interactions. Interviews are well suited to helping the researcher understand a research subject's own perspective. I was guided by Lindolf's (1995 p. 166) suggestion of qualitative interviewing:

- learning about things that cannot be observed directly by other means
- understanding a social actor's perspective
- inferring the communicative properties and processes of interpersonal relationships
- verifying, validating, or commenting on data obtained from other sources
- testing hypotheses the researcher has developed
- eliciting the distinctive language – vocabularies, idioms, jargon, forms of speech - used by social actors in their natural settings
- achieving efficiency in collecting data

I interviewed 100 respondents representing a diverse array of professions and organisational positions. The interviews lasted anywhere from 45 minutes to 60 minutes and were semi-structured. Table 4 provides details regarding the positions of the interviewees. While there was no set of questions administered to all interviewees and no specific sequencing of issues raised, the interviews focused on understanding organisation members' meaningful experiences with risk management activities. I tried to understand some of the diverse personal

meanings posed by the experience of risk management activity in the organisation.

Table 4: Positions of Interviewees

Position	Number
Senior Nurses (Grade H)	3
Unit Managers (Grade G)	4
Staff Nurses (Grades D & E)	60
Support Workers/Care Assistants (Grade A-C)	16
Consultant Psychiatrists	4
Clinical Psychologists	3
Senior House Officers	3
Registrars	2
Social Workers	3
Occupational Therapists	2

The idea of “grand tour” and “mini tour” questions (Spradley & McCurdy 1972), informed the formulation of interview questions. Broad and exploratory grand tour questions gave the interviews focus and were developed keeping my research interests in mind. For the most part, grand tour questions got interviewees talking about aspects of risk management and related issues. I sought to understand their perceptions about risk management, how well they thought it was used, and how useful they found it. Within these questions, I sought to go beyond the informants’ claims and ascertain the basis for those claims through the use of more specific and detailed mini tour questions. For example, in discussions of risk management activities, I asked for specific examples of what the risk management process looked like and I looked for examples of the products of those efforts. Such questions

allowed me to probe more deeply into the reality of risk management programme. Thus, grand tour questions set the context within which specific mini tour questions were developed. Questions were open-ended, followed by probes and framed to encourage respondents to formulate their concerns in their own words. Three principal questions were put to interviewees: What does risk management decisions means to you? What is an effective risk decision to you? If you were to describe the values that people share about risk decisions, what would they be? These questions were elaborated and substantiated with follow up questions. For example: What do you mean by that? Can you please explain that further? Can you please give an example? This enabled interviewees to elaborate and demonstrate what their statements meant during risk decision making process. The questions were designed to help explained organisational processing and actions on risk decisions, the perceived effectiveness of risk decisions, the organisational context for risk decision, shared values of the organisations and the connection between symbolism and organisation level action.

I took extensive notes and wrote comprehensive summaries of interview within 24 hours. After each interview, I also wrote extensive field notes. In selecting subjects to interview, I wanted to obtain a slice through the organisational structure. I sought informants from as close as possible to the top level of each site all the way down to the operating level, to obtain a broad range of rhetoric and experience with risk management. In my efforts to decipher “deep” structure (Geertz 1973; 1983; Horowitz 1991; Kets de Vries 1991), I had to be alert to underlying themes, hidden agendas, meanings behind metaphors used reasons for selection of words and activities of the individuals in questions.

This role required a certain level of *emotional intelligence*, that is, awareness about one's own feelings and appreciation of emotions in other people.

Documents. Documents played an important part to understanding the relationship between settings, individuals and the construction of meaning. During the study, documents were seen to be important resources in participants' speech performances (Hawes 1976), and helped me to reconstruct past events and ongoing processes that were not available for direct observation. Documents reflected certain kinds of organisational rationality such as decision rules. Policy manuals and procedures, audits, information booklets, memos, newsletters, and training materials provided further indications of specific elements of risk management activities in the settings. My participation in training sessions provided experiential evidence of the grounding organisational members received in risk management process and gave me a better sense of how organisational members used and valued training. I observed the ways documents affect the settings and the roles they played in communicating ideas and developing decision-making. Using the documents as a point of discussion in interviews helped me to understand how individuals interpret the meaning of such materials in the settings. The study also relied on public inquiry of disasters and accidents and media representations of risk management. I studied these accounts because they have significant impacts on organisations and societies (Shrivasta 1987; Weick 1988). Inquiry reports are seen as rhetorical constructs designed to bring out acknowledgment from their target audiences (Brown 2000; Van Manen 1988) that represent organisational response to crises through which organisational learning and sense making occur (Turner 1978; Weick 1995). The way in which disease and illness are constructed or

represented in texts is symptomatic of wider knowledge, belief, and value systems. Discourses on health, illness and accounts of crises construct realities in ways that are often taken for granted (Lupton 1994). From this angle, understanding of health, illness, risk and its management cannot be viewed independently from the social context in which there are situated. An exploration of the way in which health and health care issues are represented in inquiry reports and the media gives important insights into how they influence and shape attitudes towards for example, people with mental illness and care practices. Detail focus with such texts assisted me in theorising multiple levels of understandings.

Data Analysis

The study generated an enormous amount of text that have to be reduced to what is of most importance and interest (Miles & Huberman 1984; Wolcott 1999). The method of data analysis that I used was borrowed from Glasser and Strauss's (1967) grounded theory, although I did not follow their techniques to the letter. I shared with their commitment of refining and testing ideas and theory throughout the process of data collection, so that the collection of data could be guided by emerging theoretical ideas (Miles & Huberman 1984; Hammersley & Atkinson 1983). The data was analysed to uncover the meanings of nurses' and to extract values embedded in nursing practice as experienced by nurses. The research questions guided data analysis. I wanted to see how nurses think about their activities by adopting rationalities of risk and how risk rationalities became basis for patient care. I also sought to examine the conditions under which risk discourse exists, the ways it is constructed institutionally and which it is deployed. How are local practices shaped by interaction between situated knowledge and formalised

knowledge and how is knowing constructed and sustained in practice? Consequently the data were exposed to several different stages of hermeneutic analysis in order to arrive at comprehensive understanding of meanings of practice and underlying values. This meant that the data were treated as whole and analysed in three steps in order to establish the general meanings from namely self-understanding, commonsense understanding and theoretical understanding (Kvale 1983). These analyses resulted in conceptual categories (Glasser & Strauss 1976).

I started the analysis by first reading through the transcript of field-notes, interviews and documents organised in original chronological order. These readings reacquainted me with events of the study and alerted me to changes in perspective, social actors and level of detail over the duration of the fieldwork; and helped me to absorb the fieldwork in its totality as well as renewing my contact with individual situations. The starting point was acquiring a general grasp by reading the transcripts several times. The following readings were more purposeful. I began to look for indicators of concepts which I identified as relevant to the study by jotting down notes about compelling incidents, sequences of action, repetitive acts and critical details that informed my understanding of the field. These readings were repeated for content and meaning until patterns emerged (Agar 1986; Spradley 1980).

Second, I developed codes from the readings, which “serve as a shorthand device to label, separate, compile, and organise data” Charmaz (1983 p.111).” I recorded the main beliefs, themes, cultural practices, or relationships by looking at topics that are dramatised by the participants, or that are glossed over, puzzling or conflicted situations, elements that are recurring, conditions that evoke actions, rituals that that seem to exemplify processes of culture among others. I used the

constant comparative method (Glasser & Strauss 1967) by continually comparing new incidents with ones that have already been grouped in the same category in order to determine its goodness of fit. I built and clarified categories by going back through the evidence more than once and on occasions reassigning problematic incidents to different categories or split them off to form new categories. The process of this integration changes the nature of categories from mere collections of more or less vaguely coded incidents into constructs, which moves the researcher closer to the construction at hand (Lincoln & Guba 1985). Third, I analysed all the transcripts again with a focus on how participants delimited and organised what they conceived as risk management. After I had analysed each transcript, I compared participants with each other, first within and then between sites. Again this process led to some regrouping. Finally, I analysed all the transcripts once again, simultaneously focusing on what participants conceived as risk management strategy. I then cross-checked until I believed I had found the most dependable interpretation of participants' way of conceiving of risk management strategy. This cross-checking also led to clearer and more precise formulations of the conceptions. I then conducted a first categorisation of the data by categorising key words to search for patterns and important underlying concepts. At the same time it also reduced even further into a manageable set by clustering key words with similar meaning into categories.

I then tried to shape the different categories into inter-connected, cohesive unit; in other words looking for the possibility of recognising and identifying the underlying themes into a number of risk contexts as perceived by respondents. In a sense I was engaged in "pattern matching" (Kets De Vries & Miller 1987 p.245) "searching for structural parallels, looking for a "fit" in a quest for revealing

repetition (Geertz 1973). There were paradoxes such as risk management both undermining and enhancing quality of care, keeping patients safe from being proactive but also generating potential aggression due inability to take part in the decision making process among others. One likely explanation of these paradoxes is that there is more than one dominant implicit model of risk management. Here, risk management was not tied to a formal position or defined as a fixed quality but seen more openly in relationship to that which goes on in the work organisation context and the relations being formed and reformed in process of sense making, attribution and negotiation. This is in line with the constructionist approach, which sees all knowledge about risk as bound to the socio-cultural contexts in which this knowledge is engendered. Lupton (1999 p. 29) observes, that, “scientific knowledge, or any other knowledge, is never value-free but rather is always the product of a way of seeing. A risk, therefore, is not static, objective phenomenon, but is constantly constructed and negotiated as part of a network of social interaction and the formation of meaning.”

Taking an open attitude to the concept of risk management including consideration of alternative lines of interpretation before, during and after the research process benefited the intellectual inquiry (Rorty 1989).

Methodological Issues

My method of “insider-outsider” research is certainly open to criticism from traditional methodologists as it eschews the “bracketing” of personal experience (Schutz 1967) and also based on what ethnographers have been warned against of “going native” (Bryman 1988). As a psychiatric nurse researching psychiatric nurses, I was already a “native” given that I am emotionally involved with the subject of my study which undoubtedly shaped the questions I asked and the nature

of my sociological interest in the topic. How then, do we evaluate my interpretation in terms of subjectivity, replicability, generalisability, validity and reliability? Our earlier assertion that the researcher and fieldwork are inextricably related, means that apparent givens such as understandings of reliability and validity is opened to scrutiny. Operating reflexively means that any representation of reality in a research undertaking will only ever represent partial aspects of the reality being studied. Further as noted above, how these aspects are represented will be shaped and influenced by the assumptions and frames that researchers bring with them and impose on the research process (Hertz 1996). Besides the interpretative paradigm recognises the constantly changing cultures, perceptions and forms of action; because what can be observed in a site is profoundly contingent on time and on the individual human-as-research-instrument. A world consisting of multiple and constructed realities does not permit the researcher to identify any single representation as the criterion for accurate measurement. In my attempts to seek credible and dependable data (Lincoln & Guba 1985), several techniques have been useful.

Personal discipline has assisted me in avoiding excessive subjectivity. In recognising myself as a research instrument I adopted a “disciplined subjectivity” (Erickson 1973) that required self-conscious and rigorous examination for bias in decision of the research process (in each question asked, each relationship and every interaction). Following the psychotherapeutic approach it required a constant dialogue with self and the keeping of a diary. I also embraced and made explicit the subjective aspects of interaction with participants, building it into the research design. This produced a search for deeper understandings and more authentic depictions. In this way I constantly monitored self and participants perspectives on

conceptual as well concrete phenomena. Following Wax (1971), I undertook the insider-outsider role in setting aside periods for detachment, by stepping outside my involvement with subjects while still in the field and taking a vacation from the field to regain perspective. These facilitated both maintenance of perspective so that I did not go completely “native” and the capacity for seeing things as if they once again were new and different. I also sought comments from participants, mentors and colleagues in clarifying concepts, developing and refining questions gaining insight into phenomena with which I have grown too familiar. Such inter-subjective understandings means that the information gained and conclusion reached must be considered tentative until it has been confirmed by information collected by other means or from other sources thus my use of triangulation methodology (Miles & Huberman 1984; Mason 1996). Because my selfhood is caught up so strongly in the research process, replication in the same form by another researcher would be impossible. However, as I have argued earlier, the social location and experiences of a researcher inevitably shape research, so that the difference between “insider” researcher and other forms of qualitative research is a matter of degree. Yet I doubt that I would be able obtain the same depth of richness of data were I not perceived as a peer.

In my quest for validity, I drew on Kvale’s (1989) “communicative and pragmatic validity.” I established communicative validity by an ongoing dialogue in which alternative knowledge claims were debated throughout the research process whilst pragmatic validity involved testing the knowledge produced in action. Communicative validity was achieved by establishing a group of interpretation to ensure an initial understanding of participants about their work and my research; and by dialectically using follow-up questions during the interviews to help me

further ensure that I understood the nurses' ways of conceiving of risk management technology. When obtaining data, I achieved pragmatic validity by observing nurses at work and comparing what I had observed with what they said in the interviews and asking follow-up questions that required the participants to demonstrate what statement meant in practice and observing their reactions to particular interpretations of their statements. Pragmatic validity increased the likelihood of capturing knowledge in action rather than "espoused theories" (Argyris & Schon 1978). Sandberg's (1995) concept of "reliability as interpretative awareness" that is, the acknowledgement that researchers cannot escape from their interpretations but must explicitly deal with them throughout the research process was adopted. In obtaining data, I achieved reliability as interpretative awareness in ways in which nurses were conceiving their practice throughout the observation and interview phase. I primarily asked what and how questions in order to encourage respondents to focus on describing what risk management meant for them; initially striving to treat all respondents' statements about their practice as equally important and asking extensive follow-up questions that required the respondents to expand on and be more specific about what they meant by their statements. In achieving the above criteria, I do not claim that the research product is in any way definite.

Studying one's own culture is not a new phenomenon indeed sociologists have variously described it as "autoethnography" (Hayano 1979), "auto-anthropology" (Strathern 1987), Deck (1990) uses the term "self-reflexive field account" and Lejeune (1989) utilises the concepts "auto-ethnology and "ethnobiographer," and as a text which combines ethnography and autobiography – the incorporation of elements of one's own life experience Denzin (1989). I share the observation that the best qualitative researchers are those who are familiar with the phenomenon and

setting they are studying because there is a certain level of “in-built, factual trust” between the researcher and researched (Riemer 1977). In a stimulating piece, Riemer (1977 p. 467) claims that “opportunistic research strategies,” using one’s own “at hand” knowledge, unique biographies and situated familiarities as sources of research ideas and data, can be sociologically profitable. Here the researcher knows the language and symbolic meanings of this being studied, which enables him/her to avoid meaningless and irrelevant questions and the ability to probe sensitive areas with care. In addition, being an insider “acts as a built-in truth check” (Riemer 1977 p. 474) a form of triangulation. In comparison “strangers” are more easily misled and distracted and find it hard to get beyond the superficial (Miles & Huberman 1984). I believe that in conducting this research project, it was strongly advantageous for me to have been involved with settings that I was familiar with. Familiarity with respondents – the subculture, the jargon, the unwritten codes of behaviour - enabled me to dig deeply into the research without having to do all the initial work such as becoming acquainted with norms within the settings. In effect the research began with my previous career as a psychiatric nurse. This means that I had a large amount of background knowledge on which to draw and many initial ideas and hunches about what would be sociologically interesting to focus on. For example, apart from ease of access, my familiarity with everyday life and routines on the sites (e.g. scheduling interviews to allow for changes) enabled me to avoid disruption of normal group processes; furthermore knowledge of some relevant research questions enhanced capacity to elicit in-depth data.

But an “insider” research is not without problems indeed researchers have been warned against “going native” as noted above (Bryman 1988; Miles & Huberman 1984). The most obvious of these is the risk that researchers studying

their own culture might fail to see culture patterns into which they are thoroughly acculturated (Stephenson & Greer 1981). Leach (1982 p. 124) argues that, “when anthropologists study facets of their own society their vision seems to become distorted by prejudices which derive from private rather than public experience.” This is indeed a difficult venture. Researchers like other members of society, are trapped by cultural ethnocentrism and parochialism which means that the cultural phenomena they encounter are not recognised as such but are seen as natural as part of the world order. An important element for the researcher is to avoid seeing the world as self-evident and familiar, and rather to conceptualise it as a strange place. Research then becomes a matter of “de-familiarisation” (Alvesson & Deetz 2000). In a word, observing and interpreting social phenomena in novel ways compared to culturally dominant categories and distinctions. This problem is seen as a lack of distance or a great similarity, which makes it difficult to look upon phenomena and practices that are well known and natural to the “natives” with fresh eyes. This requires that the researcher ask him/herself constantly what respondents think they are up to when witnessing the customs, symbolism and practices in organisations. Following Marcus and Fischer (1986 p.137), I used the strategy of de-familiarisation by “disruption of commonsense, doing the unexpected, placing familiar subjects in unfamiliar, even shocking, context” to make me “conscious of difference.”

Had I started the research while working as a psychiatric nurse, with little time for reflection, the problem of desensitisation through familiarity might have been more serious. However, I came back refreshed after four years and made a conscious effort to make the familiar strange. There may also be a problem of selective reporting, and a bias in selection of informants. If we accept the assertion

that the positions of “insider” and “outsider” are relative and exist on a continuum (Bolak 1997) that is that we cannot have completely “insider” or “outsider,” then we can conclude that the problems identified are not different from problems encountered by ethnographers in non-familiar contexts. While doing the research, my status was simultaneously that of an “insider” and an “outsider.” I was a relative “insider” by virtue of my status as a psychiatric nurse; I worked in the sector for about twenty years until I left to pursue a career in academia. At the same time I was a relative “outsider” because of my status as academic.

The approach, taken here point to the problematic nature of arriving at accounts from empirical material. Data in the context of social science are never so robust or objective as they may appear, but constructions made by the researcher in interaction with research subjects (Denzin & Lincoln 1994). For example, language use is always an action that needs to be understood in its context, rather than a carrier of abstract truths to be evaluated against objective reality. The accounts of interviewees, from this angle, may be more appropriately be understood in terms of a desire to create certain impressions of rationality. The implication is that the researcher must be aware of how important and powerful language is by systematically considering all empirical material and evaluating them in terms of situated meanings before deciding how it can be used. Social science involves studying value-laden phenomena of which the researcher is part. The idea of using risk management strategies is for example hardly neutral even though it could be argued that effective application of risk management is in the interests of all patients and staff. But given different value criteria, what is defined as effective may vary dramatically; and therefore there is no universal definition of effectiveness capable of meeting all possible value criteria. So that the ways we conceptualise and write

about risk management does not simply mirror external reality existing independent of our conceptions. This means that we must be aware of the political dimension of research by paying attention to diverse interests. The acknowledgement of various representations, interpretations, sensitivity to complexity of language use and political awareness, inspires a non-authoritative form of research (Alvesson & Deetz 2000).

This chapter describes the process of gathering data, discusses entry and access and provides details on gathering data. My approach has been clear about the complex and uncertain nature of research. Research is not an objective picture of social reality; but a set of impressions and interpretations characterised by feelings, imagination, and a particular pre-structured understanding. What is offered is one story – which is empirically sensitive, and well-grounded and full of insights and theoretical contributions but still open to other readings. Like all empirical account, it has inevitably been structured in a certain way. The next chapter uses these insights to explore how nurses respond to risk in the contexts of their work.

CHAPTER FIVE

THE ORGANISATIONAL SETTING

The meaning of everyday life is contained in its particulars and to convey this to a reader the narrator must ground the more abstract analytic concepts of the study in concrete particulars – specific actions taken by specific people together. A richly descriptive narrative vignette, properly constructed, does this. (Erickson 1986 p.150)

Healthcare organisations are organised centrally around the issue of safety, which arises from the rationale “to do no harm” to the patient. However, given the several types and sources of hazards associated with medical technologies, in conjunction with the ethical and legal directives mistakes do occur in all branches of medicine. In psychiatry, in contrast to other branches of medicine, it is not only patients who come to harm from professionals’ risk decisions, the general public and staff may also suffer (Snowden 1994). Psychiatry is virtually always in the forefront of the media in part because of the radical changes in the last few years. The contemporary pattern of psychiatric services, of provision of care outside institutions and shorter admissions suggests that patients are spending longer periods of time “at risk” to themselves and others. Providing the multiple functions outside the institutional framework challenges the quest for public protection, control and containment. Thus the numerous critical inquiries into scandals in mental hospitals, revealing cruel, dehumanising aspects of custodial care, has given way to inquiries into scandals of community psychiatry, exposing failures to provide custody, public protection and continuity of care (Rose 1986; Walshe & Sheldon 1998). Within the institutional framework, when mistakes were made, the institution was the subject of a formal inquiry. Nowadays when errors in treatment

happen there is central focus on the management of individual cases and decision making by individual clinicians.

The data for the study was collected in the psychiatric hospital in the north of England. Its main psychiatric services were essentially intensive care, elderly, rehabilitation and admissions units. At the time of the study, the hospital was in a state of transition with increasing emphasis being placed on development of smaller units in the community. For four years I was a participant observer on three of the psychiatric units. Additional data was elicited from a nursing home also in the north of England. I sought to embed organisation theory by linking situated organisational events (accidents, incidents, hazards) to social processes in the wider society. The current understanding of complex organisations, as argued earlier, assumes that the performance aspects of a system are based on complex interaction of individuals, technology, society and organisation. This form of representation illustrates some of my basic assumptions that if an event goes wrong we should search for contributing factors in the other subsystems; which means that various subsystems contribute to safety, so that errors by each of the contributors may influence events. Hence active error should be seen as an opportunity to search for the latent errors instead of blaming individuals as the cause of an incident (Reason 1990). The focus of the study was to find out the perceptions of psychiatric nurses on risk management, how they cope with public demand for answers and significant organisational/regulatory changes following major accidents when the outcome of such changes may be uncertain, what models and techniques for event analysis are currently being used/deployed for managing risk and the precise goals for event analysis in learning to evaluate and improve risk management. More specifically the study examines the

organisational and institutional environments in which nurses work and how their dynamics the shape nurses' behaviour.

I examined documented factors, such as procedures, rules, safety policy statements and written frameworks for assessing and managing risk. These described the intended organisational behaviour, and these were compared with observable behaviour. In addition, I considered informal factors which determine the "real" behaviour at the settings, namely whether the various settings behaviour aligned with their declaration, how detected serious safety deficits were rectified and whether deviations from the safety rules were taken seriously. Such factors offered me insights into how the settings learn lessons after disasters, taking into account risk management strategies, allocation of responsibilities, workings of communication channels and allocation of resources. I analysed the cultural premises of individuals at the settings, using my understanding of these cultures as I have come to learn about them in interviews with my informants, the process of participant observation, and by the collection and analyses of relevant documents. Given the range and complexity of the issues, this study does not intend to present only one interpretation, for I believe that there are several equally valid readings to be made, each from different perspective, each informed by different interests. The important thing to appreciate is that the participants themselves are not only engaged in the creation of texts, but also in their interpretation and, in this case, their multiple interpretations. The data of and explanation of researchers must similarly be considered as interpretations, although they are generally meta-interpretations, in the words of Geertz (1973 p.9) "constructions of other people's constructions." It is my belief that the significant features of a setting are

represented and expressed in the participants' interactions with one another and so what gets said is what is important.

The following sections present illustrative examples drawn from many observations of clinical decisions, considering the actions of nurses, looking back at the conditions in which staff was working and the context in which events occurred.

The cases

Unit A

Unit A, a 19 bedded low secure unit is located on the ground floor of an elegant purpose-built building surrounded by perimeter fence. When one arrives at the Unit, one encounters evidence of concern for security and safety at every turn. There are the Unit's perimeter doors locked by special key, all other keys remain on the Unit with a recorded handover of keys at the beginning and end of each shift. During each shift one nurse acts as a security nurse who is responsible for handing over keys, checking all exterior and interior security, testing alarms, monitoring all people entering or leaving the Unit, checking cutlery, razors, occupational equipment and generally supervising and maintaining security. There is information to visitors, which declares: "our aim is to provide a safe and supportive environment. To do this we require your help to reduce the possibility of harmful items coming into the Unit." Non-prescribed drugs, alcohol, matches, lighters, razors, blades, sharp edged items, knives and scissors are not allowed and visitors are requested to leave bags, lighting materials, and cans among others in lockers provided in the reception areas. To get to the Unit, one must pass through a reception and a spacious recreational area adorned with paintings and needle-works of patients located also are table tennis and pool tables. The Unit itself is small and decorated in muted green and white. An enclosed garden is adjacent to the Unit for

supervised outdoor activities. Its location is approximately 5 miles from the city centre.

Although I had previously worked in psychiatric settings, I was unprepared for the impact that the Unit had on me. The Unit was dominated by concerns for security. Patients must be prevented from absconding or breaking rules; staff and visitors must be protected from harm. Entry to the Unit required a handing in of an Identity Card in exchange for keys and panic alarms. While my study was primarily concerned with nursing work I wanted to build trust with patients. In this spirit, I requested not to have a panic alarm (a symbol of distrust as I saw it) but was turned down. The importance of the procedure for entry into the Unit was illustrated when one of the Consultants, of the Unit was refused entry because he forgot his Identity Card. My having a panic alarm however did not cloud my relationships with patients. I came to know many of them very well and some were interested to know about my project. While it was my intent not to discuss clinical issues in my interactions with patients, it did surface from time to time in their thirst for a medium to tell their side of the story, to complain about “unfair treatment” or to criticise staff. I was concerned that staff would want to know the content of my conversations with patients not only to feed ideas into their treatment but also to look for evidence of risk matters. My movement was always under the watchful eye of staff. The response I received from the staff was mixed. Some were very cooperative and actually admitted the need for research pertaining to risk management, a few however viewed me as a naïve outsider with romantic views of nursing and were compelled to give me the “reality” about the Unit and the patients, occasionally trying to warn me against particular patients: “He is a nasty piece of work that one.” “Don’t turn your back on him.” The context was reminiscent of

Goffman's (1961) picture of total institution. All aspects of patients' lives are conducted in the same place; the same risk management strategies are applied to patients, days are structured with explicit rules and activities designed from institutional perspective. The intense activities of staff, the use of jargons, and the unpredictability of patients' behaviour combined to produce a form of cultural shock. Additionally, my own fears and insecurities about functioning in such an environment, the direction and success of the research project, and about my personal competence to cope played a role to my instability and disorientation as an observer.

The unit is divided into two wings, acute admission where patients are admitted for assessment of their mental health problems and level of risk to self and others and a rehabilitation wing, where patients are generally transferred from the acute wing but referrals are also considered from other sources such as acute admission wards, prisons and the police. The philosophy of the Unit is "to provide a safe and supportive environment by encouraging patients to be self-caring, independent and to retain responsibility for their actions with the opportunity to develop a plan of care in partnership with their named nursing team and with representatives of other disciplines." Ethical statements that represent some of the values of the Unit are: "it is important that patients have opportunities to be involved in decision-making, that patients ought to have a chance to communicate their feelings freely, that nurses have a duty to ensure safe and secure environment." The goal of the care team is "to ensure that patients receive a thorough assessment, individualised care plans, care and support for current crisis needs and assessment of risk to self and others." The Unit provides assessment, care, and treatment for people with severe mental disorders that have resulted in manifestation of disturbed

behaviour or commitment of dangerous offences. During the research almost all the patients were categorised as displaying psychopathic behaviour. The Unit has a multidisciplinary team of Consultant psychiatrists, Senior House officer, Consultant Clinical Psychologist, Ward Manager (Grade G), Deputy Managers (Grade F), Registered Nurses (Grades E & D), Healthcare Support Workers (Grades A & B), Occupational Therapy Assistant, Forensic Social Workers, Community Psychiatric Nurse, Court Diversion Officer and an Advocate. The multidisciplinary approach as I found out was one of the main attractions to staff recruitment as it creates involvement in the Unit's policies – from referral to discharge and community aftercare and thus facilitating all staff to express their opinions and have a say in patient's treatment.

The broad ethical statements reflected a belief in the value of the therapeutic community and commitment to ensuring patients' safety and security. However, the predominance of custodial obligations contradicted the unit's therapeutic community. The management of challenging behaviours such as verbal and physical aggression, absconding, offensive weapon making, manipulative behaviour and deliberate self-harm meant that the nursing role has to be incorporated within legal and physical boundaries of custodial care. Safety, the prime concern of nurses was maintained by the use of control measures such as the use of restraint, medication and seclusion. This illustrated the conflict that arises from the blend of caring and controlling functions that nurses performed. In this lies the essential paradox of the Unit's treatment processes and nursing role, namely the incompatibilities of therapeutic custody the therapy verses custody debate: a debate about whether it is possible to provide patient-centred care while confining patients often for many years for the protection of the general public. Nurses on the unit faced moral

dilemmas relating to issues of freedom, control, free will and responsibilities of patients. On the unit as in other therapeutic communities, some nurses subscribed to absolutist beliefs that patient can develop some responsibilities for their actions and have a right to express their views and feelings. However many decisions were influenced by utilitarian sentiments (the right intervention is that which results in the best interests of patients and other people likely to be affected) so that it is the consequence of particular interventions that matters. Here the possibility of patients harming themselves or others superseded other considerations.

The predominant patient group of the Unit is the mentally disordered who exhibit very disturbed behaviour or who have committed dangerous offences. The patients are almost exclusively detained under the statutory powers of the Mental Health Act 1983, which involves patients linked to criminal proceedings or already taking prison sentences. As in general psychiatry, the patients fall into established diagnostic classes, but within these broad classifications there is a medley of separate categories; homicidal psychopaths, arsonists, violent schizophrenics, self-harming and psychopathic sex offenders. The patients are accepted from a variety of sources, which include: acute admission units, magistrate court, prisons, medium secure hospital, high secure hospitals, police and probation. Patients are accepted due to their need for the increased level of safety and security. The two wings (acute and rehabilitation) have different functions and house different patient groups. In the acute wing patients are admitted for assessment of their mental health problems and level of risk to self and others. Patients are generally transferred from the acute wing to the rehabilitation wing but referrals from some of the sources listed above are also considered. The overall aim is to rehabilitate patients back into the community, into independent living or supported accommodation as appropriate.

The Unit is made of highly specialised professionals whose interests and competencies affect the way the work is done, both as regards routines and the way the patients are assessed and treated. Daily staff cover for the Unit is adjusted according to circumstances for example staff cover, at night is increased if patients require extra nursing care. The Unit has flexible rota system with staff working mornings, afternoons and nights. The Unit was suppose to be solely responsible for 24-hour cover seven days a week, without drawing on other staff under any circumstances in times of difficulty. During the study, the Unit was in effect covered on staff goodwill and were often asked to work at short notice, day or night and there were days where Agency Nurses with no knowledge of the Unit managed the Unit. The greatest problem the Unit face was securing and maintaining an adequate staff. There was a high staff turnover, a constant crisis orientation, a suspicion of senior management with daily narratives of worry, and feeling of stress and perception of tiresome work. Some of the frequent comments about the Unit heard from participants were: "It is a crazy place." "It is a hell-hole." "I hate this place." My reading of the situation was that the intensification of interactions in terms of frequency and closeness involves higher demands for social and emotional competence.

The day commences at 0700 hours when all nurses meet in the nursing office. The office is located in the middle of the Unit where in addition to meetings also hold patient records and other documents concerning current patients. Appointments to be remembered are written on a white board in the office. Before handover takes place a head count is done, monies checked and all external doors checked. The night nurse reports to the day nurses, telling them what has happened during the night, how patients feel among other things. The talk is structured around each

patient: what they did during the night, how they feel, whether there anything special to watch out for. While there were general comments about how patients feel, what struck me about the report structure was the intense efforts to format nurse communications. Lunchtime handover adopts a distinct and systematic view in a form of a written checklist. The checklist identifies whether patients name and section status were stated in full, whether nursing notes were taken to the handover and information read directly from them, number present and who gave the handover, whether information was presented clearly and accurately, whether risk issues were clearly identified and whether the content relate to individual care plans.

The following conversation with the Manager of the Unit is illustrative:

Handover audit was formulated as part of the initiative of The National Service framework on communication. The audit team looked at how we might improve communication and we felt that handovers were important part of communication for the following reasons: First, we felt that handovers were not given enough respect in terms of people going in and out of the office and phone ringing. Second, only some risk issues were discussed in handovers. Third, staffs who were writing nursing notes might not be in handover, so information could be missed. Fourth, handovers were not starting on time and not all information was relevant. All staff was made aware of the handover audit and the standard set. Patients' leave are now publicised to minimise the risk of patient being granted leave without completion of Section 17 leave form by the Responsible Medical Officer. Nursing notes are now read out so that a more accurate report of patient's present state. Diary is taken into handover to ensure our tasks are completed throughout the day. All information is now clinically relevant and all nursing entries are reflected in care plans. Handover now takes place in quiet room, therefore less interruptions and improved confidentiality. A shift manager ensures handover starts on time and number of staff left to cover the Unit reflects clinical activity.

Some nurses supported what appeared to be a highly prescriptive handover format - an important part of risk management – because; “it develops a better accountability mechanisms” “it promotes better communication.” Others nurses

however expressed irritation; “it is too prescriptive” “it does not add a jot to assessment and management of risk” “it is a ploy to give the impression that they (managers) are doing something” “they are covering their backs and passing on the buck” “it is just a paper exercise”. There were instances of “business as usual when the cats are away” which “resulted in behaviours that increase risk” to patients through lack of communications. This was brought home to me through a number of “inadequate handovers” procedures when there were failures to inform the team of patients problems, a patient who was on five minutes observation for self harm was passed on as just observation which nearly resulted in the patient suffocating himself with a plastic bag. There were also examples of failures to plan for contingencies in treatment plan and to monitor situations and team activities.

Like other professionals, nurses had informal ways of assessing and managing risk. Despite the official procedure that nurses were expected to follow, practical execution of intervention encouraged other methods. Nurses use techniques that refuted the primacy of formal rules, suggesting that nurses have the independence to make choices around of acceptable practice. Thus guidelines were ignored or interpreted in different ways and decisions were made based on experience. Such techniques that nurses relied on could be interpreted as preserving their “professional” identities. Here we witnessed the central place of interpretation of risk management strategies in the conflicting meanings that were held by different nurses. For the nurses, risk management was not an objective entity but was a process of negotiation. This shows that official guidelines and procedures in terms of risk management are shaped and reshaped as a result of ongoing activity by different nurses. These types of conflicts for most part are not tackled by rational decision making (the reduction of conflicts). The evidence suggests that decision

making are oriented towards helping actors confront conflicts with the recognition that they are inherent in the system and that uniform definition of risk management is unlikely.

Patients are encouraged to be up at 0800 hours and have breakfast at 0830hours. Cutlery is counted before entering dinning room and patients are not allowed to leave until cutlery is again counted and locked away. There was an emphasis in checking and reporting on events, illustrated in an incident thought amusing afterwards when a staff reported a missing teaspoon. Patients were kept in because of a missing teaspoon, which was found in jam bottle after two-hour search. Medication is administered at 0990 hours at the clinic room. Patients are then expected to tidy bedroom, and change laundry on Wednesday. Before dinner at 12 noon patients are assessed before attending Occupational Therapy or the gym. There is a finance department open where patients are escorted one at a time and by two staff if there is deemed to be a risk of a patient absconding. Meetings are regularly held on the Unit. Community meetings take place every Wednesday of which all staff but one attend. Patients who refused to attend are not given nursing input, except in emergencies. The meetings are used to discuss daily living activities. Patients expressed their concerns and worries, however no clinical issues are allowed and they describe the changes they think need to take place. Where clinical issues cropped up as they did on many occasions during the study they are directed to the appropriate channels. The discussion topics concern everyday life of the Unit such as people playing music too loud, matters such as taste of food and disputes between patients. The ownership of the Community meeting is reflected in the sense that patients take minutes. Alternate Wednesdays are allocated for staff support/teaching sessions. The complexity of the work on the Unit in terms of the

nature of the catalogue of offences, the risk of violence and the potential for disaster if things go wrong present a considerable challenge. For the nurses on the Unit, there are periods of high anxiety, ambiguity, uncertainty and vulnerability. Commenting on this observation, a senior nurse said:

Working with high-risk patients is stressful and good systems of support are necessary if we are to practice to the best of our ability. We need to be competent, well supervised and appropriately trained. Junior staff is not allowed to be key workers for high-risk patients and take charge of the Unit, but are advised and guided by experienced nurses who have working knowledge of individual patients and active involvement in key risk management decisions. Managers check that risk assessments are appropriate and risk management strategies achieved. This is important in terms of support and also accountability. Nurses are given the opportunity to explore their own feelings and regular individual clinical supervision is essential part of this. Supervision of individual nurses are further enhanced through staff appraisal and linked to training. There is access to additional support in debriefing which is available after distressing incidents or negative outcomes.

However, not all nurses agreed that supervision was taken seriously as reflected in the following comment by a junior nurse:

It is a nightmare working at this place. When I started at the Unit I thought there would be adequate supervision and spent lot of time interacting with patients and colleagues. These were the good few days. Then everything started to fall apart. It started with the high turnover of staff, which meant I had to work more hours taking charge and without supervision, which is very stressful. We sometimes get Agency Nurses but they must as well not be there because their lack of knowledge of the Unit means that you have to supervise their work. I worked very hard and so do my colleagues but senior management seem oblivious to the situation on the Unit.

My observations suggest that nurses often have considerable leverage in negotiating some clinic decisions and general policy matters. Official policy on supervision of junior staff were laxly monitored and enforced. This analysis shows that certain features of institutional life – seemingly bound by hierarchy and rules –

are much more fluid than conventional organisational analysis would have us believe. This shows the problematic nature of policies, guidelines, procedures governing organisations and the informal sources of power within them.

Assessing and Managing Risk

The multidisciplinary team identified above is responsible for the overall coordination of clinical activity within the Unit, considering all admissions wherever possible in advance, liaising closely with and advising the referring clinician, prioritising of referrals, monitoring and advising on care plans and overall discharge planning. The majority of the patients in addition to suffering from a major mental illness have also been through the Criminal Justice System thus many are subject to restriction orders (Section 37/41 of the Mental Health Act 1983) and have differing degrees of leave of absence depending on their current progress. In terms of treatment majority of the patients are on medication however other therapies/interventions such as Occupational Therapy, Gym, Anger Management, Relaxation, and Work on activities of daily living, Gardening project, Women's group were offered. These activities are built into weekly activity programme for patients in conjunction with a named nurse who develops individual care plans and spends time with their patients for at least an hour session each week. Care plans are constantly reviewed and updated. The multidisciplinary care team meet on a weekly basis where each patient is discussed at length and if appropriate seen by the team. A care-programming meeting is held every 8-10 weeks for individual patients where agencies from outside the Unit are invited if they are involved in the patients care. The patients are involved in all stages of their planning.

All patients are admitted to the Unit by a qualified nurse and seen either by the junior doctor or consultant psychiatrist and undergo a period of assessment which

can be wide-ranging and detailed according to individual needs. As a minimum patients are assessed as to their current mental health, social circumstances, physical health and risk factors either to themselves or others. The period immediately after admission to the Unit, especially when dealing with risk of suicide and self-harm, was usually a time of increased risk where patients are placed on continuous observation and daily risk assessment and shift risk assessment with safety strongly at the centre of management plan. The need for risk assessment and management is frequently reviewed and negotiated with the patient. Commenting on the importance of risk assessment and management a nurse said:

Every patient has a risk care plan, which is evaluated every ten days. Risk assessment, is completed on admission and repeat risk assessment completed every six weeks. All patients on Level One observations for any reason have Shiftly Risk Assessment. Some patients, for example a psychotic patient hearing voices telling him/her to hang him/herself, a patient who has been violent and a patient who is sexually inappropriate may have Shiftly Risk Assessment. Daily Risk Assessment is done when Shiftly Risk Assessment shows that risk has become significantly reduced. A nurse in charge can put a Daily Risk Assessment to Shiftly Risk Assessment, but changing from shiftly to daily is decided at multidisciplinary team meeting and Daily Risk Assessment can only be stopped altogether at multidisciplinary team meeting.

Nurses attempted to estimate the risk of future dangerousness in patients by identifying risk factors for each individual. Applying such a practice, however, was fraught with difficulties, not least because of the difficulties of assessing risk not forgetting civil liberties issues. For example, there were dilemmas of decisions about allowing patients who have expressed suicidal thoughts, threats of setting fire to buildings, violence and self-harm unescorted parole. It was not clear in most of the cases whether or not the patients would put those thoughts into action. Where nurses were concerned that a patient is “at risk” to self or others, then the liberty of

the patient has to be balanced with the rights of others safety. When the risk of harm was evaluated as being great, nurses took coercive intervention (e.g. restraint, seclusion and administration of medication), which could be harmful to patient. The restriction placed on “professional judgement” in the name of protecting patients and the public from risk seemed to represent the dissipation of patients’ potential; it constraints and limits patients actions.

The following vignette shows how a “rational decision making process” termed the Subject, Objective, Assessment, Plan (SOAP) was used by a nurse to assess the potential suicide and self-harm of a patient and revealed the difficulties of assessing risk:

(SUBJECTIVE) Tells me she feels “much better” today. Feels the medication is helping her. “I can think clearly” denies auditory hallucinations, “the voices have been quiet for a few days now.” Denies any thoughts of a self-harming nature. “I don’t want to hurt myself now, it’s just when the voices tell me to. I find them so hard to ignore but have not heard voices for days now”

(OBJECTIVE) Appears calm and relaxed. No hostility or agitation observed. Good eye contact, even when discussing issue of self-harm. Smiling apprehensively. No evidence of pre-occupation with thoughts. Engaging willingly and openly. Body language and facial expression is not suggestive of low mood.

(ASSESSMENT) Denies current thoughts of self-harm. It appears these only occur when hearing voices, but currently denies auditory hallucinations. Appears more insightful with prescribed medication, which has lessened the risk. Looking much calmer. Good eye contact indicates she is genuine in her expressions. I feel presently that level of risk re self-harm is low, but risk may increase if voices return.

(PLAN) Daily Risk Assessment to continue. Allocated member of staff to spend time with patient each shift, assessing thoughts/feelings. Should ask openly if patient experiencing auditory hallucinations and be aware of increased level of risk, if so, carry out care as per current risk care plan. Consider formal observations if deemed appropriate. Continue to monitor at medication times to ensure compliance.

The approach taken in the SOAP technique shows that risks were mainly relics of particular assumptions of the scientific models used. Different assumptions made led to different probabilistic risk assessment. There was no certainty that the perceived risk could be assessed and what the effects of its management would be. Thus risk assessments cannot but be probabilistic and that one would never be able to be absolutely certain about the impact of any care plan. This pictures risk assessment and risk management as a flow of intertwined processes rather than a sum of juxtaposed decisions. Nurses were merely participants immersed in processes they do not control and often even do not understand. The sequential order of decision making steps culminating in a choice gives way to a continuous flow of action punctuated with moments of interpretation and negotiation.

The designated role of the team, a deliberate problem-solving approach to assess, plan and maintain the safety of patients changes during emergencies situations, often demand nurses to act immediately. Here it is impossible to meet the usual requirement of careful problem definition, thorough assessment, establishment of a therapeutic contract, development of treatment goals and monitoring of patients performance. Case vignettes drawn from my observations are illustrative:

A 26 year-old man was admitted to the Unit following several extremely violent episodes, including the stabbing of his father. He had totally wrecked the house whilst attempts were made to interview him. He appeared to be experiencing active hallucinations and delusional thinking and was not able to answer questions for a prolonged period. Planning with the patient was difficult. He was unable to engage in the decision-making process, displaying constant tirade of verbal hostility and threats, clenching his fists and glaring at staff. At one point, he said to a member of staff "you are the devil and I will stab you." He suddenly threw a punch and was immediately restrained and taken to a low stimulated environment where intra-muscular was administered. Due to his continual struggle and threats, seclusion was initiated (a supervised confinement of the patient in a room which is locked for the protection of patient and others). During

seclusion a member of staff stood outside the seclusion room constantly and every five minutes wrote down exactly what the patient was doing and was reviewed every two hours by two nurses. Detailed records were kept in the patients' progress notes of the circumstances leading up to the seclusion.

A 36 year-old man was brought on the Unit after a fight with his wife. The four police officers accompanying the patient reported that the patient's wife had accused the patient of threatening to kill her. He was extremely restless and agitated pacing up and down continually shouting "let me out of here before I kill somebody." The patient was physically restrained and eventually secluded.

The cases show that where potential violent incidents occur the immediate aims are to defuse the situation thus ensuring safety for all concern. Other actions were aimed at support for the patient and staff and developing new coping strategies. In both examples, there was no clear idea of the problem (problems) and no time to define carefully the origins of the problem. The nurses quickly reviewed the events; the statements of highly distressed, threatening and extremely agitated patients and allegations that the patients posed a danger to themselves and others, the prospect of legal and professional repercussions if potentially dangerous patients were left in the community and apparently destructive family situations. The nurses dealt with multiple and conflicting demands in situations in which events seem to occur simultaneously and nurses made serious decisions about the patients' welfare with little deliberation. Under such conditions the nurses' efforts were focused on decision making that brought some degree of order and structure and not on development of a treatment relationship. Risk management does not follow in a direct and linear manner as the model suggest. In emergencies, planning ahead often is impossible because of the rush of events. Observing decision-making during emergencies I entered the following in my field notes:

Nurses involved in emergencies did not base their decisions on extensive analyses, because of time constraints and organisational pressures, but seemed to use past experiences (framed by trial-and-error) even in situations that occurred in different contexts to generate ideas about approaches. The emphasis appeared to be on problem reduction rather than problem resolutions. Well-rehearsed routines offer structure by providing nurses with patterned sequences of behaviour. Risk management is often symbolic in the sense of window-dressing activity. It is manufactured in order to reassure an external audience decisions are based on relevant set of information.

What came across strongly was the difficulty of assessing the likelihood of occurrence of risk situations. Most of the time it was only possible to plan a situation of risk in general terms which resulted in problem of distinguishing risk from worry, in a word worry was interpreted as “high risk” in written and spoken communications. On occasions when worry was high, for example in the case of violence, measures taken did not appear to bear a rational relationship to the risk and the predictable harm. There were many examples where the use of seclusion, special observation, and cancelling of leave was applied with unintended consequences. Measures taken on occasions appeared to have adverse effects. Care plans, which could be perceived by patients as oppressive had the potential of undermining their cooperation and reducing their openness. This suggests that violence may not simply be engendered from within the patient due to their illness, but may occur in a context that may include procedures and techniques used in managing risk. During the study it was evident that there were more frequent incidents of violence during the week than the weekend. The most probable explanation may be that there are fewer management and organisational activities and therefore less staff-patient contact at weekends. Such an observation is illustrated in the words of a nurse:

Patients who have violent episodes may be, in my opinion, vulnerable to poor risk assessment and management. Deep down, I think fear and to a certain extent dislike may affect decisions about them. In the name of accountability I have witnessed signs of imposition of plans to justify seclusion of patients. The environment in which we work, and our plans to assess and manage risk, can activate violence.

The use of the multidisciplinary team on the Unit was regarded as essential for developing quality of care through the achievement of coordination and collaboration of input from different disciplines, the development of joint initiatives, the achievement of better and fully informed care plans and the provision of holistic care. Much of the work of the multidisciplinary team during the study focused on nurses' accountability to the patients, the team and the organisation. Members were expected to report on risk assessment and management undertaken for or with patients since the previous meeting and to delineate further risk assessment and management to be undertaken and coordinate arrangements for patients within or across agencies. The team also on occasions engaged in extensive discussions about some patients whose risk situations were complex and where there was team disagreement or uncertainty about how to proceed. The meeting was held once a week and throughout the study there was lack of continuity of members, due to non-attendance of some members. Those present most of the time during the study were the Consultant, a Nurse, Psychologist a Pharmacist and a Social Worker. I have chosen the discussion of a female patient P as an example of dealing with a complex situation. The significant features of this particular discussion have been repeated frequently in the many case conferences I have attended as a researcher and therefore was not unique. I have edited the account somewhat for practical reasons and clarity:

P was a 28 lady was admitted to the Unit for assessment of self-harm and suicide. She was progressing very well, and

was due to go on leave, but disclosed she had been putting her medication down the sink and has for a couple of days had episodes of “hearing voices” which told her, her skin was evil and had made superficial scratches to her arm in an attempt to “peel off my skin.” It was apparent through risk assessment that P was more likely to have thoughts of self-harm when experiencing voices. Nurses have reinforced to P the importance of being honest and open when experiencing voices and thoughts of self-harm and has gained staff support by being able to approach staff to share her thoughts and feelings. This situation was discussed at the meeting:

Consultant: I think we should suspend her leave.... seems to be at greater risk of self-harm during leave because of non-compliance with medication.

Social Worker: In addition to the non-compliance of her medication, I'm a bit concerned with the family situation ...suggest we have family meeting before.....

Nurse: My daily risk assessment reveals that P thought the medication had worked and therefore she no longer needed them. It was clear that P was not aware of the need for medication on a long-term basis. I pointed out the importance re medication and has agreed to take them....

Consultant: I think we should wait for a week to see how this plays out.

Nurse: Through the daily risk assessments, it is evident that P is more likely to have thoughts of self-harm when bored and inactive and I feel that stopping the leave would increase risk. My worry is that apart from non-compliance with medication, P has been totally cooperative and had taken responsibility and approached staff when in distress and feel it is a bit punitive to stop leave when in fact P has complied with care plan.

Psychologist: I am very concerned that stopping P's leave would destroy the relationship she has established with staff....

Pharmacist: I think P needs more education in using her medication.

Consultant: Taking your various points on board I am uncertain how we might reduce risks if I were to grant P's leave.

Nurse: We will carry on with daily risk assessment and observe P closely in terms of medication, which can be given in liquid form to reduce non-compliance. Risk assessment, would be completed prior to leave by shift manager and leave would be taken only at the discretion of the shift manager. Leave will not take place if P is experiencing voices at that time or if there were any evidence of self-harming thoughts and it would be explained to P why leave would not take place.

Pharmacist: I am willing to have an input in educating P about medication.

Consultant: I would like the formulation of a care plan reflecting on all we have discussed and the measures we are taking to reduce risk. I will grant leave with a view to it being fully executed at next week's meeting.

Efforts to achieve case autonomy and contribute to decision making often produce internal conflict, which at times led to loss of professional identity and boundaries allowing the team to slip into “collegial risk management processes” that limit the blame potential for any single group in the event of a tragedy by sharing out responsibility among the parties. Often the team approach dilutes decisions which professionals would otherwise make in isolation, leading to less than appropriate therapeutic plans, namely the embracing of procedures for risk assessment and management that serve the purpose of limiting blame as noted by many interviewees. Each discipline has developed structures and work modes necessary to respond to needs of patients. For instance, managers have mechanisms to respond to their accountability for efficient use of resources, professionals have their own approaches to risk management. However, the very principles - structures, success, measures, and approaches to risk management – that serve to organise integral disciplines, also serve to separate and disconnect the disciplines from each other.

People who occupy roles in different areas view risk management from different vantage points and have different perceptions of the reality of risk management. This phenomenon contributes to the destruction of any sense of coherence in which risk management issues from the point of view of participants' fragments into several different and incompatible solutions. Actors in each arena collect information needed to manage risk, but in the process often selectively ignore

or discount information available from other sources so often arriving at conflicting conclusions. Actors tend to define as problems only those things affecting their own measure of success and often one arena's solution is another arena's problem. Since independent decisions made in each arena impact upon others, each struggles to maintain its integrity and seeks to balance the power in the system. Rather than seeing themselves as collaborators attempting to work to a common purpose, rival relations frequently develop and actors often find themselves in a struggle for control of decision making. In an environment of conflicting relationships, where different perceptions and constraining norms prevail, uncertainty is guaranteed. The existence of multiple arenas typically creates a situation in which decision making is extremely difficult. Under these conditions of uncertainty, rational, pragmatic and computational approaches to risk management tend not to work well.

UNIT B

Unit B a mixed-sex acute admission unit with 20 patients is located in an old reconverted building. Unit B's philosophy encompasses "interventions being based on a careful assessment of the patients' needs wishes and aspirations. Practice is designed around the individual, taking into account the range of past, present and future influencing factors". Unit B admits the most acutely ill, namely those assessed as immediately dangerous to themselves or others and those seriously disabled to be capable of basic activities of daily living most. Like Unit A, most of the patients on Unit B were typically impaired intra-psychically, interpersonally and socially characterised by nurses as "agitated, unpredictable, manipulative and challenging" most with histories of violence and suicidal attempts. Some of the patients, severely depressed isolate themselves in their rooms or watch television others go in and out of the Unit. Like Unit A, no client is admitted without prior multidisciplinary assessment however in emergency situations it was not possible to involve the whole team. In such stances as many team members were consulted as possible and others informed of the admission. On admission a clinical team is identified, including a Key Worker and Named Nurse, and a programme of care is formulated and implemented with the patient (and/or their carers) participation and consent where possible. The multidisciplinary team was made up of: Psychiatric Consultant Registrar Junior Nurses (Grades A – C) Staff Nurses (Grade D, E) Ward Managers (Grade F, G) Senior Nurses (G, H) Social Workers and Advocate.

The day starts at 0700 hours when all nurses meet in an office located in the middle of the Unit. The handover as compared to Unit's A, appeared more relaxed concentrating on what was deemed "important" (at-risk patient) to report. Nurses checked to see that patient care plans were up-to-date. The relaxed atmosphere

however hides the extent to which safety procedures dominates the operation on the

Unit as the following observation illustrates:

On admission we identify risk by ensuring that relevant information about past and present is available, including past history of the patient, information from others, observation and mental state examination and accurate information about past behaviour. This helps us to define future circumstances likely to present increased risk. Based on past experience, it is often possible to recognize situations under which a patient will present an increased risk. Our policy is to indicate what must change to reduce risk and suggest how these changes might be brought about, to note on the probability of interventions, to reduce risk and to record the risk management strategy. A professional who identifies a risk has a responsibility to take action with the intention of ensuring that the risk is reduced and managed effectively. This requires the creation of a management plan agreed by all involved in the patient's care. The management plan should also specify dates for routine reviews and circumstances requiring a special review (Manager).

The assessment tool represented below is highly standardised measure designed to predict a patient's chances of arson, violence and self-harm. The end result is a probability of measuring the patient's particular circumstances, as defined by information about his/her age, gender and among other things previous behaviour. The method is limited in the sense that it could only make prediction estimates about the likelihood that, a behaviour would occur:

A 26 year-old man diagnosed as having "personality disorder" was admitted to the Unit. He had low self-esteem and difficulties in understanding the consequences of his behaviour. Past history revealed that he has assaulted both parents in the past, took overdose of prescribed medication and has set fire to his parent's house. At one point during the admission process, he requested to be let out but was persuaded to stay by the Key Worker. The process of risk management took the following steps:

Specific predictive risks: His lack of understanding about consequences of his actions and poor self-esteem means there is a likelihood of repeating his behaviour of arson, self-harm or violence.

Risk Identification: In this instance the risks are of violence, arson and self-harm and considered as high. The aspects of patients' illness and lifestyle and circumstances that have formed past experience were associated with the manifestation of each risk.

Consequences of risks: There are consequences of serious harm to others, self-harm and violence if action is not taken with serious professional and organisational implications, if things go wrong.

Action required minimising risks: Risk management strategies relating to stay in hospital require close observation during the early phase as he may present risks to self (leaving the Unit for self-harm) and others (aggression and arson). Risk management strategies includes compliance with medication; assessment to with regard to self-esteem.

Date for review: Ongoing review in the early stages with monthly updating and two monthly evaluation of progress.

There was a need to communicate to external audience that the decisions made were legitimate, through demonstrating that they were made in a rational manner. Often this amounted to little more than symbolic behaviour. These symbolic behaviours were oriented towards staging a front of seemingly intelligent choice of the correct intervention.

Like Unit A, disruptive behaviour occurs from time to time on Unit B. Because patients were at times frightening, violent and hard to control, sometimes, immediate action was necessary to protect person or property. In these circumstances nurses were making risk decisions often of great complexity and intrinsically uncertain situations. In these conditions, professionals have to both frame and resolve the problem, often without precise guidance as to how to do so – which shows the uncertain nature of risk. Most risk assessment is based upon conditional knowledge because it was impossible to know in depth the complexities of every situation and all future possibilities and impacts which could result from any situation of risk. It was evident that the approach to risk was characterised to a certain extent by risk avoidance and low tolerance of errors:

Clinical intervention is now organised on what if basis. In the current climate, the emphasis seems to be on increased protective stance in which most risks appear more important than most rights. In this risk set up, we cannot consider and substitute benefits and harm to patients and society in a way, which puts the welfare of the patient as a priority but see the safety as the primary concern. Safety has become the fundamental value, in a sense in which in our efforts to help patients is now devoted in trying to ensure that patients are safe. The blame and litigation when things go wrong means that we have to be defensive in our decision making (senior nurse)

The preoccupation with safety indicates that no area of clinical activity can exempt its influence. Clinical interventions that were up till now seen as therapeutic, such as letting patients go out for a walk, assessing the level of observation to be placed on a patient, allowing a patient with a known history of aggression to leave the unit unaccompanied, are considered major risks. So that interventions that have been pursued because they were risky in order to gain benefits for patients are now classified from the perspective of safety awareness. (Senior nurse)

Other issues raised by respondents were connected to their fear over the possibility that the formalised approach to risk assessment may lead to their professional judgement being compromised and complained about the amount of paper work that they have to do. The interesting thing about these issues was the difference between senior and junior staff also evident at Unit A:

Our flexibility in making judgements about patients has been replaced by a standardised risk assessment approach. In my view, the time-honoured approach to risk assessment, which relied on personal experience, intuition and discretionary are now regarded as inferior. (Senior nurse).

As a beginner, I see the move towards risk management guidelines very useful. They are learning aids and practice tools that help me translate my experience and training into concrete practice behaviour and give me research based roadmap to work with patients (Junior nurse)

It is sheer hell to be in nursing at this moment in terms of paperwork. I spent most of my time filling forms purely to cover my back leaving little time for patient contact. (Senior nurse).

I totally disagree with the complaints about paperwork being a problem. It is an important part of nursing because it enables me to reflect and think of what I'm doing. (Junior nurse)

Because of external pressures, patient care plans and documentation are given particular attention. Nurses have to justify the need for referral of patients who are deemed unsuitable for the unit by carefully constructed descriptions documenting significant problems. While making a case for "at risk" patient for referral was a strategy to protect nurses and the unit, there were instances where nurses were convinced that patients were at risk. Nevertheless staff also acknowledged that external audiences read and assessed accounts of patients risk in view of their documentation. Respondents therefore, sought to produce not only "accurate" risk assessment, to "cover their backs" if something goes wrong but to convince external agencies as well. Like Unit A, there was difficulty in distinguishing between worry and risk where measures taken regarding a perceived risk appeared not to be specific and proportionate:

A 28 year-old man with a history of violence and hatred for women was admitted on the unit. Because of history of violence it was decided from the outset that he was too dangerous for the unit. A multidisciplinary assessment decided to refer the patient to a secure unit. Once regarded as high risk, it seemed his thoughts were judged in different context from that of other patients – in which any anger he expressed appeared to be treated with compulsory medication, restraint and seclusion. This led to more anger and therefore more control. He attacked a female member of staff and was placed in seclusion indefinitely. Staff on the unit refused to nurse him and the documentation justified the interventions on the ground of the severe risk and the danger to self and others. After weeks of discussions between the

medical and nursing staff the patient was transferred to a secure unit.

Despite the quest for safety, care management problems were observed. There were occasions when procedures were not followed allowing a patient to have access to a knife resulting in attempted suicide. Missing or wrong information exchange and misinterpretation during handovers and lack of coherence in care plans created gaps in the continuity of care. Blame avoidance enveloped approaches to risk management because too often the risk management is seen as the clinician business, a task that would go well if only clinicians follow the practice and procedures. The usual response after an accident/incident and near-miss was to start looking for “someone to blame.” Some of the comments from respondents were: “We seem to attach a high priority to placing blame.” “When an accident happens it seems that someone failed and that if we can track it down everything will be alright.” There is no room for error because it puts your job on the line.” The last comment was illustrated in the sacking of a qualified nurse for giving the wrong drug. In the context of accidents some respondents admitted being reluctant to report them. Activities after event analysis appeared to ignore any element of organisational learning. The approach to event analysis seems to be firmly linked to locating blame, with a search for what the cause of event was which led to the accident or disaster.

UNIT C

Unit C, a purpose built children therapeutic community is set in grounds surrounded by woods, has an atmosphere of a personalised family home. Each child has their own room, which is light, bright and furnished with appropriate pictures along with the child's own personal possessions. In terms of décor, great attention has been paid to style of furnishings and activity areas. Its large kitchen is designed to permit children to cook and to be part of its activities. Inside the rooms are infrared sensors, monitoring each child's movements throughout the night, ensuring total safety of every child, yet maintaining privacy. What struck me when I entered the Unit was the feeling of warmth. Two children were playing table tennis; one asked me if I wanted a game, three sat in the Quiet Room reading, others were in their rooms watching television. The Unit had a mixed therapeutic orientation – psychoanalytical methods, behaviour modification in conjunction with family therapy and pharmacological therapy. The Unit's purpose is reflected in the comment of the manager:

The Unit's ethos is designed to support the child and parent(s) in an optimum way, while encouraging each child to realise their full potential. Great emphasis is placed on building a positive environment with the expectation of long-term improvements. I think we differ from many other Units in how we view our staff. For us it is central principle that staff includes everybody, from the most senior nurse practitioner, through to care assistants, domestic staff, administrators and maintenance staff. They are all vital part of the team and have understandings to deal with at risk child.

The children's day commences at 0800 hours with an early morning call. Personal hygiene is attended to before breakfast, at 0990 hours, the children then prepare for the day's activities some Unit based, others with outside agencies such as attending schools. The children have lunch at 12 followed by a free time and then return to activities till 1600 hours followed by relaxation time, tea and the option of

taking part in various activities. Bedtime is at around 2100 hours. Weekends are relatively unstructured and activities are arranged on the Unit if the children wish to participate. Visiting is allowed any time and there are facilities for meeting relatives off the Unit in small visiting rooms.

Unit C has the same multidisciplinary team as Units A and B but with special focus on involving parents: Consultant, Senior Registrar, Registrar, Care Assistants (Grades A-C), Juniors Nurses (Grades D & E), Ward Managers (Grade F &G), Senior Nurses (G & H), Social Worker and an Advocate. The maximum age accepted for admission was 13 years. Admission is through the multidisciplinary team including liaison with education. The Unit starts from the premise that children should not be admitted if it can possibly be avoided and if admitted, the length of stay should be as short as possible. Referrals include severe emotional disorders, severe conduct disorders, psychosomatic disorders, and psychosis. Each case is discussed with the wider staff group at weekly referral meeting to draw on the multidisciplinary perspective available in formulating an initial assumption. The aim of the meeting is to determine the nature of the problem, namely assessment, treatment, the legal status of the child, location of parental responsibility and support network. If admission is decided, a second meeting is held. Parents and the child are shown around the Unit and further questions about care and treatment are answered to give the parent(s) as much information as possible in order to reach their decision about admission. Involving family members was considered vital because of interventions following discharge and the negative effects on young children of being separated from their parents. The family is seen for initial assessment including risk assessment and search for signs of parental acknowledgement, and possibilities for engagement in psychological treatments:

Our risk management process has four strands. The *parental domain* includes parental mental health and state of mind with regard to attachment; *the parent-child domain* is concerned with parental sensitivity to the child, perceptions of the child, the parent's capacity for empathy and the history of the parent-child relationship; factors within the *child domain* include the child's development, functioning and constitutional factors; *the family domain* includes all areas of family functioning for example distribution of power within the family, family violence, and expression of affect. (Manager of the Unit)

Work with families however presented particular challenges during the study.

There were arguments for limiting family contact because of the impact on the Unit's routine, the effects on the children who have few visits, and family members choosing different members of staff in whom to confide. I observed splitting within the team between staff primarily concerned with the child and those primarily concerned with the rest of the family. The category of the "at-risk child appear to underpin a good deal of the Unit's policy. Risk is representative of the family and symbolises difficulties within the family unit. The greater the difficulties demonstrated by the child, it appears the larger the number of issues the Unit pays attention to within the family. Risk assessment is instrumental in the children's daily lives and for everyday staff-child negotiations around safety and danger as illustrated by an observation of respondents:

Risk assessment is becoming ever more central to clinical practice. We are becoming increasingly aware of our accountability for mistakes in assessing and managing our patients. (Manager)

If we don't take risk seriously we are seen as uncaring or irresponsible. (Junior nurse)

Our work is shrouded in almost constant monitoring of risk and adherence to guidelines. It is a game that we have learned to play. Yet there are no easy answers. Each intervention appears to bring its own dangers. (Senior nurse)

Risk is a constant and pervasive feature of everyday practice.
(Junior nurse)

An important part of risk assessment on the unit was the likelihood that the families may be the cause of the child's mental state. From this stance, a child at risk was a characteristic of the difficulties within the family and therefore his/her behaviour was perceived as an accurate indicator of the family's stability. However families were expected to cooperate in treatment programmes by participating in family therapy and where possible adopt the features of care plans at home. Families in contrast locate the problem in the child and made it difficult for them to understand why they should be participants in the treatment. Consequently it was sometimes difficult for families to immediately understand and embrace the value of their involvement and saw staff as interfering or making unreasonable demands on their time. This was evident in the following cases:

A nine-year old boy was admitted after abuse and neglect at the hands of substance-abusing parents. On the unit he flies into a terrible range whenever he feels left out or forgotten. He is quite inconsolable and will attack staff. After an episode, he is unable to acknowledge what has happened or talk about his feelings. To avoid the risk of harm to self and others the plan was changing a pattern of behaviour/interaction, building confidence, learning new skills such as expressing anger without hurting people by involving parents. The parents however felt it was the responsibility of professionals to sort things out.

A ten-year old boy was admitted to the unit following a psychotic breakdown with a school history of non-compliance and stealing. He becomes abusive and violent when grounded for leaving the unit without permission feeling that staff is picking on him. Refuses to comply with any intervention, is seen as behaving dangerously towards staff and out of control. Time Out (a behavioural management technique used for disruptive behaviour ranging from sitting in a special chair in a communal area to using the child's own room) covered by a pre-admission parental consent was used. He becomes increasingly angry and distressed and unable to cope with staying in his room. His persistent aggressive behaviour required Physical Restraint

(used for abusive behaviour, aggression, self-harming and challenging behaviour). Staff becomes aware of how distressed he becomes if he has to be physically held and how he projects these feelings onto staff. Efforts to involve the parents to explore the situation proved futile. The situation deteriorated to an extent that Seclusion (placing a child in a room from which they cannot leave, used for abusive and aggressive behaviour - used as a last resort and which general parental consent was sought) which was seen as an appropriate risk management technique was rejected by the parents.

Risk Anxiety

The knowledge base and assessment skills required on the unit was different from those required in Units A and B because children are the target of great deal of social concern. The contemporary fears about children and childhood were enveloped in contradictions between recognising children's autonomy against the increasing emphasis on child protection and the perception of children both as angels and devils. These contradictions were concerns for most respondents:

The increasing anxiety of society about risk has resulted in a protective stance in our care. Children are seen as vulnerable innocents to be protected from the dangers of society. Our guard against potential threats to their well being have led to a preoccupation on the unit with prevention and a need for constant surveillance on children with hardly any room for error. (Senior nurse)

There is a sense in which our patients seemed to be at risk regardless of their circumstances. Issues about the everyday experience of children – the activities of daily living have become central to risk management. They inform our decisions about both the level of observation patients require and autonomy they can be permitted (Junior nurse)

There are worries about children safety and well being, but also fears of what children might do if they are not kept within the boundaries of acceptable childish conduct. (Junior nurse)

Many respondents expressed concerns about risk being a constant and pervasive feature of their consciousness and everyday practices:

In my opinion the fears we have about safety limit the patients' lives and experiences in a range of ways. It increases their dependence on us, which leads to over-protection. In the end the children will be incapable of taking responsible decisions as they grow up. (Junior senior)

The potential for providing children with a wide variety of challenging experiences has been lost in all the concentration of risk. (Senior nurse)

The use of guidelines tends to bureaucratise decisions in reaction to our patients. It produces a standardised response without taking into consideration the social context of life experience of individual children. Clinical intervention has been dressed up in a step-by-step model, which serves to define the boundaries of patient's lives. This creates a self-fulfilling prophesy so that patients cannot be competent to do things which they have never been allowed to do. (Senior nurse)

Guidelines set the scene for the conditions under which nurses carry out their roles. Although there was a feeling that there is nothing new in risk management, a number of respondents commented on the quest for safety in recent years and the increased concern with accountability. Another factor which emerged was the burden of paper work but which was seen as necessary "to cover" themselves. Yet I saw many instances where nurses ignored guidelines because: "I don't believe in them" "I haven't got time". They pointed to deficiencies in risk management techniques on professional values in being "wrapped" in paper work. But within this resistance, respondents faced difficulty in the effects of external pressures as reflected in the media, public policy and campaigns around safety and danger. Like Unit A respondents reported the greatest pressure in their attempt to accommodate and cope with the stress. Most talked about "the dread and fear of making mistakes" and "the futility of complaining" "you just have to get on with it". The sense that things have changed as a result of: "everyday organisational relationships",

increased work load”, “external pressures” was repeated over and over gain by respondents.

UNIT D

Unit D, a fifty bedded nursing home its attractive garden setting and wealth of charm and character is situated in a quiet residential area of the city. The Unit's design combines generous space with a homely feel, with tasteful décor natural wood, fitted carpets and real plants. Bedrooms are single or twin bedded with en-suite facilities and are spacious. Corridors are short with comfy chairs. Residents are encouraged to bring personal possessions, such as a favourite table, chair and ornaments for their own room. Lounge areas in each of the Unit's four wings have their own pleasant dining rooms. Activities are organised inside and outside the home and include crafts, games, and musical entertainment, as well as shopping and coach trips to places of interest. The entrance of the home is adorned with the philosophy of the home: "our philosophy is to provide a homely, welcoming and relaxing home from home for our residents. We aim to offer elderly people the opportunity to enhance their quality of life by providing a safe, manageable and comfortable environment, plus support and stimulation to help people to maximise their potential physical, intellectual, emotional and social capacity. Residents are encouraged to be involved in all decisions affecting their lives." Also displayed in the entrance is ISO9002 an internationally recognised Quality Care System award. The quality care system covers all activities and services of managing the home including nursing, medical and social care, through to the hotel services function of the Unit, which includes areas such as catering, cleaning, maintenance of the building and health and safety at work. A key part of the system is satisfaction surveys of residents, relatives, professionals and staff. Audit documentation is available for inspection from the Unit manager.

Most of the patients on Unit D suffered from dementia a chronic disorder of the mental processes noticeable by memory disorders, personality changes, impaired reasoning due to brain disease or injury. The effects of dementia manifest in loss of orientation where patients are unable to locate the toilets, their bedrooms, loss of memory, the forgetting of who their close family members are, loss of independence and the ability to perform simple tasks, for instance to eat and drink, to put on clothing. The patients also suffer from various physical disabilities either as a result of the dementia process, or as a consequence of the ageing process, such as arthritis, diabetes, poor eyesight, or loss of hearing. As a result, the patients require total supervision at all times with most of them needing to be dressed and fed. Many cannot walk or talk and majority are doubly incontinent. Patients experience some or all of states of aggression, wandering, delusions, depression and incontinence.

The team is made of professional nurses, a Manager, Registered Mental Nurses, Registered General Nurses and Enrolled Nurses who make the key decisions about patient care and Care Assistants (Carers) some of whom have undergone training and achieved National Vocational Qualification Levels 2 and 3. The prime responsibility for the day-to-day provision of patient care and the management of the Unit rested with the trained nurses. Although trained nurses were responsible for the type of care given to patients they provided little of the care themselves. With the exception of specialised nursing procedures like giving medication and dressing wounds, Carers took care of the patients. The bulk of the nurses' time was taken up with administrative duties such as ordering supplies, and dealing with people seeking admission to the Unit. This meant that nurses had to rely heavily on the performances of the Carers. Work in the Unit was organised so that Carers had a set of group of patients for whom they provided care. Carers are

involved in a whole range of care namely getting patient out of bed, washing them, bathing them, making beds, changing soiled clothes, toileting, feeding, giving pressure area care by two hourly turns and doing regular paper work such as filling in bath and turns charts and writing daily reports. Carers perceive that working with elderly people with dementia requires a variety of skills such as patience, understanding, respect, sensitivity and commitment and resent the low value given their efforts.

The greatest problem the Unit faced during the study was securing and maintaining an adequate staff. There was also a chronic problem of absenteeism, which had implications for patient care. Often during morning and afternoon shifts there were two trained nurses and six carers and two trained nurses and four carers for night duty. Low staffing levels had indirect effects on patient care. Staff experienced physical and emotional stress as a result of having insufficient time to meet patients' needs as illustrated in the following observation by a nurse:

The low staffing levels means that each nurse becomes involved in meeting the needs of all the patients on the Unit despite allocation. Patients therefore experienced interrupted contacts, which prevented staff becoming aware of patients' emotional condition to respond to them appropriately. The high staff turnover and the delays in replacing those who left, the frequent use of agency nurses, the high sickness and absence rates means that quality of care suffers from the lack of continuity of staffing over a longer period.

Central to developing a plan of care for patients, Unit D faces the challenges of assisting their patients in reaching and maintaining their highest functional level, and encouragement of patients to maintain their past interests and involvements. As it struggles to help patients maintain their independence, however, it is also challenged to create care for those who can no longer care for themselves. Staff routinely has to balance enabling patients to retain control over their lives with an

awareness of the risks they face because of their vulnerability which takes place in a context where there is acute awareness of how other stakeholders might see Unit D if a patient is hurt as result of taking risks. Like all nursing homes, Unit D, is stringently regulated in ways that Units A, B, and C are not. The emphasis on regulatory compliance appeared to result in considerable anxiety concerning options for risk decision making by or on behalf of critically ill residents. Yet the way work was organised left carers, who received very little direct supervision from nurses, physically isolated with patients.

Surviving the Risk Culture

Unit D identifies risk as an important factor in their decision-making in almost all their cases. What was noticeable is the presence of fear of being held responsible for serious accidents that may be perceived to be lack of professional observation or intervention, with an element of protecting one's own professional interests especially where an internal or external scrutiny and extensive media coverage is likely to ensue. Staff comments in support of the above statement include:

It seems as if we are under surveillance from all fronts. The awareness of UKCC, relatives questioning our practice, the continuous surge of government legislation, inspectors and their unrealistic recommendations and of course the good old media. Scandals in a handful of nursing homes have placed us in unfavourable light..., which is very difficult to rectify. There is the feeling that you should watch your back all the time (Manager).

It is frightening and stressful to work in such settings with a constant awareness that I will be held accountable if anything goes wrong. Protecting my registration formed the basis of all my interventions. (Nurse).

I am told that the responsibility of patient care rest on qualified staff but that does not stop me from worrying about what happens to the patient. I feel guilty if there are any injuries to patients. The last thing I want is to be involved with legal action (Carer).

Our responsibilities of caring is shrouded in the threat of litigation for dereliction of duty if patients come to harm. The challenge is to define a framework in which we have some room to take risks and allow risks in our patients but equally accept our responsibilities of care, restraining patients whilst taking account of rights to autonomy ensuring any care is appropriate to the individual patient. We have contracts with patients' relatives to face the realities of risk and document it in care plans. For example, if restraint is thought likely to be a necessary, permission is negotiated in advance with patients' relatives, it is then recorded in writing, which is subject to regular review and communicated clearly to all staff (Manager).

I don't know why I'm here sometimes with the whole emphasis on risk. While I agree totally with the involvement of patients' relatives which I feel is long overdue, I think it has gone over the top in a sense in which we seem to be abdicating our responsibilities. While caring for the elderly implies an assurance of safety and as they are too confused to make a rational choice about risks, I feel that like everyone else they have rights to take risks as part of normal living and that should not be denied. I believe the management of risk should focus on the extent to which people who need care can be looked after as individuals by staff who can make responsible risk decisions without seeking refuge in patients' relatives, some of whom are either unwilling or unable to take part in the decision making process. I think we live in a risky world and therefore in any perceived dangerous situation we need to ask: whose danger is it, that is, whether it is the threat to the patient, to other patients, to the Unit's routine or playing it safe. I believe we should look at how far we can take action to lessen any danger without incurring a graver threat to the well being of the patient. We should be concerned with safety from physical harm and yes from the threat of litigation; but also concern with health and dignity (Nurse-in-Charge)

When I started in this field the thinking was that patients should be encouraged to do as much as possible for themselves. A positive approach to activities of daily living was seen as beneficial because it promotes independence. Now we have got consumers, with more rights, on whom behalf decisions have to be taken to protect them from harm (Nurse)

Unit D finds itself operating in an environment that is subjected to criticism from the press, politicians, the public and relatives. For the staff it is important to strike a balance between criticism of assessing and managing risk, and the criticism if patients suffer danger through what could be perceived as inadequate practice. The comments show how risk increasingly defines practice and becoming the dominant feature in the life of Unit D. There were general fears about making mistakes, getting involved with litigation and being held accountable. There was a feeling of vulnerability anxiety, cynicism and vacillating between shutting problems out and tightening protective measures. Nurses and Care Assistants were therefore not reporting accidents or 'near misses,' and were on occasions actively seen downplaying the seriousness of those accidents:

During a night shift an 80 year-old man fell. Two Care Assistants against the policy (they should have informed the nurse in charge before moving the patient) move the patient to his bed before informing the nurse in charge. Without observing and checking whether the patient had sustained any injuries, the nurse in charge completed an accident form claiming no apparent injury following the fall. Observation was not maintained as stipulated during such accidents until the morning. After taking over from the night shift, the Care Assistant responsible for the patient noticed that the patient appeared to be in pain and brought it to the attention of the nurse in charge. Examining the patient, the nurse noticed swelling on his right shoulder and immediately sends the patient to the General Hospital for investigation, which diagnosed fracture for which he was treated. The patient deteriorated and latter died the following day.

A natural response after accidents on Unit D is to start looking for someone to blame. The topic of conversation, following accidents is usually illustrated with pointing of finger and finding out "who was in charge" and "who was on duty" when it happened. Accident investigations seemed to find out what infringement of the regulations led to the accident, who was responsible for the infringement and

whether additional regulation would prevent similar accidents The Unit seemed to attach a high priority to assigning blame and responsibility so that some Nurses and Care Assistants try to find ways of protecting themselves from a negative judgment by withholding information as observed by a nurse: “ because of finger pointing we feel reluctant to admit mistakes.” In the above case like many others everybody involved was attempting to conceal the accident. A regulation to document the accident in the patient’s case notes was not followed by the two nurses and resulted in the manger, due to involvement of the police, summoning them from home to complete documentation. A notice was placed in staff rooms reminding all qualified staff about the importance of following procedures in reporting accidents and incidents adding: “mistakes will not be tolerated.” The blame culture compelled respondents to re-categorizing “accidents” (which are documented) to “incidents” (which are not documented), downplay the seriousness of accidents and reluctance to raise issues about patients’ safety.

A 76 year-old confused woman is uncertain of her surroundings and is in a state of anxiety. She wanders aimlessly entering and removing properties from co-patients rooms, disturbing their privacy. Her wandering becomes a source of worry as she attempts to vacate the Unit. Her family is anxious and concerned for her safety. The situation demands a close observation but the levels of staff means it is impossible. The question of how to manage the patient’s movements became crucial to the staff, co-patients and the patient’s family. The discussion of how to manage the situation draws out the distinction between the quality of life and the rights of the confused patient. The concerns of the patient’s family, is primarily that of safety. The staffs are faced with the need to find a balance between any restrictions it imposes and the patient’s right to take risks. The need for staff and the patient’s relatives to be content that any injuries sustained due to wandering are justified in a quest to maintain her quality of life is therefore difficult.

Wandering is usually the reason for admission and most often documented as the problem behaviour in the care plans of patients on Unit D. One of the major concerns related to wandering behaviour is the risk of fall-related injuries. Injuries sustained from fall can lead to litigation and therefore an important aim of staff on Unit D is the reduction or elimination of wandering behaviour to avoid injury and thus legal proceedings. During the study the management of wandering behaviours were through an “accepted” and discussed form of restraint, for example, cot sides, baffle locks and medication. Other subtle methods of restraint including removing walking aids, straps attached to furniture, chairs tilted back, Buxton chairs which folds and fastens across the lap of the patient, strategic location of furniture, use of commodes which provide opportunities for limited movement, or placing patients in positions (bean bags), from which they have difficulty in moving were used. Permission was needed to use cot sides where patients wander at night and where mattresses are placed on the floor in cases where patients were inclined to fall. Restraints of patients were justified because of the danger to themselves and others. The non-professional carers found it difficult to challenge such a practice because they lacked sophisticated and complex notions about mental illness. Their interpretations of patients’ appeared to be based on lay rather than medical ideologies which increased their likelihood of using already established and familiar means of “handling” difficulties with patients namely restraint.

There were times when restraint could not be avoided or risk assessment applied such as in emergency cases of physical attack on staff or patients. In such situation a full record was supposed to be made of the incident soon after the event and written in patient’s notes. But according to a nurse: “because of the finger pointing I don’t report anything if I don’t have to”. Most of the strategies used to

manage wandering were in contrast to the declared policy of assessing and determining the risk of injury through a framework: namely, assessing how a patient could be harmed and how, evaluating the risks arising from the hazard and deciding to eliminate or reduce risk, recording the findings and reviewing and revising the assessment on a regularly basis. Although restraint was supposed to be used as a last resort, as in many instances, the approval of the patient's relatives in the above case were sought to restrain her. There was no recording of the plan to restraint the patient and it was not reviewed during the study.

A 65 year-old man about six feet eight inches tall ex-army officer is adamant that one of the female patient is his wife and rather takes exception if anybody including staff coming near them on occasions. He is very agitated and has a tendency of attacking both nurse and patients resulting in two of the latter having fractures after violence incidents. There is concern about his aggression by the staff, the relatives of co-patients and a family friend who decides to stopped visits and all contacts.

Aggression both verbal and physical was seen as a major problem. The staff felt strongly about this. Yet the above case like many others did not follow the procedure of formally assessing and managing risk. Rather there were recordings of incidents of aggressive episodes, which were presented to his General Practitioner to justify the prescription of tranquillisers. The medication however created a problem of drowsiness and eventually have to be withdrawn. On number of occasions where it becomes harder for nurses to control the patients and prevent them from disrupting the daily routines of the Unit or from injuring others or themselves, nurses in their dealings with doctors would try, often successfully to persuade them of the importance or necessity of tranquillisers for "problem patients."

A 67 year-old woman is adamant that she wishes to return home. She shows insight into her dementia and often reports episodes of neglect to her relatives. She has difficulty in mobilising continually shouting and accusing staff of hurting her. Her brother visits and spends about eight hours everyday and complains about the lack of care given by staff. Following a fall, which led to bruises, her brother threatened to sue the Unit. The named-nurse creates a folder to record all complaints from the brother after efforts to engage him in discussion about his sister's care fails.

There were many complaints during the study about patient care: "patient not being washed or fed properly" "patient being drugged" "patient being left unattended" and "patient losing their property" among others. According to most respondents, while the main types of complaints have not changed, "they have increased and become more complex due to the threat of litigation". There was a feeling that "health care has changed from a social right to a consumer right." The awareness that relatives are looking over their shoulders generated personal vigilance over the actions of the nurses. When relatives complained to nurses about mistreatment, the usual response of the nurses to such claims was to deny the occurrence of abuse by "covering their backs." They did this by collecting data in order to avert the legitimacy and the validity of the contentions. A reflexive monitoring of the nurses' action was implicated in every act of practice.

Coping with risk

While good work was done on the Unit the need for accountability appeared to divert attention from therapeutic work to custodial ideology. Carers emphasised the hopeless conditions of the patients, their enfeebled mental states and the necessity of controlling them with drugs and restraints. Care appeared to be mostly defined minimally in terms of tending to the visible bodily needs of the patients. Many respondents spoke openly of protecting themselves. Nurses find that it is impossible

to achieve goals expounded by their professions. The lofty goals of help and service learned during professional training give way to more realistic goals maintenance; rather than taking active leadership in caring for patients they withdraw from this aspect of role, become cynical and minimise their contact with patients and Care Assistants to whom nurses delegate a great deal of discretionary power. Nurses protect themselves by “documenting everything” and by avoiding information on certain patients that are regarded as “hopeless,” “challenging behaviour” or because of their “crazy relatives.” A nurse summed up the feelings of most:

I don't do risk assessment with most of the patients. What I don't know, I don't have to do anything about. For example, if I were to assess the risk of aggression its management will need close observation but this is not possible because of the staff situation. So in a sense I will be putting my neck on the block for putting this on the record. My strategy is usually to put the onus on the doctors to prescribe tranquillisers to control the problem. I have also involved willing patients' relatives who have agreed for restraints and as added voice in requests from doctors that way I am always covered.

Nurses argued against assessing risk and “putting it on paper” because it results in blame if accidents happen which was at odds with the espoused organisation policy. Because of the “blame culture” there is no chance of “learning about the accidents.” Some Care Assistants developed their survival practices on qualified staff “because it is their responsibility.” Others “protect themselves” by “seeing that nothing untoward happens on duty,” “having four eyes,” and by reporting every bruise, scratch, everything to qualified staff.” In the words of a Care Assistant:

If I'm on I see to it that I report everything, which I feel is not right to the nurses. Most of the time they find me a nuisance but I don't want anything on my conscience. When I finished work I like to think that I have done what is expected of me, and that all the patients under my care are safe. I like to cover myself.

Another defensive orientation to practices can be linked to the regulation of nursing homes. Announced and unannounced inspections were periods of intense activities to “cover ourselves”. Anticipation of a visit by inspectors was a flood of activity as risk assessment and management forms are reviewed and updated:

They (inspectors) are not really interested in what happens to patients their main concern is to see whether the documents are in order. I make sure at all times not only during inspections that all our documents are reviewed and up to date. It always seemed to be a wasted effort though because they always find faults in their reports. (Manager)

I don't see the point of rushing around every time trying to satisfy these inspectors. I am in the profession to care for patients not to jump to the whim of outsiders who haven't got a clue of what goes on here. Inspectors never ask patients or their relatives whether they are having good quality care, but always whether we are up to date with our documentation. (Nurse)

Like the other units, risk management was often symbolic window dressing; decisions were thwarted by smoothing, gaming, filtering and thus demonstrates that nurses may employ many different strategies to inhibit the visibility sought by the rational approach.

Risk Management in the Contexts in which it operates

Risk management is now associated with particular ways of seeing and trying to shape organisational process and actions as illustrated by decision processes and the structuring of organisational activities. Approaches of risk management have become not only important and valued clinical practice but also ones whose existence and consequences are difficult to unravel from the functioning of psychiatric care. The study has provided us with many interesting and useful insights into both the interpretation of risk management and ways of trying to facilitate its use in decision making situations. Although the project was not designed to generate complete and comparable data for the four healthcare settings, the data I collected suggest that the settings had differences in organisational cultures, structures and clinicians beliefs about cause of mental health problems; beliefs about competences in assessing and managing risk and how it should be done. There was diversity among the varying circumstances in which risk management practice was required. Different settings required information about different types of risk and varying time frames for prediction of the relevant behaviour. Within the settings there were different world-views, which affected not only how clinicians perceive risks but also affected what they consider to be legitimate risk management solutions. There were therefore examples of different “safety culture” within and across settings. Consequently there were several cultures making it a challenge to develop a single culture of safety.

Each of the units had a specific bias towards one of four different ways of perceiving and managing risk. Like all organisations, all the examples were

dynamic, adapting and evolving. As a result they were at times substantially different in cultural bias during the course of the study. Despite the differences in the nature of the settings, contextual factors have impacted upon them in similar ways. The study suggests that the extent of coherence in a safety cultures and norms that underpin their mission and goals, procedures and policies may be an adaptive response to environmental and task demands on the system. The centrality of risk assessment and risk management has led to the units developing new ways of categorising, classifying, thinking and acting about their interventions. Clinicians face the possibility of having their units besieged by both externally developed risk criteria and the sheer volume of knowledge work. There was insecurity because of internal and external demands for knowledge; a continuous feeling of having insufficient knowledge and a reflexive awareness those errors can be corrected through better communication rules, formats and adequate risk management techniques.

In the terms of arena concept, there were many factors including social, political, legal, historical perspectives and nursing ideology, which impacted on risk management within the settings. These factors were important in conditioning structures that underpin discourses and practice in daily life, recurrent practices, attitudes, values and taken-for-granted knowledge in the organisations. At the macro-level was the role of the state and aspect of the legal system; the micro-level was the procedures, guidelines, the structure and the nature of patients. These factors had vital influences on clinical risk decisions. For example, policy initiatives such as the Care Programme Approach and the subsequent guidelines including those on the discharge of the mentally ill and the introduction of Supervision Registers seemed to have extended the boundaries of care and created a

climate of expectation regarding standards of care and the obligations of nurses in protecting the public from incidents. There were signs on all the settings that attitudes toward the increase use of litigation might be additional factor to risk calculations when managing patients. Field data from the units also reveal the influence exerted by the various external cultures that were imported into, and nurtured within, the units' cultures. The different patients' population also appeared to influence the risk management strategies of the units due to responsiveness to local patients' needs and expectations.

Production of risk management knowledge

External demands for risk knowledge and information are becoming central to nurses' work. The distinguishing feature on all the units is the reflexive monitoring of nurses' actions in an ongoing process concerned in every act of their work: "we check every thing we do" and incorporate the results of their actions to modify their behaviour (Beck 1992; Giddens 1990; Lash & Urry 1994). Whilst in the past knowledge was generated by nurses, now it involves the close interaction of many actors throughout the process of knowledge production. Growing awareness about the variety of ways in which decisions can affect the public has increased the number of groups that wish to influence the outcome of the clinical process. Nurses' work alongside various actors as reflected in the composition of the arena concept. Interviews revealed how accountability permeates the whole risk knowledge production: "in the definition of problems" and "response to legislation". An expanding number of interest groups are demanding representation in the setting of policy agenda as well as the subsequent decision making process. This increases the sensitivity of nurses to the broader implications of what they are doing; which

demonstrates that the issue on which risk decision is made cannot be answered in scientific and professional/technical terms alone.

The risk management processes has to incorporate options for the implementation of the solutions and are affected by the values and prejudices of different individuals and groups that have been seen as traditionally outside the professional arena. They have now become active agents in the definition and solution of problems as well as in the evaluation of performance. This is expressed partly in terms of the need for “greater accountability”, but it also means nurses themselves cannot function effectively without “reflecting” in their attempt to operate from the standpoint of all actors involved. My observation revealed that nurses were under increasing pressure to explain their policies to the rest of society and in certain instances revising aspects of their clinical activities in the light of new information and values (Pilisuk et. al 1996). Nurses were now not regarded as holders of privileged expert knowledge, while other actors within the arena were to be enlightened and educated. Professionals can no longer define risk knowledge; instead it has become enveloped by debates, accountability and reflexivity. The dynamics of these changes, point to continuing transformation of psychiatric nursing. At the core of this process is how risk knowledge is “constructed” and disseminated, in particular the contested nature of these “constructions” in relations to risk definition and risk perception.

The arena model shows the inevitability of the contested nature of “construction” as regards risk definition and risk perceptions. Uncertainty and unpredictability are inherent features of knowledge-based societies in a way in which they never were in the past (Beck et al 1994; Stehr 1994). In such a context symbolic power and political mobilisation assume great importance (Thompson

1995). The politicised reaction to scientific and medical power creates major arenas of conflict and struggle, in which concepts are contested. All actors within the arena have their perceptions with respect to truth, objectivity and certainty of knowledge. Knowledge about risk is mediated and as such dependent on interpretation. The ontology of risk therefore does not give privilege to any specific form of knowledge. The unavoidability of interpretation makes risks considerably flexible and therefore opens to social definition and construction (Beck 1992). “The pervasiveness of mediation, the high level of indeterminacy and the inevitability of political involvement mean that there is no one truth, that there are no facts outside the relativising influence of interpretations based on context, position, perspective, interest, and the power to define and colour interpretation.” (Adam & van Loon 2000 p4). Here knowledge is seen as principally embodied, contextual and positional, that is to say all actors engage in situated knowledge (Haraway 1988).

Paper Burden

The everyday reality of nurses on all the units is the reporting and accounting for events which has resulted in being “saddled with paperwork.” Although this view is not universal, it was a feeling many nurses experienced. Regardless of the type of incident nurses dealt with they were required to provide knowledge about it. The total amount of time spent in “doing paper work” generated frustration on some respondents inability to be with patients. The perceived burden of paperwork led to some nurses avoiding reporting some incidents. Other respondents took issue with the complaints arguing that paperwork was an important component of nursing. A component of the “problem of paperwork” is illustrated in policy manuals and guidelines that explain the rules governing reporting structures. On the subject of risk management procedures the guidelines articulated the structure of reporting and

provided a communicative framework for action. The rigorous attempts to format communication in clinical interventions potentially enabled nurses to prospectively decide whether a particular intervention fits the established format in terms of risk management terms, in order to intervene. In almost all organisation events (incidents and accidents) the initial reaction was to find out whether a form was available to cover it. The perceived increase in paper work was attributed to a pervasive climate of accountability in the wider culture. All professions including nurses are under increasing obligation to explain their activities. Interviews and observations offered examples of how accountability demands are increasing and leading to rigid communication rules and formats.

The effects resulting from the move towards a more standardised approach to the assessment and management of risk clearly signifies a major change in the nature of clinical practice and there were concerns about the overall impact of these changes on their professional status. The concerns were over the possibility that the formalised approach to risk assessment would ultimately lead to limits being placed on their freedom to make professional judgements. Some nurses felt that their “discretionary role, the ability to think and make judgements” has been diminished to merely obtaining information and documenting it on a standardised form. However, this observation tended to come from senior nurses whose approach to risk assessment was determined by “intuition”, “personal experience”, “gut reaction” and “subjectivity”. Junior nurses in contrast felt that the move towards a more standardised risk assessment approach helped them to reflect on their work. The resistance to the standardised approach was met by deciding not to “fill in forms” or because “it was a waste of time”.

Although reporting and accounting for accidents were largely the result of internal institutional sources, they were also a respond to external demands. Risk knowledge requirements of external institutions are important source of paper work. The accountability by the wider culture means that nurses are under increased pressure to explain their activities. To meet such demands nurse must continually develop and improve the formats for communicating the logic and rules of their actions. For example, the introduction of the Care Programme Approach has resulted in guidelines relevant to the notion of care which are being used by courts to guide their judgments and behaviour of professionals. These guidelines effectively contain baseline service specification, which is viewed as representing the standard for good practice. So patients are entered into an explicit programme of care, be allocated a key worker and they must receive the complexity and quality of service appropriate to their assessed level of needs. This requires the highest standards of documentation and interprofessional communication, as a court considering a civil action may need the guidelines. The guidance accompanying the introduction of the Supervision Registers hold professionals responsible for taking all reasonable steps to remaining in contact with a patient who has been judged to be at risk, in certain circumstances, regardless of their consent. This also requires highest standard of documentation and liaison with external agencies. These developments extend the boundaries of duty of care.

While paperwork is largely created by external sources, it also a product of how nurses themselves demand knowledge. In responding to external demand for greater accountability, nurses create new kinds of accountability, as well as an overproduction of knowledge. Nurses I interviewed indicated that the internal demands for accountability were intensifying. The intensification of accountability

demands were illustrated in the prescriptive communication rules observed during the fieldwork. There were examples of new reporting requirements regarding clinical practices, such as forms for checking handovers, forms for reporting on dealings with families and internal auditing systems through which communication rules were developed. Complaints about nursing care led to new forms that offer standard accountability devices through which “procedures are seen to be followed properly”. The reporting systems were used to manage communication in major accidents/incidents, to ensure overall communication efficiency in the organisation. The engagement of methodical reviewing of particular types of critical incidents provides communication rules that have the intention of making nurses highly reflexive with respect to risks involved in care and making the units appear accountable.

The new forms of accountability were seen by respondents as a result of external pressures, (patients, interest groups, policy directions) which require them to design knowledge to suit their purposes. Nurses see no end to the obsession of demand for information as “nursing move into the community”, “interest groups and the media become more vocal” and “legislation increased”. Responding to the external pressures led to “yet more creation of knowledge that we used to cover our backs”. There was a feeling among respondent that keeping detail and accurate reports was important “just in case one has to explain at a future date”. My fieldwork recorded the fixation with detail and the propensity to have several documentations of the same things in different filing systems on all the settings. Some nurses ascribed this fixation as “the climate in which we are practicing”, “fear”, and “lack of trust”. The preoccupation with documentation led sometimes to panic measures such as re-writing reports if something goes wrong or altering

reports: this came in the form of back-dating entries to appear as if they have been written before incidents to justify the risk management plans. The paradoxical result may well be that as more energy is spent on documentation, organisational activities begin to adapt to simplifying tendencies to “what counts” leading to failure of risk management strategies.

Organisational Errors

A common reaction on all the settings after organisational events (accidents/incidents) is to start looking for someone to blame. Almost all errors were reacted to as anomalies for which the solution is to search for and blame an individual. Virtually all the clinicians knew the horrible realisation of making a mistake: “you feel singled out and exposed” “you agonise about what to do whether to tell anyone”. There was no room for discussion and when mistakes are discussed, it is the examination of the clinical facts rather than the feelings of the clinician. In the absence of mechanisms for creating a safe environment for nurses to talk about their mistakes, they find dysfunctional ways to protect themselves. Here the focus on errors and procedural violations is placed on nurses at the sharp end. This “person approach” approach (Reason 2000) views unsafe practices as result largely from anomalous mental processes such as negligence, carelessness, poor motivation and recklessness. Logically the related countermeasures are directed mainly at preventing unwanted unpredictability in human behaviour. The countermeasures as observed include writing another procedures or adding to existing ones, naming and shaming, blaming, retraining and threat of litigation.

Analyses of the process of error production on the units show that error has multiple sources. Some of these sources lie in the individual characteristics of nurses so we cannot eliminate the role of the individual nurse in the error

production. Examples of errors found during the study were, loss of coherence in care plans that occurs during handovers, loss of information between agencies. Errors also occurred when nurses had to divide their attention between too many patients. There was also failure to follow guidelines. In some instances this failure was unintentional and could be corrected by training. However, it appears in many cases nurses failure to report was deliberate. From interviews and observation, it appears nurses deliberately decide not to report incidents because of:

- the shame associated with informing on fellow professionals, especially if they will be blamed for the incident and punished. Reporting the incident is also likely to create enmities between informer and co-professionals.
- self-protection, that is, to avoid being blamed by management for contributing to the occurrence of the incident and suffering the adverse consequence of blame.
- the consequences, these include, disciplinary action, job demotion or termination, damaging comments in employment record and subsequent impediments to employment elsewhere and in some cases personal liability.

As nurses require certain autonomy, it implies that nurses must account for their actions and responsibilities. However, the person approach has serious limitations and is not adequate for the clinical arena. Several factors are implicated in error production; examples are the use of agency nurses not trained in risk management techniques and limited time available to arrive at a definitive diagnosis. Within the arena concept, errors are seen as having their origins in both human nature and organisational and societal processes. More detailed exploration of events revealed multiple gaps (discontinuities care) a result from effects of organisational and technological change. Factors that increased the likelihood of

errors included environmental conditions such as communication and patient related issues (complexity of illness, language and communication, personality and social factors), or undiagnosed conditions. Analysis after accidents/incidents pointed to complexity of chain of events that may have led to an adverse outcome. Some of the root causes of adverse clinical events appeared to lay in factors such as use of, for example, agency nurses, communication and supervision problems, excessive workload and educational and training deficiencies.

The merit of the arena model is that in looking at accountability, we must not only concentrate on professionals and their characteristics, but also to analyse how they interact with external conditions in which clinical intervention is placed. Event analyses on the units, just like catastrophic events such as the Challenger accident and recent accidents in the railways are all marked by the intricate interaction of many different actors and factors, often far removed in time and space from the moment and place of the event itself. Allocating accountability for actions, which have their effect through the mediation of a complex system, the functioning of which is outside nurses' control to a greater or lesser extent is problematic. Accountability cannot be considered strictly on the individual level, but has to be considered in terms of co-accountability. However, it appears, management has incentives to blame professionals who report an incident, (namely to shift accountability and possibly liability onto them) and often conclude that an incident was caused by human error, deliberately ignoring deeper issues. Because all members of the units were susceptible to error and vulnerable to its consequences, they have less latitude to deal with their mistakes. Ironically, this approach diverted attention from the kind of systematic improvements that could decrease errors. But if we accept the notion that the various arenas (societal, institutional and service)

contribute to safety; then errors by each of the actors may influence events, namely active error (often by the clinician) might be only one link in a sequence of latent errors.

Organisational Learning

Reporting is fundamental to the broad goal of error. Hence, barriers to or breakdowns of information flow as evident within the units must be considered as most dangerous threat to organisational learning (Argyris & Schoen 1978). An example of a barrier is the impact of perceived threats to an individual or an organisation becoming involved in litigation. Shame, blame and liability discouraged nurses reporting incidents. The complex legal context and the current litigious nature of British society and the expectation that mistakes lead to compensation are now widespread. Fear of being sued dictates a large range of nursing interventions. Litigation avoidance strategies dominate the clinical practice in forms that intensify the sense of suspicion in relationships such as nurse/patient and nurse/society. Nurses are adding additional factor to their risk calculations when managing patients; namely the assessment of civil action to themselves in the event of untoward incident. This may be leading to defensive practices in the overcautious surveillance by nurses as illustrated in what has been termed “walls of paper” - a new form of institutionalisation.

Public and regulatory reactions to information, external investigation and media coverage, which follow disasters, often create concerns about reporting incidents. The fear of being sued interferes with the willingness of professionals to report incidents. In addition, organisational culture opposes certain types of incident reporting; despite policy statements and procedures. Nurses found that incident reports which fault the organisation or managers are “unwelcome” and “damaging

to their prospects within their organisation". The approach to event analysis is strongly associated with fixing blame. Here, the objective is to find at least one party who can be found to have broken the duty of care. The purpose of investigation after an incident is to uncover stages in the chain of events leading to the point at duty of care was breached. There is little analysis of the system's causes of error and the information is rarely used to warn others about the potential for similar errors. Build into this approach is the threat for those at "whom the finger may finally point". There is a natural tendency for any nurse faced with such a prospect to "be reticent" to "limit themselves to statements which do not damage their position" to "act defensively" and to "put the best gloss on their description of events". This helps break the organisational learning cycle (March & Olson 1975) where nurses act in ways that are contradictory to their learning and insight.

The above observation suggests that accidents should be regarded as valuable opportunities for learning. It is an opportunity to learn how the shortcomings and gaps were managed, by examining the whole safety management system to cover as many other sequences as possible, which have led to the same or other serious consequences. It is a shared search for opportunities for improvement, which does not need to wait for actual disasters and thus pays attention to near misses, with the added advantage that they will be stopped before it results in severe damage. At the time of writing a new organisation (which will shortly begin to implement as system across England and Wales) within the NHS, the National Patient Safety Agency has been formed with a brief to learn from adverse events and act to prevent them happening and to promote a more open and fair culture, one in which staff who report incidents are valued and not denigrated. This involves creating a more risk-aware culture and sharing lessons that have been learnt from incidents. An

organisation learns if through its event analysis, the range of potential behaviours changed (Huber 1991). Thus organisational learning requires that event analysis traces the causal factors and determinants of an event further back into the past and further up the chain of management control; at each step asking whether actors responsible for nurses, rules and procedures, communication and organisational structure had taken suitable decisions to supervise, monitor and improve them.

The above analysis shows that a non-punitive and confidential voluntary reporting may provide more useful information about errors and their causes than mandatory reporting observed during the study. Mandatory reporting implies that the individual at fault must report the error. Yet my analysis of serious errors almost always reveals multiple systems failures and the involvement of many individuals. Voluntary reporting may provide frontline practitioners with the opportunity to tell the complete story without fear of retribution. The depth of information contained in these stories is key to understanding errors. Interviews and observations reveal that because nurses are forced to report errors “they were reluctant” to provide comprehensive information because their primary motivation “is self protection”. However voluntary a reporting programme is, on its own, it is inadequate in the absence of a strong well-designed system for analysis. The analysis shows that to improve safety, reporting must be accompanied by effective organisational changes. All the evidence suggests that reporting will occur only if nurses feel safe doing so and it becomes a culturally accepted activity.

Organisational identity and space of action

Risk control was a central aspect of risk assessment and its management involved a variety of different strategies illustrated in risk avoidance and risk sharing. The increasing awareness of risk and the uncertainty in decision making led

to situations where “it is best not to take a new risk unless its outcome can be understood in advance” This approach “the precautionary principle”, to risk management was characterised by risk avoidance and low tolerance of errors. The consequences resulting from the precautionary principle that is, operating on “what if” basis appear to prevent nurses from “experimentation” and resulted in “limits being placed on our freedom to make professional judgement.” While the “what if” approach “offered security and safety”, “it lowered expectations and change.” However there was the recognition that psychiatric nursing by definition is “a risky business within which total avoidance of risk was not an option” and the fact that “any avoidance carries its own risk.” Nurses interviewed clearly expressed concerns that the prominence of risk management strategies distracts them from their organisational role. The ubiquity of this concern and the resentment of their expression suggest that risk management strategies are part of a background set of experiences within which they articulate their sense of who they are and what they do in the clinical context (Whetten & Godfrey 1998).

Nurses articulated their concerns about the move towards centrally determined “prescriptive practice”, the “increased importance attached to assessing risk and protecting the public”, “the emphasis upon individual accountability” “the prominence upon punishment and “the decrease in the importance of understanding the social context of care”. Nurses interpreted the emphasis on risk management strategies as “crisis of identity”. Namely that some of the changes were in fundamental conflict with nursing values, that they have shifted the delicate balance of care and control, giving too much emphasis to controlling /security functions and therefore were in fundamental conflict with nursing values. In my view the changes created the situation in which aspects of nurses’ identity was relinquished,

provoking feelings of anxiety and fear in the process. The impact of risk management discourse seemed to threaten the very meaning of nurses' work. In consequence there was regression into a dependency and flight mode (Bion 1961).

Dependency mode manifested itself in the reassertion of professionalism and traditions. A significant number of nurses preserved their "professionalism" by concealing, downplaying and displacing risks. Because of the "blame culture that dominated our practice" nurses failed to regard aspects of potential risks thus giving contradicting message to the espoused "safety culture." In other instances, where nurses felt "threatened" and "insecure" they share risk by over stating the perceive risks, displacing the risk onto relatives and transferring patients to other institutions. There was also selective implementation of policy, because policy was perceived to be "vague" or "open to interpretation". In the absence of "clarity" nurses resorted to prevailing values namely professionalism. Fight behaviour, was characterised by a displacement of anger by blaming and scapegoating others for what is happening. Nurses exhibited a great deal of irritability and bitterness; these emotions were directed not toward their own organisations and practices, but toward "others" who might be to blame. Patients and their relatives, the government and society in general typically fall into that category. Extrapolating the conceptualisations derived from theories on mourning (Bowlby 1980) show that letting go of "old ways" of doing things are both cognitive and emotional processes. The perceived changes in nurses' work engendered a state of turmoil, with the anxiety level rising sometimes to the point of panic. Anxiety associated with uncertainty of engaging in something new often prompts nurses to resist change. In an effort to reduce such anxiety, nurses in the study allow avoidance behaviour.

Risk management techniques do not operate in way as to inevitably or deterministically produce passive subjects. This would be to deny the agency of individual nurses. Rather, the introduction of risk management occurs in a contested manner. The reaction of nurses depended on whether they perceived themselves as controlling or using organisational changes to improve their own position or that of their clinical work, or as being controlled by them. Identity theories remind us that fundamental changes (for example, external attempts to bring about radical change) in people's interpretative schemes is threatening not only because it may affect their sense of self-esteem but also disrupts people's need for identity consistency and continuity (Hogg M A & Terry D J 2000).

Organisations as sensemaking communities

The analysis suggests that in risk decision making nurses make sense of what is happening in the organisational environment in order to develop a shared interpretation that can serve as a context for organisational action (Weick 1995) and through that enacting their social world (Berger & Luckmann 1966; Bitner 1974). This assumes that risk assessment and risk management mechanisms are mediated through social relations thus challenging its universality. This assumes that the concepts of risk assessment and risk management may have different and cultural contexts. It is possible that risk decision makers act according to rules that are socially and professionally acceptable rather than depending on a standardised framework. From the study it was evident that problems of decision making were concerned about how to justify and argue for certain decisions as well as making the decision itself. Variables such as problem framing, organisational control systems, social influences, organisation's cultural risks values and problem domain; familiarity influence risk decision making see Fig 5.

Fig 5: Factors That Affect the Decision Context

Professional Characteristics	Experience, Knowledge, Preferences, Biases, Heuristics, Professional identity
Organisational Variables	Values, Structure, Communication System, Group Involvement in decision making
Social Influences	Social value on risk taking, Government Legislation, Policy and Guidelines, External groups
Problem Formulation	Complexity, Ambiguity, Unpredictability, Controllability, Outcomes

Professional characteristics: More experienced professionals tend to be selective on the evidence of their past actions (March & Shopira 1987) and therefore take risks that less experience professionals avoid. Individuals also exhibit habitual and routine ways of handling risk situations that influence them to react in predictable ways (Douglas 1985; Douglas & Wildavsky 1982; Perrow 1984).

Organisational variables: Taking risks depend on whether the outcome is rewarded, punished, encouraged or discouraged (Ouchi 1977). Other influences are the composition of the group with which risk-related decisions are made (Janis 1972) and the organisation's cultural risk values that determine the tendencies to prefer certainty versus uncertainty or risk seeking or risk avoidance (Douglas & Wildavsky 1982).

Social influences: Psychiatric nursing is integrative part of societal reality (Willshire 1999). Professionals' perceptions of risk as with other assessment of organisational context are influenced by societal factors. External pressures affect the decision context by modelling how risky situations are handle. Professionals view their world through the lens of social pressures that tend to distort their perceptions of situational risks sometimes by overemphasising or underemphasizing risk (Douglas & Widavsky 1982).

Problem Formulation: Risk decision making is largely artefacts of the particular assumptions and arguments of the scientific models used. Different assumptions made by various professionals lead to different probabilistic risk assessment. There is no certainty in assessing and managing risk because the modelling of clinical risk problem, that is the assumptions upon which such modelling is based, and the guidelines used, are all judgemental (Freudenburg 1996; Kunreuther & Slovic 1996). In finding solutions for problems nurses assess how safe is the solution adopted (that whether all the facts are known), if the solution is safe enough (questions about professional values) and whether they are overlooking some important factors (whether they can defend the interventions) (Freudenburg 1996).

Professional Identity: professional identity refers to the nurse's conception of what it means to be and act as a nurse. That is, it represents his/her philosophy of nursing, as such, it serve as a basic frame of reference in the nurse's reflection and enactment in nursing practice influencing what are seen as relevant problems. The motivation for maintaining a constant and stable sense of self in the face of potential change tends to lead to resistance. Change threatens the fundamentally held beliefs of a group (Huy 1999). In this sense, resistance arises from the positioning nurses as subjects within an alternative, nursing professional discourse. For many nurses acceptance of risk management practices as legitimately controlling healthcare delivery represents a betrayal of professional identity. Reaction to the changes can be characterised as resistance to the alternative construction of professional identity.

In sum, the world of psychiatric nurses is influence by pressures which have led to the development of communication systems so as to promote certainty in decisions in dealing with demands of external institutions. Procedures, rules,

CHAPTER SIX

MAKING SENSE OF RISK MANGEMENT

If we start by recognising that instability lies at the heart of the world, then we may come to realise that the optimism and the assertion of certainty, which enables life to create and spread order, cannot completely overcome this instability. We may come to realise that, even when strategies are successful, they are still dependent upon the munificence of the environment and upon the mutability of fortune (Turner 1978 p.201)

What are we to make of our findings in terms of risk management in psychiatric nursing? The study has attempted to introduce evidence to suggest the prominence of risk management strategies in healthcare settings, which it has been argued are associated with significant changes in working conditions. Simultaneously, the evidence presented has pointed to a range of individual and organisational responses and an uncertain link between espoused theory and theory in use. In observing organisational practices, I find that different groups and individuals appear to draw on risk management concept in their own particular ways to shape their approach to their work. "Risk is manufactured, not only through the application of technologies, but also in the making of sense and by the technological sensibility of potential harm, danger or threat (Adam & van Loon 2000 p2)". This suggests that there are many realisations of risk management and by implication a loose connection between risk management concepts and the way these are enacted in organisations. Thus risk management is at the same time "real" a given entity in the organisational domain and constituted "social construction" the making of sense in the ways respondents have chosen to construe various aspects of these constructs. I therefore conceive risk management as a phenomenon that is created through discourses emergent from a collectively sustained and continually negotiated in the

formats and guidelines represented what the organisations perform. The pressure for knowledge of how risks are assessed and managed and the need for accountability is leading nurses to widen their internal communication systems to protect them against litigation, threats to job security and challenges to professional status. The communication systems establish the criteria through which nurses understand and articulate their preferred courses of action and as such can be regarded as the focus for an organisation's selection definition of risks. It is important however to note that the effect of external pressures are mediated by the elaboration of internal rules so that both the internal and external rules become embedded in the categorizations the nurses use to report their activities. The main insight in the analysis shows that risk is not an objective aspect of the environment of the settings that can be assessed and managed. This suggests that risk is socially selected and continually created by actors who take decisions in relation to external circumstances and events (Luhmann 1993). From this angle, risk does not exist independently from the actors involved in risk taking, rather attitudes to risk as well as methods of dealing with it, vary between and within groups.

process of making sense (Strauss et al 1976). Sense making in this context refers to those processes of interpretation and meaning production whereby individual and groups think about and interpret risk management (Weick 1995).

Double Binds/Paradoxes

There were good reasons to suggest that situations occur in all the settings where respondents felt they were receiving mixed messages, expressed by many as “catch 22 situation” (Bateson 1978). Laing’s (1971 p.1) insightful words captured this observation: “They are playing a game. They are playing at not playing a game. If I show them I see they are, I shall break the rules and they will punish me. I must play their game, of not seeing the game.” The art of developing and handling interdependency in terms of assessing and managing risk sometimes placed nurses in a double-bind situation. Some common examples of mixed messages that confronted professionals in the case studies are illustrated in Fig. 6.

Fig. 6 Paradoxes in Organisational Life

Espoused Policy	What Counted
Take risk Report mistakes Use your professional judgements Talk through your feelings	Safety is of utmost importance You will be punished if you make mistakes Stick to the guidelines Resist public confession

Espoused policies represented positive values in an organisation and managerial context: they were in terms of risk management techniques what should happen. In spite of the espoused policy nurses were aware of what was worth doing (what counted) and were rewarded (increased status) or punished (blame, shame, reprimands). Risk assessment and risk management mechanisms led to paradoxical discoveries, for example, with all the insistence on guidelines, workshops,

appointments of risk managers, nurses learned that it paid to remain just as they were before – business as usual. Thus nurses failed to report accidents or underplayed their significance as a defensive response to the blame culture that governed their working lives which was at odds with the safety culture. In what Gouldner (1954) termed “mock bureaucracy” there were rules that nurses ignored.

Discourse surrounding risk assessment and risk management was often perceived by nurses as “hot air” that was not followed by actions and therefore a “total waste of time” (Gergen & Whitney 1996). In addition, risk management was seen as creating a different reality for different audiences. So that the representations disseminated within the organisations were not necessarily those shared within or between members of the organisations but became symbols to pursue in order to satisfy the other actors in the arena. Therefore organisations have to be seen to be adopting new risk management techniques to demonstrate their legitimacy and rationality to significant others in the environment (Meyer & Rowan 1977). “Playing the game” resulted in organisational politicking, power games and protection of careers: it led nurses to present themselves in favourable light by buying into risk management discourse (Goffman 1959) because they felt “threatened” and “insecure”. The following quote from a nurse is apposite:

Risk now embraces everything we do. We have risk audits schemes and risk working groups. We even have risk officers building up little empires to justify their positions. To survive you have to join the flow.

The analysis shows that nurses have a special role as interpreters of their organisations, and in so doing become powerful senders of messages. This implies that knowledge development processes could be considered as an essential part of organisations as social systems and in that respect part of organisations’ dynamics and their ability to develop. It is from such processes that social reality (Berger &

Luckmann 1967) - culture(s) are shaped and reshaped. In the cases studies, new meanings and social patterns emerged as members struggled to make sense of and cope with risk management techniques. There were conflict and disagreement between different subgroups about why and how to handle risk decisions. These contradictions were also embedded in different viewpoints and insights, which were engendered because nurses have different vantage points in the organisational arena (Braten 1987). The multidisciplinary nature of their work (the participation in different subcultures) also internalised contradictions in individual members. In a sense the “social reality” is a dynamic phenomenon characterised by different contradictions and tensions in perspectives. It is the dialogue of different perspectives that creates the dynamics in which new meaning emerge. Here meaning is seen to occur in the dialogue of viewpoints in and between individuals within the *reality* they initiate and in which they exist.

Following Eisenberg and Goodall (1993) healthcare organisations can be described as dialogical entities namely that they are made up of an array of discourses with a variety of meanings which are brought about because participants expressions are intertextually shaped by prior texts that also anticipate subsequent ones (Bakhtin 1986). Such an observation reminds us that risk management ideology is not the only important phenomenon underpinning discourse and practice; and that we can never achieve identity or conceptual purity. In the healthcare context, nursing ideologies, views about the epistemological character of disciplines, attitudes values, taken-for-granted knowledge as well as external pressures are equally important. The actions and behaviours of an individual nurse may be conditioned but not determined by a particular arrangement of these forces as they play out in a given context. For instance structural changes that are imposed

on a social system by external events may often change the setting and premises for old rituals and invalidate the old meaning in the process (Geertz 1974). A combination of forces may prompt individuals either to adopt risk management discursive repertoires in ways, which may well be transparent to them or may be trapped in double bind situations. The first assumption may happen if the forces ideologically support nursing discourse. On the other hand, those who feel trapped by double binds (confronted with mixed signals generated forces) could find themselves in discursive negotiation; displacement, contest, creative behaviour and confrontation that may affect the ability to learn from experience and correct errors.

Examples of discursive negotiation, opposition and reconstruction of risk knowledge and practice were evident within the settings. Aspects of nursing interventions aligned with risk management discourse, here, risk analysis was seen as giving better information for decision making and valuable in improving safety. This was illustrated in two ways: first the centrality of care in the case studies was seen as the primary rationale namely to initiate successful treatment outcomes with minimum harm and errors. Second, for most nurses many of the suggestions that flow from risk management discourse were what Perrow (1987) termed “motherhood items” and therefore difficult to argue against. In contrast, there were concerns about patient participation in and ownership of care plans and by implications empowerment of patients that challenged the risk management techniques. Nurses took control through effective strategies of resistance by “ignoring guidelines”, “concealing accidents/incidents,” and “exaggerating organisation events.” This disregard appeared deliberate – claiming professional reasons or pointing out the unpredictability of psychiatric illness. These challenges to risk management discourse are developed by the interaction and combination of

nursing ideology with other structural features such as experience of nurses, treatment disagreements, unclear task and societal demands for care of the mentally ill.

These dynamics support the relevance of the arena concept that clinical activity comprised of social context, - social interaction as well as discursive production - within which multiple communities of practice form and find coherence. Using the metaphor of an arena, conflicts in interpretation of risk can be described as a struggle between various actors on the arena stage. Categorising discourses on risk requires careful planning, thoughtful preparation and flexibility to change procedures on the demand of the affected constituencies. Clinical activity from this stance needs a structure that ensures the integration of clinical expertise, regulatory requirements and public values. The combination of these different inputs contributes to the deliberation process as regards the type of expertise and knowledge that claim legitimacy within a rational decision making procedure (Renn1998). Risk management knowledge is a result of complex and intricate work by the various actors constituting an arena network. From the analysis, an organisation's stance on risk management practice is the outcome of dialogue among the perspectives adopted by the various actors: a dialogue that reflects distribution of power and influence that determines the quality of the action taken (Gheradi & Nicolini 2000).

Clinical Implications

The descriptions of the cultural assumptions in the four settings provide evidence that there are problems in developing clinical guidelines for risk management practice. There is huge diversity among varying circumstances in which judgement of risk management may be required. In addition there are

important logistic limitations in making these judgements within a clinical and organisational context (Borum 1996). Different settings because of their different culture and the type of patients may require information about different types of risk, or have changing time frames for prediction of the relevant behaviour. This leads to diverse risk management tasks and thus the requirement of varied types of decisions and their critical action thresholds. While optimal assessment practices may be reached by consensus, the demand in certain clinical situations may need decisions to be made with a degree of immediacy that would limit the comprehensiveness of an examination. The jostling of interests among organisational stakeholders, bargaining and negotiation between groups and individuals and lack of information makes decision making uncertain. This uncertainty complicates and curtails the ability of nurses to predict the evolution and outcome of patients' medical conditions and the results of nursing interventions taken on their behalf.

What additional insights do we gain if we look at how the techniques of risk management deal with uncertainties and indeterminacies of professionals' interactions within the settings? There are three assumptions that formal risk management can be perceived, predicted and controlled. First, is the sense in which in risk management practice causation is considered as a linear and mechanistic phenomenon. It is evident in the study that there are difficulties with definition of risk, with the location of acceptability criteria and with the interpretation that is placed on the outcomes of risk management (Pidgeon 1988). The incompleteness dilemma uncovered by the analysis portrays the practice of risk management with an additional difficult paradox: a nurse can never know completely what he/she does not know. Nurses do not always make correct judgements about clinical risk

but fall prey to biases (Shrader-Frechette 1998): they often follow intuition in ways in which patients are defined as “at risk” and posing threat to themselves or others. This illustrates the hermeneutic dimension of risk responses, which is apparent from background assumptions, self-interpretation and interpretation of clinical activities (Lash 1993). Responses to risk may therefore not necessarily take place on a rational or conscious level. The findings show that risk-related practices includes both activities that needed high levels of problematisation (using guidelines and models) but also practices that are experienced as second nature to nurses. The above observation reveals the habitual and acculturated nature of risk-related actions (Bourdieu 1984).

There is an important issue here relating to the use of expertise and knowledge as illustrated in the – lay assessments of risk as irrational or ignorant versus experts as rational - controversies over risk management strategies. Wayne (1989; 1996) has countered the disparagement of lay assessments of risk as “ignorant” or “irrational” by experts bodies by arguing the extent to which scientific knowledge is itself formulaic and contextual. Other work on the public’s perception of risks as discussed above showed that the public had a rich notion of risks which took into account values and qualitative factors while experts typically focused on technical dimensions of risks (Slovic 1992). This shows that both “experts” and lay-peoples’ perceptions of risks may be mistaken because of their use of mental shortcuts or psychological heuristics and biases. There were instances where the use of “expertise” – risk identification, analysis and management – compounded the problem because of the high ambiguity that surrounded available scientific evidence. Here the problem can be considered to be trans-scientific, namely that it goes beyond the ability of science to prove (Smith 1990) so that the use of expertise

within the decision making process may be limiting. The recognition that public concerns about risk are equally valid suggests a broader notion of rationality and the need to incorporate all views in risk-related decision making. Integrating viewpoints may help resolve risk-related conflicts (the politics of knowledge in which different actors continually compete over risk definition) because it may build trust between actors with different perspectives on risk management (Pildes & Sunstein 1995).

The approach to risk management that assumes a linear model also tends to ignore the role played by power relations. If we accept that the concept of risk mediates between knowledge and power, then risk management is primarily a specialised language and set of practices (Foucault 1972). The decision to frame clinical problems in terms of risk, for example, rules out other possible ways of talking about harms to patients. Assessing and managing risk implicitly empower nurses as “experts” and excludes other actors in the arena as inarticulate, irrelevant or incompetent (Jasanoff 1999). The designation of the label “at risk” often serves to reinforce the marginalized status of actors. The labelling of certain patients as at “at risk” positioned them as vulnerable, passive, powerless or as particularly dangerous to themselves or others and therefore needing intervention, monitoring and surveillance. In terms of individual perception of risk, the attitude nurses held to their practice, their experiences, the culture of their organisations tended to influence their approaches towards risk. Nurses ignored, overplayed and downplayed certain risk situations thus individualising the risk they were routinely exposed to in their practices (Nelkin & Brown 1984). Actors’ social location and their access to social resources are integral to the ways in which they conceptualise and deal with risk (Renn1998). Rather than acting as independent agents to the risks they perceive, they act as members of social groups and social networks.

A second issue in this connection is the notion that risk originates in the inanimate world even though human behaviour as we have seen can aggravate its intensity. Attributing risk to inanimate objects in general increases the sense of control and social order (Jasanoff 1999). In the words of Jasanoff (1999 p.143) "it is easier, after all, to manage things than people, even when it is known that people are part of the problem." There are complicated ways in which the physical and human elements of organisational systems interact to produce risky conditions and periodic disasters (Clarke 1989; Perrow 1984; Turner 1978). There was evidence of active failures (unsafe acts and omissions) by nurses during risk-related activities in the forms of lapses through misreading a situation and deviations from safe operating practices, procedures or standards. Incidents/accidents resulted from fallible managerial and institutional decisions (latent failures) such as heavy workloads, ineffective knowledge and experience, defective supervision and inadequate communication system. These were factors that influence staff performance with the potential to precipitate errors and affect patient outcome. Thus no single vehicle is necessarily to blame for accidents/incidents; responsibility is distributed through a political and cultural system that kept professionals unaware of the decisions full complexity and therefore ignorant of all the possible scenarios at which decisions could fail (Vaughan 1996).

The third observation about formal risk management is the nature of uncertainty and social perceptions of it. Although the findings reveal that risk management is important and powerful in its ability to conceptualise uncertainty it also gives rise to some well-founded concerns. What emerges from the study is the socially embedded character of much of that professionals do not know, as much as what they claim they know about mental illness. In the words of a respondent:

“Despite all the advances of psychiatric carethe guidelines, policies, targets, audits, evidence-based practice we are not getting better at prediction.” The relationships between scientific inputs (guidelines, models, procedures) and successful decision making were not always a positive one. This was because of the high degree of uncertainty in clinical interventions. In risk management debates, the resolution of issues for potentially “risky” activities appeared to be the function of power of various actors in the debates rather than the quality of the scientific point of views articulated by them. This perspective provokes some important questions about the nature of decision making for risky activities. For example to what extent should technical expertise be given precedence over other inputs into decision making in interventions of high uncertainty? How do different views within the main body of expertise become integrated into the clinical making process? Other issues are the extent to which the decision making takes account of uncertainty when developing policies, procedures, and guidelines for the control of potentially risky decisions.

In addition to the above issues is the need to take into account the role of experts’ (nurses) cognitive schema and the limiting effect that may have in those debates where the issues are considered to be trans-scientific. So that while it may hold true to assume that in a well-defined problem with a unique solution “experts” may have sufficient insight into the nature of a problem to help them solve them, it may be a false assumption for those decisions in which the decisions are ill-defined. Under these conditions, it is possible that cognitive narrowing may take place as experts seek to interpret the problem within the rules of their own paradigm. Certain problems, however, may require a paradigm shift in order to cope with the demands of the issues raised and may, in turn, account for the lack of effective

communications between actors. This demonstrates that there is a political and cultural dimension to ways of thinking about uncertainty that may influence experts' approaches to grappling with the unknown. The challenge for nurses therefore is to be more open and humble in admitting their uncertainties about clinical interventions and to admit effectively that there are areas that science does not have the means to know (Wynne & Mayer 1993).

The dominant view of clinical decision making as a precise, certain and scientific practice is questionable. When clinicians make decisions they take a lot of clinical "facts" from a variety of sources about individual patients and often depend more on their sense of the situation than on general medical knowledge (Fogel 1980). This indicates that clinicians often compensate for uncertainty by drawing on commonsense understandings of the situation. Thus instead of following guidelines to explain clinical phenomenon, clinicians frequently renegotiate these guidelines. There is immense diversity among varying circumstances in which judgements may be required and as significant are the logistics limitations in making these judgements within a clinical or organisational context. As pointed out by Borum (1996 p.953) "Different settings may require information about different types of decisions of risk, or they may have varying time frames for prediction of relevant behaviour. Different risk assessment tasks require different types of decisions and vary in their critical action thresholds." Indeed, Shotter (1993) suggests that following a model is inadequate because in following rules people create, challenge, change, check and correct them as well. Similarly Berg (1992) in introducing the concept of "routines" observes that the decisions clinicians make routinely embody the safety norm and suggests that clinical practice does not always adhere to universal rules. To make a decision clinicians need a lot of different types of

information in order to build up a sufficient clinical picture; which leads to a degree of uncertainty about how to combine all the information available.

The prominence of risk analysis brings with it the potential to redefine the boundaries and relations between professionals and service users. Pressures to be more efficient coexist with standardising procedures and professional judgements that challenge notions of professional accountability and regulation (Pollit 1993). Furthermore there is blurring of role distinctions and demands for multi-professional collaboration and a rise in complex ethical issues that require interdisciplinary collaboration. The theme running through our analysis has been that clinical uncertainty characterises the experience of mental health professionals from several directions. Clinical uncertainty arises from the fact that professionals have limited and varying capacity to deal with information in other words, they are subject to bounded rationality - the assumption that all rational humans would take decisions to maximise their profit, or preferred advantage (Simon 1979). In practice perception would intervene between the decision maker and the 'objective' environment. Human perception is therefore a filter through which risks are viewed. Since not all the alternatives are known or reliably assessed, the decision maker would aim for a satisfactory rather than a maximum outcome when faced with a complex situation. This suggests that imperfect knowledge compels the decision maker to construct a simpler and more personalised model on which to act. Here the choice from a range of alternatives would be based on individual knowledge/experience; an experience which determines perceptions upon which the assessor respond to risk. Also there may be differences in the capacity of professionals due to varying competencies, resources and positions. The way professionals experience various kinds of uncertainty (risk aversion) may vary, as

does their evaluation of different combinations of stakes and probabilities. There is another ambiguity linked to risk analysis, that is, uncertainty concerning the evaluation of risk factors. How do practitioners know whether the outcome of their assessment and management of risk will be successful?

One potentially useful metaphor for describing the context of risk decision-making is that of organisational knowledge. Following Gherardi and Nicolini (2000b p.10) we can consider risk decision-making “as a form of organisational expertise, or in other words, a form of knowing that is sustained in the organisation by the interaction among various collective actors.” This cultural approach to organisational knowledge (Brown & Duguid 1991; Gherardi 1999; Weick 1991; Wenger 1998) enables us to explore the relationship between organising and knowing as a social and collective phenomenon and therefore cannot be seen as substances residing in the heads of members. Here knowledge is viewed as a form of distributed social expertise, in a sense, knowledge-in-practice situated in the historical and cultural context in which it occurs. From such a viewpoint, we can think of organisational knowledge as relational, situated in the systems of ongoing practices which is continually reproduced and negotiated, always rooted in a context of interaction and therefore always dynamic and provisional. To understand the social construction of risk decision-making, it will be useful to investigate how risk decisions techniques are enacted in work practices and also to examine the network of relations in practice among those who assess and manage risk.

The analysis suggests that powerful actors are in a position to shift the balance of risk discourse but equally it is possible for actors to employ sets of discursive repertoires that articulate and sustain completely different sets of assumptions. The study indicates that many nurses may be adopting the outside guise and language of

risk management techniques whilst continuing to practice as they have always done. In reacting to processes of risk assessment and risk management, respondents have sometimes accommodated, ignored or circumvented, (re)negotiated, mediated and moderated pressures to the effects of changes in their clinical practice. However the strength and significance of cultural change within the four settings must be recognised. Rosenthal et al (1997) remind us that systematic exposure to particular change discourses can have a considerable impact on attitudes and perceptions. Thus, in terms of risk assessment and risk management what is happening within the settings and perhaps in the healthcare systems is not just adoption of a fad that can elapse. The environment of clinical practice, along with the kind of knowledge that is valued is changing. With clinical practice embedded in wider social, economic and political values, there is no return to a romantic past.

In the context of the research it is clear that risk management concept is impinging into the domain of clinical practice – the significance of risk management, accountability, the need for negotiation, the need for open discussions of errors – all merit careful analysis. The sociological perspective suggests that perceptions and attitudes towards risks are shaped by the culture and worldviews shared by the social groups to which the individual belongs (Douglas 1992; Rayner 1992). There is ample evidence in the study, which demonstrates that risk assessments and risk management do not take place in a vacuum but are carried out in ways that are indissolubly linked to the social context. Nurses involved in the development of risk management strategies take these contexts into consideration as they make each initial selection of their clinical objectives that will guide their interventions. Clinical judgement does not therefore operate in an idealised form; often during the study it was drastically limited by the influence of other non-

clinical judgement (e.g. social and political factors). The meaning of risk management is the results of joint practices in an arena from the various cultural referents, artefacts, rules and constraints that derive inside or outside the formal boundaries of the organisation. This implies that all participants have an opportunity to influence the outcome of the decision making process. Organising and structuring discourses on risk entails careful planning and flexibility to change procedures on the demand of the affected constituencies in a word incorporating technical expertise, regulatory requirements and public values.

Risk management as culture and practice

How does the preceding discussion bear on the risks that are now confronting psychiatric patients? What are the challenges that face practitioners in defining risk that leads to intervention and accuracy of prediction of that risk? The discussion shows thus far that risk concepts are not simply neutral descriptions of our world, but are culturally and politically conditioned ways of interpreting our relationships to the world. What conclusions can we draw from what we have learned about the socially embedded character of risk assessment and risk management concepts that are currently being deployed to deal with people with mental health problems? There has been a tendency to take for granted that guidelines will resonate in the same way with all types of patients and in all contexts. Risk management, from this view, should present no challenges to practitioners: perceived difficulties are the development of commitment and the technical capacity to adhere to guidelines. The assumption is that practitioners will perceive clinical threats and challenges in the same way, particularly if they are shown how to intervene on scientific basis.

Our analysis suggests that attempts in developing risk assessment guidelines base entirely on “clinical judgement” are futile as risk is mainly determined by

social and cultural factors. The existence of separate cultural orientations means that the effectiveness of risk decision strategies will be dependent upon how well the information is integrated in terms of concerns of the various actors. It is also evident from the findings that viewing risk management as a linear and mechanistic phenomenon is problematic. Risk is the outcome of a complex process of social construction encompassing cultural and political elements that influence both individuals and institutions (Douglas 1985; Douglas & Wildavsky 1982). From this standpoint, we can argue that approaches to risk are together determined by processes of thought or perception relating to individual cognition and by the cultural dynamics typical of social contexts of membership. Each organisational setting develops its own definition and culture of risk assessment and risk management, and it is on the basis of this definition and culture, rather than on a set of probability calculations or rational judgements. Consequently, risk management is a process that is constantly sustained by organisational practices – in a sense a form of organisational action and knowing. In addition risk management practice in organisations is constituted by plurality and conflict than by consensus (Gherardi 2000).

The above observation indicates the limitation of the ideal of complete scientific objectivity and therefore the need to look at risk management and its impact on clinical interventions in some new ways. Our understanding of “risk” has changed from a phenomenon that is real if hard to measure accessible only to experts, to something constructed out of experience by “experts” and “laypeople” alike. Risk in this sense is culturally embedded and has texture and meaning that vary from one social setting to another. Trying to assess risk is therefore essentially a social and political exercise, even if practitioners adopt quantitative risk

assessment techniques. Practitioners' judgements about the nature and severity of clinical risk inevitably incorporate tacit understandings concerning the cause and uncertainty, which are by no means universally shared even in similarly situated settings. Against this backdrop, it makes little sense to manage risk on the basis of standardised guidelines, insulation from public demands, and claims to superior expertise. The different conception of risk-related processes that emerges from the study calls for a more open-ended process, with multiple access points for opposing views and unconventional perspective and an acknowledgement of its own provisional status. The empirical analysis of the institutional environment of the four settings and of its impacts on the perception and management of risk has yielded the following insights:

- *Linking of analysis (science) with deliberation (politics):* Observation of risk activities on the setting shows that decisions are not value-free or apolitical but rather other actors affected by the decisions have an input in the decision making process. This generates a politics of knowledge in which different actors continually compete over risk definition. Risk is largely artefacts of the particular assumptions and arguments of the scientific models used.
- *Importance on feedback:* The framing of initial risk assessment is almost always revisited and redrawn in light of experience. Risk assessment is probabilistic and there is no certainty of the clinical impact of any strategy pursued. The modelling of a clinical problem, the assumptions upon which such modelling are based inevitably on clinical judgemental.

These insights do not reject but enhance the traditional linear model of risk assessment/risk management by considering it as a complex process, one that is cyclical and grounded in, not separate from deliberative politics. The insights

subscribe to the contention that argues that risk is a phenomenon by which information processes, institutional structures, social-group behaviour and individual responses shape the social experiences of risk, thereby contributing to risk consequences (Kasperson et al 1998). An assertion is held that information system and the characteristics of public response are essential elements that define the nature and magnitude of risk perceptions. Food scares such as BSE, pesticide residues in fruit and vegetables genetically modified foods among others could be cited as an illustration of this notion –social amplification of risk perception. Despite the expert community determination that the estimated probabilities of hazards from eating those foods were low, major public concerns remained high perhaps because of media coverage of the consequences of, rather than the possibilities of contracting disease. Similarly, contrary to the evidence, there is held association in the public consciousness between madness and danger because of media coverage. Increasingly it is not the actual but potential harm that has become the major public concerns, with people having different perceptions of the potential harm that can be caused.

The social amplification of risk perception concept, suggests that crisis events interact with social, psychological, institutional and cultural processes in ways that can intensify or attenuate perceptions of risk. Furthermore, it argues that behavioural responses can trigger secondary consequences that have indirect effects, which can exceed the risk of direct harm to individuals (Kasperson 1992). Risk amplification occurs when these indirect effects precipitate additional institutional responses and protective actions. Not taking new risks unless their outcomes can be understood in advance as observed in the settings provides examples of the secondary impacts that can occur as a result of risk amplification. Public concern is

here translated into regulatory change, an attempt to prevent a recurrence of the problem. The approach to risk management that operate on “what if” basis – precautionary principle – centred on political rather than professional reasons, raises issues of trust, expert knowledge and the broader question of ethical approaches to decision making under uncertainty.

Nurses therefore find themselves in a culture that is peculiarly occupied with hazards. What makes the situation more fraught is that this culture is increasingly ambivalent about nurses’ judgements about risk. Thus the idea of risk management as a purely technical matter involving calculations of the probabilities of harm based upon the available evidence, viewed as the province of experts alone becomes problematic. Certainly recent years have seen the questioning of expert judgements by supposedly inexpert lay people. For instance, assurances about safety of nuclear power, chemical pesticides, food irradiation, British beef and international terrorism have been met with public scepticism. Reasons given for these competing epistemologies have been associated with “lack of understanding of the nature of technical or scientific process, lack of confidence in “expert opinions” about hazardous operations and processes, and increasing public scepticism in the certainty, or capability, of scientific theories or technical solutions to provide answers to complex environmental and health problems (Smith & McCloskey 1998 p. 46). Cohen (1999) suggests that science exists in two separate domains. One view takes science as rigorous methodology based on objectivity and truth finding - the disposition to a rational worldview. In the other, scientific knowledge plays the function of civic epistemology; an intellectual tool which people with humanistic inclinations and stronger egalitarian leanings, use both for securing social identity and defining self. Faced with dangers where scientific evidence as in psychiatry is

not sufficiently unambiguous to link possible cause and effect, people look for different approach (civic science) where the tolerance of any risk may be a function of the fairness and integrity of consultation/involvement process as much as it may be of the scientific judgements involved.

The Challenges Ahead

It is clear that attention needs to be focused on public awareness and open discussions; a creation of opportunities for participating in public decisions that is part of an ongoing meaningful dialogue. The public needs to be better informed about the complexity of healthcare including the issues of risk assessment/risk management and the broader social issues intertwined with care. The arena concept seems to offer a conceptual framework for creating the opportunities within which dialogue can take place. But such dialogue is greatly impeded by organisational factors and the fact that the various contending actors operate within the logic of alternative discourses. Among the organisational factors are the uncertainty in knowledge; the organisation of nursing care; professional control versus organisational prerogatives; the complexity of treatment task structure and inadequate information processing:

- *Uncertainty in knowledge.* Contemporary social theories as discussed earlier have drawn our attention to the uncertainty and instability of knowledge, particularly the uncritical confidence in science. The status of expert knowledge (medical knowledge) is becoming increasingly contestable (Carter 1995). People are no longer willing to accept the belief that only the health professionals are capable of understanding the complex and technical issues of healthcare. Indeed Mechanic (1996) proposes that all social institutions including medicine have fallen from public trust.

- *Organisation of nursing care.* The organisation of nursing care involves numerous service departments and many types of professionals. This means that nurses intersect with and are constituted by a wide range of risk professions and their forms of “expert” knowledge (Abbot 1988). In such an inter-institutional environment there is a constant negotiation about risk management. Each profession, unit/service tends to view its risk concerns as unique. Yet the complex nature of risk management calls for much sharing and overlapping among the various actors.

- *Professional control versus organisational prerogatives.* Nursing attempts to control and define its own practices and members (Freidson 1986). It builds rationales and collective defences against outsiders and the right to define standards of practice and mistakes (Hughes 1971). In risk management terms these efforts are essentially directed at protecting the profession’s identity of its preferred mode of work. The difficulties encountered in inter-professional and intra-professional interactions concerning risks pose problems for risk management. These are largely derived from complex interplay of illness, technology and nursing organisation. In addition actors outside nursing concerned with standard of care, equity, legal issues will continue to press their views about what is judge to be professional prerogative. The establishing of organisational accountability for risk management then requires interactions and negotiations that are not only inter-professionals but involve groups outside nursing.

- *Complexity of treatment task structure.* The elusiveness of the definition of madness (Willshire 1999) does not fit the rational application of risk management technology. Psychiatric illness makes a traditional predictable service difficult to achieve. Many nursing interventions and their consequences are highly uncertain

and unclear. Given the wide varieties of treatment options, there are lively debates among professionals as to respective risk benefits and also the appropriateness of different interventions for different illnesses.

- *Inadequate information processing*: Breakdowns are due to self-defensive mechanisms, impacts of perceived threats of an individual or an organisation becoming involved in liability litigation or of becoming the target of regulatory punishment. Mixed messages reduce the ability to communicate and learn from experience (March & Olson 1975).

Lessons for theory and practice

The study has shown that there are different types of risk and different approaches to their assessment and management. The “science-based” approach emphasises the instrumental use of knowledge. A second paradigm based in social science stresses the social circumstances: the social construction of risk, the perception of risk and the possibility of alternative contexts. Professionals, policymakers and individuals operate in a social context that influences how they construct their views of the significance of clinical risks (Wildavsky & Dake 1991). Moreover, the concept of risk entails more than just expert assessments of the probability and harm of an activity. Knowledge of the ways accidents/incidents occur is often incomplete and most risks are characterised by conflicting scientific expert evidence and opinion. Consequently the public and expert values inevitably influence risk assessment and therefore the notion of separating scientific risk assessment and risk management is doubtful (Jasanoff 1999; Wynne 1991). Thus the social, political and cultural complexities of risk management processes manifest themselves across healthcare organisations and place demands on risk decision making. This interplay between “science” and “politics” emerges as a

major theme of this study. An additional important vital issue is the role and credibility of science in assessing and managing risks.

Cultural differences and divergent value commitments and interests tend to lead to intense conflicts between affected actors. Resolving these conflicts require a process in which stakeholders are given the opportunity to take part in the decision making process. In what is term “rational discourse”, - a communication process in which all affected parties resolve a conflict – the argument is that there is a need for an organisational model of risk debates that acknowledges the conditions of the respective risk arena (Habermans 1984; Renn 1998). There is also an appeal (because of the complexities in assessing risks) for risk characterisation to become an important part of risk assessment (Stern & Fineberg 1996). Here, risk “characterisation” should include information on scientific uncertainties of the estimates and the scientific controversies surrounding them, who endures the risks and who benefits, the perceptions and concerns of the interested and affected parties and the different culturally linked views on the acceptability of the risks. But is it possible to involve others in decision making? A major problem of participation concerns the cultural, political, social differences and peculiarities of each actor involved in the processes. People have different perceptions of the legitimacy of decision making processes and have different attitudes to risk issues. The experience from the case studies is a reminder that risk management issues cannot be adequately understood with only expert assessments of the probabilities and consequences of the risks at issue. As noted, professionals across and within settings provided remarkably different risks assessment of the same issues. The research documented the inherently subjective processes of “expert” risk analysis and the conflicts and contradictions that arose among professionals. An important lesson for

practice is that risk management proceeds in the face of conflicting expert assessment of the risks and widely different perceptions and concerns about the risks on the part of the interested parties. These different perceptions among professionals and the interested and affected parties make adequate communication all the more important.

Risk communication namely informing actors (for example patients, relatives and public) about specific risks, about actions to alleviate those risks, educating about risks and increasing mutual trust and credibility about risks has become an important part of professionals' work. Mental health organisations however face ethical issues when communicating risks. They face on all three levels (professional, the institutional and societal) ethically ambiguous situations for which solutions are more difficult to identify and evaluate (Jungermann 1997):

Problems on the professional level of communication: In all the settings a patient is supposed to be involved with the decision making process and to give his/her consent. The procedure requires that the nurse inform the patient about the potential risks of the intervention. However for a patient who may be affected cognitively, emotionally and behaviourally he/she may not be able to understand the information. Such difficulties often cause ethical issues. For example, how can nurses find the right balance between respecting the autonomy of the patient? How can nurses avoid imposing directly their own views? Related to this is the unpredictability and uniqueness of the patient. Nurses are increasingly confronted by what seems to be an insoluble dilemma. There is a strong and rapidly growing awareness that patients, like everyone else, have rights that should not be denied them because they are in need of care. But care implies an assurance of safety and many of those receiving it are too confused to make "rational" choice about the

risks they are running. Questions facing nursing in risk decisions are: Exactly what is the risk feared? How serious is it? How likely is it? Whose risk is it? – Is it to the patient, to other patients, the public, and reputation of nurses or the organisation? A related question is how far can any action be taken to lessen the risk without incurring a greater threat to the welfare of the patient? Here, nurses are faced with concerns not only with safety of a patient's harm to self and others but also with health, dignity, normality of lifestyle and freedom from fear. Mental health nurses are increasingly faced with polarised versions of interventions, namely the duty to care and rights of patients with serious mental health problems.

Problems on the Institutional level: The plurality of risk constructions and interests complicate the decision making processes. As distrust of professionals continues to increase risk decision making will be increasingly difficult. In such situations, suggestions have been made to dispense with over-reliance on administrative and scientific expertise and to open the risk debates to all interested parties (Beck 1994; Renn & Klinke 2001). It is difficult however to see how nurses can take decisions in situations of emergencies. Thus a healthcare organisation might want to involve all relevant interest groups and inform them of perceived risks. But the uncertainty surrounding risk issues may render this impossible.

Problems on the societal level: Society is extremely ambivalent about the mental health patients demanding care and control in equal measures. People over the centuries have been making efforts to control the amount of danger they are exposed to their lives. For instance lepers and the mentally ill were banished from cities and witches were burned: the separation of polluted bodies from healthy spaces (Douglas 1962). Within this framework, the concept, risk is used for marginalizing an Other (patient) who is perceived as posing a threat to self and others. As

mentioned earlier, members of “risky” marginalized groups are viewed by the dominant group as polluting public spaces leading to strategies of exclusion and surveillance. Douglas (1962) also reminds us of the paradoxical nature of our yearning for purity; that which is categorised as polluting is seen as acceptable. For example, some campaigners concerned with the welfare of mental patients have presented mental illness as just normal part of life thus challenging the notion of “normality” and confronting the split between “sanity” and “madness.” At the same time however we are witnessing the construction of new psychiatric conditions, syndromes, addictions and the medicalisation of social problems. The presentation of multiple perspectives from many sources (governmental agencies, media, and interest groups among others): all present views of clinical risks that reflect their specific values and interests.

Overall, the events and outcomes of the study raise questions about the widespread assumption of science; reason and rationality as necessarily the bases for good decision making. In studying the micropolitics of decision making I have tried to provide insight not just into the specific cases, but in the larger question of risk management strategies in other organisations. The dilemmas and other observations in the case studies suggest some questions for future research on what constitutes effective communication and how risk communication may be improved. First, how can the differing risk assessment and risk management within and between the arenas be reconciled? Second, how can democratic risk management processes be established to reconcile competing perception and cultural constructions of risk problems across the arenas?

Concluding Remarks

The study sets out to extend and refine our understanding of how psychiatric nurses at the coalface construct their risk knowledge as part of their interactions with others. The findings direct researchers to new ways of thinking about key areas of psychiatric nursing. Various legislative enactments in the form of clinical guidelines permeated the decision making process. The clinical environment is characterised by a perpetual elaboration of guidelines that regulated how knowledge is communicated and used. In this context, nurses are increasingly subjected to external institutional pressures to work within a controlled framework. The need to be accountable, led nurses to elaborate internal communication rules which gave the impression of their adherence to the standardised guidelines. It also developed self-defensive mechanisms in which nurses protected themselves from perceived threats becoming involved in liability litigation or target of professional regulatory punishment.

The study can be usefully located within the literature of professional roles under the new managerialism in the public sector. Changing institutional contexts are tending to break down established professional jurisdictions into more contingent relationships of knowledge work and status. In the healthcare arena, we are observing the intensive interpenetration of managerial and nursing practices and knowledge, with resulting blurring and renegotiation of professional boundaries between nursing and management (Cohen & Musson 2000). Consequently, nurses secure their sense of meaning and reality from participation in various discursive and disciplinary practices that constitute them as subjects (Halford & Leonard 1999). The study shows that risk discourse might be expected to appear in different

forms in different arenas as it interacts with other discourses. Nurses tend to interpret risk discourse in relation to their particular circumstances and experiences.

Risk management is now well established as one of the main preoccupations of nursing practice and its relative significance is likely to increase in the future. Participants however, see risk management as problematic –criticised as remote from reality – risk management is perceived to be unhelpfully rigid. Risk management rigidity is regarded as translating into organisation-wide rigidity as it permeates and transcends all levels. Masked by such criticism however, is an implicit acknowledgement by my informants of the power of risk management's subtle ability to maintain its dominance, despite their cynicism with its relevance and appropriateness. Risk management is seen by some nurses to generate tidy information that can be audited and, therefore, that derives its significance and legitimacy from its capacity to satisfy statutory requirements. Risk management is also recognised by nurses as a technique that removes and insulates nursing care from the complexities and uncertainties of risk decision making. Using the metaphor of the arena risk management is seen as a struggle between various actors who mobilise social resources to gain attention, support and trust of the general public. Risk management from this angle becomes a means of resolving values conflicts (Renn 1998).

Nursing care is not only a matter of intervention in the lives of patients but also a response to institutional and societal demands for risk knowledge. As a result the loci of nursing activity are communication systems - rules, guidelines, forms – shaped by external sources. This makes nursing work highly visible and limits the discretion of nurses. The analysis of how notions of risk management have begun to permeate the everyday perceptions, languages, and behaviour of nurses is not to

claim that they have been colonised by it. Rather, both the external pressures and professional values in how nurses see their activities constantly mediate the effects, for example, the definitions of risk management are immensely contested in all the case studies. This shows that all risk decisions are socially situated and constrained environmentally and organisationally. So no matter how idealistic, a nurse intervention is embedded in negotiated compromises. Risk management strategies therefore play numerous roles. It provides an image of rationality (Meyer & Rowan 1977); it becomes a framework for accountability and for compensating liability claims concerning errors in clinical interventions illustrated in standardised forms. It also presents a communicative structure of what knowledge to be communicated to what actors and in what forms. Risk management also appears to have resulted in unintended consequences and produces a no-win situation by destroying elements of professional/expert work which nurses were attracted to in the first place. Strategies designed to make nurses methodical at the same time encouraged rigid and inflexible behaviour.

The findings also direct researchers to the importance of understanding how risk issues are perceived and constructed by interested and affected actors. Worldviews and interests can greatly influence how issues are framed and how risks are perceived. Clinical risk management is not only for safety of patients but also a response to institutional demands for knowledge of risk. This shows us how the profession and its working environment are changing in a society governed by risk knowledge. The proposed theoretical model argues for changes in how researchers should theorise about and study risk by the consideration of the potentially important impact societal, organisational contexts (Douglas & Wildavsky 1982). One contribution of this study is that it draws together previously unrelated factors

and shows how they provide the basis for theoretical model of risk management that is more complete and accurate than previous models. In placing psychiatric nursing in a more societal and organisational framework, the study contributes to the sociology of professions. It shows how professions are changing in a society governed by knowledge of risk. Another contribution has been to make researchers think much harder about processes and interactions that were previously invisible, denied, or thought unproblematic.

Another important lesson from the study may be the need to look beyond the functional and instrumental aspects of the rational model. Namely how it relates to people's underlying and often hidden assumptions about who they are and what aspects of those assumptions is change likely to trigger. The study shows that even small apparently insignificant changes may signal much more fundamental transformations for those involved in the project. The study suggests that organisational identity embodies contradictory identifications based on a wide range of positions that individuals take within organisations. This allows integration of stakeholder groups as participants in the hegemonic discourse that seeks to shape the identities of members. An approach that focuses on the shaping of identities within the organisation would provide a basis for understanding how such differentiation was linked to the shaping of positional identity in the organisation. Such an analysis would point to areas where conflict is most likely to arise and the ways in which such conflict could be managed. Identifying what sorts of collective changes are likely to threaten deep-seated identity beliefs will help us to make sense of how to manage change.

The study has yielded many intriguing and interesting insights concerning the role of risk management and by implication nurses in psychiatric settings. There are,

however, some caveats that should be borne in mind when interpreting these insights. By limiting my primary attention to nurses the study downplays the contributions that other groups make in the decision making process. Second, at the time of the study, my sample of the settings were in an atmosphere of major change situations and many of the processes I was examining were still fluid. It is therefore possible that my findings are of a more transitory nature than initially suspected.

Despite these limitations, the study sheds light on what I consider to be interesting dynamics of risk management as a practice. An important message for practice is that risk management more often than not proceed in the face of conflicting actors' (interested parties) assessments of risks and widely different perceptions and concerns about the risks. The research has questioned the widespread assumptions that science, reason and rationality are necessarily the bases for "good" risk decision making.

Clinical judgement as noted above does not operate in an idealised form. The arena model shows that clinical judgement within the organisations studied and undoubtedly in many areas of professional practice, is drastically limited by the influence of other nonclinical forces. It is misguided therefore to believe that clinical judgement could ever be so influential as to supersede all other social, economic, and political factors that affect people's life. Clinical judgement always occurs in a political context and therefore cannot reasonably be viewed as independent of it. The solution to the problem of clinical judgement being besieged by nonclinical forces is not to push for even better techniques in decision making. According to the perspective developed by the study, risk decision making is best understood as a field of competing social discourses. Each risk discourse is "real" to

the extent that it participates in the development, enactment and reproduction of clinical practices.

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