SOME COMMUNICATIONAL ASPECTS OF PATIENT PLACEMENT AND CAREERS IN TWO NURSING HOMES

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This dissertation is based on nine months of observational and interview work in two nursing homes. The writing and editing comprised an additional twelve months. As with any other ongoing social activity, I temporarily leave this dissertation very different from the way I walked into it—professionally, personally, intellectually. I would like to use this preface to document for the readers of this dissertation some of the changes I am aware of. These have a direct bearing on the "final" form of this manuscript and the way I would like it to be read.

The ideas, concepts, and the physical fact of this dissertation have been with me for nearly four years. In 1978 I did exploratory research in one eastern U.S. nursing home. At that time, I was concerned with gaining some preliminary perspective on the kinds of patterns of information channeling that could be gauged with an analysis of conversational topics. This research was in the spirit of what might generally be considered interactional or discourse analysis. The completion of that research left me convinced that much could be learned about interpersonal communication through the use of intensive naturalistic methods in sites such as health-care institutions. However, I was also convinced that the study of discourse structure per se did not shed much light on my primary research interest: social relationships. One of the motivations for the present research was my desire to find a way to bridge the study of the underlying organization or rules of face-to-face behavior with the study of social system
processes. This is not to say that I consider this dissertation an example of discourse analysis, or that I hope it will be read as such. Although I am concerned with the constraints on nursing home members' face-to-face behavior, I have largely attempted to describe here the broader institutional functions (in the sense of outcomes and consequences, not organismic needs) of the various codes of behavior which are isolated. Discourse data are used here, but they are primarily in the service of a broader set of theoretical concerns. In this regard, and as noted in more detail below, the present manuscript looks different from what I had originally envisaged or proposed.

The analysis and writing of the present data leave me with the belief that it is possible to work toward the type of conceptual and research bridge proposed above. Admittedly, the traditional discourse analytic vocabulary is not prominently employed here. Moreover, the "level" of my entry into the interactional data may appear to some to be more macroscopic than micro-analytic, and not truly in the interactionist tradition. Birdwhistell has long made a distinction between "coming from above" versus "coming from below" in the doing of ethnographic and structural analysis. Although I did not initially intend this to be my goal, I have focussed here more on the multiple contexts, outcomes, and general classes of behavior which can be seen to be associated with social recruitment, than on detailed descriptions of particular gestures, words, spatial arrangements, and so on. In other words, I have approached social recruitment from above, not below. I hope that the detailed contextual descriptions provided here can be
used as a basis for the more "fine grained" type of investigations.

This dissertation provides details on what it is like to be a patient in one or the other of two nursing homes located in a large city. To a certain degree, in both collecting and analyzing the institutional data, I implicitly allowed myself to assume that the social careers experienced by the residents were controlled by persons (staff members) who were themselves not effected by their charges or the institutional structure. Similarly, I held "constant" (in abeyance) consistent consideration of the role of the nursing home patients' life courses within their family systems. I treat the patients as though their lives are subject to social control from outside or above, but I do not focus on their relational reciprocals. I do not believe that the choice to attend exclusively to the institutional career patterning of the patients is in any way a flaw in the present analysis. However, I recognize that this choice has implications for the way this dissertation can be read, and for the kinds of concluding statements I am able to feel comfortable in advancing. If I were to redo this study on institutional processes of member selection and career shaping, I would strive for a less one-sided view of the institution that I must admit is presented here. But it is not sufficient to simply run parallel studies of the recruitment of patients and the recruitment of staff members; the mutuality and interdependence of each group's career lines need the kind of attention I was only able to give to one when I first entered the two nursing homes in 1980. At this writing it seems obvious to me that I needed to produce this dissertation (with its
delimited perspective) before I could rephrase and redirect the social recruitment question.

From one point of view the hallmark of the ethnographic researcher's problem (and responsibility) revolves around his/her answers to the questions: "What does it take to know something about X?" "How can I build a suitable understanding of the context in which phenomenon X occurs and from which it derives its significance?" In the present context, the X is institutional selection processes. One of the methodological requirements placed on me in carrying out this research was the drawing or creation of a boundary around the phenomenon to be studied. The question I constantly asked myself throughout the months of travel to and work in People's Home and Sisters of Faith Home was: "What are the limits of the *observational present*, those portions of the space-time continuum, that I am going to attempt to attend to, record, analyze?" As suggested above, the decision I opted for when beginning the research is not the one I would probably elect today.

Just as the definition of a research problem shifts during the period of field work, so too does the researcher's self-conception and identity. "Friend," "confidant," "concerned observer," are all terms to describe the various roles I assumed at the two nursing homes. However, I did not consider myself to be an "objective reporter" at any point in this study, not even when I first began the investigation. An important issue for the reader to consider in examining the primary data chapters is that I (along with the residents) was an object of socialization, of gradual training into the behavioral system of the two nursing
facilities. However, one advantage of the dual institutional analysis undertaken here is that the events I was observing did not usually appear to me in any sense as "natural" or "the way things had to be." Although I do not claim to have been an objective investigator, I do believe I was able to be a "critical" one. During my field work, I was periodically confronted by differences—differences in administrative attitude, in staff-patient interaction, and in definitions of the relationships I had with the institutions' members. Although I accepted the "reality" of the patterns I observed, I was always made aware through the contrast method of the relative nature of these patterns and of their anchoring in particular situations. Some of the prose below may leave the reader with the impression that I feel I observed behavior which was "senile," or "justified," or "inappropriate," etc. This is not the case. I have tried to indicate, through the extensive use of informant quotes and such qualifying statements as "as told to me by . . . ," that my descriptions are based on the institutional actors' own accounts and perceptions. If nothing else, the carrying out of this study has taught me about the "slipperiness" of labels—mine and theirs.

Finally, a brief note about my relationship to the subject matter of this dissertation is in order. Some friends and colleagues have asked me why I chose to do my dissertation research in a nursing home setting. The theoretical and methodological reasons for this choice are discussed elsewhere in the dissertation. I have little doubt that my own extended stay in a rather encompassing social institution—the academic—influenced my curiosity about institutional procedures in
general. Moreover, I am sure that to some degree my choice of the patient focus outlined above was influenced by my own position in the educational system. I now have my own university students, and the world (the social world) looks different from the "other side" of the lectern. These observations must also be granted their place in the frame of mind which readers bring to this dissertation.
CHAPTER I
INTRODUCTION

Brief Statement of the Problem

Studies of interactional behavior often focus on the codes or systems of regularities which make orderly exchanges of information possible. However, such studies do not always question the social-level function of these codes. Coming from "below" by generating data on patterns of behavior manifest in particular social situations, they rarely address themselves to an analysis of the social situation itself, the institutional context of interaction, or the constitutive social positions and relationships. In contrast, the present dissertation is specifically designed as a social communicational study of coded behavior and of the relationship of this behavior to processes of social maintenance and continuity. The research problem taken by this study deals with the generation of behavioral data which can be subjected to code analysis and which appear to be associated with a particular social process—the attainment and maintenance of social position. Toward this end, the dissertation essays an ethnographic investigation of communicational behavior in a geriatric setting, and, as noted below, aims at the development of relevant descriptive data illuminated by a contrastive frame (two nursing homes). Specific research attention is directed at that behavior which can be seen to be associated with assignment to particular social positions within nursing institutions. Moreover, this research is concerned with that communicational behavior relevant to position maintenance and reassignment.
As outlined in more detail below, definitions of social structure are utilized which posit a supra-individual nature of society, and, within a functional orientation, make possible the delineation of practices which seem to ensure the continued and orderly existence of a social system over time (Linton, 1940; Radcliffe-Brown, 1965). Within this framework, systematic investigation may appropriately be directed at regularities in the communicative behavior of individual members of society to discover how this behavior patterns with regard to social adaptation and continuity. Society is by definition multi-generational and to be continuous must constantly replace itself, i.e., constantly replace group members. This requires social recruitment, which is assumed to be one process which sustains social continuity; it is a primary focus for the present research. Social recruitment may be defined at this juncture as a multi-participant and multi-channel interaction system by which individuals are moved into filling certain places (statuses) within a social structure, or, conversely, a means by which "gatekeeping"\(^1\) vis-à-vis these individuals is accomplished. It may be hypothesized that there are codes or rule sets for entry into, passage through, and exit from social systems and the positions which constitute social structures. It is further hypothesized that as social their patterned organization and function are subject to systematic examination from a communicational perspective.

Nursing homes are viewed here as appropriate sites for the investigation of patterns of social recruitment. Toward this end, two nursing homes were selected as the contexts for ethnographic study. Although the literature concerned with gerontology contains studies on individuals' adjustments to and lives within nursing institutions, most
of these studies have assumed a psychological, and, from the point of view represented here, a reductionist stance (cf. Bennett, 1970). Little research has been published which examines the socially patterned communication behavior of staff and residents in geriatric facilities, and, more specifically, which deals with the way in which various decisions (and decision-making processes) made by residents' family members and institutional caretakers shape individuals' careers (or life courses) within the institution. The problem considered by this dissertation to meet this lack is concerned with the behavioral expectations and with the patterns of communication behavior which can be related to the position (and career) assumed by or assigned to residents.

Chapter II consists of a brief review of the ethnographic and communications literature on geriatric health-care settings and previous studies on social recruitment and status passage. Chapter III provides a description of the ethnographically based methodology which was employed in the present study. Subsequent chapters represent various analyses of the data corpus: Chapter IV contextualizes the institutional recruitment data. It begins with an historical overview on the development of nursing homes in Philadelphia, and includes a sociologically-oriented comparison of the organization, routines and "mission" of the two facilities investigated here. Chapters V and VI focus on the recruitment data for, respectively, People's Home and Sisters of Faith Home (both pseudonyms). Each of these two chapters consists of a short description of the physical plant for the nursing home under discussion, an analysis of the institutional procedures and criteria for admitting and slotting individuals, and an analysis of the
social relationships, interactional contexts, and communicational messages that are associated with particular slotting decisions. A summary and comparison of these data are provided in Chapter VII.

Theoretical Background

The present section is concerned with a detailed description of the research problem and its theoretical background. The section traces the present concern with social recruitment to an enduring sociological and anthropological interest in status mobility and social selection processes (also see Chapter II).

In keeping with the social anthropological perspective outlined by Linton (1940) and Radcliffe-Brown (1965), "social structure" is defined here as an abstraction from the ordered relations of persons. Linton writes:

By studying the social relations between individuals and observing the repetitive situations, it becomes possible to deduce the structural pattern of the society. This pattern tends to persist in spite of the steady turnover in the society's content and bears little relation to the special qualities of the various individuals who occupy places in the society at various times (1940:871).

In this manner, regularities in individuals' behavior are relatable to social structural arrangements (as well as to biological horologies) and are seen as the directly observable correlates of social structure. As noted by Linton, social patterns transcend both individual personality and longevity. In Durkheim's (1938) words, society is an entity sui generis. Individual behavioral performance may be seen to be constrained or conditioned by regularities at the social level, i.e., by the patterns for activity which comprise the social structure, but they are also partially constitutive of the social patterns.  

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Luckmann write of this dual nature of society that both persons and society itself are objective realities, and that each derives from the processes of the other:

At the moment, it is important to emphasize that the relationship between man, the producer, and the social world, his product, is and remains a dialectical one. That is, man (not, of course, in isolation but in his collectivities) and his social world interact with each other. The product acts back upon the producer. . . .

Society is a human product. Society is an objective reality. Man is a social product (1967:61; emphasis in original).

Society can be treated in this respect as an "objective facticity" (Berger, 1963), in other words, as an abstraction as real as any other utilized by science (Lundberg, 1939).

Social communication theory, which frames the present research, is based in part on these considerations of society as both a structural entity and a supra-individual behavioral process. Communication in this view is seen as a societal-level phenomenon, not an individual-level one. Birdwhistell (1970) defines communication as the dynamic or processual aspect of social structure and as that behavioral organization which facilitates orderly multisensorial interaction. Communication is thus seen both as a means by which the bio-social interdependencies of species members are maintained, and as a means by which their behavior is predictably ordered.

Throughout Birdwhistell's social communication analysis, it is suggested that communication not be defined reductively as a process by which individual cognitions are exchanged or as a process of information transmission between isolates. Although it is certainly the case that individuals transmit messages to others about internal states and often do so intentionally, it is suggested that interpersonal (or
inter-individual) messages do not typify or exhaust the human capacity and requirement for communication. Communication appears as a concomitant of all social life and as an exigency of social survival in general, not primarily as a consequence of either individual motivation or initiative (see also G. H. Mead, 1938). Further, communication serves to articulate and sustain the processual aspects of the social division of labor. In this sense, communication cannot be reduced to an exchange of cognitions. By postulating communication as a social process, however, communication theorists do not intend for the word "social" to imply individuals in sociation, in collectivities, in the physical co-presence of others. Rather, communication processes are considered societal phenomena, prerequisites for the continuity, integration, and adaptation of a supra-individual social system as defined above. Birdwhistell articulates this perspective in the following manner:

Research on human communication as a systematic and structured organization could not be initiated until we had some idea about the organization of society itself (1970:72).

To be viable members of their social groupings, fish, birds, mammals, and man must engage in significant symbolization—must learn to recognize, receive, and send ordered messages. In other words, the individual must learn to behave in appropriate ways which permit the other members of the group to recognize and anticipate his behavior. Society is that way in which behavior is calibrated so that existence is not a process of continuous and wasteful trial and error (1970:74; emphasis added).

In so delimiting the field of inquiry, the social communication theorist places within the purview of communicational studies such non-psychological and non-individual centered issues as the social and cultural regularities in members' behavioral production and the
consequences for the social system of particular patterned inter-
dependencies. As such, investigatory focus is to be directed at the
socially constructed limitations or rules governing message flow, and at
the functions (consequences) of these for the specified social system
under consideration.

It follows from this discussion that communication may be defined
as a process of information handling— including processes of production,
dissemination and reception— within a social system; this process
provides for members' behavioral predictability and societal (group)
continuity. Communication comes to be seen in this sense as a dynamic
structure which allows or prohibits various orders of information or
message flow.

Communication is not a single, temporally linear process; a number
of sub-processes, temporal laminates, and behavioral consequences may be
discerned. Birdwhistell, for example, distinguishes two dynamic
components or features of message structure:

The use of "integrational" as opposed to "new informational"
may prove artificial but, for the time being, these categories
may be distinguished. Integrational communication involves
such interaction as invokes common past experiences and is
related to the initiation, maintenance or severance of inter-
action. "New informational," while symbolically consistent
with and made up of past experience, involves the inclusion of
information not held in common by the communicants (1952:3-4).

More recently, Birdwhistell (1970) has extended the notion of
integrational communicative processes to comprise regulation of
interaction itself, maintenance of systematic operations, and
cross-referencing of particular message units to those contexts
providing for their comprehensibility. Of special note here is the idea
that communication serves multiple social ends. In a similar fashion,
Lasswell suggests the recognition of three possible communicative processes or activities:

.. Our analysis of communication will deal with the specializations that carry on certain functions, of which the following may be clearly distinguished: (1) the surveillance of the environment; (2) the correlation of the parts of society in responding to the environment; (3) the transmission of the social heritage from one generation to the next (1971[1948]:85).

The implications of these concepts, it may be observed, reside in the degree to which ongoing communicative episodes can be seen as constrained both by unit patterning (internal structure or "grammar" according to Wells [1957(1947)]) and by systemic consequences (function and external structure). This is to say that each unit of behavior can be seen as being structured by constituent units on a "lower" level, and as patterning or functioning with other units to contribute to higher-order levels of behavioral integration (cf. Hockett, 1958; Birdwhistell, 1970; Scheflen, 1974). Rulon Wells, for instance, writes: "The contrast between internal and external grammar makes precise what is sometimes meant by the contrast between form and function" (1957[1947]:190). Thus, the field of communicational studies, as an academic discipline, is charged with the goal of exploring behavior as multi-levelled and multi-functional, and with developing research questions and tools which relate behavior units to multiple levels.

The third behavioral activity outlined by Lasswell (see supra) may be considered to reflect more generally all processes involved in the perpetuation of a social system and its constitutive activities: storage and transmission of social knowledge, socialization practices, and so on. Thus, it may be hypothesized that a social system must provide for recruitment procedures in order to ensure its organized
continuity and survival, i.e., to ensure the existence and availability of persons appropriate to the particular relationships which constitute the system. In arguing that a society is an abstraction from the regulated relations of persons, Linton (1940) further suggests that the existence of a position or place in social structure must be conceptually distinguished from the particular individual (or individuals) filling this slot. As noted above, the individual organism and the social structure are not analytically simultaneous. The persistence of a social order as an integral whole and the persistence of any one constituent slot are predicated, therefore, on the capacity of the social system to provide for repetitive actions of replenishment of available positions.

Socially patterned communicative processes as defined above may be suggested to facilitate such continuity and reduce trial-and-error experimentation in social existence more generally through the provision of codes (rules) which regulate and make meaningful the behavior of members. Linton argues the more extreme position that "individual talent is too sporadic and too unpredictable to be allowed any important place in the organization of society" (1936:129). More conservatively, Birdwhistell (1970) has written of the fundamental significance of predictability for a social grouping. He suggests, for example, that all social systems attempt to standardize and to regulate the behavior of members, and that special treatment devolves on those individuals who become insufficiently predictable to others. With society viewed non-reductively as constituting supra-individual behavioral activity, it therefore appears that the perpetuation and development of the social system require some patterned means for constantly "coaxing" or
"permitting" individuals to fill positions made available through attrition (death), through obsolescence brought about by economic and technological growth (retirement), and so on. Recruitment may be proposed as an isolable and patterned system of behavior concerned with how individual members get sorted within a social system and how they are given the options of filling (or are placed into) relevant social positions. Glaser and Strauss argue along similar lines:

Insofar as every social structure requires manpower, men are recruited by agents to move along through social positions or statuses. Status is a resting place for individuals. But while the status itself may persist for many years, no matter how long an individual remains in, say, an office, there is an implicit or even explicit date when he must leave it (1971:2-3).

Throughout the course of an individual life, particularly in a social system stressing mobility and role specialization, individual members are recruited into positions within social institutions which they may not have held previously. Stated differently, individual biographies may be marked by systematic transitions from one position to another, by sharp career discontinuities, by additions to one's status affiliations, and/or by the diminution of these over time. In lieu of taking the biography of an individual group member as the unit of analysis, however, it is suggested here that one may distinguish processes by which societies regulate such mobility for multiple careers, i.e., processes by which societies establish conditions enabling numerous individuals to be moved into (or excluded from) filling available social positions, and, once filled, provide behavioral training necessary for position maintenance and/or reassignment, and career rejection or termination.
Of concern in the present study, then, is a behavioral (communicational) approach to social structure and to movement within social structure. Linton (1936) notes the inseparability of the concepts "status" (position) and "role" (status-appropriate behavior), and Goffman (1959) has more recently reiterated the communicational, non-static nature of social position. Goffman writes:

A status, a position, a social place is not a material thing, to be possessed and then displayed; it is a pattern of appropriate conduct, coherent, embellished, and well articulated (1959:75).

In addition to status as having socio-culturally defined behavioral patterning, there may be assumed to exist regularities in the recruitment or movement toward and away from particular social statuses. It is hypothesized here that the processes by which individuals "volunteer," are forced, and/or are provided with options to move from one position to another, or by which they are expected to engage in such transition, or by which provisions are made for them to do so, or by which barricades to these opportunities are created, are neither random nor idiosyncratically determined. Stated differently, one may expect to find patterns of status movement and procedures for carrying this out:

... Passages are governed by fairly clear rules concerning when the change of status should be made, by whom and by whose agency. There are also prescribed sequences of steps the person must go through to have completed the passage and regularized actions that must be carried out by various relevant participants in order that the passage actually be accomplished (Glaser and Strauss, 1971:3).

This is in keeping with what—from the individual biographical perspective—is called a career, i.e., "... any social strand of any person's course through life" (Goffman, 1961:127), or "movement through
structures" (Becker and Strauss, 1956:253). Recruitment allows for and operates around a number of career pathways, some of which are equivalent (or overlapping at times), while others are contrasting.

It must be recognized that individuals only partially possess or evidence all the rules constraining their larger socially patterned behavior, and that not all individuals share the identical or fully overlapping behavioral codes. Multiple rules (and, by implication, several career trajectories) may be observed in operation in order to "create" recruitment as a non-random and supra-individual process. Research focus must therefore be directed at both individual-centered regularities and at patterns on the level of the social system. For example, the existence or nonexistence of particular slots, and the number of available slots, may not be deducible from individual rules or individual slot fillers, but from examination over time of the stability of the social positions. Recruitment requires multiparticipant coordination in much the same manner that the formal dinner party emerges from the non-overlapping rules of, say, the domestic (e.g., who knows "to serve from the left and take from the right") and the guest (e.g., who knows only to signal completion of one course and readiness for the next). Thus is introduced the notion of patterned behavioral partials. First, any one interaction contributes only partially, i.e., as a partial subunit, to social structural processes; spatially and temporally diverse (unconnected) events constitute only moments in the larger social recruitment pattern. Second, with the unit of analysis considered a particular face-to-face encounter, only a partial or subunit of the interaction may contribute to the heuristically isolated stream of behavior concerned with social structural maintenance; it may
be assumed that the interaction comprises or contributes to other relevant social functions as well. Thus, as presented in Chapters V and VI, one might consider the initial "calibration" (adjustment—see Birdwhistell [1970], Bateson [1980]) of an institution to a novitiate, the behavioral manifestations of the latter and the expectations for his/her behavior by the set of significant others, the availability of various slotting options and the institutional procedures for slot assignment, and the communicational behavior accorded the individual which is deemed consonant with the particular slotting, as partials in an interaction system which shapes an individual's career in a nursing home.

In this light, the problem explored in the present study is the examination of how seemingly discrete and situationally bound interaction events in a nursing home—e.g., recreational activities, conversational engagements, cliques, staff-patient behavior, staff decision-making procedures, etc.—may be seen to be orderly, if not always congruent, and to contribute in a systematic fashion as partials to processes of social recruitment. Over time individuals come to assume differing roles within the institutional setting. Access to or denial of particular roles and trajectories are seen here to be influenced by (or mediated through) communicational behavior. The analyses of the present data indicate that differential access to the communicational activity exists at the nursing homes for the various patients admitted. That is, there exist contrasting opportunities and expectations for behavioral participation on the residents' part, and one consequence of this situation is the differential shaping of the patients' nursing home careers (see below).
Bateson (1971) suggests that one of the guiding principles of micro-interactional studies is that the behavior so investigated can be assumed to contribute to an understanding of the larger scene, e.g., that interactional behavior reflects and is constitutive of social structure. As noted above, however, the interactional level is not an isomorph of the social level. Bateson writes:

From what little we know of the relationship between the fine details of human interaction and the longer cycles of the career line, there is reason to expect that the longer cycles will always be enlarged repetitions or repeated reflections of pattern contained in the fine detail. Indeed, this assumption that the microscopic will reflect the macroscopic is a major justification of most of our test procedures. A major function of the techniques of microanalysis is, therefore, to obtain from small quantities of data, accurately and completely recorded, insights into human relationship which could otherwise only be obtained either by long-time observation or from the notoriously unreliable data of anamnestic reconstruction (1971:Ch. 1, p. 39).

In this light, this dissertation presents (1) an analysis of certain of the infracommunicational codes guiding conversational and spatial behavior in two geriatric institutions, and (2) an analysis of the relationship of these codes to observed ongoing processes of position selection, maintenance and reassignment.5

It should be pointed out that the regularities of concern do not reside at any one level of infracommunicational behavior, or within the communication patterning (coding) of any single interactional event. Rather, the behavior of interest can be interpreted to encompass the tripartite division of behavioral organization suggested by Trager and Hall (1954)—formal, informal, as well as technical behavior—and is multichannel. In consideration of this, the present dissertation research included the examination of formal institutional records, a systematic mapping of the physical surround, and interviews with the
different members of each institution in order to gain perspective on trajectory options and structure. In addition, observation of events explicitly defined by the members as relevant to the question of assignment (e.g., staff meetings), as well as of less formally scheduled events, was undertaken to generate data on the behavior surrounding particular assignments. The presentation of data in this dissertation is specifically concerned with: (1) the criteria used by administrators and/or administrative committees to accept or reject applications to the nursing homes; (2) the expressed criteria and procedures which justify and regulate decisions to assign and reassign patients to particular positions within each facility; and (3) the behavioral expectations for and the treatment of patients as a result of particular slottings, both by other residents and by staff members.

Nursing Home Selection

In considering locations for an examination of the communicational aspects of social recruitment, two relatively distinct research avenues seem evident: career line studies and institutional studies. With the first, analysis is made of one prespecified career trajectory culminating in a given status; one attempts to establish the sequential organization of positions which are moments in that trajectory, as well as the organization of the constitutive interaction partials. Becker's (1972[1953]) analysis of the steps in becoming a marijuana user employs this perspective (see also Linton, 1940; Suaud, 1975a, b).

Whereas career line studies focus on a particular social position and upon the routes leading to and from the chosen position, institutional studies examine a number of positions which comprise given social institutions and the means by which each position is (presumably)
differentially filled (see Linton, 1946; Warner, et al., 1944). I am using the concept "institution" in the present context in its dual sense as "... standardized modes of behavior, (which) constitute the machinery by which a social structure, a network of social relations, maintains its existence and its continuity" (Radcliffe-Brown, 1965:200), and as a spatially bounded "social establishment" (Goffman, 1961:3). Institutions are thus seen as comprised of the relationship between social statuses with their attendant behavioral expectations, and can be described in terms of an assortment of interactional patterns which facilitate recruitment and which produce a diverse array of parallel and complementary social careers. At this institutional level of analysis, one attempts to specify a constellation of social positions and to examine the behavior which constitutes the multiple levels (or facets) of recruitment. Career line and institutional approaches may be distinguished, therefore, on the basis that the former takes as its unit of analysis a single social status and explores the career patterns appropriate to the one position, while the latter takes a configuration of socially relatable positions and behaviors--i.e., an institution--and examines how the institution as a whole processes individuals and fills multiple positions within its ongoing structure. The present dissertation is in the tradition of the latter (institutional) studies.

As noted, this dissertation is concerned with the patterned behavior expected of and accorded the elderly in an institutional context, as well as with the different interactional contexts the various categories of residents find themselves involved in. Clearly, the behavior discernible within the observational present chosen here covers but an aspect of trajectory. Much of such behavior, obviously,
is a continuation of lifelong patterning. Nevertheless, entry into the institution itself may be seen to place certain demands on inmates (cf. Goffman, 1961; Marshall, 1975; Teski, 1976). In part, the various behavioral requirements can be seen to be associated with the institution's establishment of recruitment processes which enable it to continuously fill vacant residential positions. Congruent with the above discussion, it may be suggested here that nursing homes need to ensure their continuity in the face of patients' deaths, discharges or transfers by establishing patterned admissions, assignment, and reassignment procedures.

It is assumed that the behavior abstracted here is not uniform throughout a given institution; institutional members are placed onto various tracks, each with its own, but scarcely independent, behavioral expectancies. The concept of trajectory or career discussed above is used to suggest that the patterned behavior to be studied here is most profitably seen from a bounded diachronic as opposed to a closed synchronic perspective. That is, institutional members are not stationary; there is constant and regulated movement from one social position to another (or from one set of behavioral expectations to another) over time. During his/her tenure in a nursing institution, the individual may pass through such stages as being an initial arrival, a ward helper or an activities participant, someone being prepared for transfer to a different ward, and so on. It may be suggested that the institution regulates and schedules the status passage of inmates. A trajectory is a pattern of social behavior which is comprised of such movement within a social system. In this respect, it may be seen as a larger ethnographic present enabling the researcher to understand the
spot of a particular synchronic placement within a social structure. A particular social position, such as being assigned to the most prestigious ward in a nursing home, is but a moment in a career which, within the same time frame, may include membership in particular activity groups and friendship patterns, and, over time, may include movement to other sets of behavioral expectations.

Nursing homes are appropriate contexts for such a communicational study in that they can be seen as institutions which function to process individuals onto various life courses (see below), and which, as a result, provide individuals with sets of behavioral expectancies appropriate to these assignments. While some of the gerontology literature hypothesizes that elderly individuals voluntarily withdraw from interaction and "shed" previously held social roles in anticipation of death (see Cumming and Henry, 1961; also see Chapter II), it may be suggested here that nursing homes provide residents with new and institution-specific statuses and behavior codes (see Coffman, 1961; Perrucci, 1974; Jacobs, 1974; Teski, 1976). Marshall argues the importance of what is here called a recruitment perspective for gerontologically oriented research:

The notions of career and status passage are useful in directing us to some appropriate empirical questions. To speak of aging as a status passage is to point to a person negotiating a passage from one age linked status to another, and then to others, finally coming to the end of the passage through life at death (1978/79:350).

The status passage of aging was described as a distinct career because there is "no exit" from it. Aging is one of the very few inevitable and irreversible status passages. . . (ibid.:355).

With specific reference to entry into long-term care facilities, the following research needs have been isolated:
Desperately needed are studies which use prospective, longitudinal designs, and which will begin to clarify the dynamics of the several ... stages of institutionalization: (a) the decision-making processes ..., (b) the stage of anticipation of change ..., (c) the short-term adjustment stage ..., and (d) the long-term adjustment stage ... (Kasl, quoted in Kraus, 1976a:118).

The present dissertation focuses on certain of these aspects. The concept of slotting or recruitment is used to suggest that at various points in a patient's institutional career, there may exist "choice nodes," i.e., a range (although clearly limited) of alternative positions for selection or assignment by the individual or his/her institutional others. To take one possibility, which serves as the focus for Chapters V and VI, when an individual first enters a nursing home, a decision is made as to which ward (and room, and bed) the individual is to be assigned, and whether on this ward the resident is to be treated as, e.g., a "competent" or "noncompetent" member. There are a number of considerations which, on the surface, appear to influence the decision, but there is little communicational research documenting these. Within the present theoretical framework, one goal of this research is to search for information about slotting (placement) criteria and procedures in two nursing homes. It may be suggested that some slotting decisions may be based on interviews staff members have with the pre-patient's family and upon the reports of behavior provided by the latter. On the other hand, such decisions may be determined by the appearance and interactional behavior of the patient during an intake interview. The present study also seeks to question the temporal features of ward assignments. It may be suggested that slotting decisions need not all be permanent. As noted above, an allocation is here viewed as but a moment in a career. Once slotted, the individual
may be allowed or denied access to certain other behavioral alternatives and will be trained with regard to the coded behavior expected of someone occupying his/her position. Thus, there is differential access to particular trajectories, and, it may be hypothesized, different behavior is associated with and expected of the incumbents of each trajectory. Again, it is this system of alternatives and the associated behavioral expectations which are investigated here.

The initial operationalization of social position was made for this study in terms of the available beds in each facility. Ward slots, i.e., available beds, are visible to all members and observers of the institutions, and are independent of any subsequent communicational analyses I as researcher conduct in the nursing homes. That is, these data on the slots available for particular assignment and reassignment decisions are separate from the observational data on the rules guiding communication behavior for incumbents of particular positions. This delimitation of the research problem was made so as to avoid the tautology of analyzing the same data in social structural and interactional terms. Stated differently, in order to avoid the potential circularity of analyzing ethnographic data as evidence for particular social positions and then as coded behavior associated with these positions, I have chosen as an initial, independent source of the status system the physical layout of beds and residential sections.

These data on bed slots are analyzed from the perspective of their contrasting equivalences and nonequivalences. As suggested above, institutions may assign individuals to social positions and trajectories which appear to the analyst to be distinct, yet which are viewed by the participants as the same, partially or completely overlapping,
interchangeable, non-identical, or the like. In this manner, the present study considers that nursing home residents may be assigned residential positions with varying degrees of prestige and with differing associated behavioral requirements.

I am concerned here with the shapes (patterns) of trajectories within an institutional context. To gain perspective on this issue, in the initial planning of the research it seemed necessary to have the data form a comparative analysis of two nursing homes. As outlined in greater depth in the methodology chapter (Chapter III) and in the data chapters (IV, V, VI), this choice has allowed me to locate the behavioral data within larger perspective, i.e., it has enabled me to question the relative significance of particular recruitment patterns for the particular institutions chosen. A range of similarities and differences between the two institutions is noted here. As discussed in Chapter IV, certain of these similarities appear to relate to the similar and generalized place of the elderly in American nursing homes; the differences may be seen to be generated by the different structures, goals and histories of the particular institutions chosen for this study. For example, it is noted below that both institutions divide patients into competent or noncompetent categories. However, the criteria and procedures used for recruitment to these categories are different.

Permission for one site for this research was secured from a nursing home owned and supervised by the Catholic archdiocese (Sisters of Faith Home). All administrative decisions and most ward routines at this home are carried out by nuns who are members of a religious community dedicated to "Christian social service." The ethnic
composition of this facility varied over time, but approximately seventy percent of the residents (based on an average for the nine months of field work—October, 1980 to June, 1981) were described or described themselves as Irish Catholic. For the second nursing home, I chose to return to the institution where I conducted thesis research for my Master of Arts (Sigman, 1979). This selection proved to be especially helpful because of the extended period of field work and the larger time perspective on some of the data it afforded. This nursing home, here called People's Home, has residents of a comparable economic status to those found in the Catholic home (middle-class, with children likely to be middle to upper-middle-class professionals). The population is described by the administrators as being between sixty and seventy percent Eastern European Jewish, ten to twenty percent (Irish) Catholic, and the remainder Protestant. It will be noted in Chapters IV and V that, although the ethnic composition was heterogeneous, People's Home was perceived by certain resident families as a "Jewish facility."

It should be pointed out that I first attempted to gain permission for this study from two homes which would have represented more clear ethnic contrasts, but several rejections led me to select the institutions described above. In this regard, Sisters of Faith Home and People's Home represent what might be considered a secular/nonsecular (and profit/nonprofit) institutional contrast. The gerontology literature suggests that the duration and actual process of patient adjustment to institutionalization differ for nursing homes which are church-related and those which are not. Referring to Protestant and public-assistance nursing homes, Pan indicates that
"... residents (of the former institutions) showed better familial relationships, more hobbies, and deeper religious convictions" and, moreover, "... may be considered definitely better adjusted than the same from public institutions" (1950a:382). In addition, research seems to indicate that the locus of "control" for status passage in the various geriatric facilities is very different. Church homes, for example, tend to have a pre-existing structure and set of rituals established by staff members to which patients, viewed by the staff as individuals, are expected to conform. In contrast, the residents of religiously nonaffiliated settings tend to attain particular statuses through participation in resident-created and resident-sustained activities and groups. Marshall writes in this regard:

At St. Joseph's the administration seeks to socialize passagees for impending death through the use of formal ritual (funerals), while a high degree of control is manifest over other aspects of their lives.

At Glen Brae, while the administration makes no formal attempts to socialize passagees for impending death, neither does it seek to exert control over other aspects of the residents' lives. This leaves them free to develop their own ways of dealing with death as a community phenomenon (1975:364).

The present data extend these observations by indicating that the presence/absence of particular social positions and recruitment practices in the two institutions can be related to the ostensible goal of each (a profit motive at People's Home, Christian charity at Sisters of Faith Home), and that these differences in turn shape staff-patient social relationships and patterns of message flow. More specifically, Chapter IV indicates that residents enter People's Home, which is structured around a number of distinct wards, for the medical care available, and for the opportunities for peer social contact. On the
other hand, Sisters of Faith Home residents enter the nursing home in order to find a hospital-like atmosphere; what sociable interaction there exists in this home is defined, not by one's section affiliation (bed and floor assignment), but by the various activity programs administered by the staff.

It should be reiterated that the present study represents an institutional contrast. Both SFH and PH are multi-ethnic, although there is a higher percentage of Irish Catholic individuals residing at the former and Jewish patients at the latter. Birdwhistell (personal communication) suggests that one of the advantages of a non-homogeneous setting is that this may make the objects of our attention more manifestly Jewish or Irish, for example, through their own awareness of and reactions to others "who are different." Birdwhistell reminds us of the self-consciousness of new Oraibi Hopi in the presence of old Oraibi. One unintended benefit of mixed subject populations is revealed in Chapter IV, where individuals' reasons for entry into a nursing home and their expectations once there are analyzed; the opportunity to compare Irish Catholic residents in two institutions enables the present report to make a statement about the differing goals and organizations at the institutional (rather than specifically ethnic) level.

In summary, the following research questions concerned with social recruitment are addressed in the remainder of this dissertation:

(1) What institutional procedures and criteria are used to slot or assign incoming patients to positions within the facility (here operationalized as section and bedroom)?

(2) What institutional procedures and criteria are used for reassigning residents living at the facility? In other words, what are the temporal dimensions of particular assignment decisions?
(3) What communicational messages are engaged in and expected of residents with different position assignments by other social actors (staff and patients) in the nursing home? What changes, if any, in behavior patterns exist in association with (just prior to, subsequent to) reassignments?

(4) What alternative practices for recruitment are available to and employed by nursing homes? That is, what differences can be found with regard to admissions, assignment, and reassignment criteria and procedures in association with the type of geriatric facility?

As noted, these questions are addressed with data from two nursing homes, a Catholic facility, and a private-profit one. The social communicational significance of this contrast for the differences in the recruitment systems of the two institutions is discussed in Chapter IV and Chapter VII. Chapters V and VI concern themselves with the data for the above questions for, respectively, People's Home and Sisters of Faith Home.
A gatekeeper is someone who channels or selects information (see Lewin, 1948; Giber, 1964; White 1964). I am using the term in the present context to refer to the process of diverting individuals from certain status trajectories.

See below for a discussion of "partials."

"Career" is herein used as the positional trajectory.

The use of the term "partial" is intended to convey the interdependence of behavior units, in terms of their conditions of appearance and their functions or meanings (see Birdwhistell, 1970; especially pp. 79-80).

Although the present study is concerned with and employs communicational behavioral data, it should be noted that interactional or discourse analysis per se is not a primary goal. The goal, rather, is to see how interaction rules and patterns of behavior provide a repertoire which can be utilized by participant members in the definition of their status and relative prestige, and in the maintenance or modification of these definitions.

Of course, the specific trajectory that characterizes the aging process is likely to vary from culture, or from one institutional arrangement to another. It is ethnocentric to suggest that one's participation in one's social world terminates with biophysiological death (cf. Van Gennep, 1960).

Pseudonyms for the institutions and the social actors are used in this dissertation.

Marshall is unclear as to whether it is the residential structure or church affiliation which accounts for this difference.
CHAPTER II
BACKGROUND STUDIES

The present chapter is divided in two sections. The first discussion centers around the anthropological and sociological literature on social recruitment and status change. The second section surveys the existing research on communication patterns in geriatric settings, the site for the present study on career patterning and social recruitment.

Status Passage

In the preceding discussion (see Chapter I) I took the position that social recruitment for research purposes may be conceived of as a behavioral system concerned with certain processes by means of which individual society members are sorted within a social system and are provided with various options for filling (occupying) existing social positions. This research concern is consistent with the perspective on status passage as articulated by Glaser and Strauss:

Insofar as every social structure requires manpower, men are recruited by agents to move along through social positions or statuses. Status is a resting place for individuals. But while the status itself may persist for many years, no matter how long an individual remains in, say, an office, there is an implicit or explicit date when he must leave (1971:2-3).

Emphasis on the social patterning of status passage derives from a functionalist orientation which argues "the need for continuity of the social structure as a system of relations between persons. . ."

(Radcliffe-Brown, 1965:47). Within the premises of a functionalist
orientation on social existence, the persistence of a social order as an integral whole, and the persistence of any or all constituent statuses, necessitate procedures for recruitment of individual members to relevant social statuses. Linton (1936) defines a society as an abstraction from the relations among persons, and, moreover, states that the structure of society must be conceptually distinguished from the particular individual(s) occupying the constituent places or positions (see also Kroeber, 1948; Radcliffe-Brown, 1965). Congruent with this definition, Aberle, et al. note that the perpetuation of a society may be viewed as distinct from the perpetuation of individual members' lives:

The identity and continuity of a society inhere in the persistence of the system of action in which the actors participate rather than in the particular set of actors themselves. There may be a complete turnover of individuals, but the society may survive. The individuals may survive, but the society may disintegrate (1950:101).

Thus, the perspective taken here assumes the existence of patterned processes within a society which regularly fill the existing vacancies in the system. As Sorokin writes:

Any organized group existing for any length of time incessantly loses members through their death and in other ways. To maintain its initial size and to grow, a group must continuously recruit new members. Otherwise it will shrink in size and eventually disappear (1947:400).

The perpetuation and continued adaptation of a social system are assumed to require some means for constantly "coaxing" or "allowing" individuals to assume (or "dissuading" them from) the various social positions which comprise the society. These social positions can be seen to be made available as a result of attrition (death or physical disability), obsolescence brought about by economic and technological growth (retirement), and other changes in the "personnel" of society.¹
From the perspective of the life courses of individual society members, social biographies can be analyzed as marked by regulated and patterned transitions between social positions. Comparative investigations of social organization have revealed that "... every society classifies and organizes its members in several different ways simultaneously" (Linton, 1942:589). Gerth and Mills also write in this respect:

The concept of role (units of behavior which by their occurrence stand out as regularities) does not of course imply a one person-one role equation. One person may play many different roles, and each of these roles may be a segment of the different institutions and interpersonal situations in which the person moves (1953:12).

Such allocations of status and role in a society are not static. During the course of a lifetime, an individual may be seen to take on or depart from a variety of statuses and social responsibilities. Status changes may thus take the form of additions to individuals' status affiliations, the substitution of incumbency of one social position for another, or the diminution of status affiliations over time. Becker and Strauss write that constant and regulated status change or mobility is a fundamental characteristic of social life:

... Central to any account of adult identity is the relation of change in identity to change in social position; for it is characteristic of adult life to afford and force frequent and momentous passages from status to status (1956:263).

In this respect, the sociological concept of career is used to describe the larger (more inclusive) pattern of movement between statuses (see Hughes, 1937; Becker and Strauss, 1956; Coffman, 1961) or the "occupancy of a status over a period of time" (Scheff, 1966:155) which constitutes an individual's life course. A career may be thought of as a positional trajectory, and assignment to a particular position as one component of that career (trajectory).
Expanding upon Durkheim's (1933) earlier development of the division of labor concepts, Kemper writes that "the ineluctable condition of humankind is interdependence" (1972:741), which means that "humans cannot supply their wants and needs exclusively by their own efforts" (ibid.:742) (see also LaBarre, 1954). By definition, a society is composed of interdependently functioning members whose activities are characterized by (constitute) a division of labor. Linton writes that "the transformation (from aggregate to society) normally begins with a division of labor of the activities necessary to the immediate well-being of the group and their assignment to particular individuals" (1936:92). Chapple and Coon also note: "... Most complex techniques (in society) involve the activities of more than one person, and, in fact, where people practice a number of complex techniques, extensive interactions must take place to coordinate the work. . . ." (1942:250).

Social interdependence can thus be seen to involve members contributing partial functions to the group's maintenance and adaptation processes. Lowie (1948) and Murdock (1937) note the near universality of various social distinctions, e.g., classifications of group membership according to age, sex, and kinship affiliation. Each such categorization which is recognized by a society establishes behavioral expectations for individuals, i.e., delimits his/her participation in the activities necessary to the group as a whole:

The age-sex categories and their derivatives are the building blocks of the society. They determine the individual's impersonal relationships with the society's other members and the sectors of its total culture in which he will participate (Linton, 1940:872).

Each classificatory device serves to specify a particular role or function (Sorokin, 1947) which an individual is to assume; as noted above,
during the full course of an individual's life one is likely to assume a
diversity of such societally-relevant roles.

Although sociologists and social anthropologists indicate the
fundamental importance of role differentiation as it contributes to and
is patterned by a society's division of labor, they further suggest that
the concept of role differentiation needs to be related to theories of
social mobility and social selection processes. Aberle, et al. write,
for example, that the functioning of a society extends beyond the
division and intercalation of social activities: "A system of role
differentiation alone is useless without a system of selection for
assigning individuals to those roles" (1950:105-106). As noted above,
social groups lose their membership and/or require individuals' status
changes for a variety of reasons. Sorokin (1947) notes that a social
group rarely establishes membership within its ranks exclusively through
birth, since the correspondence between the number of births and deaths
is not always exact, and not all children of members will be able to
perform successfully the functions of that group. Thus, intergroup
recruitment and mobility characterizes all but the most rigid of social
systems, e.g., Indian castes. It is important to note, however, that
social mobility is not only or always a response to member attrition or
an unequal birth-death rate; rather, it may also be the result of a
swelling or increase in the available positions at a particular level of
society. Increasing technological sophistication may make obsolete
certain individuals who therefore need to be replaced with newly trained
persons: "The flow of occupational manpower in a society has its
ultimate source in technological developments and corresponding shifts
in economic demands" (Blau, 1968:476). In addition:
In times of social upheaval and calamity—major reforms, war, revolution—territorial mobility in voluntary and especially in involuntary forms tends to increase sharply in both the individual and collective forms (Sorokin, 1947:408).

In brief, social recruitment processes can be seen to be operative whenever a social system (society or sub-group) needs to fill positions which have been left vacant for any of a variety of reasons.

Glaser and Strauss (1971) have pointed out that no formal and substantive theory on status passage and social recruitment exists. They have argued that the building of such a theory is dependent upon the isolation of properties of status passages examined in a variety of situational and cultural contexts. The remainder of the present discussion will review some of the contributions to the building of such a general theory. In specific, the discussion will consider the various partials or constituent units of social recruitment in diverse settings that researchers have isolated and examined.

One of the earliest systematic studies of rituals of status change, that provided by Van Gennep (1960 [1908]), has contributed a model for the development of a general theory of types and structures of status passages. Van Gennep's work suggests that rites de passage, or transition rituals, exist in some form in nearly all human societies.

Congruent with the perspective outlined above, Van Gennep writes that "the life of an individual in any society is a series of passages from one age to another and from one occupation to another" (1960:2-3), and that rites de passage co-occur with and serve as social recognition of such movement. It is important to note that Van Gennep's concern is with socially defined statuses and movements, not with the biological antecedents or concomitants of these. He points out, for example, that many initiation rites mark the occasion when an individual is granted...
societal permission for particular orders of behavior, but that these rites may not always coincide with physiological changes experienced by an individual:

... Physiological puberty and "social puberty" are essentially different and only rarely converge (1960:65).

One is therefore led to think that most of these rites—which sexual nature is not to be denied and which are said to make the individual a man or a woman, or fit to be one—fall into the same category as certain rites of cutting the umbilical cord, of childhood, and of adolescence. These are rites of separation from the asexual world, and they are followed by rites of incorporation into the world of sexuality and, in all societies and all social groups, into a group confined to persons of one sex or the other (ibid.:67).

As Linton also writes, rites surrounding status passage function as signals of socially defined changes, not biologically determined ones:

... Ritual emphasis and elaboration are most frequent at those points in the age-sex series where (a) the transfer from one category to another entails the greatest changes in the individual's culture participation and (b) where the changes are most abrupt (1942:600).

Rites de passage, as they were first analyzed by Van Gennep, are divided into three phases (or sub-rites): rites of individual isolation from the group, of transition per se, and of incorporation into a new status or group membership. Van Gennep further suggests that this three-part structure is a universal format by which societies acknowledge those individuals who have been involved in status shifts—including in this category death, marriage, and puberty—and the changes in the individuals' status-specific behavioral duties. When a member of society undergoes a status change, he/she is first separated from the group in which membership is held, experiences various behavioral taboos (e.g., on clothing and food), and then is provided with a new social membership and reincorporated into the society. Often these changes are marked by shifts in personal name and/or appearance.
In a number of societies, for example, bodily mutilations exist as one element of the total rite, and apparently serve, along with other symbolic behavior, as permanent markings of the individual's entry into a particular social group and assumption of a different social position (see Chapple and Coon, 1942; Radcliffe-Brown, 1964 [1922]; Young, 1964). (We will note below that other orders of communication behavior exist by which social groups indicate membership and non-membership.)

As noted, rites de passage may be viewed as markers of changes in one's status affiliations. Additional functions of rites de passage have been outlined by writers subsequent to Van Gennep's initial treatment of the subject. Chappie and Coon (1942) suggest, for example, that transition rituals serve to maintain the equilibration of a social system. These writers suggest that when an individual enters a new institution or into relationships with new persons, this condition establishes a "social crisis," a disturbance in his/her regular interaction with others. Therefore, "in these ceremonies (rites de passage), the new system of relations of the individual is dramatized in such a way as to condition all the disturbed individuals to the order, amount, and frequency of the new interaction rates" (1942:484). Chappie and Coon further suggest that the relative amount of the disturbance for the social system can be seen to condition the relative scope and importance of the ceremony which is performed. For instance, a ceremony for a dead infant, whose interaction with his/her social environment has been minimal, is likely to be less elaborate (i.e., involve less sustained interaction and fewer participants), than is the burial of a valuable adult male.
With regard to the Andaman Island rites de passage he studied, Radcliffe-Brown suggests that it is during initiation rites that the initiate, the individual undergoing the status change, learns the customs and attitudes appropriate to adulthood, or whatever other social position is to be attained. Rites de passage thus provide for a status training period:

The ceremonies teach the youth or girl to realize what is implied in being a member of the society by putting him or her during the period of adolescence in an exceptional position, and, as it were, outside the society (1964:278).

We may say that partaking in the performance of rites serves to cultivate in the individual sentiments on whose existence the social order itself depends (ibid.:146).

Congruent with this, Young's cross-cultural study on "status dramatization" concludes:

... The initiation ceremony helps the boy learn his sex role by placing him, once he is physically ready, in the appropriate sector of the social structure. It is not that he learns during this short period any significant knowledge, or even attitudes, nor is it adequate to say that the boy internalizes his role by experiencing a shift in status from the team that is not initiated to the team that is. Rather, the ceremony gives the boy access to another symbolic world. The men allow him backstage to their "show," and he is concomitantly barred from the doings of women. Now the real learning begins... (1965:32).

In brief, rites de passage serve at least three social functions: (1) to signal for concerned group members an individual's transition to a social position; (2) to ease the initiate's interaction with others; and (3) to provide a period of training in status-relevant behavior.

Glaser and Strauss (1971) argue that Van Gennep's classic, as well as the research which has been influenced by it, tends to focus on a limited aspect of status change:
A principal and limiting feature of most status passages studied implicitly by anthropologists and sociologists is their relatively scheduled nature. Those passages are governed by fairly clear rules concerning when the change of status should be made, by whom and by whose agency (1971:3).

Sociologists have tended to assume in their analyses that status passages are fairly regularized, scheduled, and prescribed. But those three properties of passages can be absent or present only in some degree in some types of status passage (ibid.).

An alternate way of saying this is to suggest that the concept of rites de passage tends to presuppose criteria for and the scheduling of individuals' selections for status alterations. The concept focuses on the practices by which a society member about to undergo a status change is first separated from his/her previous group, is required to pass through a liminal phase, and is then presented with a new or additional social membership. This does not account for the social conditions under which a status selection or decision is made. As Sorokin describes in his summary statement on intergenerational status movement: "Mobility has always been controlled by mechanisms for the testing, selection, distribution, promotion, and demotion of its members" (1947:424). Studies to be discussed below indicate that prior to an individual's attainment of a new social position or incorporation into a new group (or sub-group), i.e., prior to the necessity of the rite of passage itself, there may exist patterned interactions to facilitate the selection or rejection of candidates, novitiates, and future incumbents. In addition, research indicates the importance of selection criteria which may require individuals to demonstrate "talent" appropriate to slotting to a particular social position. Moreover, not all individuals may be permitted access or entry to particular social positions, and so there may exist gatekeeping processes which serve to block movement from...
or to particular status courses, and which thus preclude the implementation of transition rituals.

The existing literature on social recruitment is concerned with issues broader than the processes by which individuals move between social statuses, although the importance of *rites de passage* should not be minimized. In addition to considering the structural features of the status transition itself, previous studies (e.g., Benedict, 1934; Linton, 1940, 1942; Warner, et al., 1944; Sorokin, 1947; Whyte, 1955 [1943]; Erickson, 1976) have examined the evaluation procedures and criteria associated with the selection of individuals to fill available social positions, as well as the organization and mythology surrounding gatekeeping and channeling interactions. For heuristic purposes, the following aspects of social recruitment may be isolated for the present discussion: individual abilities or "talent"; (institutional) evaluation procedures; treatment of the individual as a consequence of position selection or denial; the availability and organization of social slots or positions; and the set of verbalizable explanations and justifications surrounding particular status passage patterns.

The concept of recruitment is concerned with the rules governing those interactions in which individuals are given or denied access to particular social structures and positions. It has been observed by various authors (Linton, 1940, 1942; Warner, et al., 1944; Sorokin, 1947) that individual "talent" is used by "recruitment agents" (Glaser and Strauss, 1971) or evaluators in assessing the likelihood of movement to transpire for potential recruits; i.e., that the general process of status movement is often contingent upon certain behavioral
manifestations. Glaser and Strauss suggest that "a standard way of organizing the recruitment of passagees or agents for a passage is through comparative selection" (1971:60; emphasis in original).

Further, they write that the salience of behavioral prerequisites is one means by which society is able to control individuals' passages:

Another basic means for controlling the shape of a passage is to prescribe types of persons suitable for it. . . . Getting those agents and passagees requires well organized and conceived processes of recruitment as the basic means for filling the prescriptions. Otherwise the alternative dimensions upon which a passagee or agent are recruited can vary too easily, and later the recruiter may find that the wrong person has been recruited (ibid.:59).

Sorokin writes that a social group which is able to fill individual positions with appropriately skilled individuals is likely to survive longer than a group which regulates neither status movement itself nor the prerequisites for status selection:

Other conditions being equal, the organization . . . which succeeds in such a distribution of its members among the group's positions which is nearest to the principle "to everybody according to his talent," such an organization has greater chances to survive than the organizations which greatly deviate from that rule (1947:534; emphasis in original).

As noted above, few social groups (i.e., within a larger society) can self-perpetuate through the birth of individuals, and some form of personnel selection is necessary for group survival. However, no social system can survive which has totally unrestricted movement or selection, since this would undermine the group's functioning (Sorokin, 1947).

Career paths often provide waiting stations during which individuals are prepared and tested for future social roles. As Marvick notes for the political arena: "Apprenticeship and examinations, both
formal and informal, often precede incumbency in political jobs" (1968:277). In other cases, individuals are selected for certain positions because of existing behavioral performances, skills, attitudes (including group loyalties), etc. Gerth and Mills suggest that certain individual biological propensities may be socially elaborated and utilized in the process of the selection of persons to fill positions:

Certain biological capacities and traits . . . often become particularly relevant to the demands set up by new roles. Thus, if a society needs aviators in order to fight an air war, those individuals who have good biological capacities for "balance" have increased chances to assume these roles. . . . What specific aspects of man's biological nature become prerequisites for role-taking are socially and technologically determined, and accordingly, those aspects which become relevant to our explanations of conduct, are thus determined (1953:16-17).

In a comparable manner, Joos suggests that an individual's command of formal linguistic registers may be used as a touchstone by society for recruitment into positions of responsibility:

The community's survival depends on cooperation; and adequate cooperation depends on recognizing the more and less responsible types of persons around us (e.g., through their differential command of linguistic resources). We need to identify the natural burden-bearers of the community so that we can give them the responsibility which is heaviest of all: we make them responsible for cooperation itself (1967:14-15).

The development and exhibition of particular linguistic behavior by an individual society member can in this manner be seen as among the initial stages of particular career paths, and as providing one necessary condition for position selection and/or group entry. Similarly, physical strength in the Italian-American community (Whyte, 1943), or the propensity for hallucinatory experiences among Plains Indians (Benedict, 1934), is often looked for by societal members when
recruiting individuals to serve, respectively, as group leader or as tribal medicine man.

Kaplan (1981) hypothesizes that, in Jewish families, there is preferential recruitment of individuals to assume the various roles which comprise each family's division of household labor. Some of these are drawn along sex categorizations (see Linton, 1942; Lowie, 1948). For example, husbands are apparently preferred over their wives when it comes to being selected as the responsible party within the family for the paying of bills.

Becker and Strauss indicate that a variety of factors enhance or detract from the chances of a candidate's being accepted into medical schools, but that not all are directly related to the schools' ostensible mission of training talented individuals to become physicians:

Some kinds of persons, for occupationally irrelevant reasons (formally, anyway), may not be considered for some positions at all. Medical schools restrict recruiting in this way: openly, on grounds of "personality assessments," and covertly on ethnicity. Italians, Jews, and Negroes who do become doctors face differential recruitment into the formal and informal hierarchies of influence, power, and prestige in the medical world (1956:255-256).

Hughes also notes that there may exist "auxiliary traits" which do not directly qualify or disqualify a person from attaining a particular social position, but which are generally expected of incumbents. Again with reference to the medical profession:

... It remains probably true that the white, male, Protestant physician of old American stock, although he may easily fail to get a clientele at all, is
categorically acceptable to a greater variety of patients than is he who departs, in one or more particulars, from this type (1944:354).

However, Dalton (1951) notes that because there was no relationship between selection criteria (ethnicity, membership in the Masons) and an individual's ability to perform a job in the business plant studied, promotion errors were frequently made, and required that the person promoted be given a limited set of work responsibilities.

The existence and potential relevance of career behavior should not be seen as the initial or necessary causal elements for a particular career path or trajectory placement. Rather, the above research literature indicates that such behavior can be seen as conditions which delimit career options for an individual or provide rationalizations for either self-selection or other-recruitment. Status-relevant talent and skills may establish the particular trajectory an individual may follow and the scheduling of events along that trajectory. Such behavior serves as indices of a person's rightful or appropriate claim to a particular status or trajectory. It may be suggested here that this behavior establishes conditions for the appropriate existence of subsequent interactions which may result in recruitment, and that the latter are often adumbrated by the former. As we will note below, however, denial of access to particular social statuses may be directed even to those individuals with the requisite behavior, e.g., because of limitations on the available positions.

Prior to an individual's incorporation into a new social group, a series of interactional sequences (situations) may be observed which function to test and select novitiates and future incumbents, i.e.,
which provide for the initial designation of candidates. As noted above, individuals may need to demonstrate talent appropriate to slotting for a particular trajectory. However, the salience of particular units of status-appropriate behavior may be mediated within the context of interaction with recruitment personnel and the evaluation procedures which govern (albeit tacitly in some cases) this interaction. Several students of deviant behavior observe, for example, that the mere fact that one has been brought before some entrance committee is often seen as justification for confinement in an institution and/or conscription to the deviant role (Goffman, 1961; Erikson, 1966; Perrucci, 1974). On the other hand, the status one will assume as a result of a particular slotting decision may be negotiated to some degree in the interview context. Psychiatric evaluations, which are not guided by absolute and explicit rules in the military context, provide a suitable example of this situation. Daniels notes that the decision to label an individual with a particular mental illness and to provide the attendant behavioral slotting (exit from the military, sick leave, return to duty) involves a diverse set of considerations: visible symptoms as presented in the psychiatric interview; the psychiatrist's informally felt responsibility toward the patient as determined by the latter's number of years in the service; the differential entanglements in the military bureaucracy for the various decisions; and the presumed amenability of the patient's deviant behavior to "the type of psychiatry we're practicing right now" (1972[1970]:565).

Social theorists have pointed to a variety of recruitment modes or formats. Gerth and Mills write that, among other possibilities, social
"institutions may be classified according to the way in which their members are recruited" (1953:24), and Marvick notes with reference to political positions that "institutions use a variety of devices to fill all jobs" (1968:277). Gerth and Mills draw a distinction between institutions whose ranks are filled through compulsory recruitment, e.g., compulsory education or required attendance at church as a consequence of infant baptism, and those which are filled through voluntary means, e.g., civic groups. With regard to the political arena, recruitment to the various positions may be accomplished through co-optation by equals, mobilization of "supporters," appointment, election, and rotation (Marvick, 1968). Merton (1968) suggests that recruitment in bureaucracies may be patterned on the basis of open competition among individuals with specialized knowledge and previous experiences, or on the basis of patronage. Finally, Sorokin (1947) outlines two dimensions by which recruitment may be analyzed. Expanding upon Linton's (1936) distinction between ascribed and achieved statuses, Sorokin first suggests that social selection may be either automatic or nonautomatic. In the first category are inheritances of caste, nationality and occupation by children from their parents; in the latter category are such means of recruitment as appointment, election, draft, and coercion. With regard to specific patterns of mobility, Sorokin suggests that one can find examples of both "normal" mobility, which is patterned and expected by society members (e.g., elections, promotions), and that mobility which results from unusual social upheavals (e.g., revolutions, outcastings, overthrows).
Warner, et al. (1944) observe that certain social institutions, such as schools, serve a sifting function for society, in that one of their activities is the channeling of individuals to various career paths and degrees of mobility. Sorokin also writes in this regard:

Many do not realize that our schools are not only training and educational agencies but also—and perhaps even to a greater degree—testing, selecting and distributing agencies for all the other contemporary groups (1947:441).

For example, Warner observes that not all individuals with equally high grades will be encouraged by teachers to continue their studies on through college; parents' socio-economic status and the student's racial identity will also be taken into account.

As suggested, the channeling of individuals to the various social positions often is based on evaluation interactions. Erickson provides data on gatekeeping encounters in several interview settings:

I wondered what "the Man" did as a gatekeeper, whether he dealt with interviewees of his own ethnic group differently from black and Latin interviewees. If so, how were these differences played out in interactional performance, and what social meaning did such differences have for interviewees and for the gatekeeper himself? Two points of gatekeeping contact with mass society could occur between late adolescence and the beginning of young adulthood: going to see a school counselor or a job interviewer. . . . I wanted to see what effect ethnic and racial similarities and differences between the two persons in the encounter had upon the character and outcomes of interaction face to face. Identifying the character of interaction involved considering not only speech forms and speech functions but the form and function of nonlinguistic behavior as well. Identifying the outcomes of interaction involved considering how a gatekeeper disposed of the case before him: whether he fostered or hindered social mobility and by what interactional means he performed these gatekeeping functions (1976:118).
Erickson points out that the outcomes of such gatekeeping encounters are, in part, a consequence of each participant's ethnically patterned interaction style. Help toward social mobility for each interviewee tended to be proffered from interviewers of similar ethnic background and interaction style.

In a similar fashion, Birdwhistell (1970) provides a personal anecdote to show barriers and evaluative interactions may exist even for entry into a family system. Birdwhistell refers to a visit by his brother's girl friend (and potential fiancee) which ended in parental disapproval:

I have often thought of the test of the young lady from Shaker Heights. Her background and her familial system were sufficiently similar to ours that she must have known very soon that this had not been a successful visit. But, in a larger sense, perhaps it was successful. She and my brother may have each been steered by the incident to more appropriate mating later, the incident a temporary setback in the courting procedure. A failure at one level of communication is often a success at another. . . . We might, from our perspective, say she was interviewed and did not get or take the position, or, we could say that the familial context could not adapt to her addition (1970:53).

Also note the following comments by Suttles on the relationship of territorial access and family membership:

At first sight, then, the family household appears to be a collection of territories, but on second thought, each of its portions seems only a membrane which sorts entrants rather than rejecting them altogether. The family is open to the wider community through its living room entrance, although a person who feels he must remain there—or in the living room itself—will be only a peripheral associate of the family. . . . (A)s in dating relations, increased access is negotiated through preliminary exploratory movements and a range of responses (1972:179).

Studies indicate that, under certain conditions, a status assignment may be temporary, a waiting station for further evaluation or for competition for other positions; it may also provide a context in
which subsequent career options are made available to the individual.

Becker and Strauss write:

In general, while commitment to a given career automatically closes paths, the skills and information thereby acquired open up other routes and new goals. One may not, of course, perceive the alternatives or may dismiss them as risky or otherwise undesirable (1956:260).

It may be suggested that status passage and trajectory scheduling are constantly being negotiated and recalibrated. Glaser and Strauss urge in this respect a particular view of social structure:

It is important that we continue to see a status passage temporally rather than statically. The passagee is in constant movement over time, not just "in" a status. To aid in this conceptualization we must think of temporal social structures—that is social structures in continuous process—and of their processual aspects (1971:47; emphasis in original).

I will detail below some aspects of the organization of this movement.

No matter the duration of a slotting, behavioral requirements devolve on the incumbents of particular social positions. Coincident with a particular status selection, the individual can be observed to be accorded sets of expectations for his/her own behavior and behavior on the part of others which are deemed appropriate to an incumbent of the position assigned. Linton writes: "Every culture includes a series of patterns for what the behavior between individuals or classes of individuals should be" (1936:103). In this respect, Gerth and Mills also write: "Institutions not only select persons and eject them; institutions also form them" (1953:173). For example, a ward assignment in a mental asylum generally is (1) seen by institutional members as an appropriate judgment on the capacities of the individual so placed, and (2) taken as indicative of the individual's rightful status and role (Goffman, 1961; Perrucci, 1974). Thus:
Assignment to a given ward is presented not as a reward or punishment, but as an expression of his general level of social functioning, his status as a person (Goffman, 1961:149).

These definitions of status may be seen to have multichannel behavioral consequences which incumbents of the various statuses must follow:

Maintenance of the formal caste-like structure depends upon spatial separation, occupational separation, prescribed and proscribed activities for each stratum, rituals of avoidance and shared symbolic representations of rank and status (Perrucci, 1974:25).

As noted above, Van Gennep (1960) describes the various orders of dress, demeanor and bodily appearance which individuals evidence in order to signal their participation in a particular rite de passage and their attainment of a particular social position.

Some of the nursing home patients at People's Home (Sigman, 1979) were accorded title plus last name as a form of address. In contrast with the other residents who received first names, nicknames and pejoratives, these residents were considered the non-senile group at the home, lived on a ward with a minimum of supervisory staff, were included in certain activities, and were respected by their peers and by the staff. This is to say that individuals were differentially provided with access to particular social positions at People's Home, and that these positions correlated with differences in interaction behavior accorded patients.

This differential behavior can be seen as a means of continuously reaffirming for the others the particular social positions individuals occupy. Whyte provides an excellent example of the behavior of group members as they attempt to keep others "in their places" in order to ensure maintenance of their own high social position:
When Doc, Danny, Long John or Mike bowled on opposing sides, they kidded one another good-naturedly. Good scores were expected of them, and bad scores were accounted for by bad luck or temporary lapses of form. When a follower threatened to better his position, the remarks took quite a different form. The boys shouted at him that he was lucky, that he was "bowling over his head." The effort was made to persuade him that he should not be bowling as well as he was, that a good performance was abnormal for him. This type of verbal attack was very important in keeping the members "in their places" (1943:24).

In other cases, such behavior has been shown to serve as preparation for or adumbration of a status change, a movement to a different social sphere:

Kenneth Peabody is being rewarded by his family for wearing nice clothes and speaking proper English. As soon as he is old enough to suffer from the disapproval of his Hometown agemates for his fine clothes and upper-class ways, his parents remove him to a private school where he finds a new group of agemates who dress and speak the way his parents want him to dress and speak (Warner, et al., 1944:15).

In brief, previous studies of social recruitment make clear the importance of considering the differential codes for interaction by which individuals are encouraged or excluded from assuming certain social positions, and, further, of considering how these differential codes serve to maintain existing social position assignments.

In addition to this, research has taken account of the various career paths which are available for selection by evaluators and potential recruits. Researchers concerned with recruitment have traditionally examined (1) the availability of slots in a social system, and (2) the patterned connections or processes of movement from one position to another. Students of careers suggest that, not only is there differential recruitment of individuals, but there is sometimes differential and limited availabilities of slots to be filled. As Sorokin writes: "The first determining factor (for the selection and
distribution of group members) is the group organization itself, which defines who shall occupy each of its strata and positions and under what conditions" (1947:437; italicized in original).

As noted, investigation of social positions to be filled may be made from one of two perspectives: (1) the quantitative patterning of slots; and (2) their qualitative organization. The first question concerns quotas. Within his more general perspective on the division of labor in society, Durkheim points out that it is pathological for the overall specialization and integration of a social system for there to be no limitations placed on the attainment of social positions:

... There are societies where there are too many functionaries, or too many soldiers, or too many officers, or too many intermediaries, or too many priests, etc. The other occupations suffer from this hypertrophy. But all these cases are pathological. They are due to the fact that the nutrition of the organism is irregularly taken care of, or that functional equilibrium has been broken (1933:271).

Sorokin (1947) suggests that access to group membership in an "open society" is differentially limited based on the relative advantages and disadvantages of attainment of particular social positions, although there is likely to be some fluctuation during periods of economic and technological expansion or decline. Congruent with this assertion, Warner's research suggests that the number of individuals who can reach upwardly mobile positions is limited at any one point in history, although the amount is not permanently closed:

One important qualification should be made with respect to the generalization that only a limited number of people can be accommodated in the upper social and economic levels of our society. While the number is limited, it is not fixed at the number we have in our society today. The proportion of doctors, teachers, and other professionals who serve other people might increase greatly if more money were spent on health service, education, and other social services. Thus, the number of positions in the upper half of society might be increased considerably. But even if this number were
doubled or tripled, the number would still be limited to a small fraction of the total adult population, and many young people in our society would be disappointed in their efforts to achieve these positions (1944:151-152).

On the other hand, Erikson (1966) points to the stability over time of deviant slots in Puritan communities in America. He writes:

... Social groups are likely to experience a relatively stable "quota" of deviation, partly because their social control machinery is calibrated to handle a steady flow of deviant conduct and partly because a group's definition of deviant behavior is usually phrased in such a way as to embrace a given segment of its range of experience (1966:163-164).

Various studies have examined position quotas in medical settings. Access to a position as helper in mental hospitals is often limited in number, and subject to a cyclical pattern of availability-nonavailability (Perrucci, 1974). This cyclicity is a result of the work demands placed on staff members, which open up the opportunity for a patient to serve as helper, and of a patient's behavior of inappropriately "stepping out of line," which closes this opportunity for a brief time. Finally, Lang (1981) discusses the existence of patient or client quotas in mental health clinics. The number of patients seen by the staff is limited by scheduling and work load demands, as well as by the doctors' attitudes towards certain illnesses:

Cases judged to indicate poor prognosis, for whatever reasons the staff deemed relevant, were less likely than those judged to be "good cases" to be formally assigned to particular workers for a systematic program of treatment. For cases were not selected by workers in order of their contact with the clinic, but in terms of whether a particular worker "liked" or was "interested" in the case. Staff members had considerable latitude in selecting cases, and these private discretionary judgments implied a distinction between good cases and bad cases... (1981:294).

In addition to the quantitative study of individual positions, one must also consider the larger structural system itself. This takes
account of such issues as the type and variety of total available slots within a social system, the minimal behavior required for achievement of or ascription to particular slots, the additional pathways (options) available to fillers of certain slots, the relative equivalence of prestige and power accorded each position, and, more generally, the patterned interconnections of all slots (cf. Linton, 1940). This may also include what Glaser and Strauss consider the prescribed rate of a status transition or passage, i.e., "... the number of transitional statuses, in what order or sequence they fall, and how long the person will be in each transitional status" (1971:41).

The literature indicates the possibility that the number of slots within a given social system may not be limited, but that not everyone will evidence the prerequisites (in the form of previous statuses held) necessary for recruitment. That is, the limitations or constraints placed on position filling may not be quantitative in nature but qualitative. Gerth and Mills note that social positions may be analyzed according to the likelihood and patterns of movement: "Roles in voluntary associations are often stratified as permanent, provisional, or transient" (1953:169). Linton provides important perspective on the organization of social positions with his Madagascar data:

It is also plain that there are few points in the life of the individual where he is brought into competition with other individuals for status. In the female life-cycle there is only one, the competition between girls in Status 2 (adolescent girl) for the status of first wives, Status 6. For males, there may be rivalry between occupants of Status 13, warrior, or Status 14, ombiasy (medicine man), but no real competition since the number of persons who can occupy either of these statuses is not culturally limited... The whole picture is that of a society in which the individual progresses smoothly upward in prestige with age, with no sudden transition in responsibility from one age level to another and with little competition or conflict (1940:879-80).
In addition, Linton's analysis considers the patterned routes available to individuals, i.e., the appropriate paths which may be taken by individuals as they move through the social structure from one position to another:

It will be observed that the statuses shown in these charts are arranged in series, the individual passing from those in lower to those in higher age levels. At particular points in such series there are usually alternatives, i.e., the individual having reached this point can move to any one of two or more statuses, and this selection will limit the range of statuses which may be occupied thereafter. Thus in the Tanala female series ( . . . ) the adolescent girl, status 2, may become either a head wife, status 6, or a second wife, status 3 (1940:874).

The analysis of the organization of social positions is also concerned with the existence of exit nodes and alternative career options. Those individuals not allowed entry onto a particular status trajectory may either exit from the system or follow the paths which appear to remain open. To some degree, however, an individual's failure to follow a prescribed trajectory may result in various forms of pressure or social control:

It should be emphasized that in all societies the stimuli employed for the reconditioning of individuals to successive age category roles involve a combination of rewards and punishments. The punishment for clinging to the role of a lower age category is easy enough to observe in all societies. It comes in the form of ridicule and ostracism by members of one's own age group (Linton, 1942:602).

On the other hand, an institution may be organized so as to regulate a certain percentage of exits:

About half the students who enter high school take a college preparatory course and no more than one in three of this group of "college preparatory" students actually enters a college. Less than half of those who enter college finish a college course. Thus the high school and college operate crudely as selective agencies by admitting about six times as many students to the college preparatory course as actually finish college work (Warner, et al., 1944:151).
Interestingly, Gerth and Mills note that exits often create problems for an individual's attainment of other social memberships:

In a world of national states, to be expelled from one state for political or religious reasons often makes admission to the territoriality of another quite a problem. Leon Trotsky, after his expulsion from the Soviet Union, for instance, found himself in "a world without visa". . . (1953:170).

In addition to the study of the interactional behavior surrounding recruitment, researchers have directed their attention to the cultural "mythology" of status passages, e.g., the rationalizations and justifications surrounding particular behavioral requirements, evaluation and selection procedures, and specific patterns of movement. Within the geriatric setting, Gustafson (1972) suggests that institutional expectations may be unable to accommodate to the socially active or gregarious inmate, and that the latter will be recruited into more passive roles. That is, available nursing home social positions may be justified on the basis of staff and family expectations for the behavioral potential of geriatric patients. In a similar fashion, military psychiatric classifications are, in part, defined by the doctors' beliefs regarding the type of behavior which counts as deviant, excusable, and/or correctable (Daniels, 1972). Ideological systems often function to supply explanations for particular mobility patterns. With regard to societal age-grading, Luckmann and Berger refer to the expectations for nonmobility by older individuals in America in this way:

. . . The future ends with middle age. Beyond that point, anticipated mobility becomes increasingly unrealistic and implausible. This constitutes the central problem of social gerontology. Modern society has produced an ideology of eternal youth. The structural roots of this ideology are to be found in the functional requirements of industrial economy, with the mobility patterns generated by the latter (1964:338-339).
Becker and Strauss suggest that the study of mobility or career line mythologies should consider what counts as an acceptable rationalization for one's "failure" within the system, or one's ostensible willingness to remain at a given status level and not seek movement:

Most positions filled by failures are not openly regarded as such; special rhetorics deal with misfortune and make their ignominious fate more palatable for the failures themselves and those around them (1956:257).

Becker and Strauss imply that such rhetoric may be used to legitimate downward mobility or movement to social positions which are held in low esteem. Goffman refers to this same function in his analysis of the "sad tales" exchanged by inmates of total institutions:

\[
\text{. . . The inmate tends to develop a story, a line, a sad tale—a kind of lamentation and apologia—which he constantly tells to his fellows as a means of accounting for his present low estate. In consequence, the inmate's self may become even more a focus of his conversation and concern than it does on the outside, leading to much self-pity (1961:67).}
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Finally, Glaser and Strauss point out one additional function of a recruitment mythology. They suggest that appropriate tales may function to attract recruits:

A story, ideology, or line about the passage is proferred, and on its basis the person tends either to accept or reject entry to the passage. Proferring is designed to help a candidate discriminate between what is and what is not real about the passage. What is actually proferred, however, may be ideology or myth designed primarily to persuade recruits (1971:61).

To summarize, there is clear indication in the social science literature that social recruitment is not a unitary process; in addition to transition rituals, there exist procedures for selecting individuals to assume relevant social positions (i.e., to undergo status passage), as well as procedures for gatekeeping or blocking mobility. In this
manner, recruitment involves evaluation procedures in which individuals' fitness for particular positions is tested; potential candidates may need to demonstrate various orders of skill, acumen, attitude, etc. Initial assignments or subsequent transitions to various social statuses, or exits from the particular social system altogether, may be based on these evaluation interactions. A mythology may be seen to exist which justifies, establishes selection criteria for, and regulates particular selection decisions and movement patterns. Finally, it should be reiterated that recruitment is seen to be functionally necessary for society (or particular social groups) because of the personnel changes which inevitably occur over time (e.g., death and sickness) or the existence of societal changes (e.g., economic growth, war and revolution). Social recruitment and the partials outlined above enable a society to fill those social positions made available for whatever reasons in a continuous and regulated (patterned) fashion.

Nursing Homes

Every human society gives attention to those who are no longer young. Institutionalization, in the sense of housing and/or isolation, is an activity of a relative few. This section is concerned with a review of the ethnographic and communications literature on geriatric institutionalization. The present discussion focuses on the existing literature on what the individual patient must adjust to, i.e., the social environment, upon entering a nursing facility (and not on the psychological processes surrounding adjustment). Bennett and Nahemow suggest that there are three components to the process of an individual's adjusting to institutional life:
social integration, which refers to participation in activities and social interaction; evaluation, which includes the concept of morale insofar as it reflects an evaluation of the social environment; and conformity, which is behavior enacted in accordance with social norms (1965:44).

In the sense that a period of adjustment is made possible (or hindered) by the new inmate's caretakers and peers, and is subject to their expectations and monitoring (evaluative interactions), then the present concern with social recruitment at Sisters of Faith and People's Homes can also be seen as a study of "adjustment" to the patterned life courses of each institution.

It should be pointed out that no one study that I have been able to find specifically addresses the issues of social recruitment in nursing homes as outlined above. However, there is available a small but significant literature which is concerned with the kinds of social interactional environments and the patterns of communication behavior characteristic of nursing homes (and other geriatric settings). In surveying this literature, I will focus upon: (1) the expectations for social participation (and the social relationships permitted) that nursing home staff members have for their charges; (2) the expected and accorded communication behavior; and (3) the contexts and outcomes (intended and unintended) of particular interactions.

One approach to the study of institutionalization of the aged employs certain concepts derived from "disengagement theory" (Cumming and Henry, 1961). Although this perspective has proved controversial, Kastenbaum argues that disengagement theory has the "... advantage of being the first conceptual framework developed especially for application to psychosocial aspects of aging" (1965:13). Disengagement theory states that individuals "voluntarily" withdraw from society as
they age, and, more specifically, from interpersonal contacts and the performance of their various social roles. Cumming and Henry note that the individual who disengages may reduce the number of his/her interactions with others, the variety of others with whom there is interaction, and his/her adherence to socially sanctioned norms of behavior (i.e., presumably in favor of more idiosyncratic conduct):

In our theory, aging is an inevitable mutual withdrawal or disengagement, resulting in decreased interaction between the aging person and others in the social systems he belongs to \(1961:14\).

This theory is intended to apply to the aging process in all societies, although the initiation of the process may vary from culture to culture, as may the pattern of the process itself \(1961:15\).

In addition to this, mutual disengagement is considered functional both for society and for the individual who withdraws. First, it is the individual's anticipation of death and his/her declining physical capabilities which are seen by the authors as generative of the disengagement process. With respect to its function at the social system level, disengagement seems to represent a means by which society recruits individuals out of certain productive social roles and channels them toward nonfunctioning ones:

\[
\ldots \text{Success in an industrialized society is based on knowledge and skill, and age-grading is a mechanism used to ensure that the young are sufficiently well trained to assume authority and the old are retired before they lose skill} \(1961:213\). \\
\text{Disengagement in America may be initiated by either the individual because of ego changes or by society because of organizational imperatives, or by both simultaneously} \text{\(ibid\.)}. \\
\text{In this respect, nursing homes may be seen as a "dumping ground" or social storage area which enables individuals and society to disengage in mutual fashion} \text{\(see Lieberman, 1969; Gustafson, 1972\).}
\]
As noted, disengagement theory has not been without its detractors (see Cumming, 1975; Markson, 1975). One of the stiffest criticisms lodged against disengagement theory is its purported status as a universal. Gutman (1976), to take one critic's arguments, points out that Cumming and Henry's theory is essentially a developmental one, but, he suggests, it represents a developmental scheme for idealized middle-class American aging, not of the aging process per se. Although not originally tested cross-culturally, the disengagement propositions advanced by Cumming and Henry predict increased passivity (and hence, social withdrawal) of older persons in all societies. Gutman, among others, provides disconfirming data:

The case of the Druze Aqil indicates, however, that disengagement need not be compulsory; and in particular it demonstrates that passivity is not inextricably tied to disengagement. Quite the contrary; in the Druze case (and probably in other traditional folk societies that have a strong religious orientation), the so-called passivity of the older men can be the central, necessary component of his engagement in age-appropriate social roles, traditions, and associated normative controls (1976:106-107).

Here Rose summarizes the cross-cultural argument against disengagement by pointing to Cumming and Henry's ethnocentrism:

... It considers this fact (disengagement) to be a function of American culture in this (current) phase of its organization, not a universal for all time. ... Many other societies accord special prestige and power to the elderly, do not disengage them from adult roles, or create new age-graded roles of importance for them (1964:48).

Interestingly, Jacob's study of an American retirement community questions the nature of disengagement even in Western industrial society:

Where do the Fun City residents fall on the engagement-disengagement continuum? It is clear that the theory of disengagement does not have an inevitable or universal application to Fun City residents. ... Let us begin by
considering the five or six hundred active club members (about 10 percent of Fun City's population). These residents were clearly engaged. In fact, engagement in the pre- and post-retirement period characterized the life style of this group. They constitute a clear counter-instance to disengagement as a general phenomenon (1974:79-80).

A second question with regard to disengagement theory, and one which has special implications for the present dissertation's concerns with institutionalization, addresses the varying social conditions under which individuals withdraw from purposive co-present interaction and those under which individuals are allowed to maintain active social participation. Arguing against the inevitability and naturalness of the disengagement process based on situational considerations, Hochschild writes:

The research cited in this chapter, and my own field work suggest that this theory describes nothing "natural" but merely what happens under certain social conditions. Old people living among peers are much less likely to disengage, to isolate themselves, or to be isolated (1978:32).

Hochschild's study of a retirement apartment complex indicates that previous roles performed by the residents may give way to a new complex of (equally engaging) roles, especially in a new community in which the above quoted conditions are met.

In a similar fashion, the nursing home as one social context for the aged may be seen to establish conditions under which the individual resident sheds or disengages from previous work and family roles, but it is also one which provides inmates with new behavioral codes and social statuses. Once again, however, the inevitability and the voluntary nature of the disengagement process may be called into question. Several researchers of nursing homes note that the institutional context may in fact foster disengagement, rather than be a neutral environment.
in which this occurs. Borrowing from the sociological theory of careers, Marshall writes that the status passage of the institutionalized aged is marked because it is under the influence of the institution itself, not of the individual passagees:

Institutionalization severely threatens the aged's ability to maintain status passage control, for so much is structured for them, and compliance with institutional routines is deemed necessary to keep things "running smoothly" (1978-79:354).

Also, the institution may be credited with expectations and behavioral routines which impel individuals to disengage:

The disengagement theory of Cumming and Henry (1961) offers another explanation for the lack of communication (among nursing home patients). However, in this situation as in the outside world, disengagement may not be voluntary. Although no staff members or relative will directly discourage the patient from making new friends in the nursing home, he is often not expected or encouraged to do so. . . . Admission to the home is usually treated as the end of one's useful social career (Gustafson, 1972:230).

Bengston and Dowd (1980-81) recently advanced a further refinement of disengagement theory with reference to institutionalization. These writers propose that when the withdrawal behaviors assumed to characterize disengagement are examined in context, then the importance of power differentials (e.g., between institutional caretakers and inmates), rather than endogenous features of the patients, must be considered. Furthermore, Bengston and Dowd, who are developing a perspective on aging derived from exchange theory, suggest that the individual's prevailing life context may influence either positively or negatively the likelihood of disengagement:

Utilizing these concepts from exchange theory, an alternative to the prevailing activity/disengagement paradigm can be developed. From an exchange perspective, the problems of aging are essentially problems of decreasing power resources. The aged have very little to exchange which is of any instrumental value. What skills they once had are often outmoded. . . (1980-81:66).
Exchange theory permits one to "see" that withdrawal of old people from social interaction (as in the oft-lamented under-utilization of senior center services) is due in large part to the perception of the aged shared by many service deliverers as senile, sick or merely helpless. . . . For them, these old people "need their help." The fact that such accounts belie an invidious power-dependent relationship either remains unrecognized or is defined in non-problematic terms (1980-81:67).

Although disengagement theory (and its modifications) may partially explain the particular behavioral initiatives and reactions of patients in nursing homes—their silence, their lack of interest in social activities, etc. (cf. Lieberman, 1969)—it fails to account systematically for the demands and expectations held by the institution for these individuals.

One approach to institutional social life which has garnered some attention from social gerontologists derives from symbolic interaction theory. More specifically, several writers suggest that nursing homes bear a relationship to what Goffman (1961) has generically called a "total institution." Goffman defines this concept, which is intended to apply to mental hospitals, boarding schools, monasteries, and the like, as follows:

The central feature of total institutions can be described as a breakdown of the barriers ordinarily separating these three spheres of life (sleep, play, work). First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution (1961:6).
Of fundamental importance to Goffman's overall approach, and one which has been picked up by several gerontologists, is the notion of mortification rituals or processes. The conception of self with which an incoming recruit to an institution enters is systematically removed by the institutional personnel. Mortification occurs through a series of degrading verbal encounters, nonverbal interactions, and material possessions which the individual is expected to accept:

The recruit comes into the establishment with a conception of himself made possible by certain stable social arrangements in his home world. Upon entrance, he is immediately stripped of the support provided by these arrangements. . . . He begins some radical shifts in his moral career, a career composed of the progressive changes that occur in the beliefs that he has concerning himself and significant others (1961:14).

Bennett (1964) was one of the first researchers to deal with the total institutional concepts as appropriate to nursing homes and to make a systematic attempt at such application. Bennett suggests, for example, that entrance to a nursing facility implies a levelling process for the inmates (akin to mortification) in which social characteristics previously considered important to daily functioning and identity, i.e., important in the outside community, are minimized or eliminated by the institution:

Upon admission each resident is required to turn over all his property to the Home. . . . Residents who receive social security benefits must turn them over to the Home. These funds are then pooled and used to maintain all residents. . . . Major decisions about the allocation of funds are the responsibility of staff members. Thus the aged person gives up one of the major decision-making functions of adulthood, that of how to use and distribute his private property (1964:76).

I will discuss some of the more specific communicational concomitants of this below.
Another study which makes use of Goffman's concept of total institutions is reported by Swain and Harrison (1979). This study was conducted in a small (seventeen bed) nursing home in Sydney, Australia, and was designed to test the effects of institutionalization on residents' behavior. The authors' conclusions are wholly compatible with the previously noted concern for the social contexts engendering disengagement. They write: "The analysis suggests that much of the 'negative' behaviour observed among inmates results from the institutional structuring of a dependence role" (1979:274).

Swain and Harrison begin their analysis by exploring the "first order" implications of a situation, described by Goffman (above), in which individuals are required to carry out all daily life activities and functions within the same circumscribed area. First, they note that an overriding concern held by the nurses in the home is that of uniform treatment and expectations for their charges:

Certain sociological implications follow from the fact of large blocks of people being subject to the form of bureaucratic management characteristic of total institutions. First, with few exceptions, all residents are treated alike and little attention is paid to individual differences. One nurse only knows the residents as room numbers, yet calls all of them "darling."

Second, a daily schedule of activity is rigidly adhered to, without reference to individual needs. Such flexibility as may occur is limited, and generally only results from the personality of individual staff members. In the nursing home, all residents must be up, washed, dressed and ready for breakfast by 7:00 a.m. (1979:276).

Swain and Harrison further indicate that ". . . a major cleavage exists between the small supervisory staff and the inmates, with each group conceiving of the other in terms of (usually narrow and hostile) stereotypes" (1979:276). This borrows from Goffman's observations that
total institutions consist of ideologies which justify certain orders of behavioral treatment and involve concomitant definitions of self for all actors concerned: "I am interested in the fact that expected activity in the organization implies a conception of the actor and that an organization can therefore be viewed as a place for generating assumptions about identity" (1961:186). What then are some of these conceptions fostered by nursing homes?

Swain and Harrison point out that recent entrants to the nursing home they studied no longer found themselves considered autonomous or competent beings:

One elderly woman was brought in by her husband. It was to him, and not the new inmate, that the sister-in-charge addressed her inquiries. She was compelled to sit and watch while a nurse unpacked her personal belongings (1979:277).

According to this perspective, the institutionalized individual is no longer treated as a full human being and is deprived certain basic personal experiences. Similar observations are made by Posner, who argues that part of one's application to the home is a relinquishing of one's claims of competence: "... Social workers (making applications for older individuals) must prove that their clients are not bona fide collectivity members" (1974:359).

Swain and Harrison note that institutional caretakers are in the position and have the right to define as appropriate (or not) behavior to and from the patient. For example, Swain and Harrison observe that patients are denied opportunities by the institution to vent the anxieties they may have surrounding death, institutional life, and so on:
Inmates are generally conceived of, and treated as, child-like, mentally incompetent (whether or not they have any diagnosed mental disorder), and not to be taken seriously as functioning adults. Any discussion of death for example, is taboo: a patient expressing anxiety on the subject is brushed off with replies such as "Now, you're alright, dear" (1979:277).

Other writers indicate that nursing homes often use various means of information passage control in order to decide what information is accepted (and acceptable) from patients, and also what the desired information to patients is. One study by Gubrium (1975) indicates that the reality of death and its inevitability are systematically denied by institutional personnel through such techniques as concealing actual deaths and refusing to talk about dying patients. This study is also noteworthy because it provides data which demonstrate that information and the rights to its handling may exist as commodities separating residents and staff members into relatively powerless and powerful factions. Gubrium writes about the non-profit nursing home he studied:

Staff takes advantage of a number of physical arrangements to contain the spread of death news. Among these are closing doors, pulling curtains, feigning routine patient treatment, and removing a body while patients or residents are dining (1975:333).

In the case of the deceased, they (the nurses' aides) must not only bathe the body, but they must do so as if performing the usual bed-and-body work on living bedfast patients. For example, when a roommate is present on the other side of a pulled curtain and that roommate is believed to be "alert," aides preparing the body will not talk about the body in a depersonalized way, which would signify to the roommate that it is lifeless. The dead patient is adjusted (face and body posture) to make him appear as if sleeping (1975:335).

In much the same fashion, at one geriatric facility (a Catholic nursing home) described by Marshall, it is noted that death and dying are organized by the institution's staff for the patients, and never by the patients themselves:
Then, if or when the prognosis of "dying" is made, the resident is moved to a special room, called at times the dying room, but known to both staff and residents as "St. Peter's Room" (not a pseudonym), which, ironically, is room 13. At times there is a waiting list for this room. . . . The dying trajectory implications of the room are appreciated with great clarity by the residents. One man, for example, who was placed in St. Peter's room with a "dying" prognosis, got up in the middle of the night and made his way back to his own room (1975:355-356).

On the day of one funeral, a birthday party was held in the afternoon. No references to the funeral were made as the residents enjoyed the festivities marking off an additional year's passage toward the same fate (1975:356).

This contrasted with a retirement community also studied by Marshall which apparently did not evidence the degree of totality found in the nursing home and which fostered independent activities and decision-making by the residents (see below for a discussion of degrees of totality). There the residents organized their own support groups and requested that the management avoid euphemistic terms when referring to someone's death and when posting obituaries.

This issue of information control in the nursing home context has been discussed in the literature from another vantage point. In specific, studies indicate that it is not uncommon to find new residents in nursing homes unfamiliar with the facility they are about to or have just entered; in many cases, the research reports show that patients are not told of the intentions for commitment--intentions either on the part of the patients' medical caretakers (e.g., physicians) or family members--prior to the actual entry. In one study involving twenty-three separate nursing homes:

A large majority of the patients were completely without knowledge of the home prior to admission. Only 24 out of 80 had any knowledge of the home. This small percentage indicates that it is not common for patients to be prepared
for living in the home either through visiting homes or by being well briefed in advance (Dominick, et al., 1968a:74).

The authors of this study further indicate that one consequence of this lack of foreknowledge is a decrease in the success of the patient's adjustment to the facility (adjustment as measured by staff evaluations). Interestingly, those individuals with more experience with total institutional life, as in the case of former patients of mental hospitals, are seen by researchers to be better adjusted than those without such prior experience.

Similar results are discussed by Dooghe, et al. (1980) for three-hundred-and-sixty residents of institutional homes in Belgium. Those individuals who had visited the home prior to admission (and, by implication, knew of the impending institutionalization) showed higher frequencies of adjustment than those who had not made an initial visit. Furthermore, those entering with positive expectations showed higher frequencies of adjustment when compared with those with initially negative expectations. Dooghe and his colleagues indicate that over thirty-four percent of the patients surveyed had not anticipated or been notified of an impending institutionalization.

Data on this issue are also provided by studies on the effects of enforced relocation. For example, Smith and Brand note that individuals arriving at a nursing home from a previous medical care institution usually show lower amounts of life satisfaction when compared with individuals entering voluntarily from their homes:

These findings led to a rejection of the hypothesis that there is no difference in life satisfaction between the two groups of patients and suggests that involuntary relocation may promote stresses detrimental to personal adjustment in the elderly, and this may be more marked for those in poor health who are economically dependent and relocated from one institution to another (1975:257).
Approximately thirty percent of the patients interviewed for this study were victims of what the authors described as forced relocation.

Swain and Harrison point to another way in which institutional caretakers manage information flow from and to patients. They observe that residents' efforts to keep abreast of current events outside the institution, either through conversation or the mass media, are frequently singled out by staff members for derision. They write:

During the conversations I had with her (a female resident, former school teacher) about solar energy, I offered to bring her a magazine on the subject. She was so interested that I brought in four and said she could keep them. On hearing this, the sister-in-charge dismissed the event: "She can't read most of it, and she's probably not really interested anyway" (1979:278).

Interestingly, the present author's earlier investigation of conversational behavior at People's Home produced similar incidents:

Mrs. Raymond reaches into a box for some envelopes. After about five minutes of silence, Sandra (the new activities intern) starts telling Sheila, the head of activities, about the state inspectors who had been visiting while Sheila was out sick. She says that "everyone was in a panic," that she had to wear a badge and the nurses all wore their caps. She says that one of the Black inspectors who had interviewed her was concerned with finding more Blacks working in administration, but she told him that she was only concerned with working with and hiring qualified people. . . . She then tells Sheila about a recent trip to a nearby private garden, and both she and Carol tell Sheila about how to get there. None of the residents looked up from the envelopes they were stuffing, and Sandra, Sheila and Carol were all looking at each other while talking. . . .

When later questioned about their reasons for not also talking to the patients about their "outside" adventures, all three agreed that "they're not interested in that any more" (Sigman, 1979:185-186).

Such data are needed in order to place the earlier criticisms of disengagement theory in perspective as applied to institutional settings. Withdrawal from active social participation may not be an
inevitable consequence of either aging or institutionalization, but may be seen as a response to the "demands" for this type of behavior placed on inmates by their caretakers (cf. Carmichael, 1976). Contributing to this argument are studies which point to a series of assumptions about the individual's social career in a nursing home, and about the meaning of institutionalization itself. For example, Gustafson suggests that the career of the nursing home patient can best be seen as a regressive one, in which maximum success is attained by delaying the movement to next stages; in this case, the culmination is presumed to be death. This contrasts with other status passages in the medical context (e.g., the tuberculine hospital) where movement to the next stage of the career is eagerly anticipated, i.e., where success is marked by progression.

A majority of patients in a nursing home for old people are, more or less actively, dying. Except in cases where the patient is severely incapacitated intellectually, patient, relatives, and staff almost always know that, generally speaking, this is a "terminal case" (1972:227).

As quoted above, Gustafson also notes that the individual is often discouraged from socializing (or, at least, not encouraged to do so) because of the assumption held by staff members and patients' relatives that institutionalization is the "end of one's useful social career."

Markson notes that one norm subscribed to by health professionals is that "old people should be allowed to die at home" (1971:48), although it is recognized that most older people who enter institutional settings usually also die there. Moreover, Markson suggests that older people are specifically sent by their families to institutions in order to die (often, as in the case studied by Markson, to mental hospitals) and that social life as a result is structured around impending death:
The Fairview program structured the patient's career as one of dying rather than of active physical or psychiatric treatment (1971:50).

It is interesting in this regard to note physicians' attitudes toward geriatric patients and toward nursing homes. In a review of the literature provided by Miller, et al. (1976), several trends are apparent: Many administrators of geriatric institutions suggest that physicians, who generally have low records of attending to their institutionalized patients, lack an understanding of the psychological needs of geriatric patients. Moreover, studies of medical socialization indicate that student physicians hold misconceptions about and prejudices toward older patients, and favor working with younger ones. Miller notes that eighty-seven percent of the physicians he questioned stated a willingness to accept new older patients, although the writer points out that this is not the case for nursing home elderly, noting that it was difficult in the research site (White Plains, New York) to attract physicians. Twenty-five percent of the physicians stated that they did not find geriatric medicine (here operationalized as medical treatment for individuals who are seventy-five years or older) challenging, presumably because of its linkage with impending death. Forty-three percent of the young doctors judged themselves as giving better care to patients under fifty, and, for all doctors surveyed, only thirty-eight percent stated that patients under fifty and those over seventy-five received equal care. When the doctors were asked about efforts on behalf of institutionalized versus noninstitutionalized elderly, thirty-nine percent of the respondents indicated equal treatment and twenty-eight percent stated a preference for private
patients. These findings were consistent with a general definition of nursing homes provided by the doctors:

About 38 percent of all respondents viewed the nursing home as a place for old people to die. For those who worked in nursing home settings, even a greater percentage of physicians believed this (1976:502).

Although 85 percent of the respondents felt the physician should be involved in the process of placing the ill aged person in a nursing home, it was startling to learn that the physicians did not feel really in charge of the patients' care thereafter (ibid.).

These observations and prejudices can be seen to have definite interactional consequences. Data provided by Sommer (1970), an early researcher of interpersonal space, indicate that the above generalized expectations get patterned into the use of specific communication channels in the institutional setting. For example, in the geriatric (mental) hospital which Sommer studied, the patients were seen as engaging in very little talk. Sommer argues that the physical environment (such as the seating arrangements) made interaction physically difficult and uncomfortable, and so served to discourage socializing among the residents:

With as many as 50 ladies in the large room, there were rarely more than one or two brief conversations. The ladies sat side-by-side against the newly painted walls in their new chrome chairs and exercised their options of gazing down at the newly-tiled floors or looking up at the new fluorescent lights. . . . To talk to neighbors, I had to turn in my chair and pivot my head 90 degrees. For an older lady, particularly one with difficulties in hearing and comprehension, finding a suitable orientation for conversation was extremely taxing. I hardly need add that there was no conversation whatever between occupants of the center chairs which faced different directions (1970:27).

Interestingly, family members who came to visit patients were more likely to rearrange chairs into small conversational circles. Unlike
the patients, they were not hampered by and did not feel compelled to adhere to the institutional layout. The side-by-side arrangement of chairs was preferred by staff members whose duty it was to clean up the lounges; staff members said that chairs neatly arranged in rows, and tables uncluttered by magazines or the like had a cleaner appearance and were more easily tidied up.

Sommer argues that these and similar architectural arrangements are not the inevitable outcome of patients' desires for social disengagement. They are, rather, a response to certain institutional demands and expectations for decreased socializing in aging populations. He disagrees with an argument made by a researcher of a British nursing home, who suggests that "... sociofugal architecture is peculiarly suited to social withdrawal and social relationships in which emotional investments are maintained at levels which the residents find manageable" (quoted in Sommer, 1970:37). Sommer comments that this ignores the fact that institutional care patterns have a direct effect on the residents and are themselves the result of certain ideologies or assumptions about those who are being cared for:

The internal geography of most geriatric centers is determined not by the needs of the residents themselves but by those of the nursing and custodial staff. The residents adapt themselves to the sociofugal arrangements by reducing their level of intercourse. . . . I have seen too many active, emotionally alive, senile patients to accept a view of them as asocial. The withdrawal that observers notice in old-age homes seems more a product of the institutional environment than of the aging process itself (1970:37-38).

Similar findings are noted for verbal behavior in nursing homes. Lipman, et al. (1979) point out that training in medical as well as social skills should be given to staff members of nursing homes; their observations of actual interaction behavior reveal that very little time
in a staff member's day is spent in non-instrumental (non-medical) activity with patients. In one of the British nursing homes in which the authors conducted their research:

... Our records of a 2 h observation session in a sitting-space show only three instances in which staff entered the room. These were when a care attendant helped a resident in a wheel-chair into the sitting space, during which brief stay she instructed one of the seated residents to call her in the event of "difficulty." Some three-quarters of an hour later, without speaking to the occupants in the room, she returned to wheel the resident in the wheel-chair out. Then, some 50 min later, another attendant brought the customary evening drinks into the room. Her encounter with the residents took the form of a sequence of some eight exchanges, all of which were of the following type: Staff: "Ovaltine?"; Resident: "Ta"; Staff: "Tea?"; Resident: "Yeah" and so on. . . (1979:282).

Utilizing a content analysis of verbal exchanges, Lipman found that talk among the residents was higher in "socio-emotional" content than that between residents and staff, and that the predominately instrumental staff-patient exchanges did not vary between residents called "confused" and those seen as "rational."

These data on verbal behavior are important because they were developed by one of the few systematic attempts to study verbal interaction in the institutional setting. Lubinski's review of the literature concludes:

Considering the apparent significance of spoken communication for all people, concern for the topic would be expected in a review of the social gerontology literature. However, topics and research which are tangential to spoken communication emerge. There is generally little specific reference to spoken communication relative to interpersonal communication. Finally, the research to date has not systematically explored communication from the viewpoints of the participants in this interpersonal act (1978-79:239).

In the survey conducted by Lubinski, staff members and residents of one institution were asked to comment on their verbal interaction. Residents perceived their communication as "meaningless," "disparaging"
and "of no value." In contrast, staff members perceived the verbal environment of the institution in a far more positive light. Although the staff members acknowledged that interaction was limited, they reported that they were "too busy" to engage in talk with the patients, i.e., non-task-related interaction seemed to be considered less important than that dealing with the conduct of the institution.

In a study on tactile behavior in a home for the aged conducted by Watson (1975), it was also noted that sixty-eight percent of the one-hundred-and-eighty-seven interactions observed were "instrumental" in nature. These included treating and grooming patients' bodies, assisting with eating, and distributing medicine. Watson also observed a number of differences in the frequency and contact region of touch based on the sex and status of the initiating staff member. He suggests that touch formed part of the institution's system of social control.

Another implication of the above expectations for residents' social participation in nursing homes can be seen in the structuring of activity programs. Swain and Harrison write on this matter:

Various activities are organized for the residents, though matron complains that it is often difficult to get them to join in, and that most do not "appreciate the extra work" which is done for them in this regard (1979:279).

Swain and Harrison hypothesize that non-participation by the residents is an attempt at distancing themselves from identification with those in control.

Data by Marshall indicate that residents of a Catholic nursing home he studied are spectators rather than involved participants, and he felt that this is apparently a consequence of staff members' initiatives:

There is a monthly party, a birthday celebration for those having a birthday during the period. And the auxiliary does run a monthly bingo game. Yet residents are primarily

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spectators at these events. During bingo, for example, a volunteer stands over each player and when the number is called, moves the tab on the card (1975:352).

Other studies indicate that nursing homes pattern who is in control of participation, and, moreover, who is defined as appropriate or inappropriate for activity inclusion. Research by Posner (1974) provides an interesting perspective on this issue. In the Canadian home for the aged (and day-care center) which Posner studied, activity programs were observed to be under the control of institutional staff who held very specific notions on who should be allowed to participate:

The fashion show is clearly one of the highlights of the year for female residents. The women always appear very thrilled to participate in such an event, and they usually get their hair set by the Beauty Salon, wear corsages and also have their pictures taken by professional photographers. All in all, it appears as though this particular program is a sort of last chance to be the "belle of the ball." Residents act with coyness and girlish pride as they parade on and off the stage. Staff too, tend to see this activity in a similar light. In fact, some staff who are involved in choosing the ladies to model the outfits, appear to make their judgments on the basis of who needs the ego-lift or morale-boost most. It takes little intellectual capacity and/or physical competence to participate in this show, which consists of walking or wheeling around for a few minutes. Wheelchair residents often participate in this program by modelling housecoats, robes and other applicable items. Thus there is the suggestion that individuals are chosen to participate on the basis of the unattractiveness and incompetence, and this runs clearly contrary to our usual expectations about fashion models on the "outside" (1974:361-362).

Posner alludes to several factors which probably influenced the staff's decision to reject one woman's request to serve as a model in the show. The woman was looked upon as an elite resident, who was recovering well from a stroke, and who was visited regularly by family and friends.

Posner concludes from this:

This . . . social labelling probably leads the social worker to conclude that such a woman does not need the opportunity of proving herself as a model as much as other residents who are not capable of doing anything else. The fact that Mrs.
S. felt that she needed to be a model, then (sic) was not taken into account (1974:362).

Activities are seen in this light as a staff-initiated program of therapy, not necessarily a patient-centered means of socializing.

Posner further suggests that the nursing home she studied represents a mirror image of the outside world in terms of the "innocent until proven guilty" maxim usually followed in day-to-day encounters. Posner suggests that nursing homes are designed for the least competent members of society, and that one unintended consequence of a nursing home admission is that the elderly individual leaves a world where full competence is rewarded and deemed prestigious, to live in one where relative incompetence is expected:

To be granted admission into the Home may be advantageous in many respects, and most clients are eager for their final approval for admission after months spent on long waiting lists. But clearly, the implications of "winning" admission have unintended consequences which confuse the criteria for evaluating social behavior within the institution's confines. With regard to normal society and bona fide membership rules, winning admission means leaving one social reality for another and changing games, rules and players (1974:360).

... The primary purpose of the Home is to shelter and take care of incompetent elderly persons. Therefore all administrative efforts are ostensibly in this direction. Thus, those who are most incompetent can take best advantage of Home services and facilities. In essence, the Home is oriented toward the least competent (ibid.).

An additional implication of Posner's study is that nursing homes may be seen to consist of diverse populations. For example, the above home for the aged placed patients into one or two categories--competent versus incompetent--and established differing provisions for each. Posner observes, for example, that the least competent members of the resident population were more likely to receive private rooms; this was done, it is suggested, to avoid the noise and chaos that would result
from placing several senile residents together in the same room. Also, as noted above, staff members established different guidelines for including the different resident types in the activities programs.

In much the same manner, Ross' (1974) study of a retirement residence outside Paris indicates that there existed three distinct groups informally defined by the residents, and that acceptance into one of the three groups followed distinguishable career pathways:

New arrivals in the residence eventually either become community members who participate in the social world of the residence through organized and/or informal activities or remain isolates who are marginal to community life (1974:213).

As noted, predictable paths or trajectories were observed to culminate in one of the three outcomes:

The new arrivals whose participation eventually includes organized activities typically find a permanent place in the dining hall soon after their arrival, then experiment with organized activities and maintain those activities as they gradually create more informal ties to other residents. Newcomers who learn to participate in the community through informal social contacts usually also find permanent places in the dining hall soon after arrival and experiment with organized activities, but withdraw from this when they can be replaced by informal ties. New residents who become social isolates are typically those who never find a permanent place in the dining hall, never experiment with organized activity, or try it and drop it without substituting informal participation (1974:213-214).

Ross suggests that, unlike the formal (i.e., controlled by the staff) socialization and transition rituals which characterize total institutions, at "les Floralies" newcomers learn about life in the community from their peers:

Since there are only rare and erratic official channels of communication to inform new residents about organized activities, they are dependent on informal sources. The established residents who make an explicit effort to make contact with new arrivals are leaders and activists of the two political factions (Communists and anti-Communists).
Their interest in newcomers is naturally in their potential as recruits to the faction (1974:218).

Individuals who are accepted by the anti-Communists are usually those who eventually will be involved in both organized and informal social activities in the community; the trajectory for Communist sympathizers, however, is that of a gradual movement away from the formal ties to the residence in favor of informal activities.

It is interesting to note that there appears to be a process of differential recruitment to each of the different social groups, with each faction leader seeking out only those individuals who demonstrate particular traits:

The new resident's political orientation can be visible in several ways. Another resident sometimes simply recognizes him from a previous contact, a job or a vacation, which had already revealed political tendencies. In a few cases, new arrivals had names so well known that recognition depended only on verification that the person was the Lacroix whose husband was the Resistance hero and editor of the Communist party newspaper. . . . For most people, a more elaborate exchange of cues is necessary to establish political identity: newspaper subscriptions, attitudes about the Resistance and the Vichy regime, mention of a union official who facilitated the red-tape of entrance into the residence. . . (1974:217).

A deaf-mute, for example, was clearly seen as an unlikely recruit, and neither faction followed through the process of communication through gestures and notes, which was not only difficult, but also unsuitable for the subtleties of exchanging initial political cues (1974:218).

Similar data exist for the total institutional context. Hendel-Sebestyen's (1974) data on a voluntary home for Sephardic Jews in New York City indicates that community distinctions which were salient on the outside may be used by residents to direct social interaction within the institution:

. . . The religious and kinship roles, and other behavior that emerges out of their still cohesive cultural traditions function side by side with those roles assigned to
them as residents or patients in a total institution. Another way of putting this is that the Sephardim associated with the Home interact with one another in terms of numerous identities, not just the ones assigned to them by the organizational framework. The opportunity to function in terms of previous identities is especially important in an aged population because senility usually affects recent memory most adversely (1979:22).

... Arguments among kinsmen will momentarily cease if one involving Judeo-Greek speakers vs. Judeo-Spanish speakers erupts (ibid.:23-24).

Hendel-Sebestyen concludes her analysis by suggesting that the existence of community ties and shared cultural backgrounds requires that the analyst of total institutions look at roles which are imposed from within and those which are carried on (continued) from the outside.

It should be pointed out that it is not entirely accurate to suggest that, when the various living arrangements for the elderly are compared, no forms of peer socialization exist in the most regimented of these institutions. Bennett (1964) argues that it is wrong to assume that a world of social interaction is not sustained among residents of nursing facilities, although admittedly, this may be circumscribed to some degree by the staff. Bennett observes, for example, that, by communicating to newcomers the relevant behavioral expectations, residents uphold the normative system imposed by the staff:

From interviews conducted with administrative, social work, and psychiatric personnel it was ascertained that residents act as socializing agents to orient newcomers to the norms of the Home. This is through informal friendships which develop and through formal devices such as the Home club. In the course of resident interaction "oldtimers" and "newcomers" are always integrated; they may room together, eat together, and be neighbors and friends (1964:76).

Many "oldtimers" voluntarily greet "newcomers" as well as visitors to the Home and will gladly spend time extolling its virtues. For the most part, these oldtimers are intelligent, personable, literate, and dedicated to the Home.
Since there are no situations in the Home in which "newcomers" are segregated away from "oldtimers," as they are in schools or the army, they play a vital role in socializing newly admitted residents to the Home. This probably accounts for the rapidity with which residents learn what is expected (1964:82-83).

Even though there may exist staff-imposed sanctions and behavioral guidelines, various studies show that younger patients in nursing institutions look to already established peers for advice and information. A report by Friedman indicates that older residents of homes for the aged usually possess more prestige than newer arrivals as a result of this:

... A resident who was above the median age, and who also had lived in the home for more than the median number of years, was likely to be significantly more popular with her fellow residents than a resident having only one, or neither, of these attributes (1967:476).

One implication of these data is that this prestige may be both a cause and a result of the older patients' assumption of an influential role in the institution:

Another possible interpretation of the data presented here is that the oldest and longest institutionalized residents were seen by the others as "testing the parameters" of both old age and long-term institutionalization. Association with these individuals may have allayed some of the anxieties which beset older persons, particularly those who have taken the symbolically important step of entering a home for the aged (ibid.).

In brief, whatever social interaction that exists among residents of nursing homes is considered to function in part as institutional socialization (training) and to adhere to institutionally-patterned rules of interaction.
The literature indicates that residential peers share certain guidelines for behavior with each other. Bennett's study referred to above indicates that the rules adhered to and advocated by the residents closely paralleled the administrative expectations for "ideal" patients:

From interviews and resident publications, it was possible to discover some of the expectations that the residents had for their behavior in the Home. The following statements represent some resident norms:
1. A resident should not criticize or complain about it.
2. Not only should a resident not criticize but he should praise the Home and come to regard it as his home.
3. A resident should be active and busy.
4. A resident should not argue with others in the Home. If possible, he should avoid others or be formal and only say "good morning" or "good evening" (1964:80).

Interestingly, Bennett observes that residents adhering to these rules become apologists for the home; they reject the friendship overtures of those others who are critical of the tacit rules and they often state that the demands made upon them in the home are justifiable and reasonable.

Teski's (1976) analysis of a Chicago retirement hotel similarly reveals adherence to rules constraining conversational behavior. Teski observes that the residents could be divided into several groups based on their participation in activities at Mayfair and on the level of reality on which most of their conversations focussed. The active residents were those who enjoyed the highest status at the facility; their conversations were certainly more animated than those found by Bennett (1964), but they did also largely adhere to statements of a positive nature about life and the hotel. The conversations among the lowest status residents dealt with topics unacceptable to the others: usually complaints about old age and hotel life. The former patients avoided interaction with the latter to the extent possible, and
limited this to certain conversational topics.

Kahana suggests that the act of segregating elderly individuals in nursing homes away from other patient populations serves to create a total institution environment, which she suggests should be avoided:

In the majority of institutions for the aged, residents are segregated with regard to age, sex, social class, ethnic background, physical and mental illness. It is assumed that specialized care could be best provided to a very homogeneous group. Yet in fact the institutions are only carrying one step further the isolation of the aged resident from the varied interactions he was used to in the community. The lack of attention to individual needs and the tendency to treat everyone alike have been seen as the very essence of institutional life. Goffman's . . . concept of the total institution applies to many aspects of institutional living in homes for the aged (1971:55).

Brody, on the other hand, argues for the utility of patient segregation based on medical diagnoses:

Experience at PGC indicates that the relatively intact (that is, those who do not require round-the-clock supervision, who are ambulatory, and capable of self-care) should not be mixed with the more impaired. Those who are mildly forgetful can often live with the more intact, depending on their level of functioning. Residents whose impairment is evidenced by marked confusion and severely disordered behavior should be segregated; they require more intensive staffing patterns and create anxiety on the part of the relatively intact (1970:305-306).

As Natenshon (1969) indicates, there appears to be little agreement among professionals regarding the relative benefits and costs of housing elderly individuals in segregated (total) or integrated dwellings.

Implicit in the above discussion is that there exist certain similarities and certain differences with regard to communication patterns in the various facilities for the aged. In applying Goffman's total institutional concepts, Bennett and Nahemow (1965) suggest that the various categories of geriatric facilities can be seen to exhibit differing degrees of "totality." Furthermore, these differences have an
effect on adjustment procedures and the behavioral expectations that new entrants will encounter. Ten dimensions for the degree of totality of institutions for the aged are proposed: these include the duration of residence for which the institution was designed; the type of rewards and punishments system; procedures for the dispensation of personal property; and so on. Low totalistic institutions, e.g., retirement communities, are those which are characterized by voluntary recruitment (entry) patterns, minimal to no scheduled group activities, private living quarters, and no removal of residents' personal property by the institution. At the opposite extreme are geriatric mental hospitals and nursing homes in which one typically finds congregate living, an involuntary pattern of recruitment (i.e., "committals"—see above), continuous observation of residents by the staff, scheduled group activities, and the appropriation of most personal belongings. As for social interaction criteria in nursing homes, Bennett and Nahemow write:

There was virtually no staff-patient interaction apart from the giving of nursing care. Patients who needed to be reprimanded or warned to obey the rules were usually seen by their welfare worker, who was called in by the nursing administrator. What was even more striking was that there was very little interaction among residents. Many of them spent every day sitting in the corridors in close proximity to one another without ever speaking (1965:69).

Patterns of adjustment contrasted between institutions with varying degrees of totality:

In homes for the aged, adjustment criteria were fairly explicit and participation in formal and informal activities emerged as a major adjustment criterion. In retirement housing, participation in informal social relationships seemed an important adjustment criterion. In mental hospitals, nursing homes and Veterans' Administration centers there were virtually no social adjustment criteria. Mainly, people were expected to receive medical and nursing care passively (1965:72).
The latter criteria are noteworthy given the discussion above regarding staff members' expectations for residents' social careers.

Lawton, et al. (1976), who examined the spatial behavior of patients before and after room reassignments, provide an important communicational study on patients' adjustments to geriatric settings. This research indicates that patients who are transferred from one ward to another in a nursing home tend to increase the amount of time spent in their bedrooms and decrease their use of the common lounges or their walking through the facility during the two-week period following reassignments. Lawton maintains that such patterns reflect an increase in "passive" types of behavior needed by the patient in order to (re)orient to the physical and social surroundings: "The open doors and other signs of reorientation are necessary to later increased mobility" (1976:24).

To summarize, the following points may be made about the institutions for the elderly surveyed in the present section: First, nursing homes can be seen to engage in various levelling or mortification rituals vis-à-vis residents. These rituals serve to redefine the inmates' identity, i.e., in terms of criteria which the institution views as relevant, and not those of the outside community, and also to make uniform (and thus more easily managed) their behavior. In part, specific rituals and behaviors accorded patients of nursing homes (both newcomers and veterans) can be seen as a consequence or adjunct of a particular ideology which defines old age as a process of social withdrawal and inactivity, and which defines institutionalization as "the end of the road," a place for dying. Consequences of these assumptions can be seen in the form of information (verbal) control,
structuring of contexts and opportunities for social interaction, and so on, by the staff. Although most writers on institutional phenomena do not see disengagement as inevitable, the literature does recognize low verbal activity, spectatorship, etc. on the part of nursing home residents. It is suggested that disengagement is an interaction process between institutional caretakers and patients, and is not an inevitable developmental process for all individuals.
NOTES

1 Sorokin further suggests that such changes occur slowly and thus enable a social group to maintain its unity and integrity:

Though the membership incessantly changes, some members dying or dropping out and new members being born or joining the group, this change goes on in such a way that at any given moment the bulk of the members remain constant. With the exception of periods of catastrophe and spasmodic changes, the incoming and outgoing streams of members flow gradually and imperceptibly (1947:384).

2 Sorokin writes: "For a satisfactory performance of especially the upper strata special talent is often necessary. Such talent is possessed by only a limited number of persons" (1947:432).
CHAPTER III
METHODOLOGY

The ethnographic data utilized in this report are based on the investigations of two nursing homes. The data from People's Home were collected from January to June, 1978, and from October, 1980 to June, 1981. Sisters of Faith Home was studied concurrently with the latter period. A total of approximately seven hundred hours was spent observing and interviewing in the two facilities. On the average a full day of field work at each nursing home lasted six hours; the remainder of each work day was devoted to rewriting field notes and transcribing taped interviews. During the first half of the 1980-81 field work I alternated weeks at each of the two facilities; this allowed for some continuity of observation and allowed me to carry on the interviews during regular periods. During the last five months of field work, after particular interactional contexts and special informants had been selected for in-depth study, my schedule was arranged so that I could visit each nursing home at least twice within the same week. Most of the research was conducted during weekday mornings and afternoons. However, an attempt was made to spend a few evenings and weekends at each facility. I alternated spending major holidays (e.g., Thanksgiving, Christmas) with the residents of the two homes.

It should be pointed out that, while methods of cultural description and comparison based on anthropological procedures are employed here, cultural data in their most general and widely accepted usage are not the present object of study. Margaret Mead writes of the traditional focus of ethnography:

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The model situation on which the anthropological concept of culture is based is that of the total learned, shared behavior of a functionally autonomous society that has maintained its existence through a sufficient number of generations so that each stage of the life span of an individual is included within the system (in Mead and Metraux, 1953:22).

The present study makes use of methods derived from ethnographic practice, but nursing institutions are not self-sufficient social systems to be studied in and of themselves. In this regard, some recent writers have argued the need for a distinction to be drawn between an ethnography (a cultural description and interpretation) and an ethnographic study (one which uses selected anthropological tools) (see Fetterman, 1982). Although there is little agreement between the conservative and liberal interpreters of ethnography, there is some acceptance of certain methodological principles: focus on socially patterned over biologically inherited behavior; the avoidance of a priori category schemes; and the use of contrast analysis:

The use of the term ethnography for any form of qualitative research is a misnomer. Ethnography is a methodological approach with specific procedures, techniques, and methods of analysis. The adoption of random elements of this method without attention to the whole results in the loss of many built-in safeguards of reliability and validity in data collection and analysis.

... The values, the most important elements of the anthropological system, have been left behind: phenomenology, holism, nonjudgmental orientation, and contextualization (Fetterman, 1982:18).

As noted, ethnographic methodology has been based traditionally on the development of descriptive data to be placed within appropriate frameworks of comparison. As a method it aims at a posteriori categories (units) of behavior. It is this spirit of ethnographic work toward which the present research is devoted. The aim of this chapter is to outline briefly the various premises, some of the "values," which
underlie the methodology of this study, and the techniques used in attempting to search for consistency with such values.

Chapter I notes that this dissertation selected two nursing homes as sites for research into the question of social recruitment; the choice of the two facilities represents the selection of a secular/nonsecular (and profit/nonprofit) contrastive framework. Chapter IV considers the impact and significance of various differences between the two nursing homes on the recruitment data collected; a more detailed consideration of the rationale for a contrastive analysis per se is provided here.

Glaser and Strauss (1971) propose the following uses of a comparative method: It provides for the generation of a formal theory based on a wide variety of cases; it enables one to achieve accurate evidence and empirical generalizations; and it facilitates the verification of an hypothesis. In addition, the development of a universal etic grid for initial descriptive purposes is made possible through the generation and comparison of a variety of culture-specific (emic) behavioral systems (Pike, 1967). In this regard, Birdwhistell (personal communication) suggests that without a series of points and contrasts, it becomes impossible to talk about patterns of observed phenomena; in such a situation, one can provide only an historical account.

The comparative data base in the present context attempts to reduce the likelihood that the analysis and generalizations about social recruitment derived here are but artifacts of the peculiar situation of a single institution. More specifically, the comparative framework assists this writer to state some of the ways in which the research findings are rooted in and apparently are limited by the specific
institutional contexts studied. For example, Chapters V and VI discuss
data which indicate that nursing homes organize their recruitment
systems in at least two different fashions (with or without distinct
wards). The present dual institutional framework enables the analysis
to develop some generalizations about social recruitment which fit both
nursing homes studied. In addition, this study is able to suggest the
possible organizational and historical divergences between the two
institutions which seem to influence and account for the alternative
recruitment systems. In this respect, Radcliffe-Brown suggests the
following reasons for employing the comparative method when doing
ethnographic research:

The student is told that he must consider any feature of
social life in its context, in its relation to the other
features of the particular social system in which it is
found. But he is often not taught to look at it in the
wider context of human societies in general. . . . With­
out systematic comparative studies anthropology will be­
come only historiography and ethnography. Sociological
theory must be based on, and continually tested by, sys­
tematic comparison (1958:110).

These considerations enable us to distinguish ethnography from a case
study method which relies on only one analysis unit and which thus fails
to provide itself with certain methodological safeguards. It may be
suggested that, in general, case studies are unable: (1) to separate
those observations which are unique to a particular institution from
those which may have a wider, more generalizable distribution; (2) to
assess the conditions under which certain patterns and/or idiosyncratic
elements are manifest, i.e., the relationships of the observed elements
to larger social and cultural patterns; and (3) to provide a nearly
exhaustive system for behavioral description, especially of those units
which appear in one contrast situation but not in another. On the other
hand, and as noted in more detail in Chapter IV, the dual institutional contrast employed in the present study permits a statement to be made regarding possible diverging influences (ideological, organizational) on each nursing home's ward system, selection and assignment criteria, and expectations for residents' social life.

Glaser and Strauss suggest that there are two rules of comparability which studies such as this one must follow:

One rule states that to be included within a set of comparison groups a group must have enough features in common with them. Another rule is that to be included it must show a "fundamental difference" from the others. These two rules for verificational and descriptive studies attempt to hold constant the strategic facts or to disqualify groups where the facts either cannot actually be constant or would introduce more unwanted differences. In sum, one hopes that in this set of purified comparison groups spurious factors will not influence the findings and relationships and render them inaccurate (1971:184).

Several writers have noted the impossibility of testing for the fundamental nature of a contrast with only a two-item comparison. For example, Joos (1957, 1967) argues that pattern analysis is only possible when the units in a paired contrast enter individually into further contrastive frameworks. Moreover, as Hockett notes, contrast relevance is always relative to a particular observational level:

Sometimes a difference which is by definition contrastive in the immediate environment is damped out, as it were, as one mounts to higher size-levels. The interchange of case and instance throughout this talk . . ., would make very little difference to the talk as a whole (1960:183).

With a two-item contrast, one is able to record or specify sameness or difference of the behavior units observed. However, what difference these similarities or differences make (see Bateson, 1972:381) requires recourse to additional analytic levels and to other paired comparisons which are not provided by the original item contrast.
In the present context, both SFH and PH are licensed as skilled care facilities designed for the care of geriatric patients. In addition to the contrast provided by the differences between a private and a denominational facility, there are a number of other differences between the two homes. Central among these differences are the sizes, religious compositions, and ties with other social service agencies. Since it is nearly impossible in the non-experimental world to find research contexts which contrast on only one dimension—although it could be argued that these other differences cluster with the private/denominational contrast—the conclusions drawn in the present study must be considered tentative and potentially influenced by these other differences between the two facilities. Curry and Ratliff point out that institutional size needs to be controlled when the kinds of social relationships engendered by nursing homes are investigated:


Administrators themselves in large institutionalized homes may tend to discourage relationships between nursing home residents and to foster a feeling of dependence and inactivity in their patients. Additionally, the fact that smaller homes are usually converted into nursing homes from large private residences may give these homes a more "residential" tone, where friendships are felt to be appropriate (1973:298).

In this regard, the present study does not claim that the contrast between SFH and PH in terms of church/non-church affiliation is in any sense dominant among other possible contrasts. As noted above, the relative significance of the various differences cannot be assessed with only a two-item contrast. The present analysis attempts to be consistent in describing the recruitment data themselves, and in relating them to the general institutional contrast (e.g., attitudes towards patients, perceptions of the role of nursing homes). In this manner, this study is able to test for the appropriateness and significance of the
particular contrast framework, but not necessarily for its primacy or priority.

Initial entry into the recruitment data for each institution was made at the level of conversational behavior and spatial allocations. These infra-communicational channels were selected because of previously documented relations that exist between conversational and spatial codes and social networks in the institutional context (De Long, 1970; Teski, 1976; Lubinski, 1978-79; Sigman, 1979). During the course of the research, I was also led to consider tactile behavior, as well as dress and other artifacts (wheelchair belts, restraining bibs, etc.) as communicational concomitants of assigned social position.

As noted in Chapter I, relative social position was operationalized as the arrangement of beds into rooms, sections and/or wards. Although such an arrangement of social positions in a nursing home is not always immediately self-evident, and requires more than a description of the physical facts of available and occupied beds (see below), this initial delimitation of the research problem was made so that the data needed for the social position analysis would be reasonably independent of the data needed for the subsequent communicational (rules) analysis. More specifically, in order to avoid the tautology of deriving the organization of social positions at each institution, as well as the rules governing the behavior of incumbents of these positions, from the same sources, an attempt was made here to provide two distinct data corpuses.

During the first few weeks of field work, detailed maps were made of each facility; these maps especially concentrated on the various residential sections. In a sense, at this earliest phase of the study,
an initial etic description (Pike, 1967) of each nursing home was attempted: the number of rooms per section; the number of available beds (positions) per room; the presence and location of lounges, activity rooms, and dining halls per section. Traditionally, the notion of "etics" is used to provide a descriptive terminology which considers the physical appearance of behavior apart from the behavior's possible functional significance or from its equivalence of meaning with other units (Pike, 1967). In the present context, I am using the term etic to suggest that the initial descriptions of each nursing home considered physical "facts" of the architecture, and attempted not to assign a priori significance to the apparent layout and composition of the rooms.

It should be pointed out that an etic description is not completely "objective" or without certain arbitrary or conventionalized (emic) decisions. Hockett notes that the establishment of even tentative units requires a decision as to which units are to be classified as the same and which as different:

To assert that two events are the same is not to assert that they are the same event. We can be confident that suitable measurements would demonstrate the falsity, in a physical frame of reference, of every such identification. If there are no other measurable differences between two events, at least their coordinates in the space-time continuum are different (1960:179).

Thus, in order to provide an etic description of each residential section in the two nursing homes, it was necessary that I delimit what constituted the boundaries of this larger unit, i.e., the section. This was based either on the existence of an institutional label (e.g., "A" section, "E" section) or on such visible architectural features as the existence of separate floors (e.g., a first floor, a second floor).
Social position was not simply derived from a map of the physical plant, although this was an initial step in the process. As is evident from the research interests expressed in Chapter I, this dissertation does not rely upon a definition of social position in strictly physical or architectural terms. Rather, the emphasis is on the apparent significance of each bed or room for the inhabitants of the institution, and on the impact of this patterning on slotting/reslotting decisions. Further, the present research is concerned with the equivalence/nonequivalence of each position in the nursing home from the perspective of those using certain criteria in filling each of these positions with incoming patients and from the perspective of the behavioral expectations devolving upon the incumbents. As the studies discussed in Chapter II indicate, the various statuses or positions within a social system are not all equivalent; attainment of particular positions and movement between them are differentially regulated and limited. In a sense, the present research is directed at the emic status or categorization of the bed units at each institution, i.e., the emic status of the etic units as defined above. This study attempts to be consistent with Pike's original formulation of the etic/emic distinction: "(Etic) units are different emically only when they elicit different responses from people acting within the system" (1967:38). An emic approach to behavior considers that behavior units, irrespective of their identificatory or appearance properties, can be classified by the analyst into functionally (and hence, communicationally) similar or dissimilar categories.

Data for the emic phase of the analysis were generated as follows: After I had provided the initial physical descriptions, staff members
were asked to judge the similarity of the patients occupying the various beds and/or sections, the criteria used in assigning patients to the various positions available, and the monitoring procedures used in observing patients and in deciding the necessity of reassignments. In addition to such general questioning, the individuals concerned with assignments or reassignments were asked to describe in detail the context, rationale and outcome of specific slotting decisions—i.e., the nature of the application, presenting medical diagnoses, considerations which went into accepting or rejecting the application, considerations in choosing a specific bed, decisions to transfer, etc. The following is a sample set of items for which data were generated during these interviews:

When an individual first enters the home, what are the criteria that are used for deciding where to place him/her in the home?

What are the formal as well as informal procedures for making that decision?

Which categories of patients are not accepted into the home at all, or are particularly encouraged to apply?

What are the various choices that are available for assigning residents a place to live (ward options, number-of-bed-per-room options, etc.)?

What are the procedures and criteria associated with placement reevaluations? What scheduling is used for reassignments and what kinds of authorization are required?

In addition to this, observations were made of the initial interviews between the nursing home administration and applicants to each facility, staff meetings where decisions to admit, discharge, assign and/or reassign patients were made, and other situations (such as the staff dining room) in which patient histories and administrative decisions were discussed.
As detailed in Chapters V and VI, the movement from the initial etic description to an emic reclassification was not without its problems. For example, People's Home contained a section labelled "A/E," which consisted of four rooms in a circular pavilion whose hallway connected two other sections of the facility, "A" and "E." Chapter V suggests that the status of this area during most of my field work was "ambiguous"—for me, and for the participants at PH. "A/E" section shared its nurse's station with "A" section, and, in this sense, could have been considered part of "A." However, it was assumed by the administration that "A/E" section contained residents identical to those found on "E," and that both groups should socialize with each other. Furthermore, whenever "E" was referred to by staff members or residents, "A/E" seemed to be included; for these reasons, "A/E" is viewed as a component of "E" for the present analysis. Similar problems arose in the analysis of "B" section, which shared equivalence with two sections ("E" and "C/D") which were apparently contrastive. Because the general methodological considerations which led to the acceptance or rejection of particular treatments are bound up with the corpus itself, I will leave the discussion of the criteria used for deciding emicity to the separate analyses presented in Chapters V and VI. At this juncture, it should simply be noted that social position—although initially operationalized as a bed slot—has been analyzed for the present study in terms of the apparent equivalence of assignments to particular beds in each facility. The arrangement of beds into equivalently functioning "wards" is also assessed.

The outline of each major data chapter (Chapters V and VI) closely parallels the above sketch of the analysis procedures. Each chapter
begins with a description of the physical plant, and then develops a perspective on the social patterning of the physical slots (beds) at each institution. This latter discussion includes descriptions of: application, admission, assignment and reassignment procedures; family and social work interviews; the social, financial, and medical documentation needed for particular admission classes; and so on. Subsequent sections of each chapter are devoted to the communicational implications and concomitants of the assignment patterns. Interview and observational materials were collected on the behavior that could be found in each of the individual locations. These data permit an analysis of the differences in communication behavior among the various residential sections of each nursing home. Staff members (and later, residents) were questioned on the differential duties, behaviors, treatments, etc. of the patients residing on the various sections. The interviews, which were open ended, attempted to tap information in the following areas:

Are residents of different placements expected to behave differently, to become involved in institutional life in differing ways, etc.?

As a result of particular placements, what are the differential treatments (if any) of residents by the staff? For example, are all residents given a tour of the home? Are all residents provided with an opportunity for joining particular activity groups, informal social groups, etc.? Are residents dressed differently as a result of their assignments, encouraged to participate in certain "extras" (such as the beauty parlor), provided with certain conversational engagements, etc.?

What are the procedures for introducing new patients to older ones? Is this handled by the staff, or by volunteers, or by the residents themselves?

Are there any other categories of patients? For example, do any of the residents become ward helpers or assistants
to the recreation staff? Do residents help out in the kitchen? What are the procedures and criteria for assignment to these positions?

Similar questions were asked of those residents whom I was able to rely on as informants (see infra for a consideration of ethnographic informants). They were asked about how they evaluated new residents, the various categories of residents, the behavior they expected of and accorded their peers, and so on. Most of this questioning of the residents focussed on their reactions to specific others, some of whom were ward-mates, and others of whom resided on other sections. In addition to this, a number of life histories which asked individuals to reconstruct specific experiences associated with institutionalization were also collected. These data are considered in Chapter IV, which is concerned, in part, with patients' pre-institutional careers and expectations for the nursing home.

The above data were checked and expanded upon against observational data. Observations were made of the residents during meal times, in the beauty parlor, in physical therapy, in the lounges assigned to their residential sections, and so on. During the first few weeks of field work, I attempted to sample a variety of physical locations in each facility. Over time, I tended to focus on those contexts (the activities room at SFH, the lounges at PH) where I had learned to expect frequent patient-patient and staff-patient interaction which seemed to be relevant to emerging hypotheses about the contribution of particular locales to patterns of overall recruitment. Field notes were taken on the actual talk which transpired during particular interactions. Descriptions were made of the identities of the participants involved, as well as of the physical setting and concurrent activity, the presence
of onlookers, and so on. Some of the verbal interactions were audio recorded, and transcriptions were derived from these tapes. These data are used in the analyses which appear in Chapters V and VI of the kinds of behavior that were found to be typical of the various residential sections in each nursing facility. In addition to this, emphasis was given to the ways in which newcomers to either SFH or PH were treated by their peers and staff members, and the kinds of reactions that were elicited from recent entrants. Observations were made of residents who had been given particular placements or who were being "prepared" for transfers. These data, taken as a whole, are used to attempt to generate rules for the (1) communication behavior which is considered appropriate to (and thus seems to maintain) particular position assignments, and (2) treatment accorded patients as part of the process of effectuating a transfer.

The observational data were analyzed, in so far as possible, through methods comparable to those employed by "structural" linguists. The term "structural" is used in the sense of a method, not primarily quantitative, concerned with elucidating pattern or regularity in the behavioral stream, with units derived from directly observable data. This is in contrast with other methods which code behavior units according to pre-selected criteria of semiotic function, referential meaning, or psychological correlate—i.e., which do not first look at the appearance of the behavior itself. Structural analysis is not unconcerned with function and meaning, it should be pointed out, but it is nevertheless considered axiomatic that behavior patterning as it exists is within a phenomenal (as opposed to phenomenological, functional or causal) universe which must be delineated in the process
Structural analysis may be divided, at its most basic, into (1) distributional analysis and (2) emic analysis. The first (which forms the bulk of the analyses presented in Chapters V and VI) is concerned with patterns of unit co-occurrences, substitutability, and sequentiality; the second, while resting on the foundations of distributional analysis, seeks to discern the emic (within-system) equivalence or nonequivalence of the variously patterned units (cf. Pike, 1967). The aim of the structural analyses presented here is to isolate units of behavior and to examine the rules for the appearance of these units within specific contexts. For example, Chapters V and VI consider how particular units of conversation (e.g., the presence or absence of talk, the conversational topics exchanged, etc.) and spacing (e.g., access to certain "public" locations) co-occur with each other and distribute (are correlated) with specific social positions in each facility.

One of the questions that needs to be addressed at this point relates to the establishment of explicit criteria for judging the correctness/incorrectness of particular analyses. A brief heuristic may explicate this issue. Let us say that I have reason to develop a generalization stating that those residents who are judged "competent" by the staff adhere to a rule requiring them to refrain from certain conversational topics (e.g., talk about the staff's private lives). However, no such taboo appears to exist for or is known by the other residents. A weak "proof" for the generalization might be developed from the contrast in the conversational behavior of the variously judged residents, i.e., by examining the differential appearances (presences
and absences) of various conversational units. This is considered weak in the present context because the detection of such a contrast may not mean that a specific conversational rule exists which is different for the two resident types. Rather, it is entirely possible that no opportunity for such conversational engagement presents itself to certain residents. Additional data are therefore needed in order to strengthen the analysis. For example, the residents (and/or staff) may express a negative evaluation of certain topics, and these topics may be the ones found in the conversations of the "incompetents," or they may appear as criteria for deciding ward placements during staff evaluation meetings. Perhaps one of the hypothesized taboo topics is seen to appear in the conversations recorded for the assumed competent patients. The presence of this behavior unit does not automatically negate the generalization; however, what the analysis then requires is consideration of how the behavior functions within the larger interaction. In other words, the consequences of an individual's performance of the behavior must be assessed. Is the individual immediately sanctioned for talking about the topic? Is the individual subsequently avoided by certain other residents? Is the behavior (and the subsequent reactions to it) reported to the staff and to other residents, and does it appear to result in a placement re-evaluation?

This discussion can be seen to be concerned with the rules of evidence for ethnographic and structural research. It can be suggested here that justification for particular analyses and interpretations of data must move beyond consideration of the appearance of specific behavior (cases). Consideration of informant statements of a normative regularity underlying behavior, observations of apparent breaches,
informant reports on specific cases and reactions to these, situational contrasts, and further data seem necessary. In this respect, Henry Lee Smith, a linguist who assisted in the codification of structuralist methodology, points out that the analyst's job extends beyond the isolation of specific units of behavior:

> No single part or segment of the total system we have been describing has any fixed, self-contained meaning. Instead, the significance of any communicative event—word, phrase, construction, pitch rise or fall, gesture, or what you will—is entirely a function of its relation to the whole shape and pattern of the situation (1960:346-47).

The structural analysis of the data in the present report takes into account: (1) the occurrences of particular behavior complexes which can be seen to be heuristically isolatable units; (2) the behavioral reaction to these complexes by institutional members in comparable contexts; (3) co-occurrence relations with other behavior units; (4) contrastive analysis with those contexts in which a particular complex of behavior does not occur or appears to be in alternation with some other unit; (5) informant statements regarding this behavior, such as its significance with reference to a particular slotting decision; and (6) sequential patterns to particular constellations of behavior which may be seen as the sequential stages of a particular social career. While various other analyses of the same data are possible, it is important to consider that each analysis presented here makes explicit how this was performed and the considerations which went into the building of a particular interpretation. This is a point similar to that stressed by the culture-at-a-distance researchers who, in their concern with the validity and reliability of their analyses, suggested that the
individual values, talents and selections of each ethnographer must be brought to bear explicitly and consciously to the data:

But analysis depends also upon training and experience which, on the one hand, enable one to refine one's own perceptions and to some extent to make up for one's deficiencies, and, on the other hand, help one to develop and use flexibly the skills necessary to making delicate comparisons. Consequently, no two individuals will work precisely in the same way on the imagery of the same culture, for each will bring to the study a unique combination of abilities and skills, modified by the experience each has already had in working on other cultures. And, even when both share in the same material, the final synthesis which each constructs will reflect an individual relationship to the culture (Metraux, in Mead and Metraux, 1953:359-360).

The construction I make and that made by another anthropologist will differ in terms of the kinds of clues we habitually use and of models with which we work, but providing we have chosen our material carefully, the two constructions will match, and, taken together, will be a more complex statement of the configurations of a culture (ibid.:362).

In addition to the nature of the validity/reliability claims which set ethnography apart from other research traditions, it is necessary to consider here the unusual status of an ethnographic informant. Fetterman (1982) points out, in his paper on the diffusion of ethnographic methods to the field of education, that one of the factors which distinguishes ethnography from other "naturalistic" studies is the concern for phenomenology: "Phenomenology requires that investigators be guided by the insider's viewpoint, the emic perspective" (1982:18). Although it is inaccurate to imply that emicity is equivalent to verbalizability, it is true that a primary concern in anthropological work is to give comparable status to the researcher's observations and to the meanings, explanations and significances of this behavior for informants. Radcliffe-Brown writes:
In explaining any given custom it is necessary to take into account the explanation given by the natives themselves. Although these explanations are not of the same kind as the scientific explanations that are the objects of our search yet they are of great importance as data. . . . The reason given as explaining an action is so intimately connected with the action itself that we cannot regard any hypothesis as to the meaning of a custom as being satisfactory unless it explains not only the custom but also the reasons that the natives give for following it (1964 [1922]:234-235).

Ethnographic informants, whose identities are known and understood by the investigator, are selected and treated as cultural representatives. In order to use the reports of an informant, the researcher must be aware of the particular individual's relationship to the social system, his/her attitudes towards the resultant status and towards the verbal reports that are provided, and his/her consistency or inconsistency of response over time. Furthermore, ethnographic interview data must be analyzed with reference to the researcher's knowledge of the contexts eliciting particular statements, and, whenever possible, must be cross-referenced with observational material. Birdwhistell cogently summarizes the various issues thus:

. . . An informant, if used as an access to cultural values, needed to be understood in terms of the relationship the person had to the society he or she represented. Terms such as "sample" or "respondent" as used in certain types of opinion polling or as a source of auxiliary data in an experimental situation are not substitutable for knowledge about the investigator's source of data. Informants are not rats; all too often they learn in a single session (1975:3).

Not all individuals at both institutions could be employed as informants for the present study; this was especially the case within the ranks of the resident populations, where inconsistency of response, memory lapses, fear of retaliation by staff members, and impatience with the interview process made it difficult for me to establish an ongoing
interviewer-interviewee relationship with some patients. Even when an individual was selected for repeated interviewing, not all his/her responses were accepted on the surface and used in the analysis. As Radcliffe-Brown (1965), among others, writes, interview data are subject to scrutiny and cannot be taken as "face valid" evidence for particular behavioral patterns. Birdwhistell writes that an informant's answer to the questions posed by the investigator "... provides further data for analysis, not an acceptable conclusion to ... analytic research" (1971:Chapter 3, p. 27). Also, Warner and Lunt indicate that the truth or falsity of an informant's statement is itself valuable information which must be analyzed:

The researcher does not always know whether he is being lied to or whether he is being told the "truth." However, the information gathered about social relations is always social fact if the informant believes it, and it is always fact of another kind if he tells it and does not believe it. If the informant does not believe it, the lie he tells is frequently more valuable as a lead to understanding his behavior or that of others than the truth (1941:52).

For example, one Sisters of Faith resident, Catherine McGeorge, appeared eager and willing on several occasions to sit and talk with me in the fourth floor lounge near her bedroom. On one occasion she complained to me that residents were no longer allowed to eat in the dining room; she indicated to me that she thought this was because the nursing home administration had been changed. On the surface, this incident seemed to support one of the analyses on information flow at SFH (see Chapter VI), namely, that residents who are defined by the staff members as inactive are not given access to the information network within the institution. Mrs. McGeorge, who was one resident considered to be inactive, apparently had not been told by the nurses or social workers...
that the dining room was undergoing remodelling (there had been no change in administration). Although this appears to be a good illustration of a lack of information flow to a resident, it should be pointed out that this incident is not used to bolster the analysis in Chapter VI. Closer examination of the woman's complaint revealed that she had said that things were better when a "Mrs. McFey" was in charge of SFH. In looking over other interviews I had held with Mrs. McGeorge, I noticed that the woman referred to McFey as someone who had headed the boarding home she previously lived in; in addition, she frequently lamented having to leave McFey's place. Given this (apparent) confusion, it was decided not to use this informant's statements on certain issues.

Dominick, et al. (1968b) note that differing staff conceptions of successful patient adjustment and of the organization of the nursing institution at large may be expected based on the staff members' level of training (RN, LGPN, etc.). In the analyses which follow, all staff informants are identified according to their training, occupation, and the location of their work responsibilities (a specific ward, the entire house, etc.). Comparably, all resident informants are identified according to their room assignments. The use of these distinguishing features was necessary because, as was expected, residence or work on a particular section tended to limit one's perspective on events and on procedures for the institution as a whole and for particular sections.

I presented myself to staff members and to the residents as a university student engaged in research on "interpersonal communication in a nursing home." The various individuals interpreted my task and their ability to contribute to it differently. Nurses and social workers at
Sisters of Faith Home regularly anticipated (although usually incorrectly) my need for subjects by encouraging me to observe and interview specific individual patients (see Chapter VI). I frequently needed to remind these staff members that I was interested in staff-patient and patient-patient interaction. I found it easiest and most productive to interview the individual staff members soon after the conclusion of a committee meeting we had attended. This shared meeting provided a background and framework which enabled me to attempt to elicit specific recruitment data. PH staff members appeared more willing to talk with me for brief periods of time during, e.g., a coffee break or a lull in their work activities. These individuals were also questioned in detail after specific staff meetings. At least one nurse from each residential section, and at least one staff member from each service department (e.g., activities, social work, administration, etc.) were interviewed for each nursing home. Since the bulk of this field work was carried out during mornings and afternoons, all but two staff members interviewed here worked the day shift.

Interviews with residents at SFH were generally collected under more formalized conditions than were those at People's Home: I needed to reserve an office in the administrative suite and pre-arrange times with Sisters of Faith Home residents. This was because there were very few situations at SFH where I could just sit casually with the residents over a period of time, and gradually collect interview material. In contrast, most of my informants at PH provided me with data during ostensibly non-interview situations, e.g., while we were sharing meals in the dining room, sitting in the living room, etc. As will be noted in Chapters V and VI, whereas PH residents regularly spent part of their
day in one of the ward-specific lounges and engaged in talk there, SFH patients lived relatively more isolated lives, and there were fewer contexts in which residents simply got together to socialize. Those interviews which are described as such in the analysis were audio taped; those labelled "discussions" were conducted under the more informal circumstances and were not taped, and are based on hand transcribed notes. At least two residents from each floor or section were selected for in-depth questioning. Several other individuals were periodically questioned "in passing," i.e., for brief periods of time. Those individuals from this latter group who expressed little fear in speaking with me and whose consistency of response over time I felt confident in were selected for the more detailed interviews.

In general, the present analysis employs informant statements in order to delimit or point to a particular issue or range of phenomena, e.g., possible section assignment criteria or expectations for conversational participation. Observational data are then presented to expand on this issue, either to support, or refute, or clarify patterns initially suggested by informant statements. Further informant statements are interpolated with the descriptions of particular observations in order to provide for the meaning (more accurately, that meaning which is verbalizable) that the behavior has for the participants.

A third source of data and the problems attendant to its use need to be discussed. In addition to generating observational and interview materials for both Sisters of Faith Home and People's Home, the present study collected and selectively employed various written documents. Permission was secured from the administrators and chief nurses in the
two facilities for me to have access to patient charts, admissions applications, physicians' evaluations, social work reports, minutes of various staff meetings, and the like. These documents enabled me to support particular status assignment/reassignment analyses by providing data on, e.g., the (recorded) chronology of events surrounding transfer decisions, the official certifications of a patient's skilled health-care needs, and medication administration schedules. It should be pointed out, however, that these documents are not taken as objective records of the events they describe. Rather, they are employed in the present study as a source of data to be used in conjunction with my own observations of the episodes documented therein, and with my discussions with staff members.

Documents are not unbiased and distanced recordings of events, but are, in many cases, part of the events themselves, requiring appropriate social knowledge for their interpretation. Garfinkel, writing on some "good" institutional reasons for the keeping of "bad" records, indicates in this respect: "... The folder contents, much less than revealing an order of interaction, presuppose an understanding of the order for a correct reading" (1974:121-122; italicized in original). For example, prior to the administrations' discharge or transfer of a patient, nurses at both SFH and PH were ordered to document all examples of "bizarre" behavior. This selectivity of observations and recordings was apparently mandated so that the administration could provide a sufficiently detailed case which justified its actions vis-a-vis the patient (justified for family members, attorneys, and government inspectors). Goffman similarly observes:
The case record is an important expression of this mandate (for the mental hospital to know all aspects of a patient's life in order to facilitate a "cure"). This dossier is apparently not regularly used, however, to record occasions when the patient showed capacity to cope honorably and effectively with difficult life situations. Nor is the case record typically used to provide a rough average or sampling of his past conduct. One of its purposes is to show the ways in which the patient is "sick" and the reasons why it was right to commit him and is right currently to keep him committed; and this is done by extracting from his whole life course a list of those incidents that have or might have had "symptomatic" significance (1961:155-156).

Although the SFH and PH records are used in Chapters V and VI to describe the processes surrounding a ward transfer, these data are presented from the perspective of the role they played in the overall recruitment system, i.e., they were part of the social work needed to instigate a patient transfer, and not that of passive recordings of events.

It was also necessary to keep in mind, while examining the documents, the identity of the individuals producing them and the identity of the individuals being described. Staff members often described what appeared to me as identical behaviors very differently, depending on where in the nursing home the behaviors took place and where in the home the nurse was usually stationed. For example, the behavior of mutual support and aid which was found on "E" section of PH was described as a positive attribute of the "elite" group of women residing on that section; similar behavior on "B" section, which was undergoing a period of decline after having been the most prestigious ward for a number of years, was used to describe patients as "clingy" and dependent. Therefore, as with the informant data discussed above, it was necessary to analyze patterns of "response," i.e., to consider the influence of the writer's context on the documents produced.
In summary, the present study represents an intensive effort to explore the question of social recruitment in two nursing homes, and reports on interview, observational, and archival data. The problem regarding social recruitment has been defined for the present as a concern for the patterned processes by which a social system continuously fills available social positions, trains incumbents with regard to status appropriate behavior, and regulates individuals' movements between selected social statuses. Each major data chapter (V and VI) begins with a description of the physical plant for the nursing home considered in the chapter, and surveys the different residential positions and sections available to patients. The data are analyzed for the equivalence or nonequivalence of each residential section for decisions to admit individuals to the facility, assign them to particular positions, and/or reassign or transfer them. Rules guiding certain aspects of communication behavior among the residents and between residents and staff members are also considered. The attempt with these data is to provide perspective on that behavior which appears to accomplish position assignment, maintenance, training, discontinuation, and/or alteration.
CHAPTER IV
BACKGROUND ON THE TWO NURSING HOMES AND ENTRY INTO THEM

The present dissertation is primarily concerned with patterns of communication behavior which are associated with individuals' entry into and adjustment to geriatric nursing facilities. Thus, this study must focus on the behavioral expectations that nursing home personnel have for inmates. It is assumed that these expectations will, at least in part, be reflected in the criteria and routines surrounding ward assignments and reassignments. Despite this within-institution focus, nursing homes are not self-contained "small societies" (see also Etzioni, 1960).1 Therefore, in order to place the data of Chapters V and VI into their appropriate context, the present chapter briefly considers the history of Philadelphia nursing homes in general and of the two facilities studied here. In addition, this chapter attempts to describe selected aspects of patients' pre-institutional life courses.

Most germane for the present research are studies which delineate current attitudes toward the aged and institutionalization to be found in the historical background of nursing homes. Haber (1977), a student concerned with an American civilization approach, has done this with specific reference to Philadelphia nursing homes. Haber documents the growth of age-segregated institutions in Philadelphia from the 1800s until the early part of the present century, and outlines the changes in conceptions of the elderly that accompanied the developments during this period.

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The first Philadelphia nursing home, which was founded in 1817 by a Quaker charitable society, was designed as a place "... (to) house poor but respectable old ladies unwilling to accept public charity" (Haber, 1977:240). By the end of the nineteenth century, however, and throughout the next few decades, a redefinition of what it meant to require elderly care ensued. No longer were these homes considered as mere alternatives to almshouses; rather, they evolved into places where all elderly people could go, regardless of sex, degree of sickness, or personal finances.

No longer limited in scope to the poverty-stricken, these institutions attracted a broad cross section of Philadelphians. By 1900, they were providing shelter for lonely, tired, and sick individuals whose age alone qualified them for institutionalization. The formation, character, and goals of these organizations had changed completely (ibid.:241; emphasis added).

Interestingly, a change occurred not only in how society defined the role of nursing homes, but also in how it viewed the elderly in general. Haber suggests that, by the early part of the twentieth century, being old was seen as a problem and disease, no longer a natural and venerated part of life:

No longer just alternatives to the almshouses, they (nursing homes) had developed into substitutes for family, church, and hospital. Based on the definition of old age as a disease, they then carefully quarantined their inmates to preserve their dissipating their strength and to guard them against the harmful effects of youthful society. By the beginning of the twentieth century, therefore, they would present themselves to the public not as mere residences for the old folks but as modern medical establishments especially equipped to deal with "the problem of old age" (1977:257).

Ackenbaum (1974) also remarks about this modification of cultural values regarding growing old during this time frame. He writes:

... Definitions of old age changed significantly over time. In the earlier part of the period (1865), old age was idealized:
writers described the elderly as the true survivors of the fittest and emphasized the important societal roles they played. In the latter part of the period (1914), writers challenged this idealistic image of old age: they stressed the physical, mental and behavioral deterioration accompanying old age and argued that the elderly contributed very little to the well-being of society (1974:48).

Ackenbaum suggests that this shift was the result of increasing scientific attention directed toward the medical realities of old age, and emerging corporate retirement policies which "argued that the presence of old people in the working force hampered a business' operation" (ibid.:55).

As noted above, the growth of nursing facilities ran parallel to these trends. The first geriatric facility in Philadelphia, the Indigent Widows' and Single Women's Society, was reserved not for all who were poor, but for those who had been born into the middle class and were now without money. It was assumed that there were sufficient charity houses for the chronically poor. Also, the emphasis was clearly on admitting only those females who had no families to support or shelter them. As Kosberg (1975:207) points out, the earliest custodial homes for the aged were designed for "... only those elderly without families, friends, or means for independent living. ...

At first, maintaining a respectable life for the women was a primary goal of the earliest institutions. "Separate rooms were therefore provided so that each inmate would have privacy, while meals taken at a general table were meant to insure a feeling of family unity" (Haber, 1977:242). The residents were expected to donate labor to the house in the form of sewing, knitting and quilting. This policy was inaugurated in order to ensure the financial integrity of the house and to provide the women with some means of independent activity and a
feeling of self-worth. A radical shift occurred around mid-century, however. Thirty-five years after its founding, the Society no longer required the employment of residents; in fact, this was fervently discouraged:

"It will be remembered," the management wrote, "that all the beneficiaries here are very aged, the youngest considerably more than sixty years old, the rest beyond seventy, eighty and ninety, and that as a matter of course they are rarely free from infirmity and disease and few are able to contribute by their industry to their support" (ibid.:244).

It was during this period, as Ackenbaum (1974) notes, that the tendency to overvalue "youth culture" and the contributions of youth to the general labor force, and to focus on geriatric medical problems, was gradually reshaping attitudes toward the aged and institutions for the aged.

The period just prior to and after the Civil War was marked by other rapid changes. The number of applications to what were then two geriatric institutions in Philadelphia in 1852 were steadily escalating, and by 1864 the Society had a four-year waiting list. The years between 1859 and 1890 saw the construction of twenty-two new institutions. Within this time frame, the various churches, synagogues and trade unions in the city began to organize interest groups for the aged; the homes that were then established through these new efforts were intended for members of particular religious, sexual, occupational or racial groups. Haber writes of the profound effects this had on the conceptions of nursing homes:

With these developments, the concept of private homes for the elderly had grown beyond its pre-Civil War definitions of care for the white, formerly middle-class single woman. By 1890, it covered the single man, the married couple, the black and the poor (1977:252).
A second important development during this period was that many existing nursing homes were moved and newer facilities built away from the city-center of Philadelphia. The shift was to less populated and ostensibly more tranquil surroundings:

The location of the homes further added to this rejuvenating process. During the last quarter of the century, several of the institutions moved to less populated sections of Philadelphia. These new locations allowed the elderly to escape the noise and tensions of the city as well as to breathe the country's fresher air (ibid.:256).

The founding and gradual development of Sisters of Faith Home, a Catholic facility, closely mirrors the above general historical observations, and can, in fact, be seen as an example of the later societal conditions discussed. Sisters of Faith Home currently sits on a four-acre stretch of land immediately outside the city limits of Philadelphia, on the city's southwestern border. The home consists of three adjoining buildings (or building sections) with a total bed capacity of three hundred and eighteen. The oldest section of the present structure was built in 1949 and constitutes the southern-most third of the overall structure. The middle section, which is identical in architectural detail to the first building, was completed in 1954. Originally, the two structures were operated independently, until, as the current administrator of the home expressed this, "... one day they just took the plaster down and it was this huge building." The last building, which is also connected to the other two, was opened for occupancy in 1978 and represents the "deluxe" wing of the home.

The administrator of SFH, Sr. Marie, is a member of the Community of the Sisters of Faith. It was she who provided me with details about the original founding of the home:
The initial mission of SFH was to care for individuals requiring varying degrees of convalescence and medical attention on three charity wards. Three small country cottages were purchased in 1913 by a local priest and a volunteer civic group in order to handle the variety of cases. Today one of the original buildings still stands and now houses a nursing school. Because SFH was conceived as a charity house, one section of the original older female building was blocked off from the rest and reserved for unwed mothers:

"Also at this time, they had a section in one of these buildings for pregnant women. Some married, some not married. . . . They kept the women and some of the children for I don't know what period of time. Since I have been here, I've gotten letters from people saying, 'My mother was a patient at SFH back in 1918, 1920, and I am. . . . Is she still a patient? I'm trying to locate her. . . .' Mr. Martin, who is here now, says that only certain people could work in that section, either in the building or in that section of the building that were very prudent, and not everyone could work there. So the identities of the patients were kept very privately."

In other words, from its earliest days, SFH was a general medical care and charity facility--not limited by age or sex.

Although the priest in charge of SFH at its founding was supervised by the Philadelphia Archdiocese, he had petitioned for and was granted permission to purchase land for his combination old age home/home for unwed mothers outside the city proper. The original name of the facility, in fact, symbolized the bucolic and isolated setting that had been chosen.
In 1913, with the help of a small group of women, he (Fr. Welch) purchased a piece of land in the beautiful suburb of Dixon and converted an old country house into a convalescent home for poor women and unwed mothers whom he saw discharged from the hospital with no place to go. In an atmosphere of peace, quiet, country air, and with nourishing food, they were soon restored to health and society (Document I:8).

The purpose and function of SFH did gradually change however. Most significant was the fact that, over time, fewer young (unwed) females were admitted to the facility, this service being taken over by other Catholic charitable organizations which developed in the late 1930s. Beginning in 1935, the number of males at SFH steadily increased, and they were housed in segregated quarters until 1978.²

Even though there were such changes in patient composition, and, later, building construction, certain features of SFH remained constant. For example, Sisters of Faith Home was considered at its founding to be a health-care facility, not merely a domicile for the elderly. This emphasis, which is self-consciously carried on today (as noted in Chapter VI and below) is reflected in Sr. Marie's talk about the founding clergyman and the reputation that the Sisters of Faith brought to his facility:

(Interview):
"Cause I see a man way ahead of his time. We talked about it in (terms of) extended care today. But he was provid(ing) for that back then. . . . It was all free. Uh, they expected to receive donations and people who worked here would volunteer their time. After two years the (workers) would no longer volunteer their time. . . . And they then went to the Bishop who asked, well, he gave a list of names of communities to Fr. Welch but recommended Sisters of Faith. . . . And this was in 19 I believe 16. We were already in our Home for Childhood Diseases in Boston. . . . And our reputation (for health care) preceded us."

The fact that nursing care was being provided at such an early part of the century, and that Sr. Marie (and others at SFH) is aware of this,
is important to note. Kosberg observes that, to the contrary, in most early homes for the aged, little thought was given to the employment of professional health caretakers:

Due to the custodial nature of homes, directors saw little need for the utilization of professionals. Those who became sick were taken to the hospital; and doctors visited homes only periodically, giving but a moment or two to an individual. The tasks performed by staff with these homes—which emphasized mainly physical ability—required a non-professional staff (1975:205).

Indeed, the establishment of health programs at SFH, and at other homes in the late 1890s, represented a radical departure from earlier inclinations:

In their official policy statements, many of the homes stressed emphatically that they were not created to be hospitals. In most cases, a doctor's examination was required before admittance to insure that the applicant had no incurable disease. If an inmate became senile during his residence at the institution, he was often removed to the almshouse or hospital so that he would not disturb the tranquility of the "family" (Haber, 1977:253).

In brief, SFH was founded at a time when geriatric medicine was beginning to be practiced, and when nursing homes were becoming more responsive to the health needs of residents (see also Ackenbaum, 1974).

The historical developments at People's Home are less well documented than is the comparable SFH history, and, indeed, fewer personnel at the home are familiar with PH history. Several interviews were conducted with the administrator of the home, the owner, and key social service and nursing personnel. Only the owner was able to provide me with sufficient details on the inception and development of PH; as we will see below, even these were talked about from a somewhat limited vantage point by the owner. Also, although there had been several brief papers documenting the history of SFH and the role of the Sisters of Faith community, no similar archival items were available for the present discussion of PH history.
In a conversation I had with the owner of People's Home, Sam Applebaum expressed to me what was for him the salient feature of his facility. He did this by contrasting PH with other types of nursing homes: "County facility, sterile. The nonprofit homes are very wasteful, they cost more. Private nursing homes (such as PH) have got to be competitive: these must offer the facility in order to attract customers." The history that Mr. Applebaum was able to provide, therefore, centered around changes in the physical appearance (building construction, redecoration, etc.) of the home, and the changing makeup of the residential population as a result.

People's Home first opened its doors in 1965, although the corporation which operates the facility had been involved with other nursing homes since 1939. People's Home was originally licensed as an extended care facility (a category of facility now placed under the more general rubric of skilled nursing facility—see below), and initially attracted both geriatric and nongeriatric patients. Soon after PH was established, the administration contracted with the Veterans Administration to provide health care and long-term housing to veterans. This contract is still in operation today, and, interestingly, many of the first veterans to be moved to PH from VA hospitals have remained as residents.

People's Home is an expansive, ranch-type facility, which consists of four major residential sections emanating from a core pavilion. This central pavilion is comprised of a main living room, a dining room, and the kitchen. "C/D" section was the first section to be built in the mid-sixties, and is the one that now contains most of the male residents on Veterans contracts. Mr. Applebaum pointed out to me that the increasing
governmental financing of health care and welfare made it possible in the late 1960s and then throughout the 1970s for PH to be "expansion oriented." Section "A" was built in 1969, section "B" in 1972, the extension of "B" section (which forms a triangle with "B" and "C/D") in 1974, "E" wing in 1975, and the connection between "A" and "E" (called "A/E") in 1979.

The original location for People's Home was chosen because, as Mr. Applebaum expressed this, "I wanted a place where people could retire out of the city." Thus, Mr. Applebaum selected a site in a northern section of Philadelphia. The surrounding neighborhood is residential, except for several other nursing homes and a training institute within a few yards of PH.

The various efforts toward facilities expansion were associated with a redefinition of the PH clientele. Each new section of People's Home that was built was promoted for and attracted patients of differing mental and physical functioning levels. Increasing state and federal compensation after the mid-sixties also meant increasing governmental regulation. Being the businessman that he is (and prides himself to be), Mr. Applebaum took these regulations as an impetus to alter significantly the aesthetics of the home. In our interview, Mr. Applebaum noted that the guidelines specify the amount of space that must be allocated patients:

(Interview):
"Now there are regulations that institutions must follow, and they constrain what I want, and what the architect plans. There's got to be fifteen feet the length of the room: two and one half feet clearance from wall to bed, three feet (across the bed), four feet between beds, three feet (for the second bed), two and one half feet (clearance from the second bed to the other wall). But we use sixteen and one half as a minimum. Our aim is, of course, to sell our rooms, like the Hilton, or any hotel."
Newer wings were therefore subject to increasing governmental restrictions, and, at the same time, to Mr. Applebaum's desire to "outdo" them. The chronology of each section of PH thus becomes important because each new construction represented increasing attention being paid to the physical plant. As Mrs. Richter, the administrator, suggests, later sections of the home became prestige wards:

(Interview):
"B," "new B," "E" and "A/E" are basically the same. "A/E," the newest, is the plushest. Traditionally, a new wing brings a plusher feeling. It attracts a different client. Some in old "B" are pretty bad, they could be accommodated in "C/D" or "A," but there's no room. "E" and "A/E," you get demanding prima donnas."

The ward system considered in Chapter V, i.e., the system of allocating different sections of the home to different patient categories, appears to be the direct result of a particular section's age and the clientele attracted to this.

In brief, PH history indicates a profit-oriented facility, initially conceived in an era of burgeoning governmental support, and oriented to distinguishing between the various clienteles usually found in a nursing home.

Given these historical descriptions, we may now turn to certain sociological considerations surrounding geriatric nursing facilities. Specifically, I want to consider here the status of SFH and PH as specially licensed medical facilities, and the perception of this licensure each administration holds.

The two nursing homes which served as research field sites share important commonalities even though they have experienced different histories; in specific, both SFH and PH are classified as skilled care facilities. This means that all residents and potential residents of
these two facilities must require particular amounts and types of nursing care in order to be admitted. As a result of the inception of Medicare and Medicaid programs in 1966-67, all nursing homes which receive federal or state reimbursements (for any or all residents) have to meet specified minimal standards for skilled care licensing. These regulations stipulate the number of hours that personnel must spend with each patient on a daily basis, and the minimum number and type of medical professionals that each facility is to employ. The following is a definition by the Pennsylvania Department of Health of a skilled care facility:

Any premises in which nursing care and related medical or health services are provided, for a period exceeding 24 hours, for two or more individuals, who are not relatives of the operator and not in need of hospitalization, but who, because of age, illness, disease, injury, convalescence or physical or mental infirmity need such care (1975:9).

Some of the guidelines these nursing homes must meet are as follows:

These homes provide the most intensive nursing supervision and care available in institutions for the elderly. . . .

In these facilities medication and treatment are administered on doctors' orders, and a registered physical therapist must be available to patients. The homes must be able to accommodate those on special diets. The scheduling of regular recreation programs is mandatory (Eckman and Furman, 1975:38).

Skilled care facilities, also known as extended care facilities, represent the most intensive and complete form of non-hospital medical care available to individuals. As such, they contrast with the various other options available to the elderly, e.g., domiciliary care (residential facilities), intermediate level care (nursing facilities without the various therapies), retirement communities. Atchley notes that nursing homes represent a housing situation available to individuals possessing the minimal degree of independence: "... Total
care, including health, personal and household functions" (1977:273). As we will see below, staff members and residents of PH and SFH differ on the importance of a total care certification for entry into the respective homes.

Of the numerous state and federal regulations which skilled care facilities are bound to follow, perhaps the most interesting for our purposes centers around staffing requirements. In the State of Pennsylvania, for example, in order to qualify as a skilled care facility, a nursing home must be able to provide two and one half nursing hours to each patient during each twenty-four hour period. This includes the professional services of registered nurses, licensed practical nurses, and trained nurses' aides.

Since these are minima which are circumscribed, it should not be surprising to find that SFH and PH differ slightly in the actual amounts of nursing care offered each patient. Indeed, the directors of nursing present during the course of my field work expressed this difference quite often to me:

( Interview with Ms. Serreno, PH):
"The state requirement is two point five nursing hours per patient per twenty-four hours. Mr. Applebaum keeps me to that. He gets copies of the monthly reports, so he watches."

( Interview with Mrs. Wilson, SFH):
I ask Mrs. Wilson about staffing requirements and she gives me the following breakdown of personnel: She says that in the Pavilion, the shift from seven o'clock in the morning to three in the afternoon consists of one professional (RN), four nurses' aides, and one unit clerk per floor; the other two shifts consist of one professional and two aides. In the main building, the first two floors have two professionals, seven aides and one unit clerk around the clock; the third and fourth floors have two professionals, nine aides, and one unit clerk. In addition, Mrs. Wilson says that she employs "bed technicians" to help with cleaning and stripping the beds and bedding: two to three technicians per floor on a "change" day, and one to two on other days. Later on in our discussion, the topic changed to
the differences between private and profit nursing facilities. Mrs. Wilson suggested that the differences could be seen in her staffing: "Tight reins on supplies (in the profit sector). In the profit making, you had accountability, you have to account for everything. Sure you have control here, but I guess what I'm saying is that the concern is not the mighty dollar. And there (profit) it was rigid; flexibility is what I see here, I run over the two point five; it's always two point seven or two point nine, and that doesn't include the bed technicians. I run over three point five every day."

There is something other than mere staff time which is indicated here; in addition, each nursing director is reflecting on the administrative attitude or ideology toward nursing care in her respective institution. This is a suggestion which requires further elaboration.

In their references to the patients' needs, and in my observations of the services available to the patients, it appeared to me that Sisters of Faith Home personnel see themselves as having a much more complete helping attitude than the staff of People's Home. Consider the SFH administrator's descriptions of her residents and her staffing expectations:

(Interview with Sr. Marie): "Occupational therapy is not covered in a nursing home except if you're in a hospital, and you're discharged, and fourteen days of discharge from a hospital and a doctor orders it. And what I find in long term care is that after the patients are here a period of time, say with a stroke or (heart disease), whatever, they begin to lose functions. Now say you're a ten year old stroke victim. Like a ten year, the stroke is ten years old? They need the therapy; we provide it over a total (population). That, to me, is charity, charity. I would say that is one of the big areas I'm involved in. And I'm always trying to find ways, you know, different ways to increase the number of staff to help the patients. SFH's staffing pattern is the same for every unit, which is above the Medicare requirement. I think that's very big around here, getting as much help to the patients."

In contrast, members of the PH community do not see themselves as committed to the total servicing of each patient. Rather, the administrator and the head of activities at PH expressed the belief
that their purpose was to assist the patients, not "serve" them:

(Staff meeting):
Carol describes for the others present what happened during the family conference session held at PH the previous weekend: "It went rather well. The group went in a direction we hadn't expected. But we agreed it was successful nevertheless. We had a few surprises. We started by we introduced ourselves. They had to introduce themselves. Marion laid the ground rules, but they all gave long winded explanations of why they came. It was going really well. It got to two sisters, their mother is here. Actually before that, the one problem we had was we never really did get to discuss the role playing (exercise). Also, there were these two sisters, and their attitude was they're here because they're paying for a service, not because we're helping their family member. It's a difference in attitude. The others recognized that we don't can't do everything for them."

(Staff meeting):
Mrs. Richter says that Esther Salk's daughter stepped into her office last week to complain about Nurse Duley. She said that she had wanted her mother to wear a particular summer dress, had instructed the nurse about this, but that the nurse had an "attitude" about her in responding. Mrs. Richter at first thought that the daughter was complaining about a new aide on "E," and that she totally discounted the complaint when she found out it was about Duley. Mrs. Duley became very red in the face when Mrs. Richter said: "I've known Mrs. Duley for a very long time, and she just couldn't have an attitude about her." Carol said that Salk's two daughters attended her family conference, and they were both very disruptive. Carol says that they have a very wrong conception of a nursing home: "They expect to be served. They expect us to be serving Mrs. Salk, not helping."

A revealing parallel to the above can be found in the expressed attitude toward (and actual utilization of) volunteers at each institution:

(Staff meeting, PH):
Mrs. Talbott, director of nursing, brings up the availability of a teenager to work a half shift after school five days a week. Mrs. Richter says she has no objection in principle, except she wants to know what will happen to this girl's job function when she is not here the other two days. Mrs. Richter expresses a general dissatisfaction with volunteers (although this girl would be paid): "Volunteers are a responsibility and a liability. They're sometimes a pain. They're not always very motivated. We did have a fourteen year old girl once, but she was an exception; she had a lot of energy, she was all over."
(Discussion between Carol, activities director, and a woman who is inquiring about doing volunteer work):
Carol says: "People don't come here to die. They come here alive, they come here to live. We are doing everything we can to make this their home. They come here to live, they may not want to live here, but we want them to come here to live. You have to understand that if you volunteer here. I don't know yet what we can do with you; perhaps you can visit some of the patients, I could draw up a list. We don't get many volunteers; we manage with the staff that we have. Anyway, think it over; you said talk with your husband, it's up to you."

(Discussion with Mrs. Simon, second director of activities, SFH): "I think our volunteer program is the best I've ever seen anywhere. We have over sixty volunteers and they never miss a day. And then they'll do almost anything for the residents. In fact, I feel the volunteers are the backbone of any organization, so we're fortunate to have a backbone."

(Discussion with Sr. Constance, first director of activities, SFH): I ask Sister about the volunteers, and she says that they come from local parishes as well as from the community: "Relatives of former relatives, residents, come back to do volunteer work. I ask for a commitment, initially, of at least one day. I reject very few people. If they tell me they can only come one hour a month, I grab at it. In the summertime, there's usually a slack, with people on vacation or the kids are home. The slack is usually taken up by the students looking for something to do in the summer. If they're interested in medicine, this gives them a chance to see if they're really headed in that direction . . . . Persons who come here know about the kind of care they know about here. Some are here for their own sake. Some have a need to be needed, so some of the volunteers are being helped with their needs as we're being helped with their services."

Interestingly, each of the photographs in the promotional brochure distributed by Sisters of Faith Home depicts a patient or group of patients being attended by a nurse, a nun, or a uniform-clad volunteer worker; none of the pictures shows residents by themselves.

It should be pointed out that both PH and SFH are concerned with meeting the medical and psycho-social needs of their patients. These quotes are taken from the promotional literature distributed by the two nursing homes:
PH Nursing Centers are licensed, skilled nursing facilities which provide nursing and rehabilitative care on a short-term or long-term basis.

Our highly qualified staff is dedicated to helping each resident attain his or her highest level of functioning, with constant attention paid to the dignity and self-sufficiency of each person (Document III:1).

Sisters of Faith Home cares for patients with varying degrees of physical and mental incapacity. An atmosphere of comfort and encouragement is provided by our skilled and compassionate staff. The dignity due each patient is observed at all times (Document IV:1).

Both facilities make available to residents a variety of activity programs, therapies, dietary options, and so on. Indeed, the skilled care certifications that PH and SFH have been granted are contingent, not only on minimal nursing hours per day, but also on the availability of periodic social service and activity programs, and of various health professionals (e.g., dieticians, social workers, etc.). Again, however, these are general guidelines which may be molded according to each facility's "mission." To take one additional example, while it is true that skilled nursing facilities are formally charged with the requirement of providing patients with the services of a social worker, some degree of latitude is available to the nursing homes with regard to how this requirement is met. At People's Home, the director of activities doubles as the director of social services, and a consulting Master of Social Work visits periodically to aid in the updating of patients' charts. In comparison, at SFH, three full-time social workers and two clerical assistants were employed in order to meet the goal of serving a "needy public." In brief, although both SFH and PH are skilled-care facilities, we have noted here that the two institutions differ in terms of their "informal" ideologies, i.e.,

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their expressed attitude toward their role relative to the patients and
their families. In this sense, a skilled care facility is in fact
represented by a variety of institutional arrangements.\(^5\)

It should be pointed out that the patients themselves, in order to
be admitted to either SFH or PH, also must receive a skilled care
certification. Medicare, a federal entitlement program, pays for only
one-hundred days in a skilled care facility following a person's
hospitalization. Medicaid, a state-administered financial aid program,
subsidizes extended stays in nursing homes provided that the patient (1)
has no other means of financial support, and (2) requires the kind of
skilled nursing care outlined above. In order to meet the latter
criterion, residents must be certified by the director of nursing or an
attending physician on the necessity of skilled care placement. To aid
in this certification, a diagnostic instrument is employed which assigns
point values to various measures of a patient's ability or inability to
carry on specified daily activities independently (e.g., self-feeding,
bathing, dressing). Patients who score beyond a certain number
(thirty-three points) are immediately eligible for skilled certification
and entry into SFH or PH, while those who score below this are judged to
be in the questionable range. Under these latter conditions, further
written documentation by the patient's physician and/or each nursing
home's Utilization Review Committee is mandated:

\[. . . \text{As in those cases where the application of the guideline}
\text{results in a total point value of less than 19 or from 28-32,}
\text{THE PROFESSIONAL JUDGMENT OF THE ATTENDING PHYSICIAN SHALL BE}
\text{GIVEN SERIOUS CONSIDERATION. In all cases. . . , it shall be}
\text{incumbent upon the attending physician to provide sufficient}
\text{documentation in the clinical record to support the determina-
\text{tion made relative to the level of care required (Document II:40h;}
\text{emphasis in original).}\]

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One would suppose that, with such explicitly worded definitions and a presumably objective measure, one should find fairly uniform populations in nursing homes licensed to accept skilled care patients. As the director of nursing at People's Home once commented, however, nursing homes are subject to far more discretionary power:

(Discussion with Ms. Serreno):
"First of all, private pay patients can be anything they want to be. That's not regulated by DPA Medicare. Really, they're all supposed to be, but . . . . Betty Thayer (an "E" resident) could be in an apartment. But there are advantages to her to stay here—social programs, companionship. It needn't be all skilled care patients in a nursing home; the regs are only for the facility itself, nursing routines, things like that. And if the doctor doesn't like the way the point system came out, the family doesn't think so, the doctor can always bring it before a board and fight it."

As can be inferred, the actual skilled care needs of the patients at PH (and SFH) vary widely. As we will see in the chapters that follow, residents of nursing homes are differentiated by a variety of classificatory terms (e.g., alert-oriented-confused, ambulatory-nonambulatory) and each nursing home has its own set of valences for deciding on the relative status each of these will receive. At this juncture, it may simply be noted that nursing homes are initially presented with heterogeneous rather than homogeneous entering populations.

Within certain broad limits, skilled care certification can be effectuated even without an exact need by the patient for this, and nursing home staff members and residents' families acknowledge a much wider set of reasons for entering a home than a requirement for skilled care. The clinical charts of all patients at PH and SFH provide a space in which a doctor must indicate the medical condition warranting skilled placement. In many cases, the doctor indicates this by listing the
physical ailments afflicting the individual, such as high blood pressure, senile dementia brought on by arteriosclerotic disease, diabetes, and so on. What I want to suggest here, however, is that medical diagnoses are often secondary to other expressed reasons for nursing home placement. Several charts I examined at PH contained the following clearly tautological certifications:

(Patient chart for Mrs. Thayer):
The director of social services has an entry of 1/15/80 which notes: "... (The patient) states she is unable to care for herself... and does not care to be a burden on (her) daughter." The doctor's skilled care certification on 11/13/80 indicates: "I certify that this patient requires skilled care because she requires total care."

(Patient chart for Mrs. Scott):
The doctor's certification on 8/21/80 indicates: "I certify that this patient requires skilled care because she cannot care for herself." The nurse's summary entry for April 1980 notes: "She requires minimal supervision and ADL (activities of daily life) and she is able to take care of her personal needs such as bathing, dressing, and general grooming..."

The reason these are noteworthy is that doctors and nurses recognize that many of the diagnoses found in nursing homes are found outside as well. The medical charts for the above cases clearly indicate various physical problems (e.g., Betty Thayer is diabetic). Yet, as Ms. Serreno noted above, this symptomatology alone is not so debilitating that many nursing home residents could not realistically live on their own. The doctors' certifications apparently take into account that physical ailments alone do not suffice, and that skilled care certification can only be confirmed when the patient's "dependency" is specifically indicated.

The administration of SFH presented itself to me as firmly committed to admitting only skilled care patients—regardless of whether they were private-pay or Medicaid.
(Staff orientation meeting):
Sr. Marie is introduced to the group by Sr. Elizabeth. Sr. Marie says hello and then tells the group that she wants to talk about what it means to work in a skilled care facility: "I am the administrator and what that means is leadership. But in order for me to lead there has to be a team. We take a team approach here at SFH. We are all here to care for the patients. The patient is also here as part of the team, they're the central part of the team. There's one thing you should keep in mind. The residents were once like you here now. They once were sitting there starting a job. They never planned to be here, they never planned to be handicapped. Perhaps you can remember that on a day when we're understaffed, or a day like today, when it's kind of blue out."

(Discussion with Sr. Marie):
I ask Sister if there are any patients other than skilled care certified, and she says that SFH makes allowances for seven intermediate care patients. She says this is done because Medicaid rates for intermediate care patients are lower than for skilled care. I ask her if a patient needs intermediate care and is private paying if she makes an allowance. She tells me that there are no "rules in a book," but that SFH is a skilled care facility, that she is now working to get licensure as a rehabilitation center also: "We're staffed for the skilled care patient in mind."

Interestingly, the following admission was approved at SFH even though all board members acknowledged that, at the time, the applicant was not a viable candidate for skilled care:

(Admissions board meeting):
Mrs. Wilson, the director of nursing, noted that Hamlin's application indicated she was willing to pay for a semi-private room for at least one year. Several board members reiterated that Hamlin did not require nursing care, but Catherine, the administrative assistant, pointed out that it was Hamlin's intention to enter SFH once her husband (now a patient) was settled in here.
Mrs. Wilson: She's really not skilled care now, but she can come in on intermediate. The doctor might say she needs skilled, it's difficult to say with some cases.
Sr. Marie: Let me see if we have consensus. We're saying to approve the application and admit her this week.
Mrs. Wilson later says that even though Hamlin is not skilled care at this time, within the year her condition may deteriorate and her certification may therefore change. The application is approved.
Further data were provided by the two physicians who serve on the Utilization Review Committee at SFH (an internal board charged with the duty of seeing that all patients in the home are skilled care):

(Field notes):
Mrs. Wilson explains to me that the committee decides on skilled care certifications: "This is a skilled care facility, which means that all patients must be certified as needing skilled care. The state, however, when checking the skilled care status of patients, checks only Medicare and Medicaid patients." During the course of the meeting, the two SFH doctors who were signing the certifications, questioned the certification of one of the patients:
Dr. Flynn: What's skilled about her?
Dr. Timpson: She's skilled because the doctor said she's skilled.
The two doctors look toward Mrs. Wilson, and then sign the form. One of the doctors says that with Reagan's new rulings, the criteria for skilled care will assuredly become more stringent. The other doctor says that if nursing homes were not free, many families would have to keep their members at home: "There are many people here who could live on the outside. There are many outside who could use to be here."

These observations provide us with a contrast to the "formal" and "technical" (Trager and Hall, 1954) view of what a skilled care facility comprises, and prepare the way for a later analysis of the varied expectations and behavioral treatments actually accorded patients by their institutional caretakers. Both facilities have a number of residents who, while physically ill to some degree, are acknowledged to be able to live independently, i.e., away from the nursing home situation. Chapters V and VI consider the fact that the existence of fluctuating entry quotas in each facility results in varying stress being laid on a potential patient's skilled care certification when his/her application comes up for review. Both facilities are oriented to the needs of skilled care patients; nevertheless, as we have seen, both facilities do admit (or make certain allowances for) patients who are certifiable in other categories. In this sense, one can note the
existence of heterogeneous resident populations in each facility. Although PH and SFH are both skilled care facilities, they differ in the degree to which they adhere to this self-description when talking about patients and applicants. SFH speaks more directly to the suggestion that all patients are (ostensibly) in need of skilled care; the personnel at PH appear more liberal in their interpretation of this. This would seem to relate to the observation made above that PH and SFH contrast with regard to the view each administration holds of the goals and structure of the respective facility. SFH self-consciously describes itself as a total nursing facility; PH couples this description with a realization that each of its different sections attracts patients with different care requirements.

At this juncture, I want to follow an alternate line of reasoning. The above variations in skilled care certification should alert us to the possibility that something other than (or, at least, in addition to) medical needs in the most technical sense are being met and offered by nursing institutions. In fact, when we turn to the reasons given by residents and families for nursing home placement, a variety of these which go beyond medical care are discernible. The geriatric literature reports that elderly applicants to nursing homes do differ on certain physical (medical) dimensions from noninstitutional control groups. Kraus, et al. (1976a) found a higher percentage of cerebrovascular disease, decreased mental functioning, and increased prior hospitalization in those individuals applying for entry to nursing homes. Interestingly, applicants demonstrated an increased reliance on family and neighborhood support just prior to institutionalization, thus suggesting to the authors that institutional placement is inevitable and
is not the result of family apathy:

A substantially higher proportion of Group A (applicants) than of Group I (nonapplicants) had received total or extensive help from family members, and even from friends and neighbors, presumably in response to their greater problems and needs. The evidence suggests that any feasible extent of additional help from family or friends could not have played a significant role in keeping more of the elderly out of long-term care institutions (1976a:124).

In a subsequent publication by the same authors, it is noted that a variety of factors tend to lead to nursing home admission:

... The most frequently mentioned reason was the excessive burden on family members; this was given by 14 percent of interviewed applicants and by 51 percent of interviewed family members of uninterviewed applicants. The second most common reason was a new specific health problem in the applicant. Next in order were several reasons involving the applicant's physical or mental health, and several involving problems in the family. Other fairly frequent reasons included: urging by a physician, planning ahead or getting set in anticipation of future needs, social isolation, inability to obtain or retain adequate hired help, and disruption of previous housing arrangements (e.g., by fire) (Kraus, et al., 1976b:166).

An extensive survey of why individuals and their family members applied for institutional care was not carried out in either SFH or PH. Nevertheless, these data were sought and collected as part of the general field work. A variety of settings were employed at the two nursing homes to yield some perspective on why the individual entered the home; these included formally scheduled interview sessions with patients, casual conversations with patients and/or their visiting families in the lounges, conversations while sharing a meal or jointly participating in an activity. These data support and extend the Kraus, et al. results. For example, residents did often suggest that it was impossible for them to move in with their families or to continue living with relatives or friends:
(Discussion with Mrs. Karp, PH):  
"You can never live with the son, because of the daughter-in-law."

(Family conference held by the PH director of social services/activities):  
One woman says that she doesn't feel guilty about having her husband committed to PH because she realized it was the only thing for her to do. The fact that she repeated several times that she had no guilt made me a little suspicious. In any case, she said: "They are all sick here. I realize that. I don't feel guilty. I had nurses round the clock, but you worry. If one can't make it, who do you call? It just didn't work."

(Interview with Frances Rossini, SFH):  
"I had fallen, I had a very bad fall. Gee, I had a broken nose. I had a very bad, I was living with my daughter for three years. I had to give up my home. It was impossible. I lived there for three years after my husband died. . . . It was impossible. I couldn't live alone. And uh, I went to my daughter's. They built uh, a room, uh downstairs with a shower and, and the room was nice, and, but, I was there three years and I wasn't happy. It was just me. I didn't like, I would always find myself in my own little room because I didn't want to be in the way of whether my daughter was entertaining or the children. . . . So I had asked my daughter one time. I said, 'You know, I would like to go into a nursing home.' I asked her would she look into it for me. Well, she was a little surprised."

(Interview with Mae Olney, SFH):  
"My mother left me a home because she wanted me to have a home of my own. I lived with my brother and sister-in-law and niece. My sister-in-law is sickly. She has a very bad heart. My niece goes out to business every day. She has a very good position in an office and she can't be there (at home) all day. My brother is an old grouch. He had cataracts in his eyes and he had them taken off. . . . I needed help. I needed somebody to take care of me. My sister-in-law got sick and she couldn't help me. My niece had to go out for business and my brother was helpless. He was not kind around sick people."

(Discussion with George Kenner, SFH):  
"I don't want to go with my kids. I got a son and a daughter. My daughter, she lives in New Jersey. They move around a lot. They just came back from Texas. They got their own families. My son, he don't have the room for me. It's only a three bedroom home and he still got two kids at home."
As can be seen, the stated inability to live independently or with family members covers a diversity of other factors. One way of analyzing this in greater depth is to consider the residents' responses to my questions about their choice of a particular nursing home and the process by which the selection was made. This will enable us to consider selected features of the pre-institutional career as viewed by the residents. Interestingly, doctors and other medical personnel are often credited with (or blamed for) the initial suggestion of a nursing home placement (cf. Kraus, et al., 1976b).

(Discussion with Josephine Wilde, SFH):
"I was over at that rehabilitation center. My doctor kept at me to come here. He hit me with that church stuff. He said you better take advantage of it, or you're not getting another chance. They called me three times before I finally said yeah."

(Discussion with Mrs. Lutz's daughter, PH):
SJS: If I may, why did you choose this particular place?
Daughter: This place is very cheery. The moment I saw it, the room they showed me was very bright. The doctor pressured me to find a place for my mother. He kept on saying that she shouldn't be alone.

(In "B" corridor, after lunch, PH):
Tony: This is my home too.
Mrs. Lutz: Yeah. My doctor said he didn't want me being alone. There should be other people for me. My daughter looked around, and she said this is the best one she thinks. There are people. I like it.

(Admissions interview between Diane, one of the social workers, and Mrs. Foley's husband, SFH):
Diane: Why did you choose SFH?
Foley: We wanted it for the religious aspect here.
Diane: Why was she admitted to the hospital in the first place?
Foley: Incompetency. Yeah, that was one reason. And the visiting nurse thought she might have had another stroke, and she should be checked. Incontinency more or less settled it.
Diane: This past July is when you decided you couldn't take care of her.
Foley: Yeah, it was the nurse's decision.
The husband comes out to talk with me in the hallway. He tells me that it was a very difficult decision to make, i.e., putting his wife into a nursing home, that he never thought he would have to make a decision like that. He tells me that the doctor had said that he just couldn't take care of his wife any longer. She had had a stroke two years ago, right before Christmas and Thanksgiving, and the doctors had said then that it would be difficult for Mr. Foley to take care of her right before the holidays. The doctor was surprised that indeed he did manage to take care of her for nearly two years, until "this new condition took over."

(Application interview between Sr. Rose, the intake worker, and Mr. Kenner's son and daughter-in-law, SFH): The son says that his father has been in and out of the hospital of late because of his problem with breathing and renal failure. He says that the doctor recommended that they look into an extended care facility for Kenner because he could no longer live at home, and the family couldn't fulfill his medical needs any more, e.g., through visits or keeping him at their houses for awhile. The son notes: "Dr. Staub said that the family had a crack at it and you can see you can't handle it." The son says that he had been stalling about making any moves or inquiries about nursing home placement. . . . He says that both he and his father share this "macho attitude, we both do, I guess you call it," and that his father has always been independent, and would not like the idea that he would be told he can't move back home. . . . Finally, the son admits that the doctor said to the family, "he had to be explicit to me. He said that your father will not improve. He needs skilled care."

A cautionary statement about these data is needed. It is difficult to know what role the family physician actually plays in instigating a nursing home placement, much less the full sequence of these events (e.g., does the doctor provide the first idea about the possibility of a placement, as some patients and families indicate, or is the doctor merely the first to verbalize this "out loud" as it were?). The present study takes the position that residents and their families are not necessarily providing objective descriptions of the events which lead to institutionalization, but rather present "accounts" (Scott and Lyman,
1967), i.e., attempts to make some sense out of what happened and to provide socially (and personally) acceptable explanations.

Part of the application procedure involves the construction of a "social biography," a statement explaining why nursing home placement is sought and outlining the set of prior experiences (medical diagnoses, interactions with medical and social service personnel, other nursing home application procedures) culminating in the present inquiry. The examples above are especially noteworthy in this regard. Doctors' suggestions or orders were often employed by relatives and patients as an explanation for institutionalization when the individual was being interviewed either by me or by nursing home social workers. Although doctors do indeed make such suggestions, it must be remembered that it is the family members (or the individual him/herself) who actually makes the commitment. Families have some discretion over what to do with the doctors' suggestions, but invariably they refer to these suggestions when making applications to nursing homes. Mr. Foley indicates that he decided to ignore the doctor when his wife first became sick, but in now seriously considering placement he repeatedly refers back to interactions with visiting nurses and doctors. The doctor referred to in the last example above is ascribed a singularly important role in advocating the institutionalization of Mr. Kenner's father. It may be suggested here that the doctor's advice is being used selectively by this family. Subsequent to the actual admission, Kenner senior and his son decided that SFH placement was neither economically feasible nor personally satisfying. Mr. Kenner repeatedly claimed that he was "over my head" and "out of (my) league." In their discussions among themselves, with me, and with SFH personnel, as they began to
prepare for a discharge, the Kenners no longer made references to the doctor's original recommendations. These were simply dropped as Mr. Kenner began plans to stay only a few weeks in the home. In other words, references to the necessity of skilled placement, and, moreover, the role ascribed to doctors in this area, are selectively employed by residents and families. To a certain extent, such is also the case with the residents' references to illnesses, etc., and to the reasons given for selecting a particular nursing home (see below).

A key reason for discussing the pre-patient biography, as expressed by residents and their families, is that these are the same "sad tales" (Goffman, 1961) that are told the nursing homes during the application procedure. In other words, to a large degree the nursing homes are dependent on the medical and social case histories presented to them in making decisions on applications. As we will see in Chapters V and VI, the system of assignments/reassignments makes use of this information, and also is structured to handle discrepancies in information provided, e.g., once a person has been admitted and is seen by the institutional personnel.

When going before nursing home admissions boards, and probably because they are encouraged to apply to several facilities, families attempt to build a case which will ensure an acceptance. The analyses of the admissions procedures in Chapters V and VI indicate that, during the course of their discussion with nursing home personnel, the applicants learn what does and does not qualify. Also, to a certain extent, previous meetings with social service agencies prime the families with advice on the best way to handle the myriad forms and questions they are confronted with. As one social worker explained:
(Interview with Miss Smith, City Social Services Unit): "The social workers for the city or in private (agencies), they call around almost every day. To find out if there are any if anything's available. We tell the families to do this. Sometimes it works. And we always tell them what each place is looking for, what they should stress."

It should also be pointed out at this juncture that social workers are often very skilled in terms of the presentation of acceptable applications. Here the administrator of PH expresses the problems inherent in the nursing home's reliance on patient descriptions provided by those working with the families:

(Staff meeting):
Mrs. Richter brings up continuing problems with a recent "C/D" patient, Miss Pasternak: "Classic VA misrepresentation of a patient's condition all the way down the line. She's not alert. We've already moved her. The memory span is zilch. She needs a lot of time. There's not enough time in a day to devote to her. If you give her ten minutes she wants half an hour. It's not the kind of facility where we can give her hours after hours."

(Discussion with Mrs. Richter about the Pasternak case): "We think of social worker, we have an image of social workers as being very concerned, they try to help people. But the social workers in a hospital work differently. Their role is to free up the beds. Their role is to get them out, open up the beds. So they don't know a lot about the patients. It's not that necessarily they don't care."

In brief, one aspect of the pre-patient career, as referred to by residents, involves family members in interaction with medical personnel, social service agencies, and, finally, the selected nursing homes. Chapters V and VI indicate the degree to which the (often traumatic) experiences surrounding the attempts to find a nursing home placement remain vivid in the minds of residents. For example, the application procedure at SFH requires the filing of several medical forms, often a month's wait before the application is brought before
the appropriate board, and then up to six additional months before the individual is actually admitted. Understandably, SFH residents often speak of this facility as a hospital and are often heard to say: "You've got to be real sick to get in here" (see below).

Events other than a doctor's suggestion also may be observed to have some influence on the decision to enter a nursing home, and these appear in the patients' talk about this process. Kraus, et al. (1976b) observed that nursing home applicants have an increased probability of at least one hospital stay during the year prior to the start of the application procedure, as compared with a control group of nonapplicants. My discussions with residents and their families revealed that the hospitalization was sometimes needed to convince them that some form of extra-familial medical care was required by the individual. In addition, hospitalization was often seen as a necessary first step to a more permanent placement; for example, it is often talked about as the easiest way to smooth the transition from home to nursing home:

(Admissions interview between John, the director of social services, and Mr. Crenzi's daughter, SFH):
Daughter: This is a very hard time in our life. It's not easy, but when you have no choice. When he needs twenty-four hour supervision, you have no choice.
John: You said he was violent.
Daughter: He went to throw, there was something and my nephew was living there and he stopped him. And the doctor said he must he must you have no choice and that's when we admitted him to St. Claire's (Hospital). So he was in the hospital, so the next thing was to look what next. I must emphasize this, when we first came to Sr. Rose, we painted a very different picture (i.e., from Mr. Crenzi's present appearance). . . . In the hospital he was just sitting like a living vegetable. I say we painted a very different picture then because things were different with him. He couldn't walk by himself. He couldn't feed himself. . . . Now that he's not with sedation, we're all very thankful for that, he can walk,
he takes care of himself. (-pause-) I'm sorry for being so long winded, but I did want to let you know.

(Interview with Mrs. Rossini, SFH):
"And as I turned around (in the daughter's kitchen) the crutches went under me and I flew across the room. Actually flew across the room, with the crutches under me and my shoulders aren't the (best), because I had work (an operation) in the shoulder. . . . So of course, the uh, it was the pedamedics. . . paramedics. Oh, they were there within five minutes, and I went off to the hospital. And I'm lyin' there and I'm thinking: 'I'm out of the house, it's now or never.' Because if you have to leave from the house, I think it's too traumatic, it's uh, well, we could say blah blah and tears and blah blah. So, ah, I was talking to the uh the social worker there, and uh, she wanted me to go back to my daughter's house and I said, 'No, no, I want to go someplace else.'"

(Field notes on health care team meeting, SFH):
The staff discusses the fact that Mr. Holt has had a very poor relationship with his wife, and that this might be the real reason he was placed at SFH. One of the nurses says: "She's home alone and I think she prefers it that way. I don't think he really belongs here. He's independent except for cooking." One of the assistant nursing supervisors says: "Sounds like a couple which needed to be separated. And the only way was for him to go into a nursing home. The sons can't very well take him—that would create problems with the mother. . . ." Someone else remarks that Holt was admitted to SFH directly from the hospital and that the wife first made the application when Holt went into the hospital suffering from Parkinsonism. At first John, the director of social services, questions if the health team's goal shouldn't be an eventual transfer for Holt to an intermediate facility; one of the nurses remarks that even though Holt is completely independent, the Parkinsons diagnosis "probably got him the skilled care status."

(Interview with Carol, PH):
I ask Carol if she sees any differences in terms of adjustment for patients who come to PH from the hospital as opposed to those who come from home. She says at one point: "Those coming from hospital versus those coming from home in terms of adjustment, sometimes it's a physical (disability) difference. If they come from the hospital a stroke might be more recent. Most of them come from the hospital. I think sometimes that sets the whole thing in motion."
While there was apparently no difference between SFH and PH residents on these issues, the two populations did contrast in other respects; specifically, on the reasons for coming to the particular nursing home that they did. During an early phase of my field work, I noticed that residents of SFH were more likely than their PH counterparts to explain their institutionalization in terms of "needing medical care." In turn, residents of PH spoke about sociability and the desire to be among people as their primary reasons for entering this facility; medical needs (while not inconsequential) were talked about as "givens" and as secondary to not being alone. In the following quotations, two patients describe their doctors' urging them to enter a nursing home, yet the reasons imputed to each doctor are not the same:

(Conversation between Mrs. Lutz and Tony, PH residents):
Mrs. Lutz at one point says: "Yeah. My doctor said he didn't want me being alone, there should be other people for me. My daughter looked around, and she said this is the best one she thinks. There are people, I like it."

(Interview with Mrs. Roche, SFH):
"You've got to be real sick to get in here. My doctor said, 'Give up the apartment. It's time you moved in where the nurses can take care of you.'"

Even when a doctor's intervention or stimulus is not in evidence, PH residents (and families) talk about a nursing home as a place where they can be with people like themselves. Furthermore, the facility is often viewed from the somewhat narrow perspective of being a primarily residential community:

(Interview with Mrs. Raymond):
Raymond: I was at my daughter's when I came here. They thought I should be with older people. Bull-shwoir.
SJS: What do you think about that?
Raymond: Oh, I don't like the idea.
SJS: Why?
Raymond: . . . I didn't see why I had to be with old people. . . (I) think that what they had in mind was
that there'd be company for me and all like that. But I
don't want to be with old fuddy duddies and things like
that.

(Main living room):
I enter the living room at approximately 11:15 a.m. Rosary
prayers are being said in the dining room. Anna Pollack calls
me over to area 3 in the living room where she is seated.
Pollack: Son, I have a question for you. Will you do me a
favor, answer one question for me?
SJS: I'll answer two.
Pollack: Thank you. Why did the Lord take away the elderly
their strength? I can sing, I can walk. But . . . I sing
because my husband, before he died, said don't stop singing.
Don't stop singing he told me. I'm not a poor woman. I'm
not a rich woman, but, the strength, it's just not there.
SJS: I don't know, Anna.
Pollack: I have the answer. Why won't they take me home?
I've got a beautiful new home in Sterling Community. It
was built four, maybe five years ago. They say: "You'll
be alone there and here you have so many people." I was
alone for four weeks after my husband died.

(Observation in living room area 2):
Mrs. Polo tells her son that she can be taken out of PH,
that this is allowed, but in response to the son's ques­
tion of where he should take her, Mrs. Polo does not say
anything. They are silent for a few minutes and finally
the son says to Mrs. Polo: "There are a million people
here. You're not alone. I looked around. This place
has a lot of people. You need to be here. You're sick
here."

(Discussion with the daughter of Mrs. White, a new patient
on "A" section):
Mrs. White's daughter says she's really not sure if a
nursing home is what her mother needs or if what she
really wants is a more residential facility. She tells
me that Mrs. Richter had told her when she first visited
PH that putting her mother on "A" section would give her
the friends and companionship she wants for her. She
says that her mother is disoriented to place and time,
but not to person, that she has a slight heart condition,
but that she's only been confused for about six weeks,
since the change in medicines.

Even when ambivalent about the overall placement, the PH resident ex­
presses a preference for the company provided by the nursing home:

(Discussion in dining room with a new patient, Mrs. Fogel):
Fogel: My family did this. I don't know why I'm here.
SJS: Maybe they want you to rest?
Fogel: Why? I'm not tired. (-pause-) Dopey me, I gave my sister power of attorney. I couldn't figure out why at first. Now I know. (-pause-) Tell me, how do you reverse the power of attorney? I guess I need a lawyer, right?

SJS: I don't know.

Fogel: I still tell you, it's still better than sitting all alone at home, by yourself. It's a wonderful place here. I wish they'd get me out. I don't know, maybe I'll adjust. There's still nothing like your own home. I guess it could be worse. I have my own, a duplex; I've got a tenant.

In contrast, when SFH residents refer to their facility, they tend to speak more about the medical services available to them, e.g., the number of trained professionals (including five physical therapists, two speech pathologists, and an occupational therapist) employed on a daily basis, than about the other residents. Also, it is noteworthy that some residents even referred to SFH as a hospital.

(Discussion with Charles Hayward in the fourth floor solarium):
Charles is pedalling his wheelchair around the free-standing ash tray. After I have told him about my work, he tells me that the hospital associated with the University of Pennsylvania is a very fine one. He says that he searched for many years for a doctor before going to HUP, and that if he had gone earlier, he probably would not have to be "hospitalized" (his word) now.

(Discussion with Mary Cooke in her room on the third floor):
I introduce myself to Mary, tell her I'm a student and would like to talk with her. She is a bit hesitant at first, but she says she could use some company. She says that living at SFH is a bit depressing, that she remembers how independent she used to be. I ask her if she goes to activities, e.g., to keep herself busy, and she says that she goes to therapy. She says that everything has happened all of a sudden; she has had three hip operations and she just lost her husband. I ask her why she came to SFH and she says that she had been in another nursing home before coming here, right after her last hospital stay. She says that someone told her "they had great therapy here."

(After the coffee hour in the activities room):
As Anna leaves Mrs. Pronsk’en's side, she says to her: "That's why I'm here. I look okay, but I'm sick."
(Interview with Mrs. Gibson):
SJS: What reason would you use for coming to SFH in particular?
Gibson: Because this particular institution is Catholic and I could go to daily mass. Also, my daughter checked on the nursing homes in Dixon County and she felt that this one was the best. She had worked in nursing homes so she knew what to look for, and, therefore, I took her advice.
SJS: I see. What did you expect Sisters of Faith to be like when you first came here?
Gibson: Very much as it is.
SJS: Which is what? How would you describe it?
Gibson: Someplace where people take care of others who can't manage for themselves.

(Interview with Mae Olney):
SJS: What did you expect once you came to Sisters of Faith?
Mae: I guess I knew that it was a nursing home that would take care of me.

(Interview between John, social worker, and the son of an incoming patient):
John: We use Harrah's Pharmacy to get all the prescriptions. Is that okay with you, or do you want to make other arrangements?
Son: No, we want to use whatever is convenient for the hospital. You can still use that place.

(Fourth floor lounge):
Martha Hamlin has been sitting in the lounge during the (conversation in which Mae Olney and Catherine McGeorge were complaining about SFH). As the aide comes in to tell Catherine and Mae to leave, she also hands Martha her husband's food tray. She takes this, places it next to him, and begins setting the tray up. . . . As Catherine and Mae leave the room, Martha says to the aide: "They have the whole hospital reorganized."

(Interview with Mr. Kenner, a new patient on the fourth floor):
SJS: Have you met many people here?
Kenner: What do you mean?
SJS: Do you go to activities?
Kenner: Yeah. I go to that therapy in the morning.

(Discussion with Mrs. Gibson):
She says that she does not always get to mass every day, and I ask her why. She says that some mornings the aides do not dress her in time to get there; she says that this starts her day off badly. She complains that nurses give precedence to patients going to physical therapy: "That shouldn't be in a Catholic hospital."
A religious motive is also offered by residents as an explanation for their decision to enter SFH. For some, however, the meaning of this is not limited to opportunities for worship, but also includes the assurance and protection associated with being part of the church hierarchy:

(Discussion with Mrs. Racer):  
"I like being with nuns. I have always liked nuns. I've always liked going to school with nuns, working for them."

(Discussion with Edith):  
"I go to mass, but the big thing is the nuns. You know they'll take care of you. I was so afraid after what I read about Atlantic City and those crooks there."

New residents invariably asked about the order of nuns which staffed SFH. Many had had previous experiences with or been informed of the reputations and charitable services of specific orders, and hoped to find a familiar face at SFH. In other words, SFH residents searched for those who had taken care of them in the past.

One hypothesis that was tested in order to explain the above data was that these different perceptions of nursing home placement underscored a Jewish-Irish contrast, these being the predominant ethnic groups of PH and SFH, respectively. This hypothesis would have been supported by the anthropological literature on various ethnic groups' differential reactions to health care in the United States (e.g., Zborowski, 1969). This literature suggests, for example, that the Jewish experience of pain is one which emphasizes interpersonal dependency, the sharing of one's sickness with others. In contrast, persons of Irish background view suffering as an individual and solitary affair. Also, with the latter group, pain is generally ignored until it interferes significantly with work, and, although it is usually a long
process before a doctor is consulted, when this does happen the individual unhesitatingly submits to all medical routines and services called for.7

The method of testing the above hypothesis was to consider statements from informants in the two nursing homes who were not members of the majority ethnic group. Interestingly, the result of this was that the residents of each facility, regardless of ethnic background, referred to their institution in the one way outlined above. Irish and Jewish residents at PH adhered to the institutional pattern of stressing the importance of socializing with peers and not having to be alone. Indeed, as we will see in Chapter V, PH was characterized by a number of resident cliques which spent many waking hours in various activities. On the other hand, Irish and Italian residents at SFH emphasized their need for constant medical attention, and one of the "social activities" seen as primary by these individuals was work with the several physical therapists. In addition, when these patients were asked a general question about friendships at SFH, they were more likely than their PH counterparts to refer to social relationships and interaction with staff members, i.e., to talk about the staff as a major component of their social world (see Chapter VI).

What the analysis suggests, then, is that the contrast we have been considering represents institutional differences not reducible to the resident (ethnic) composition alone. This is not to reject the possibility that the "minority ethnic group" has acquiesced to, or, more simply, learned the majority's way of thinking. An alternate possibility is that of a self-selection process; individuals regardless
of ethnic background choose facilities with ideologies similar to their own. The present data as collected do not enable us to choose between these alternative explanations, and it may very well be that they are really interdependent. We have previously seen that the definitions of the two institutions as expressed by the respective personnel do differ, and it may be noted that they contrast in a manner similar to the distinctions provided by the residents' perceptions. The rationalization of socializing may, in this respect, be a product of what PH seems most to offer residents and applicants—a skilled care context divided up into a number of different wards, which enables individuals to interact with others similar to themselves. In like fashion, the patients' emphasis on health care at SFH may be the result of what this institution provides its charges—a definition of itself as primary caretaker and protector.

To summarize, this chapter has laid the groundwork for the intra-institutional data discussed in the remainder of this dissertation. Historical studies seem to suggest that the general definition of a nursing home has changed during the last one-hundred-and-fifty years. The earliest geriatric facilities were designed as charity homes for elderly women who had lived respectable middle-class lives; the latter part of the nineteenth century saw a redefinition of aged individuals as diseased and senile, and a redefinition of the institutions as medical and custodial facilities.

The history of SFH most closely approaches this general history, the institution having developed from an almshouse to a major skilled care facility. Although it is a charity facility, SFH was founded at a time when geriatric medicine was developing in the United States, and
when nursing homes were becoming more concerned with residents' health care needs. This attitude has been carried into the present; SFH perceives itself as a medically-oriented institution, thus reflecting the goals with which the founder and original nursing staff established the home. The administration of SFH views the facility as a health-care institution, not solely or principally a domicile for the elderly. The residents' attitudes towards SFH are similar to these staff definitions; entering a nursing home is seen by SFH residents as an admission of one's need for skilled medical care. It is interesting to note in this respect that many visitors and residents refer to SFH as a hospital.

People's Home, which was founded during a period of increasing governmental support in the 1960s, has also changed from a generalized nursing facility to one primarily directed toward geriatric care. This institution is also very much a product of its history. Because it is a profit-oriented facility, PH emphasizes its ability to attract a number of different clientele types through its several wards, which are the result of separate periods of facilities expansion. Residents of People's Home talk about a nursing home as a place where they can be with other people; in this sense, PH is viewed from the perspective of being a residential community for the elderly, and, secondarily, a medical facility.
1 Etzioni compellingly writes about the inadequacies of limited analytic perspectives in his discussion of mental hospitals studied as discrete societies:

... The assumptions and associations that such terms as "small society" and "therapeutic community" bring to mind are quite misleading. Use of the term often indicates a tendency to neglect the influence of external factors on the internal processes of the mental hospital, and also to oversimplify some aspects of the internal process.

... This approach often overlooks such factors as trade unions and professional associations; communal ties such as social groups, governing boards, political institutions, and other structures and attitudes which affect the organizational process; and such internal factors as the influence of multigroup membership (1960:17).

2 The details surrounding the move to an integrated facility reveal several important factors which account for the present reputation of the different sections at SFH. Between the period of from 1935 to 1978, all the patients on the fourth floor were male. The idea of increasing the number of male patients at SFH in general came about in the early 1930s, when the Sisters of Faith nurses tended to a group of European seamen who had become sick while in port. To this day, the fourth floor—where these seamen and all men until 1978 resided—is considered a "heavy" work load by nurses, and is often avoided by residents (see Chapter VI).

3 During the 1980-81 period of field work, there was one nursing director at SFH, and two at PH (one after the other).

4 Note the following complaint and implicit comparison with other medical institutions:

(Field notes on the family conference held at PH): One of the patient's children, the son of Betty Wiesner, complains that this type of meeting should be done "from day one." He complains that there was no social service intake when his mother was first admitted; that during the first six months he interacted only with an administrator. He says that he is a doctor, specializing in hemodialysis, and that he always provides patients who are about to start on hemodialysis treatment and their families with several counseling sessions with a staff social worker prior to and during treatment. In addition, patients are referred to other patients and families already in treatment to ask questions, get their non-medical perspective, etc.
One possible outcome of these differences is that residents looked more toward the staff as their reference group at SFH, and PH residents had both peers and staff to look toward (see Chapters V and VI).

See Berger (1963:54) for a general discussion of the selectivity of social biographies; also, Chapter V.

Consider the following statement by a social worker associated with one of the Jewish social service agencies in Philadelphia:

(Interview with Thelma Sacks):

SJS: My sense is a lot of Jewish people go into nursing homes prematurely.

Thelma: They go in privately. They're not clients, they're put in by the families, put mom or dad or aunt into a long term placement, less for medical reasons. For companionship, etc. When a lot of these Jewish homes developed, the idea was a protective environment for the elderly to have a dignified and restful place as a person gets older. It's changed now. Now they really are nursing homes. The families haven't caught up with that; they say there's got to be a protective, wonderful environment for the aged.

Zelditch (1964) suggests that many Jewish nursing homes were originally homes for the aged, and that the primary goal of domiciliary care has given way to increased concern for medical and nursing programs.
CHAPTER V
SOCIAL RECRUITMENT AT PEOPLE'S HOME

Introduction

People's Home, the nursing facility discussed in the present chapter, served as the field site for my M.A. thesis research (Sigman, 1979). Although a number of changes occurred between the two periods of field work (January to June, 1978, and October, 1980 to June, 1981), in personnel and in the physical appearance of the facility, many patterns of behavior remained constant. The data immediately relevant to recruitment presented in this chapter are primarily based on the 1980-81 observations; they will be supplemented by material from the corpus of conversational behavior collected for the earlier study.

During the 1978 field work, PH consisted of four primary residential sections. These sections ("A," "B," "C/D," and "E") radiated from a central building which contained a reception area, administrative offices, a wide hallway which doubled as a movie screening room, the kitchen, the main living room, and the dining room. During the last two months of the second period of field work, plans were being readied for the completion of a small building connecting the centers of the "B" and "C/D" sections. This building will eventually be used as a staff dining room (housekeepers currently eat in the kitchen or in the main dining room after the patients' lunch hour) and as an all-purpose activities room and movie theatre. Before I began my dissertation research at PH, an extension was built which connects "A" section with one end of "E." Although each wing of the
facility contains its own nurse's station, "A/E," as this new area is appropriately called, shares the station with "A" section. Because of the layout of "A/E" in relation to "A," the nurse's station now sits among the "A/E" rooms, and nurses monitor the "A" corridor through a closed-circuit television (see diagram infra). "A/E" occupies something of an ambiguous position at People's Home. It is serviced by nurses accustomed to patients requiring "A" routines (e.g., putting ambulatory patients in the "A" solarium during the day), however it is assigned by the administrator to residents more typically found on "E" section. As shall be seen later, the "A/E" section is treated by the staff as part of "E," and not as a separate residential section unto itself.

There is a second composite section at People's Home. "C/D," as its name implies, was originally considered two separate wings, and they were, in fact, the first two sections built at People's Home. These now house what are viewed by the administrator and other personnel as identical patient types and are serviced from one nurse's station.

Each wing of the facility also has its own day room or solarium. A possible exception to this is "E" wing, which, closest to the central living room, makes use of approximately one-half of this room for "E" residents. The living room is intended as a space in which all residents may congregate and is utilizable for many home-wide activities. In terms of actual usage, however, most of the room has been informally appropriated (and recognized as such) for occupancy by the "E" residents. As will be discussed more fully below, access to these and other locations at PH is jealously guarded by their habitués, and various means are employed by them to discourage encroachments
FIGURE I

PHYSICAL LAYOUT OF PH

(Not drawn to scale; certain features obscured)
either by inappropriate residents or by activities which they feel should be held elsewhere.

The "B" solarium is located in a portion of "B" which is called "new B." The "new B" half of the section was built several years after the original portion, and forms a T with the latter half (see diagram). Interestingly, few residents from "B" actually use the "new B" lounge, apparently preferring to sit against one wall in the main dining room. One reason for this may be the great distance most patients must travel to get to the "B" solarium, making it, for example, largely inaccessible to patients in wheelchairs. Moreover, and perhaps more important, there is some indication that "B" residents have used a section of the dining room as a sitting spot for many years, long before the construction of "new B" and the "new B" lounge.

These patterns of space utilization were found during both phases of field work. I think it is reasonable to conclude that they reflect institutional regularities and definitions of spatial allocations. They persisted despite changes in the resident population brought on by death, discharge, or transfer to a different section of the facility. This last point is especially important because, as the discussion below indicates, PH residents are most often reassigned a ward slotting when their current behavior no longer matches that of their ward peers. They are, in turn, expected to adhere to the routines of the new section. These expectations will be described in the chapter sections that follow.

Each of the four sections of PH contrasted with regard to physical appearance. Some of these physical differences (e.g., the presence or absence of carpeting) were intentionally designed with the
patients' functioning levels in mind (e.g., continence) and are discussed in greater detail below. Other differences, of a decorative nature, apparently were the result of varying degrees of attention being paid to "aesthetic" detail when each section was first constructed. For example, "B," "new B," "E" and "A/E" all have matching wall papers in the corridors and in the bedrooms, signed and numbered lithographs or water color paintings throughout the hallways, etc. In contrast, the walls of several rooms on "A" and "C/D" were painted pale blue or grey, while others had mismatched wall papers, such as a roll of boldly striped paper next to a different stripe or even flower pattern. Posters and reproductions of oil paintings in inexpensive frames dotted the hallways. In this regard, it should be remembered that the expansion of the facility from its earlier structure to include "B," "new B," "E" and "A/E" was accomplished with the idea of attracting "better" clients (see Chapter IV).

Although there were some changes in personnel between field work periods I and II, and, continuing through the latter period, the relationship of staff to residents seems to have remained the same. Of special importance in this context are the changes made in the activities/social service personnel. Sheila, the first activities director, left PH to marry and to pursue an alternate career; Carol Jones, her assistant, was promoted to fill the position. Two full-time assistants were then hired. These three individuals are responsible for coordinating home-wide activities, such as the monthly birthday program, the sewing circle, and bingo, and for activities geared to specific sections, the book club on "E," exercises and physical games on "A" and "C/D." One major change was the institution of a residents' council,
which was to meet monthly and discuss grievances, offer recommendations for changes (dietary, activities), etc. This had been discussed during the last month of my 1978 observations and was organized approximately eighteen months later. During the nine months which constituted the latest field work, a meeting of the council was held only once. As was found during the 1978 field work, residents were not solicited to be involved in the initiation or organization of any activities; such tasks were left solely to the staff (see Sigman, 1979).

Assignments

This section and the next one are concerned with ward assignments and reassignments at People's Home. These data are derived from observations of staff meetings in which transfers from one section to another are discussed for particular patients, from interviews with the administrator regarding her decisions to admit patients to the facility and assign them specific locations in the home, and from interviews with other personnel about "typical" patients of each section. The data center around the procedures by which family members make application to this particular nursing home, as well as the institutional procedures for deciding on particular applications. The present section, furthermore, analyzes the criteria used by staff members (nursing and administrative) for initial and subsequent bed, room and section assignments. Descriptions of residents commonly found on each section of the home as provided by the staff are included here in order to demonstrate the differential perceptions and evaluations that are held for each section of the facility.

A word about the organization of the data analyses may be appropriate at this juncture. This section and the following one
analyze the data on assignment and reassignment criteria and procedures; remaining sections are concerned with the staff-patient and patient-patient interactions which carry out particular assignments/reassignments. In a sense, the divisions of the present chapter are between an analysis of ward-related assignment decisions on the one hand, and of patterns of communicational behavior associated with particular slotting decisions on the other hand. However, the division is not between what might otherwise be considered "formal" versus "informal" recruitment. Trager and Hall define this distinction in the following way:

Formal cultural behavior connotes the traditional, the ideals, the means whereby a group maintains its solidarity and uniqueness, the things "everybody knows," the standards that everyone is expected to uphold and impose on others and to resent the violation of. Informal behavior connotes the situational, the things taken for granted and out of awareness, the individual adaptation to the formal, the things learned by observation without "thinking" about them (1954:146).

Employing these terms would suggest that the assignment/reassignment data presented here are only idealizations that individuals refer to as guidelines for their behavior, while the communication messages exchanged between patients and staff "really" constitute recruitment, i.e., they are the actualization of the ideal. This is not what the organization of the present chapter is intended to convey. A preferable approach to the data is to make a distinction between (1) staff-initiated decisions and the rules which guide these decisions, and (2) the treatment of individual residents by members of the resident and staff populations as a result of these decisions, i.e., as a result of where the individual is placed. It is not the case, as will be demonstrated below, that the first set of data are explicit and
verbalizable, while the second are only implicitly understood and not amenable to reference in the speech of participants. There is no one explicit framework or set of reasons for particular assignments which can be cited by administrative, social service, and nursing personnel. Particular slotting decisions appear to be the result or culmination of previous staff-patient and patient-patient interactions. Failure to live up to the expectations of ward mates by a newcomer to the facility, coupled with complaints to staff members about the inappropriateness of the original assignment by the former, are as important to the overall recruitment system at PH as are the actual ward determinations made during staff meetings. As we will note throughout this chapter, members of both the resident and staff populations play decisive roles in shaping the social careers of other residents. Thus, what I intend to describe here is not simply the context for the behavior of assignment and reassignment at PH, but the regularities which are evidenced in specific slotting decisions.

People's Home is operated as a for-profit facility. One consequence of this profit orientation is that the home is structured so as to be maximally appealing to its various customers. This entails the employment of a ward system whereby different physical locations of the facility are provided with different social meanings; each section of PH is reserved by the administration for a different category of patient, and has been designed to take into account presumably distinct health and safety needs.

Goffman offers the following general description of a ward system in a mental hospital:
... This usually consists of a series of graded living arrangements built around wards, administrative units called services, and parole statuses. The "worst" level often involves nothing but wooden benches to sit on, some quite indifferent food, and a small piece of room to sleep in. The "best" level may involve a room of one's own, ground and town privileges, contacts with staff that are relatively undamaging, and what is seen as good food and ample recreational facilities (1961:148).

In the first part of this chapter, it was noted that the four primary sections of PH are administered by staff assigned to different nursing stations, and that there are certain very obvious physical appearance differences between them. Here I will argue that there exist contrasting criteria for entry onto and maintenance within each of the four sections, and that the range of criteria enables the institution as a whole to attract a broad range of clients.

Mrs. Richter, the chief administrator at PH, is solely responsible for the initial decision to admit and place a patient. No input or recommendations are secured from the staff, but it will be interesting to note below that applicants' family members are often influential (perhaps "demanding" is more accurate) with regard to the initial assignment. Several factors can be said to dominate Mrs. Richter's decision to admit or reject an applicant. These include (1) the availability of family funds, (2) the number and type of beds which are vacant at the time, and (3) the kind of patient for which placement is sought. Each of these criteria is discussed in detail below.

It should be noted that the admissions procedure and the initial room assignment procedure are one and the same; they are carried out simultaneously. This is because no waiting list is maintained at People's Home, and, when a specific bed becomes available, Mrs. Richter...
accepts the first individual to apply \textit{at that time} who is considered appropriate to that slot:

(Discussion with Mrs. Richter in the dining room): I ask her to describe the admissions procedure. She tells me that she is the one who receives the initial contact from someone wanting to place an individual at PH. She tells me that she first asks about the type of patient he/she is (wanderer, ambulatory, continent, etc.). She says that families often cannot or just will not realize the extent of senility.

(Discussion with Mrs. Richter in her office): Mrs. Richter says it is the availability of a bed, and the fit between the area of PH and the patients' needs which determine admission: "If we only had a bed in 'C/D' area, I wouldn't take an admission at that time, if the patient was fully alert. If I only had a bed in 'E' and the patient was very noisy and abusive, I wouldn't take the patient. The nature of a nonprofit home is that there is a lot more leeway. They can discriminate for religion. In a facility like this, there's no long-term waiting. There's either an available bed or not. We don't keep up a waiting list."

As noted, ideally, potential residents are allowed entry into the facility only when a match between patient characteristics and the available section space exists. (We will note exceptions to this below).

Before considering what is entailed by the concept of "matching," there are several implications of such an admission system in general which require elaboration. One consequence of the PH application procedure is that there is usually a very short duration between the time when an initial inquiry is placed with Mrs. Richter by a prospective family and the actual admission date. My observations and statements by Mrs. Richter suggest that the decision by a family to place a member in a nursing home is arrived at slowly. However, once this decision has been made, entry into a facility organized like PH usually occurs soon after:
(Discussion with Mrs. Richter):
She tells me about a new resident, a male now on "B," 51 years old, suffering from Huntington's Chorea. Mrs. Richter says that inquiries were made several times by the man's wife over the past few months, and finally she and the husband came in to see the available room. Upon my asking, Mrs. Richter tells me that they were shown a room on "B" because the man, although unable to speak clearly, is lucid, and except for "C/D," the only available bed was on "B." They were shown the bed and two days later the man moved in. Mrs. Richter concluded: "Once the decision was made, he made the final decision, he wanted to do it as quickly as possible. She (the wife) was at the hospital where he was staying, and after the initial inquiry, they made no decision. They thought they'd keep him at home. He was back in the hospital before coming here. The decision is never hasty."

(Field notes):
Today I went through the admissions records for all patients who entered the first half of this month (February). August Freund was discharged from the hospital with a dx. of compressed fracture of the spine, malnutrition and ASCVD. She was admitted on 2/6/81, and the charts indicate that the family made its first contact with Mrs. Richter and visited PH on 2/5/81. The other patient admitted to PH was Mrs. Rice (age 84) with a slight CVA and a "nonfunctioning right arm." The charts indicate an inquiry date of 2/3/81 and an admission date of 2/6/81.

Because there is no waiting list, Mrs. Richter feels under no obligation to offer a bed to individuals in the order in which initial inquiries are made. As a result, as soon as a bed is available, she accepts the first patient wanting to enter. 4

A second component of the PH admissions procedure is that prospective residents, or, more likely, their families, are shown only those rooms which are vacant when they arrive at the facility for an interview. Applicants are told during the initial inquiry that they will be allowed to consider only certain areas in the facility (if any choice is available at all) and why this is so. Individuals do not apply to the facility and then wait for an appropriate slot for entry; rather, they must apply for a specific section at the outset.

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(Discussion with Mrs. Richter):
We are interrupted at this point by a telephone call inquiring about a bed. I overhear Mrs. Richter say to the caller: "With a man of this condition, he should be in our confused area. Since he's a wanderer he'll have to be restrained. This is not like at home where you can close doors. Fire safety regulations require us to keep all doors and safety exists open." On the yellow sheet of paper Mrs. Richter uses to record prospective applicants, she indicates need for a "C/D" bed. She says she will call as soon as a bed becomes available, and suggests that the individual call back as well.

The decision to admit one's self or a family member is thus based on having seen the available and offered slot(s) at PH, and, for whatever reasons (see below), concurring that this is indeed the best assignment for the individual. In the above example, the inquiring party was not asked to visit the facility, since, as noted by Mrs. Richter, there were no immediate vacancies. When tours of People's Home are offered, the individuals are shown the particular bed(s) and section(s) in which there is an opening, as well as the solarium for that section, and the central living room and dining room. If a more general tour is requested, this is not denied. Given her own initiative, however, Mrs. Richter only presents those areas she feels are of immediate concern to the applicant.

(Discussion with Mrs. Richter):
Mrs. Richter tells me that she has an inquiry later this afternoon, from the daughter of a prospective female resident: "I know she's confused. I know she was at Kent Hospital, and she's been discharged. They are looking for financial help, third-party pay. I can offer her a four-bed room on 'C/D.' I'll show it to them when they come in. Now if she were perfectly alert I wouldn't put her there. I would offer a different section." Later in the day, I accompany Mrs. Richter on her tour with the James family. Mrs. James says she has a neighbor whose mother is at PH, and when Mrs. Richter is told the patient's name, she says: "Oh, yes, she's on our 'E' section. But we're not going there."
(On "B" section, noon):
Mrs. Richter is escorting two men on a tour through "B" section. They are looking for a room for their mother. Mrs. Richter stresses the newness of "B" wing to these people. She stops at one of the double rooms which has one available bed; she knocks on the door and tells the patient inside the room (Sadie White) that she wants to show someone the bathroom. She tells the two men to follow her in, and she opens the bathroom door. She points out certain features in the bathroom. As they leave the room and walk back through the "B" corridor to Mrs. Richter's office, she says to them: "As you can see, the rooms are really quite lovely. There are nurses on duty. If you want that room, we can give it to you."

We will see below the criteria used for placement to each section. At this juncture, it should simply be noted that the application procedure at People's Home consists of a concurrent request for admission to the home in general and to a specific section in the home.

A third component of the admissions procedure at People's Home incorporates significant reliance on family descriptions of the potential patient. Chapter IV notes that residents are rarely seen by the nursing home staff prior to their actual admission; admissions boards, or, in this case, the administrator, must depend on the reports provided by family members (and sometimes doctors and social workers) on the individual's health needs and functional level. Therefore, the issue of Mrs. Richter finding an appropriate match must be translated into finding a match between the family members' descriptions of the patient and the available slot at PH:

(Discussion with Mrs. Richter regarding Pasternak, a "C/D" patient):
"We got a call from the VA. Unlike most of the nonprofit facilities, we don't evaluate the patients, or even see them before the admission. We rely on what the family tells us. Now, in this case, we had to rely on the social worker. We're having problems (with the patient now); they (VA) haven't sent us all the records and we really don't know the full story."
(Discussion with Mrs. Richter about Al Bosch, a "C/D" patient):
"He lived alone in Center City. The son realized that
the father wasn't taking care of himself. The daughter
came in over a year ago, and then I didn't hear from
her. Then the son called; his father was in the
hospital and he just knew he couldn't go back to
living alone. He said right away that his father
should be in a confused area. He was very realistic.
He (the father) was a very bright man, an inventor for
Nova Corporation, I think. He has over sixty patents.
It's a shame really. His memory span is now zilch.
And he knows he's mixed up. But the son was very
realistic. I took him around to all the sections and he
said: 'My father should be on "C/D."' At the time,
it was the only room we had for males, on 'C/D.'
Usually we get the reverse. They're (the families)
not always honest to us or to themselves. We get that
every day: 'My father's not that bad.'"

One consequence of such important yet unquestioning reliance on the
reports of others by the staff is that the match between patient and
slotting is not always as appropriate as might be desired by the staff.
As we will see below, this is one factor which contributes to transfers
at PH.

While Mrs. Richter prefers to meet individuals in advance of their
admission date, the health circumstances of most patients mitigate
against this. My examination of the admissions records reveals that,
during the period of June, 1977 to May, 1981 inclusive, 295 out of 412
total new patients (i.e., approximately 71%) were hospital admissions.
Mrs. Richter suggests that such a high percentage is the result of not
having a waiting list; the applicant can, in most cases, be accommodated
directly from the hospital.

Since the severe or emergency nature of a placement is evidenced by
the hospitalization at the time of admission inquiry, it is perhaps not
surprising that this is taken for granted by the applying family members
(see Chapter IV). Mrs. Richter suggests that many cases in fact
underestimate the medical deficiencies (especially the mental functioning levels) of the patient. Two explanations for this seem warranted by my interviews with families. First, to a very real extent the patients' relatives are not aware of the totality of the individual's condition because they have not interacted with him/her on a daily basis or because only fairly recently administered medical treatments are at the root of the individual's apparent senescence:

(Discussion with Mrs. White's daughter):
She walks up to the table where I am seated (in the dining room). She says she knows I can't be a patient, that I'm too young, but that she's seen me on a few occasions since her mother arrived at PH. I tell her that I'm a student at Penn working on a communications research project. She says that she wouldn't think there would be anything for me to study, that there is not much communication here. I then ask her how her mother is adjusting to the nursing home, and she says she's not sure that this is the best place for her. She says that her mother has a heart condition, and appears disoriented as to place and time. She says that her mother has been confused for only about six weeks, that it happened all of a sudden, since the administration of some new medication.

(Discussion with Mrs. Richter):
Mrs. Richter tells me that it is often very difficult convincing family members how ill the patient actually is: "They don't see the patient twenty-four hours the way we do. Sometimes the patient is alert and talkative at night when they visit for an hour or so, but they're noisy the rest of the time." Mrs. Richter tells me of a case in point, in which an elderly woman, who was living in a Jewish retirement hotel, would be taken out to lunch almost every day by her daughter. The woman would wait in the lobby for the daughter's car to arrive. The woman was always clean, well dressed, etc. The woman was eventually transferred to the nursing unit of the facility when it was discovered that she was defecating and urinating on the walls of her apartment. Her daughter had not visited the apartment in several months, and so did not know about this.

Second, there is no advantage gained (in terms of increasing the likelihood of an acceptance) in overemphasizing the sickness of the individual. Indeed, with certain sections of the facility, "E" and "B"
for example, a lessened medical condition and proneness to senility (disorientation, forgetfulness, etc.) are indicated. This second explanation was voiced by a family applicant who said:

(Interview with Betty Thayer's daughter):
"You have to hope that when you call there's something available for what you're looking for. My mom's alert, very alert, but we wanted someone to help her watch the diabetes. She's on 'E,' which is the kind of place we were looking for. Other places only take them if they're really senile, they stay in bed all day. We made sure to tell Mrs. Richter that she's alert; we didn't want anything else (another section)."

An additional role played by family members in the admissions procedure needs to be mentioned. PH families often place demands on the administrator regarding her assignment decisions. Family members and residents not only provide Mrs. Richter with descriptions on which a slotting can be based, but they also actively go about negotiating with her for the placement type they are willing to accept. Their demands encompass specific preferences for bed, room, and section locations, as well as for roommates.

(Discussion with Mrs. Richter in her office):
We return to our discussion of Elias (an "A/E" patient): "The daughter wanted 'E' wing, a little Jewish lady; she said she should have an alert Jewish lady. She stressed alert, alert, she's alert. I didn't have such a bed in 'E' wing. Many weeks went by. Finally, I got 'A/E' with Mrs. Ricardo. The room is bright and beautiful. Ricardo has her marbles, quote-unquote. This is what the daughter said. I invited her to come and see the room. We had the admission right away after that. There have been a lot of problems. It's going to be a continuous thing. She didn't like that it was next to 'A' nurse's station. And the mother was used to a one-to-one private nurse. She wants a piece of candy and she wants it right away. She's very demanding on little things. I could move her to 'E-112' with Peter. But they won't get along at all. She won't get along with a Jew. There's a lot of bigotry both ways. A lot of anti-Semitism. Even in their worst (mental) state, they're hostile, they carry their bigotry. I have to be careful about whom I put with a black."
In other words, the individual applies for and enters into a particular bed, but a bed which in many cases the families have dickered for with the administrator.

The profit home, as indicated in Chapter IV, is selling a service and a location, and so the family comes to PH for an initial inquiry and tour in order to check out a particular room. Since there is no waiting list, the family knows from the outset of the application procedure the bed availabilities and where Mrs. Richter is inclined to place the relative. Family members are, however, equally determined to negotiate a placement which, from their perspective, incorporates the most appropriate surroundings. In the case discussed directly above by Mrs. Richter, it was revealed that the Elias family would only accept a roommate with specified qualities. Also note the following:

(Staff meeting):
Mrs. Richter discusses another new patient, Esther Salk: "There's a lot of family involvement. Perhaps they're too involved. They said that Mrs. Salk didn't understand Nora (her roommate). I spoke with them about Nora. They told the mother that Nora has her senses, but she has a speech impediment. I told them that that wasn't fair, and they did apologize to me. But Nora has been very quiet ever since. I don't know if Nora heard what the daughter said to Mrs. Salk."

Family members in part define the status of their parent in terms of the status of the roommate, thus placing great weight on the assigned residential area (see below on transfers).

There is yet another implication of family involvement in the admission/assignment process at PH. Family members not only influence the parent's initial placement, but their continuing presence usually means influence on where in the home the individual might be transferred (see below). More important for the present discussion, their presence
influences the possible roommates that might subsequently be admitted.

Even after a patient has been institutionalized at PH for some time the family may attempt to negotiate aspects of his/her social and physical environment. In the following example, a patient's children argue against the assignment of a new roommate:

(Staff meeting):
The staff members are discussing Mrs. Dale, who lives in room "E-116," and her new roommate, Mrs. Ford. Mrs. Richter says that the family is not pleased with Ford and will be upset with any patient who is basically not very healthy—both physically and mentally. She says: "The family is upset with a non-aesthetic patient. Her hair not done, or not busy going to activities, Carol. They don't want anyone who'll be in bed. They don't want anyone who's sick. They want their hair done, wearing street clothes, and sitting out there in the living room. Ford fits that beautifully. It's just that she's a little confused."

Interestingly, the family was initially quite pleased with Ford as a roommate because of her well-kept physical appearance ("to look at her you'd think she was like you and me"). Once the family began interacting with her, however, they quickly became dismayed and presented their dissatisfaction to Mrs. Richter.5

Family attempts at influence extend beyond the initial admission of self or other:

(Staff meeting):
The staff members discuss other ongoing problems. Mrs. Richter says that Mrs. Homan's daughter came in to complain to her the day it was decided not to let her mother eat in the dining room any longer. Carol says that the daughter spoke with her as well, and was very agitated during their meeting and cried several times. Mrs. Richter expresses the daughter's feelings, but then she says that they are unrealistic: "When you're taking her out of the dining room, (she feels) you're taking her away from socializing. The mother is passive withdrawn. She can't accept this. She says we confined her. Her mother is up against the wall (in her room)." It is decided that Mrs. Homan should be taken to the dining room after lunch to socialize with the women there.
Family members attempt these interventions in part because, as they reported to me, they perceive their relationship with PH to be a business one—one in which they will try to get the best deal. Moreover, family members are aware of the relative status of residence in each of the four sections and often negotiate for the best possible status. Through their conversations with Mrs. Richter and with other staff members, and through even the most casual of observations, families (and residents) recognize that each ward is differentially evaluated. Since this evaluation reflects on the parent's mental and physical status, family members often encourage particular placements—placements for other residents, as well as for their own relatives.

In this light, the precise dimensions by which Mrs. Richter matches applicants and available slots in the facility need to be understood. Mrs. Richter provided the following initial considerations:

(Interview):
"It's difficult to say. Well, first, I guess, there's money of course. Ability to pay. I have to balance the number of public assistance patients with privates. I usually prefer to bring them in for a few years with their own money. But I'm not like other nursing homes. No one is thrown out who has to go M.A. (medical assistance). I keep everyone."

Mrs. Richter must consider which section is appropriate from a financial standpoint before she decides the fit between an available ward and the applicant's medical status. For individuals who are private paying—and, as indicated, Mrs. Richter prefers this for all initial entrants—there are no restrictions on section. It is true that families may decide on their own to limit expenses by not choosing the newest wing, or by avoiding a private room in favor of a double or quad.
In any case, these are restrictions established by the families themselves. If they are unable to provide any private funds and must depend totally on public assistance, families are limited as to the rooms they will be allowed to consider. The economic pressures placed on People's Home (and other nursing homes) limit the choices for M.A. applicants. The Department of Public Assistance pays nursing homes a base fee for each M.A. patient which is usually lower than the standard facility charges. This reimbursement is calculated for the entire facility and is based on the age of the building:

(Discussion with Mrs. Richter):
Mrs. Richter explains to me that currently 50% of the patients at People's Home are supported by Medicaid. This is a Federal program administered by the state. Each nursing home is paid according to a cost reimbursement schedule. She says that PH receives a relatively low reimbursement because most of the buildings are older constructions. . . . She says that this payment type is somewhat better than what it was before: "We fought it when it was a flat rate." I ask Mrs. Richter what happens to a patient who comes into PH as a private-pay but must later go on Medicaid. She tells me that after a person has exhausted all his/her funds, she helps with an application for public assistance and usually allows the individual to keep the same bedroom.

Private pay charges, reflecting the age of the section, are not uniform throughout the building. 6 "A" and "C/D" are the cheapest units of PH; "E" and "A/E" the most expensive. In order to ensure an annual profit, therefore, Mrs. Richter must keep in check the number of slots being paid for at the full rate and the number which can be charged at the reduced M.A. rate. Mrs. Richter indicated that her goal is usually to maintain each at fifty percent. Thus, when a patient matches the behavioral or medical criteria for a particular section, the absence of an appropriate financial base precludes such a placement:
(Discussion with Mrs. Richter):

Richter: Now, if she were perfectly alert, I wouldn't put her there ("C/D"). I would offer them a different section.

SJS: What if the woman were alert, but still needed financial assistance?

Richter: I wouldn't put a Medicaid patient on "E."

This is not to say that there are no public assistance patients on the most expensive sections, "E" (including "A/E") and "B" (including "new B"). However, it must be noted that these patients originally entered PH privately and have been allowed to remain in these sections after their own funds were depleted.

The physical and mental functioning level of the patient, the second dimension of assignment fit, forces Mrs. Richter to depend at least in part on the applicant's and/or the family's accounts. The different physical sections or locations at PH are associated with and intended for different resident types. The analysis below will attempt to consider the equivalence of each section for specific slotting decisions. In describing a then recent admission to the facility, Mrs. Richter points to some of the salient distinctions between the various sections and residents at PH:

(Discussion):

The conversation returns to the man with Huntington's disease on "new B" wing: "That was the only bed that was suitable. She (the wife) didn't look at anything else, there was no choice. That room, her reasoning was that it had a private bath. The patient in there now is rather alert. His (the husband's) mind is alert; it's only his speech that's affected. He could have fit on 'E,' but there was no bed available. The others wouldn't have been right. 'C/D' is confused. 'A' is sort of a halfway house."

The statement that "there was no choice" specifically denotes a lack of options in the decision to assign Mr. Jacobs a bed on either "E" or "B" wing. It is important to note that during the last week in which Jacobs
and his wife applied to and visited PH, two beds in separate quad-rooms and a single bed in a double-room were vacant. These slots (one on "A," two on "C/D") were not available for Jacobs. Thus, in the above statement, Mrs. Richter signalled the approximate equivalence of "B" and "E" sections, and the nonequivalence of these two with respect to "A" and "C/D" sections. In a subsequent admission case, however, she somewhat inconsistently referred to the equivalence of "B" and "C/D" (but not of "E" and "A"):

(Discussion with Mrs. Richter):
Richter: The hospital pushed the daughter to get him out. She's guilty about it. The father (Mr. Hoover) said that the money he saved, she should have. So she feels guilty about using the inheritance. He seems a little better today. He was totally confused in the hospital.
SJS: Why did you assign Hoover a "B" bed?
Richter: There was no other bed. Maybe he belonged on "C/D," but I didn't have any. The people around him now, Glick, Mr. Morris, they're not very aware. It's appropriate in that sense; he fits into the mental status of people around him.

This ambiguous status is, in fact, recognized by Mrs. Richter and other staff personnel at PH. For example, Carol, the director of activities, notes:

(Interview with Carol):
"There's a very big difference in the patients. Activities we can do on 'A' or 'C/D,' or they're interested in (doing), we can't get away with on 'E' or 'B.' Actually, 'B' is difficult to describe. 'B' is, you have some very fine women there; they'd get along with Mrs. Bergman and the others at 'E.' Of course, we don't have room for them. But then you have some which are just well they're like our 'A' or 'C/D,' and you've seen what they're like."
The following equations are indicated by the data presented so far:

"A" = "C/D"
"B" = "E"
"A" ≠ "B"
"C/D" ≠ "B"
"C/D" = "B"
"A" ≠ "E"
"C/D" ≠ "E"

Equivalence at this juncture is derived from data on whether the same individual is allowed to enter PH on each of the four sections. The data indicate that an individual may enter PH through any one of the four sections, but that entrance is not equivalent for each. The apparently contradictory equations are, in actuality, not contradictory, but seem to be symptomatic of the "transitional" status of "B" section:

(Staff meeting):
Mrs. Richter describes Irene Wulff, a new patient on "B": "She's very, very confused. She was out on the patio last night. They had to restrain her after the patio incident. The change of shifts, we have to watch out for that. We'll have to be more watchful. She's likely to do that again. . . . I think you can tell our 'B' section is changing into 'A' section. Three-quarters of our patients there belong in our 'A' category. We just don't have enough 'A' beds now."7

(Staff meeting):
Mrs. Victor (LGPN) suggests that a room be found on "B" section for Mrs. Dansk, now on "E." She says that this might be an appropriate section for someone like Mrs. Dansk, but then the others present say what a shame it is that the character of "B" wing has been changing recently. Mrs. Victor says: "B" is a psychiatric setting." Carol says that "B" is getting a very bad reputation, that it now has "worse patients" than it has ever had.

It should be remembered that "B" (including "new B") is only three to four years older than "E." Nevertheless, "B" already shows its age by no longer being able to attract the "best customers." With the gradual expansion of PH to include "E" and "A/E," the more alert residents began

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filling these later sections. In addition, the increase in the number of confused patients has required that "B" take the overflow from "A" and "C/D." As the above quotations indicate, this fact is lamented by staff members who remember when "B" section and patients had the status now enjoyed by "E" and "A/E." Mrs. Richter often attempts to offer "B" to families unable to afford "E," with the understanding conveyed to them that "B" still contains some "very fine" residents. After all, from one perspective, "B" and "E" are still equivalent (see below). Nevertheless, the following is a typical reaction to such a placement:

(Discussion with Mrs. Henry's daughter):
"Mrs. Richter said, 'Put her on "B," it's really just like the new rooms.' The difference in money is not that big a deal. I'd rather she be with people she can make friends with. I just don't think "B" is right."

There is an interesting feature here regarding the structure and definition of the available slots at PH. Although patients must fit the available section, over time a section may come to fit the available patient supply. There are three sources for this eventual transition. One is the aforementioned observation that, when given a choice, family members are likely to pick the best sections for their parents. Thus, with the opening of "E" and "A/E" section, "B"'s competitiveness diminished; it is changing, therefore, in part because it no longer receives the most alert patients. In addition to this, because it was opened before "E" and "A/E," "B" has a slightly older population, and one which has been institutionalized for a longer period of time—a population more prone to debilitating illnesses. Thus, "B" is in a state of flux because the patients themselves are undergoing transition (i.e., medically). A third source of transition is that the number of confused applicants (relative to alert ones) is increasing, and "A" and
"C/D" are no longer able to accommodate these. The availability of "E" (and "A/E") for alert patients means that "B"'s role can be increased to handle the "A" and "C/D" overflow.

It is possible to examine the conditions which the staff uses to distinguish the four major sections from each other, and to determine the patient characteristics which warrant these distinctions. Mrs. Richter points out that physical and mental differences surface when the four are compared:

(Interview):
SJS: Can we go through each of the sections, you tell me about the type of patients there?
Richter: "C/D" is very disoriented, confused, noisy and most are incontinent. They are management problems. They touch other persons' things. They go into other patients' rooms. "A" is kinda the halfway house. There are some there not as confused as others. Some have been there a long long time, and many have deteriorated over time. The people are confused, but not real management problems. "B," "new B," "E" and "A/E" are basically the same. New "E," "A/E," the newest, is the plushest. Traditionally a new wing brings a plusher feeling. It attracts a different client. Some in old "B" are pretty bad, they could be accommodated in "C/D" or "A," but there's no room. "E" and "A/E," you get demanding prima donnas.
SJS: Medically?
Richter: No, they're spoiled, they had help at home. Besides when people gravitate to a more expensive room, luxurious setting, they're people who are used to having help around, people around. "New B," that's a mixture. It's a cross between "B" and "E." "B" used to be like "E" when "E" was new. It doesn't have a private bath in each room. Those have adjoining bath rooms, doubles with adjoining bath rooms.

The second director of nursing during the 1980-81 field work advocated the appropriateness of such a ward system because it enables patients to interact with individuals who are functioning similarly, and avoids undue pressures to conform to the expectations of others:

(Discussion with Ms. Serreno):
"A" has become a lot like 'C/D.' Maybe a little nicer atmosphere. A nicer building. There's a large group of people who are confused. The pressure is off there. You
can do whatever you want over there and it won't call any
attention to it. Mrs. Wulff is very demanding, but she's
accepted and acceptable there. She doesn't scream out as
much as when she was on 'B.' But whatever she does isn't
reacted to in the same way. I don't think we should lock
people off in a dark corner (as if) they're no longer human.
But with certain groups there's a pressure to conform to.
Irene Wulff, she doesn't realize there's a television on,
but there's some input, and she's just not as agitated as
she was on 'B.' There is a social order here. If I put
you in an apartment next to Irene Wulff, you're going to do
something."

Each section of the facility entails a different staff-patient
ratio, which reflects the increased health and supervisory needs on
"A" and "C/D" as compared to "E" and "B":

(Discussion with Ms. Serreno, director of nursing):
"We need more staff on 'B,' that's one thing. I haven't been
here working here long enough, but I've been told 'B' was
once like 'E.' Not now. 'A,' 'C/D' and parts of 'B,' I
constantly have to ask Sam (Applebaum, the owner) to up the
ratio. You've got people who need to be watched more, fed,
and a lot of incontinence."

Again, the transition status of "B" can be noted in the fact that the
number of staff members has not been increased there to reflect the
larger number of confused, bedridden and/or incontinent patients. As we
will see below, individuals whose medical and social needs can no longer
be met by the staff members of their current slotting, usually receive a
section transfer.

When referring to an acceptable patient-section fit, staff members
also speak about the importance of a patient's being able to socialize
with peers. As Ms. Serreno noted above, the direct result of the
differential slottings of patients is the existence of a social
organization comprising several different "social types." Staff members
recognize that each of the four sections promotes and is guided
(constituted) by different rules for social interaction. Furthermore,
the establishment of friendships with one's ward mates is predicated on the assumption that individuals do best in situations with similar patients:

(Discussion with Sheila, activities director during 1978 field work):
She says to me about the "C/D" patients: "We know they are different," and that these patients, especially the veterans, function well in the home because they need a protective environment. . . . She says that most of the men are placed on "C/D" because it is an environment best suited for them to function (in that more services are taken care of for them). She says that most of them are not social people, and stay to themselves because they're "loners."

(Discussion with Carol about a recent transferee from "B" to "C/D"):
"I think we've seen an improvement. I don't know. Maybe she's just blending in. At least she's in the lounge, so that's a good thing. There are people she can sit with there. I guess the best thing is she's not isolated in that room any more. There's something to be said for blending."

These distinctions proved something of a problem when "A/E" was first opened. As noted, "A/E" is the newest extension built at People's Home, and consists of four rooms which extend from the "E" corridor and intersect the "A" hallway. Residents of "A/E" are assigned to servicing by the "A" nurse's station. The "A" nurses are closer to the "A/E" rooms than to the "A" corridor itself. However, because it is the newest wing and is likely to attract the most alert residents, it is assumed by the administration that there will be minimal interaction between "A" and "A/E" residents, as compared to interaction with those on "E." One "A" nurse's routine prompted her to bring a non-ambulatory "A/E" resident into the "A" lounge for meals and companionship, instead of into the main living room where several of the "E" women occupy certain seats during the day. This created problems for the resident and her family:
(Noon):
I eat lunch with Roberta Brim, Carol, Mary and Jeanne in the staff meeting/dining room. Most of the conversation does not revolve around PH or residents (e.g., about wok cookery), but at one point Roberta makes the following observation about one of the newer residents, Eva Elias, "A/E": "She asked me, 'Do I eat in the same lounge as Louisa?' I think she's afraid we're going to put her in the 'A' lounge."

(Staff meeting):
The discussion turns to problems with the Elias family:
Richter: The daughter and her husband looked at the room. I thought "8" was good. They were stressing alert, alert, alert. Now they don't like it, because they (the nurses) put her on "A" lounge. I told them it was called "A/E."
Carol: Why not orient her to going to the living room? That might be easier than making a room switch, then there'll be other problems.
Richter: I know she's not going to get along with Scott (if moved).
Carol: She went to activities, jumped the gun; she loved discussion group. There's no problem with her being in the living room, she's not incontinent.
Richter: There were a lot of stipulations of roommates. Louise Ricardo is perfect. She's (Elias) not going to be happy with Scott at all. Leave it as it is for now.

This ambiguity existed throughout my field work at People's Home, and, because this never was resolved to the satisfaction of the family members, Elias was discharged to another facility.

In brief, assignment to a particular section of the home entails the most likely social group(s) which the new patient will be encouraged or expected to join. Thus, one of the assignment criteria is concerned with the applicant's appropriateness for and potential contribution to social life on the particular section.

There are telling physical differences between the sections themselves which seem to influence the initial slotting judgment. Some of these are due to the age of a particular section, i.e., when it was originally constructed, while other physical feature differences are the result of specific and intentional attempts to accommodate the section.
to the patient-type. A good example of a combination of the two factors is found in the use (and nonuse) of carpeting throughout the facility. One visual indication of the changes "B" has undergone can be deduced from the observation that some bedrooms there are carpeted, while others have linoleum flooring. On the other hand, both "B" and "new B" corridors have carpeting. This situation contrasts with the two older sections ("A" and "C/D") which were originally provided with linoleum in all rooms and corridors, and with the latest section, "E," in which there is only carpeting. "B" and "new B" were originally equipped with carpeting. During the last two months of the 1978 field work, Mrs. Richter first instituted the policy of allowing incontinent individuals to occupy rooms on "B." Moreover, several of the individuals already housed on "B," and who were then "failing," were allowed to remain there and not be transferred to other sections. In order to adjust the physical plant to these newly presented medical conditions, carpeting was removed from several rooms and replaced with linoleum:

("B" section):
A janitor leaves one of the rooms where the carpeting is being taken up. I ask him what is going on and he tells me. "It's better with this new stuff. They piss on the carpet and it stays right in."

(Staff meeting):
The issue of a transfer for Mrs. Kanter is brought up again. Several nurses present at the meeting say that Kanter's behavior toward her roommate, Dr. Unger, is becoming more and more uncontrollable. Mrs. Richter reiterates that Unger's son won't allow her to be transferred. She says that they removed the carpeting in Unger's room with the understanding that she would stay on "B" section.

Thus, one of the important elements of match between patient and PH section is medical condition, especially mental level and degree of incontinency.
The rules considered so far for admission to the facility have been phrased as if such approval is granted only when there is a match between patient characteristics and available ward space. Exceptions to these rules do exist however. One major source of deviation results from a situation at the core of the admissions procedure: the administrator relies totally on descriptions of patients as relayed by family members. As noted in Chapter IV, certification as a skilled care patient provides for a sufficiently vague and flexible set of needs determinations as to make assignment decisions problematical. In addition to this source of error, Mrs. Richter reports that applicant families often are unable or unwilling to provide detailed and accurate descriptions of the potential patient. Recognition of these false impressions is usually taken as grounds for a rapid reassignment to an alternate slot at PH once the patient arrives and is seen by the staff. This issue will be analyzed further in the discussion on transfers below.

A second deviation from the idealized rules of slotting patients to a matching ward also results in an immediate transfer. In this case, the anticipated reassignment is part of the initial admittance. I am referring here to instances in which a patient is provided an "inappropriate" slotting because of the emergency nature of the medical condition. The patient is admitted to the facility with the understanding that a transfer procedure will be initiated as soon as a more appropriate slot opens:

(Interview with Mrs. Richter):  
Richter: When a bed is limited, I have to be honest with them. It would be depressing to him (i.e., to be placed on the wrong section), and I would call once something becomes available.
SJS: Do you ever put people together who aren't the best match?
Richter: I can get two patients who really don't belong together, but there is no choice. If a person is in the hospital, and must get out, for example, and all I have is "C/D," then they (the family) may ask me to keep him there temporarily. Move him once a new bed becomes available. Then, if they're really strapped, I would do something like that.

With the awareness that a transfer will be effectuated when other rooms become available, Mrs. Richter is able in the meanwhile to fill an additional bed and start collecting fees. Such flexibility is needed if People's Home is to survive economically:

(Staff meeting):
Mrs. Richter begins the meeting by telling the others that she recognizes Mr. Fine on "A/E" is not the best selection. She says that Fine's daughter called a few days back, and told her that the hospital was going to discharge her father and she needed to make some quick arrangements. Mrs. Richter says: "We had the space. It's not like he was taking it from someone else." She tells the others that the daughter expects to be able to find another nursing home in about two weeks.

The entrance of "inappropriate" individuals to the nursing home was usually made possible whenever the census count was low and Mrs. Richter was concerned with the number of beds left vacant over a period of days or weeks. This association between seemingly inappropriate assignments and the need to maintain the population was never directly verbalized to me during my interviews with the administrator. However, at several of the weekly meetings I attended, the administrator would make a point of saying to her staff, after discussing a new patient with seemingly inappropriate qualities for the placement, that the census had been improved with this new admission.

From one point of view these inappropriate placements were not altogether improper or unpatterned. It was not at all unlikely for a patient to be granted admission to "E" ward even though all individuals concerned acknowledged the somewhat confused state of the patient. The
extenuating circumstances which made the individual suitable to the facility consisted of two additional criteria: (1) continence, and (2) quiet. Several residents of "E" were not fully oriented to their present surroundings, but their families were willing to pay for an "E" bed. From the administrative perspective, there were no visible features to bar the admission. It will be remembered from above that Ford was admitted to "E" wing because she exhibited all the aesthetically correct properties of an alert patient: street clothing which was clean and contemporary; facial makeup and professionally coiffed hair; etc. It was only after her fellow "E" residents interacted with Ford that they (and then the staff) began to consider the inappropriateness of the placement. Further, it was some time subsequent to the initial admission (two weeks) that Dale's children and other "E" residents began complaining to the staff about the need for a transfer for Ford. This analysis of there being certain rule-governed exceptions to "E" placement helps explain the following nurse's chart entry for Mrs. Green, another member of the "E" elite:

(Nurse's Charts):
Date of admission: 1/26/79
Nurse's entry: March 1981
"Patient is an 85-year-old F who is confused but appears alert. Pt requires supervision and some assistance with ADLs (activities of daily living)."

Mrs. Green's confusion was manifest in her forgetfulness about the type of meal she had just eaten, and by her insertion of occasional comments which seemingly bore no relation to the remainder of the conversation (see below). However, Green was usually a very taciturn woman, one also who always dressed impeccably and whose medical charts revealed only occasional bladder problems. To the extent that
she did not annoy the other patients, then, Green was "appropriate" to "E" section.

A second illustration of apparently patterned exceptions to the stated rules may be noted. During both periods of field work, "E" section contained one four-bed room reserved for males. Although many of these men are "confused" (this is a description taken from their charts), they spent their entire careers at PH on "E" section, presumably because they did not disrupt the behavior of others. These men remained in their rooms and no complaints were harbored against them by the other "E" residents. In some cases, there were some complaints when the individual first entered the facility, and so these patients were apparently made more appropriate to their surroundings through the introduction of medication:

("E" corridor):
I leave the room and walk near "E" nurse's station where I see the director of nursing, Mrs. Serreno. I tell her that I have just left Mr. Wulffwasser's room, where he has stripped himself naked. Serreno asks me if I had a good conversation with Wulffwasser, a new "E" patient, and I tell her he called one of his roommates a son-of-a-bitch. She laughs, then says: "He'll be okay in a couple of days. Once we get him on some medicine."

For a while, Wulffwasser's behavior was viewed by the staff as disruptive; it required significantly more nursing attention than did that of the other "E" residents, and so it was suggested that a transfer might be needed:

(Discussion with Carol about Mr. Wulffwasser):
"They had him restrained in front of the nurse's station on 'E' yesterday. I'm sure he's a candidate for a section change."

In actuality, this turned out to be an example of a non-change. One week after the administration of Haldol (an antipsychotic, major tranquilizer), Wulffwasser became something of a pliant and reserved
"play thing" for the other residents of the section:

('E" corridor):
I observe Betty Thayer collecting sugar packets from the food trucks. She calls over Mr. Wulffwasser, who is a few feet from her, by calling "Harry." She tells him she's collecting the sugar so that when she has enough she can go to Paris. The aide accompanying Mr. Wulffwasser asks her why she won't take him, and Betty says she already has someone to go with. Wulffwasser approaches Thayer and takes her elbow as the two of them walk together toward the nurse's station. They talk about going to Paris. As they approach the station, one of the nurses tells Wulffwasser that his wife is coming soon. He immediately lets go of Thayer's arm and begins walking toward the "A/E" area. Thayer laughs. The aide quickly catches up to him. Thayer and the nurses laugh, saying he's afraid his wife will catch him. Wulffwasser winks at me, and tells me Thayer hasn't enough money.

Wulffwasser had therefore been made appropriate (or manageable) within the circumstances.

Mrs. Richter assigned Wulffwasser to "E" instead of "A" or "C/D" because there were no other beds available. Thus we are returned to the issue of quotas (the number of available beds to be filled), and the importance of this for the admissions phase of PH recruitment. As it was discussed above, Mrs. Richter needs to balance public and private paying clients on an approximately equal sharing of PH spaces. It is necessary for her to attempt a ninety percent occupancy rate. Consistently, the structure of "E" section makes possible both the slotting of individuals for reasons of "homogeneity," with a match between the applicant and the other residents on the ward, and, at the same time, for reasons of "complementarity," which puts together a percentage of non-matching residents. Taken together the two slotting criteria enable Mrs. Richter to regulate the continuous filling of available beds and to maintain the occupancy rate.
There are other factors which account for the existence of the ambiguous four-bed slot on "E." We have seen that it is certain superficial qualities of alertness which are sometimes used for selection on "E." If a patient can be made to conform, either "voluntarily" because he/she is quiet by nature, or through the implementation of drugs, then the possible inappropriate slotting is overlooked. Second, and perhaps more directly, it must be noted that the original planning of a four-bed unit on "E" did not take into consideration the fact that few of the applicants for that section would want other than a single or double room. The two four-bedded units on "E" had their carpeting removed soon after they were constructed. They were thereafter defined as being for (1) "E" residents who were "slipping" (i.e., deteriorating medically), but who did not warrant removal from their "E" social grouping, and for (2) new residents who shared certain of the superficial qualities of a typical "E" resident. Deviations from these required assignment to a different section.

The data can be summarized thus far by positing the four principal sections at People's Home as possible entry nodes into the facility. These are, clearly, contrasting points of entry for new residents. Functional (emic) equivalence was discussed for sections "A" and "C/D"; that is, an individual whose initial slotting is "A" is considered by the PH staff to be appropriate for "C/D" section as well. "E" (including "A/E") and "B" sections have historically been considered functionally equivalent to each other, and distinct from "A" and "C/D." The use of a larger time frame for the analysis leads to the consideration of "B" section as an alloform (an equivalent unit) of two
otherwise contrasting sections, "C/D" (or "A") and "E." This double-meaning or double-functioning of "B" results from changes in the type of residents this section is now able to attract. This leads me to treat "B" as a distinctly functioning unit.

Transfer Procedures

The same nonequivalence of wards discussed above for the initial assignment can be seen in transfer procedures at PH. Given the rather explicit and rigid ward system outlined above, it is perhaps not surprising that one of the situations staff members commonly refer to when asked about reassignments is of when a patient no longer fits his/her milieu:

(Discussion with Miss Hill, "B" charge nurse): "We moved Mrs. Miller out just yesterday. She'll be better on 'A'; she just wasn't working out here any more."

Several variations on this theme can be observed at People's Home. First, such an assessment (reassessment) of a patient's changing or changed match may occur immediately upon the individual's entry to the facility. This occurs whenever Mrs. Richter and her staff have had the opportunity to evaluate the patient and the original descriptions provided by family members, and decide that the discrepancies indicate the need for a different initial assignment. On other occasions, a transfer may be initiated after the individual has resided at PH for a considerable period of time, but no longer is judged to qualify for the original assignment. The charts of individuals who have lived at People's Home for several years often indicate a series of transfers from one section to another.
A variety of factors result in both types of temporally defined transfers: (1) a mistaken or tentative initial placement; (2) significant changes in the behavior exhibited by the patient; and (3) evaluations of the patient by other residents and by staff members not involved in the initial assignment. In this regard, it should be pointed out that, unlike the admissions procedure, transfers at People's Home are decided upon by a staff committee headed by Mrs. Richter, but also composed of the director of nursing, the activities/social services director, their assistants, the dietician, and one or two section nurses. Decisions to institute a particular reassignment are likely to be brought up at staff meetings by any one of these individuals, and the floor is opened for a general discussion before reaching some consensus is attempted.

Most of the transfers that were approved involved assignments from one section in the facility to another. During the period from September 2, 1980, to June 16, 1981, twenty-one transfers were approved at staff meetings, but only five (25 percent) of these involved a transfer of a patient from one room to another within the same section. These numbers are important because they reflect the general attitude toward transfers and toward the organization of PH slots held by the administration and staff:

(Discussion with Nina, former director of nursing and now involved in staff development):
"Mrs. Richter tries to put people where they fit best. Of course, if someone fails, if it doesn't seem to be working out, you have to try something else."

Simply stated, rooms within a given section are viewed by the staff as equivalent—with the possible exception of the "E" rooms noted above—but they contrast to varying degrees with the constituent slots

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of other sections. There are a few cases in which an intra-sectional transfer is deemed necessary, but the organization of available positions is more amenable to reassignments across sections. The criteria for intra-sectional transfers will be discussed further below.

As noted, one of the major sources of pressure resulting in a transfer is a patient's inability to meet the entry and maintenance requirements for the currently assigned section. In the case of a new admission, this may be realized by staff members even before the individual has been secured and settled in his/her new home:

(Discussion with Mrs. Richter about a new "C/D" patient, Miss Pasternak):
"First, we had scheduled a 'D' bed; the VA has been notoriously unreliable with medical, but also psychiatric and social information. They told us about her medical condition; she has MS. Actually, it's more complicated than that. We had originally scheduled Pasternak for 'A.' They said she was absolutely alert, absolutely alert, the social worker at the VA. But they're inept over there, if it were the Philadelphia hospital, I'd say they're inept. I don't know what it's like at New Jersey. By the time we got her, they discharged her, we didn't have any spaces on 'A,' we filled up there. We changed it to 'D,' we decided she'd be admitted to 'D.' When she appeared at the original admission, she appeared at the original admission to be alert. So we got her down there ('D') and she didn't seem like she belonged, she seemed alert. She was talking to us, asking us regular questions. So we didn't admit her to the 'D' bed. Instead, I said give her 'B.' But very quickly things changed. The next few hours we discovered she's not alert at all. Also, there were some instances of psychotic behavior. Really, we got a sketchy description from the VA, medically and psychiatrically. I'm trying to get her records, but I don't know if I'll ever get them. She was on a psychiatric ward, but the social worker didn't say anything to us about this. We don't know if she was there because she's psychotic, diagnosed psychotic, or if it's the medical condition, she has MS . . . . There was some psychotic behavior which is not normal behavior. She knocked down a patient. She's been in and out of hospitals for years. She's had a number of VA contracts. She really belongs on 'D.' Now I can see that. Her behavior is bizarre. There's no social interaction. She hasn't established any relationships. There's no people she's friendly with. She's very demanding, she bosses the nurses around. We think she's well placed there on 'D.'"
It should be noted that the reference to "violent behavior" is not the sole justification for the transfer. In addition, Pasternak is said neither to exhibit the appropriately quiet persona which is preferred of "B" residents, nor to express an inclination to socialize with her peers.

There are other specifications for the role of staff awareness of inappropriate or bizarre behavior in transfer decisions. When inappropriate behavior manifests itself and is so noted by the staff, the report is shared with others through records kept on the nursing charts (see below) and through the weekly staff meeting discussions. At such times, the possibility of a transfer is likely to be broached, and staff members then question which of the four main sections is best able to accommodate the "bizarre" behavior. Bizarre behavior is, of course, seen relative to a particular section. Transfers are made when it becomes clear that (1) the nurses on one section as opposed to others are better prepared to handle the patient's behavior, and/or (2) the residents of a given section are more likely to be tolerant of the individual than are his/her current peers. Accommodation of the facility to the patient thus derives, in part, from the other residents of each of the four sections; "A," "B," "C/D" and "E" residents are assumed to differ in their proneness or capacity to notice behavior and to be disturbed by it. Moreover, decisions to transfer finally rest on the recognition that nurses in different sections are accustomed to handling different behavior and differing patient types.

(Discussion with Carol Jones, director of activities/social services):
I tell Carol that I notice Mrs. Ford was transferred to "A" wing, and she says: "She was quite confused and almost anxious. To use a better word, she was obsessed. She caused a lot of
problems for her roommate, Mrs. Dale. There's no reality awareness there, she turned into a bit of a wanderer. Although at first she could take directions, she was becoming more confused. She needed the watchful eye of 'A' lounge, the structure of 'A' wing. She's good over there—she has the socialization. But she's still fastidious. Also, there was a change in meds.; they put her on Haldol and I think that was much better for her."

(Staff meeting):
They then talk about a new resident, Mrs. Dansk, from "E-116." They talk about the possibility of a transfer to "B" wing, but one of the nurses says: "She'll be too isolated on 'B.' She wants to be with people." Mrs. Richter says that Dansk's daughter's eyes swell up with tears every time she tries to talk with her about her mother. Richter says the daughter cannot accept the fact that the mother is becoming confused. The daughter cannot accept that Mrs. Dansk (who eats her meals in her room now) put her food tray on top of the toilet saying that it was a refrigerator, or hid cereal boxes in her closet which upset her roommate. The daughter told Mrs. Richter that if her mother was given her meals in the dining room, she wouldn't have that problem. No decision on a transfer is made at this time.

In the first instance, Mrs. Ford's wandering, i.e., her walking around without her ability to report where she was going, was inappropriate for "E" wing. It was reported as annoying her roommate and other "E" residents (as evidenced by entries in the nurse's charts and the residents' reactions to her). The wandering did not cease when she was moved to "A" wing. However, the hope that the wandering might be abated by the transfer was not raised by the staff as a justification for the transfer. Rather, "A" is viewed as a section with an enclosed lounge area and an established set of nursing routines, which, when these are unable to extinguish wandering, are at least able to interpret it as neither deviant nor improper.

(Discussion with Mrs. Hunt, "A" nurse):
"'A' has its share (of wanderers). If they stay in the hallway or in there (points to the lounge), then it's really no problem. We try not to use restraints—unless it's time to eat, or we're afraid they'll fall and hurt themselves."
There are procedures on "A" which are used at such times as meals, cleaning the floors, etc. when the residents' wandering is held in check. At these moments, the "A" patient is restrained by a chest bib to a chair. This is a routine which is considered inappropriate on "E" and whose use is avoided on that section.

As noted, patient appropriateness is in part conditioned by the perspective of other residents. In the following example, staff members discuss the viability of a transfer, since the patient, Irene Wulff, might not meet with peer approval even on the new section:

(Staff meeting):
Mrs. Richter says that Wulff is being taken for a CAT-scan next week. She says that the family may need to see that there is physical dementia in order to accept the reality of Wulff's condition. Mrs. Richter says that the family claims that Wulff was perfectly "alert and fine health-wise" when she was at Friend's Home, and that she got sick only after arriving at PH. Mrs. Richter says that this is ridiculous, that there is nothing about "B" section that could cause her to become sick. All laugh and agree. Mrs. Victor says that, in fact, it is Mrs. Wulff and not "B" section which is the problem: "She is very inappropriate. She doesn't belong on 'B.'" Mrs. Richter asks about the medication that Wulff is on and Mrs. Victor says that this may need to be increased: "Well maybe she should be on a lot because she needs to be controlled. But she sleeps all day, and we don't want that. We've got to get her quieter; the other patients won't tolerate it. She's really a 'C/D,' but maybe even they won't want her." Carol agrees that there have been many complaints about Wulff by some of the other women.

On the other hand, it is generally hoped by the staff that a reassignment can be made to some section of the facility where the patient will be acceptable and accepted:

(Discussion with Carol Jones about Mrs. Fogel, transferred from "B" to "C/D"):
"I think we've seen an improvement. I don't know. Maybe she's just blending in. At least she's in the lounges, so that's a good thing. There are people she can sit with there. I guess that the best thing is she's not isolated in that room anymore. There's something to be said for blending."
(Discussion with Nurse Williams about Mrs. Fogel):
"She's not restrained all the time. We let her walk around during the day, and that tires her out. I tell her to go to bed or to sit in there. She does."

Although the outcomes of many transfer decisions are seen as beneficial to the patients, this is not usually reviewed as a reason for the particular transfers. Residents who have been reassigned sections, and who do not experience an increasing medical or psychological deterioration, eventually seem to "blend in" with the others. Furthermore, because certain social pressures are presumably removed from the patient as a result of the transfer, the individual is judged by staff to be in a healthier and more supportive context.

(Discussion with the director of nursing, Ms. Serreno, about "B" section and patients):
"There's a whole social grouping there, a social structure, people doing the same things they were doing whenever. There's more pressure there. Mrs. Seiler really does not belong there, but her daughter won't let us (move her). She's in the hospital right now. Mrs. Lutz (another "B" resident) was on the telephone one day last week, and she turned to Mrs. Seiler and said: 'Didn't anyone ever tell you not to listen into someone else's conversations?' It's true, but Seiler just isn't reacting on that level."

(Discussion with Carol):
"We moved Esther Feigenbaum from a semi-private on 'E' to a four-bed unit. That's a big difference. She was becoming a problem for the other women--more so than when you first were here; you know the way she always talked about herself. Anyway, now she's in there with Lucy Fischer, and that's been beneficial. Fischer takes care of her; she's almost like a little child now. She wheels her around so the other women aren't disturbed; and she calls the nurses if there's a problem."

(Discussion with Carol Jones about Mrs. Evers' transfer from "B" to "A"): "The patient was getting to the point that she was becoming deteriorated. There were more periods of confusion. That turned out to be a positive change. She's improved. She's out in the lounge now, she has more stimulation. She needed that 'A' stimulation. It's been good for her."
Despite this, the initial transfer decision is not based on a therapeutic rationale, i.e., on the expectation that the patient will improve. Quite literally, the patient is seen merely as being given a slot to be matched up and filled—a square peg in a square hole as it were. In the Evers case, for example, the move to "A" is seen in a positive light, but the initial reason for the transfer was the patient's deteriorated condition. (When, in Chapter VI, the SFH recruitment procedures are discussed, this distinction will become more salient.)

Transfers of this general type are associated with a patient's declining health status. Again, however, it must be reiterated that it is the appraisal of the changing medical condition of the individual as measured by the standards of a specific ward that is taken into account. For example:

(Nurse's charting of Frances Smith):
"A 91-year-old white female who is alert but has periods of confusion and forgetfulness. She requires supervision and assistance with activities of daily living, such as bathing, dressing and general grooming. . . . She was transferred from 'B-20' to 'A-3' due to her increasing confusion. She would use the bed pan and dispose the urine by throwing it out the window. This she denied but the window sill was rusting and there was urine on it and also outside the window."

(Discussion with Carol Jones):
Carol: Approximately six months ago, right before the summer I think, she was moved to "A." Frances had been becoming increasingly confused in her actions, not her orientation to herself.
SJS: What do you mean?
Carol: She did something, I guess it made sense to her, but it was a management problem. If she had to go to the bathroom, she would urinate in her water cup and then throw it in the garden. We couldn't reason with her. That went on for four weeks or so. She also had an abusive streak in her, she was being hostile to them.
SJS: Is that why she was moved?
Carol: That kind of behavior (the urination problem) is not
manageable on "B." "B" is pretty much, although it is changing, it's for people who are able to help themselves most of the time. "B" wing is so large, it is not manageable in terms of supervision. We need people there who won't do anything inappropriate or do anything harmful to themselves. That doesn't mean they're without physical ills, just that they can usually take care of themselves to some extent.

(Discussion with Carol Jones):
"B" now has people who have been there for a long time. Now more of them need to be helped for eating. We were noticing that the aides were not getting to the dining room on time to help the feeders, that's what we call them. More of them need help now. Mrs. Holbey—she was formerly on 'B'—we moved her to 'A'; she needed care that 'B' wing could no longer give her. Sometimes room changes come about, in this case, the catalyst was the aides—they weren't getting out. We needed them there, so we moved her to 'A' to Mrs. Latini's room."

(Discussion with the director of nursing):
SJS: Why was Michelle moved to "A"?
Talbott: She was becoming more confused and incontinent. That's a problem on "E" because of the carpeting.
SJS: When did this happen?
Talbott: Beginning September, I would say. She was becoming increasingly incontinent.
SJS: When was she moved to "A"?
Talbott: About two weeks before she died.
SJS: How did she react to the move?
Talbott: A lot of wandering. Trying to find herself, I think. Surprisingly, it only lasted for a few days. I would say, and then she sort of settled into routine. But she tended to walk out and stay near the nurse's office. She used to stay back there (in "E" area) and only go to the nurses for a cookie after lunch, every once in a while. Now, every half hour she was at the station.

(Discussion with Carol):
I ask Carol about Michelle's transfer from "E" to "A." She says that Michelle was becoming incontinent and forgetful, and these were the principal reasons for the transfer. She says that there were also some tensions with her old roommate, Nora Silverman. She says that she needed special care and attention that the "A" nurses are used to.

(Discussion with Mrs. Roght, RN, about Esther Feigenbaum):
I stop Mrs. Roght at the nurse's station in "E" and ask her about why Mrs. Feigenbaum was moved from a two-bed to a four-bed room. She answers: "Incontinence. That room (that she is in now) doesn't have a rug in there. She's been going down for the last six, seven months. She comes across clear, but she's very confused. She was all along, but now more so. She is very demanding of Mrs. Fischer (her roommate), the
woman opposite her. She's quite dependent on her. But they all take care of her."

Such transfers are seen as an attempt by the staff members to meet the newly presented health needs of "declining" patients. The staff says that patients will fit better with others on that section (i.e., they will be accepted for social interaction there) and that the nurses are prepared to deal with the presenting medical problems.

Interestingly, the latter case is an example of an intra-ward transfer. This exception to the usual movement of patients to different wards is justified by the staff on the grounds that Mrs. Feigenbaum had deteriorated physically (incontinence), but had not become so disoriented that she could no longer benefit from the social interaction which characterizes "E" women. Also, it must be noted, Feigenbaum was able to stay on the same ward because "E" section has one female room which lacks carpeting, a necessary environmental feature to control (accommodate) her incontinence.

Thus, the administration is able to maintain the physical integrity of a particular section and of the facility as a whole by maintaining a population appropriate to particular sections. I was told by one of the two nursing supervisors that the profit nature of People's Home accounted for the need to segregate patients, and to remove them from certain physical areas:

(Discussion with Mrs. Talbott):
I explain to her my interest in movement between wards and she laughs. I ask her what she means by her laughter.
Talbott: It's nothing, it's just that it's not a priority of mine if they're wetting and need to be moved. But then I've never worked with a profit-oriented institution before. I just don't see it as a priority of mine.
SJS: You didn't bring up the idea of the transfer (for Michelle) then?

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Talbott: It's my guess, I don't remember, that it was someone from one of the other services.
SJS: Are there any criteria you can see for movement?
Talbott: If someone is rowdy, and keeping up their roommate at night. Then I might bring it up. If someone has drainage and that becomes an offensive smell to the roommate, if you have a roommate who can smell it, then I think it can be a priority.
SJS: You said there is a difference between profit and where you've worked before.
Talbott: . . . If you can't prevent incontinence, you just clean it up afterwards. They (hospitals) either all have carpeting or they don't. So I really don't see it as a priority.
SJS: I'm not sure how to ask this, but--
Talbott: Should it be a priority?
SJS: Yes, that's it.
Talbott: No.
SJS: Why?
Talbott: When you have someone on long-term care, whether a year or six months, a move can be traumatic for the type of patient we're dealing with here. I think we need to look at what is best for the patient, not us.
SJS: And why are such moves best for you, or the home?
Talbott: So they don't have to buy new carpeting. I guess there's another way of looking at this. She was wandering around a lot on "E." Perhaps she was making the environment difficult for people, patient people, not staff people.

(Minutes of the staff meeting, October 28, 1980):
"Michelle, 'E-103,' has deteriorated greatly. She is incontinent of feces. Mrs. Richter contacted attorney and we have permission to order underwear, etc. for her. She could be moved before she gets incontinent on rug, etc. She will be moved to 'A-1' (uncarpeted). Attorney will be notified of the room change by Mrs. Richter."

In brief, accommodation of one of the facility's four main sections to patients can be seen from three perspectives, that of staff qualifications and routines, resident social acceptance, and environmental considerations.

Transfers are rarely instigated hastily at PH. With the exception of cases such as the Pasternak one above, in which a new resident was moved to a presumably more appropriate section on the first day of arrival, most transfers take between one and four weeks for
implementation. In the Dansk case, a transfer was suggested at three consecutive staff meetings, and each time a decision was made to wait for the most appropriate opening (an "A" bed). In some instances, this hesitation to move a patient stems from the apprehension over "transfer trauma" alluded to above by Mrs. Talbott, and also from the hope that the new patient will eventually become adjusted to the new surroundings. This attitude is expressed by the director of social services and activities:

(Discussion with Carol):
"Every patient who comes in here goes through an adjustment period. . . . I bank on the fact the patient we see during the first few weeks is not the patient we will be dealing with later."

In this regard, note the following documentation:

(Minutes of the staff meeting, March 3, 1981):
(Mrs. Dansk, 'E-116.' She has been hospitalized in Connecticut twice since January. First with a broken hip and then again with a bleeding ulcer. In between hospital stays, she was in the Norman Silberman Rehabilitation Center; somehow the records of the first hospitalization were never sent to us. Her daughters are pushing for her to have PT (physical therapy), but without those records we have nothing to prove her need for therapy. She has three daughters looking after her and all are very unrealistic and extremely protective. She is so confused that last night she crawled into Mrs. Dale's bed. The family has arranged for her to have a private duty nurse from 3 to 6 p.m. everyday so she will have someone to talk to. We all feel she might be better placed elsewhere in the facility, but we will observe the situation awhile longer to see if there is any change."
This waiting period also allows the staff members time to try alternate means of handling a difficult patient. Specifically, many of the inter-section transfers are preceded by the use of various medications and psychiatric consultations:

(Staff meeting):
Because of the problems they felt are being created between Mrs. Kanter and Dr. Unger (two "B" patients), it is suggested that the former be moved. Carol asks if Kanter is on any medication and Mrs. Victor, LGPN, says that they have a PRN order for Benedryl. They say that a move might prove traumatic for Kanter. Mrs. Victor says: "It's an unhealthy situation with Unger. But she (Kanter) has enough awareness that to move her to another wing, she'd have a big adjustment." Mrs. Richter suggests that they get a psychiatrist's consultation and a possible change in medicine before making any room changes. She says that Benedryl usually calms "old people" down, but that Kanter may need a different dosage. Also: "For people who are slightly confused, they think they're in a new building. It can be a really big blow for them."

(Discussion with one of the nurses on "B" section):
"Kanter causes Unger to get confused. The poor old lady, she's already confused. They're gonna have a psych consult on Kanter next week; maybe they'll get a prescription to help."

(Nurse's charts):
"Irene Wulff, 5/14/81: transferred to 'A' wing; Haldol prescription increased."

In part, the attempt here is to see if certain aspects of the patient's behavior can be controlled chemically, and if the patient can be "made" to fit. "Taking the edge off" a patient, i.e., attempting to reduce a patient's anxiety and frenetic state, eliminates the need for a transfer altogether, or, at least, forestalls the need for an immediate decision by allowing the staff to wait for an appropriate opening. In one situation, however, the use of medication worked so effectively that a transfer to another ward became even more necessary. Mrs. Fogel, a resident of "B," had been primed with so much medication during her first weeks at PH that it became necessary to eliminate drugs for awhile.
and transfer her to a section which could accommodate her loud screams and wandering:

(Discussion with Carol Jones):
"She was always anxious, needed constant reassurance. That remained, but she became very lethargic. She didn't have any idea where she is. She has been up and about, but it's almost impossible to reach her, she can't integrate anything any more. I'm glad I asked about her today, because it seems that it is the medication. The Haldol does that to them. We'll try to reinvolve her. It became inappropriate after awhile, she'd be in that lethargic state all day. She was the same old Jessie, only worse, all that anxiety. If she didn't know this was Philadelphia or People's Home, she at least knew it wasn't it was a home of some sort. Then nothing. Meds can be really something."

Decisions to transfer are rarely hurried because of the need to build a case which clearly warrants the transfer. This "case," the pre-transfer social work, incorporates two requirements placed on skilled facilities by governmental regulations: (1) documentation of all aspects of patient care on the individual medical charts and in the minutes of the staff meetings; and (2) relaying information to family members about the current medical status of the patient and anticipated changes in nursing procedures, etc. The latter information is usually conveyed to families by the director of nursing or Mrs. Richter. This consultation is intended to lessen the families' shock and resistance surrounding the inevitable transfer:

(Staff meeting):
The discussion . . . turns to recurring problems in the facility. The nurses say that Mrs. Ford ("E-116") is occasionally seen as an annoyance by some of the other "E" residents, and is constantly walking around in a confused state. Mrs. Richter says that she recently spoke with Ford's sister and told her about it. She says she did this since it may become necessary to institute a room change. The nurses say that her roommate, Mrs. Dale, is frequently agitated by Ford's behavior. Mrs. Richter says: "I spoke with the sister to tell her she's confused. Her physical appearance, it's so great, it's so hard, incongruous, to see her. But I didn't want to spring it on the sister one day, all of a sudden say that we have to have a room change."
(Staff meeting):

Mrs. Richter informs the staff about Ted Hoover, in "B" section. She says: "His daughter knows he's confused, but not how difficult he is. He's really a 'C/D' patient. I think we'll have to tell her that, so she won't be so surprised if we have to move him. I don't know what she wants us to do with him. Beyond keeping him restrained and clean. I don't know what else we can do. He won't improve. He was more confused in the hospital." The nurses tell of his emptying the water bottle near his bed in a drawer, and then defecating in the bottle. His daughter found his socks floating in water in the drawer and was upset by this.

(Discussion with Carol Jones):

"Kanter still has illusions of being Unger's I guess her mother. I don't know how long it's been; we're still talking about a transfer. We couldn't move Dr. Unger, her family would hit the roof. There's no way they'd allow us to move her. And there's nothing appropriate yet for Kanter. We're looking. I didn't go to this morning's meeting, I had a concert. There's nothing yet, but I want to keep it on record, let them know we're still looking for a transfer."

(Staff meeting):

Mrs. Richter turns to Ms. Serreno: "Do you think we'll have any problems with the family if we move Kanter? You're going from that first room on 'B' which is so plush, to a little room on 'A.' Will you talk to him (the son), tell him that we've tried everything else, we've given her a test as long as humanly possible after the surgery and when she went on meds. But she's just so anxious. And we'll have to have her eat in the ('A') lounge. She'll have to be oriented to 'A' social life."

(Minutes of the staff meeting, April 28, 1981):

"Mrs. Seiler and Mrs. Lutz are continually fighting. Mrs. Seiler is more of the 'A' type of patient (rather than 'B') and should be moved as soon as possible. Mrs. Richter will start to prepare the family for the possible move."

(Minutes of the staff meeting, May 26, 1981):

"Irene Wulff ... is much better now that she has been moved. Her daughter is upset because she was never told that there was a problem with her mother. Unfortunately, she is completely unrealistic as far as her mother is concerned. This did, however, bring up a valid point. Families should be made aware of every problem that occurs. This way if we decide to move someone it will not be a total shock to the family."

Such discussion presumably provides the families with ample time to prepare for the transfer and to begin to accept its implications with
regard to their parent's health status. More simply, it enables the PH
staff to test the family members' reactions. Several of the citations
above indicate that residents' families act as advocates on behalf of
the patients vis-à-vis the institution. Family members act to delay or
encourage transfers, either for their parents or for others:

(Discussion with Ms. Serreno):
"Mrs. Seiler really does not belong there ('B'), but her
daughter won't let us move her."

(Minutes of the staff meeting, December 30, 1980):
"Cecilia Conn, 'C-8,' a very quiet woman. Her daughter feels
she has not been placed correctly and would like to have her
moved. The daughter is devoted to her but unrealistic about
her condition. In addition, the mother's placement was very
traumatic for the daughter. It was decided that Mrs. Conn
will be moved to 'A-10,' bed 2."

(Minutes of the staff meeting, January 6, 1981):
"Eva Elias, 'A/E-105,' nice woman with a very demanding
daughter. It seems that the daughter wants her to have a
Kosher diet. We do not provide this type (only Kosher-
style) and she has been told this several times. In
addition, the daughter does not like the room because it
is too close to the 'A' lounge and she does not want her
mother in the lounge. We discussed moving Mrs. Elias but
felt it would be too traumatic (n.b.: revised version:
felt her daughter would not want it). Her aides will be
told to take her into the living room instead of the
lounge. As for her diet, her daughter will again be
reminded of our dietary provisions for Jewish Residents."

Families appear to be aware of the significance of a transfer at
PH, i.e., its association with parental deterioration. Therefore,
whenever it is feasible (as when they have the "clout" as private pay
customers), relatives will tend to fight against such moves. Staff
members frequently need to hold conferences with family members in order
to make them aware of the reality of a particular condition.

(Minutes of the staff meeting, April 7, 1981):
"Irene Wulff is scheduled for a CAT scan later in the month.
This will give the family some concrete evidence for her
dementia (sic). We will need to hold a family conference about the results. Maybe this will help them be more realistic."

Other examples that we have seen indicate also that family members act to ensure the parent's rights by rejecting certain roommates and by encouraging their transfers. Staff meetings were therefore usually filled with queries about how the family was expected to "take" a transfer before this decision was ever finalized.

The emphasis placed on documentation at People's Home requires an additional consideration. It must be remembered that all nursing homes are subject to an annual examination by State welfare authorities. Putting things "on the record" is necessary if the nursing home does not want its actions toward the patients viewed as unjustifiable or capricious.

(Minutes of the staff meeting, February 3, 1981):
"It was mentioned that Pasternak has become more cooperative now that her walker has been returned to her. But she changes her mood very quickly. Last weekend her grandmother and sister came in to visit her. She threw them out of her room, after which she withdrew behind a closed door and did not eat her dinner. Mrs. Richter reminded all nurses to document all happenings such as this. Any decisions regarding her placement will wait until after Pasternak has met with her VA Social Worker later this month. Any action that can be taken will be done by the Social Worker."

(Minutes of the staff meeting, March 10, 1981):
"Ellen Vox, 'C-41,' total care patient. She returned from the hospital with a feeding tube inserted in her abdomen. Because of this tube she is eligible for Medicare. There is a new regulation stating that we cannot refuse to accept a Medicare patient on the grounds that there is no space in the Medicare approved area. Mrs. Vox will be a Medicare patient until the tube is removed. Everything concerning her must be documented carefully."

(Minutes of the staff meeting, March 23, 1981):
"Last week we discussed Irene O'Hara and her aggressive behavior. A psychiatric consult has been arranged. We must be careful to document any behavior she exhibits that is unusual."
(Minutes of the staff meeting, December 2, 1980):
"Anna Mehan, 'B-3,' readmission after a long hospital stay following a below the knee amputation of her leg. She has complained about not getting cold cereal for breakfast, but because of her diet it is not permitted. She was advised to tell her doctor about it. It was brought to our attention that about two months ago Dr. Rush noted in her chart that treatments to her foot were not being carried out. The treatments were indeed being carried out but the patient would unwrap the dressings and ambulate to the bathroom with an uncovered foot. The chart is being checked to make sure all comments were noted."

In this regard, staff members wait until an appropriate incident ("the final blow") occurs before feeling completely justified in promoting a transfer. A specific case in point may help clarify what I mean by this. For several weeks staff members had been talking about the need to separate Mrs. Kanter and Dr. Unger, two "B" residents. In her somewhat forgetful state, Kanter referred to Unger as a little girl (sometimes, "my little girl") and treated her as one might treat a neighbor's child left in one's care for the day. Kanter dressed Unger in the morning, sat with her during meals, attended and guided the somewhat disoriented Unger to house activities, and so on. This behavior infuriated the staff, who, at the time, were bemoaning once more the decline of "B." They were also ostensibly concerned that Kanter's behavior was causing Unger to become passive.

(Discussion with Carol Jones):
"They always clung together, now Kanter has completely taken over. She won't give her a second to herself. Not that she asks for it. Kanter dictates what she should do, where she should sit, what activities to go to. She treats her like a child, her child. In the beginning, Kanter was giving her help, watching her bouillon, but now it's something else. Dr. Unger is able to retain her own individual, but once Kanter takes over—I want to see Dr. Unger start playing the piano again, but Kanter directs everything. Sometimes it's positive; Dr. Unger will ask for her mother and Kanter sometimes she'll snap back to reality, and tell her no."
Several weeks passed, however, before Kanter was actually transferred (a possible transfer of Unger was quickly ruled out for the reasons indicated in the citation on page 204). During this time, three separate beds on "A" section, where Kanter was eventually moved, became available, but Kanter was not immediately reassigned. At first, medication was expected to provide the solution, but even when this did not prove successful, no transfer decision was immediately made. Kanter's reassignment was finally approved a day after she had a "violent outburst."

(Field notes): I was not at PH for the staff meeting yesterday, but Carol relayed the following to me. Mrs. Victor, LGPN, said that she thought it was getting close to when they would have to transfer Kanter. Kanter and the "B" nurses have been fighting over control of Unger, and a few days back Kanter is reported to have been hysterically crying because the nurses would not let her sit with Unger near the nurse's station. Mrs. Richter is reported to have said that since they've tried medication, and since Mrs. Kanter is becoming hysterical, they should decide then to move her to "A."

It seems clear that once staff members have decided to initiate a transfer, this is done as soon as a sufficiently convincing case can be documented and made.\textsuperscript{12}

Although the majority of transfer cases at PH concern reassignments to different sections for purposes of facilitating a match, examples of intra-ward transfers and other reasons given for transfers should not be ignored. First, intra-ward transfers are sometimes recommended to relieve current roommate tensions and to serve as a stop-gap until an inter-section move becomes available:

(Staff meeting): The conversation turns to Irene Wulff. Mrs. Richter says that her daughter knows she's confused, but feels that the rooming situation is only making it worse.
Mrs. Richter says that the family just doesn't see how confused Wulff actually is (i.e., on her own). Mrs. Barry, RN, says that one day Wulff was crying and screaming in the afternoon, and then "she spent two very quiet hours of conversation" when her daughter came in the evening. . . . A transfer is approved for Irene Wulff to a different bed on "B" wing. Mrs. Richter says that this will ease the situation between Wulff and O'Hara, although Mrs. Richter feels that Wulff may in fact be a "C/D" patient. As for this particular room change, Mrs. Richter says: "Wulff doesn't really know her room, so there won't be any adjustment."

There are other occasions which apparently result in reassignments. For example, there are cases where a current ward assignment is considered appropriate but a room transfer is made to ease or redistribute the nurses' work load:

(Discussion with Carol Jones):
I ask Carol why Mr. Morris and Mr. Glick were moved from their previous room to the one they are in on "B." She says: "He (Morris) needed to be closer to the nurse's station. He needs supervision and it's closer to the dining room. He was a wanderer—we needed to move him. Poor Mr. Morris, he's really down now, he can hardly walk." I ask Carol why Glick was moved along with Morris and she answers: "It was that we couldn't have him and Mr. Samuels who was coming back from the hospital in the same room; they would have killed each other or the nurses. The move had nothing to do with anything about Sam (Samuels), it's just we knew the roommate situation (Samuels and Glick together) would have been bad." I ask Carol if it could have been in order to keep Morris and Glick together, and Carol says that is not usually a consideration.

Other institutional needs are utilized as justifications for inter-ward transfers as well. Most commonly, these involve a decision to transfer a patient to a particular section, and, in order to provide such an opening, an additional decision is made to transfer someone from the selected section to a different location in the facility:

(Discussion with Carol):
Carol: That's been less than a year. She was moved with
Flora. They were roommates on "A." It's been almost a year. It had to have been in the winter. I forget which patient was involved, was it Frances? It was a patient we wanted to move to "A." There were beds on "C/D," but they weren't appropriate for them. It was decided at a staff meeting that Nordstrom and Flora wouldn't feel the effects of a move to "C/D"—we've always felt their awareness of the surroundings was not great. Especially if they went together we thought there wouldn't be any adverse effects. We obviously take that into account. Their move was not made to fulfill their needs, but to accommodate someone else's. Sometimes it's a really difficult puzzle. Male-male rooms. Male-female bathrooms. Sometimes we move patients not to meet their needs, but we always voice an opinion if we don't think so-and-so will fare well. We discuss who we think might fare better.

(Discussion with Carol):
I tell Carol that I notice that Mrs. Karposky is no longer on "A," and Carol tells me that she was moved to "C/D" section: "I think again it wasn't a thing where she needed the room change personally. I think it was to facilitate a change for someone else. It was Ford. Ford really wasn't a "C/D," but I don't think it mattered as much, made any changes for Mary. "C/D" can be an "A" wing for some people, and so I think that's why she really fit in. We had to change Ford, and had to free up Mary's bed." I ask why Mary was the one who was selected for this, and Carol responds: "What was thought of who would be hurt the least to be moved to 'C/D'? Most of the others on 'A' are really too settled in there. Agnes Latini was mentioned, but she's still alert and she'd be more affected. Then of course there were all those men we couldn't move," i.e., because a female bed was needed.

As indicated, while this transfer is not initiated for the patient's direct benefit, an attempt is made to provide a suitable relocation for her.

The avowed purpose of the majority of transfers at PH is to provide residents with what is considered by the staff to be the most fitting living context. In the light of this, it is interesting to see that the general flow of reassigned patients is marked by movement from "better" to "lesser" wards in the facility. This statement is based on the distributional data contained in Table I, as well as on the informant...
### TABLE I

PEOPLE'S HOME TRANSFERS

(September 2, 1980 to June 16, 1981)

<table>
<thead>
<tr>
<th>TO:</th>
<th>&quot;A&quot;</th>
<th>&quot;B&quot;</th>
<th>&quot;C/D&quot;</th>
<th>&quot;E&quot;(&quot;A/E&quot;)</th>
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<td>4</td>
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<td>&quot;E&quot;(&quot;A/E&quot;)</td>
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statements above. Certain relevant features of these data should be noted. First, no transfer during the period of September 2, 1980, to June 16, 1981, involved reassignment to what are considered the best sections, i.e., there are no examples of a transfer being made because an individual's condition improved and warranted "E" (or "A/E") placement. "A" section received the most number of reslotted individuals, but in only one case was a transfer patient moved there from the next worse section ("C/D"). This single unexpected case was initiated, it should be pointed out, to accommodate a "B" to "C/D" move. "B" also evidenced a substantial portion of its transfers (36%) as within-section moves, reflecting the reasons outlined above for this.

The general flow of patients may be summarized by the diagram contained in Figure II. Thus, there seems to be a general tendency to transfer (1) when a patient is considered failing, and (2) to do so to a lesser section of the facility. This attitude of moving patients as they grow sicker was summarized by one resident's daughter who said to me: "Did you ever hear of someone in a nursing home getting better?"

It will be necessary to keep these data in mind as we consider other components of PH recruitment in the remainder of this chapter, and as these are contrasted with the procedures at Sisters of Faith Home.13

Recruitment Interactions

One implication of the data in the previous section is that staff members continuously monitor the medical conditions and communication behavior of residents. This practice provides the staff with opportunities for ensuring that a sustained match between patients and PH wards exists. In addition to this, the suggestion was made that
FIGURE II

PEOPLE'S HOME PATIENT FLOW
residents influence each others' (re)assignments and hence the careers experienced in the facility. As noted, this influence is in part mediated by the residents' families, who often play a decisive role in the initial assignment of their own parents and who serve as advocates in either accepting or rejecting proposed assignments and transfers for others. The present section presents data to the effect that residents directly pattern the life courses of others at the facility through their interactions with them. Staff reassessments of the patients do not occur in isolation, but are influenced by and take account of residents' and family members' communication with each other and with the staff. The present discussion examines the patterns of messages exchanged among the residents (and between residents and staff personnel) which serve to maintain the differential slottings at People's Home, and which are associated with (or culminate in) specific assignment and reassignment decisions.

During the 1980-81 period of field work, several transfers were observed for "E" females who had been living at the facility for only a short period of time. As previously discussed, these transfer decisions were initiated once the administration and nurses conferred about the incorrectness of the original assignment. Two cases, those of Elizabeth Ford and Reba Dansk, considered inappropriate to their "E" placements, are exemplary. The reassessments of Ford and Dansk were, in part, engendered by complaints to the staff made about these women by other "E" residents, as well as by the reaction to them by their new ward mates observed by the staff.

The initial period of entry into a nursing facility, particularly one organized like PH, can be seen as one comprising opportunities for
socialization (training) and "audition." During their first few weeks, newly admitted patients can be seen to interact with their peers and with the professional staff in such a way that the subtle rules which constitute life in that facility are provided and made evident. Each physical location at People's Home is constituted by differing expectations for the behavior of individual patients, and differing routines of ward personnel. Successful adjustment to the facility is, as we will see, bound up with the learning of appropriate intra-ward and inter-ward behavior patterns. In addition to this, the novice's own behavior initiatives and reactions to the interaction he/she has with others may be used by other residents, as well as by staff members, to assess the new patient. It is appropriate to consider this an audition procedure in that the new resident provides information to others which they then use in determining how well the patient matches the slotting, i.e., how well he or she fits the demands likely to be placed on an incumbent of that section of PH. As discussed below, individuals may be rejected by their section peers for further interaction if the audition fails. However, in most cases attempts are made initially to get the individual reasonably able to conform. Lack of such conformity and ultimate peer repudiation are observed by staff members. These observations are significant because the information gained is likely to be conveyed to other staff members and employed in decision making by the staff committee.

The above process occurs not only on "E" section, from which Ford and Dansk were transferred, but to varying degrees on the other sections as well. Each of the various sections can be seen as having entrance requirements in terms of behavior which residents are expected to
exhibit (or avoid) in order to gain peer acceptance. Members of the lesser evaluated wards at PH, such as "A" and "C/D," are no less likely than their prestigious counterparts, "B" and "E," to pass judgment on the behavior of others and to base the possibility of further interaction on this judgment. When staff members refer to the adjustment of a new patient to People's Home, they speak about the need for the individual to meet with acceptance by at least one of the ward-specific social groups. Staff members recognize, however, that such acceptance is not automatic and is not simply a derivative of the ward slotting:

(Discussion with Carol):
"Each section has its own little, I guess you could almost call it a family. If one family doesn't work out, we try another."

One difference between the outcomes and staff perceptions of rejections on the various wards is that transfers are less likely from "A" and "C/D" to take these into account, simply because there are no lesser sections to which a transfer can be made. There are several implications of this: First, the accounts which are offered to explain "A" and "C/D" transfers do not usually specify rejection by one's peers or failure to gain entry into a social group. Instead, the medical needs of an individual or the institutional needs to open a slot are more likely to be used to justify a transfer. Second, there is an overall staff perception of "A" and "C/D" which needs to be noted:

(Discussion with Nurse Serreno):
"It's not a tense group there ('C/D'), it's very relaxed. People who are confused, can't walk on their feet. There's very little demands on them. They can all go off and do their individual things."
"'A' has become a lot like 'C/D.' Maybe a little nicer atmosphere. A nicer building. There's a large group of people who are confused. The pressure is off there. You can do whatever you want over there and it won't call attention to it."

It is difficult to know whether this attitude derives initially from the residents whose heightened medical infirmities indeed lessen social pressures, or it is a judgment principally imposed by the staff who would otherwise have no recourse for handling "A" and "C/D" social pressures. It must be admitted, however, that behavior which is accepted and acceptable on one ward may be rejected or negatively evaluated on others. We will see several examples of this below in terms of seat restraints, talk, and so on.

As noted, individuals' adjustment to the nursing facility takes place within the context of and is facilitated by monitoring interactions with peers. In these interactions, newer residents are informed how best to conduct themselves with the staff ("how to make it") and what rules of interaction are to govern peer conversations. In the following excerpt, one of the more recent entrants to PH imputes the wrong label and social evaluation to her peer group's sharing of negative comments about food, and she is quickly corrected on what their talk is "really all about":

(Noon, in living room area 4):
Edith Gould: I smell fish today.
Mrs. Bergman: No, I think it's grilled cheese. Some sort of cheese thing.
Gould: Oh, well, that's fine. It's better than that (--) they serve.
Bergman: Oh, yes. I don't like that at all.
Gould: And they put so much seasoning on it. That's the most fattening thing they can serve.
Bergman: I know.
Pearl Axelrod: I don't like it with all those spices.
Gould: Let's just say that we have nothing else to complain about, so we complain about the food.
Bergman: We're not complaining. We're just passing remarks.
Gould: That's true. Yes.
Axelrod: Yes.

"E" women especially frowned on any talk which hinted at a dissatisfaction with life at People's Home and enjoined each other to reinforce and project a positive attitude.

(Field notes):
After lunch and her walk through "B," Mrs. Bergman enters the living room. She passes by Mrs. Jacobs in area 5 and asks her if she enjoyed her lunch. Jacobs scowls and says that she did not enjoy it at all. Bergman walks past Mrs. Welsh, a stroke patient, sitting next to her husband, visiting. Bergman asks the woman if she had lunch and if she enjoyed it. The woman says that she did, that this was the first time the ham tasted like ham. Bergman then says that she enjoyed her lunch. Looking toward Mrs. Jacobs, Bergman says to Welsh: "You can't please some though." The woman nods her head. Bergman walks on to her seat in area 4.

(Staff meeting):
Carol says that Renee Cooper, "E" resident, is having problems with the other women on that section. They were overheard telling her one day, "Stop talking. Why don't you shut up?!" Carol then says about Renee: "She's threatening and very overpowering. She wants them to be as tolerant of her as she is of them. She's such a go getter; she's always coming up with suggestions, things to change. They want her to leave everything alone."

(Mrs. Polo, an "A" resident, is in the living room talking with her son):
The son explains that his wife is sick at home and that the doctor has been in to see her. Mrs. Polo says she is worried, and says that she wants to see Bertha, the daughter-in-law. The son says that this is not necessary. Polo: How far is it?
Son: It's very far. You don't have to go anywhere. I came to visit you.
Polo: I don't know where to go.
Son: You're not going anywhere.
Polo: Why, do I live here?
Polo: Oh, I didn't know that. But I need to go away. There are people coming for dinner.
Son: There are no people. I came to see you. With this, the son becomes totally exasperated and wheels the mother out of the living room and in the direction of "A." Instead of following, I listen in on the reactions of some of the other residents to what has just happened:

Bergman: It would be better if she were home and they had a nurse. Baron: He pleads with her so nice. It's difficult. She's unrealistic. She can't walk with a broken hip.

(Interview with Mrs. Scott, an "E" resident): "There's nothing to complain about here. I must say they take excellent care of us. They should pick patients as well as they do personnel. There are some here who are just never satisfied, they're always complaining about this or that. I don't sit with those people."

Residents who did not eventually adhere to these rules (or to a superordinate rule of silence—see below) were scrupulously avoided by ward mates when it came time for interaction, and/or were eventually transferred because of the complaints that were rallied against them by their peers.

Staff members suggest that a criterial feature of "E" and "B," when these sections are compared with others at PH, is that the residents there exert tremendous pressures on each other in their expectation for a certain amount and type of interaction with each other.

(Discussion with Carol about patients' adjustment to the facility based on their section assignment): "There is some difference. I don't know if it depends on the individual patients, but, for instance, if someone goes into 'E' wing it's a bit more cliquish in the sense, I get feedback from the patients about how they're reacting to a new admission. If the patient is friendly, they might be more solicitous, they take her in in the sense, if they really like that patient, they may bring them into the fold. But that also means the person can be rejected if they don't get along right away; they let me know that too."

(Discussion with Carol): "With 'A' and 'C/D' friendship, our hopes for them, that's really minimal. We're more concerned with stimulation on
a basic level. We don't really, there's not much friendship there. The few that are really stand out. I think the big thing there is just getting them to interact. But 'A' is a unique case, I guess, it's really not like that totally. There are friendships there in the lounge, it's not always, they don't always deal with each other realistically, but there's a certain amount of companionship, buddies, there. They're protective of each other. 'She needs to go to the bathroom. She had liver today, and so and so.' Like Agnes Latini and Olivia Raymond. Although she's a quiet lady, they're alert. They look after each other. They occasionally talk to each other. They all hate Janice Lull when she throws things."

(Discussion with Ms. Serreno):
"They're less confused, more alert (on 'B'). Those who are confused are not confused all the time. There's a whole social grouping there, a social structure, people maintaining the same things they were doing whenever. . . . 'E' is like our little society. They're mostly independent, they don't sit in a group and do things in a group as much as they do on 'B.' They're living there like they're in their own apartments. They visit with each other, but they really don't do a lot in a group."

However, it is clear that social groups exist on "E" section. Nurse Serreno's statement seems to reflect the fact that, while "E" women do not attend all social activities en masse, they do interact with (converse and sit with) other residents, and their interaction circle is likely to be drawn from "E" section only. The nurse's charts for "E" residents and discussion of these patients during staff meetings indicate awareness and positive evaluations of the importance of social activity:

(Staff meeting, discussion of Mrs. Elias):
Richter: The daughter and her husband looked at the room. I thought "8" was good. They were stressing alert, alert, alert. Now they don't like it, because they (nurses) put her on "A" lounge. I told them it was called "A/E."
Carol: Why not orient her to going to the living room? That might be easier than making a room switch, then there'll be other problems.
Richter: I know she's not going to get along with Scott (possible new roommate)."
Carol: She went to activities, jumped the gun; she loved discussion group. There's no problem with her being in the living room, she's not incontinent.

(Charting for Betty Thayer, "E" resident):
Social services entry by Carol on 1/15/80: "Recently lost a son through illness, who at time was also a patient here. Seems to have accepted his death in a healthy manner—able to go on with her life. Avails self of activities of interest. Has distinct circle of friends in facility—which she utilizes as an integral system of support and social contact. . . . States she is unable to care for herself (nursing confirms) and does not care to be a burden on daughter."

Monthly nurse's entry on 10/80: "Patient is an 88 year old W/F who is alert with periods of confusion and forgetfulness. She requires supervision of assistance with all ADLs such as bathing, dressing—manages general hygiene on her own. . . . She socializes with a select group of people. She also likes to assist other patients but needs to be reminded not to do anything to(o) much for her. She is continent. . . ."

(2:00 p.m., near "E" nurse's station): I am asking Mrs. Nelson, RN, about Ann Streiber (an "E" resident confined to a wheel chair), who is crying to everyone in the living room that she wants to be taken back to her room. Mrs. Nelson says: "Mrs. Streiber would be content to stay in her room all day; but this is no good for the patients. We try to get them out even if they don't talk to anyone. Her family and her doctor want her to be in the living room. I'm trying to get her active in the book club."

Birdwhistell (1970) writes that communicational predictability is a sine qua non for the adaptability and continuity of a social system. It is against a background of coded or patterned behavioral expectations that individual participants are able to contribute messages indicating the need for changes in the system, as well as messages which reference the stability and continued functioning of the system. One means of ensuring such predictability during the course of life in the nursing home is through the establishment of procedures which typify or categorize the behavior of others, and which form the basis for
meaningful action. For example, one "survival" technique in a nursing home is to learn with whom one can have interaction, and those whose bids for interaction are to be avoided or minimized. A nursing home like PH is comprised of a diverse and (within limits) a heterogeneous population. Although it may be said that the "mortification" period characteristic of total institutions in general is designed to make uniform the behavior of inmates (Goffman, 1961), it is also the case that a facility characterized by a ward system must emphasize or make use of differences between persons. The discussion below deals with staff members differentiating between residents on the basis of patterns of observable behavior. First I want to explore a different avenue by considering the attempts by the residents themselves to classify the behavior of other residents.

Residents are apparently able to find predictability in others (or impose this) through continual monitoring of each other's performances. In the examples above, residents can be seen to inform others about (and themselves evidence) the rule-governed expectations for behavior. Clearly, the residents gain information about others through direct interaction with them. Older residents also warn others that their present behavior is unacceptable and give them some sense of the consequences of not "improving." Customarily, new residents come to People's Home ill-prepared for the routines; to some extent, their interactions with other residents sensitize them to the accommodations in their behavior they need to make. For many individuals, entry into People's Home is instituted by others, so that the residents can have little first-hand familiarity with the facility. In some cases, it can be so traumatic an event that they can not yet fully orient to their
situation. Peer interaction seems to serve a useful function in this regard. For example:

(Mid-afternoon, in living room area 4):
Mrs. Baron: You've got to make the best of it. It's a home. You'd have to have somebody to take care of you.
Ellen Frankel: I'm seventy-nine.
Baron: I was eighty-three this month. My son investigated the whole lot of them. This is the best of the lot. They have parties.
Ellen: I'm concerned about trying to help others who are sick.
Baron: Don't do anything. You're not supposed to do anything. And you're not supposed to wait on anybody. I know it seems heartless, but just lie in the bed and ignore it. You're sick too. You can't watch out for everybody else...
Ellen: I get so nervous from the old ways.
Baron: You don't have to do it. We're not supposed to do it, dishes and beds.

(Near "B" nurse's station):
Irene Wulff: Do you have the time?
Irene O'Hara: What do you need the time for? (to me): You'll have to go away. I don't have the time for that now. I'm all busy on my mind.
Wulff: Do you have the time?
Mrs. Duncan: It's a quarter of two.
Wulff: Oh, a quarter of two. I thought it was more than that. (Wulff begins to unbutton her sweater).
O'Hara: What are you trying to do now?
Wulff: I'm taking the buttons off, I'm going to put new buttons on.
O'Hara: No, come on now, don't make so much for yourself. You have it inside it.
Wulff: I always do it like that.
O'Hara: Well, you don't do that with a that. That should never be inside all tied up like that.
Wulff: I can always put on grey buttons. I can get grey buttons.
O'Hara: Oh, I see, I see. (O'Hara gets up from her seat and walks toward the dining room).
Wulff: You have money with you?
Duncan: What do you want?
Wulff: You have money with you?
Duncan: What do you need money for?
Wulff: We need the money, the money.
Duncan: You're all by yourself, and your family comes to where you're sleeping. What do you need money for. Won't they give you money if you ask for it?
Wulff: Why should they give me? They need it too.
Duncan: Oh, I see. (pause) Does she know you're here?
Wulff: I can be here. I'm here, they pay for it.
Duncan: Yes, I know, does she know you're here?
(no answer; to me): Oh, she's really got a latch.

(Opposite "B" nurse's station):
Mrs. Kanter's face becomes very agitated, and she starts moving in one direction, stops, and starts moving around in a circle. Mrs. Duncan (who has been watching Kanter's outbursts and) who is sitting in a chair outside her room next to the telephone says to the nurse: "I look at her face, I get sick to my stomach. (to Kanter) Cry, cry, cry. You have such a pretty face. She runs her eyes all the day. Why don't she laugh once in awhile. She gets me so upset. I look at her I can vomit."

(Dining room, mid-morning):
Grace Hamilton: Your lunch is paid for. Your dinner is paid for. Since you've been here, has anyone asked you for money?
Mrs. Goldstein: So, should I stay here?
Hamilton: Yeah.
Goldstein: I think I'll stay here.
Hamilton: You know, sometimes I think you're screwy, and then I won't talk to you any more.
Goldstein: No.
Hamilton: Yes, since you've been here, have you had to pay?

(Corridor of "new B"):
While sitting in the activities room, I overhear the following:
Mr. Gold: You gotta do the best thing you can do.
Mr. Samuels: No you don't.
Gold: What ya gonna do?
Samuels: Break out.
Gold: Ahh, that's silly talk. I'm eighty years old. I been with my wife sixty-four years. I had a house, but my wife got sick. My children said come here, it's not the same, but we're here.
Samuels: What the hell does one have to live for? You're past eighty, what you got to live for?
Gold: Just make the best of it.
Samuels: No I won't. If I can't have ( ), then I can't want to live. I'll manage. I'm not gonna let them boss me around.
Gold: Oh, you're just talking crazy. You're here, make the best.
Samuels: Oh, it's none of your goddamned business. (Mr. Samuels wheels himself away from Gold, toward the lounge at the other end of the hallway).
(In living room area 4):
Bergman: They'll make your bed up. They're supposed to.
Mrs. Green: I'm so upset. I can't dress myself. I don't like this place.
Bergman: Well, you just got to get used to it. That's why we're here. We all like living here on "E." You wouldn't want to live anywhere else.

(Noon, in dining room):
I sit in a chair near the first large round table. Reba Dansk is seated in her wheelchair at this table, as is Mrs. Ricardo, in her wheelchair. Dansk tries to step up from her seat, but she falters. I go over to her and tell her to stay seated or she will fall. She tells me that she has no money, and I say that that is okay, that she doesn't need any. She says that she doesn't want to be embarrassed, and I say she won't be. I return to my seat. Dansk begins to rummage through her purse.
Dansk: I lost my money.
Ricardo: You lost your money?
Dansk: Yes.
Ricardo: Where?
Dansk: In the street, I guess.
Ricardo: The street? No, you no go in the street today.
Mrs. Renee Cooper wheels herself into the dining room and sees Mrs. Dansk beginning to stand up.
Renee Cooper: Sit down, Mrs. Dansk. You'll have lunch with us today.
Bergman: That's the second time she got up.
Renee Cooper: Don't worry about the lunch—it's paid for. I promise you.
(Mrs. Dansk produces about eighty cents worth of change).
Renee Cooper: No, Mrs. Dansk, you won't need that.
Dansk: I don't need that?
Renee Cooper: No, put it away. Really.
Dansk: How can they survive? How can they survive like this? Where do they get their money from?
(There is no verbal response from the table).

As can be seen, residents are informed of what will be considered conforming behavior. Moreover, they are informed of the consequences of not adhering to these general expectations. As Birdwhistell writes:

The membership, in learning to coordinate their activities with their fellows, must learn appropriate behavior which informs the members, in familiar terms, of their state of being, of their tendency to behave, of their identity within the division of labor system (1968:52).
In addition to this, peer interactions enable older residents to scrutinize the new entrant's responses and behavior. This activity provides estimations for likely future interaction. The data indicate, for example, that residents monitor each other's performances, and, what is important here, share the results of this monitoring with each other. In part, the act of monitoring is in itself an act of membership and a statement of self and relationship. Not to monitor is a very powerful statement of deteriorated relationship (Birdwhistell, personal communication). Interestingly, observations and assessments are made on newer residents and even those one has known and lived with for a long time:

(After dinner, in living room area 6):
Mr. Hobart, who had been wandering around in the living room, is taken back to "E" by Gladys Harrison, an "A" resident. Mrs. Jacobs then comes out of "E" and walks over to area 6 where she sits with Mrs. Scott and Mrs. Cooper.
Scott: You had a visitor again.
Jacobs: Oh, who?
Scott: The visitor in your room.
Jacobs: Oh, him. He's confused.
Scott: Yes, he must have been looking into your closet that time looking for his coat.
(They all laugh).
Jacobs: No, I tell you what I think. He opens closet doors, and he thought that that would lead him to the street.
Scott: He asked me for money. I told him the bus is not running, but he said they run every day.
Cooper: Ah, you couldn't fool him.
Scott: No, but I told him that he should stay because it's going to rain.
Jacobs: No, it's not. I just heard.
Scott: I know, but I was just telling him.
Jacobs: It's going to be sunny and in the forties tomorrow.

(Evening, in living room area 6):
Gladys Harrison tells Mrs. Scott and Mrs. Jacobs that Mr. Baxter has been sick for the past few days, vomiting, etc. Mrs. Harrison then walks over to area 1, where Mr. Baxter and Mr. Serrento are sitting, to see how Mr. Baxter
is feeling. He is sleeping and, as Mrs. Harrison approaches, she says softly: "Mr. Baxter, you're sleeping." Mr. Baxter's eyes open almost immediately, and he denies that he has been sleeping. He then tells her: "You're mistaken." Mrs. Harrison seemed a little startled. As she walked back to area 6, Mr. Baxter turned to Mr. Serrento and said in a very loud voice: "She's drunk. Who does she think she is, coming over here and saying I'm sleeping?"

The following conversation then takes place in area 6:
Harrison: I think he's lagging. This time for sure.
Jacobs: Stay away from him, Gladys.
(They then talk about Mr. Baxter in the past tense):
Scott: He was such a good piano player. I loved when he sometimes would play for us at night.
Harrison: Tears used to come to his eyes when I told him I came to visit his sister. But he never visits her.
Scott: She gets a lot of visits from her husband's family, and I think he must be jealous. They hardly visit him.

(Late afternoon, in the dining room):
Mrs. Goldstein is sitting with Mrs. Galloway near the window. Goldstein points to Mrs. Donald sitting a few feet away from these women on the vinyl-padded bench.
Goldstein: She don't know where she is. One day last week she asked me who I am, and I tell her I live across the street, the hallway, from her.
Galloway: You don't have to tell me how nuts she is. I've seen her. I've been here longer than you have. Why she sometimes don't recognize her husband, and he comes every day for her. (−pause−) He's a doctor, her husband is.
Goldstein: I didn't know that.

Also, such assessments are made not only for ward mates, but for those one comes in contact with in the more "public" areas of the facility. For example, observations of individuals in activities, the living room, the dining room, the beauty parlor/physical therapy room, etc., enable residents to know how these individuals are going to be handled on that occasion and on subsequent meetings:

(Morning):
I enter the beauty parlor/physical therapy room. The beautician asks me if I want anything and I say, "No, not really." She asks, "Just looking?" and I say yes. I tell her my name is Stuart and she says that she's
seen me around. I say that I'm a student doing a paper for school. One of the patients turns to the beautician and says "It's wonderful, Jean, to sit here and just relax." I take a seat about eight feet away from the beautician's work area, near the hair dryers. Mrs. Greenberg is wheeled into the room, and Jean tells the aide to place her near the platform. During the next ten minutes, Greenberg leaves her chair, goes onto the Physical Therapy platform, and then back to her wheelchair three times. At one point, Jean and I help Greenberg back into her chair, but a few minutes later Jean runs over to Greenberg trying to leave the chair again. As Jean returns to her work at the sink, Mrs. Ezzell (sitting in the chair in front of the sink) says to her, "Geesh, you gotta have eyes everywhere. Don't you?" Jean just smiles at her, says nothing.

Again, this information is shared with others at the facility:

(Discussion with "A" nurse's aide):
"Have you noticed the chains of information in this place, man? That Gladys finds something out because she is all over the place, and she be (sic) relaying the information she gets to Mrs. Raymond and the others. And those four who play bingo, if one knows something, they all know, they have their own circle."

(Living room area 4):
Gladys Harrison and Mrs. Scott talk about the fact that Nora Silverman's husband (a resident of "B") does not recognize Mrs. Silverman (because of the physical problems caused by her illness). They talk about the husband and they note that he attended the birthday party a few weeks back.
Scott: Tell me, Gladys, you should know, you're always near there. Does he have one leg or two amputated?
Harrison: Y'know, I honestly couldn't say.

When a resident does not or cannot conform to the expectations of the other residents, the latter share and act upon this information. This seems to me to be an attempt to make some sense (predictability and self-governing) out of that behavior. For instance, in an example below, a rather distraught resident is informed by another that it is appropriate to view the woman who was annoying them as "crazy." This is used as a justification for avoiding further interaction with the woman.
Residents do not sit in on the meetings which evaluate and transfer new
residents; nevertheless, their influence is very strongly felt in these meetings. Residents inform each other that a new resident has failed the initial "screening," as it were, and should no longer be interacted with. Staff members overhear these warnings and observe the outcomes of the warnings as manifest in conversational exclusion and avoidance. In addition, residents complain directly to the staff members about new residents (as well as older ones), or do so through family intermediaries. Clearly, these reports influence the decisions of the staff members.

It is difficult to know whether the residents intend to influence the transfer decisions or are attempting to ensure and maintain reasonable predictability in their own lives by avoiding interaction with inappropriate residents. In either case, I feel confident to say that, as soon as residents decide that a peer is unsuitable, a subtle campaign begins in order to exclude this individual from the ward-specific social groupings. My observations indicate that this is not an individual effort, but rather involves more or less organized attempts by several residents on a given section to define and interact with the peer in a limited way. A telling example of this can be found in the events which led to (preceded, but not necessarily caused) the transfer of Mrs. Ford from "E" to "A" section. Ford was originally placed on "E" because, as Mrs. Richter explained, "she was described to me as a nice quiet lady, very clean, very well dressed." Indeed, in many respects, Mrs. Ford could be considered a typical and ideal candidate for "E." She wore street clothing all day instead of housedresses; although she used no cosmetics, her close-cropped hair was always neatly combed; she spoke in a low voice.
Although Mrs. Richter had not met with Ford prior to the admission, there was no hint that she expected the "E" placement to be inappropriate and thus a temporary one. Moreover, while the initial nurse's charts indicated an awareness of the intensity of Ford's behavior and of her memory lapses, these records did not anticipate a transfer:

(Nurse's charts for Mrs. Ford):
"Quiet and clean white female. A little confused. Will need to orient to sitting with women in the living room."

The perspective of the "E" residents diverged from that shared by the administration and the other staff members. For example, when Ford began to interact with other residents, they reported that, although physically appropriate, she could not meet their other behavior demands.

(Field notes):
It seems that the women who sit in area 4 were being annoyed by Mrs. Ford today. Ford is a very nervous-appearing, thin woman. She is very forgetful, and so is always asking people the same questions repeatedly ("Are they going to have lunch for us today?" "Where should we be?"). She also carries around an activities schedule with her and a notepad, and frequently asks people what she should write down or where she should be. Bergman is apparently hoping to discourage Ford from sitting with the group by suggesting to Baron this morning that they all not speak with Ford.

(Field notes):
Mrs. Ford was walking back and forth in the corridor outside the living room and dining room for about ten minutes. Jeanne, the activities assistant, passed by at one point and told her she would take her to sit with the other women. Ford repeatedly asked the women in area 4 of the living room (where Jeanne left her), "Where should we be? Is this it? Is this it?"

One afternoon, after she had sat with the "E" residents in the living room carrying on in the above manner, Ford picked herself up and went to her room. After the departure, Mrs. Bergman warned Mrs. Baron not to indulge Ford any longer:
(In living room area 4):
Baron gets up and starts walking to her room in "E."
I have just walked into the living room and so am not
sure at the time of what precipitated what I overhear:
Baron: I will see you after lunch.
Bergman: If you come over later, and you talk to her,
I won't talk to you.
Baron: I can't hurt her.
Bergman: You don't want to hurt her, but you can't
hurt yourself.

In a previous conversation, Mrs. Baron, albeit hesitant in the above
episode, vehemently warned another resident to pay no attention to
Ford, and, in addition, labelled her "unbalanced." This incident is
significant too because it shows how the residents' attitudes and
reactions to Ford could be relayed to a member of the nursing staff:

(In living room area 4):
Mrs. Baron complains for Mrs. West to the nurse taking
the latter's blood pressure. She says that Mrs. West
was annoyed and upset by "that woman who is constantly
taking notes and asking questions." The nurse tells
West that the woman is just very nervous that she'll
forget things unless she writes them down, but she
shouldn't be afraid of her. After the nurse leaves,
Baron says to West: "Now keep quiet. Turn the other
way. Your blood pressure." West says: "That's easier
said than done." And then Baron responds: "I know,
but you just can't pay attention. She's sick. Mentally
unbalanced. She's not boisterous but what can you do?
Just pay her no mind, or your pressure is going to go up
again."

Several weeks passed before a transfer to "A" was finalized for
Ford. During this time, roommate complaints about Ford were conveyed
to Mrs. Richter through family members. During the period just prior to
and after the transfer, "E" residents avoided all forms of interaction
(extended conversations, brief greetings, co-present sitting) when Ford
entered the area in the living room where they all sat. Furthermore,
she was not encouraged to participate in the activities enjoyed by the
other "E" females:
(Mid-afternoon, in the living room):
After a few minutes, Ford gets up and walks to an empty seat in area 4, where Green, Bergman and Axelrod are sitting, waiting for the book club to begin. Ford passes by Mrs. Schwartz who is sitting (in her wheelchair) in area 3. She stops Ford and asks her if she isn't cold, if she doesn't need a sweater. Ford mumbles something that I do not understand and then Schwartz tells her that the book club is scheduled for 2:00. As Ford sits down, Mrs. Bergman calls across to Schwartz: "She's not interested in that, Mrs. Schwartz."

"E" residents appeared satisfied when the transfer was approved. Their discussions of this did not seem vindictive. Rather, they seemed to express their earnest belief that they did what was necessary to protect themselves and what was best for Ford. Some time after the transfer, Mrs. Bergman happened upon Ford in her new surroundings and then reported her reactions back to her "E" friends:

(12:45 p.m., in "A" section):
Mrs. Bergman enters the lounge to use the pay telephone there. Ford is sitting in a chair near the telephone and against the wall as Mrs. Bergman passes her. Bergman also passes Riley, in his wheelchair, as she first enters the lounge. After using the telephone, the following conversation ensues:
Ford: Do you want to sit here?
Bergman: No, thank you. I'm going to my room.
Ford: Are you sitting?
Bergman: No, no, stay.
(Ford straightens out Bergman's sweater as she brushes against her).
Bergman: Thank you. It's good to see you. Good to see you again.
(Mrs. Bergman walks toward the door to the lounge and approaches Mr. Riley).
Bergman: Are you all right? Are you all right? (Riley shakes his head "yes."). Just stay that way.
Riley: Yeah. I'll see you later.
Bergman: Yeah.

(Later in the afternoon, in living room area 4):
Bergman has been reading the newspaper to Axelrod, but has been silent for about twenty minutes. Then Bergman turns to Mrs. Baron sitting on the couch:
Bergman: I telephoned my sister. She'll be coming on Sunday. (-pause-) I saw Mrs. Ford in that "A" lounge.
Baron: Yes?
Bergman: She's doing much better there.

Exclusions from conversation and other social activities can be seen as one general technique to be employed by residents for passing judgment on and hence influencing the slotting of others. It should be pointed out that the ward system in operation at People's Home is associated with definite territorial allocations for the members of each ward. Individuals avoid coming in contact with selected categories of residents by maintaining guidelines as to the locations they routinely enter upon. Because residents are presumed to be interested in and capable of interaction only with ward mates, staff members suggest that newer residents must be "oriented" to the places in the main dining room where their peers sit. Comparably, new residents are shown the usual locations on the wards (lounges for "A" and "C/D," an area of the main living room for "E" and "A/E," and either a portion of the dining room or the corridor opposite the nurse's station for "B" and "new B").

Territorial encroachments do occur, however, by unsolicited ward mates as well as by those from other sections. In these cases, there is usually a cessation of activity and/or an absence of conversation during the time that the violating individual is present:

(Discussion with Mary, one of the activities personnel):
I then ask if there have ever been any efforts on the part of the staff to include new residents in the "select circle." Mary describes to me what happened with Mrs. Polo: "When she came here at first, she was sitting at that lunch table with Mrs. Bergman and the other women. They sort of included her in that group. We thought she'd be able to get along with that crowd. Roberta and Carol decided that. They (the other residents) didn't tolerate it. They did at first. Mrs. Polo doesn't always speak clear sentences. I guess they just lost their patience trying to understand her. She went
to the hospital and when she came back, I think she was there for awhile, the dining room got crowded. She came back with a private duty nurse, and so it just made more sense for the tray to go to 'A' since the nurse is not here for dinner, so she has to eat in 'A' lounge."

(Late morning, in the living room):
Mrs. Elias is brought into the living room from physical therapy; her wheelchair is placed facing Scott in area 5. Mrs. Elias sits there for about five minutes, and then, as I am walking past her from where I was sitting in area 6, she asks me to come over. During the preceding five minutes neither she nor Scott had exchanged a word with the other. She asks me to turn her straight, which I take to mean away from (not directly facing) Scott. I place Mrs. Elias's wheelchair parallel to Scott's and facing the middle of the living room. Mrs. Elias says very quietly—half to herself, half to me: "She doesn't want to talk to me. All right."

(In the living room):
Mrs. Green is sitting in the couch closest to the piano. Mrs. Axelrod's wheelchair is placed to the side of this couch, near the window, and Mrs. Bergman is seated in a wooden school chair next to Mrs. Axelrod. Mrs. Bergman is reading the newspaper out loud, in a voice certainly loud enough that I am able to hear it about fifteen feet away. Mrs. Dansk is wheeled into the living room, and placed near the couch Green is sitting on. The nurse puts the brakes on the wheelchair, but Mrs. Dansk tries to stand up. Dansk is not restrained, but she falters and the nurse helps her to sit back in the chair. The nurse says: "You stay there. Listen to the newspaper." Mrs. Dansk asks: "I should stay here?" The nurse says yes and walks back to the "E" nurse's station. Mrs. Bergman has stopped her reading while Dansk and the nurse were talking, and she looked out over the newspaper to look at them as the nurse was getting Mrs. Dansk to stay seated. Mrs. Bergman resumes her reading as soon as the nurse has left Mrs. Dansk's side, but she does so in a much lower voice. Although I am able to hear her voice, I am unable to make out specific words.

(In the living room):
During this time, Mrs. Salk and Marylou are in their wheelchairs near the water fountain. Mrs. Spangler, who is sleeping, and her private nurse are sitting on the second couch (facing the piano) in area 4. The nurse is reading a newspaper and at one point gets up from the couch to go into "E" section. She is gone for about ten minutes. During her absence, Mrs. Powell ("C/D") enters the living room from the hallway entrance. She wanders
through the living room and stops at the couch in area 4 where she sees the empty place next to Mrs. Spangler. She walks past Mrs. Spangler, picks up the newspaper that the nurse had left, and turns around so as to ease her back into the seat. Mrs. Bergman has stopped reading and looks at Mrs. Powell making herself comfortable in the chair. Mrs. Powell smiles at Mrs. Bergman and Mrs. Axelrod. Bergman frowns in Powell's direction. She then turns to Mrs. Axelrod and says that "we'll continue the reading after lunch." Mrs. Axelrod shakes her head up-and-down once, and in her faint voice says yes.

The fact that Mrs. Polo now has a nurse is used by the staff to explain her withdrawal from "E" social life. It should be noted, however, that several other residents have had private-duty nurses at various times. Polo had been in the gradual process of exclusion by the "E" women. Thus, after her return from the hospital, staff members saw no need to attempt to reactivate her vis-à-vis "E":

(In living room area 4):
Marylou: Has anyone heard from Mrs. Polo?
Bergman: Yes. They say she'll be back soon.
(-pause-) They've already put someone in her bed.
Axelrod: That's okay. We don't need her here anyway.

To briefly review, the residents' contribution to the slotting of others constitutes a three-fold interaction process. First, older residents interact with recent admissions to the facility in such a manner that the newcomers are provided with information necessary to survival at PH; this helps to maintain and to reaffirm the patient's initial slotting. Second, if a new patient is judged unacceptable, he/she is shunned by the peers. Third, staff members are able to see and review the residents' responses to particular slotting determinations (e.g., acceptance or rejection of the slotted individual); this influences the staff's further assignment choices.

The Ford case is not unique and illustrates clearly the way in which residents monitor and comment upon the behavior of others. This
is consistent with the situation in which I was urged not to interact with a patient already negatively evaluated by a group of women who had "taken me under their wings" and looked out for me:

(In living room):
Mrs. Scott and her smoking companion, Edith, are sitting between areas 1 and 2. I sit down next to them. We exchange hellos. Scott says that she notices that I haven't been around for quite awhile and I say yes, that I've been very sick. I notice a woman in a wheelchair trying to untie a bed sheet around her waist, near the card table (area 2). She is well-dressed, in a pants suit and with a pocket book. I ask if that is Mrs. Dansk and they say yes. Edith: Haven't you talked with her.
SJS: No, not yet.
Scott: Don't waste your time.
(Both women roll their eyes and look at each other).
SJS: Why, what's the matter?
Scott: She wants to know where she is, she doesn't know where she is. She'd go up and down, they finally had to put her down, restrain her. It's not done for meanness though. I must say that about them. She broke her hip or something.
Edith: She used to do a lot of screaming.
Scott: If she does, she'll really frighten you.
SJS: It looks like she's getting up.
Scott: Of course, it's not my job to tell her to sit down. That's what the nurses are here for. Of course, if she should fall, of course, I'd call a nurse for her, if something happens.

Some general comments on the above data are necessary. The efforts of residents towards others do not seem to influence the initial components of the recruitment system. Assignments and the establishment of criteria for quota filling are left totally to Mrs. Richter. The residents' behavior does function beyond this to ensure the behavioral integrity of the ward, i.e., to reaffirm their own assignment to that ward and the criteria in general for that: Conversational, activity and territorial exclusions can be seen as means by which residents search out appropriate "team members" (see Goffman, 1959), ones who are capable
of meeting the section's behavioral demands and of sustaining a joint definition of situation. Further, it is clear that the patient's status is not defined nor imposed exclusively by the staff. The status of any resident is influenced by the individual's interactions with his/her peers as well. New residents may be assigned a particular position within the facility based on the section slotting, but then this status is likely to be "renegotiated" in the context of interaction with the resident's peers. Thus, staff members, in making a particular slotting decision, provide the individual with a number of options and opportunities for social interaction and social relationships. The full set of options is narrowed, however, when the patient enters the facility and begins interaction with others. This narrowing takes place because the other residents have certain expectations for behavior of the newcomer. Failure to meet these demands over a period of time results either in ostracism or in demands for a transfer. From Mrs. Richter's perspective, Ford was an appropriate "E" resident. Although forgetful and anxious, she had enough characteristics of a nonsenile patient that Mrs. Richter hoped Ford would fit in, and, perhaps more important, be allowed to fit in. As Mrs. Richter confided to me: "I thought it would work, give it some time." Nevertheless, this was rejected by the residents who on a daily basis were placed in the position of being in Ford's presence. This rejection, it should be noted, was based not on Mrs. Ford's faulty time orientation, but on her inability to sit quietly and still when in the living room with the remainder of the "E" residents. Unfortunately for her, it was Mrs. Ford's tendency to talk incessantly--repeatedly reminding the others of
her memory lapses at the same time—which was her "undoing." Mrs.
Green is another "E" resident who on occasion appeared uncertain as
to her place or time orientation. Her medical records indicate the
following awareness on the part of the nurses:

(Nurse's charts):
"Female, 88 years old. Slightly confused, quiet. Sits with
select group of women in living room. Attends activities
with solicitation."

Green sat quietly with her peers in the living room and spoke when
she was apparently not confused. In this light, it may be easier to
understand why Mrs. Ford was transferred off "E" section, and Mrs.
Green was not.

What is it that the residents look for when evaluating other
residents? First, on both "E" and "B" sections, the kind of clothing
that is worn is used in determining how sick an individual is. Street
clothing is the preferred mode of dress, with housedresses and bed
clothing coming in a poor second:

(Living room):
Mrs. Neumann passes Mrs. Scott, Mrs. Jacobs, and me in living
room area 5. Mrs. Neumann is returning from getting her copy of
the daily newspaper from the receptionist and is walking to "E"
corridor. Mrs. Scott tells me that Mrs. Neumann used to write
for a major city newspaper. Then she tells me that she finds it
curious that Neumann walks around PH in a bathrobe and house-
dress all day—never street clothes.

(Discussion with Anna Pollack, an "E" resident):
Anna points to a woman, Mrs. Waldbaum, sitting in section 3 of
the living room, wearing a pink housedress: "She is clever but
not too talkative. She watches me like she's my own mother.
She was here for two years, but nobody talked to her. She's
not fancy like the others. She's a Jewish lady, but not
fancy. A simple pink dress. She's my friend."

"E" residents especially pride themselves on a certain physical
appearance, and avoid all situations in which their peers can see them
if not fully dressed. Those residents who need assistance dressing in
the morning usually must wait until eleven o'clock or so before visiting
with their friends in the living room. In contrast, "A" and "C/D"
residents are wheeled into their respective lounges for the day wearing
pajamas or a night gown, a housedress, and sometimes a bathrobe.

Related to this are the negative sanctions placed on the presence
of body restraints on "E" and "B" sections.

(Opposite the nurses's station on "E"):
Mrs. Lutz, Mrs. Kanter and Mrs. Seiler are seated in a row a
few feet from the water fountain, where I am seated. Lutz
looks over at Seiler, and then says to Kanter, who is in the
middle: "She must have done something. They tied her down."
Mrs. Seiler asks me to come over to her side, which I do, but
then says something which I cannot make out. As I leave her
side to return to my seat, Mrs. Lutz says to Seiler: "They
want you to sit and not roam around. The young man don't
know why you're sitting like that. If he wants to know he
can go to the desk and find out. He has that privilege. I
can ask too. We have that privilege."

In one very interesting example, an "E" resident suffering from multiple
sclerosis required some device to hold her limp body in place while in
her wheelchair. For several months, this resident refused a restraining
bib, which is typically used on "A" section, and to a lesser degree on
"C/D" to prevent patients from wandering. Once it became obvious that
she would not be able to be placed in her chair during the day without
some restraint, Marylou Edison finally allowed the administration to
make inquiries with various agencies about getting a seat belt.

(Minutes of the staff meeting, January 27, 1981):
"Marylou Edison has become more spastic particularly in
her legs. Because of this she is sliding down in her wheel­
chair. She will not wear a restraint and the belt she has on
her chair will not keep her up. It was suggested that we
write to the M.S. Society to see if they provide any equipment
or if they know of anything that might help her. It was also
suggested that Marylou might benefit from an evaluation at
Hendricks Rehabilitation. Her doctor will be consulted about
this."
Finally, the importance of conversational behavior can be reiterated. It should be pointed out that it is not the case that an individual who breaches conversational rules is simply avoided. Rather, over time, these breaches and the relatively minor sanctions arrayed against an individual at that time are used to build a biography of that individual, a career statement, a case for either physical or mental inappropriateness or decline, which can lead to requests for a section reassignment. 19

One should not conclude from the above discussion that staff members make decisions about residents which have been determined by the residents themselves, or that residents control the processes leading up to and the outcomes of staff decisions. As noted earlier, I am not attempting to develop descriptions of "formal" versus "informal" slotting. Instead, the actions of both residents and staff—for the latter, in staff meetings as well as on the floors—are components of an encompassing behavioral system which slots individuals, and then allows them to maintain their positions or requires them to change. I would like to provide one specific example at this juncture of the role staff members may play in leading up to a transfer, i.e., the interactional implications of ward criteria and slotting/reslotting decisions from the staff perspective. This single case is used because of the detailed observations I was able to make over a period of several weeks. Other examples of staff treatment of patients discussed below are compatible with the present case, but do not evidence the total range of behavior this one example provides.

The example I wish to describe is the transfer of Mrs. Kanter from "B" to "A" section. As noted previously, this reassignment was agreed
upon because staff members felt that Kanter's treatment of her roommate, Dr. Unger, made it impossible for the latter to express herself independently.

(Discussion with nurse on "B" section):
"Kanter had her (Unger) here at six a.m., they told me, up and dressed. She doesn't let that woman sleep. All we can do is try to keep them apart. It's not good. Dr. Unger is becoming more and more dependent. You should have seen them all at a quarter to three the past few days. Looney bins. I don't know if there's any truth to that story about the full moon, but that other day, you could have filled your book with that. The situation is really unhealthy for both of them, but to separate them from their rooms all at once, that could be too much of a blow for Mrs. Kanter. You have to ease it slowly."

(Staff meeting):
Mrs. Victor (LGPN) brings up the fact that "B" section is deteriorating. She says that there are more psychiatric problems there, not merely the usual organic brain syndromes. Carol says that there is a "circular effect" there, even with every one on medication, and that Mrs. Kanter is the root of the problem. She says that "they all feed off of each other," and that Kanter probably "starts them all running."
Mrs. Barry (RN) says that the medication is now making her appropriate.

(Nurse's charts for Mrs. Kanter):
Mary, activities personnel, entries for 4/3/81.
"Resident displaying marked anxiety and agitation. Displays behavior in unrealistic approach concerning roommate. Does not like roommate to be out of sight, unduly concerned with every detail concerning roommate. Offers resistance when roommate is invited to activity, but relents when it is explained firmly that roommate welfare is being considered. Dominates roommate's actions. Speaks of roommate at times as 'my child.'"

Staff members acknowledged that Unger, who at one point in her life, had been a practicing physician, was an extremely confused woman. For example, the director of activities noted for me that Unger evidenced no awareness of her former career. It was felt, moreover, that Mrs. Kanter's ever-watchful eye over Dr. Unger was only leading to further disorientation and quiescence. Various efforts were initiated...
by the staff to rehabilitate Dr. Unger, i.e., attempts were made to restimulate and reactivate Unger to previous interests.

(In living room):
Carol brings Dr. Unger into the living room from the dining room, and sits her at the bench in front of the piano. She encourages her to start playing and opens up some sheet music placed on top of the piano. Unger hesitates, but does slowly produce a tune. She thumbs through one of the books on top of the piano and then sets the open book on the stand. Carol stays with Unger the entire time, and every now and then encourages her to play. Sometimes Unger says that she can't do it, that she needs practice.

Before pursuing these data further, I should point out that this analysis does not (indeed, can not) attempt to specify the legitimacy of the reasons given for Kanter's transfer and the staff members' fears regarding Unger's passivity. Such an investigation is beyond the scope of this dissertation and this writer's training. It is important to note, however, that at least two other dependency-inducing relationships apparently existed at PH; although they were commented upon by staff members on several occasions, neither one resulted in a transfer. It was suggested in the third section of this chapter that staff members vehemently called for a transfer for Kanter at nearly the same time when they were becoming increasingly aware of and alarmed about the changes being experienced on "B" section in general. In what follows, however, I will not focus on the why of Mrs. Kanter's reassignment, but rather on the staff's part in the how.

To a certain degree, Mrs. Kanter did place a number of demands (some unrealistic) on her roommate:

(Near "B" nurse's station):
Carol walks up to Dr. Unger sitting next to Kanter. Carol tells Unger that Sr. Anne is coming in, and asks her if she wants to go and receive Holy Communion. Dr. Unger says no, she does not want to go. Kanter tells Carol that Unger is
Jewish. Carol tells her that Unger is Catholic, but Kanter insists that this is not so. Carol then tells Unger that they're going to say the rosary, but she says she doesn't want to go.

(Dining room):
Irene O'Hara, Mrs. Kanter and Dr. Unger are sitting near each other on the vinyl bench. Irene tells Kanter she should leave; Kanter's face becomes perplexed as she asks why. I approach the women closer, and sit opposite Kanter in one of the chairs. Kanter stands up and is about to get Dr. Unger when Irene tells her to sit down. She sits down and Kanter complains that first Irene told her to stand/leave, and now is telling her to sit. Irene (pointing to me) tells Kanter that they shouldn't let me sit. Kanter says that I didn't come to take their seats, that I come here to write. Irene turns to me (about three feet away) and says that I'm always upsetting the women with my walking around. I reach over to Mrs. Kanter's hand, hold on to it, and say that all the other women think of me as their friend. Kanter says yes, that I'm a lovely young man. Dr. Unger shakes her head and says yes. Kanter then gets up followed by Dr. Unger. They take seats about ten feet away from where they were originally, still on the vinyl bench. As Mrs. Kanter approached me, she said: "Some people are very bossy. The best thing to do is just walk away." She held tightly onto Unger's hand as she led her.

Mrs. Kanter enjoyed dressing Dr. Unger early in the morning and bringing her out to sit opposite the "B" nurse's station with her. They spent various hours of the day there, holding hands, napping, occasionally conversing in German (which may account for Kanter's assertion that Unger is Jewish). When a home-wide activity such as bingo or a movie was scheduled, Kanter preferred to escort Unger to the activity and sit next to her as well, than entrust her to one of the nurse's aides.

Kanter's seemingly overprotective demeanor was not directed only toward Dr. Unger. Furthermore, her behavior appeared to be a general reflection of what nurse Serreno described as the social structure and attendant pressures existing on "B":

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(Discussion):
"There's a whole social grouping there, a social structure, people maintaining the same things they were doing whenever. There's more pressure there. Mrs. Seiler really does not belong there, but her daughter won't let us move her. She's in the hospital right now. Mrs. Lutz was on the telephone one day last week, and she turned to Mrs. Seiler and said: 'Didn't anyone ever tell you not to listen into someone else's conversations?' It's true, but Seiler just isn't reacting on that level."

Kanter was thus also a recipient of the solicitousness of her "B" peers. Despite this, staff members did not evaluate the group ties on "B" quite the way they did those on "E":

(In "B" section):
Jeanne walks over to Mrs. Kanter near the nurse's station. She is holding Mrs. Lutz's hand. Jeanne asks Mrs. Kanter if she wants to go to listen to the music in the living room. She says no, that she's tired and that she's been very sick all last day and today. Jeanne asks Lutz who also says that she's not been feeling well, but that when she is better she always attends. She also says that she is looking after Kanter. Kanter tells Jeanne that Lutz can't leave her, that Lutz is watching her today. Jeanne says that it's not fair to have Lutz be her keeper, but Kanter says: "Aren't you glad I have someone to take care of me?"

On another occasion, Kanter reciprocated this kind gesture to Lutz:

(In "B" section):
Mrs. Lutz comes up to the women sitting near the nurse's station. They say hello to each other, and Mrs. Lutz says that she's been having difficulty seeing today, that her eyes hurt her. She says she is going to take a walk and Kanter volunteers to go with her. Lutz says this is not necessary, but Kanter rejects this: "I'm gonna walk with you whether you like it or not. Because when a person don't feel well . . . they're not well, you don't leave them alone."

Staff members evaluated these behavior patterns in an inconsistent fashion. For example, Kanter's mothering of Irene Wulff during an outburst by the latter (another "B" patient subsequently transferred to "A") was seen as appropriate and acceptable by the nurses:
(Staff meeting):
Jeanne says that she thinks the Haldol is being effective on Mrs. Kanter, or, at least, Kanter is not as psychotic all the time in her behavior. Carol agrees with this: "Wulff, the other day, was sitting there restrained. Very upset, she was very upset." Mrs. Kanter tried to calm her down. She was being very appropriate to her. She said, 'Why are you screaming? They're only trying to help you.' I think it (the medication) is really helping."

Interestingly, Kanter's behavior was accorded a positive evaluation once it had been placed under the control of medication.

After several weeks of "tolerating" Kanter's behavior, the staff decided that medication and a psychiatric consultation might help eliminate the "bizarre relationship" she had with her roommate.

(Nurse's notes):
"Haldol orders received early April; psychiatrist also suggested moderate amounts of stimulants 'that might increase functions and interest rather than sedate her.'"

(Psychiatrist's report):
"She denies any knowledge of the relationship with her roommate. What we can infer from some of the material is that she can repress quite quickly to many anal and dependent concerns (i.e., 'baby' and 'bowels')."

(Minutes of the staff meeting, April 7, 1981):
"A psychiatrist has been in to see Mrs. Kanter and has started her on Haldol. Hopefully, the Haldol will calm her down and she will become less possessive of Dr. Unger."

The reactions by Kanter's peers during the first few weeks were generally supportive. Since they all looked after each other's welfare, there was nothing surprising or aberrant (to them) about Kanter's attachment to Unger.

(Discussion with Mrs. Lutz):
I sit down next to Mrs. Lutz near the nurse's station on "B." She has just witnessed Kanter's frantic plea to the nurses to show her where Dr. Unger is. She then says to me: "This house is home for us. And you get more or less to see different incidents which happen. She's (Kanter) a good-hearted individual, from what I see of her. You know, there's nothing like this. I don't know how to say this, but we were like strangers, and now we share all of this."
Admittedly, this supportiveness was mixed with some ambivalence. While the other "B" residents had few problems accepting Kanter's concern for Unger, they were unwilling to accept her description of the situation. The following examples show somewhat hostile behavior toward Kanter, but it appears as though this hostility is directed at the way Kanter goes about talking about her relationship with Unger, not at the relationship itself:

("B" section):
As I approach the "B" nurse's station, Dr. Unger and Mrs. Kanter are seated in the chairs opposite the station. Dr. Unger is sleeping in her chair, with her hands clasped in her lap. Both women are fully dressed in street clothes. Kanter is awake, sitting to Unger's left. As I walk near the two women, Kanter says, "Hello dear," and I smile back. I sit at the chair next to the water fountain (about five feet to the right of Unger), in order to observe Kanter's behavior with Unger. As I am beginning to write these preliminary notes, I see Mrs. Lutz leave her room, and walk to the nurse's station. She is wearing a bathrobe, a floor length night gown, and gold earrings. She walks to the counter at the station and bends over it to see no one there. She then walks over to Kanter and sits to her left. As she seats herself, she tells Kanter that she is waiting for her bath. Kanter says nothing about this. Kanter does then tell Lutz that she had to put a sweater on Unger: "I had to dress her with a sweater this morning." Lutz says that perhaps it is cold for Dr. Unger, but that it is not cold for her. Kanter says that Unger is wearing a thin dress (it looks to me like the same polyester knit as Kanter's), and as she says this she rubs her fingers around the hem of Unger's dress. She says that because the dress is so thin she made her wear a sweater. Lutz asks Kanter why it's any of her business, and Kanter says that she's in charge of Dr. Unger. In a very quick and cutting voice, Lutz retorts: "What do you mean 'in charge'? Say that she's in your room." Kanter rather defensively says that that is what she means, and Lutz then says: "I can understand you, but other people can't understand you."

("B" section):
As I walk through the main "B" corridor, Mrs. Kanter and Mrs. Lutz are walking out of the latter's bedroom. They approach the nurse's station (with me following behind them), and an aide hands Mrs. Kanter two towels. I later find out that Mrs. Kanter had a bowel accident during lunch and her underwear is now wet. Kanter and Lutz walk over to the
seats, and they put the towels on one of them. I now observe the two women from across the corridor, standing by the nurse's station.

Lutz: You had an accident, an unfortunate accident. Now sit on that chair, put the towel so you can dry off.
Kanter: I don't care about me. I'm looking for the three children.

Lutz: What three children? What are you talking about?
Kanter: The children. Your cousin.
Lutz: Cousin? Honey, you just woke me up from my sleep. I'm drowsy. Tell me what's going on.

Mrs. Lutz complains that she's still drowsy and doesn't understand what Kanter is talking about. She says that Kanter woke her up after the accident, and Lutz came to sit with her, but now Kanter is not making any sense. Mrs. Kanter pleads with Lutz to help her find the children. Mrs. Lutz asks her who she is talking about, and Kanter says: "Your cousin." Lutz very quickly responds with: "Stop that. She's my roommate. She's not my cousin."

Kanter then says that she also has to find "the little girl, Dr. Unger." The aide who gave Kanter the towels (still standing behind the station), tells Kanter that Unger is not a little girl, that she is old enough to be Kanter's mother. Mrs. Kanter responds immediately: "I doubt that very much." Mrs. Lutz tells Mrs. Kanter that she thinks she needs to see a doctor. To the aide, Mrs. Lutz says that Kanter had an accident last week and "now again." She tells the aide that they should get a doctor to see her today. Kanter's face becomes extremely pained; she says that she has to get to Dr. Unger, that she is in charge of her. Lutz starts yelling at Mrs. Kanter: "What the hell are you talking about?" She asks one of the nurses behind the counter why Kanter is having so many accidents. The nurse says she doesn't know but that Lutz should try to calm Kanter. Mrs. Lutz says that she's not concerned by the fact that Kanter is looking for Dr. Unger. She says she understands that Kanter needs to do this. She says that she thinks Kanter should be taken to the doctor: "We need to know why, why are these accidents?" The LGPN does not answer Mrs. Lutz; she walks out from the nurse's station with a tablet and some water, which she hands to Kanter. After the nurse has walked away, Kanter then asks: "Now that I did that, can we go look for the little girl?"

Several weeks after the initial administration of the medication, Kanter no longer appeared as anxious as she had previously. Although she remained concerned with Unger's welfare, "the edge" had been

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removed. Medication of this type (Haldol) does tend to reduce mental acuity and increase such problems as fatigue and memory loss. The most pronounced of these effects appeared in Mrs. Kanter's interactions with other residents; her behavior began to isolate her from her friends:

(Near "B" nurse's station):
Kanter then turns the discussion to Lutz's impending bath by asking if she has to pay for a bath. Lutz again retorts in a very quick voice: "Gert, sometimes I think you have sawdust in your brain. You pay for everything you get here." They repeat this little scene several times: Kanter keeps on asking when one pays for the services, and Lutz says that it is all part of the monthly bill. Kanter concludes the discussion by saying: "Sometimes the neighbor has sawdust in the brain." She apologizes to Lutz for upsetting her, but she says that she is still very agitated from last night. Lutz says that she wasn't there last night, and so asks what happened. Kanter says that she found Unger "in the restaurant, outside." Lutz asks: "What do you mean 'outside'? Outside the front door? No. Say 'in the restaurant.' It's just a few feet from your door." Mrs. Kanter tries to continue her story and she repeatedly refers to the "outside" which annoys Lutz. Lutz begins moving in her seat, as if squirming from what she is hearing, and she frowns. Kanter never finishes the story because Lutz interrupts her and says: "Gert, you know, half the time I don't understand you. Half the time you shouldn't talk to me." Kanter responds: "Alright, fine. Agreeable."

The staff's labelling of the Kanter-Unger relationship as unhealthy, and their deliberations on an eventual transfer, served to justify for them the kind of behavioral treatment accorded Kanter. In the following excerpt, Mrs. Kanter has been taken to look in on Dr. Unger, who is in the living room listening to a concert. The staff members refuse to allow Kanter to enter and sit with her roommate. This scene lasted nearly an hour, during which time various efforts by Kanter to win some compromise were thwarted. Cooperation between a nurse and a ward mate is also noteworthy:
(In "B" section, mid-afternoon):
Carol tells Kanter that Dr. Unger is fine where she is, and she doesn't want her to be disturbed. Kanter begins to cry, saying that she's in charge of Dr. Unger. Carol, in a very loud and striking voice, says: "Honey, listen, you're not in charge of anyone here." Kanter's face turns white at Carol's voice; she says: "I know that. But I just want to make sure she's enjoying herself. She's a guest in my house. I don't want her to go back and say she didn't have a good time." She begs Carol to tell her where Dr. Unger is, and Carol agrees to show her if she promises not to try and disturb her. Carol and the nurse take Mrs. Kanter into the dining room. I follow behind them. Carol points to someone sitting in the front row of couches near the piano (through one of the openings in the dining room/living room divider), and Mrs. Kanter at first says she can't see her. I tell her that I see the back of Unger's head, and Kanter tells Carol that she would like to sit next to Dr. Unger. Carol says no. Mrs. Kanter says she has to go and get her roommate (sic!), but the nurse and Carol physically hold back Kanter from moving. They tell her that they're not going to let Mrs. Kanter get Dr. Unger, they are not going to let Dr. Unger be moved. They say that Unger is fine where she is, and when Kanter asks, they say that one of the staff members will take Unger back to her room. This issue of how Unger will "find her way back home" (Kanter's words) is repeated several times as the nurse and Carol walk Kanter back to the "B" nurse's station. When they reach the station, Carol continues on to her office, and Kanter takes a seat next to Mrs. Lutz. The nurse walks behind the counter.

Mrs. Kanter tells Lutz that she saw "the little girl," and that they promised to bring her back after the concert. Lutz asks the nurse to give Kanter something to calm her down, but the nurse says that she already has. Mrs. Kanter then tells Lutz that, as soon as the concert is finished, she will go over and get Unger. The nurse overhears this, looks at me with exasperation, but says nothing. (I am seated in the chair near the water fountain, about three feet away from Mrs. Kanter and Mrs. Lutz). Lutz suggests to Kanter that she will comb her hair, that that will soothe her. The nurse tells Lutz that that is a very good idea. Kanter says that she can do it herself, and Lutz says: "Well, come with me." She takes Kanter by the hand, and walks with her into her room. She gives her a comb and Kanter combs her own hair. Kanter sees me standing by the threshold and she asks me if I need something. I tell her no, that I was just seeing what was going on. As she and Lutz leave the room, Kanter tells me that sometimes people need privacy. I say nothing in response.

Kanter and Lutz return to their seats near the nurse's station. A maintenance woman passes by with her truck, and Kanter asks her for some toilet tissue. When Kanter disputes the woman's
statement that she's already left some in her room, she goes with the woman to her room to see... .

Mrs. Kanter returns with the cleaning lady. She tells the nurse that she's going to see Dr. Unger in the living room. The nurse says nothing, and Mrs. Kanter raises her hands, almost in prayer, saying: "I will stop it. I just want to see it. And then I will stop it." The nurse says nothing. Mrs. Kanter's face becomes very red, and she starts moving in one direction (right, toward the dining room), stops, and starts moving around in a circle. Mrs. Duncan, who is sitting in a chair outside her room, also opposite the nurse's station, says to the nurse: "I look at her face, I get sick to my stomach. Cry, cry, cry. You have such a pretty face. She runs her eyes all the day. Why don't she laugh once in awhile. She gets me so upset. I look at her I can vomit."

Nurse: Yes. Isn't she being annoying? (There is silence for about five seconds, and then):
Kanter: She's in my custody.
Nurse: No, she's not.
Kanter: Today, today she is.
Nurse: Not today, never. She is not yours.
Mrs. Kanter breaks down into uncontrollable tears... . A few minutes later, during the hubbub of the change in shifts, Mrs. Kanter walks out to the living room. I follow her.

Also note the following:

(Near "B" nurse's station):
Mrs. Templeton approaches the nurse at the station and asks her if she's seen Mrs. Kanter. The nurse says that she gave Kanter something to make her sleep, and Templeton asks if she can go visit her. The nurse says that they want Kanter to sleep and not be disturbed.

Kanter's social support system is apparently undermined by the reactions staff members have toward her. More specifically, one finds in this example (and in others to be reported on below) an attempt (1) to make the patient predictable through the administration of medication, i.e., to get the individual to conform more to the behavioral expectations of the section, and (2) to implement a symbolic removal of the patient from inclusion in activities with his/her peers. The latter can be seen as a complementary process to that engaged in by the residents. It was noted above that, after finding a new resident
unsuccessfully adjusting to life on the particular section, "oldtimers" label, avoid and exclude the patient from their social group. Staff members contribute to this by gradually isolating the individual from usual activities on the ward and from his/her peer group. In the above examples, Kanter's concern for Dr. Unger is overshadowed by Kanter's "hysterical" and "whining" demeanor—characteristics which are not acceptable to many of the other "B" residents or to staff members. While Kanter's friends understand and seem to agree with the intent of her friendship bonds with Unger, they are disturbed by her inappropriate talk. When Kanter's anxiety for Unger appears to be exacerbated by the staff's treatment of her, the peers' annoyance becomes even more noticeable. Mrs. Kanter's descriptions of her roommate are riddled with several inconsistencies (at one point she refers to Unger as her roommate, at another as a visitor). As a consequence of these inconsistencies, the staff members label Kanter as confused and act to keep Kanter and her roommate apart. One signal from the staff members of an imminent transfer, then, is the removal of the individual from the usual contexts of interaction with others on the section.

I do not intend to question here the correctness of the decision to transfer Kanter to "A" section (or Ford for that matter), or to make a judgment about how unhealthy Kanter's relationship with her "B" roommate was. Rather, I have been concerned with how conversational behavior can be used by residents and staff personnel as part of a system of status maintenance or alteration. Toward this end, it was noted that conversations establish rules for directing the participants' social
relationship, and provide information—such as danger signals—necessary for continued functioning in this world. The presence of this "phatic talk" (Malinowski, 1972) enables the residents to monitor the behavior of others and to provide them with the necessary sanctions and information for maintaining a current slotting. On the other hand, the absence of such talk, e.g., conversational exclusions, is an early phase of the reassignment procedure. From the staff's perspective, the decision to begin a transfer usually entails a gradual separation of the patient from social life on the particular section.

**Selected Contrast Analyses**

As I have stressed before, when an individual enters a nursing home, the career which is realized for him/her is likely to be shaped to some degree by the initial placement in a particular bed in a particular place in the facility. Staff members (and fellow residents) hold differing expectations for the residents related to the section to which assignment is made. As a result of, or, at least, congruent with these differing expectations, there have developed contrasting institutional procedures and guidelines for social relationships with each of the resident types. There is an assumption among the staff members that a ward assignment is not a mere residential slotting (a place to sleep) but is also an implicit message about the patient's degree of "competence." This is broadly defined to include the interest and ability to interact in specified ways with others, and the probable acceptance of the individual into one of the ward-specific social groups.
The expectations that are held about a new entrant by staff and residents are shaped by general knowledge held and shared about the particular ward to which the individual has been assigned. The act of assignment may be interpreted as including the placing of a frame of "communication predictability" on the individual. Staff members construct expectations for the behavior of others, and, in turn, anticipate how they (the staff) will need to interact with patients, based largely on the initial slotting. It is interesting that I never had difficulty at People's Home in inducing staff members to make generalizations about various patients. The staff members were apparently not hesitant to speak with me in terms of categories of patients. Further, their answers to my questions included explicit descriptions of assessment/reassessment criteria, and of the typical behavior observable in each section of the home. As the data already presented indicate, residents were often described in terms of their membership in a particular social grouping at the facility, or as being representative of a specific ward. This situation contrasts, as it will be seen (Chapter VI), with my interviews held at Sisters of Faith Home. At SFH, the residents were repeatedly referred to as "individuals" and staff members seemed hesitant to clump residents together in some generalizing statement.

Predictability conceptualizations also derive from discussions among staff members during their weekly meetings. Although it is true that certain expectations devolve on residents living on particular sections, it would be inaccurate to conclude that a ward slotting fully determines the associated behavioral outcomes. A number of criteria (some conflicting) are used to justify specific slottings, and, as noted.
in the previous section, ward sloettings provide a variety of behavioral options. Talk in the weekly staff meetings can be analyzed from the perspective of staff members sharing, being supported in, and being informed of the meaning and intentions behind particular assignments. The discussion on transfers above notes how staff members gradually negotiate specific reassignment cases during staff meetings. In addition to this, during the weekly staff meetings, Mrs. Richter reviews recent admissions, readmissions and ongoing problems with her staff. In the case of a new admission, Mrs. Richter provides the nursing and activities personnel present with background information on the new patient, his/her family, why a particular section choice was made, and the kind of behavior that can be expected of the patient.

(Minutes of the staff meeting, April 21, 1981): "New admission, John Gill, 'D-17,' typical vet."

(Minutes of the staff meeting, April 28, 1981): "Tony Santo, 'C-7,' typical vet. He was wandering outside the building over the weekend but has calmed down since then. His wife is very concerned and responsible. She works in a nursing home so she is very sympathetic to the situation."

(Minutes of the staff meeting, December 30, 1980): "Louis Harris 'B-10.' His son is very realistic about his father's condition while his mother is not. The son is very satisfied with placement. Mr. Harris needs to be motivated to do things. It was suggested that one of his exercises for the day should be to walk to the dining room. This would insure that he gets out of his room."

(Minutes of the staff meeting, December 30, 1980): "Mr. Sommer, 'B-18,' very nice man with nice family. He is only here for a short term. He can not take care of himself and his wife is in the hospital. He was originally placed in 'C-8,' but was moved to facilitate a more appropriate placement."

When Mrs. Richter refers to Anna Mehan as being "pretty much Anna Mehan" (i.e., no change) or to a new "C/D" male as "a typical vet,"
she is providing the other staff members with a set of classifications to be applied in various ways to all PH residents. These labels are used to indicate how similar the individual is to others around him or her:

(Staff meeting):
Mrs. Richter tells the group that she has just placed a new resident, Ethel Powell on "C/D" because of some slight confusion. She says that they've already got an order for bed sedation and that Ethel is "an appropriate 'C/D' patient."

(Minutes of the staff meeting, January 13, 1981):
"Ted Hoover, 'B-17,' a confused man who may have been misplaced. He seems to be like those patients on 'C/D.' This situation will be watched carefully. His daughter is very nice but is unclear about his condition. He had been living on his own for several months, but was really not capable of doing so."

The use of these terms is one means by which Mrs. Richter indicates to her staff the reasoning behind a particular section choice and the kind of behavior to be accorded and expected of the patient. It must be remembered that it is Mrs. Richter alone who is responsible for initial slottings. Staff members may be seen to need information from her at some point on the background of a particular case.

(Staff meeting):
The discussion turns to Mrs. Fogel, a new "B" resident. One of the nurses says that she has no clothing or shoes, and that she's been wearing the same dress since she came in. Mrs. Richter provides the others with the following information: "She has been, she's a widow. Her poor sister, Fogel has no children, she's had the responsibility for checking up on her, moral responsibility. This is a very sad case. The house was not taken care of, the sister says its roach infested." Carol says that this is perhaps why no clothing from the house was brought to PH. Mrs. Richter does not say anything to this but does say that the sister reported that Fogel never bathed. She also says that Fogel's family is really unable to take care of her, that they even had difficulty finding time to bring her to PH: "They're tied up in business. Their routine is five o'clock in the morning until late. I told them they could even bring her seven o'clock in the morning and even that was too late for them." Mrs. Richter says that they finally agreed to bring her in over the weekend.
(Staff meeting):
The staff turns to a readmitted patient, Mr. Tohn. Mrs. Richter says that the daughter-in-law is more demanding than the patient. Several nurses say that Tohn seems depressed. Carol says that she is going to have to apologize to Mr. Tohn, that she had tried to get him interested in going to activities when she first spoke with him but that she hadn't been informed that he is a recent widower.

As noted, the ward decision is made in most cases prior to the administrator's meeting with the patient. Thus, the patient enters the facility with a set of expectations imposed from "above," i.e., expectations held for a category of assignment. The patient may be unable to live up to these expectations upon entry, as seemed to be the situation in the cases of Dansk, Ford, Kanter and Fogel above. Under these circumstances, expectations are modified and/or transfer procedures instituted. Initially, however, Mrs. Richter apparently must share with her staff some of these expectations. One of the implications of being classified as a "veteran" or as a "typical 'C/D'" patient, for example, seems to be that there is very little expectation of entry or transfer trauma, i.e., no negative feelings about initial placement or subsequent reassignment to "C/D":

(Discussion with Mrs. Richter):
"With our 'C/D' patients, we expect they'll settle right in. A lot of them come from other homes or the hospital, so we expect them to know the routine."

Such descriptions and categorizations are further used to justify the kind of social life which is found on "C/D" (see below).

Terms of classification appear to be invoked when a resident breaks from the usual routine of a section. An example of this may be found in the case of the assignment of a somewhat confused man to "E" section:

(Minutes of the staff meeting, December 30, 1980):
"Knopf, 'E-101,' a nice quiet man who is well placed."
Under other circumstances, when a resident enters "E" or "A/E" section, Mrs. Richter and Carol (who, as director of activities and social services, interviews patients during their first few weeks at the facility) usually inform the other staff members of the importance of integrating the individual into "E" social life:

(Interview with Mrs. Richter):
"With 'E,' it's important to have them meet the other women. I know Carol tells the nurses to make sure to bring them out to the living room."

The reference to Knopf as a "nice, quiet man" is interpreted by the staff as an indication that (1) he is not to be forced to be included in "E" social life, but that (2) he may remain as an "appropriate 'E'" as long as he remains quietly in his room. Understandably, in this context, Mrs. Richter's words are later echoed by the nurse in charge of Mr. Knopf's care:

(Discussion with Mrs. Roght, RN):
"I like him—he's cute, I don't know. He stays pretty much in his room all day. This way he doesn't disturb anyone, but he is quiet. We don't bring him out to sit with the others much."

I will discuss below how the placement of a confused individual on "E" patterns a particular social career in the nursing home. It is interesting to note here that another confused male was assigned to "E" but he did not display the same quiet demeanor which characterized Knopf, his roommate. Since no other beds were available at the time, and the family members insisted he be allowed to stay on "E," no transfer was instigated. 21 Mrs. Richter's first staff meeting comments about Mr. Wulffwasser indicated a need to "make" his behavior more in conformity with the rest of "E":

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(Minutes of the staff meeting, May 12, 1981):
"Harry Wulffwasser, 'E-101,' he is extremely confused and highly combative. He is wandering into other rooms, ripping off his clothes and using abusive language. He has been given Haldol, but it will take time to build up. We will call the doctor to come in and give him something to calm him down in the meantime."

In other cases, the weekly staff meetings provide Mrs. Richter with a context which enables her to forewarn the staff of potential problems:

(Staff meeting):
Mrs. Richter brings up a new "A/E" patient, Mrs. Elias: "She was here previously, with her two sisters. Previously to PH, she was at Miles House, with a private nurse." Mrs. Richter says that Mrs. Elias and her family are not happy with the room and with the food not being Kosher: "We never told them that it was. We had the three sisters here, y'remember Minnie Elder. They all knew it wasn't Kosher. They all ate." Mrs. Richter says that there have also been some negative feelings about the room: "The daughter and her husband looked at the room. I thought '8' was good. They were stressing alert, alert, alert. Now they don't like it because the nurses put her on 'A' lounge."

(Minutes of the staff meeting, November 19, 1980):
"Elizabeth Ford, 'E-116,' pleasantly confused. Seems to have adjusted very well. Roommate, Mrs. Dale, is going to be a problem as Mrs. Ford goes into her things."

(Minutes of the staff meeting, September 30, 1980):
"Paul Munich, 'B-24,' an alert man in his 80's. Wife is totally unrealistic about his care and will prove to be a problem."

This forwarding message expressed to the staff permits them to act in certain ways with the patient and his/her relatives:

(In dining room):
Mrs. Short (dietician) walks over to where Mrs. Elias is eating. She asks her how the food has been, and Elias says that it is terrible, that she wants Kosher food. Short says that Elias knew that this was not a Kosher facility, and Elias says she knows that but there are certain foods she won't eat. She says she would like a piece of rye bread toasted—that she's never been given toast before, only "that
soft white bread." Short says, "Why don't we try a slice of whole wheat for breakfast tomorrow?" but Elias responds, "Please, darling, some rye bread toast, please." Elias then complains that she's been given sausages for one meal and she just could not eat them. Short repeatedly says, "We don't serve sausages," and Elias holds strong saying she knows she was served them. Finally, Short asks Elias if she means hot dogs and Mrs. Elias says, "You call it hot dog, I call it sausage." Mrs. Short says to Elias that she will make sure that she is no longer given hot dogs.

In this particular case, the patient eventually left People's Home:

(Discussion with Carol):
"Eva's family took her out. The family member had problems with us. Eva had too many complaints for us. She was the one who was here a year ago, or so, on a temporary basis. There were no complaints then. But, I guess, if you're paying forty-eight dollars a day or whatever it is, you feel you have a right to complain. She went to Stewart Nursing Home. I don't know if they're Kosher, that was one of her problems. She just didn't seem to fit into any of the groups here. I really don't know why. The family was very demanding, I know that."

In one variation of this forewarning behavior, Mrs. Richter provides a directive to the staff to watch a new patient and to prepare detailed documentation of all "bizarre" behavior. Eventually, both ward staff and administrative personnel collaborated in sharing information and in building a case about this patient. This mounting evidence was used to justify a particular treatment:

(Staff meeting):
Mrs. Richter begins talking about a new "C/D" patient, Miss Pasternak: "I have reason to believe she was in the psych unit at the hospital. They haven't sent us the hospital report, we don't know what the real diagnosis is. If she becomes physically violent, we can tell the hospital to take her back. Right now she's not violent." The nurses relate incidents of having touched Pasternak and then her responding by slapping their arms back. Mrs. Richter says she has seen this, and the staff will need to watch things closely: "Right now, she's just reacting. But we'll have to watch out for violence. I think she needs a tranquilizer. . . . I think we have to be firm with her. Medically she does not need a doctor. She does not need a nurse. We cannot spend all hours
shopping for her, exchanging the knee-length stocking for anklets. We're not a store. She has a sister downtown; that's why they wanted placement, that's why they wanted to bring her to Philadelphia. She has money; she can call up Wanamaker's, have them delivered to her. . . . She's more hostile now than when she first came. We're trying to change her routine. We can't let this one person devour us, it's just physically impossible. We're now at a hundred percent census. She's misplaced. In my heart, I know she's misplaced. She belongs in a psych unit."

(Staff meeting):
Mrs. Richter tells Roberta to document the fact that Pasternak refused to eat any food during the weekend. Also, she tells the nurse to document on the charts that Pasternak refused to see her relatives who came in from New Jersey to visit her, that she told her grandmother to leave the room, etc. She says that she's afraid that, once Pasternak is no longer on a VA contract, and if she "acts out," it will be difficult if not impossible to transfer her to another facility. She says that while she is on a contract, "they (VA) are responsible for her," and will have to take her off Richter's hands if she does become a problem.

In this case, the collaborative work proved so successful that a transfer to another facility was made possible:

(Discussion with Carol about Pasternak):
"She left. Apparently she was on a six month contract, and we were hoping to get rid of her. We were fearful of her affect. She was psychotic, but nothing in the records, VA records, reflected that, but we suspected that. We didn't think she was appropriately placed. Mrs. Richter requested her complete file from the VA. And that's how we found it, but it was all through a mistake. Someone sends the original house chart, the master chart, they made a mistake; they're only supposed to send a copy. To compound it, they sent it to People's Home in Maryland. Anyway, they never told us about the psychiatric diagnosis; they withheld all of that. We knew we weren't working with the usual depression associated with MS. I think we used that as a lever to get them to take her back. She was inappropriately placed here. There are no shrinks here daily. If on a good day she wanted passes going into town. There is no crisis intervention. I liked her, but I felt that she wouldn't attack anyone, but if she felt threatened she might lash out. So we took the first opportunity.
At the outset, Pasternak was labelled a "potential problem" and the staff members used this in time to effectuate a discharge.

One categorization that is applied to residents across all sections has become a code word used to describe a general pattern of adjustment to the facility. This is called the "Dr. Johnson syndrome," and is used to refer to a patient who insists that his/her tenure at PH is short-term (not permanent):

(Minutes of the staff meeting, September 16, 1980):
"Dr. Johnson, 'A/E-4.' Family does not want him told this is long term. Tell him it is a convalescent home. We discussed our view on the reality of not telling patient the truth but agreed for this time we would certainly abide by families (sic) and ease into long range plans at a later date. He should be observed for dining room."

Several individuals were admitted to People's Home with a presumed understanding between the incoming resident and his/her family members that institutionalization was temporarily needed for convalescence. From the resident's perspective, this implied that a doctor's release was certain and imminent. From the family's perspective, however, institutionalization was regarded as permanent. Family members said they assumed (or hoped) that the resident would decide on his/her own to stay at People's Home after living there a few weeks:

(Staff meeting):
One of the nurses brings up a resident, who lives on "A," and whether she should be allowed to make outside calls. It seems this woman is constantly calling her 94-year-old sister, who is also in a nursing home, to come and take her out. Her sister is full of guilt. Furthermore, the woman's daughter has stayed away from PH for quite a few days. It seems that the woman suffers from what the staff calls the "Dr. Johnson syndrome":

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the woman was told by the family that she would be living at the nursing home for only a very short time. They have been staying away ostensibly so the woman will adjust quicker. The woman does not leave her room, go to activities, etc. All she says is, "My daughter is coming to pick me up this afternoon."

Conveying the possibility that a resident represents another case of the Dr. Johnson syndrome is an indication to staff how the patient is to be best treated. First, the patient's insistence that he/she will eventually be leaving the facility should not be countered by staff members who possessed knowledge that this was not so. Although staff members vehemently espoused a "reality orientation" approach when interacting with residents, they were required by administrative policy to wait for the family members' willingness to have the resident informed of the truth regarding placement. Because residents' families were hesitant to comply with this, staff members found it difficult to encourage residents to attend activities or to make friends with others at the facility.

(Patient charts for Dorothy Keller):
Nurse's entry for 11/17/80:
"Resident appears to be alert, yet unrealistic and apprehensive concerning placement at PH . . . as evidenced by inappropriate remarks (about) 'going home today.' Maintains aloofness in attitude concerning surroundings, residents and staff. States she has no interest or need of events at PH as she is 'going home today.'"

(Minutes of the staff meeting, September 30, 1980):
"Dr. Johnson's family is beginning to cooperate more with the staff with regards (sic) to the doctor's care. Dr. White wants occupational therapy for him, but it is our opinion that he does not need it. Dr. White wants Dr. Johnson to keep himself busy doing something with his hands. Recreational therapy will accomplish this. Dr. Johnson doesn't come to activities and Carol seems to think it is because he doesn't think he will be here long so he doesn't have to be involved. If the family would accompany him to activities it might help."
These residents were therefore treated as short-term placements—often for many months—even though they were not; they could not be encouraged to eat their meals in the main dining room or sit with section mates in one of the lounges. Instead, and with minimal protest on the part of the staff, these residents tended to withdraw into themselves, waiting for the day soon to come (so they said) when the doctor would sign their release papers. In contrast with those entering the facility knowing full well the reality of long-term placement, these individuals did not wish any feelings of belonging and so resisted all efforts from others to involve them. Further, as might be expected from the previous discussion, residents, in turn, shunned those who were unrealistic in their outlook on the PH placement.

It has been suggested that the classifications conveyed to and shared by the staff members serve to regulate and to justify particular courses of action. What are these classifications and what are the behavioral expectations that are associated with each of the sections at PH? What are the contrasting life courses patterned by the different wards? One way of considering these issues is through the examination of the careers of patients who have undergone at least one transfer while residing at PH. This should provide some indication of the ways in which the recruitment system with reference to assignment/reassignment criteria is realized through staff-patient interaction. For purposes of discussion I will also contrast the careers of individuals who present similar medical and psychological diagnoses but have been given different section placements. Such an analysis of the data can be used to support the observations made in this chapter that, in both word (e.g., staff's verbalizable criteria for placement) and deed (e.g.,
their behavioral initiatives vis-à-vis the residents) a differential, and, within limits, flexible, ward system is continuously being constructed. Furthermore, this contrast analysis enables us to recognize that we are dealing here with social definitions of status and interactional competence based on the ideology and structure of a particular total institution. We can see that patient care is no simple reaction to biophysiological symptomatology.23

Since we have focussed upon the Ford case, it may be useful to begin the present description by considering events in Ford's post-transfer career at People's Home. It may be recalled that Ford's reassignment to "A" from "E" was prompted by increasing agitation on the part of her peers over the initial placement. Ford was ignored by them and not encouraged to attend the social activities of the "E" women (e.g., news and discussion, book club, Mrs. Bergman reading the newspaper to the other women). This dissatisfaction over the original "E" slotting was also voiced to the staff members, who, in time, began the necessary procedures leading to the transfer.

There are two principal components of Ford's life on "A" which I wish to discuss. First, Ford found near immediate acceptance by the other residents on "A" section. Second, Ford's wandering behavior was treated by the staff in a manner different from the way it was handled on "E."

The new environment to which Mrs. Ford had to make adjustment is summarized in the following statement by the director of activities at People's Home:

(Discussion with Carol):
"There's much more opportunity on 'E' wing and 'A' wing on one level or another (to make friends). More comraderie."
'B' wing—more loners. The fellows in 'B-102,' they stay to themselves. Our concern let's say with Mrs. Lutz (a 'B' resident)—she doesn't have much interaction. She doesn't have a confidant. We try to look after that. With 'A' and 'C/D' friendship, our hopes for them, that's really minimal. We're more concerned with stimulation on a basic level. We don't really—there's not much friendship there. The few that are really stand out. I think the big thing there is just getting them to interact. But 'A' is a unique case, I guess, it's really not like that totally. There are friendships there in the lounge, it's not always they don't always deal with each other realistically, but there's a certain amount of companionship, buddies there. They're protective of each other: 'She needs to go to the bathroom.' 'She had liver today.' And so and so. Like Agnes Latini and Raymond, although she's a quiet lady, they're alert. They look after each other. They occasionally talk to each other. They all hate Janice Lull when she throws things. They all sit together in that lounge together. They're together a lot."

During the first period of field work, the following observations were made of "A" section:

(After lunch):
I go to the lounge in "A" area. It smells of urine. About a dozen men and women are sitting around the one television in a semi-circle; most are sleeping, and one or two are watching the television; there is no conversation from this group. . . . Three of the women have catheter tubes . . . attached to them. A man with one leg amputated and a woman with . . . no legs . . . are dozing in front of the television. There is also much more talking to oneself taking place here than I have been accustomed to witnessing at People's Home. . . . I hear two women screaming, "Hello, mommy. Hello, mommy," rather loudly. This continues for quite some time, and reappears throughout the time that I am here. . . . A woman with a heavy Irish brogue calls me over and asks me something about the mail and cashing checks. I tell her honestly that I have no mail with me in my brown shoulder bag. . . .

Also, the following sociable, although somewhat confused conversation was recorded then:

(12:30 p.m., in "A" lounge):
Mrs. Karp has just asked me if I went home for Passover, to which I respond yes. I then take a seat on the opposite end of the room from her and overhear the following:
Mrs. Karposky: Do you make fry matzoh?
Karp: Where am I gonna make it?
Karposky: At home.
Karp: Oh, at home. I used to make it.
Karposky: Do you use chicken fats.
Karp: No, oil.
Karposky: I don't like chicken fats. It's not good for the stomach.
Karp: No, I don't like chicken fats.
Karposky: Here there's no good oil.
Karp: I used to love making it.
Karposky: Did you have bread for Passover.
Karp: No, I ate only matzoh.
Karposky: You're strictly Jewish?
Karp: No, but I ate out. But I didn't eat bread during Passover.
Karposky: That's okay. Seven weeks before Easter we'd have no meat. That's the religion.
Karp: Oy, I love gefilte fish. I haven't had it in three years, and when I had it last week I had three pieces. And I got so sick.
Karposky: I make gefilte fish.
Karp: What kind of fish do you use?
Karposky: Carp. Always use the carp. It's the best. With eggs and some matzoh meal.
Karp: I'm hungry. All I had for breakfast was
Karposky: That's right. That's all. Wait 'til we go home. We'll cook good.
Karp: They have good coffee here. I love the coffee.
Karp: Oh, Nescafe.
Karposky: With canned milk.

The latest period of field work further indicated the importance of the lounge to "A" social life, and the attempts that are made to provide the residents there with opportunities and a context for verbal interaction. In this regard, staff members became upset with one resident's family because of its efforts to discourage opportunities for resident interaction:

(Field notes):
Mary Nichols (an "A" section patient) is sitting with her son in the large hallway outside the living room and dining room. The son is trying to talk with Mary ... about the New Year's celebration. ... the weather, etc. One of the social service workers (Jane) walked up to me, pointed to Mary and her son, and said to me: "That's very interesting." She tells me that Mary's family keeps her hearing aide at home and gives it to her only when they come to visit. They say they are afraid it will be stolen or Mary will lose it. Jane then says: "He plugs her in while he's here, and he takes it when he leaves."
Sure enough, a few minutes later, the son tells his mother that he has to leave and he begins to take the hearing aide and battery case away from his mother as he says: "I'm going to have to take this off so it won't get lost. So I'm gonna say goodbye." The hearing aide is already removed by this time and so he waves goodbye to his mother. He walks her back to "A" lounge, where, a few minutes later, a nurse comes in and restrains her to a gerry chair.

In general, staff members do not pass judgment on the kinds of interaction that are found on the "A" lounge. Rather, they suggest that residents are provided with a context which permits whatever types of conversation they are capable of engaging in. The attitude of the staff towards its "A" charges is perhaps best summarized by the following chartings and comments:

(Nurse's chart for Janice Lull):
Notes by Mary, activities personnel, February 19, 1981 entry: "Confused: person, time, place. Pleasant, enjoys conversation, company. Although confused, socializes with other residents readily. Appears restless--walks through halls throughout day. Resident has expressed interest to 'be busy.' Attends some activities to date with solicitation, direction to activity."

(Discussion with Jeanne, activities assistant): "Some of the conversations are really quite funny. Take Mrs. Karposky: one day she's in, she's talking to the other women at that table, and the next she's yelling at you in Russian. But no one judges. They talk when they talk."

One resident who had been transferred from "B" to "A" prior to the start of the second field work at People's Home expressed this same idea by calling her new ward mates more "cosmopolitan":

(Discussion with Frances Smith, in dining room before lunch is served):
SJS: How long have you been living on "A" wing?
Smith: Damned if I know. I like the people on "A," they're more cosmopolitan, more talk, that's one thing for sure. But what do you expect, they're more sick on "B." We have a nice lobby (on "A"). It's in the front. I can see people and the grass. I like sitting out on the terrace.

Ford's transfer to "A" section was carried out one morning with the nurses on "E" dressing her as they usually did, and then escorting
her to the "A" lounge. At the end of the day, the evening "A" nurses showed Ford her new room, to which her clothing and other belongings had already been moved. During the day, a place was set for her near one of the long dining tables in the lounge. There she was restrained to a chair along with other residents. On subsequent days, she was similarly placed with other men and women from "A" around this table, or in a semi-circle near the one color television in the lounge. The following quotation from an aide on "A" indicates that Ford was expected to be fully integrated into this life and accepted by the other "A" residents:

(Discussion with Beverly, "A" nurse):
"She's sitting in there (points to the lounge) right now. Miss Ford will do just fine here. This is not your 'E'; we know it's different. She'll make friends here; there won't be any problems with that."

As noted, residents are seated either around the dining table in the second half of the room, or facing the television in the front half. There seems to be much opportunity for extended conversations throughout the day, such as the one between Karp and Karposky. The orientation of the two speakers in that dialogue is apparently somewhat distorted. What is interesting, however, is that it is through this talk that the residents of "A" cement the particular "buddy" relationship depicted by Carol (above). Consider the following also:

(Living room, mid-afternoon):
Mrs. Karposky is wheeled into the living room by an aide from "A." She is placed near Mrs. Latini— with whom she usually spends the day in the lounge—in the middle of the living room. I walk over to Mrs. Karposky to say hello, and she has a big smile on her face as she too says "Hello." I tell her they are going to have a birthday party, and she says "yeah," but I'm not really sure at the time if she understands. She slouches very low in her wheelchair, and her back is bent over in half. I try to get her to sit up, but this lasts for only a few seconds, and she goes back to being hunched over. Latini tells
me that she's stopped counting her birthdays, that she's had too many. I tell her that my birthday is this week, and she says to me that birthdays are still a big joke for me. Latini then says almost immediately after this that she is taking Mrs. Karposky to "the wedding" sometime in June. I ask: "Oh, really?" She says that Mrs. Karposky is a good friend to her and that Mary promised to take her with her when she is discharged, "to keep her company." I say that that does sound like a good friend, and Latini says yes, but she wishes she could understand what "puttah-puttah" is, i.e., what Mary's mumblings mean. I tell her I don't know.

(In "A" lounge, approximately 11:30 a.m.):
SJS: Mary, are you watching television?
Mrs. Karposky: Yeah.
SJS: What are you watching?
Mrs. Karposky: Sure. (She points to the television.)
Latini: She's going to watch TV when I take her home with me. I've got a colored TV. A nineteen inch, y'know nineteen inch across, like that one.
SJS: Good.
Latini: And if she wants a drink, I'll go to the kitchen for her. Beer. Wine. She can have what she wants.
SJS: Mary, you like to drink?
Mrs. Karposky: Sure.
SJS: Mary, do you know this woman?
Mrs. Karposky: Yeah, she's my cousin.
Latini: How do you like that? That's a real friend. I'm gonna take care of her for sure when we get out.

("A" lounge):
Agnes Latini, Mrs. Friedkin and Mrs. Raymond are seated around the television set. Friedkin asks Raymond if she saw a certain program on television last night; Raymond says that she had a stomach virus (?) and so went to bed early. Latini tells Friedkin that her roommate had the television on and they watched it together. She tells Raymond that the program will probably be on again.

Soon after her arrival on "A," Ford found herself a similar object of conversational attention:

(In "A" lounge, 12:15 p.m.):
Mrs. Ford is sitting in the front room, a few feet away from Mrs. King. She is restrained in a gerry chair and is trying to stand up. Mrs. King tells her to come nearer to her so they can talk, and Mrs. Ford tells her that she's coming. Of course, she remains restrained in the chair and is unable to get out.

(In "A" lounge, almost noon):
Ford is restrained to one of the low-backed vinyl chairs.
next to another restrained woman, Janice Lull: both women are about a foot away from the dining room table on the right of the second half of the lounge. They exchange a few remarks, but they both speak very softly and I am unable to make out specific words. Janice is handed a plastic cup with water in it by one of the aides. She takes a few sips as the aide walks away. When Janice Lull outstretches her arm but can't reach the table to put the cup on it, Ford takes it from her and puts it on the table. A little later, Janice reaches for the cup, takes a few sips again, and then asks Ford if she wants any. Ford takes the cup from Janice and finishes the water. Ford begins speaking in a very low whisper; I am sitting about two and a half feet away and am unable to hear what she says. Janice stops Ford in midsentence apparently and says: "If you think my hearing is good enough to hear you, my ears are not good enough, you're whispering." Ford continues speaking but does not raise her volume. Janice's eyes being to wander and she stops and fixes on my face. She smiles to me, and I smile back. She then points to her eyes while looking at me. I walk nearer to her, and, resting myself against the end of the long table, I ask her what she means. She says that I have beautiful blue eyes; she then says: "I wish you the best of luck." I thank her. There is silence between us after that, while a news update on Reagan's health condition is reported on the television. Janice Lull then says to me and Ford that it's a shame that someone assassinated the president. Ford says in her whispy voice: "I didn't know that." I tell her (Janice Lull) that an assassination was attempted, but that the doctors were able to save Reagan in the hospital. Her face lights up with a big smile and she says: "Thank you for giving me such good news." I ask her how long she's been living here and she says "For many years, since the end of World War II." I ask her where she is and she says Sons of Israel Residence. She describes being on some sort of governmental pension, but I am unable to follow her words and do not have more detailed notes than this. When she stops talking, I point to Ford and ask Janice if this is her friend, and she says "Yes, we go way back, y'know." I tell her I didn't know this, but am glad she has such a good friend. Ford echoes with: "Oh, yes. Very good friends, I know."

Although Ford's confusion seems to have been heightened during these conversations—as compared to when she was living on "E"—her level of observable nervousness appeared to me to have decreased. No longer was she constantly exhorted to "keep quiet" or were her queries for information ignored. She may now have received the wrong information when she asked a question of her ward mates, but she was
apparently treated by them as a full interactional partner. In part, this seems to indicate that they could all share with one another:

(In "A" lounge, mid-morning):
Mrs. Ford is given a can of food supplement by an aide who tells her: "Here's your milk shake, Mrs. Ford. Now don't you go sharing that with no one." The aide walks out of the lounge; Ford takes a few sips and then asks Mrs. Leomet opposite her if she wants it. She hands it to her, and Leomet takes the straw out and begins to drink.

Also, Ford was encouraged by the "A" staff to feel useful toward her ward mates. For example:

(Observations after lunch):
Betty Ford is wheeling Mrs. Zimmerman through the main hallway and into the living room. Betty stops every few feet so that Mrs. Zimmerman can say hello, exchange a few words with Nora Silverman, Marylou Edison (both sitting near the water fountain in the living room). Mrs. Bergman calls out to Mrs. Zimmerman, and when she doesn't hear, she tells me to tell her to look at her. Ford wheels her closer to Mrs. Bergman by moving one of the spindle-top chairs from area 5, and wheeling Zimmerman closer to the window where Mrs. Bergman is seated. Bergman calls to her: "Hello, dear." Mrs. Zimmerman holds out her hand and says: "There's my sweetie." Bergman says nothing to Ford.

One additional item of behavior might have contributed to the lessening of Ford's anxiety. When she first arrived on "E" section, Ford was handed a monthly activities schedule by Carol, the director of activities. Apparently understanding the importance of the calendar, Ford frequently referred to it (as well as to the other "E" residents) in order to find out "where we should be." On "A" section, her activities were more regimented, i.e., they were circumscribed by the staff, who restrained her when it was meal time, who came for her to attend a house-wide activity or entertainment, etc.

It should be pointed out that staff members encourage such interaction as that reported above by their presence in the lounge. All residents (except for a few bed-ridden ones) take all their meals in the
"A" lounge, and, moreover, are required to spend the entire day there. The television set is tuned to stations carrying soap operas, and, throughout the day, staff members (nurses, aides, and custodial personnel) from "A" and even other sections pop in to spend a few minutes with the residents and to watch these programs. In some cases, the residents themselves become the focus of the staff's conversations, while in others they are permitted (and encouraged) to engage in whatever talk that is going on:

(In "A" lounge):
Suspenseful organ music is heard on the television as one of the nurses walks into the lounge to distribute medicine. Nurse: What was that suspense I just heard?
Aide: Where?
Nurse: Weren't you watching? Were you watching?
Private nurse: I was showing her these pictures. (Points to an envelope that says Kodak on it.)
Aide: Oh, what's his name wants to know who had who took the checks from in his drawers and only Murdock had the key.
Nurse: Sean? Sean?
Aide: Yeah. Sean.
Private nurse: God, this has been going on for thirty years.
Janice Lull: It's the same story for thirty years.
Private nurse: It is, isn't it!

(In "A" lounge):
Mrs. Polo's nurse is sitting next to Mrs. King. She points out to King that she's wearing two different shoes. She tells her to uncross her legs and shows her the two different shoes. The two aides on the opposite end of the room start laughing and Mrs. King laughs too. She then says it doesn't matter, she's not going anywhere. The nurse asks her what would happen if she went out with two different shoes, and she begins to laugh. A picture of the Pope appears on the television, and one of the aides asks: "Why would anyone want to hurt the Pope?" Another aide says: "He really is a Pope of Peace. It's crazy." Mrs. Polo's nurse says that celebrities are going to have to wear a protective bubble with a helmet; she makes a gesture of the entire body with her hands. Lillian Gold stands up and says: "That would be just terrible." One of the aides says: "You think so?" Mrs. Gold responds yes.

(In "A" lounge):
The television is tuned into a news program. It is just after noon, and several residents still have their food trays.
Private nurse: Oh, she had a baby.
Aide: Who?
Private nurse: Patty Hearst.
Mrs. Polo: No big deal.
Nurse: No big deal?! She just had a baby.
Polo: Oh, a baby. Congratulations.
Nurse: Not me, Miz Polo, Patty Hearst.
Janice Lull: May I ask you something? Come here, please.
2nd Private Nurse: Oh, no. You're not gonna hit me.
Janice: Hit you. Why my dear!
Aide: Do you want some pear? Chew it, are you chewing it?
Janice: I can't.
Aide: Try. Break it up.
Janice: I can't. Take it.
Aide: Do I get a thank you?
Janice: What?
Aide: Do I get a thank you? I gave you something at least.
Janice: Yes, you did.
(A few minutes later, Janice strikes up a conversation with
Mrs. Lavey's nurse who is sitting next to her).
Janice: What hospital do you work for?
Nurse: I don't work for a hospital?
Janice: Are you a nurse? What hospital do you work for?
Nurse: I work in this hospital.
Janice: This is not a hospital.
Nurse: I work for the Jewish hospital.
Janice: They're good to work for.
Nurse: Yes they are, because you're Jewish.
Janice: I don't think I'd like to work with surgery.
Nurse: That was many years ago. Many years ago. Things are
different today.
Janice: I used to do that work.
Nurse: You did?
Janice: Yes, many, many years ago.
Nurse: That long?
Janice: And then I went into the army.
Nurse: Were you in the army?
Janice: Oh, yes. I worked in the hospital with the doctors.

Although I did not have the occasion to observe this, it was reported to
me that staff members occasionally held informal "parties" with some of
the residents in the evening. Perhaps this accounts for a scrap of
paper pasted to the side of the public telephone inside the lounge with
the name and number of the Roy Rogers fast food service.

One complication clouded Ford's life on "A"—she was allowed to
wander occasionally, but she was now also restrained for a certain
period of time each day. Restraint orders require a physician's
signature and usually specify the use of restraints for only limited periods of time during the day. Ford was thus permitted to wander through the facility:

(After lunch):
Ford is walking on her own through the living room. She props herself up on the counter which divides the dining room from the living room, and looks in on the housekeepers cleaning the tables in the dining room. Ford mumbles a few words to them which I am unable to make out; she appears to me to point to spots on the tables they are cleaning. They say nothing back to her. Ford is not carrying an activities schedule with her, and this is the first time I have seen her in the living room since the transfer. Ford walks over to Jacobs who is sitting in a wheelchair in area 5. Jacobs immediately waves her away and tells her to go away. Ford walks through the "E" wing doors, where an aide spots her and walks her back to the "A" lounge.

While wandering had previously been considered a problem and something totally inappropriate to "E" section, it was tolerated on "A" and only mildly complained about as an inconvenience. The remarks of one nurse sum up the "A" attitude: "We have our wanderers. No big deal." While this is true, Ford found herself in a paradox. With her transfer to "A," Ford's wandering was now more or less acceptable, but so was one staff device for controlling this wandering:

(In the living room, mid-afternoon):
Mr. Einstein has just finished playing the piano for the residents assembled in the living room, and the residents are beginning to disperse back to their rooms. I notice that Ford is restrained in a chair. She manages to stand up and begins walking out of the living room with the chair around her back. An aide stops her, makes her sit down again, and releases her from the restraint.

As previously noted, restraints are seen as a form of punishment and a sign of status deterioration by "B" and "E" residents. The limited and minimal use of restraints on "E" section is said to be the result of a staff assumption that no resident there requires them.
Further, the staff members say that the presence of restraints serves to upset residents. This is in spite of the fact that residents such as Dansk and Ford lived on "E" for varying periods of time. Presumably, Ford's mental condition did not change in the transfer from "E" to "A" section (at least during the short period of time I was able to observe this) but the social definition of Ford's condition did. Staff explanations about the use of restraints are likely to emphasize the fact that such restraints prevent wanderers from falling and hurting themselves. Nevertheless, the use of body restraints varies from section to section, and, in this respect, seems from my data to hold some social meaning beyond the purely utilitarian function. During her period of audition on "E," Ford was not restrained either in her room or in a chair in the lounge. Although Ford's apparently aimless walking was annoying to the other "E" women, staff members realized that if they were going to try and get Ford accepted, initially they would have to avoid the use of restraints. The transition from "E" to not-"E" (i.e., "A") status meant that bodily restraints were then acceptable. A similar incident can be observed with Mrs. Kanter's transfer from "B" to "A." Prior to the reassignment, staff members attempted to use medication and interaction to control Kanter's behavior. Her move to "A" legitimated the introduction of restraints.

(Interview with nurse on "B"):  
RN: We should get a restraint order for Kanter; then we could keep her away from Dr. Unger during the day.  
SJS: Why don't you?  
RN: We could get it. But she (Kanter) has friends here, and we're all agreed that probably wouldn't be good.  
SJS: What?  
RN: For them to see her for her to be restrained.

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In order to understand fully the contrast between Ford's pre- and post-transfer career, it is necessary to consider further differences between the two wards ("A" and "E") to which she was assigned at different times. It will be recalled that "E" section (with its addition, "A/E") is considered one of the best wards at People's Home. The definition of self projected by the residents and accorded them by the staff is constituted by a superior attitude vis-à-vis the other sections and residents of the facility.

(After dinner in living room area 6):
After a brief period of silence, Mrs. Scott says to me (without my asking): "I like the fact that we don't have to look at painted walls. That we have wallpaper in our rooms. I've visited other homes, and none has such a living room, with pictures and plants. I'm sure you know it, this place is top rated."

The majority of residents on "E" are women who live in semi-private rooms which are carpeted. Residents typically do not spend the majority of their day in bed, but rather with a group of women all drawn from "E." These women sit in the area of the living room closest to the "E" entrance and "E" nurse's station (area 4). We have already noted that while staff members regard these women as "cliquey," they consider this tendency to be proper and positive. Although the criteria for entrance to the facility are ostensibly stringent, one finds in actuality that the definition of sanity characterizing the "E" residents is a social attribution based on several appearance features: clean clothing, quiet demeanor, and neat hair. In my informal sitting and conversation with the "E" women, it was clear to me that the "E" residents saw themselves as distinct from the others who reside at PH. It is worth noting that, during the first period of field work, I was accepted into the "E"
circle almost immediately—I was allowed to participate in the weekly "private" bingo game and became a frequent object of the women's concern:

(Discussion with Sheila, director of activities during 1978 field work):
Sheila tells me that she notices that I've been playing bingo with the "E" women in the living room in the afternoons. I tell her that I don't particularly like bingo, but that it's a way to develop a friendship with the women. She says that I should be honored that they're letting me play, that they've rejected several residents whom she had suggested they include.

Upon my return to People's Home in 1980, I was once again encouraged by the "E" residents to share a meal with them in the dining room, to sit with them in the living room, or to engage in some joint activity.

(Field notes):
Today was the first day of my return to PH. Carol took me on a brief tour of the facility to reintroduce me to the place and the residents. We went through "E" section, where several of the women I had known from the earlier field work said they recognized and remembered me. In the living room, Scott, Thayer and Bergman all said hello to me, and said that they were happy to see me again. I told them that I was coming back to do another study, and they all said they would cooperate in any way they could.

Despite this friendly and inviting attitude towards me (and towards other outside visitors—the rabbi, a church group), in their speech to me the "E" residents disassociated themselves from my research, and, moreover, from the presumed objects of my research:

(Field notes):
Earlier in the day, Mrs. Bergman stopped me in "E" hallway to ask me "how your patients are going." I told her that my work is going fine, but found her question strange; I distinctly had the feeling that she was not including herself in the list of "my patients."

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(In living room area 4):
I sit on the sofa next to Mrs. Bergman and Mrs. Axelrod. In her faint voice, Mrs. Axelrod asks me if I am getting what I need from PH. At first, I am unable to understand Axelrod, so Bergman repeats the question to me. Axelrod shakes her head yes, this is the question. I say that everyone has been very cooperative. Mrs. Bergman then asks me if I am able to interview the "others" and, again, I say that everyone is cooperative. She tells me that she wishes me luck, and that she hopes I am able to get "them" to give me the information I want.

This behavior was consistent with the "E" women's tendency to disparage the other residents at the facility and to view themselves as more like the staff. As noted, this cliquish behavior was recognized by the staff. Furthermore, staff members recognized the importance of urging new patients to socialize with others on the ward, and, reciprocally, of inducing already established residents to allow the former to join in and be accepted:

(Nurse's chart for Mrs. Pollack):
Entry by Mary, activities personnel, June 18, 1980: "Resident is very pleasant, friendly, and willing to converse. Often sings to self in Yiddish, sings for others also. Patient appears to be adjusting at this moment, socializing easily with others, who let her. Patient is basically alert, but becomes disoriented, confused at times. Resident verbally expressed grief over recent loss of husband. It appears that the loss has left a large vacuum in patient's life according to son. At this point, patient will participate in some activities, but only passively, with exception of any Jewish activity in which patient participates actively. Goals: (1) increased socialization to overcome grief concerning loss of husband; (2) maximum activity participation. Approaches: (1) utilize relationships patient has already established (ladies in 'E' wing)."

(Discussion with Carol):
"... If someone goes into 'E' wing, it's a bit more cliquish in the sense, I get feedback from the patients about how they're reacting to a new admission. If the patient is friendly, they might be more solicitous, they take her in in the sense, if they really like the patient, they may bring them into the fold. But that also means the person can be rejected. ..."
The concept of "cliquishness" needs to be examined from two perspectives: in terms of (1) the rules which negate or make impossible the boundary penetration of particular persons and/or orders of information, and (2) the rules which internally sustain the interaction and definition of situation. The former data have already been presented under the discussion of exclusionary tactics by "E" (and "B") residents. It was noted that People's Home residents consistently act in a manner which can be seen to monitor ward behavior; in addition, or as an aspect of such monitoring, they avoid interaction with "undesirables" and reduce interaction when in their presence.27 The present discussion will consider the behavioral expectations which sustain interaction on "E."

The women on "E" section prided themselves on being alert. This was a term applied to them by the staff and employed by them in their own talk with me. Moreover, these women joined together in such a manner as to sustain a particular positive impression of themselves as being alert. They were interested in maintaining standards of life on "E" section and at People's Home in general which were expressly different from those on other sections. They placed a high value on a positive attitude. This definition minimized talk which might be heard as expressing negative feelings towards themselves or the facility:

(In the living room, 2:15 p.m.):
Mrs. Baron: Mary Ann, Marylou, did that woman (Mrs. Salk) have her food?
Marylou: I don't know.
Bergman: No, she didn't. She said she doesn't like the food.
Baron: Well, she's going to have to get used to it. She has to eat.
(In "E" corridor, right after lunch, near the nurse's station):
Thayer: Can I help wheel, can I help you, Marylou?
Marylou: Who is that? Betty? Betty, is that you?
Thayer: I'm sorry. Yes.
Marylou: Would you wheel me in there, by the water fountain?
Thayer: Hold on. Hold on. How is your new roommate doing?
Marylou: She cries all the time. I wish she'd stop that.
Thayer: I heard her this morning.
Marylou: When?
Thayer: They took me to a bath. You were still sleeping.
Marylou: I know. She's always crying.
Thayer: They (staff?) should, they should, I don't know what they can do, really.

The earlier field work at People's Home (Sigman, 1979), which was concerned with patterns of topic construction in a nursing home, primarily focused on the conversations participated in by "E" women. As noted there, and in an earlier section of this chapter, these residents did not sustain prolonged periods of talk, and silence was neither negatively evaluated nor judged to be something which should be avoided. Second, the brief moments of conversation which did exist apparently were bound by a "no complaints" rule— I interpreted this rule as enabling the residents to project and reinforce a positive image of themselves and of nursing home life. Furthermore, the "E" residents were seen to engage in a type of verbal game which apparently facilitated the construction of a "we-they" attitude (Goffman, 1961), i.e., a means of aligning themselves with their caretakers and distinct from other classes of residents.

Two facets of this behavior may be noted. In the first place, a particular joking relationship was sustained by the "E" residents (as well as some of the "B") with the staff, and the former prided
themselves on having this. Moreover, staff members encouraged this behavior:

(Near "E" nurse's station, 3:15 p.m.):
Scott: It's nice having a lady like you around.
Aide: Oh, yeah.
Scott: I tell you I'm out for ten days and you said: "I know, I didn't miss you once."
Aide: Ha-ha. Y'know what I said, I said I knew you was gone, the air was, there weren't no smoke.
Scott: Oh, you.

(In the living room):
I am sitting with Mrs. Scott and Edith in the chairs between the game table (area 2) and area 1. Mrs. Rought passes where we are sitting, and Edith calls over to her to light her cigarette. She doesn't hear this, and it is not until her return trip to "E" wing that the women are able to attract the nurse's attention. Mrs. Rought laughingly says that they need to speak up louder. Mrs. Rought walks away after just lighting Edith's cigarette, but Mrs. Scott calls back to her: "What about me? Mrs. Rought says that she should say something if she wants it done, and Scott feigns being insulted: "Oh, yeah." After Rought has lit the cigarette and has left, Scott turns to me to say that there is no ruling against patients lighting their own cigarettes, but that Rought "prefers it this way." She says that they won't be pulling anything sneaky when at a few minutes after three o'clock (when Rought is no longer on duty) they light their own cigarettes.

(Discussion with Renee Cooper, an "E" resident):
"They take very good care of us. And, did I say this already, they're human, we can talk with each other, or tell each other little things. It's very relaxed."

In addition to this, it was noted during the first field work that the "E" (and "B") females overhear the loud complaints by other residents during medicine distribution and have patterned a "game" version of this:

(After lunch, in Mrs. Scott's room):
Mrs. Nelson approaches Mrs. Scott who is sitting by her bed.
Scott: I don't think I'm going to take that today.
Nelson: You don't, do you?
Scott: Nope. (as she reaches for it—)
Nelson: Well, I'd offer you a beer, but I know you'd take it.
Here's water instead.
(They both laugh.)

(Near "B" nurse's station):
Mrs. Thompson: Your medicine, Mrs. Goldstein. Now take it like a good girl.
Goldstein: Only if you give me a cookie. I want a cookie like—(Mrs. Thompson walks away, laughing, says nothing.)

Sigman (1979) suggests that this behavior is a "transformation" of actual recalcitrance observed when senile residents are given medicine:

(12:00 noon, in "A" lounge):
Sarah did not see the nurse coming to give her the medicine as her back was to the entrance to the lounge. The following conversation ensues:
Nurse: Sarah, here I have something for you. (Sarah turns around and opens her mouth.—) Isn't it good?
Sarah: I don't like that. I don't want that.
Nurse: I don't blame you. Do you want some bread and butter?
Sarah: I don't like that.
Nurse: Do you want some cookies?
Sarah: Yes.
Nurse: I'll go get you some cookies. (—pause—) Do you want some water? I'll leave it for you.

(Near "B" nurse's station):
Mrs. Butt (LGPN) takes out three different pills and puts them in a paper cup.
Mrs. Seiler: That's enough.
Butt: What?
Seiler: That's too damned much. That's too damned much.
Butt: Take 'em. You have a headache. That's why you have so much.
Seiler: If I die, it's your fault.
Butt: If you die, it's my fault? Come on, dear. Take the medicine. Drink the water? Did you swallow them?
Seiler: Mm—mm.
Butt: No you didn't. Come, swallow them. I know you're sick, but swallow the pills and lie back down. Swallow the pills, dear.
Seiler: I did.
Butt: Up the tongue.

(Right before lunch, in "C/D"):
I am standing next to Mrs. Karposky, but have not said hello to her as yet. The nurse approaches, stirring a medicine container with applesauce.
RN: Mary.
(Mary looks up and immediately opens her mouth. The nurse puts the dipstick with some applesauce into Mary’s mouth.)
Mary: That's enough.
RN: That's enough? I'm not finished yet.
(The nurse puts a second dipstick into Mary’s mouth.)
RN: Here, that's enough.

In brief, "E" residents behave in ways which sustain patterns of interaction which maintain a definition of their particular relationship with the staff which all see as distinct from that of the other residents. This contributes perspective upon the significance of the exclusionary behavior previously described. The "E" residents at People's Home are apparently supported by the staff in their attempts at distancing themselves from other PH residents. The "E" residents' behavior is viewed by all as appropriate for incumbents of the "E" positions that are occupied, and can be interpreted to stand as testimony of the presumed correctness of the original slotting.

When the "E" residents are asked about how they spend their day, they usually refer to the living room, where they spend a good part of the day in each other's presence. As pointed out above, co-silence is seen by these residents as supportive. In the same light, such clearly regular behavior as the emphasis on positive affect conversations is seen as reassuring and as evidence for the group self-estimate. Other orders of behavior are similarly used. For example, Mrs. Bergman, a former elementary school teacher, spends a certain period of each morning and afternoon reading from the newspaper to the other women:

(In living room, 3:15 p.m.):
Mrs. Bergman is sitting on the wooden chair in area 4. She is reading the paper out loud. It looks as if she is doing this primarily for Mrs. Axelrod. She occasionally puts the paper down to make a comment about a particular article and receives acknowledgement from Mrs. Axelrod, as well as from Mrs. Pollack, and Mrs. Baron, sitting on the sofa in area 4.
As already noted, the absence of this steady-state behavior can in itself signal the presence of an intruder or inappropriate individual to the other "E" women. Although this is not its exclusive meaning, dysphoria or alertion is signalled by pattern violations (Birdwhistell, personal communication).

It can be observed that the self which is constructed by the "E" women is a product of the behavior directed to staff members and non-"E" residents, as well as by their interaction with in-group peers. Residents of "E" avoid being seen in an unflattering manner by the others. This may explain Marylou Edison's prolonged refusal to use a safety belt in her wheelchair, until sitting became otherwise impossible (see above). This similarly affects eating arrangements. The following incidents reveal the importance of keeping up a particular appearance with "E" ward mates, and the lengths to which residents go to accomplish this:

(Staff meeting):
Roberta Brim, food supervisor, says that Nora Silverman has continued to refuse to have her meat ground. Mrs. Richter asks if she's lost weight, and Mrs. Barry, RN, says she has. The suggestion was made that perhaps Nora would not want to be seen by the other women in the dining room eating ground food. Roberta says that she has already brought this up to Nora, but she refused the ground food and to be taken out of the dining room. They all agree that nothing can be done to force Nora to take her meals ground, and so they will just have to wait for her to come around. In closing this discussion, Mrs. Victor, LGPN, says that she knows that the reason Mrs. Axelrod eats in her room instead of the dining room is that she refuses to allow the other "E" women see her being fed by the aides.

Although there are exceptions to this, most of the "E" women eat their lunch and dinner in the main dining room. From the staff's perspective, assignment to the dining room contributes to the definition of the relative status of the resident. Staff meetings were often taken up by
a discussion of a new resident's request to be served meals in the dining room, and the necessity of shuffling patients (often excluding some) in order to accommodate the newcomer. This is not subtle. In one instance, a new resident to "A/R" vehemently protested being made to eat in the "A" lounge. She wanted to be reassured that she could eat in the same location as her roommate:

(Field notes):
I eat lunch with Roberta Brim, Carol, Mary and Jeanne in the staff meeting/dining room. Most of the conversation does not revolve around PH or residents (e.g., wok cooking), but at one point Roberta makes the following observation about one of the newer residents, Eva Elias: "She asked me, 'Do I eat in the same lounge as Louisa?' I think she's afraid we're going to put her in the 'A' lounge."

Thus, placement in the dining room for the "E" women was a further indication of the appropriateness of the individual for various types of social interaction.

The pressure of "keeping up" is also seen in the emphasis that "E" women place on a weekly or bi-weekly appointment with the beautician. This is similar to their insistence on being dressed in street clothing in the living room.

Concomitant with the pressures to "keep up," the "E" residents manifested a solicitous and caring attitude towards their peers. During their meals in the dining room, for example, the residents looked after each other's needs, checking to make sure that the correct meal tray had been delivered, or, in some cases, helping them cheat on a particular meal:

(In dining room, noon):
As Tony (a "B" male) approaches the table, Mrs. Bergman tells him that his shirt tail is hanging out. Tony looks behind him, realizes this is so, and then thanks Mrs. Bergman. The trays have already been delivered and put on the tables as Tony sits down. Bergman, Betty Thayer,
Frances Smith and Esther Salk are already seated. Everyone at the table gives Betty the parsley on his/her tray. The women all give Tony the small plastic cups filled with milk from their trays.

(In dining room, noon):
Anna Pollack, Mrs. Ricardo, Nora Silverman and Renee Cooper are all seated at one of the large round tables to the left of the room, as one first enters. Anna Pollack places her ice cream on Mrs. Ricardo's tray. Mrs. Short, the dietary consultant, is walking past the table as Pollack does this, and she tells her to take back the ice cream. Pollack removes the ice cream cup from Ricardo's tray; she makes a sheepish grin to Mrs. Short, who is standing at the edge of the table opposite Pollack, to me, and then to Ricardo. While this is happening, Mrs. Renee Cooper leans over to Nora sitting next to her and says to her: "I'll get someone for you." Nora blinks her eyes. Mrs. Short walks away, toward the opposite end of the dining room. Renee Cooper says she'll call for an aide to feed Nora.

The aide goes for a chair, places it next to Nora, and begins feeding her. Ricardo calls Roberta to come to her by beckoning: "Complaint. Complaint." Roberta, who is in charge of food services, approaches the table and asks what the problem is. Ricardo complains about the dessert she has been given (an apple) and Roberta then turns to me to tell me that normal blood sugar levels are between one hundred and one hundred and forty, but that Ricardo's is four hundred. I say nothing.

(In dining room, noon):
Mrs. Bergman receives her tray first, and Thayer a few seconds later. Thayer looks at her tray and then at Bergman's; she remarks on the fact that she did not get any bread pudding. Bergman asks her if she wants hers and Thayer says: "I guess it's diabetic," i.e., indicating that it is probably not for diabetics, which Thayer is. Without saying anything, Bergman puts the plate with the bread pudding on Thayer's tray. Thayer says nothing. Mrs. Salk hands Bergman a piece of fresh parsley from her plate, and Mrs. Bergman automatically puts this on Thayer's tray, along with a piece of parsley from her own plate. Mrs. Green and Mrs. Smith both gently toss pieces of parsley onto Thayer's tray; Tony stands up (he is sitting at the opposite end of the table) and does the same. They all eat in silence for approximately four minutes. Then Thayer asks Tony if he wants her roll, which he says he does. Thayer passes it from her tray to Mrs. Bergman, who then passes it on to Tony. Over the next few minutes, the women pour some
of the milk from the little plastic cup into their coffee containers. They then pass the remaining milk to Tony.

This case of meal time in the dining room demonstrates the fact that the residents behave in ways which monitor each other in contexts outside the living room. Furthermore, while controlling, the residents at the same time accommodate to each other's personal tastes and needs. Interestingly, it is in the breach or in the absence of supportive social etiquette that changing inclusion in "E" social life is signalled for a patient:

(After noon, in the dining room):
Several of the women from "E" are still seated around their table in the dining room after the trays have been cleared. I am sitting a few feet away, by the entrance to the dining room from the main corridor. Mrs. Smith, formerly a "B" resident now on "A," who usually eats with the women, gets up and leaves the table. After Mrs. Smith is gone, Mrs. Thayer turns to Mrs. Bergman, sitting to her right, and says that she notices that Mrs. Smith left the parsley on her tray. Mrs. Thayer is half laughing while saying this, but Mrs. Bergman asks her if she wants it. Thayer says no. They all sit in silence for about a minute, and then Mrs. Bergman says that she notices that Mrs. Smith no longer sits with the other women in the living room in the afternoon. Thayer says she usually notices Smith in the "A" lounge when she goes for her daily walk. Thayer says that Mrs. Smith has been staying to herself ever since being moved to "A."

Birdwhistell's (1970) suggestion that integrational communication is at least as important as new information transmission seems well served by these examples. A patient's deviations from the otherwise continuous and predictable flow of social amenities (i.e., refusal, forgetting, etc.) are taken by his/her peers as an indication of failing status, the inappropriateness of the present slotting, and, most likely, the individual's withdrawal from "E" routines.
Interestingly, during her first few weeks at People's Home and prior to her transfer, Ford was allowed and encouraged to be part of the mutual caring that characterized "E":

(Field notes):
I take a tour of "E" section and stop outside Mrs. Dale's room. I notice that she is standing in front of the full length mirror opposite her bed. Mrs. Ford is standing behind her, holding a brush in one hand and some of Dale's hair in another. She is gently brushing Dale's hair, and then helps her put it into a braid.

The gradual disaffection for Ford was indicated by her roommate's refusal to allow her further participation in this grooming, and by the other "E" residents' apparent avoidance of interaction with her.

The staff members seem to support a particular mythology about the "E" women. These women are considered the most alert patients, yet this definition seems not to be based on strong and explicit evidence. The staff members of "E" have not been confronted by the incontinence and disorientation which is said to have changed the character of the next best section, "B." This set of attitudes about "E" provides the staff with a set of standards, a conception of their charges and a broad description of the behavior to be expected of them. As the notes cited throughout this chapter indicate, "E" residents are perceived as being relatively independent, and as restricting interaction to a select group of people. Except for "protecting" the residents from an inappropriate placement, e.g., an unsuitable new patient, the need for staff intervention in the activity routines and daily social life of the "E" residents was felt by the ward nurses to be minimal. Consistent with this, few efforts were made by the staff to include "E" residents in certain house-wide programs. The women on "E" were expected to attend
and contribute to the news and discussion group, but were not required to be part of the various exercise programs. Moreover, it was assumed that they would create and participate in their own activities. Such programs include the private bingo games, Mrs. Bergman's reading of the newspaper to the others, and the like. Exercise programs were conducted by the staff in the "C/D" lounge, and in the dining room, but the only "E" women asked to attend were those few who lived on the four-bed unit described earlier.

The above discussion indicates certain broad patterns of behavioral expectations shared by the staff members for residents of "A" and "E" sections. Foremost in this regard, both "A" and "E" are characterized by an emphasis on socializing with section peers. However, this emphasis is interpreted differently for the two sections. It was noted that a major shift in the behavioral treatment of Ford was signalled by her transfer from "E" to "A" section. While both sections regulate a particular degree of interaction, Ford's ability to live up to these pressures made her appropriate to one section but not the other. Perhaps the chief difference is that in "A" socializing is controlled to a large degree by the staff, whereas such activity is carried out predominately by the residents in "E." Many of the "A" residents are bed-ridden or require wheelchair assistance, and the expectations and demands placed on them by the nurses and nurse's aides force them into the living room and to activities. There is very little choice for the "A" residents in this regard.

"E" contrasts with "A" in the interpretation of the treatment rules based on physical dependencies. Staff members assume that after a brief adjustment (1) the new individual on his/her own will seek out the
continued company of the other "E" residents, (2) the other "E" residents will take over the task of introducing the initiate to routines and personalities in the home, and (3) the individual will be allowed to remain within the initial slotting to the extent that he/she is accepted by the others. This takes a number of forms. In the following case, a new "E" resident was forced to spend the entire day seated in the living room to become oriented to social life there. Nevertheless, this patient was eventually transferred because she continued to complain about being institutionalized, refused to leave her room, and, in time, was avoided by the other residents:

(Near "E" nurse's station):
I am asking the RN about Ann Streiber, an "E" resident confined to a wheelchair, who is crying to everyone in the living room that she wants to be taken back to her room. She says: "Mrs. Streiber would be content to stay in her room all day; but this is no good for the patients. We try to get them out even if they don't talk to anyone. Her family and her doctor want her to be in the living room. I'm trying to get her active in the book club."

"A" residents, on the other hand, are not expected by the nurses to be in control of either their own adjustment or the audition procedure. Recent and seasoned residents alike are brought into the lounges or allowed to rest in their beds; they are permitted to wander or are restrained in wheelchairs and high-backed "gerry" chairs—all as these are prescribed by the nurses' work schedules and routines. A transfer out of "A" ward usually results, not because of peer rejection, but as a consequence of the staff evaluation that the resident can no longer benefit from and contribute to lounge social life.

Another ward should be added to the contrast analysis. In order to explore some of the above differences further, the careers of two male residents, one from "C/D" and the other from "E," will be compared.
These two patients initially presented very similar medical conditions to the administration. This comparison should underscore some of the differences in behavioral expectations found among "A," "C/D" and "E." This should provide further insight into the importance of the ward slotting (apart from individual biophysiology) for individual patients' careers. The two men, Mr. Bosch and Mr. Knopf, entered People's Home one week apart. Bosch entered "C/D" one week before Christmas and Knopf entered "E" during Christmas week. The men were diagnosed at similar levels of disorientation; both were somewhat confused as to where they were or what time in their lives it was.

Mr. Bosch was placed in a double room on "C/D" because his son agreed with Mrs. Richter that this area was best equipped to handle his confused behavior. While Knopf also was reported to have periods of confusion, he was placed on "E" section. At the time of admission, "E" had the only available bed, and Mr. Knopf's family was willing to pay for such a spot. As noted above, certain "inappropriate" slottings to "E" are made to the four-bed unit there; this was Knopf's initial assignment. The differences in slottings seemed to shape the institutional careers of the two men. Knopf spent his entire day restrained in a wheelchair in the room with his roommate, Mr. Wulffwasser, with whom he constantly fought, and who was kept in the room all day under physical restraint and medication. Mr. Bosch, in the double room on "C/D," on the other hand, freely walked throughout the facility, and, over time, became acquainted with a few of the other men at People's Home.

In reviewing this situation, it seemed to me that, in order to preserve the integrity of "E" area, an "inappropriate" individual is

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likely to be chemically or physically restrained in his/her room. The restrained patient thus receives very little contact with peers. In addition to this, since such patients are tucked away in the room all day, they are further removed from the eyes of activities personnel. Whereas the "C/D" wanderer is visible and so more likely to be included in activities, the census records of attendance at house-wide activities indicates the prominent absence of "E" men like Wulffwasser and Knopf.

Wulffwasser and Knopf, to reiterate, remained in their rooms for most of the day. They were not brought out to the living room as was the custom with other "E" residents. Consider the following descriptions:

(In "E" section, 3:00 p.m.): Mr. Knopf is seated in a chair in his room. He is fully dressed and apparently he is sleeping. His head is resting on the portable bed stand.

(In "E" section, after the change of shifts): I enter Mr. Wulffwasser's room. The nurse says to an aide coming on duty that she won't have any trouble with Wulffwasser. He is totally naked, and is restrained in bed; he is wearing only the restraining bib and a shirt. The nurse says that Wulffwasser said that he prefers to sleep naked. She says that he hasn't gotten out of bed all day, hasn't eaten or voided anything. She tells the aide that she doesn't think he'll be a problem tonight. She says that he's been taken off his medication, but that that hasn't worn off yet. She says that his doctor will be visiting tonight, and that he should check Wulffwasser's meds.

The men left their room for brief therapy walks only. Incidents such as the following prompted the nurses to place both men under sedation:

(In "E" section): Mr. Wulffwasser, a new patient, is brought into the living room after his wife and daughter leave. He sleeps there for about half an hour and at the 3:00
shift change he is brought into his room. The nurse restrains him to a chair opposite from where Mr. Knopf is seated. Wulffwasser begins to squirm; he becomes agitated and begins shouting. After the nurse has left the room, Wulffwasser is actually able to get out of the restraint by slipping through from the bottom. He takes his pants and shoes off. I call the nurse who enters the room to see what happened.

Knopf: Someone tied him up.
Nurse: Tied him up? I did.
Knopf: You tied him? That's a bad girl.
Nurse: Why?
Knopf: I think, leave the man loose. The man didn't do anything. You do it again. You see you pass by here you get in trouble.
Wulffwasser: No, don't do that.
Nurse: What's the matter, Mr. Wulffwasser?
Wulffwasser: My shoes.
Nurse: Who took your shoes off?
Wulffwasser: He did.
Knopf: I didn't. I'm blind. 33 Mister, don't say that.
Nurse: Mr. Wulffwasser, he didn't take your shoes.
Wulffwasser: He put this on me.
Knopf: I didn't tie you up. Go find out the person who tied you up. (The nurse leaves at this point without saying a word).
Wulffwasser: Oh, shut up, you dope.
Knopf: Shut up, dope. Okay. I can't help you. Give me a hundred dollars. Give me five hundred dollar dollars. I can't help you. What are you doing? I can't see what you're doing. Where do you live, Mister?
Wulffwasser: Now you have me tied up.
Knopf: What, what?
Wulffwasser: Oh, fuck. Go home.
Knopf: I am home. This is my home.
Wulffwasser: Tink, tink, tink. You son of a bitch.
Cocksucker.
Knopf: Call me a son of a bitch?
Wulffwasser: Give me a scissors.
Knopf: I can't find it.
Wulffwasser: Don't you know what a pair of scissors is?
Knopf: Of course, I know what scissors are. I gotta go into the kitchen to find the scissors. How am I gonna find it?
Wulffwasser: You're a bastard and a son of a bitch.
Knopf: Don't you call me a son of a bitch.
Wulffwasser: Well, you are. You won't last long. That's what I tell you.
Wulffwasser's charts indicate that the nurses considered him "difficult" until the medication took hold.

Knopf's confusion was said by the nurses to eliminate his involvement in activities. It was said that he was disruptive and that he would not benefit from activities participation:

(Patient chart for Mr. Knopf):
"Mr. Knopf is an 87-year-old white male who is confused. He requires total nursing care with all of ADLs. . . . He requires a lot of TLC and asks to be told about everything done to him because of poor eye sight. . . . He attends social and recreational activities rarely because of his confusion. He was ordered Benadryl 25 mg., q.i.d. prn agitation."

It is significant that this excuse was never given for confused "A," "B," or "C/D" patients, and that these patients were encouraged to attend house activities and entertainments.

One interpretation of these data is that "E" wing was unable to accommodate a confused patient without restraining him and circumventing his interaction with others. "E" section is apparently not staffed with enough personnel to allow for constant monitoring of such individuals (a one-to-twelve ratio, as opposed to one-to-nine for other sections). Moreover, nurses on "E" are not prepared to handle a patient who does not conform to the "E" pattern considered above. As noted, during their talk about patients such as Wulffwasser and Knopf, staff members are not provided with the usual descriptions of an "E" resident, and are not offered alternative plans for action. More accurately, the alternative they are supplied with discourages them from attempting to bring such patients into "E" social life.

(Discussion with Carol):
"We have two rooms, four-bed units, where the patients are not up to the rest of the section. The women can take care of themselves, but they are more confused"
(than the other 'E' patients). Mrs. Feigenbaum used to be in a double room, but now she's in the quad--she's incontinent a lot. Lucy Fischer looks after her. I think it satisfies some need for Lucy. The men there are very different, difficult. The nurses keep them pretty much to the room, or else they're noisy. There's not much else the 'E' nurses can do for them. We have no activities."

It should be pointed out that, except for a few aides who are rotated, all nursing staff members are assigned to particular wards and develop ward-specific routines. In the present instance, the social integrity of "E" section is marred by a patient whose behavior does not meet the rather high standards of both the personnel and the other patients. Thus, one frequently finds the staff members and the alert patients jokingly exchanging comments about the various confused patients with whom they briefly come into contact (also see above).

In contrast with the "E" situation, "C/D" section allows for two types of patients: those who are very sick and need the constant supervision provided by the staff in the lounge area (similar to "A" patients), and those who are ambulatory, although somewhat confused. The director of nursing refers to the multiple patient types in the following citation:

(Discussion with Ms. Serreno):
"'C/D' is the easier one to start with. That unfortunately . . . the general standards are not up to the rest of the house. That's obviously why the VA contract men go there. Physically it's just not the same. You have some very confused people, and then you have Frank--he's compulsive but really not confused. There is not one group there. Some psychiatric problems. Some senile groups. It's not a tense group there, it's very relaxed. People who are confused, can't walk on their feet; there's very little demands on them. They can all go off and do their individual things."
Mr. Bosch, the contrast person on "C/D" for Knopf and Wulffwasser, is of the latter type. Bosch was frequently found in the company of other "C/D" men, walking the hallways or occasionally sitting at the edge of someone's bed talking. In addition to this, Bosch's presence in the hallway and lounge in "C/D" wing made him a prime target for being asked to join home-wide functions. For example:

(In the hallway outside the dining room): Bosch and another man from "C/D" whose name I do not know are walking back and forth in the hallway. At one point, Bosch looks down at the man's pants and notices that his zipper is open. He tells this to his friend, and when the man does nothing about this, Bosch zippers the pants for him.

(Mid-afternoon, in the living room): Bosch is escorted into the living room by Carol who tells him that the rabbi is going to be here in a few minutes. She takes him to a seat near area 3, with the chairs facing the center of the room. Jeanne walks up to Bosch and gives him a prayer book and a skull cap. Carol and Jeanne begin to walk away, and Bosch stands up. A big smile all of a sudden appears on his face as Mr. Rice, sitting about eight feet directly opposite him in area 2, waves to him. Instead of sitting, Bosch begins walking to where Rice is seated. He passes behind Carol, and, as she turns around, he asks her if he can sit "over there," pointing to an empty spot next to Rice. Before he hears her answer, he quickly walks the remaining few feet and approaches Rice: "I haven't seen you for such a long time." Rice tells him to sit down next to him, and they both shake hands once Bosch has seated himself. The rabbi then comes over to the two men to say "Shalom," which they extend to him also.

(In "C/D" lounge, just after lunch): Bosch is seated a few feet away from the television. Mary enters the lounge and looks around at who is there. She walks up to Bosch and tells him she's going to take him to the concert in the living room, that there is going to be a piano player there in a few minutes. She gets him to stand up and walks with him out of the lounge.

(Discussion with Jeanne, activities personnel): SJS: Who do you how do you decide who to take to activities? Jeanne: It's really by chance. I'd say, whoever is
around at the time, sitting in the living room already, or in the lounges if we poke in there.

Bosch was not the only resident on "C/D" to be a wanderer:

(Field notes):
Mrs. Powell was observed walking through the "C/D" corridor with a newspaper under her arms and also carrying a pocketbook. She walks through the dining room and into the "B" corridor, where she takes a chair next to Mrs. Kanter and Mrs. Seiler near the nurse's station. Seiler and Kanter sit only a few minutes longer, and then leave to their respective rooms. They do not say anything to each other as they get up to leave. Powell also leaves after a few minutes and returns to her room on "C/D."

(In "new B" corridor):
Mrs. Powell is walking through the corridor, poking her head into some of the bedrooms. She asks me if there is a ladies room here she can use. I say there isn't any and she will have to go back to her room. She asks me where that is and I tell her I will show her. We walk through the remainder of the "new B" corridor and into the back section of the "C/D" corridor. I offer her my arm at one point, and she interlocks hers with mine. We approach her room, "D-10," and I show her her name outside the door. She says she never noticed it before. She asks me if she can go in the room and I say yes. She asks me if she can use the toilet in the room, and again I say yes. She enters the room, and I walk further down the corridor.

(In "C/D" corridor):
I observe A. Henry shakily walking down the corridor with his cane as I enter the section. He is holding on to the hand rails as he moves from room to room, looking at the name plates on the walls outside each room. I approach him and as I do, I say hello. He asks me: "Do you know where Henry is?" I ask who Henry is and he says he is. I tell him I'll take him back to his room. On the way, I ask him how he is today and he says "miserable." I ask why this is so and he says: "What can you expect from someone almost ninety." I ask when his birthday is and he answers that it is this month (which is February). I ask him the date and he says that his birthday is July 21. We approach his room, and I show him his name on the nameplate.
The nurses' entries for these patients rarely indicated "wandering." Rather, references to this mobility were usually worded as "the patient spends part of the day off the ward." This is not to say that staff members were not aware of the "C/D" patients' confusion and peripatetic behavior, rather that this was not recorded (or negatively sanctioned) as "wandering." In this regard, "C/D" is the most institution-like of the four sections, but it is also the one which places fewest demands on its patients:

(Discussion with Carol Jones):
Carol: "A" is a bit more serene. I know they have their crazy days every once in a while, but there's not as much noise there. They seem to have an easier time of it than on "C/D." That's the most institutional. That's defined in terms of being an institution, it's very regimented.
SJS: Why is "C/D" perceived as an institution?
Carol: The floors are always being mopped, someone's always being dragged down the hallway. It's a long hallway. Physically, the hall is longer and the lighting is harsher. You've got tiles on the floor which don't match; they replaced broken tiles with whatever they had. I haven't been in there recently, but when I first came, but I know they used to give their treatments there in the lounge. For example, they empty the catheter tubes in front of everyone. It just has more of an institutional feel about it.
SJS: You said that it's more regimented.
Carol: Some of them have to sit in the lounge all day, they're restrained there. Or they never get out of bed. You've got a lot of people who stay off the ward, the section, all day. They sit in the living room, or they're off on their own on that patio area. I don't think they all know where they are, but, you can all see them coming back to "C/D" for meals. They go away and come back.

Wandering is thus not considered inappropriate on "C/D," and restraints are generally only used for wheelchair-confined patients.

The "C/D" residents spend their day much as the "A" residents do, i.e., sitting in the lounge watching television, or pacing through the hallways or in their rooms. However, there was very little of the
staff-patient interaction that characterized "A" lounge. This is because "C/D" is considered a "heavy" section; it has one of the largest resident populations, many of whom are bed-ridden, incontinent, etc., and so staff ostensibly do not have time for this. Three or four times a week a different activity program (e.g., baking, exercises, arts and crafts) is brought into the lounge, and these residents are also encouraged to attend the house-wide birthday parties and bingo games.

As was found on "A" and "E" sections, the "C/D" patients were very much aware of each other's idiosyncracies and personal needs. Because "C/D" is occupied by a large proportion of veterans, the rumor circulating about these men by the other residents is that they were all "shell-shocked during the war." Staff members view the men essentially as loners:

(Discussion with Sheila, activities director during the 1978 field work):
She says to me: "We know they are different," and that the veterans function well in the home because they need a protective environment. . . . She says that most of the men are placed in "C/D" because it is an environment best suited for them to function (in that more services are taken care of for them). She says that most of them are not social people, that they tend to stay "pretty much to themselves. They get together now and then, but really they find their own little niche and stay there."

Despite this, the men and women on "C/D" had managed to construct a miniature "society" of their own, although this had largely escaped the attention (or concern) of the staff. This was in part due to the fact that "C/D" residents were not under the constant surveillance of the nurses, but perhaps more to the point, "C/D" section and residents were simply not defined as requiring or benefiting from group behavior:
(Discussion with Ms. Korn, LGPN):
"Sometimes you'll see someone wheeling someone else, but that's as far as it goes. They're not aware of each other, where they are..."

In contrast to these staff perceptions, throughout both periods of field work, it became evident to me that in the exchange of pleasantries, in their helping each other because of physical or mental incapacities, etc., these residents did manifest an acute awareness of each other:

(In a "C/D" room):
I tell Frank: "Boy, whenever I see you, all you're doing is lying in bed, Frank." He says: "That's what there's to do when you're a patient in here. Ain't it?" I tell him that I suppose so, and I am about to walk out the door when Frank asks me to go on a walk with him. At first I think he means within the building, but he tells me that he wants to take me around the building where he usually goes off. Frank escorts me through the "C/D" lounge and out onto the patio facing the front of the PH lawn and Nelson Avenue. Frank introduces me to Mr. Palling, who is sitting in a garden bench on the patio. Palling tells me that his birthday is today and Frank tells me that his birthday is next Saturday. I say happy birthday to both men. Frank asks Palling what he's going to get him for his birthday; Palling thinks a minute, and while he's doing that, I say to Frank: "What're you getting Mr. Palling for his?" Frank says he gave Palling two dollars. Palling says that he gave Frank two dollars last year, who returned it as a present this year. Palling says he wants to think of something different for this year. I ask Mr. Palling how old he is. At first he says sixteen, laughs, then says sixty. I ask Frank how old he will be and he says sixty-seven. He asks me if that's old and I say there are older living at People's Home. Palling says: "Oh, they last. Whether it's good or bad, they last."

(Staff meeting):
One of the nurses says that she will check to see if Mr. Palling has been buying extra cigarette lighters from the stockroom and then giving them or selling them to Mr. McCauley another "C/D" man, who is not allowed to smoke. She says that she knows that Palling occasionally does this for the other men.
(In "C/D" lounge):
Mr. Ball lights a cigarette for himself. He then goes around to several of the amputees in wheelchairs and offers them a light.

In part, the definition of these people as "loners" legitimated the lack of constant staff interaction with these residents and intervention in their routines.

In a sense, "C/D" section consisted of two very different social worlds: the ambulatory and somewhat confused men and women described above, and the incontinent patients suffering from organic brain syndrome. It was these latter patients which affected me so during the 1978 field work and which made me hesitant to enter the "C/D" lounge during the second period of field work (see fn. 34).

(Lunch time):
The lounge in area "C/D" was quiet, except for the dialogue coming from the one television. Most of the patients are either in wheelchairs or gerry chairs; and most are being fed by staff. . . . This is a much larger lounge than in "A" (more than double), so that each patient is placed around his own little square table, lined up side-by-side and in rows, in the general direction of the television set. They sit with no one else, and talk to no one.

("C/D" lounge):
I enter the lounge and sit on the chair to the right of the entrance. I observe Nordstrom a few feet in front of me. She is scratching at her wheelchair, and picking up bits of food from the table beside her. Several women are screaming at each other from across the room. A nurse enters to change the bag attached to the catheter tube.

It was this aspect of the "C/D" section which staff members emphasized when deciding the Jessie Fogel transfer case (formerly of "B"). The need to provide Jessie with an environment in which she could "go crazy" was very much in evidence in the staff members' thinking:
(Discussion with Mrs. Richter prior to Fogel's transfer):
"If she needs to act out, she can't control it, she'll fit in there ('C/D'); it won't bother any one."

(Discussion with Carol Jones after the transfer):
"I think we've seen an improvement. I don't know. Maybe she's just blending in. At least she's in the lounges, so that's a good thing. There are people she can sit with there. I guess the best thing is she's not isolated in that room any more. There's something to be said for blending."

(Discussion with Ms. Williams, LGPN, after the transfer):
"She's not restrained all the time, the way they had to have her on 'B.' We let her walk around during the day, and that tires her out. I tell her to go to her bed or sit in there (the lounge). She does."

In the above quotes, the staff members allude to the fact that Fogel was unable to adjust to the demands placed on her by the "B" residents, and that as her anxious and boisterous behavior mounted, she was no longer capable of being sustained in a room there. This requires some consideration of the differences between "B" and "C/D" sections; I will in part use Fogel's pre- and post-transfer career to provide such a description.

"B" section consists of several small interaction groups scattered throughout the section, i.e., near the dining room, near the nurse's station, in the corridor outside someone's room. Much as the "E" women do, these residents monitor each other's behavior, and discourage interaction with those not passing muster:

(In dining room, mid-morning):
I enter the dining room and walk over to the women sitting near the window. I notice Wulff, a new resident of "B" sitting with her roommate, Irene O'Hara. I say hello to Mrs. Wulff and ask her how she is doing. She asks me if I know where her home is, and I tell her that her room is right down the corridor. She does not respond to this. Before I have the chance of asking another question, Irene
O'Hara tugs at my sleeve and says: "That's enough, dear. There's nothing more to say. She's ill, really ill, dear." I ask Irene: "Oh, what's wrong?" She replies: "They're trying to take her out, y'know. I'm a clean woman. I go to the bathroom myself. She needs help with it."

(In dining room, 12:30 p.m.):
Dansk is sitting at the large round table near the window. She is sitting next to Mrs. Apple and Mrs. Hyatt, who are talking to each other in a very low voice. I am sitting about four feet away, in a chair near the window. The two women are exchanging speculations as to what is on the menu for lunch. Mrs. Dansk looks in their direction, and they look at her once, smile, but say nothing. . . . After lunch, I ask Mrs. Hyatt what she thinks of the new person sitting at her dinner table, and she says: "She seems okay, but why is she in that chair? I mean, she's got a rope around her. Why don't they want her out?"

(In dining room, mid-afternoon):
. . . Dansk returns from her room and sits next to Mrs. Gleason. Every few seconds she moans rather loudly, "Oy, oy . . . ." After a few minutes of this, Gleason turns to Dansk and tells her "Shush." Dansk quickly retorts: "Shut up yourself. You should feel like I feel, you'd scream. You baby." Gleason says nothing in return. . . . A few minutes later, Mrs. Dansk's daughter enters the dining room and walks up to Dansk. Dansk opens her eyes and looks surprised. Her daughter asks her what she's been doing and Dansk says she's been crying. The daughter asks her why she's crying and Dansk says: "This life, I can't get used to it." The daughter says, "You'll get used to it," as she helps her mother out of the seat, and walks her to a table in the middle of the dining room. . . . After Dansk vacates the seat, Mrs. Hyatt gets up from hers and takes the seat right next to Mrs. Gleason. Hyatt asks Gleason what all the screaming was about, and Gleason says: "She said if I felt like she does I'd scream. I said, 'Does it help?'" They then remain silent during the rest of my observations—about twenty-five minutes.

(In dining room, mid-afternoon):
Gleason, Mrs. Hyatt and Nella Smythe are seated against the window. Dr. Unger has been sitting toward the center of the orange vinyl bench which runs perpendicular to this wall with the window. I am also sitting on the bench, mid-way between the three women and Dr. Unger. At one point Unger leaves her seat and walks
up to a chair in the middle of the room. It looks as if she is "inspecting" a tear on the back of the chair.

Gleason: She's washing the chair.
Hyatt: Yep. (laughs)
Nella: She's got a new job. Good, she'll stay there.
Hyatt: She's washing the chair.

(Dining room):
Grace Hamilton: You know, sometimes I think you're screwy, and then I won't talk to you anymore.
Mrs. Goldstein: No.
Hamilton: Yes, since you've been here, have you had to pay?

It is interesting that, although there appears to be an audition procedure among the "B" residents, which as we will see Fogel failed, these same residents are rarely accepted by the "E" women.\(^{35}\)

(In living room areas 4 and 5):
Irene O'Hara places a piece of cellophane (a candy wrapper) on the window sill near where Mrs. Bergman is seated.
Bergman: Honey, that's yours.
O'Hara: What, what.
Bergman: The paper on the sill.
O'Hara: No, it's not.
Bergman: You shouldn't it shouldn't be there, left there.
O'Hara: That's not mine.
Bergman: Oh yes it is. I saw you put it there.
O'Hara: I didn't, it's not mine. It's there on the chair. It's not mine. I'm very surprised at you.
(O'Hara takes a seat in area 5, with her back to Mrs. Bergman).

In general, there was a certain inconsistency of response by the "B" residents, which made them unable to pass the "E" entrance requirements:

(In dining room):
Mrs. Hyatt asks me if I speak German. I tell her no, but that I do speak French. She says: "Parlez-vous?" and I say yes. She tells me that she spent a year and a half in Germany. She says that she had two uncles who were teachers and who lived in Germany; she visited them and spent time with them, which is how she learned to speak German. She tells me that the German language is very hard to learn and asks me if I didn't find it so. I tell her that I don't speak German. Upon my questioning, Mrs. Hyatt tells me that she used to live in Center
City, Philadelphia, and that she's been living at PH for about a year. She asks me if I've been here long, and I tell her that I visit from time to time. She asks me how long I've been here again, and I tell her that I moved to Philadelphia from New York almost five years ago. She asks me if I speak German and I once again tell her I know some French. She says: "Parlez-vous?" and I say yes. . . .

Differences between "E" and "B" were evident to even the most casual observer. In this regard, "E" women travelled through "B" section to get to the beauty parlor and to use the pay telephone at the far end of the hall. They were, therefore, confronted with one of the presumed signs of mental deterioration there—physical restraints:

(Discussion with RN about Mrs. Seiler, restrained in a chair near "B" nurse's station):
"Y'know, she wanders out, to where she's not supposed to be. She gets in the way. I don't know exactly why; she was restrained before we got on."

(In one of the bedrooms on "B"):
Mr. Morris is fully dressed, lying in his bed, with the bed rails up. He is trying to get his legs to go over the rails. I enter the room, go over to Mr. Morris, and ask him what the problem is. He tells me that he needs to leave and that he needs to take the bed with him.

Furthermore, some of the interaction rules regulating behavior on "E" did not seem in evidence on "B." One important difference was that there did not appear to be the avoidance rule proscribing negative comments about the facility:

(Near the window in the dining room):
Jeanne: Mrs. Gleason, do you want to come out and listen to Mr. Einstein?
Gleason: I can hear him well enough from here. It's not that good.
Jeanne: Well, Marie, why don't you go? You like Mr. Einstein's piano. He's not that bad.
Marie Hyatt: Where, on the other side?
Jeanne: Yeah.
Gleason: Marie, he stinks.
Hyatt: Who?
Gleason: He stinks, they have him come here, he stinks.
The musician.
(Dining room):
Fogel: How're you doing?
SJS: Okay, how're you doing?
Fogel: I'd like to go home.
Mrs. Hyatt: I think we all would.

Related to this was that "B" residents frequently complained about not being kept busy enough:

(Discussion with Mr. Goldman):
I ask him if he's been to activities or to the other programs, and he says he usually stays near his room to look after his wife: "No bingo, that's not for me. I walk around, get my exercises. Stop in with the boys, say hello. I went up to the office there, see if they had something for me to do. Always ready to help, that's me... Sometimes they don't want you to do nothing, they wanna do it themselves."

(Dining room):
Jessie Fogel: I told them, give me work, something to keep me busy. I don't want any money, just something to keep me busy.
Mrs. Miller: Well, I guess why not, you're not getting any money now.

In contrast, the attitude of the "E" women was expressed by one informant who said: "Sit back, relax, and be taken care of."

Mrs. Fogel was placed on "B" because of the assumption that she would benefit from the close but unrestrained peer contact there. In time, however, Fogel became unable to live up to the demands of "B" staff members and residents, and a transfer to "C/D" was instituted.

Fogel's entry to the facility was markedly traumatic. Somewhat confused before her arrival, Fogel entered PH with little understanding of where and why she was being taken by her sister, and for what duration. During her first two weeks at People's Home, Fogel spoke to her sister daily, but received no visitors. Visiting was discouraged by the staff in the hopes that Fogel would more quickly adjust to the new people and surroundings. During the telephone
conversations, the sister made no mention of the plans that were then being readied for selling Fogel's house. There was no indication of how long Fogel should expect to stay at People's Home. Staff members were not permitted to relay the fact that placement was permanent:

(In dining room):
Fogel is sitting at the table where she usually takes her meals. I sit near her, by the window. She says to me: "I would go home earlier. They got the keys. Y'know what? I have money. I get social security. I have money in the bank. But how can I get home? Who can I call with ten cents? You can't make a call for ten cents. I'm so upset. I've never done anything like this." I have been instructed by the administration not to tell Fogel that PH is her home now; however, I do tell her to stay here and try to relax for awhile. She tells me that she can't relax, she's too nervous. She says she doesn't know how she'll get home. She says she wishes she knew how many weeks have been paid for here. I say nothing.

Despite this, Fogel was encouraged by the staff members to get involved in the "B" activity program and to join the residents sitting in the dining room or near the nurse's station. Although some of her behavior was unacceptable to these women, on the whole they were initially willing to make allowances for her and to permit her their company:

(Near "B" nurse's station):
Kanter: Don't you like it here?
Fogel: Me?
Kanter: Yeah.
Fogel: Not when I'm so upset. My sister tells me to stay here, but I can't stay here, it's nice, but I didn't take no money. Never, I never left the house like that. And I got a house.
Kanter: Why don't you just relax, and see what happens. It's very nice here.
Fogel: I'm just too nervous to sit.
Kanter: No one's gonna throw you out. Just relax and don't talk anymore. So when the people come, they'll pay for it.
Fogel: They paid, they paid.
Kanter: Well, whatever. Y'know they're not going to
throw you out. They're paying for it.
Fogel: She's (the sister's) a wonderful person.
I'll never forget what happened here. I never go
out without money. This has never happened before.

(3:30 p.m., in dining room):
Fogel: I'd like to get the hell home, but she took
the key.
Mrs. Miller: Call her.
Fogel: I can call her, but I don't have money.
Miller: Can you ask someone?
Fogel: She said I should stay here.
Miller: It's up to you. You can go if you want
to go home.
Fogel: She said there's nobody to take care of
you. And I said I don't need nobody. She says I'm
better off here, it's better off here than at home.
I don't have no money for this.
Miller: What're you gonna do?
Fogel: She'll have to pay it. She says don't worry
it'll be taken care of. They bought me dresses. What
do I need new dresses, I just want to get the hell home.
But they want me to stay. So let them pay. It's just
that I get social security, and I have a duplex. I rent
it to a very lovely couple, so there's money. But I
can't get it. That's the predicament I'm in.
Miller: I have one sweater and I can't find it.
Fogel: I'm not gonna say a word. If they say I'm
better off here, then let me stay. Let them pay for
it. I got a home, a beautiful home. Alright, so let
them pay.
Miller: I feel sorry for her. (She points to Dr.
Unger on the bench).
Fogel: I do too. All those years she worked so
hard, now she don't have a thing, like me.
Miller: She's just an oldie. I told my sister that.
She braids herself. She unbraids them.
Fogel: She's a brilliant woman. That's what they
tell me.

... ...

Hyatt: You'll sit and stay with the gang.
Fogel: Huh?
Hyatt: You want to stay with us.
Fogel: What I want is to go home.
Hyatt: I think we all would.

Staff members saw this initial acclimation to the groups on "B" as
an indication that Fogel was beginning to "adjust":

(Discussion with Carol):
"Well, she's settling in, she's adjusting fairly well.
She's still very nervous, but I think she always will be.
There's less talk about, y'know, the kind of talk about money. About not ever doing anything like that. She's sort of found her own little group there on 'B' wing. The funny thing is, she's the only one when you ask them to come to something, she says, 'Sure, let's do something.' She came to news and discussion today. I can't say she contributed all that much, she's not really lucid, but she said one thing I had to agree with. She said has there ever been a war that wasn't fought because of money, y'know, the rich, and I had to say yes. She kept up, 'Do you agree? Do you agree?' Yes, I agree. She's a classic one. We all should have known: give her time. I don't know if she'll ever be a complete turn-around, but she's doing alright. You remember Mrs. Goldstein? They're the same."

Fogel's career on "B" did not proceed as smoothly over time, and Fogel did not meet with full acceptance into "B" social life. While it is not possible to judge why this was so, Fogel's anxiety about her home and her financial situation never completely abated. One day, Fogel was discovered wandering through the hallways. Staff members were uncertain as to whether she was attempting to leave the facility or simply had lost her bearings. In either case, Fogel was labelled a "wanderer." The staff response was to keep her restrained in a chair near the "B" nurse's station or in her room. "B" section is not prepared (in terms of the number of staff) to supervise wanderers, and so the use of body restraints was mandated. In addition, Fogel was placed on tranquilizers so that she could not disturb other patients:

(In "new B" corridor):
I approach Fogel's room, and as soon as she sees me approach the door, she shouts out to me: "I'd like to take a walk—with you." I enter the room and walk to where she is seated, restrained in a chair. She tries to stand up, but I tell her she has to sit back. I ask her how she is doing and she says: "Nothing's happening—for me anyhow. I'm getting so blue. Maybe you can get something up. Maybe you can get something happening for me. I could talk with someone."
(Field notes):
The nurse's notes stress that Fogel is an agitated woman who is prone to wandering. She is first given Haldol, then Benadryl, and is now on Librium to control her condition.

The act of restraining Fogel (physically and chemically) was a decisive moment in her career on "B" (as it was for Kanter—see above). As the following details from my field notes indicate, the other residents on "B" took this as an indication of the staff's negative evaluation of Fogel:

(In "B" corridor, near the nurse's station):
Fogel: I've gotta eat, I'm hungry.
Mrs. Lutz: Sure, we all get hungry. Don't they serve it to you?
Fogel: I don't know.
Lutz: You don't know? What's the matter with you? You don't know!
Kanter: What do you want? (She is just now walking toward the nurse's station, and takes a seat near Lutz).
Fogel: Will I be able to get food?
Kanter: (to Lutz) What is she saying?
Lutz: (to Fogel) Naturally you get it every day, three times a day. Since you've been here, you get it every day, no?
Fogel: I do?
Lutz: You talk as if you're senile, you're not that old.
Kanter: Maybe she is.
Lutz: If you didn't get food, since you got here, you wouldn't be alive if you didn't get your food. You get three meals a day. Didn't they give you three times since you got here?
Fogel: What do you mean? Will you get me some food?
Lutz: I just told you if you didn't have any food you'd be six feet under.
Fogel: (pulls on her restraint) I can't get out, I can't get any food.
Lutz: Just sit there. They'll take you. They know you're tied down.
Fogel: I don't know why.
Lutz: You must have done something bad. You must have said something, or you did something bad.
Fogel: (turns her body to me) Mister, will you come here?
Lutz: Leave that young man alone. Young man, just ignore her. You know, you don't belong here. You belong in a cuckoo house, you're stupid.
Fogel: I'm stupid.
Lutz: They don't tie it down for nothing. You must have done something real bad.
(Fogel calls to Charles Ruskin, who pedals his wheelchair past the nurse's station).
Fogel: Sir, sir.
Lutz: Why don't you leave that man alone?
Fogel: Will I be able to walk around?
Lutz: They'll unbuckle you for lunch. Then you'll be able to walk around. They're not gonna take you in your chair. Why don't you think? I don't know why I talk with you. I don't understand how you can think.
Fogel: I appreciate it.
Lutz: If you appreciate it, then shut up.
Fogel: (waits about a minute, then turns to me) Sir, sir, can you help me?
SJS: I can't get you any food. It'll be here, Jessie. It's almost twelve. They'll bring it to you soon.
Kanter: I can't take this any more. I'm going.
Lutz: Where are you going?
Kanter: The restaurant. We can sit there.
Lutz: No. Go. I'll come soon.
(Mrs. Kanter gets up from her chair, walks past me, and in the direction of the dining room).

Fogel: (to nurse behind the station) Miss, will you come here?
RN: What d'ya want, yenta?
Fogel: I need some money to get food.
Lutz: Geesh.
RN: You don't need any money. Your food is all paid for.
Fogel: Oh, it is?
RN: Yup.
Fogel: (to me) Stay with me, I'll get you some lunch, too.
SJS: Okay.
Fogel: You'll stay with me. Mister, will you stay with me?
SJS: Yes, Jessie. Just try to relax.
Fogel: Miss.
Lutz: Oh, shut up. I don't want to hear anything from you. You're a nuisance.
Fogel: Will you get me some food?
Lutz: No, you're gonna starve. What do you think you've been having all this time? (She stands up and walks away, toward her room).
Fogel: (to me) Did you ever see a person like that, rotten, she's so rotten. All I did was ask her a question.

The minutes of the staff meetings indicate that it was hoped that the medication would calm Fogel enough so that she could remain on "B."

A transfer to "C/D" was approved when it became apparent to the staff...
that Fogel was no longer able to sit with the "B" women and so could not benefit from peer contact. Moreover, at one point it became necessary to cease the administration of medication because of the destabilizing influence it had:

(Minutes of the staff meeting, April 7, 1981):
"Jessie Fogel was seen by a neurologist and has had her medications changed. She seems much better."

(Discussion with Carol):
"She (Fogel) was always anxious, needed constant reassurance. That remained, but she became very lethargic. She didn't have any idea where she is. She has been up and about, but it's almost impossible to reach her, she can't integrate anything anymore. I'm glad I asked about her today, because it seems that it is the medication. The Haldol does that that to them. We'll try to reinvolve her. It became inappropriate after awhile, she'd be in that lethargic state all day. She was the same old Jessie, only worse, all that anxiety. If she didn't know this was Philadelphia or People's Home, she at least knew it wasn't it was a home of some sort. Then nothing. Meds can really be something."

Fogel's "bizarre" outbursts were not expected to disturb the other "C/D" residents, and the nurses were assumed to be accustomed to this type of behavior. As noted above, also, Fogel was allowed on occasion to wander through the "C/D" lounge and hallway—she was not continuously restrained. The following notes were taken just prior to my termination of field work at People's Home:

(In "C/D" lounge):
Jessie Fogel is restrained in a chair in the middle of the room. She is seated perpendicular to the television and so is unable to see it. She is shouting: "Are you crying, sir? Miss, miss, why? Are you crying? Oh, God. You crying too? The dolls. The dolls. Are you crying?" A woman across the room shouts out: "Keep quiet." Fogel seemingly responds: "She's crying too." Throughout this, Fogel has been pulling at the diaper she is wearing and at one point is able to get her hands underneath it. She begins poking herself and rubbing her hand underneath the diaper. She rocks back and forth in the chair. One
of the nurses comes in to distribute medication to the patients and sees Fogel. She puts the medicine tray down and walks over to Fogel. She straightens out the diaper after removing Fogel's hand from underneath it and tells her: "Look at the TV, okay. Keep your dress down, Jessie. Do you have to go to the bathroom?" Fogel says yes, and the nurse says she will go and get an aide.

In brief, Fogel was transferred to a section more willing and able to accommodate her behavior. However, as the example of self-stimulation above might lead us to suspect, the "C/D" context now placed certain limits on her social contacts. It is in this respect that the social contexts in which restraints are found on "A" and "C/D" differ significantly. Except for her meals, Fogel was not seated around a table with other patients, and she was not part of joint television watching and reciprocal conversation with staff members—both of which characterized "A."

Summary

One apparent consequence of the profit orientation of PH, at least as this is perceived by the administration, is that this home must organize its residential sections to attract and keep a diversity of customers. This entails the establishment of a ward system whereby different physical locations of the facility are provided with different social meanings and evaluations. Furthermore, each residential section at People's Home is reserved for a different category or type of patient.

The administrator, Mrs. Richter, is solely responsible for deciding admissions and initial bed selections. Several factors seem to account for the administrator's decision to admit or reject applicants. These include: (1) the availability of funds, (2) the number and type of
slots which are available at the time of application, and (3) the kind of patient seeking placement. The application, admissions, and room assignment procedures are carried on simultaneously. No waiting list is maintained at People's Home, and there is very little lag between the time of application and the admissions date. Moreover, applications to the facility are only taken when a bed is already vacant, and the potential resident is appropriate for that position. Individuals do not apply to the facility and then wait for an appropriate slot for entry. Rather, they apply for a specific section and bed at the outset.

Each of the four principal sections of People's Home can be considered an entry point for incoming residents; however, they are not equivalent entry points. Physical differences among the wards, and mental and behavioral differences among the patients, are evident when the four sections are compared. Each section of the facility entails a different staff-patient ratio, reflecting the presumably different health and supervisory needs of the various patients. In addition to this, staff members suggest that different rules guide the behavior of residents on each ward. The staff members predicate friendship among the patients on the basis of residence with similar types of patients; therefore, it is considered necessary that incoming residents be assigned fitting or matching locations. Finally, the physical appearances of the various wards contrast, and residents are assigned a residential section based on these physical plant considerations. Incontinent residents are not given access to "E" or portions of "B," for example, because the floors there are carpeted. On the other hand, "alert" patients are assigned "E" and "B," where it is assumed they will
be able to appreciate the aesthetic details (e.g., expensive lithographs, matching wallpaper).

The data discussed above further indicate that the organization of residential sections into distinctly evaluated wards patterns decisions to transfer (reassign) patients at People's Home. The general situation which staff members suggest serves to instigate and justify reassignments develops when a patient is no longer appropriate to his/her current slotting. This is usually viewed by the staff in terms of a decline or deterioration of the patient's medical or psychological condition.

The absence of a fit between the patient and the section can be seen in terms of the same three criteria discussed above for initial assignments: (1) the presence of staff members and institutional routines on each ward which are capable of satisfying the patient's health and safety needs; (2) the suitability of the individual for interaction with ward mates; and (3) the limitations placed on various medical conditions by the physical plant itself. It should be pointed out that the ostensible aim of a transfer is to select a section of the facility which matches the patient's current medical condition or functioning level. In this manner, the general flow of reassigned patients can be seen to go from the most prestigious sections in the home ("E" and "B") to lesser evaluated ones ("A" and "C/D").

As noted, social relationships at People's Home are organized around the area of residence. This limits friendships to within-section groupings, but it does not predict specific friendships. The appropriateness of the individual to the initial ward assignment, or perhaps more accurately, to the ward-specific set of behavioral
expectations, further serves as an organizing principle of social relationships. Certain individuals (especially on "E" and "B" sections) may be ignored by their peers, for example, if the latter consider the initial slotting decision to be inaccurate or not in accord with their own reasons for living on that section. In this manner, the newcomer's status and social identity at PH is defined both by the outcomes of interaction with his/her peers, and by the career options provided by the ward structuring.

To a large degree, then, it is not the case that the patient's status at People's Home should be seen as an exclusive definition or imposition by the staff. Instead, the data indicate a three-fold interaction process representing the residents' (and staff members') contribution to the position slotting, maintenance, and/or discontinuation of their peers. First, the residents can be observed interacting with newcomers to the facility in such a way that the latter are provided information (e.g., about communication rules) which is congruent with and necessary for the particular assignment made by Mrs. Richter. Over time, and to the extent that the newcomer is included by the other residents in their informal cliques, such behavior may help to maintain and reaffirm the newcomer's initial slotting. However, if a patient is judged unacceptable by the others, then he/she is avoided by them. Such avoidance is usually automatic for individuals not residing on one's own ward. In the case of ward mates, it is usually after the patient has been observed, interacted with, and potentially trained with regard to the appropriate communication rules, that avoidance of a newcomer occurs. It was observed that conversations
establish rules for directing the participants' social relationships, and provide information necessary for continued functioning in the home. The presence of "phatic" talk enables the residents to monitor the behavior of others and to provide them with the necessary sanctions and information for maintaining a current slotting. On the other hand, the absence of such talk, e.g., conversational exclusion, is a signal of pattern violation, and may be an early phase of the reassignment procedure. Staff members are able to see the residents' responses to particular slotting determinations (e.g., the acceptance or rejection of the slotted individuals) or are directly informed by the residents about their reactions. In either case, this information influences the staff's treatment of the patient (e.g., medication distributed, encouragement/discouragement to participate in activities) and the possibility of further assignments.

Staff members hold differing expectations for the residents based on the section to which assignment is made. Two types of contrast analysis are performed in this chapter in order to provide perspective on these various expectations: comparisons of the different wards for individuals who have undergone transfers, and comparisons of individuals with similar medical conditions but different ward placements. These analyses indicate that patient care at People's Home is not a simple reaction to patients' medical symptoms, but results, in part, from socially patterned frames of reference placed on staff and resident behavior. These frames of reference or category schemes are distinct for the various residential sections. They constitute organizations of values which serve as regulators of and justifications for particular orders of behavioral treatment (e.g., the use of restraints or...
medication, the proffering of invitations for individuals to join activities, and so on).

In brief, the present chapter describes one possible recruitment system which a nursing facility may employ. People's Home has instituted a differential ward system, and can be seen to pattern different patient careers based in part on this organization of the residential sections.
The analyses in this chapter indicate that "E" residents are considered the most "alert," while "A" residents are usually labelled "confused" and in need of constant supervision. "A/E" patients are sometimes referred to as "E" patients, and the staff members expect them to participate in all "E" activities.

Resident residents on Veterans Administration contracts usually reside on "C/D" section. These patients are considered the most "disoriented" and in need of the greatest health care and supervision.

I was not fully aware of the ramifications of this during the 1978 field work. Thus, the thesis research on People's Home was unable to assess the degree to which a differential ward system exists there.

This might possibly help explain why the initial entry to PH is so traumatic for many patients, many of whom have not been told that they are being permanently placed.

Mrs. Richter so recognizes the strength of family intervention that she once lamented that the potential roommate for one of the brash and demanding "B" patients would have to be family-less:

(Staff meeting):
It is suggested that Irene O'Hara be put on Haldol to "take off the edge." They say that she is very pushy and can be abusive. Roberta says that O'Hara pushed Mr. Jones at the party last week and told Roberta that she is in charge of the seating in the dining room. Mrs. Richter says that the kind of roommate Irene O'Hara will need is a patient who is totally confused and has no family to make complaints about Irene. They say that Irene is constantly complaining that Mrs. Wulff doesn't belong in her apartment.

The approximate daily charges during the 1980-81 field work were as follows:

- "A" = $43.00
- "E" = $47.00
- "B" = $45.00
- "A/E" = $47.00
- "C/D" = $40.00

Remember that "A" = "C/D."

"Alert," "confused," etc. are the staff's (and residents') descriptive terms, not mine. What constitutes these categories is in part what this dissertation considers (see below). With regard to the analysis of "B" section, there is a problem in the structuralist literature as to how such "ambiguities" are to be handled. For example, Clark writes:
If an event A has the same permissible occasions of use as an event B, and B has the same occasions of use as C, then A shares all occasions of use with itself (the relation is reflexive), B shares all occasions of use with A (the relation is symmetric) and A shows all occasions of use with C (it is transitive) (1977:50).

Similarly, Pike indicates:

In algebra, if a=b and b=c, then a=c. The (linguistics) student is likely to assume that if "x" and "y" are submembers of a phoneme, and if "y" and "z" are submembers of a phoneme, then "x" and "z" must be submembers of that same phoneme. This assumption holds true for data which are sufficiently detailed and accurate, but proves invalid for incomplete data (1947:94).

The above data do not conform to these methodological strictures, apparently because of the diachronic (transitional) perspective used for the analysis of "B" section.

Mrs. Richter is ostensibly talking about any inappropriate placement, but she continues to talk in the third person male pronoun. This may be because there are more available female beds than male ones, and so, given this lowered set of options, an inappropriate male placement is more likely.

(Staff meeting):

Mrs. Richter introduces the new director of nursing to the others. Her name is Ms. Serreno. Richter tells her that the meetings are very informal, "like a Quaker meeting, every one gets a chance to say anything."

Warner and Srole write: "Children, of course, are not so rigid in keeping class distances as are adults. If there is a lapse, the parents are quick to separate them" (1945:91). At the nursing home, the children and parents often reverse roles; children often worry about the positional placement (status) of parents—especially as this is assumed to be reflected in the circle of potential interactants available to the parents.

Although this is difficult to prove, it is my belief that Kanter was transferred because of her visible behavior of mothering vis-à-vis Unger, and not because of the apprehension over the dependency it was purportedly fostering. I believe Kanter's behavior was a reminder to staff members of how dramatically the quality of "B" life had changed. Partial support of this thesis comes from the fact that a second dyad on "B" was said to have this same inappropriate mother-child relationship:

(Staff meeting):

It is noted that Mrs. Miller has also returned from the hospital and that her sister, Margaret, who is also her
roommate, is trying to take care of her. They talk about the possibility of moving Rose, because they say it is no good for her to become dependent on Margaret. They say: "She's gotta know we're the ones taking care of her here." No transfer decision is made at this time; it is suggested that Margaret might go looking for Rose in her new room, and that a room change won't solve "the problem."

Margaret and Rose stayed in their room all day, and so this dependency was never overtly displayed to all of PH. No transfer was ever finalized for either of the sisters.

13 Contrast the function of transfers in another total institution, mental hospitals:

Some patients seem to use various groups as a ladder on their way to convalescence. With improvement in their mental health, they climb to more "advanced" patient groups. The hospital, it seems, should encourage such mobility, and support and create opportunities for multigroup memberships for patients who are ready for it (Etzioni, 1960:20).

14 Goffman suggests that the issue in total institution is not one of socialization but of mortification:

Now it appears that total institutions do not substitute their own unique culture for something already formed; we deal with something more restricted than acculturation or assimilation. If cultural change does occur, it has to do, perhaps, with the removal of certain behavior opportunities and with failure to keep pace with recent social changes in the outside. Thus, if the inmate's stay is long what has been called "disculturation" may occur—that is, an "untraining" which renders him temporarily incapable of managing certain features of daily life on the outside, if and when he gets back to it (1961:13).

15 This statement may prove an inaccurate concern, since the residents' complaints and avoidances are but moments in a continuous system of behavioral monitoring which is ultimately functional for them over time. In this regard, Radcliffe-Brown points out that both public and private misdeeds may upset a group's well-being and may require some form of social reprobation:

The immediate function of the reaction is to give expression to a collective feeling of moral indignation and so to restore the social euphoria. Its ultimate function is to maintain the moral sentiment in question at the requisite degree of strength in the individuals who constitute the community (1965:212).
In its basic form the law of private delicts is a procedure for avoiding or relieving the social dysphoria which results from conflicts within a community. An offense committed against another member or group of the same community, by inflicting a sense of injury upon the victim, creates a disturbance of the social life which ceases only when satisfaction is rendered to the injured person or persons (ibid.:214).

Groups beyond institutional walls have been known to employ similar methods. Sherif writes:

Such insignia of membership (tattoos, articles of clothing) made the question of whether one was or was not a group member a clearcut matter. In at least one group . . ., the practice of fighting as a test of entry into the group was also employed on occasion.

However, the most general criterion of membership in all groups was simply whether other members accepted a boy when he hung around with them, and how frequently he was included in their plans (in Argyle, 1973:239).

Also see Berger (1963).

Although it may at first appear as if the exclusionary behavior is an aspect of Mrs. Bergman's "personality," it should be pointed out that she is only the most vociferous of the "E" women, and that staff members judge her general conduct and her reactions to certain patients as highly appropriate. Birdwhistell (personal communication) suggests the applicability of Fritz Redl's concept of "role suction" to these data.

In an analysis of the conversational topics most frequently found at PH, Sigman (1979) indicates that silence was an acceptable, and, on certain occasions, a preferred means of self-presentation. One female informant said then: "Only senile people talk all the time anyway." One way of thinking of these data is to suggest that the behavioral criteria were flexible enough to allow certain individuals to "cheat" or "pass," terms used by Berger (1963) to describe the assimilation of light-skinned Blacks in white society.

Gustafson suggests that residents may use certain objects to remove themselves from the dying career trajectory:

In the nursing home, as in the TB hospital, patients sometimes use extraneous criteria to improve their bargaining position (with regard to the social definition of their closeness to death). Provision with glasses, hearing aids, dentistry, occupational and physical therapy, and other aids and services
which staff may consider nonessential are often highly valued by patients mainly as status symbols indicating that they have social value and possibly a long future (1972:232).

19 Witness Berger:

To compile a biography, then, is to record . . . events in chronological order or in the order of their importance. But even a purely chronological record raises the problem of just what events should be included, since obviously not everything the subject of the record ever did could be covered. In other words, even a purely chronological record forces one to raise questions concerning the relative importance of certain events (1963:54).

20 See Chapter II for a discussion of the three phases of transition rites as outlined by Van Gennep (1960).

21 Not all family requests of this type are honored: Consider the following:

(Staff meeting minutes, 6/2/81):
"Mrs. Wulffwasser would like her husband to eat in the main dining room. Harry is not ready for a switch like that. Maybe if he calms down he will be moved."

22 Reality orientation stresses that staff members not reinforce in speech or nonverbal actions any inaccurate statements (delusions, memory lapses, etc.) provided by patients. With regard to the Dr. Johnson syndrome, Dominick, et al. write that such patients are usually poorly adjusted to nursing home life: "Successfully adjusted patients showed greater foreknowledge of the nursing home than did the poorly adjusted ones" (1968a:69).

23 Compare Van Gennep's (1960) discussion of the differences between social puberty and biological puberty, social kinship and biological kinship, etc.

24 Latini's "alertness" in particular must be seen in the light of the definitional delimitation of being appropriate expressed by Carol: looking after and talking to others; hating Lull's violent and loud behavior. Apparently, Carol is not aware of or excludes from consideration the content of Latini's talk with her ward mates, e.g., about taking Mary Karposky home with her.

25 I suspect that the reports are true. Although I did spend several evenings at People's Home, I never felt that I established the degree of trust or acquaintance with the night staff that I did with those on day
shift (Chapter III). Not fully convinced of my role (occasionally, a new worker would ask me if I was an "efficiency expert" or administrative supervisor), these staff members may have decided not to hold their parties in my presence.

26 Refer to Figure I. Also, refer to Sigman (1979) for more detailed descriptions.

27 Interaction is multichannel and continuous. A more delimited way of saying that interaction is reduced is to indicate that focused interaction is apparently avoided or is not observable.

28 There are several other considerations for this transformed conversational behavior. Sigman (1979) points out contexts in which this behavior is likely to occur, and differences in the units comprising the primary and transformed frameworks.

29 Consider the following:

There is almost a total absence of any planned activity programs in Europe. It is considered as an intrusion on the privacy of the individual to direct daytime activities. The residents are highly individualistic and resent this type of regimentation (Cohen, cited in Kosberg, 1975:213).

This appears to be the case for certain activities for "E" residents.

30 The differences between treatment of "A" and "E" residents are not the result simply of physical capacity of the former warranting being taken in and out of the lounge. One "E" resident (Axelrod) is a quadriplegic, but she and her friends are constantly reminding the staff to bring her to the living room.

31 This type of transfer is discussed in greater depth above. There it is noted that this type of evaluation does not occur periodically, but is likely to be used when there is a need for an "A" bed. Since it is assumed that the patient is unaware of his/her surroundings, it is expected that the resident so transferred will experience no trauma as a result of the change.

32 It requires reiteration that the contrast we are working on now concerns one of two types of individuals placed on "E" section (the quiet but confused male) and a typical "C/D" male. We have already provided some description of the requirements of the other "E" trajectory (alert females) in our discussion of the interaction surrounding Ford's transfer. This suggests again to us that a ward does not have a single career line attached to it: one must consider the varying reasons for placement on a particular section as conditioning the subsequent career.
33 Mr. Knopf has severe cataract problems, although he is not legally blind.

34 During both periods of field work, I hesitated for a very long time entering the "C/D" lounge. Witness the following journal entry:

(3:20 p.m.):
I enter the "C/D" lounge and write the following:
"Why have I avoided going in here until today (nine weeks after starting field work)? The smell, especially in the entranceway is difficult to take—urine and ammonia. So many of the residents are screaming or talking to themselves.

35 Frances Smith, a former "B," used to participate in the private bingo game on "E." Since her move to "A," she has had less dealings with the "E" women.

36 If we take Mrs. Fogel as our unit of analysis, it is impossible to explain her career at PH. On the other hand, if this is taken from a relational or interactional perspective, then it is possible to consider her social career in terms of the regularities that were expected of Fogel, the behavior she produced, and the responses that were elicited, etc. Bateson's caveat seems appropriate here:

Relationship is not internal to the single person. It is nonsense to talk about "dependency" or "aggressiveness" or "pride," and so on. All such words have their roots in what happens between persons, not in some something-or-other inside a person (1980:147).

37 It is ironic that Kanter, whose career on "B" was ended in quite a similar manner, played a role in the interactional redefinition of Fogel's status.
CHAPTER VI
SOCIAL RECRUITMENT AT SISTERS OF FAITH HOME

Introduction

This chapter examines social recruitment processes at Sisters of Faith Home, the second nursing home located in Philadelphia. SFH is a private, skilled-care facility owned by the Catholic archdiocese. It is administered by the Sisters of Faith, an order of nuns who operate several hospitals, orphanages, and nursing centers in various areas of the United States.

Sisters of Faith Home is comprised of three hundred and eighteen beds, spread over three building sections. The Main Building is made up of two building sections. There are four residential floors in the Main Building. Each floor consists of two single rooms, two double rooms, and approximately eleven four-bed rooms. With the exception of the first floor, each floor has one nurse's station and two day rooms (solariums), one in the center of the building (at the intersection of the two halves) and another at the north end of the building. The first floor of the Main Building contains one nurse's station. The first floor center day room doubles as a hallway and as an anteroom to the chapel. The original northern first floor day room has been eliminated and replaced by a reception and waiting area. This area extends into the Pavilion building and serves as the main entrance.

The second building, which is the newest wing of SFH, is called the Pavilion; the Pavilion and Main Buildings form an L with each other (see diagram). The Pavilion consists of three floors. The first floor
Figure III

Physical layout of SFH

(Not drawn to scale)
houses the administrative offices, the activities room, the therapy suite (rooms for occupational, physical and speech therapy) and the reception area noted above. The remaining floors are residential: half the rooms on each floor contain single beds and the rest are doubles. There are no quads in the Pavilion. Each residential floor has a nurse's station, a sitting room, and a lunch room which is equipped with a refrigerator, a stove, and an ice chest.

In addition to differences in room type between the various buildings, the Main Building and the Pavilion contrast in architecture and appearance. One staff member said that the Main Building reminded her of a hospital:

(Discussion with Rhoda, activities assistant):
"There's a big difference in the attitude generally. I find more withdrawn patients in the Main house than in the Pavilion. A lot of them will not leave the room (in the Main Building), but at the Pavilion they get out more, they go to the lounges for meals. I suppose there are a lot of reasons for it. There are more people in each room (in the Main Building), so the people in the Pavilion have more privacy. . . . There's a definite difference in adjustment. The four bed, going back to hospitals, there's less space, the decor's not as nice (in the Main Building). You always hear complaints about the roommates. It's like a hospital. But the Pavilion is more like your home; you have your own room, the decor is nicer."

All the floors in the Main Building are linoleum-covered; most of the corridor walls are papered with rolls of solid grey or blue, or a striped wallpaper (in some places, all three). Bedroom walls are painted a dull green or yellow, with the paint noticeably chipping in several places. In contrast, the corridors and bedrooms of the Pavilion are wallpapered either with a bright yellow or a bright orange paper.
In addition, all floors have a dark carpet, and the walls are decorated with reproduction oil paintings which are scattered throughout the building.

Sisters of Faith Home appears to provide its charges with more services than does PH. In addition to the differences in medical staffing between the two homes (see Chapter IV), SFH employs more social service, activities, and therapy personnel. There are two full-time social workers (one B.S.W., one M.S.W.), one intake social worker, and two administrative assistants. There are three full-time physical therapists and one full-time speech pathologist; in addition, both departments of physical and speech therapy employ three to four part-time assistants and consultants, and there is also one part-time occupational therapist. The activities room employs one director and three full-time assistants, and, because of the proximity of SFH to several neighborhood churches, the activities program also relies on several dozen volunteers during the week (see below).

Assignments

There is nothing inevitable about the ward system which People's Home utilizes (Chapter V). Various criteria and procedures may be employed by nursing homes in filling institutional slots. The data on Sisters of Faith Home presented here demonstrate the fact that, in the absence of section (physical) boundaries between different resident classes or types, other devices may be employed to embody and signal social distinctions. These are necessary because SFH does not use a differential ward system to organize slotting and reslotting decisions.
Unlike People's Home, where a single administrator controls initial family contacts and decisions regarding applications, Sisters of Faith Home is comprised of several committees which are each responsible for separate phases of the recruitment procedure (i.e., admissions, assignments, or reassignments). Unlike PH, during much of the research period SFH has drawn a distinction between the processes of passing judgment on prospective residents' applications and of subsequently deciding on room assignments. For a brief period during the field work, the administrative committee which customarily concerned itself only with applications became interested in the chief social worker's slotting criteria and took over this function for approximately six weeks. In consequence, admission and slotting procedures varied somewhat during the course of this study (see below).

Initial applications to the nursing home are screened by a staff member assigned to the social services unit. This person—Sr. Rose for the first seven months of the research, and Anne Callahan for the last six weeks—was the institution's first contact person for prospective families. Applications are not handled by telephone; the applicant (the patient and/or relatives) must complete a written personal form and a physician's report. This is followed by a personal interview. This interview is conducted by Sr. Rose and is designed to enable her to verify and to expand on information detailed in the written applications. As part of this interview, Sr. Rose provides the applicant(s) with a tour of the facility. She takes the opportunity to explain the institution's procedures for judging applications. The intake social service worker is responsible for maintaining the application files and for presenting each application before the admissions
board during its monthly meeting. Moreover, this worker communicates with relevant family members concerning the board's decision to accept or reject an application. On some occasions, she may have to request additional information from the applicant before a final vote is taken.

The director of social services expressed the procedure as follows:

(Discussion with John Stevens):
I ask John about the initial application procedure. He tells me that someone calls or comes into the home, and fills out a record of inquiry. This person is usually a "responsible party"—a relative of the potential resident, sometimes a friend. Then the various application and medical forms are mailed to the inquirer. The individual then calls to make an appointment for an interview, and brings along the completed applications. The initial inquirer shows up for the interview: "We ask that the potential resident come if this is at all possible." If the resident does show up, then the interview involves all the family members at the same time. The interview lasts for about one hour, dealing with such questions as: How does the family feel about the institutionalization? Finances? "There's a lot, not a whole lot, but there are feelings about bringing someone to a facility like this. They can't take care of this. We're concerned if they are able to handle it financially."

As noted, the initial interviews are designed to serve a preliminary screening function. During her meetings with the applicants, Sr. Rose relays the importance of having a "strong case" to present to the admissions board. This specifically means making the necessity of documenting the skilled care needs of the patient clear to family members:

(After intake interview between Sr. Rose and the Castor family):
I ask Sister about her evaluation of Rosemary's candidacy, and she responds: "This will make a good case. She's very confused. She's been turning on the stove, leaving it on, the gas predominately. Safety reasons for her being taken out of her apartment. She can no longer be maintained in her own apartment. She leaves the water boiling and it dries out."
(Intake interview between Sr. Rose and Mr. O'Rourke): Mr. O'Rourke's brother (William) is 56 years old and his aunt (for whom he is making application) is 67 years old. She has cataracts and has been blind for nine to ten years. Mr. O'Rourke says that he has been trying to apply for a State Blindness Pension for his aunt ever since his mother died (the two women and the brother lived together). He says his mother, a "proud Irishman," never wanted to apply when his aunt first went blind. Rose asks O'Rourke about his aunt's level of functioning. He says that she bathes and dresses herself, but that she needs someone to lay out her clean clothes for her. He says that she is alert, that she knows, for example, that Christmas is coming. He then says: "My brother gave up his what y'd say his married life for the two of them (aunt and mother). But now he's kind of tired of taking care of her." He says that his aunt is very religious: "She says the rosary every day before the statue of the blessed mother." Rose asks O'Rourke if he has made application to other nursing homes, and he says: "We want her in a strictly Catholic place." Rose suggests that he contact Catholic Social Services to find out the names of other Catholic homes.

Rose figures out that Elizabeth (the aunt) has enough funds for private pay for one year.

At one point, O'Rourke says: "She's not trouble at all. It's just that she's blind. We take care of her a week at a time. My wife picks her up and bathes her. I tell her she shouldn't, she's too heavy."

After the meeting, Rose says to me that this applicant does not look like a skilled care candidate: "The question is if she's better off in an intermediate facility, but Medicare does not pay just for custodial care." She says that the diagnosis of hypertension may not be sufficient for a skilled care status. Also, she says that she will probably be asked for documentation on the mental retardation indicated on the physician's report, that there does not seem to be any evaluation or diagnosis by a doctor indicated.

(Intake interview between Sr. Rose and the Kenners): The son says they are frightened that, if Mr. Kenner (the applicant) were to live with the family, they would not know what to do if he needed an injection, etc. The son says that his father is fully independent as far as ambulation, feeding and dressing are concerned. Sister Rose expresses some concern that Kenner may not be certifiable as a skilled care patient, and this
immediately perplexes Mr. and Mrs. Kenner. They say they really don't know why the doctor feels the father needs a skilled/extended care facility, since even the doctor indicated that the patient was independent. Sister's questions seem to have made the Kenners even more tense. I think that she misunderstood the doctor's notes; although Kenner is independent in ADL (bathing, feeding, etc.) the doctor indicated that Kenner needed constant nursing supervision. Sister suggests to them that, since the admissions board will not be meeting for another week, they should look into other nursing homes, as well as the possibility of taking Kenner into their home. . . . After the couple leave, Sister and I briefly go over the application. She reiterates to me that she doesn't think Kenner is skilled care, but I do not tell her that I think she misunderstood the doctor's report. Sister says she is surprised that the father wants to take care of his own expenses, sign his own legal documents. She says that she supposes that that is good; that Kenner sounds like a feisty and alert man. She then questions whether "we will be able to satisfy his needs here. I know the set-up. I don't know if there's enough stimulation with the men here. I don't think we have any men who are oriented, do we?"

In one quoted interview above, Mr. O'Rourke did not submit enough evidence to warrant a "skilled care" designation as measured by Sr. Rose's initial impressions. For example, he did not stress the patient's blindness and any problems which result from this. Neither did he refer to the patient's hypertension or the need for bathing supervision. The one item he was adamant about was the desire for a Catholic facility. Sr. Rose is the advocate for the patients before the admissions board. It is she who reads a summary of the applicant's background and diagnosis to the board, and she must be provided with sufficient information (and information of a specific type) in order to feel confident about a successful outcome. As Chapter IV indicates, a skilled care certification is not given on request, but must be negotiated for. The certification is largely based on the patient's biography constructed by Sr. Rose and the family members.1 In the
case of the O'Rourke application, the admissions board decided that a more detailed physician's assessment of the patient's educational and psychological level was needed. As expressed by Sr. Rose: "To us she doesn't look skilled care. We need a doctor to make this judgment."²

In addition to this screening function, Sr. Rose helps families analyze their financial status and helps them understand and arrange for the various subsidy programs. For example, of particular concern to Sr. Rose during the interview is a private source of aid available to Catholics. The wait list which exists at Sisters of Faith Home is divided into three sublists: private paying patients, the religious affiliate's program, and Medicaid applicants. These are arranged in the priority order in which individual names are taken from the master registry and admitted to the home. As is the case at PH, the administration of SFH prefers that all newly admitted patients enter as private payers for at least one year. In fact, there was usually no waiting time for those able to pay privately for a year or more:

(Discussion with Catherine Anderson):
"If you can pay privately, you can get in faster. Medicare only pays for a hundred days, and so it's much more difficult to accept these patients."

(Discussion with Sr. Rose):
Sr. Rose tells me that Dr. Green is coming in as a patient today. She says that the application was just made a day or two ago by a close friend. Sr. Rose says that "this business" is not what she thought it would be, i.e., that she thought she'd be helping the poor more. I ask her what she means and she refers to the fact that Green's application was hurried along, with no meeting of the admissions board, because he has money. She says that a friend of the doctor picked up the application and immediately went to the hospital next door to tell them that Green would be moving to SFH. I say that since Green is probably getting a Pavilion room, he really is not taking space away from anyone else. She says
that this is true; after all, she remarks, he's been asked to sign on for a six-year private paying con-
tract.

Second in priority, individuals on the religious affiliate's program enter the facility almost as quickly as private patients.

During the course of her interviews with inquiring family members, Sr. Rose attempts to ascertain the applicant's qualifications for religious affiliate's aid. This is a program administered by a consortium of Catholic social service agencies and charity organizations, and is designed to provide support monies for those who, at various times in the past, donated work to their local parishes and parochial schools. In the case of nursing home patients, funds from the affiliate's program are paid directly to the facility to supplement fees provided by public assistance.

Sr. Rose is not permitted to ask directly about the individual's potential applicability for this program. Rather, the intake worker attempts to ascertain if the family has spoken with its local priest and if the priest has offered to write a letter on behalf of the application to SFH. Such a letter, specifically documenting the individual's contributions to the Church, is used by the facility to apply for the affiliate's program:

(Discussion with Sr. Rose):
I ask Sister to describe the religious affiliate's program. She tells me that it is a program adminis-
tered by the archdiocese to supplement the funds for those patients on Medical Assistance. The residents do not know about the program, and even those being sponsored by it do not know they are on it. Those individuals who, through the years, helped out in their parishes and receive a letter from their priests, are considered for the program. Because SFH receives more money for religious affiliate patients than for Medical Assistance ones, the former are given somewhat higher priority on the wait list.
(Discussion with Sr. Rose after an intake interview):
After Mr. and Mrs. Castor leave the room, Sr. Rose shows me a letter the couple had brought from Rosemary's (the applicant's) parish priest. This indicates that Rosemary can be a candidate for the religious affiliate's program, which is administered by Catholic Social Services in Philadelphia. . . . Sr. Rose says that "we can't ask if they're Catholic or if they go to church. That's discriminatory." However, if on their own, applicants get a letter of support from a priest, then this may be used as part of the application. Sr. Rose says to me: "They probably went to their parish priest. In this area, everything is done by letter by the priests."

In brief, the wait list is so structured as to give differential priorities based on the applicants' financial base. In her interviews with families, then, Sr. Rose attempted to determine which sub-list was most relevant to the particular case. I will discuss other aspects of the wait list below since it is the application procedure itself which is of concern here.

In addition to screening the applicant's medical and financial status during the initial interview procedure, Sr. Rose informs the families that, upon the admission board's approval of the application, there may be up to a six month wait before a bed becomes available:

(Intake interview between Sr. Rose and an applicant's daughter):
Mrs. Dougherty asks me and Sr. Rose if it is feasible for them to make their son sleep in the living room so that her father can move in with the family. I say nothing and look to Sister who says that she can't answer that kind of question. She does say that it will take a month before the application is approved, and several more weeks on the waiting list before the father is admitted. She says they need to think about alternatives until a nursing home bed opens up.

(Intake interview between Sr. Rose and the Castor family):
Sr. Rose asks about the family emotional supports. At first, Mrs. Castor must have interpreted this to mean financing, but, after Rose asks if there is someone else who could take care of Rosemary for a
while, Mrs. Castor responds: "The family is not close that way. For having thirteen children it's only wakes and weddings. There's no hostility, but they just don't get together. We talk about a reunion." A bit later she says: "No one wants to take her in." Sr. Rose then summarizes the medical history she will present before the admissions board; at the conclusion of this, Mr. Castor says: "If her environment were changed, it (her forgetfulness) would definitely be improved." Rose then says she will ask the admissions board for a four-bed unit in the Main Building, with private pay for ten months. She explains that the waiting list for a private pay is about two months, and for an immediate Medical Assistance patient the wait is six months; she suggests that the family make applications to other nursing homes. Mrs. Castor then reiterates the urgency of the placement. She says that Pat's (her sister's) health is not too good, and that, at best, putting Rosemary with Pat is only a temporary solution. She says that Pat is 78 years old. Mrs. Castor says that she herself has diabetes and an ulcer, and that her daughter and grandchild have just moved in with her. She then asks Sr. Rose: "Is it feasible to put a ten year old (her son) in with his father?" Rose responds: "I can't answer that." But she reiterates the importance of applying to other nursing homes.

Certain distinguishing features of the admissions procedure at Sisters of Faith Home can be noted from this example. First, SFH applications are made for a type of bed and room placement, not for a specific bed. Individuals have a choice in terms of the slotting type (private room, double, quad), but, at the application stage, do not have much to say regarding the particular bed or room. This can be related to the second general feature: Applications to the home are made without respect to the time dimension of the individual's eventual admission. Because there is a wait list, the individual applying to SFH is, in fact, applying for a place on that list, not for immediate entry to the facility.
In my interviews with Sr. Marie, the chief administrator, I was interested to note her surprise when she was told that other nursing homes (e.g., PH) do not utilize a wait list. For SFH, the wait list is an indispensible tool for handling the number of applications processed each month (on the average, ten) and for maintaining equity with regard to the order in which individuals enter the facility. Furthermore, Sr. Marie suggests that the list has symbolic importance in that it gives family members some hope that they will eventually be able to find a placement:

(Interview with Sr. Marie):
"I did not know that people did not have waiting lists. I guess I feel you know, you can even talk to fellow church people and they only want to take certain applications as the state aid applications, Medicare, they take their quota, and they will not even consider taking the applications. I feel that the people need a chance. You know, you might say to them, 'You're twenty-fifth on the waiting list, it's a long waiting list, but we're going to take your application and we'll move it up. You know. And we're concerned about you, but we might not call you for a year. Okay, you understand that.' And at least the person has some faith that they're not lost at sea, or no beds anywhere. Um, I have a real hard time on the admission committee trying to, I know that we have to balance the private payee and the state. And I know that because of the salaries. That's the reality. But I have great difficulty when we're not admitting a state patient."

The attitude expressed here is perhaps one major difference between the two facilities studied for this dissertation. PH chooses individuals to enter the facility based on a mesh between the available bed and the available patient pool (those immediately applying). In contrast, the SFH administration feels an obligation to admit all individuals who qualify for placement. In addition to the wait list, which establishes a time frame for admissions, there exists at SFH only the minimal traces
of a ward system (discussed in greater detail below). This, it seems to me, further speeds up the process by which individuals are "matched" with openings and are allowed to enter the facility.

In brief, the initial application procedure provides an opportunity for the social worker to furnish information about SFH to prospective applicants, and, in turn, for the social worker to garner appropriate information for the construction of an acceptable biographical statement.

As already noted, the admissions committee was governed by shifting rules during my observations at Sisters of Faith Home. For the most part, the board was charged with the responsibility of deciding on the applications that Sr. Rose brought before it each month and of establishing a wait list. At one time, however, the chief social worker, John Stevens, came under scrutiny by the other administrators because of the criteria he was using to admit patients from the wait list into the facility. During this period, the admissions board changed its functioning; it would place names on the wait list and then admit names higher up on the list.

(Admissions board meeting):
The board decides to approve all five applicants and to admit them immediately. Mary McRhodald is to be admitted to a private room in the Pavilion. Jess Palatino is to be admitted to one of the four-bed units. Elaine Goody, who requested a semi-private room, will be offered a private room. Flo Chiles will be admitted to a four-bed room. Hamlin will be offered room 400-A (semi-private room) and told that he can be moved from this once a four-bed unit becomes available.

Sr. Rose then presents several medical assistance applications. It is decided that one of these applications, that of Catherine Nolan, will immediately be admitted, rather than those even on the wait list because her application has been around since 1979.
(Admissions board meeting):
It is decided that Marjorie Dexter should be admitted to one of the four-bed rooms. John says that there is a problem because all the available rooms are dis-oriented. It is decided to admit Miller, Dexter and Hamlin (Martha) immediately, and to let the transfer committee work out the details. It is noted that there are several M.A. patients now in semi-private rooms who can be moved to four-bed units.

(Admissions board meeting):
Mrs. Wilson is asked her opinion about Mrs. O'Keefe's chances of being certified as a skilled care patient. She says: "She's really not skilled care now, but she can come in on intermediate. The doctor might say she needs skilled, it's difficult to say with some cases." Sr. Marie says that they are going to approve the application, then, and admit Mrs. O'Keefe this week. Catherine Anderson says that this means that they can fill all the empty slots with Mrs. O'Keefe and some people already on the wait list. Sr. Marie then says that the three additional female applicants approved today (Olney, Benson, James) will be "priority on the wait list," i.e., offered a bed as soon as possible.

The criterion that John (in consultation with the director of nursing) originally used was similar to the one in operation at People's Home: to find a match between the patient's degree of senescence and that of the other residents in the section where a bed was available. We will see below that, for the most part, SFH is not structured around such a ward system in which each of the six floors is reserved for a distinctly different resident population, and the committee felt that John's attempt to provide incoming residents with roommates who approximated their own functioning level contradicted this.

John's responsibility for assignments was briefly assumed by the committee, which reported that John's tactic meant that a bed might be left open for several days even though names appeared on the wait list. The method preferred by the rest of the administration was to bring a new patient into the facility as soon as a bed became available, and to
consider finding a more "appropriate" slotting later. This attitude was expressed to me by Sr. Rose who noted: "The important thing is to get a bed. We can always transfer them later." Also note the following:

(Discussion with John Stevens):
After the transfer committee meeting, I go with John into his office to get the paper on new admissions and placement decisions he had been keeping during my absence. He notes that most of the people were brought in because of bed availabilities, and that no other criteria were used: "I've tended to speed up the admissions process somewhat. Because they want me filling up the empty beds more, not wait."

(Discussion with Sr. Rose regarding a new patient): "She's oriented. I hope, my hope is that she'll be in a room that's stimulating. The basic thing is to get in at least, and then later get them on the transfer committee. Sometimes it's up to the peace of mind of the family (to tell them that transfers can be arranged). The individual doesn't usually follow up. We tell them that they can, but if they're disoriented, they don't do anything, of course. It's the families. There's usually a lot of guilt. When I talk to them, I tell them there's a bed available, they say, 'We can transfer them right? We want to do right for mom.'"

(After the transfer committee meeting):
Olivia, LGPN, looks at the folders that John placed on the table of the two patients to be admitted this week (Marie Sanders, Jess Palatino). She says she doesn't understand why Sanders who is totally disoriented is being given room 405 which is fairly oriented; she suggests that she be placed in Helen Strunk's room. She also says it's a shame that Palatino is being placed on third floor since her description indicates that she is fairly independent and fully alert. John says nothing to this other than that he needs to make a telephone call. . . . He later catches Olivia to tell her that it is the only available bed, and that he has been asked to bring in all patients on the wait list.

In keeping with this policy, one of the staff social workers indicated to the husband of an incoming patient that he should wait some time before complaining about what she (the social worker) knew to be an inappropriate slotting.
(Interview between Diane and Mr. Foley):
"I think you'll find the room will work out. Give it about a month or so, and then we'll see what we can do. But I'm sure she's not going to be too happy with anything in which she's not home."

In the discussion below, I will be concerned with the institutionally sanctioned criteria surrounding application decisions and assignments, and will not specifically discuss the politics associated with who carried these out at different times.

The admissions board consisted of six individuals: the administrator of SFH, Sr. Marie; her assistant, Catherine Anderson; the home's business manager, Mr. Ted Daniels; the director of nursing, Mrs. Wilson; the head social worker, John Stevens; and the intake worker, Sr. Rose. The procedure employed at the meetings was for Sr. Rose to read a summary of the medical history and financial background of each applicant. After deliberating on the individual cases, the board reached one of three decisions for each: (1) to accept the patient and place his/her name on the wait list; (2) to reject the application on either medical or financial grounds; or (3) to delay a final judgment in order to request additional information about the patient—personal financial resources, the disposition of a Public Assistance application, further medical or psychological reports—from the family.

Sisters of Faith is under the same constraints that we have seen to pressure the basic operations of People's Home. These constraints, in the final analysis, determine the outcomes of the board's deliberations. For example, a skilled care nursing facility is not permitted knowingly to admit certain psychiatric diagnoses:

(Admissions board meeting):
One question that is raised is about Catherine's diagnosis of schizophrenia. It is noted that there
is no psychiatric evaluation included in the application, and that the doctor who filled out the application gave no specifics of when and the circumstances under which this was diagnosed. John says that he doesn't think it will be necessary to ask for a psychiatric evaluation before acting on the application since, at one time, "chronic undifferentiated schizophrenia" was a label given to many people and had little actual clinical significance. Sr. Marie says: "We have a policy of not admitting psychiatric diagnoses; we don't have the facilities to protect the patients."

Second, all residents of SFH must be skilled care certified. Although a diversity of medical conditions and functioning levels may qualify as skilled care, the important point here is that ostensibly no individual is admitted without this certification.

A third constraint is provided by the individual's financial base. Although no application was rejected during my observations for the lack of private funds, it was not unusual for the admissions board to defer placing a name on the list because of insufficient documentation of finances:

(Admissions board meeting):
Sr. Rose says that the family has indicated (on Belle James' application) that she has one thousand dollars in a pension fund and a few hundred dollars in a savings account. Sr. Marie asks if the application is for a private-pay contract or M.A., and Sr. Rose says she hadn't noticed before, but that the family indicated both. Ted Daniels says that they obviously haven't enough money for private paying, unless they're including family funds which aren't indicated. He suggests they write for more information, and Sr. Marie nods her head yes.

During several meetings of the admissions board I observed a debate about the appropriate financial criteria to be used when structuring the wait list. At one time, the head administrator, trying to make it feasible to bring in M.A. patients faster, suggested the idea of replacing the bed left vacant by a public assistance patient who had
expired or been discharged with another M.A. patient. This policy, which had flaws which were pointed out by the business manager, was never fully implemented:

(Discussion with Sr. Marie):
Sr. Marie says to me that she has a great deal of difficulty when the admission of state aid patients has to be postponed. She realizes the reality is that she must pay the salaries. At one time, she would watch the number of M.A.s who died and would fill their beds with M.A.s on the wait list, until it was brought to her attention that certain private paying patients would also soon be going M.A. She says she refuses to discharge a patient who goes onto the M.A. plan.

Influenced by this discussion, a quota system was developed to limit the different admission types into the major buildings of the facility:

(Field notes):
I attend the staff orientation meeting in the basement seminar room. This is conducted primarily by Catherine, but Ted Daniels comes in to talk about payroll, and one of the dieticians comes in to talk about safety. Catherine mentions that there are over three hundred staff members. She provides a census of the residents: over fifty percent medical assistance (federal and state); over forty percent private pay; approximately six to eight percent Medicare and Blue Cross.

(Admissions board meeting):
This application, as well as the other M.A. applications, prompts the question of the number of medical assistance patients one can have in the home at any one time, and whether it is better to leave a bed empty or give it to an M.A. patient. Ted Daniels says that there is no formal limit, but that usually they don't want more than fifteen M.A. patients in the Pavilion and while there is no limit set as to the number of M.A.s in the Main Building, SFH should try not to exceed a fifty to fifty-five percentage of M.A.s.

In one example of the implementation of this stricture, less than one-third of the then available beds were filled by the admissions board since all of the patients on the wait list were M.A.:
(Discussion with Sr. Rose):
Sister tells me that currently there are no private pay prospective patients on the wait list (a private paying patient is one who will sign a contract to pay privately for a period of at least one year). The current census indicated that there were ten available beds (nine female beds throughout SFH, and one male bed in the Pavilion). Sister told me that John called the business office to see how many medical assistance patients could be brought into the home. The business office indicated that three M.A. patients could be brought in and so the top three names on the wait list will be offered beds. All three are female.

Although staff members were aware of the need to limit the percentage of medical assistance patients, these field notes indicate that they felt a tremendous discomfort in adhering to this policy.

It is necessary to consider the SFH room apportionments in order to understand the significance of the above three criteria as contrasted with the much smaller influence they seemed to exert at PH.

As noted, the chief social worker was temporarily relieved of the task of assigning individuals so that he could learn the institutionally approved criteria for admission. John Stevens began employment with SFH less than four weeks before I began the present research, and shortly after that, was called to task for not adhering to implicit institutional criteria. Apparently John was attempting to organize a ward system (similar to the one found at PH) in which each physically differentiated section of the facility was to be distinguished socially as well. My own observations during the first weeks of field work had indicated to me that no such ward system had previously existed at SFH, and it was my impression that such an arrangement was likely to meet with strong resistance. My later interviews with the chief administrator and the director of nursing confirmed this feeling. In a
discussion I had with Sr. Marie, it was apparent that she had established
guidelines which encouraged the integration of confused and non-confused
patients:

(Discussion with Sr. Marie during lunch):
I ask Sr. Marie how it came about that residents
(both confused and non-confused) are scattered
throughout SFH, but that third floor has the
highest percentage. She tells me that it was
her idea to mix the resident populations that
way; she feels it's better for the confused.
She says that the third floor used to be a
locked ward before she got here, but "I have a
problem dealing with restrained residents, with
locking them in, probably because I wouldn't like
it for myself." She says that she has no aversion
to putting confused patients on the first floor,
that she does not want to turn the first floor into
a showplace: "I don't want to give families the
wrong ideas. I'd put confuseds throughout the
building. It's unrealistic to show them only the
first floor. I'd put the confused on the first
floor too. Show families there's nothing to be
ashamed of." Sister says that it is good to mix
confuseds with alerts because it raises the "level"
around the confuseds. She says, however, it's im-
portant to try and get some sort of support system
for the alerts as a result.

Since the outset of her tenure at SFH, Sr. Marie had attempted to
continue a tradition presumed to have been established by her
predecessors of not separating individuals:

(Interview with Sr. Marie):
"SFH's staffing pattern is the same for every unit,
which is above the Medicare requirement. My previous,
well, my predecessor believed that the patient's bed
and the section of the room was their home. When they
came back from the hospital she provided for their
Medicare, because they deserved it. The staffing was
very adequate. . . . She did not put them in a segre-
gated section of the building (a usual Medicare
requirement at that time), which caused the home
great difficulty when the inspector came and asked on
the fourth floor one day, 'Can I have the Medicare
chart?' And the nurse handed her one, when she should
have said, 'I have no Medicare patients. The second
floor is the Medicare patients.' So when I came, my
job was to move everyone who was receiving Medicare
benefits to the segregated section of the building, which was not a popular move, let me tell you. Those people had been here ten, fifteen years. And I had to say I agree with my predecessor and disagree with the Federal Government and that people shouldn't be moved out of that kind of environment."

(Interview with Sr. Marie):
"I worked with teenagers, and I could trust them (living on integrated floors)... I kept saying to the staff (at SFH), 'What do you think of moving males and females on floors?' The staff thought it was a good idea. Of course, they never thought they would (actually do it).... We, uh, sat down with the nursing department, social service, and came up with a plan to mix the building. The plan took several months, over a hundred transfers, with patients, because we had to move sixteen people at a time."

It should be noted that this idea of a totally integrated facility was an ideal that SFH had never quite reached, largely because of the reputation of the Main Building's third floor. In a second interview, Sr. Marie remarked on the difficulties in desegregating the third floor of the Main Building. She told me that, since the founding of the building in 1949, third-Main primarily housed confused patients:

(Interview with Sr. Marie):
"Okay, the third floor, when I came, was all confused. The idea is that if you, there are two schools of thought. If you put the confused patients with the oriented patients you may help them to become a little bit oriented. But the other school of thought is if you put oriented people with the confused, they then become confused. So you have to keep it balanced out. We, at one point, talked about mixing the third floor, mixing the oriented and disoriented people. And now, uh, I would say there are four patients up there, oriented. And immediately the families and three of the patients wanted them to be moved off of there. ... Therefore, housing (there) has been very confused, and has (been) since the conception of the third floor back in 1949. That floor is no different today, with confused patients, than it was then. Well, I should really say '54 or '55. I was here in high school, a volunteer, unpaid, a volunteer. And the third floor was very confused
then. So I don't really see all that difference today. We have tried to put oriented patients up there, and then watch them very closely to be sure they are not regressing."

Other staff members at various other points expressed to me the difficulty in getting the third floor to be fully integrated with the rest of the facility:

(Discussion with Rita Knott, social worker):
"Talking with people, they said that third floor a long time ago, it was labelled really confused. But that was a while back, but the stigma is still attached there. Mae Olney's trying to get down to first, even though she has Anna and Catherine up there. It's a circle you can't get away from. Y'know, a circle. You try to put an oriented patient on third floor to try to change it, but then they start getting depressed or they think the confusion's gonna rub off on them. So we move them down to the first floor, and there's no real change up there. I don't think it's good to have different sections, because then the patient is stuck. 'Oh, he's on third floor, he's confused.' You automatically react to the patient based on the floor."

(Discussion with Diane, social worker):
"The third floor is where we place ... it's a noisy and confused floor."

Note Rita's hesitance in calling third "confused" in the following statement:

(Discussion with Rita Knott):
"With someone who's oriented and alert, if you put them up on third floor I hesitate to say that third floor is confused, I'm trying to get away from seeing third as black sheep. If you put an alert person up on third floor, their adjustment is very slow and sometimes it never happens."

Similarly, the director of nursing indicated to me that, with the probable exception of the third floor, there was an approximate equivalence of the various sections at SFH:

(Discussion with Mrs. Wilson):
"Basically, throughout the house is all geriatrics. Third floor is your more confused residents, if you've been up to third. First floor is they try
to keep it (with) people who try to get around on their own. But that's changing. I've seen feeders there. And total care also. Every floor has just about every type."

She seemed to equivocate, however, with regard to the benefits of mixing patients:

(Discussion):
"It varies with personality. If I'm a CVA (cerebro-vascular accident) and alert, and I've adjusted well, then yeah I could have a real ball with them. I could get a charge up there with the confuseds. But that's just me, my personality. Then there are other days, when I'm not so sure I'd want to deal with it. I don't think there's any cut-and-dried answer to that."

It should be pointed out that the social worker's earliest attempts at segregation were directed toward entire floors. That is, John attempted to develop a ward system in which different resident types were funneled out to different floors (or different sections within a floor). Although these efforts were thwarted, he was somewhat more successful in segregating individual rooms, i.e., in producing a system of heterogeneously populated floors, but with homogeneous rooms.

(Interview with John Stevens):
SJS: How do you feel about mixing patients within a room?
John: I'd have to be take more time with that, we'd need a more thorough screening process, to see if certain things are reversible, memory, orientation. That would require a real intensive treatment, including the roommates as part of the treatment team. I think the first thing is really to disperse a floor, make sure it's integrated throughout the floor."

(Discussion with Rita Knott):
"We try to get the patient to fit the room. The intake worker tells John what the patient is like. Sometimes we'll skip the first person on the list if the bed available is for someone else. It doesn't always work; the hospital worker may see it (the patient's condition) one way, and we see the patient very differently."
This was the implicit policy prior to John's arrival, and its implementation was encouraged by the present administrators.

Despite this encouragement, the importance of maintaining the population census (see above) often worked against efforts to produce distinct room types. Given the choice of leaving an opening unfilled or bringing in an "inappropriate" individual, John opted for the latter. It seems to me that he rationalized the admission on the basis that the transfer committee could rearrange things later. In other words, the policy sanctioned by the administration placed the priority for admissions on the bringing in of all patients as soon as beds became vacant. Thus, matching patients and rooms was permitted, but was largely not emphasized.

The director of nursing and the social workers operating within John Stevens' department contributed to the decisions which assigned patients to particular areas of the nursing home. Apart from the nurses, these members of the staff have the most daily contact and hands-on experience with patients on the floors. Their knowledge is utilized in the evaluation of the kinds of patients residing in various rooms. John was interested in matching certain medical and psychological symptoms of incoming patients with those of possible roommates. However, without the benefit of a system which continuously slots the same types of individuals to the same kinds of floors, i.e., without the benefit of a ward system as the term is used here, there is not likely to be any consistency of rooms over time.

Three items, in descending order of salience, seem to account for the outcomes of specific slotting decisions: First, an individual was allowed into the facility in the order prescribed by the wait list; as
noted, the ranking of names on the list comes from the date on which the admissions board approved an application. This is, of course, also influenced by the three sub-lists (private, religious affiliate's, Medical Assistance). The second consideration centers around the type of room the family members and the patient have requested and are willing to pay for. Unlike PH, applicants at SFH are not provided with a choice of different wards. However, as already noted, some families are discouraged or, on their own, refuse to accept a third floor slotting. SFH patients are provided with a range of bedroom types from which to choose. For example, there are both single-person and double rooms in the Pavilion and in the Main Building. In addition, most of the Main rooms are four-bed units. Since fifty-five percent of the patients enter as private payers for at least twelve months, there is considerable discretion available to family members with regard to room choice. Thus, room assignments made by John take family room preferences into account:

(Discussion with John):
I ask John why Mr. Crenzi, a new patient on the second floor, was offered the room that he was. John says: "He did have the option of a private in the Pavilion, no Main Building, I believe that was offered to them, or a Pavilion bed that's open. They don't want that. This was the only four-bed male room—which they had requested."

(Discussion with Sr. Rose):
I ask Sister to go through the list of names of patients who were recently admitted and to tell me why they were assigned their rooms. She tells me that Mary MacRhodald, who was admitted on January 29, 1981, to room 356, was given that room because "she definitely wanted a private-pay Pavilion." Flo Chiles, who was admitted on January 22, 1981, to room 411-B, wanted a semi-private room. Mr. Hamlin, who was admitted on January 22, 1981, also, to room 400-A, was assigned there "because his wife wanted him in a semi-private room."
(Discussion with John Stevens): I ask John about the criteria used in assigning Jess Palatino to a room on the fourth floor. He responds: "No thought. They had asked for semi-private. We offered them a private room and they agreed to it."

The available funds limit the options John has for placement. This was expressed to me several times by John and by Sr. Marie, who stressed the importance of choosing a room which did not exhaust the patient's money before a year was up:

(Discussion with Sr. Marie): "We are very careful of the patient's money and where in the building we place him. Since you're doing a paper on this, we try to get the families to sign a contract to pay privately for a year, one full year. Sr. Rose goes through the financial reports they give, and she figures out how many months (on a private pay contract) they can afford."

Finally, it is the stated goal of the institution to match incoming residents' medical and psychological diagnoses with the facility. This is not altogether consistent with the fact that John Stevens, Mrs. Wilson, and their respective staffs occasionally try to match specific rooms (rather than sections) with specific patients:

(Discussion with John Stevens): "If a person is confused or disoriented, we try to put them in a room with others like them. We sometimes can't though. If they're really disruptive, then we really don't like to put them with other people who are more oriented."

(Discussion with John Stevens about a new patient's placement, Rosemary Burke): "I know one of the persons in that room, Katherine Ross. The other two I don't know. It was based on what we know about Rosemary Burke. Katherine is a little confused, but she's not noisy. I wouldn't call it a completely disoriented room. Rosemary, they said, was somewhat disoriented. It was brought up in the application that the short and long-term memory was bad. But today when I saw her,
I think I noticed that she's fearful of the sister. I'd ask her a question, and she sort of looked away.

(Discussion with Sr. Rose about Rosemary Burke): "She's forgetful, but that's different than being confused. I'm forgetful, but don't put me in a four-bed unit. It's not being batty. We wanted to keep her as stimulated as possible. John's not too satisfied with that room though. It's not the best."

(Admissions meeting): John is asked why the two private pay patients already on the waiting list have not been offered beds, since there are so many available. John says that the two women need an oriented room, and there is none available at the time. He says that the male patient is waiting for a four-bed unit.

(Discussion with Diane): I ask why Mr. Hopkins, a new first floor patient, was assigned to room 102. Diane responds: "It's the only available (male) room. We have a semi-private on the fourth floor but Medicaid does not pay for semi-private rooms. It sounds terrible to say. . . . I never would have put him in 106 because everyone there is out in left field. I would have had to make a transfer on the second floor for Hopkins, but he would have been even more depressed there. Let's see, who would I transfer. The three of them (in 106 now), I wouldn't have wanted to move. There really was no choice."

The match system as discussed for PH is based on a ward system which allocates whole sections to specific resident types. When a new admission is granted, the patient is brought into that section of the facility which has historically been designed for a certain patient type. The patients comprising a given section may change, but the differential slotting criteria for each section remain reasonably the same. At SFH, in contrast, the individual is not matched to ongoing criteria of a particular section or room, i.e., to criteria which supercede specific persons currently occupying places. Rather, the actual roommates living in the room under consideration are matched with
a potential new patient. An "oriented room" at SFH, for example, is not
a room which has been set aside for alert residents, but is one in which
the current occupants are considered alert. These individuals might
die, "fail," or be discharged, and the next round of occupants might all
be confused. Rooms at any point in time are described by the staff as
being oriented or not, but, over time, these descriptions change. One
social worker told me that rooms tend to take on a life and character of
their own only for brief periods of time. It is this transitory
character which must get matched at any given moment:

(Discussion with Diane):
I ask Diane why Miss Wrenn was placed in room 403
and she says: "As I remember, I didn't want to put
her in that room. Why did we? That room is a very
 unmotivated room. Rooms tend to fall into a pattern.
405 is another. Carmella gets around, but the other
two never do anything for themselves, unless there
really is no one else around. They usually don't
even feed themselves if an aide is there."

In this regard, staff members acknowledge that it is difficult to keep a
room constant for other than brief periods:

(Discussion with Cynthia, LGPN):
"Our thing is if there's an incompatibility between
patients (then we transfer them). Sometimes if the
family wants the move. . . . Sometimes we hope
there'll be more stimulation, verbal, in that room,
even if the person can't contribute to it directly.
But that's rare. We have alert rooms, but they don't
stay that way too long. I don't know why."

As noted, one consequence of such patterning is that John and the other
social workers must from time to time review the status of a room in
order to know what type of resident is appropriate. I have no data
which indicate that there are enduring characterizations which are
section-specific.
One reason that a room does not maintain its identity is that John and the admissions board must fill every available slot:

(Discussion with John Stevens):
"At the last admissions meeting, there was pressure to bring people in. The census was very low. We had available, let me see, three privates in the Main Building, a semi-private in the Pavilion, and two privates in the Pavilion." John says that the "bed selection was a little less than planned," that he needed to bring people in on M.A. telling them they were getting private rooms until four-bed rooms became available.

(Meeting of the health care team):
Helen Burris, a female patient on the third floor of the Main Building, comes up for review. The nurses indicate that she is disoriented times three (i.e., disoriented to person, place, time), and that she has become withdrawn, decreasing her attendance at the choir and other activities. Sr. Constance, the head of the activities program, says that perhaps she needs to be encouraged more, assisted down to activities. Nurse Zeak, the charge nurse for third-Main, says they try to get her down, but that she usually refuses, saying her feet hurt her or are shaky. One of the other nurses remarks that Burris had been placed in an oriented room, but that now her roommates are two women who are disoriented.

Second, as at PH, the institution may be provided with an inaccurate or incomplete description of a patient. Clearly, if a transfer is not ordered, a non-fit may over time change the character of a room. In some cases, flawed information can be seen to result from the long wait between application and admission necessitated by the wait list. For example, Sr. Rose acknowledges that outdated information can lead to a faulty placement:

(Discussion with Sr. Rose about Caroline Santori):
Based on the 1977 application made by Caroline's sisters, Sr. Rose gave John the following description of Caroline in order that he could decide on a room assignment: She's oriented, depressed, noisy, ambulatory, continent, bathes and dresses with assistance. Sister tells me that perhaps she did not portray an accurate picture to John since Caroline's condition has now
changed. "In talking with the sister, since December, she's changed. She's only shuffling and holding on to things as she walks. She's incontinent. . . ."

Also, the following:

(Discussion with Sr. Rose about Rosemary Burke): "I said to the family it's the best available space we have to offer. And I told them they should tell me if it's not what they want. Now they say she's becoming more confused, but she stays two weeks with one sister, and two weeks with another. She's shuffled back and forth. So she may be becoming more confused."

(Admissions interview between John and Mr. Crenzi's daughter): At one point, the daughter says: "I must emphasize this, when we first came to Sr. Rose, we painted a very different picture (i.e., from Mr. Crenzi's present appearance). . . . In the hospital, he was just sitting like a living vegetable. I say we painted a very different picture because things were different with him. He couldn't walk by himself. He couldn't feed himself. . . . Now that he's not with sedation, we're all very thankful for that, he can walk, he takes care of himself. I'm sorry for being so long winded, but I did want to let you know."

When a match was attempted by the staff, the assignment was made so as to accommodate to the particular functional level of the incoming resident. For example, the chief social worker described the importance of providing disruptive patients with roommates who would not be bothered by their noise:

(Discussion with John, director of social services): The interview between John and Mrs. Nunnely's step-son is concluded. The son says that he wants to go up to talk to the nurses before Helen (Nunnely) arrives. I remain with John. I ask him and he tells me that Helen has been assigned to room 301-B. I ask why, and John provides the following: "The social worker from Quiet Haven told us about the kind of room she had there, and suggested that we do the same. She's gonna be on a ward where she'll be the least problem. If they're gonna be disruptive, we try to put them where they will disturb the least number of people."
Also:

(Nurse's station, fourth-Main):
The nurses tell me that Helen Strunk, one of the patients, is suffering from Alzheimer's disease. They say that a consultant came in to use behavior mode techniques with Helen on a one-to-one basis and she showed considerable improvement. They say that the consultant is no longer coming in, and because the disease is progressive, Helen's behavior is deteriorating: "We don't have time for her, such individual attention." They say she's very noisy, and that that is a problem for filling the bed next to her. They say they will basically need a comatose person for the fourth bed in Helen's room; she annoys the others in the room with her constant singing, screaming, etc.

(In room 419, Main Building):
It is early morning, and I have on my list of things to do today to visit the new patient brought into Helen Strunk's room. Her name is Marie Sanders. . . . I enter the room and walk to the first bed on the left side of the room. Marie is in bed, mumbling to herself, clapping. I ask her her name, she smiles but says nothing. The bed rails are up, but she pushes her hand through the spaces and extends it to me; I take it and hold it for a few minutes. Then she lets go, and begins clapping her hands softly. I leave the room and go to the nurse's station where I ask to see Marie's chart. I note the following entry by the social worker, Rita: "Resident is alert but confused and disoriented. She will respond to touch and to her name, but she is unable to respond verbally."

From the staff's perspective, the primary reason for dispersing resident types throughout the facility related to the organization of the work load. John Stevens and Mrs. Wilson, in deciding where to place an individual, were concerned with the best ways to distribute the various patients as related to the demands placed on the nurses and aides. This included both the distribution of patients in the larger facility and of those in the rooms on a specific section:

(Admission board meeting):
In discussing the bringing in of seven M.A. patients, Mrs. Wilson, the director of nursing, asks for the assistance of social services in spreading the new residents--since they all will require total care.
(Discussion with Diane, social worker): 
"Another consideration is that we have to balance self-care with total-care. In a room, and for an entire floor. Carmella gets around. Catherine Knight is kind of confused, paranoid. Perhaps legitimately. But she never leaves her room. I think she went out once and when she came back her perfume was missing."

(Discussion with Sr. Rose, intake worker): 
We discuss the recent admission of Mary Tansoff, and I ask Sister why Mary was assigned room 300-B. Sister responds: 
"John tries to match up, y'know, according to the level of orientation, y'know, in the room. Also, if that part of the hall is heavy with nursing, we question if it's good to put the patient there. She's in another facility now. The funds are running out; we want the funds to run out here. That's terrible to say. But they're going to have to find another place anyway. Where she is now, they don't accept Medical Assistance."

In the following excerpt, the chief social worker told me that, while he did not wish to over-burden any one section, his decision to place two confused total-care patients on separate floors was "arbitrary":

(Discussion with John concerning his criteria for assigning three incoming patients): 
John: There were two total cares: Mrs. Weaver and Mary Tansoff. I didn't want to put two total care admissions on the same floor. Also, they all requested four-bed units. SJS: Of the two total cares, why did one go to the third and the other to the fourth? 
John: It was an arbitrary decision at this point. 
SJS: At this point? 
John: There may be a transfer. I'm still not that familiar with the residents. That third floor room shouldn't be a problem, given the applicant's condition--she's disoriented. Her roommates are fairly disoriented. I know hardly anything about fourth floor. 
SJS: What about Santori? 
John: Again, there was a request for a four-bed unit. That was the primary consideration on that. 

This supports the contention that SFH seeks to avoid the development of a ward system. Patients whose applications described them as "confused" or "alert" were evenly distributed throughout the facility. Other medical or emotional "problems" were distributed in much the same way.
To summarize the data discussed to this point, the various sections at SFH may be seen as functionally equivalent. This equivalence is derived from the analysis of the statements of informants supported by my observations. An entering resident may be placed in any of the sections without regard to his/her mental functioning level or medical diagnosis. Entry into the facility was governed by a wait list which prescribed admissions order (in turn, based on payment category and application date) and the availability of a particular bed type. In addition to these considerations, specific slotting choices were made (by the admissions board as well as by the chief social worker) with the even distribution of staff members' work loads in mind. One possible exception to all of this may be found on third-Main. Interestingly, the ambiguous nature of this floor during the period of my research was similar to that which was found for "B" section at People's Home; both "B" and third-Main appeared to be in transition phases; i.e., a change was taking place in the definitions of the clientele for which each was reserved. One difference between the two facilities' transitional sections was that the alteration processes operated in reverse. PH's "B" section is formerly a prestigious and highly valued ward within the facility; it is currently suffering the loss of the most alert patients to "E" and "A/E" section. Thus, the transition there is one of decline. To the contrary, at SFH, third-Main has historically been a section where confused and physically ill patients are placed. Until recently, it constituted a closed or locked ward. During the course of this study, Sr. Marie, John Stevens, and the others were trying to change the reputation of third-Main by assigning alert and partially self-care patients to this area. Resistance to this change can be noted in the
fact that certain staff members were hesitant to call third-Main a "confused floor," while others at SFH discouraged the integration of this section and thus implicitly accepted the historically-relevant label.

It should be pointed out that a second possible nonequivalence existed at SFH, that between fourth-Main and the remaining floors at SFH, although this did not seem to influence slotting decisions. On several occasions, staff members described the fourth floor of the Main Building as differing from the others:

(Discussion with Sr. Rose regarding an incoming patient): "In talking with the sister, since December, she's changed. She's only shuffling and holding on to things as she walks. She's incontinent. She needs to be fed, and now she's unable to bathe and dress herself. She's continued to be disoriented, adding to this she's wandering at night, she has medicine for that. I have to get back to John, but I think he'll keep her there. Where she will be placed, fourth floor, that's noted for heavy nursing care. Heavy feeds, heavy in carrying, etc."

(Discussion with Rita Knott): "There's something about first floor, I don't know what—everyone likes first floor. Those on fourth, if they're alert they want to come down. They feel more isolated from the main stream. There's that reputation thing we're trying to get away from. Mae Olney's niece called up a few weeks ago and said she wanted her aunt out of the fourth floor solarium, but definitely not third."

These and other staff members were never able to pinpoint for me the distinguishing behavioral markers of fourth-Main. An interview with Sr. Marie revealed that this floor used to contain only male patients and so had a reputation among the nurses for being a "heavy" duty:

(Interview with Sr. Marie): "... The staff had very little morale (on the fourth floor). They thought their floor was too hard, the men were too heavy, uh, they were over-worked and underpaid. Uh, it was the most difficult floor in the building. At the same time, the third floor had a lot of confused patients. . . ."
Despite these statements, my observations of the admissions board meetings and my discussions with the social workers never revealed that the fourth floor was used as a discrimination for patients. In other words, historical divergences aside, five out of the six sections at SFH are used equivalently for slotting purposes, as measured by the presence of both confused and alert patients on these floors. In this sense, and based on the data discussed above, the following equations may be used to summarize the organization of residential positions at SFH:

\[ 1M = 2M = 4M = 2P = 3P \neq 3M \]

A third exception to the rule of equivalent sections may be noted. This develops from the non-equivalence of rooms within each section. Although no explicit ward system existed at SFH, as noted, staff members did on occasion endeavor to create rooms which were distinctly "alert" or "confused." Staff members acknowledged problems in this regard. The rapid turn-over of residents and the fact that specific rooms were not reserved continuously for one or the other patient type worked against the probability that residents were always "matched."

**Transfer Procedures**

With the above summary as a base, attention can be directed to the impact of the patterning of section equivalences and nonequivalences on transfer criteria and types. Transfers may be divided into a variety of classifications. For example, a transfer may involve a room change only, a room and section change, a room change between sections which are considered equivalent, a room change between sections which are considered nonequivalent, and so on. Given the rather "loose" criteria governing initial assignments, it is perhaps not surprising to note that...
transfers at Sisters of Faith were as likely to involve intra-ward changes as they were inter-ward changes. Table II indicates that, for the period of January, 1980 to May, 1981, fifty-five percent of the transfers at SFH took place within a single section. Of the remaining inter-section reassignments, an additional thirty-seven percent involved a transfer to an equivalent section (i.e., any unit but third-Main). Finally, only eight percent of the forty total transfers during this period consisted of transfers between differentially evaluated sections.

These quantitative data are reinforced and accounted for by my interviews with nurses and social workers which indicated staff awareness that intra-ward transfers were common. The reported criteria for transfers further indicated that transferring off a section was not usually a salient consideration. Note the following:

(Discussion with John):
"At times of new admissions, that's when the juggling is done. When someone who's deteriorated is moved to another room, a more suitable one."

(Discussion with Diane):
"We bring people in and transfer them later. After we've seen them for a while we know what roommates would be best. We sometimes move them from room to room until we find something."

Reassignment decisions were made by a committee other than the admissions board. The composition of the transfer committee changed annually. At a minimum, one nurse and one nurse's aide from each floor attended the bi-monthly meetings, along with the director of social services and a second social worker. In addition to this, a second administrative staff member (Sr. Marie, or the director of nursing, or one of their assistants) also attended and served as head. The committee convened every two weeks in order to discuss problems encountered on each floor and the viability and efficacy of transfer
TABLE II

SISTERS OF FAITH HOME TRANSFERS

(January 1, 1980 to May 31, 1981)

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Same Ward Transfers = 22 (55% of total transfers)

Different Ward Transfers = 18 (45%)

Same Type Transfers* = 15 (37%)

Different Type Transfers** = 3 (8%)

All Equivalence Transfers*** = 37 (92%)

* Transfers on/off any section but 3M, between two sections

** Transfers between 3M and another section

*** Same Ward plus Same Type Transfers
solutions. Recommendations were also made to the health care review team (a separate administrative committee with some memberships overlapping with the transfer committee) with regard to requests for psychiatric consultations and medication reevaluations. I know of no transfers completed at SFH without the prior awareness and, in most instances, the approval of the patient or his/her legal representative. As a result of this policy, Sr. Rose told me that many transfers approved in committee were never carried out.

A variety of reasons, some similar to those found at PH, were offered as justification and causes of transfers. The relative weighting and meaning attributed to these criteria differ between the two institutions:

(Discussion with Mrs. Wilson, director of nursing):
I ask Mrs. Wilson for some of the criteria for transfers and she lists them as follows: "People not getting along with each other, and that's really weighted out. Family requests. Patient requests. Sometimes the family puts in a request to move the patient to the Pavilion for air conditioning, for health reasons, we've done that. Sometimes for the safety of the residents if they're really battling each other."

(Discussion with Cynthia, LGPN):
"Our thing is if there's such an incompatibility between patients. Sometimes if the family wants the move, 'My mother's not as confused as the lady next to her.' Sometimes they're right and we'll move them. Sometimes we hope there'll be more stimulation, verbal, in that room, even if the person can't contribute to it directly. But that's rare. We have alert rooms, but they don't stay that way too long. I don't know why. And most of the alerts are down at activities all day."

It is interesting that the first reason offered by each nurse concerns personality problems. Indeed, nearly twenty-six percent of the transfers analyzed for this study were justified on the grounds that the roommates were "incompatible" or "not getting along." In association with the absence of a differential ward system, staff members at SFH
emphasized that careers at the nursing home were individually
determined, i.e., shaped by individual personalities (see infra). SFH
staff members hesitated whenever I asked them to generalize about
patients or sections, and they preferred instead to talk in terms of
specific individuals and individual characteristics. Consistent with
this emphasis, personality conflicts between individual residents were
cited as one reason for which a transfer was considered appropriate:

(Discussion with Rita Knott, social worker):
Rita and I talk about the transfer meeting which was held
yesterday, but which I missed because it had originally been
scheduled for today. Rita tells me that several names were
brought up for transfers but none was approved. She says that
Anna Balsamo is unhappy with her first floor roommate,
Florence Guest, with whom she is always fighting. Rita tells
me that Anna has a history of fighting with all the roommates
she's ever had, and that she is periodically moved from one
room to another. "Anna has to go past Florence to get to the
bathroom; it's something really petty like that." Rita says
that Anna is on a private pay contract for now, and she will
see if she can talk the family into a transfer to a private
room.

(Discussion with Catherine Anderson, administrative assistant):
Catherine hands me the book with notes on the transfer committee
meetings, and we discuss some of the decisions that have been
made recently. A decision to move Anthony Temple from room
208-B (Main) to 200-B (Main) was approved but never carried
out. The reason for the transfer was that there were roommate
problems between Anthony and his roommate; there had been many
"verbal confrontations." There was no indication as to why
the transfer was not carried out.

As I attempted to evaluate these discussions, it seemed to me that many
of these "personality" conflicts could, in fact, be interpreted as
incompatibilities based on functional level differences. The difference
between this rationale for a transfer and that provided at PH needs to
be addressed. From one perspective, the transfer of Ford from "E" can
also be seen and justified as a "personality conflict" with her roommate
(see Chapter V), this "conflict" being contextually determined.
However, the rhetoric at PH translates whatever else the conflict may have been into a poor match between the resident, her peers, and the section-wide, supra-individual behavioral expectations. On the rare occasion at PH when staff members suggested (to me and to each other) that two roommates were not getting along, it was agreed that the individuals did not have to stay together during the day, and, therefore, no transfer was approved. The present analysis, then, can be seen to be considering differences in the structure and meaning for the participants of assignments at each nursing facility. The rhetoric at SFH seems to emphasize individual differences over section matching with regard to transfer decisions.

John Stevens referred to the weighting given to personality conflicts and individual problems when suggesting that many transfers at Sisters of Faith are arbitrary:

(Discussion with John Stevens):
Our conversation turns more informal, and at one point John says that admissions board meetings are not very interesting: "They're so dull. Not like the transfers, they're very tense." Why? "The nurses bring with them a whole set of feelings about individual patients. Some don't think a particular transfer should be made or should be. Some feel moves are arbitrary. It seemed to me some are arbitrary at times. I've tried to say that a few times. A lot of staff take things personally. If you inquire about patients, how they're doing, they bring with them these feelings to a transfer meeting. I know Diane (now a former social worker at SFH) felt powerless. She always said she felt as if she couldn't do anything. There are two social workers and nine nurses. So if you put it to a vote, you know you'd lose."

It would appear that what seems arbitrary in such transfers results from the fact that, given two residents who are fighting, one of the dyadic members is "arbitrarily" transferred to alleviate the problem. Residents are aware that the decision to break-up a feuding pair serves to place the onus of fault for the trouble on the individual who is moved.
(In John's office, with Joe Peters):
After the transfer meeting, John meets with Joe to discuss the possibility of a transfer. When John explains to Joe about his being moved (because of problems with a new roommate), Joe takes this to mean that everyone thinks he was at fault for the previous night's fighting. He says that he refuses to move. Throughout the discussion, Joe is quite agitated.

Joe: That man (Phil, an older roommate), eighty-five-years-old, always playing with his radio. He's eighty-five-years-old, I don't give a damn. I'm handicapped, he don't give a damn. What floor do you want to move me to?
John: Second floor.
Joe: What room?
John: 201. Right above your room.
Joe: (Shouting) No, I not gonna move. I told Diane, I hope I gonna stay here for life. I don't want that. I didn't do anything. The other man, eighty-five-years-old, he raised the cane. . . . The other man, he turned my radio off yesterday. . . . And the nurse this morning, she didn't do right. I'm in room 102 for life. I'm handicapped now, John.
John: Joe, I know, we want you to understand, we're not saying it's your fault.
Joe: It's their fault. They stay in the room all day. They stay in bed all day. I go around all day. He hits me almost last night.
John: I'm not saying you're wrong. It's that we only have one--
Joe: I won't. Put them two up there.
John: Where are you gonna sleep tonight.
Joe: In the room I slept in last night. Until you get those two men out.
John: But Joe, we only have one bed on second floor.
Joe: John, I didn't make any problems. It's the truth. They put me from the fourth floor to the first already.
John: You're saying you never want to be moved.
Joe: No, I didn't do anything. I want to stay 102 for life.
John: I cannot promise you.
Joe: I'm not moving, no sir.
John: Alright Joe. I want you to know that we weren't proposing to move you because you were at fault.

(Nurse's main office):
John goes into Helen James' (nursing assistant supervisor) office to tell her about Joe's decision not to accept the move. The evening duty nurse supervisor is also present, and the following conversation ensues:
Helen: I don't understand this. Phil and Joe get along fine until Hopkins.
John: When was Joe moved?
Nurse: Joe's been moved so many times, but we didn't move him because of a problem he did.
John: He feels he gets punished every time he moves.
Helen: He wasn't moved because of a problem, but because we were trying to distribute all the patients.

A number of the staff members say that while personality clashes are used to justify transfers, rarely do such reassignments alleviate what is seen as the problem. They based this opinion on first-hand experiences of having transferred trouble-makers (often several times):

(Discussion with Rita Knott):
Rita tells me that Mr. Porter's name was brought up to the transfer committee, but that no transfer was approved. He is considered "violent," he has been beating his roommate and he frequently goes on hunger strikes. Rita says: "We decided not to move him as yet. We didn't know where to put him and that really doesn't solve the problem."

(Discussion with Rita):
"He (Hopkins) had a fight with Joe Peters this morning. He said Joe owed him thirty cents. He raised his fist to Joe, he didn't hit him, just raised his fist. Joe told the nurse and he said he was afraid to go back to his room. The nursing supervisors want to move him (Hopkins) off the floor, or at least out of the room. But a move won't really change the problem. He'll act out with any one he's with. John told him he can't stay here if he's gonna threaten the patients. I tend to think he'll be just as bad on another floor. Hopkins did ask for a room change, it's not as if we're doing it to him. Maybe he doesn't get along with the staff on the first floor."

(Discussion with first floor nurse):
I ask the nurse if any decisions were made in the Anne Phillips/Anne Cort battle. She tells me that no transfer has been made, that the other nurses try to encourage Cort to stay out of the room during the day: "It's not too bad right now. Cause Anne Cort is out most of the day. And the other two can't hear, so she can't annoy any of them."

(Transfer meeting):
... The nurses bring up a transfer for Constance Anton. They say that Margaret Baxter is constantly being barraged by requests from Constance, and has started to complain that she wants a transfer. The nurses say that they can switch places between Anton and Cort, but one of the other nurses questions the logic of this, i.e., putting a non-confused person (Constance) in a disoriented room. One nurse says that Constance is not in her room all day, but this prompts someone else to say that if Constance is not in her room all day, how much time could she have to annoy Baxter: "She's up at
seven, and they're cleaning them. And then she's out at ten, for Mass, and she's gone all day, activities, PT. She doesn't put her to bed to almost ten." Another nurse says that Anton won't get along with anybody, so she questions the appropriateness of a transfer altogether. They all agree that they are afraid to put Anton and Anne Phillips together because this will only result in Anton "stimulating" (exciting) Phillips, which will result in the same problem as previously existed between Anna Balsamo and Phillips.

The nurses also say that Constance Anton is on 10 mg. Novine which seems to "control" her somewhat. They still say that she is a problem patient. She is constantly asking the staff to do things for her, such as getting her a cigarette.

Over time, staff members say they learn to live with the problem rather than continue with further transfers. This appears different than cases seen at PH where transfers seemingly solved the problem. At PH different expectations and guidelines devolved on the newly transferred patient as he or she moved from one ward to the next. This was not the case at Sisters of Faith Home. For example, even after SFH's Hopkins was reassigned a room on the fourth floor, he would daily visit the individuals on first-Main he had previously haunted and annoyed:

(Discussion with Rita Knott):
"He was thrilled to death that he's moving, and now he's down on first all the time. He was so happy on Friday. I went to see him and he was ready to cry, he was so happy. When I came in on Monday, he was downstairs on the first floor. 'I can't stand it up there. There's nobody to talk to,' and things like that. I told him to give it time, 'you don't know any of the other residents yet.' There are residents he can talk to. He said he didn't care... If he's content to spend his day downstairs and his nights upstairs (shrugs shoulder). I asked him if he's having any problems with the elevator and he said no. So as long as he behaves himself..."

Similarly, a patient was transferred from second-Pavilion to fourth-Main in order to break up the fighting with her roommate. The woman was restrained in a chair in her room on both floors, i.e., before and after the transfer. Staff members acknowledged that this treatment served to
increase the resident's anxious behavior, but made no provisions for changing this:

(Interview with Sr. Rachel, fourth-Main nurse, about Joan Miles):
"We can't have her walking about. She wobbles. She's wobbly. Mrs. Ray (nurse), down on second, wanted to get her (Joan) away from Bessie. They just fought at each other all the time. . . . (Joan) wants to get out (i.e., of her restraints), but--."

In some instances, reports concerning personality clashes can be seen as post hoc justifications for certain transfers, and probably should not be treated as disinterested descriptions of the pre-conditions. Several considerations may be used to support this interpretation. First, some transfers which used personality clashes as an explanation involved not just a room change, but included a section change as well. In this manner, the nursing staff under which the patient was cared for was also changed. Second, staff members under these circumstances were observed to remark during the transfer meeting: "Now you have to contend with her for awhile" and "We don't want them back too soon." A revealing case in point may be found in the transfer history of Sophia Garcia who, in the two years she resided at SFH, has lived in all four floors of the Main Building. Garcia is a small, wheelchair-ridden woman, who spends her day making pom-poms from yarn and cursing in Spanish at whoever walks past her. Although it was her roommate, Mrs. Phillips, who was said to be the ostensible difficulty in one transfer decision, the existence of roommate problems was used to justify reassigning both patients from their first floor slotting:

(Transfer meeting):
The first floor nurse begins by suggesting that Phillips be moved. She says that she is constantly upsetting Sophia Garcia. Someone remarks that "she's been all over the house" and that they can't continue giving Sophia
phenobarbitol to calm her down. It is suggested that Sophia be moved to the third floor, and further that she be placed in 311-B. The third floor nurse says: "There's Eva Keeper. Mrs. Brookline says nothing to nobody. Sophia won't bother them." In going around the table, Betty Skelton is mentioned for a first floor room by one of the nurses, and John brings up the idea that he would like to move Marie Wiser to an oriented room on the second floor. Another suggestion is made for Anne Phillips to be given 211, saying that then it will be a completely disoriented room. Diane objects by saying that, while Anne is a very difficult patient, she is also oriented. She asks if it is fair to place Anne in a disoriented room, but no response is made to Diane's question. . . . The following transfers are finally approved: Sophia Garcia will be moved from 123-B to 311-B, and Phillips from 123-A to 228-D.

In other words, "roommate problems" and "personality clashes" were used on occasion to justify inter-section transfers for patients who, it would seem, were proving to be an annoyance to the staff.

A second situation which results in (or, is used to justify) a transfer concerns the changing health status of patients. When an individual is no longer seen by the staff as benefiting from, and perhaps, is seen as suffering from a current slotting, then a room change is discussed:

(Health care team meeting):
Helen James, the assistant director of nursing, suggests that they bring up Margaret Fahey's name for a transfer: "It seems as though she's failing, withdrawing or giving up. She's not in the best room: Mrs. Smith, Mrs. Farley, Denise Evans. I'd withdraw in that room. Maybe one of our goals should be to get a room change. Staff should make an effort to get her off the floor--to activities or to Mass. It sounds as if she's not getting enough communication."

(Transfer meeting):
One of the fourth floor nurses suggests that Margaret Fahey be considered for a transfer. The nurse says that Margaret has periods of confusion and that her mental condition seems to be worsening: "She seems to be going down." The nurse says that they have begun a bowel and bladder regimen with Margaret to ensure some regularity in this, and that they will start asking her down to church on a daily basis so she can socialize with others. She says that she thinks it will be a good idea to move Margaret from 419-A to 424-B, that Catherine Hobart is leaving and Margaret will probably benefit from some
aspects of that new room: "The roommate will talk to her. She goes out to therapy and so is out of the room part of the day. It's not the ideal room, but it's a little better for her."

(Discussion with Diane about a new resident on fourth-Main):
SJS: Are you thinking of moving her now that you've seen her?
Diane: No, there's no reason to. If she really deteriorates, if there's a drastic change, but not now.

This situation contrasts with that which I observed at People's Home. A PH patient, whose health or mental status was considered on the wane, was usually transferred to a ward which those responsible felt would place fewer demands and pressures on the individual. In other words, the attempt was made ostensibly to match the individual with his/her living context. At SFH, on the other hand, the decision to transfer a "failed" patient was as likely to encompass merely a room change as it was a ward change. Perhaps more significantly, staff members described such transfers as providing an opportunity to reactivate the individual socially. That is, such transfers were made, not to rooms which would place lessened pressures on the patient, but to rooms with roommates who were presumably more alert and active. If an individual entered the facility with staff expectations for an alert and active career, then any sign of diminished capacities was often met with efforts designed to improve the patient's condition, or, at least, to slow the decline. Rather than provide the patient with a room and set of routines that matched then current abilities, SFH attempted to provide the failing patient with a context he/she needed to "live up to." This type of transfer can be seen as arising from a basic philosophy which turned the failing patient into an object of increased staff attention:

(Discussion with Rhoda, activities personnel):
I ask Rhoda whom she is going to take to the movies. She says Mae, Catherine and Anne Yovich: "Those are the main ones,
cause they've regressed. I told Sr. Constance that maybe that she (Mae) should be brought up to the Health Care Team."

One implication of this transfer criterion is, as indicated by one nurse quoted earlier, "alert rooms (rarely) stay that way." The gradual importation of confused patients into rooms occupied by ostensibly alert patients, often resulted in the character of those rooms changing over time. Formerly alert rooms were eventually seen as inappropriate for the remaining alert person(s), or, staff members suggested, the remaining alert person(s) began to fail. Furthermore, a number of staff members acknowledged that there was no evidence that this rationale for transfers actually worked. In part, this was because there were no procedures for maintaining the integrity of, e.g., an alert room over time. In one case cited above, after Margaret Fahey was moved into her alert room, a second bed became available because of the death of one of her new roommates. This fourth slot in the room was filled with a patient whom John Stevens described as "mildly confused." Anne O'Donnell was assigned to this room because of the open slot, and because it was felt that she would fit in with and not disturb the others. In other words, to satisfy the necessity of filling an open slot, this room was redefined as a "halfway" house.

The cyclical nature of transfers was also evidenced in the following example:

(Transfer meeting):
One of the nurses says that Mary Dougherty's pressure has been very high, and the probable cause of this is her roommate's antics. The nurse says that Sally Dugan has been periodically stuffing the toilet with paper, which causes it to overflow. It is decided that Mary be moved to a different Pavilion room, where Gertrude Tardy has been living, and that Tardy be given Mary's bed. Tardy has been being annoyed by her roommate.
Sally's new roommate was considered alert, however, and so, in time, was annoyed by Sally's antics as well. The new roommate eventually requested and was granted another transfer.

While SFH personnel make it clear that no definitive ward system exists at SFH, attempts were made on occasion to match residents through the transfer route:

(Third-Main): I go to the nurse's station on the third floor, and tell one of the nurses behind the desk that I noticed that Helen Nunnely is not in the room she was originally assigned. The nurse, Anne Paige, says to me: "We mostly get senile people (here on the third floor). But we got a period with about six lucid ones. So we usually put one here, one there, and that don't do them no good. Mrs. Zeak, the charge nurse, decided to put four of them together. But Helen wants to move now into a semi-private room."

(Transfer meeting): Another female resident from the second floor, who is now in the hospital, is suggested as a possible switch for Nancy O'Hara on the third floor. Mrs. James, the assistant director of nursing, rejects this: "You can't put Nancy on third floor (when she gets back from the hospital); she's doing well being oriented."

It should be remembered that most rooms at SFH contain four beds, so that the potential influence of roommates for one's definition of self and sanity may be greater than when in a double room. Residents often requested transfers to other rooms so that they could be with more alert people:

(Discussion with Cynthia, LGPN, about Mrs. Frake): "She's much better now than when she first came in. I don't know if she'll ever adjust fully. It's her usual personality I think. She's used to calling the shots at home. Mrs. Frake doesn't look as if she's going to be too friendly. She has her own TV. She wasn't put in the best room to begin with; they weren't all well there. Now we put her in a room, and we moved Mrs. Foley--she's oriented but aphasic, so they really can't communicate."

(Discussion with Mrs. Frake after her transfer): Frake: They moved me from 311 to here, but it's just the
same. There's not a one you can hold a conversation with. This one here (points to her right, to the bed next to hers) never stops yelling. I was out for three days for Thanksgiving, and then they put me here when I got back. But it's not an improvement. It's just the same. You'd think they'd put them all together.

SJS: What do you mean "them"?
Frake: The ones that aren't orniated, orenated, what do you say oriented.

(Discussion with Rita, social worker):
We talk about Evelyn Pound's transfer from the third to the fourth floor: "She really wanted to be moved on Thursday. She said, 'Rita, get me out of here.' There wasn't much choice. We wanted to wait but Evelyn seemed really desperate. She wanted a room with three other ladies: who didn't leave the room all day, who were oriented and could be talked to, and who were young." Rita tells me that she had to explain to Evelyn, who is an M.S. victim in her early forties, that this is a nursing home: "At least we gave her two women who stay in the room all day."

(Transfer meeting):
Another nurse says that Anne Cort wants to be moved to a room on the first floor. Someone says that it's really the daughter who wants the transfer, that "she won't rest until she's on first." Diane says that this is probably true, but that the daughter has got Anne wanting the transfer as well. Diane says that whenever she speaks with Anne and asks her how she is doing, Anne invariably replies: "Oh, I'll be much better once I'm on first." Nurse Zeak raises an objection by saying that she would hate to lose Anne from her floor. She says that all of the staff on third floor worked very hard with Anne and have seen a lot of improvement. Also: "She's one of the few oriented residents we have."

(Transfer meeting):
Another transfer case is briefly raised, but no decision is made. Diane, one of the social workers, says: "Mrs. Mullen asked when she first came in if there was a room with someone she can talk with. I don't know if she still wants it."

(Transfer meeting):
One of the third floor nurses raises the necessity of a transfer for Catherine Neill. She says that the floor is getting on the patient's nerves, and that she has already had one nervous breakdown. The nurse says that Catherine is afraid she will have another if she stays on the third floor. Mrs. Zeak, the charge nurse for the third floor, says that if she has to lose Catherine, she wants her to go to the first floor. She admits that the room situation is not the best: One of the roommates taps on the bed tray all day; Eva Dempton is constantly screaming; etc.
Because new residents are repeatedly brought into SFH without regard for "match," patients for whom such a room choice is important may have to request transfers every year or so. Parallel to the situation in response to interpersonal conflict, staff members report that the confused person is more likely to be the one who is moved:

(Transfer meeting):
The discussion turns to current problems with Florence Guest, on the first floor. The nurses say that Florence has been rifling through her roommates' drawers. They say that she can't be substituted for Baxter because she doesn't get along with Margaret. They say that Florence is confused but alert, and that some change will have to be made soon. They say that none of the roommates will talk with her because of what she does. They say that Mrs. Balsamo, one of the roommates, is going "to bust her pacemaker" if a change is not eventually made. Florence stole her clothes this past Saturday, which she had packed to go for a visit to her daughter. The staff members agree that they do not seem to have any available beds to make an appropriate transfer for Florence, and so they decide to wait until the next meeting.

In subsequent sections of this chapter, it will be seen that those alert patients who, for whatever reasons, were not invited or encouraged to participate in the daily arts and crafts program, tended to withdraw to their rooms (and television sets) during the day. Alert patients confided in me that they were trying to avoid those individuals wandering in the hallways or restrained in the sun rooms. Several instances of exits (or near-exits) from the facility resulted from the frustration these patients experienced in being forced to live with confused individuals and from the perhaps realistic fear that senility was somehow contagious:

(Discussion with Rita Knott about Mrs. Gill, who was just discharged from SFH):
"It's funny, that happened so fast, so unexpectedly. Mrs. Gill went to visit Mrs. Markson, the younger niece, and she decided she didn't want to come home. Mrs. Markson called the next day and said Mrs. Gill refused to go back to 'that place,' that's what she called it. It sounded like a real
emotional thing they had. She tore off the bracelet. She said she didn't want to live if she had to go back. Mrs. Markson said she was calling about discharge, how to go about doing it. It really was a speedy discharge."

(Discussion with Diane about Mrs. Frake, recently discharged):  
"Mrs. Zeak called me last Thursday, Friday, to tell me that she was going home the next day. I called the son. Frake was upset at the floor, the room. She was afraid that if she stayed around disoriented people, she'd become disoriented within six months. I asked the son about the possibility of a floor change and talking with the mother about activities, y'know, she doesn't have to stay in her room. I asked the son if I could talk with her before he came to get her and he said try. I told her, 'I wanted to talk with you about her.' She was very hostile. I didn't talk with her in the room, I brought her down here. She was very hostile. She folded her arms like this (crosses arms). I thought this was gonna be challenging. She hated the rooms, roommates; she was angry at the entire family. She said she was able to go home. I asked her why she came to Sisters of Faith, a nursing home, in the first place. She just sat there and didn't say anything. . . . Most oriented people go to activities. They don't stay in her room. She said she didn't care, she was going home. Obviously there wouldn't be anyone on the floor to talk with."

(Discussion with Rita about Jess Palatino, requesting a transfer from the fourth to the first floor):  
"She wants to be in a private room near the chapel and activities. Her family wants her to be in a more alert section of the first floor." Rita tells me that the family "did a number" on Mrs. Palatino over the weekend. They took her out and, according to Rita, tried to convince her how unhappy she was. On Friday, she was saying to Rita how good it was at SFH, because there was always someone popping his/her head in all day; but Monday, after returning from the weekend with the family, Palatino kept on complaining about how terrible everything is. Rita says that there is a family conflict: The son, who is a social worker, wants Mrs. Palatino to stay at SFH, but the daughter wants her at home--even though she works all day, she feels the mother will be better at home. Rita tells me that she thinks Palatino is "heading for a discharge."

The last case is especially interesting because it did not result in a discharge. In part, this seemed to be because there was no one within Mrs. Palatino's family system who was truly willing to take her in. Moreover, Mrs. Palatino's attitude toward SFH changed after she was
transferred to a private room, and after arrangements were made to include her in the circle of "active women" (see next section).

One final criterion for transfers needs to be discussed briefly. A number of transfers occurred at SFH because the financial basis of payment changed. Certain transfers resulted for those patients who were no longer private paying and who had been placed on the Medical Assistance program.12

(Discussion with Rita): Rita and I talk about some of the recent transfer decisions. She tells me that Mary McDade was moved to a four-bed unit on her same floor (third-Pavilion) because all her private funds had been exhausted and she is now being supported by M.A.

(Discussion with John): John tells me that a new male patient, Mr. Dano, is entering SFH tomorrow. He has been given a private room but will be transferred to a four-bed unit as soon as one becomes available. Dano is an M.A. patient, but there are no four-bed male rooms available at this time. The admission board decided to bring Dano in and transfer as soon as another room is opened.

(Discussion with Catherine Anderson): Catherine tells me that Mrs. Conway was transferred from 308-A to 320-D. This patient entered on Medical Assistance with the understanding that as soon as a quad bed became available, she would be moved.

Sr. Marie told me that she discouraged the transfer committee from reassigning M.A. patients when they had lived in their same rooms for a long period of time:

(Interview with Sr. Marie): "My, our rooming policy is that once you go into Medical Assistance you will be moved into a four-bedded room. Everybody is told that. What I have done is that if they go into State Medicaid and there is no need for those rooms, so there is nobody on a waiting list for any building at the time... The staff, nobody really cares whether you're private or not... So, if we cannot, if we do not have to (transfer), we won't. We have to provide what people want too. It's very hard to (do) justice. So I question myself, 'What is just?' We want to give people what they want. We
want to provide an environment for them to live in, we want to be fair to all people."

In fact, M.A. transfers were more likely to be initiated by the admissions board than by the transfer committee. Such transfers were not automatic. All new M.A.s were not transferred as soon as their private funds were exhausted. Rather, transfers were implemented when the admissions board needed to make private and semi-private beds available:

(Admissions board meeting):
They agree to accept all the applications discussed by Sr. Rose. Sr. Marie tells Mrs. Wilson and John to think about bringing these people in immediately, and, if need be, arrange for transfers to free some semi-private rooms (which were requested). She says that the census report from Mr. Daniels' office indicates that several semi-private patients are already on M.A. She says: "Well, they knew that once they went M.A., they might be moved."

To summarize, transfers at Sisters of Faith Home are justified on the basis of at least four considerations: (1) personality clashes between roommates; (2) the changing health status of a particular patient; (3) a request by a newcomer to be provided with an "alert" room; and (4) the depletion of a patient's private funds and his/her enrollment in public assistance.

Being Active

In the previous sections of this chapter, I have described the institutional social positions recognized by SFH, the various evaluations of relative prestige and the desirability of each of these positions, as well as the procedures which are used by the nursing and social work staffs in assigning and reassigning residents to these positions. The present section examines the worlds of social interaction to which residents are exposed and which they are made part of as a consequence of particular position assignments. Chapter V notes
that ward placement to a large degree influenced, but did not determine
the residents' daily activities, the social relationships, and the
conversational and spatial behavior at PH. This patternning of
activities and behavior seemed to be a concomitant of a system for ward
assignments which limited access to and movement between residential
areas to different patient categories and characteristics. In contrast,
SFH provides for maximum similarity of each residential floor with
reference to assignment/reassignment choices. As a consequence of this,
differentiation of patients into distinctly evaluated and treated types
at SFH is based on other criteria than ward/room assignment.

In order to make the remaining discussions in this chapter
responsive to the type of recruitment system analyzed up to this point
for SFH and to the data collected there, I must use a different
descriptive format than that employed for PH above. Instead of
contrasting the behavior expected of and accorded patients floor by
floor, the present discussion deals with the separate contexts of
interaction which are recognized by residents and staff of SFH as
appropriate to and characteristic of different resident categories. I
will describe the interaction patterns characteristic of each context
and the types of residents for whom these are said to be intended. In
the process, certain floor by floor patterns will emerge. During the
course of my field work, I attempted ward by ward descriptions of health
care routines, communicational activity, and the like. These data
proved non-contrastive (see above). On several occasions I interviewed
staff members about what they saw as the varieties of patient categories
at SFH. When pressed for an answer, staff members did give me a number
of different categories. However, none of these categories reflected or was associated with the separate residential floors:

(Discussion with Rhoda, activities worker):
I ask Rhoda if she thinks there are any "types" of patients at SFH, and she says yes, but that they don't relate to the different sections. She says that throughout the facility one can find confused, semi-confused and totally alert patients.

(Discussion with Sr. Marie):
Sr. Marie says that she notices four patient types: (1) those who receive frequent visits by their families; (2) those who are taken out for frequent family trips; (3) those who receive no visits; and (4) those who have no families but are adopted by other visitors.

Other staff members were insistent that it was impossible to provide any generalizing statements, for each of the residents was his/her own "individual":

(Interview with Cynthia, LGPN):
SJS: Are there any categories of patients?
Cynthia: It's an individual thing. You've got sixty-two people (on the section) sixty-two individuals.

Consistent with this stress on the particular patient, the staff (and residents) interpreted my presence at SFH and the goals of my research as individually oriented. Whereas at PH I was urged to study the differences between the four residential wards and the different social groupings that existed there, at SFH it was repeatedly suggested that I observe and talk with individual patients:

(In activities room):
Margaret Beaty calls me to her side, and says she wants to tell me something about Nancy Dugan, with whom I saw her fighting yesterday: "I don't want to be mean, Stu, but just because she's a hundred and one, she doesn't have to complain all the time. If you want to talk to someone nice, go to Marie on the fourth floor, or there's Catherine on two. She speaks very nice."

(Activities room):
I introduce myself to one of the activities assistants in the room, Betty White. She tells me that Sr. Marie had already informed her that I would probably be coming in to observe.
She says that she was told that I am interested in communication, and I tell her that I am working on my dissertation research. She tells me that she will give me a list of names of people I should talk to. I tell her that I will want to observe people communicating with each other, but she directs me to a woman seated at a table a few feet in front of us, Mary Harlin. She says that Mary has a lot of "good stories" to tell me, and to be polite, I sit down, and introduce myself to Mary.

When the nurses and social workers at SFH were questioned further, it became evident that, despite their rhetoric, they held generalized expectations for the patients. Insofar as I was able to discover, however, the staff members did not associate these expectations with any one floor of the home. Staff members did not base their characterizations of the residents in terms of locale. Rather, staff members suggested that the differences seen between, e.g., alert and non-alert residents could be based solely on participation in the daily activities programs:

(Discussion with Rita about Mrs. O'Keefe):
"She's been going down to activities every day. I started taking her down, and she really, really likes it because all the other residents really admired her crocheting. She was real proud and some of them asked her to teach them. I was really adamant about getting her down to activities. I think that was where all her being upset was. She was just sitting around, waiting for her family to call or come to visit. I was able to show her that we're not all crazy here. . . . I made a point of taking her down every morning to activities. Now I have to start getting the nurses to do it."

(Discussion with Jane Simon, director of activities):
"I found they adjust better the quicker they get out of the rooms. Otherwise they stay in their rooms and they become too comfortable just staying there. Our most alert patients are the ones who come down here (gestures to the entire room). I always said that if I went into a nursing home, I'd want to be pleasantly confused. But then you get someone who's fully alert, and whose faith in god really carries through with them here. The fact that they're with confused doesn't bother them. You really can't lump people together—they're all such individuals."
(Discussion with Cynthia, LGPN, about Mrs. Nunnely):
"I found her a highly sensitive woman, really very perceptive and alert. I felt sorry for her; she just gave up. She had a big fall to come down to; it's a bad enough thing just to get old. It's really a shame. . . . When she first came in, she wanted to get involved. She wanted to maybe teach ballet or do a show. I brought my daughter in and I didn't tell her anything, and she started to do the various positions; I didn't tell her anything, and she (Nunnely) named all the positions. She's not a woman you can cut down to nothing, and then expect her to go on. Sister (Constance, the first director of activities) never encouraged her, never said, 'Bring Helen down.' She went completely down completely down hill."

Statements by the resident informants who attended the programs or who tried to get an invitation to do so seemed to support those of the staff. In specific, from the residents' perspective, participation in the programs in the activities room was taken as a sign of one's own prestige and alertness vis-à-vis the other residents, and as an opportunity to make contact with people similar to themselves. In a sense, "making it" in the home and developing friendships were bound up in acceptance by the others who attended activities:

(Discussion with Mrs. Gill, a new admission):
"I haven't met too many people. I guess once I get into an activity, I'll start making friends then. They had me to stringing beads—I guess they start you simple. Next maybe I'll do some sewing, I guess. I don't know if I'm any good, I never crocheted."

(Activities room):
Jane Simon is walking around to the various tables, introducing herself as the new activities director to the residents. She stops by Jess Palatino who greets her. When she asks Mrs. Palatino what she is making, the latter says: "I come down here in the mornings and I work for them. After lunch, I stay in my room to make those infant afghans, that's my own business. I got four grandchildren that keep me busy." Palatino says that she doesn't want to go senile, and that she is trying to stay busy. Also: "Up there there's no action; I got a private room, and it's all quiet up there."

(Interview with Eleanor Racer, first floor resident):
SJS: What do you think of the activities program?
Eleanor: Well, I think it's good, I mean, it certainly does give the patients some incentive and ah gives them some place
to go and socialize and you can talk to the other people and I think most of them like it. Some of them are very handy and can contribute a lot, others can learn too.

SJS: Did you meet most of your friends in the activities room?

Eleanor: Yes, I got acquainted with ah most of the people that are my friends now I did get acquainted with over there.

SJS: Do you think most people meet their friends through the activities room?

Eleanor: I do, because you probably have pretty sick people that are roaming in the same place you are and you can't go any place or do anything with them.

(Interview with Frances Rossini, Pavilion resident):

SJS: You go to the activities a lot.

Frances: Mm-mm.

SJS: Do you enjoy that?

Frances: Oh, I enjoy it, Oh.

SJS: Yes?

Frances: To get out of the room, oh, indeed.

SJS: What do you do?

Frances: I enjoy teasing. Oh, I love to tease. I love to tease. And Margaret and I, uh, we seem to uh she's a good partner for me. I like to tease Margaret. But uh, no, I enjoy being there and I enjoy the ladies there.

SJS: What do you do there?

Frances: Embroidery. Very slowly. Very, very slowly. I haven't done that since I was a child.

The discussion below indicates that being labelled an "active" by participating in the activity program contributed to the residents' prestige and to broader nursing home careers. The staff was explicit about this, as were fellow patients when dealing with newcomers. When new residents were greeted by Margaret Beaty, a second-Main resident who was the "welcome wagon," they were informed of the overall importance of joining the activities circle and of insisting daily that the nurses and aides assist the individual in question:

(Interview with Margaret Beaty):

SJS: Margaret, when a new resident first comes in, you greet them, right?

Margaret: Geesh, Stu. You already know all that.

SJS: What do you tell them about SFH when you first meet them?

Margaret: That this is their home and they'll like it. To do what the nurses say.
SJS: Anything else?
Margaret: If they want to get off the floors, they gotta come down. I tell 'em, "I'm there, I'll show you around."

Comparably, the floor nurses told certain residents about the program and encouraged them to attend:

(Interview with Mrs. Zeak, RN):
"We ask all the residents (during the first few weeks of their stay) if they go to Mass, or if they want to start going. Then there's therapy; we see if the doctor ordered a consult (e.g., with the speech pathologist or physical therapist). There are some we tell about the activities on first, and the aides take them down."

The selection of the residents who were/were not so notified will be discussed later.

From the vantage point of those residents who spend a considerable portion of their day in the activities room, everything that was important at the facility revolved around their "work." The activities room was a central focus of their lives at SFH:

(Front corridor):
Margaret Beaty passes me in the reception area. She asks if I'm going home for the weekend, and I tell her that I will be here at SFH on Monday (Memorial Day). She says to me: "Stu, we're closed Saturday, Sunday, Monday." I ask her where she's going if everything is going to close down, and she says she means that the "downstairs" (activities) will be closed: "What are you gonna do, Stu?"

(Interview with Eleanor Racer):
"I go to church and that lasts until ah and that starts at ten o'clock and lasts til about ten minutes til eleven, and then we come over, the balance, this is the present time, but we come over for the balance until quarter til twelve and the lunch wagon comes, we go over to ah the activities room for work over there. . . ."

Whereas the stated emphasis of the various activity programs at PH was to keep residents occupied, the goal of the SFH arts and crafts program was to have the participating residents be productive and feel as if they were making a positive contribution to SFH life:
(Discussion with Jane Simon, director of activities):  
"In the other nursing home (where I worked), we had activities all over the building. There wasn't one room. The residents would forget where they'd have to go. Here everything is so centrally located. And that's especially good for arts and crafts; we'd have to get the supplies there, it would take us an hour to get everything all packed up and then get it to the different floors. Here everything is very well organized, with individual boxes with their (the patients') names on it. They can come in after breakfast and go get their baskets. They can get their own work right away. At the end of the day, we just put the baskets up and they're ready for the next day. And they're all very serious about it here. We call it 'work.' There are some women who they compulsively need to keep busy; if they're not busy they have problems. This program is really good for them."

(Discussion with Sr. Constance):  
Sister says that after the formal evaluation procedure for new patients, she assesses what the person is physically capable of doing. She will then approach Betty White about including the person in the daily arts and crafts program. She says that if it is decided that, at this point, an individual is not up to such participation, she may indicate a goal such as "encourage and assist to general house activities. That includes the music program. Even the most disoriented can benefit from music." She says that sometimes she needs to encourage patients to join the arts and crafts group because they are afraid they are going to fail, especially if they've never done any hand work before. Also, once they arrive in the activities room, new patients are given very simple tasks, such as stringing beads, "to have them feel successful."

There was very definitely a work ethic at SFH as opposed to a mere recreational emphasis. As noted, residents spoke about their participation as work and prided themselves on their usefulness to SFH. Unless they were scheduled for speech or physical therapy for this time, residents usually entered the activities room at approximately nine o'clock each weekday morning, and stayed until supper time at four o'clock in the afternoon. Their only "break" during the day was at ten in the morning for church services (these worker-residents were always the first to be wheeled into the chapel by the aides and the volunteers) and at noon for lunch. With the exception of two individuals who,
because of physical handicaps, did not produce any crafts, each resident participating in the program had his/her own bin for storing work-in-progress. Residents produced goods—everything from placemats to wooden towel racks to hand-crocheted afghans—for sale at the annual Christmas bazaar. Some of these items were also displayed and sold by the gift shop throughout the year. Each individual had his/her own individual specialty (cutting out pictures to be traced, needlepoint, sanding wood, stringing beads, etc.), but all individuals contributed something to the bazaar.

Interview with Frances Rossini:
Frances: But I think if I would try to sew, I think maybe I would've made something of it.
SJS: Do you make different embroidered things for the bazaar?
Frances: Yes, for the Christmas bazaar.
SJS: The Christmas bazaar? I hope to come back for that this year.
Frances: But, uh, as I say I'm so slow. Oh, well, last year I think, I think I made four scarves and uh, and a pillow case. The pillow case was very, it was blue with a cow. And it was so colorful. In fact, one of the nurses here bought the pillow.
SJS: Oh?
Frances: And she told me she was going to give it to someone as a Christmas present. And her husband said, 'Oh, no, you don't. We keep it.' So I was kind of proud to hear that. But, uh, no, I'm not clever, I'm not smart. I was a slow learner as a child.
SJS: You sound clever to me.

Interview with Eleanor Racer:
Eleanor: ... I've been making an afghan and a
SJS: What are you making it for?
Eleanor: Well, I guess, it's for the Christmas bazaar. They sell most of the things they make at that time, so I don't know what else is being done with it. I think it's for the Christmas bazaar. I still have some work on it yet.

Discussion with Jess Palatino:
SJS: Do you go to activities?
Palatino: I help out, do something for the bazaar.
I'm starting to make a granny afghan. When I get it finished so they can sell it at the bazaar.
SJS: Have you made any friends there?
Palatino: I sit with this Italian lady, Anna.
SJS: Balsamo?
Palatino: I never asked her her last name. What is it?
SJS: I think it's Balsamo.

(In one of the bedrooms on the first floor):
Laura introduces me to Florence, one of her roommates, sitting on the opposite side of the room, but the latter says nothing in return. Laura lowers her voice, looks down at her lap, then up toward me, and says: "Some people are queer." I ask Laura how she is doing and she says everything would be okay if they'd untie her (she is restrained). I tell her I know. I then turn to Marie, who is sitting to Laura's left. I tell her my name is Stuart and what I am doing at SFH. She says it's nice to meet me, that there is someone young visiting SFH. . . . I ask her how she spends her day, and if she's ever gone to activities. She says: "I made plenty of stuff for them. I made blankets and a robe. I didn't make anything recently. I made some candles. I haven't gone recently. . . . I like to watch my soap operas. And I'm a faithful goer to the chapel. I really miss that if I don't go." I tell her that is understandable. I wish her well and tell her I will stop in to see her again. She says thank you.

(Activities room):
At one point, one of the volunteers holds up something from Sally Dugan's basket and calls out to Betty White, the activities assistant: "Betty, is this a pin cushion? Very cute. Very cute. I bet they go very well."

Those individuals who did not produce the sale merchandise—a hemaplegic stroke victim and someone suffering from a massive hematoma—engaged in essentially self-functional activity (jigsaw puzzles) and sat at a table separate from the others. Finally, the following citation from the field observations indicates the extent to which the goods one produced in activities indeed belonged to the nursing home's discretion and not that of the patient:

(In one of the social worker's office):
Before I am about to leave Diane's office, Catherine Haskins comes in to make last minute arrangements for her transfer (she is leaving SFH on Wednesday for
another nursing facility—intermediate care). Catherine says that a friend of one of the other patients agreed to drive Catherine to Holy Home, but she doesn't know the person's name or telephone number. Diane says that it will cost Catherine about forty dollars if she has to request an ambulance for her. . . . Catherine says fine, thanks Diane, and says she will "settle up" with Diane before leaving (Diane is going to do Catherine's last laundry). Finally, Catherine says she is interested in the afghan she has been making in activities and wonders if she will be allowed to take it with her. Diane calls Sr. Constance (director of activities) to explain the circumstances, and asks if Catherine will be allowed to have the afghan she has been working on. . . . After Catherine leaves the office, Diane tells me that Sister said, "It's the property of Sisters of Faith Home."

As quoted earlier, Sr. Constance, one of the directors of activities at SFH, expressed the importance of giving residents tasks which met their respective functioning levels and which enabled them to contribute successfully to the overall goal. Also note:

(Observations in the activities room):
Not all residents crochet. Margaret Beaty makes placemats by weaving yarn through plastic netting (Margaret is paralyzed in her left arm). Mrs. Wilde (also paralyzed in one arm) strings beads to make costume jewelry. Marie Lerner cuts and sorts greeting cards to be used as templates for foam cutouts. . . . Joe Peters counts out bundles of plastic spoons for the kitchen. The emphasis is clearly on productivity here and the residents sense this. During my observations, Joe calls me over to his table. He is sitting alone at the table where the men usually sit; there are no other men in the room at the time. Joe tells me to look and take notice of the fact that he is the only man who has recently been coming to activities. He says: "Hey, Stuart, that man, he no come here. He waits for his wife upstairs. That man over there (points to where Mr. Krank usually sits), he just play with the puzzles. Hey, Stuart, I work. See, Stuart."

With non-bazaar projects, such as the production of Valentine's Day cards for sale near the receptionist's desk, a division of labor was instituted so that each individual could contribute to the overall goal that which he/she was physically capable:
(Residents' Council Meeting):
Frances Rossini is asked to read from a card Barbara (the social services assistant) has given her on the amount of money in the treasury. Everyone then agrees that selling Valentine's Day cards will be a good way of making money. They begin to decide on a division of labor for the project. Margaret Beaty says that she won't be able to make the cards (because her left arm is paralyzed), so she will sell them. Margaret Harriet volunteers to write some poems to put on the cards, and Barbara asks Josephine Richmond to do the same. Frances Rossini says that she cannot cut out the cards (because of her arthritis), but that she can trace the designs. Frances suggests that Sally Dugan and Mary Oscar be asked to cut. Barbara asks Sally if she can cut and she says yes, she will. Mary Oscar says that she helped cut out the hearts last year, but her eyes are not as good this year; Margaret Beaty and Frances tell her to try at least, and she says she will. . . .

This definition of self as a productive worker can be seen to be associated with the residents' emphasis on certain rules which guided behavior. As noted above, ward placement was not described by the residents as a basis for friendships. Although the alert residents (more accurately, the active residents) were often times quite fond of the more confused residents, they were not seen to spend much time with these confused residents. Instead, the staff decision to bring one's peers into the activities room was used by the resident as a sanction for establishing extended interaction relationships:

(Interview with Eleanor Racer):
"... I don't think there are too many cliques, really cliques, 'cause they don't get a chance to do that much together like go some place or do things that would create a clique. They might meet at therapy but they're busy doing their exercises and whatever they have assigned them to do, walk and so forth. . . . (There's not much visiting between the rooms). Because they come up to the lobby to talk together and usually there's excuses, excuse me, there's always four in the room and or if there isn't there's one single room on our floor. . . ."

(Interview with Mrs. Gibson, Pavilion resident):
SJS: Do you like the third floor?
Gibson: I have gotten to know and like most of the nurses up there now.
SJS: What about the other residents?
Gibson: The other residents are nice. There are a couple of o.b.s's that are pretty far out and they're kind of hard to take, but for the most part I enjoy the other residents. In fact, I've come to really love one or two of them.
SJS: Do you feel like you have developed some close friendships?
Gibson: Yes. I don't know if you could call it friendships because there's one little old nun who has very bad organic brain syndrome. She calls me Mommy for example. I love that old lady, but I don't know if you could call it friendship.

Interestingly, individuals who did not evidence all the presumed qualities of an alert patient (e.g., in their conversations) were apparently not ignored by the others. Rather, to the extent that they were perceived as being productive, their participation in the activity program was still encouraged by their peers:

(Activities room):
Sally Dugan tells the other women at her table that she has lost her clothes. They all seem surprised by this, and Frances Rossini asks her who does her clothing (the laundry). Sally says she does, and Frances then asks how it is possible for the clothing to have gotten lost if Sally washes it herself. Sally says she doesn't know. Frances laughs and Margaret Beaty looks over toward Sally with a scowl. Frances then says (partly to herself it seemed to me): "Then you probably don't do your dresses yourself."
In a louder voice, seemingly directed more toward Sally, she says: "Don't worry, they'll show up soon."

(Interview with Mrs. Wilde):
"She's (Sally Dugan's) cuckoo, but we don't have to talk much. And she makes them (crochet) dogs. I got a bum hand."

According to the active residents, the worst of their peers were those who constantly complained—about sickness, feeling abandoned by their families, life in the nursing home, or whatever. Whether the gripes were valid or not, it was suggested to me that one not dwell on what could not be change, and instead concentrate in conversation on those pleasant aspects of life at SFH.
(Discussion with Frances Rossini):
"... You never know how the conversation is going to
go, you know. Somebody might say something about their
childhood and then I always pick it up from there. And
sometimes you hear some very funny things. And uh, and
then sometimes it's very quiet, because we don't have uh
too much to say, so it's just naturally quiet. There's
always something nice to talk about."

In their conversations with each other in the activities room, this
rule implicitly governed the residents' conduct. Moreover, when
breaches were noted, fellow residents called such behavior to the
attention of the offending individual, who was instructed as to the
appropriate way of behaving:

(In activities room):
Frances Rossini calls me over to the table and tells me
that Anna Balsamo is Margaret Beaty's best friend.
I ask Margaret if that is really so and she says, "Oh,
yes." Margaret says that Anna is such a complainer,
that she is never satisfied with things at SFH, and that
this is why she is not well liked by most people here.

(In activities room):
Jess Palatino, a new resident, is busy crocheting
at a table with several other women. At one point, after
a period of silence, Palatino says: "If you weren't
old, we wouldn't be in a place like this. I guess we
should be thankful we c'n at least come here." None of
the other women says anything to Palatino right after
this, but their eyes do dart around towards each other's
faces for a few seconds.

(In activities room):
Eleanor Racer: Do you like it here anymore?
Anna Balsamo: What? What you say?
Eleanor: Do you like it any better now? You didn't
like your roommate, do you like it now?
Anna: No, I no like it.
Eleanor: Y'don't? Well, if you're gonna complain,
you shouldn't stay here.
Anna: What's it matter, what's a you business? No?
(she winks at me).
Eleanor: Well, I'm just saying.
Anna: You want be happy all the time? (Winks).
Eleanor: What're you winking over at him for?
You're not gonna pull one on me.
Anna: All right, all right.
Eleanor: It's not right not to be happy.
Anna: You don't have to laugh all the time.
Eleanor: You don't have to laugh all the time, but that doesn't mean you have to be unhappy.
Anna: I'm not happy all the time. I'm not sad all the time.
Eleanor: But you should be smiling all the time.
Anna: You smile all the time, I can't.

This sort of behavior was looked down upon, whether the complainer was an active participant in the activity program or one's floor mate:

(In the activities room):
Margaret Beaty calls me to the table as I enter the room. She says that she has something to tell me. She tells me that she didn't want to give me the wrong impression when she scolded Nancy Dugan on her floor yesterday: "I don't want to be mean, Stu, but just because she's a hundred and one, she doesn't have to complain all the time. If you want to talk to someone nice, go to Marie on the fourth floor, or there's Catherine on two. She speaks very nice."

The present discussion is not intended to suggest that, during my stays at SFH, I never observed a complaint made by an active. Rather, I never observed such passing complaints being developed into extended discussion topics:

(Activities room):
I am sitting in the activities room, going over my notes, and I overhear the following conversation regarding a resident on third floor of the Pavilion:
Frances: Gee, she doesn't have a home.
Margaret: And who does?
Frances: And no one cares for her.
Margaret: So what about all of us?! Geesh, Frances. Both women then fall silent.

On the other hand, doing things "correctly" was very important to the residents, both while engaging in the morning crafts program and in the various games which were played in the activities room in the afternoon:

(Discussion with Mrs. Crenzi, wife of one of the second-Main patients):
Mrs. Crenzi says that her husband has not been going to activities lately. She says that Joe Peters complained to her one day about Mr. Crenzi's
behavior there; Crenzi is aware of Peters' complaints and is afraid to go back to activities. Crenzi was having chest spasms one day and he became very agitated and excited. He began jumping up and down, and (according to Peters) was disrupting everyone else's work. Joe scolded Mr. Crenzi then, while Betty called the nurses to come and check Crenzi's condition. . . . When Peters complained to Mrs. Crenzi the next day that her husband was a nuisance, she in turn tried to explain to him that Crenzi had been very ill. Ever since that day, Crenzi has refused to go to the activities room. He says that he gets too nervous being with the other residents and he is afraid he'll have another attack. He is also concerned that he will embarrass himself in front of the others and disrupt their work. There is no indication in what Mrs. Crenzi told me that any of the other residents has tried to talk Crenzi into returning to activities.

(In activities room): During the first game, Helen Kelp begins yelling at another woman for moving her (the woman's) bingo card and so "screwing up the game." She accuses the woman of not keeping the numbers covered and of not knowing how to play. Helen clears the woman's entire card and tells her that she will have to wait for the second game. Even when the woman has a number called on her card, Helen does not let her play it, because "You're not gonna win anyway, you messed up the card before." During the second game, the woman asks Helen about the appropriateness of her actions: Female Resident: Am I behaving all right? Helen: Yeah. It's just that don't shake your card up. I'm trying to help you.

To repeat, the actives were guided by rules for extended contact with out-group individuals and for appropriate comportment with fellow activities members. The rules for in-group relationships proscribed the discussion of particular conversational topics. The talk of the actives was observed, however, to be more than a negation or avoidance of certain topics. Instead, I found in the talk of these patients evidence for rules which permitted and even encouraged certain topics, especially those related to the patients' work and their relationship with activities personnel. The following excerpts indicate the diversity of
interactional activities which appeared in the activities room and which seemed to be permissible:

(In activities room):
Leila says to the group of women at her table that she weighs only 79 pounds. Frances says that she's amazed that anyone can be that thin. She then tells the story of a woman on her floor who is so thin that after she's taken a little walk in the hallway during the day, she is so tired out that whatever room she's near she enters, and takes the cover down on the nearest bed and takes a nap. The other women laugh. Betty, who has been in the beauty parlor all morning, preparing for the "Look Good/Feel Good" program, enters the activities room. The women greet her and she says hello back. Tony, sitting at a separate table, calls Betty. He tells her that he has almost finished his puzzle, but he is unable to put the last few pieces in their appropriate places. Betty takes a look at the puzzle, and coaxes Tony to put one of the pieces she holds in her hand into the puzzle. . . . Betty calls to Crenzi, who is about ready to walk out the door, and tells him that she'll give him some painting to do. She says that she wants him to paint the wooden towel rack he's been building. He walks to the table where Tony is seated, while Betty goes to the closet for Crenzi's smock and the paint materials. After Betty has set Crenzi up, Tony tells her that he has finished the puzzle. She walks to his side, where he points to the completed puzzle. There is a very big smile on Tony's face, and Betty congratulates him. She then notices that there is an extra puzzle piece, and she asks: "Where does it go, Tony?" Tony says that he doesn't know. Betty congratulates him again by saying, "You did real good," and he responds, "Yeah." Betty then looks to see where the extra piece might fit; she wonders out loud if it is a duplicate of a piece already in place. She says she is going to throw it out, but Tony says no. Betty then says, "What're you gonna do wit it, Tony?" Tony takes it out of Betty's hands, and quickly puts it in his shirt pocket. Betty laughs and says: "Okay, Tony."

(In activities room):
After the coffee hour, Betty Amber and Frances Rossini sit around the second table. Catherine Anderson is at first kneeling on the floor next to them, and then Betty White brings over two chairs, one for her, and one for Catherine. Maxine Dick (the new activities assistant) returns from taking a patient to her room upstairs, and as she enters, Betty tells her to pull up a chair. Betty Amber asks Catherine: "When is it going to be?" and Catherine says that she's waiting as much as Betty is. She smiles and Betty
says she thinks she knows something that Catherine is not telling, indicating she thinks that Catherine already knows that she is pregnant. Betty then asks Catherine what time the Mass is on Saturday. At first Catherine questions what Mass Betty is referring to, and then says that it is on Sunday. Betty says she thought it was on May 23, but Catherine says that it is May 24. Frances asks them what they are talking about, and Catherine says that there is a special Mass for Father's anniversary on Sunday. Frances asks if anyone can go; Catherine says the reception is invitational but anyone can go to the Mass. Frances says she wonders if she shouldn't go until Catherine tells her that it is being held at the church down the road, not in SFH's chapel. Frances says that that makes up her mind for her, that unless they push her (wheelchair), she is not going to go. Jane Simon says that maybe they should get Frances a pair of roller skates. Frances laughs, but she says that she guesses that she won't really be able to go. Catherine asks them if they're all looking forward to the belly dancer on Friday, and Betty Amber asks her if she is going to be the belly dancer. Catherine says that with her belly "that'd be more than what a belly dancer means." Frances says perhaps she can take lessons so that they can have belly dancing every week. Catherine says that with her belly she'd lose the jewels. Betty Amber says she didn't know there was going to be a belly dancer, and Catherine says: "We're getting around." Betty White says: "We're giving you experiences you never had before."

The world of social relationships organized and maintained through the residents' verbal behavior seemed to center on several interrelated topics. I observed frequent references to the various activities at the nursing home engaged in by the residents, and, moreover, references to the residents' affiliation with the clergy and with general church activities that life at SFH represented. One can find expressed in the residents' statements pride in the fact that the individuals involved were continuing a contribution to their churches which existed prior to institutionalization. In part, this was congruent with the overall structuring of the activities program. The director of activities for the first six months of field work was a nun, and she frequently stressed the value of the residents' assistance with and contributions
to the Christmas bazaar. In addition to this, the activities site was a
frequent spot where staff members and volunteers stopped in on the way
to delivering residents to the nearby therapy rooms. Many of these
visitors were nuns or members of the clergy.

(Activity room):
Sr. Maria Katina is standing at the head of the table
where Margaret Beaty, Eleanor Racer, et al. are seated
as I enter the room. I take a seat at the opposite end
of the table; I listen as Sister concludes telling the
other women present a story about an incident in the life
of Jesus. As Sister finishes, Betty White looks and
says: "That was beautiful, Sister." Margaret Beaty
asks Sister to come in more often to the activities room;
she says she always enjoyed bible instruction as a young
girl. Sister Maria says she has to leave now and get one
of her patients in the (physical) therapy room, but that
she'll be back.

Being near the clergy thus gave the residents much to talk about and
many people to talk with:

(In activities room):
I enter the activities room, and overhear Margaret
Beaty and Eleanor Pronsken talking. I take a
seat against the wall with all the windows, about
seven feet from where the two women are seated.
Pronsken asks Margaret if she went into the
chapel this morning, and Margaret says that she did.
She says that there are lilies all over the altar
area. Leila enters, and as she is walking to the
table where Pronsken and Margaret are seated,
she says hello to them. Leila says she wanted to
say some prayers at the feet of the Holy Mother
(statue) and saw how beautiful the chapel looks
today. Margaret says that the lights in the
chapel were on last night. Pronsken says they
must have been working in preparation for today's
mass, and Margaret says: "It's Father all alone."

(In activities room):
The staff members are busy helping Father cut out
material for appliques for his silver jubilee vest-
ments. Eleanor Frazer is not working today (she says
to me that her hands are too stiff to do this intri-
cate work). Rhoda is cutting out cardboard patterns;
Father is at the sewing machine; Betty White and
Maxine are cutting out material to be used as adorn-
ments on the vestments. At one point, Eleanor asks
Father the meaning of the symbol on the drapery on the back of the chapel. He says that it is a symbol from the Middle Ages, and that it is a symbol of the Roman Catholic church which the Sisters of Faith use. He says a new drapery is being prepared for the upcoming anniversary celebration for the Sisters.

These conversations must be related to a larger class of topics concerning the residents' active participation in various SFH projects and the apparently relaxed interactional relationships that were developed with the staff members and with volunteers:

(In activities room):
Catherine Anderson enters and walks to the table where the women are seated. Pronskn looks at the charm Catherine is wearing around her neck, which is in the shape of an infant's boot. Margaret Beaty asks her when she and her husband are going to get another boot, and Catherine responds by saying that Sophia (a nurse's aide) promised to make something (?) for her when she has her second child. Catherine says that Sophia no longer plans on doing this, so she's not going to have another baby. I ask Catherine why it isn't two boots for each baby, and she says that to get the second boot she has to make another baby. Margaret tells her that she has the easy time of it; she smiles in her awkward/shy sort of way while saying this. Catherine tells her that she'll start planning another baby when Sophia plans her project.

(In activities room):
Eleanor is wheeled into the activities room by one of the volunteers, Jeff, a high school student. The boy wheels Eleanor to a spot to my left, and as he locks the brakes, Eleanor and I say hello. Margaret and Betty White, who are also at the table, then ask Jeff if he will come to SFH next Monday to play the piano for the Easter party. At first, Jeff says yes, but then says that he can't. The following conversation ensues:
Jeff: Sure.
Betty: Will you?
Jeff: Yeah, if you want?
Betty: You gotta tell us definite, or else we'll count on you.
Margaret: Can we count on you? Can you play for us? Come on, Jeff.
Jeff: Yeah.
Betty: What time are you coming in?
Jeff: I'm working on Monday.
Margaret: There ain't no school.

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Jeff: Down at St. Alice. I'm playing for the Mass.
Margaret: On Easter Monday?
Jeff: There's mass at seven, at eight, at ten, and--
Margaret: On Easter Monday?
Betty: Margaret, it's weekday Mass.
Margaret: No. They have one or two Mass, but never that many on Easter Monday.
Betty: Jeff, what time do you finish there?
Jeff: At two.
Betty: So you can't get here before two thirty.
Jeff: About two thirty.
Betty: Well, the party'll be over by then.
Margaret: Geesh. We can't get anyone Betty.

(In activities room):
After the concert, a group of singers from a local church, several of the residents stay behind and talk with the staff members. Frances Rossini asks Rhoda (activities assistant) if she would like to meet a Jewish Gentile, and Rhoda says that her brother is Jewish. She says that her family celebrates both Chanukah and Christmas. Margaret Beaty says she should make up her mind, that she can't be both. Frances says that she loves matzoh, and Rhoda says that she does too. Margaret asks Rhoda what she celebrates for Easter, and Rhoda says both Easter and Passover are celebrated. . . . Margaret tells Jane Simon that she went to the seminary for October dinner; she says that she was taken by Father, and that Mrs. Williams also went. She says that the menu gave them a choice, that she ate lasagna, delicious raisin bread. . . . Jane says that since she began work at SFH, she's been to the seminary once, and that the highlight was the food.

(In activities room):
It is just after first lunch, but Margaret Beaty and Leila are already back in the activities room. They ask Betty White what is on the schedule for the afternoon, and she says that she and Margaret will call the numbers for bingo. Two of the female volunteers enter the room as Margaret asks her question, and after Betty's response, one of the women says: "But Betty, we're gonna lose our job." They all laugh. Leila says that there are surely plenty of other jobs for them to do, and Margaret says that the patients are going to take over. They all laugh again.

In addition to this, one also finds that activities provide an opportunity for the residents to share information about others at the facility, and, in the process, for them to develop and affirm what
Goffman (1961) describes as a "we-they" attitude. As already noted, the active residents indicated their preference for leaving their floors for as much of the day as possible in order to avoid their cramped living quarters and the often bizarre behavior of the others. Their discussions in the activities room, however, concerned happenings and persons encountered on their respective floors. In some cases, such talk merely reported on an amusing or poignant incident. This talk served to pass on information about one's ward nurse(s) or about residents who did not attend activities. Interestingly, on only one occasion did I hear a resident refer to the transfer of a fellow patient (a transfer all agreed was foolish—see below). Neither did I hear allusions made to specific sections of the facility. On the other hand, I did hear negative remarks made about those inappropriate individuals attending the activities program:

(In activities room):
Two women, Mary West and Rose Fitzpatrick, are seated at a table away from the other women. Mary tells Rose that she had a problem with someone on her floor yesterday. She says that the woman told her she needed to use a bathroom, and "I told her I couldn't help her. What'd she want me to do?" Eleanor Racer, at the other table, says to Margaret and Mrs. Wilde: "Oh, listen to what they're talking about." Margaret says: "I wish people like that'd stay upstairs. Talking about going to the bathroom."

(In activities room after the belly dancer's performance): Frances Rossini says that there are days that she feels like throwing it in, her arthritis becomes so painful. I tell her she's too young to die, and Eleanor Racer says to her: "No talk like that, understand?" . . . Margaret Beaty says that she knows that Jim Hopkins is trying to get transferred back from the fourth to the first floor. She tells Betty, Eleanor and Frances that she thinks Jim was crazy for leaving the first floor originally and putting in for a transfer. Eleanor turns to me and tells me that all the men are saps anyway. I ask her why, and she says that there is one man, George Tucker, who has a girlfriend he is always breaking up with. He was lost without her (when she was in the hospital); but then he
wants to spend so much time with her that they wind up fighting a lot with each other.

In this talk among the actives, the speakers can be seen to be disassociating themselves from other (implicit) categories of SFH residents. This talk tends to reflect the values placed on being kept active and on contact with alerts:

(In activities room):
Margaret Beaty talks to me about Mr. Crenzi: "Did you meet Caesar Romero over there? Mr. Crenzi. That's his name, Mr. Crenzi. His wife don't leave til he's ready for bed. He takes a nap in the afternoon and at night. His daughter comes in every day. That's a bad habit—he don't do anything without her. He's waiting for her all day."

Volunteers and staff members alike interact with the residents in such a way that the "prestige" and "sanity" of the activities participants is apparently continuously being reaffirmed. Active residents engage with staff members in a variety of in-home and out-home conversational topics (see above). We will see in the next section of this chapter that residents who seemed alert to me and who remained on the floors during the day participated in primarily task-oriented interactions with attending staff. Furthermore, these floor-bound residents suggested to me that they felt isolated with few peers and no staff members to speak. In contrast, the active participants in the activity program prided themselves on the frequency of contact they had with the staff members and volunteers. Moreover, through these interactions, residents became privy to "in" jokes, i.e., those which disparaged other categories of residents, and set these others apart from the in-group:
(In activities room):
Mary West (a volunteer) is talking to Frances, Margaret, and co., by their work table: "I took this lady back to her room. I walked her through the whole hospital, the nursing home, and I always stop by Mary's room, to say hello--she only speaks Italian. She told me to shut up, she's sick. That's some gratitude huh. She couldn't remember me."
They all laugh.

The prestige of these women, and, more important, the positive appraisals of the interactional contexts in which they found themselves, extended beyond the activities room. In point of fact, the activities room should be seen as an aspect (perhaps the core) of matrices or larger networks of interpersonal routines, recreational programs, and work activities.

(Discussion with Barbara, social services assistant):
"There are the always the same few who do (activities). It doesn't seem to project further than that. I keep on reminding myself that this is a skilled care facility. I think we'd get more activity in an intermediate care. Frances Rossini, Margaret Beaty, Dugan. For the most part, they're the real ones who do anything."

The nurses and aides considered it inconvenient to accompany the residents in their charge to the first floor for the various entertainment and activity programs there. The activities staff (the director and three full-time assistants) therefore had to rely on the availability of community volunteers and the few ambulatory residents. A director of activities noted that volunteers were the "backbone" of SFH:

(Discussion with Jane Simon):
She also says to me that another thing she's noticed about SFH is that "up until now, the residents aren't used to helping the other patients. At James House, we were able to get more residents to wheel each other, to bring them down to activities. We need to encourage those (at SFH) who are healthy to do this."

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It was thus somewhat easier for those residents who were regularly brought to the arts and crafts program (or, who regularly attended on their own) to get to the first floor for the various entertainments, parties, and meetings. As several staff members observed about arts and crafts, "It's the same old people":

(Discussion with Dr. Rick, speech therapist):
"You remember Betty White in the cafeteria, talking about Rose Bandini. She ate the beads and took the ribbons off the bows (in activities once). Betty complained that she had to redo it. But it seems to me that that is just a way of looking at a person's full capacity--no matter what they do with the beads. Predominately the same people are there (at activities). There are so many new people being added (to the home), why aren't they being added to activities?"

During the period of my research at Sisters of Faith Home, a number of the Residents' Council members were elected from among those who participated in arts and crafts: Mrs. Beaty was president; Mrs. Racer, vice president; Mrs. Pronsken, secretary; and Mrs. Rossini, treasurer. Previous to this, Mrs. Racer had served as secretary and Margaret Beaty as treasurer. Moreover, the activities participants were awarded particular homewide honors:

(Activities room):
The women talk about the special Mass that was held this morning in the chapel. The Mass was held to honor the Lady of Fatima, and was sponsored by the Lady of Fatima society in Philadelphia. Frances, Eleanor, Josephine Pronsken and Wilde all thank Sr. Constance for making arrangements so that they could "march" (they were wheeled in by volunteers) in the procession. Margaret Beaty has a big smile on her face, and thanks Sister for choosing her to lead the procession and carry the statue.

In addition, these same residents were, from time to time, asked to attend affairs outside the facility. For example, members of the SFH women's auxiliary committee host a luncheon party in their homes every six weeks or so, and between six and ten residents are invited to
attend. Staff members did make an attempt to get some of the non-activities men and women to agree to go, but their efforts usually proved unsuccessful. The activities residents could always be counted on to say yes to such invitations:

(Discussion with Rhoda, activities assistant):
"You have to be careful who you choose. Obviously, it's got to be someone who can feed herself. That's a must. We only send one aide along, so whoever goes has got to be able to go to the bathroom themselves. A lot of them from first (floor) are willing to go, but mostly it's the same people, Margaret Beaty, Mrs. Wilde, if she's not feeling bad about her wheelchair."

Obviously, only certain individuals are permitted to participate in these luncheons. In fact, staff members use a successful "performance" at these and other outings to evaluate patients and to add to their prestige:

(Discussion with Rita Knott regarding Laura, a recent admission):
"The day they went out to the auxiliary luncheon, Laura went. She went to the bathroom by herself. She ate everything on her plate. She had good manners. She was well behaved. Rhoda saw her a half hour later when they got back. Rhoda was really upset because she was restrained. I got there about 4:30. It was tied around her neck. In all the nursing homes I've been in, I've never seen a restraint like that around a neck. . . . They (the nurses) were reversing all the good that the outing did."

These outside-home and activities room events provided the residents with a number of topics for their discussions:

(Discussion with Eleanor Racer):
Eleanor says to me that she and several other patients are going to the circus on Thursday. She asks me if I'll be here, and I tell her that I have to be in West Virginia for a few days then. Eleanor quickly says, with a big smile on her face: "Oh, I'm all ready for that." Frances asks me if I'll be here on the 25th for the picnic, and I say I doubt it. Betty White, standing near Jane Simon's desk, asks Eleanor if the nurses came around telling the patients who was specifically going to go to the circus. She says she knows that they went around asking people if they wanted to go, but with only twenty tickets not everyone will be able to. Eleanor says to me that
she went to the circus last year, and so doesn't mind too much if she has to miss it this year. She says that a funny and frightening incident happened at the circus last time. The residents who were in wheelchairs were placed on a top-most section of the arena, where there were no seats. She said that being so high up in a wheelchair was frightening enough. At one point, she turned to the man placed next to her to point out one of the circus acts to him. The man and his wheelchair were not there, she said; he had rolled back several feet, and was balanced crookedly up against the wall. Mrs. Wilde and Frances Rossini laugh hysterically, when Eleanor says how "panicky" she was, that she called an aide to go and look for the man. Frances laughs and says that those are the hazards of going on trips.

(In activities room):
11:30 a.m. As I seat myself near the third table where Margaret Beaty and her cronies sit, I overhear Eleanor Racer wondering out loud what they are having for lunch today. No one seems to know. Then Eleanor says it would be nice to get pizza at the Residents' Council meeting this afternoon. Everyone agrees that they hope pizza is served. Sister Constance, who has been toward the back of the room near her desk, tells the women they should speak up more if they want something to happen at the Council. Sister smiles and says hello to me as she approaches the women to talk with them. It is my guess that the following conversation on Sister's part is for my benefit (given our discussion yesterday). 16

Sister: It's your Council.
Margaret Beaty: I know, but it's not my fault if we don't get it.
Sister: It's not your fault, but it says Residents' Council.
Sister: What's on the agenda?
Margaret: Oh, I don't know, I'm only the president.
Sister: You're the president.
Margaret: It's not a gripe session.
Frances Rossini: Who says it's a gripe session?
Sister: Well, I don't know, I haven't been to all of it, but what I've been told is that it's just a gripe session.
Frances: But, yet, if I say something, they say bring it up to the meeting. So I bring it up to the meeting. That's a gripe session.
Sister: But it shouldn't be. It should be for positive suggestions.
Frances: Positive suggestions. I would like to have deodorant in the room. Last night the room was really bad.
Sister: You mean room freshener. You should talk to housekeeping about it. That's an individual problem. What do we have what do you want to do for activities?
Margaret: Oh, geesh, that's what you do.
Sister: I know, but I'm running dry.
Margaret: We're all running dry.
In addition to this, the activities residents were likely to be asked to join the staff members in other contexts of the nursing home:

(Cafeteria, mid-afternoon):
I wheel Eleanor Racer from the receptionist's area on the first floor to the cafeteria. I wheel her through the cafeteria line, and she offers to pay for my tea. I tell her thank you, and tell her that I will reciprocate the next time. We sit at a table with Betty White, John Stevens, and some nurses. Betty tells us that she will be going on a retreat weekend this coming weekend. Eleanor asks her where she is going, and Betty names a place I am not familiar with. Eleanor asks me what I'll be doing this weekend, and I tell her I'm going up to New York. She asks me what is doing there, and I tell her my family lives in Brooklyn. She says that she's only been to New York a few times, with some girl friends, but that she always loved it.

Although any resident could enter the staff and visitors' cafeteria for a mid-afternoon snack, my observations revealed that only those who were habitually seen in the activities room were seated at one of the staff tables. In the following extract from my field notes, several residents were wheeled or escorted to the cafeteria by aides on break, and then left to sit at solitary tables:

(Mid-afternoon, in the cafeteria):
Pat, one of the nurse's aides from the fourth floor, wheels Mae Olney into the cafeteria, followed by Catherine McGeorge, who is now using a walker instead of a cane. The aide seats the two women at a table in the middle of the room, near one end of the buffet line. She walks up to the coffee urn by the counter, and pours out two cups of hot water; she takes two tea bags and returns to Catherine and Mae. They each hand her a quarter. She asks them if they want anything else, and both say no. She says that she'll give them their change later. She walks to the other end of the counter and places the two quarters on top of the cash register. She picks up some change and puts it in her pocket. She then proceeds to pour herself a cup of coffee, and then walks to the table at this end of the counter where several other aides and activities personnel are seated.

Clearly, not all residents become members of the activity circle and thus become identified as "actives." Because they were considered by the staff to be uninterested in arts and crafts, few of the residents

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who participated were men. The women who attended activities were drawn from all the different sections at SFH except third-Main. In addition to having no representatives at the arts and crafts program, third-Main had the fewest residents in attendance at the afternoon entertainments and extra-mural functions (see Tables III and IV).

During the several months of my research, only one resident joined and became a permanent member of arts and crafts. Others participated in arts and crafts for brief periods of time before dropping out or being dropped. Several new residents were invited to the afternoon programs, but with the one exception, the membership of the activity circle remained the same throughout my period of research.

Activity staff members held very specific assumptions about those who should be encouraged to attend the various programs. Only residents who were regarded as physically adequate and capable of being productive were invited to activities. Individuals who were blind, incontinent and thus in need of constant supervision, or those who were thought to be unable to follow orders, were evaluated by the director of activities and her staff as not warranting a place in the activities room. In the following, one of the activities assistants expresses one criterion for bringing residents to house-wide activities. She made it clear that the patient must give the appearance of appropriate comportment in the room:

(Interview with Rhoda):
"If they can sit through a movie. If they don't holler and scream, and can sit downstairs. Even if they're not orientated. Even a birthday, everyone in his life has had someone sing 'Happy Birthday.' So they can go there."
# TABLE III

SISTERS OF FAITH HOME ACTIVITIES CENSUS (BY SEX)

(October 1, 1980 to June 30, 1981)

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<tr>
<th>Activity</th>
<th>MALE</th>
<th>FEMALE</th>
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</tr>
<tr>
<td>ATTENDANCE AT CHRISTMAS PARTY</td>
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<td>43</td>
</tr>
<tr>
<td>ATTENDANCE AT MOVIE #4</td>
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<td>28</td>
</tr>
</tbody>
</table>
TABLE IV
SISTERS OF FAITH HOME ACTIVITIES CENSUS (BY FLOOR)
(October 1, 1980 to June 30, 1981)

Attendance at Christmas Party

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<tr>
<td>THIRD</td>
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</tr>
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<td>FOURTH</td>
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Attendance at Daily Activities*

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<td>--</td>
</tr>
<tr>
<td>SECOND</td>
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<td>2</td>
</tr>
<tr>
<td>THIRD</td>
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<td>2</td>
</tr>
<tr>
<td>FOURTH</td>
<td>2</td>
<td>--</td>
</tr>
</tbody>
</table>

*Average for observational days.
Also note the following:

(Health Care Team meeting):
Patrick Sweet from the second floor, is brought up for evaluation. One of the second floor nurses says that Pat is becoming more disoriented. Helen James, the assistant director of nursing, asks Sister Constance if Pat attends the activities program. She says he does not go to activities; she says the last time he went to an activity was the annual picnic last year, but that he called out the entire time, disrupted the entire group. The nurses look up the doctor's report which indicates that there is no physical cause of the disorientation. Helen asks Sister Constance if she wants to encourage Pat to attend activities and she says no.

(Health Care Team meeting):
Sister Constance is asked if Jim Hopkins is included in activities, and she responds: "No way does he want to come out to do that, like wood working. He sits mostly near the business office all day—bossing."

(Discussion with Betty White concerning Carol Lane):
Betty says that Carol, a fourth floor resident, does not attend activities: "She would never stay to do anything when she was first brought down. She would never stay. Someone had to sit with her. She had a low attention span."

(Discussion with Betty White):
While the volunteers are calling the numbers for bingo, Betty says that she has a few minutes to speak with me. I tell her I am interested in various residents' participation in the activities program. I ask about Pearl, a resident on the first floor. All that Betty says about this patient is that "She's blind, so—." The implication it seemed to me was that the patient could not contribute to activities, did not fit in, and so was never asked to attend.

Similarly, the following excerpt from a patient-staff interaction during activities reveals the extent to which the former were expected to be fully self-sufficient and not exhibit any medical needs:

(Activities room):
Mr. Kean calls Betty over. She notices that his pants are unzipped, and she tells him loudly (it seemed to me) that she is not going to take him to the bathroom. He says, "No, no, no." She asks him if he wants her to fix his zipper and he says yes. She begins shouting that she won't do this, that he has to go upstairs (to the nurses) for that. She turns to the women seated at the middle table and says that if she had wanted to do things like that, she would have been a nurse.
As already discussed, the activities room is not regarded primarily as a context for socializing, but rather as one in which the patients must demonstrate productivity. Staff members acknowledged that many of the alert patients who stay on the floors all day (in isolation for the most part—see next section) would have benefitted from social contact with their peers, but the definition of the activity room such as it was precluded this:

(Health Care Team meeting):
The discussion turns to Mae Olney, an 87-year-old female on the fourth floor. . . . Helen James asks for an assessment of Olney's current social level, and the fourth floor nurse says that it is good, that Olney has a "dry sense of humor" and that she spends part of the day in the television room with two women she's befriended. Helen asks why she is not going to activities and the following conversation ensues:
Sr. Constance: She's not the kind of person who's done crafty things all these years. She's used to work (her own business).
Diane: Perhaps you can encourage her.
Constance: She's really not interested.
The discussion then turns to goals to be reached during the next evaluation period. The nursing and physical therapist departments both say they want to try and increase Olney's ambulation and her ability to walk stairs. Sr. Constance's social/activities goals are to provide a volunteer to supervise Olney's smoking and to ask Olney to attend general house activities. Again a question about this is broached:
Physical Therapist: Don't you want her daily?
Constance: Her whole life has not been geared to that. But she can come to socialize. She does.
Therapist: Yeah, okay. Because I sometimes ask her after we finish.
A two month review period is decided.

(Discussion with Rhoda):
I ask Rhoda if Evelyn Pound, an MS patient on the fourth floor now, is ever brought down to activities. She says: "Not too much. Because she's the last one they get up in the morning. I went up there one day to get her for bingo, and they were putting her to bed. She's either in the chair or in bed. There's not much she can really do at arts and crafts."

Family members in interaction with certain staff members are influential in getting their relatives taken to the activity room.
Jess Palatino, a resident of the fourth floor who successfully joined the activity program, is a good case in point. During the first few weeks of Palatino's stay at Sisters of Faith, her family threatened numerous times to have her discharged if her room was not changed. Palatino resided in a private room, but according to her and her family, she was completely surrounded by people they felt were senile. They insisted that a private room on the first floor be found for her. The social worker, Rita Knott, told them that there were no single rooms available, but that Palatino would meet women like herself if she started going to activities:

(Discussion with Rita):
"I was really adamant about getting her down to activities. I think that was where all her being upset was. She was just sitting around, waiting for the family to call or come to visit. She really wasn't dealing with the whole nursing home. She just sat in her room. I was able to show her that we're not all crazy here."

Another woman, Mrs. Gill, was taken out of SFH by her family members. Interestingly, the social worker indicated to me that if her department had been given an advance warning, the staff members would have made the suggestion of the activities program prior to the discharge.

It is difficult to evaluate the relative contribution of the various factors which result in or preclude an activities invitation. Staff members did acknowledge, however, that it was not always the judgment of the residents' appropriate relationship to particular activities which prevented their inclusion. It was said often to be a matter of the lack of a personnel support base:

(Discussion with Rhoda about Laura, a first floor resident): "They don't bring her down. I'm sure if I went down to get her, she'd come. It'd be good just for the stimulation. But if I did that I wouldn't get any of my other work done. She can chain, so we can get her up to the point of crocheting."
What else? I'm trying to get Laura to the circus trip and the shopping trip, probably for a couple of hours."

(In activities room, a few minutes before noon):
Anna Balsamo: I see you after lunch?
Jess Palatino: Look at the trouble I have.
Anna: No, you come down. You come down. I no understand how you stay up there all alone like that.
Jess: Oh, look, I feel so embarrassed.
Anna: You think only you up there. There are others.
Volunteer: Don't think you're the only one. Ask the nurses, Jess. You have to tell them if you want to come to bingo.
Jess: Oh, I never ask them.
Volunteer: Jess, ask them.
Jess: But they're so busy.
Volunteer: I suppose they are, but that's why we're here. That's why there's volunteers, Jess.
(Maxine, one of the activities assistants, begins to wheel Palatino out the door.)
Anna: You come down?
Jess: If they get me. But I'm not gonna ask the nurses. They're busy.

Even when a physical handicap is not at issue, the residents must still depend on their caretakers for inclusion in activities and other social programs. For example, in order to know of them, residents must be informed of daily social activities, and must therefore rely on staff members who are willing to encourage, solicit and provide information about such occasions. Unlike the situation at PH, which encouraged the participation of the largest possible percentage of patients through direct solicitations on each ward and through multiple distributions of the monthly calendar, at SFH a single notice was posted (usually too high for wheelchair patients to read) near each nurse's station:

(Interview with Mae Olney):
Olney says that she loved to needlepoint when she was at the rehabilitation center. She says she would like to go to activities here, but then she asks, "They don't have needle work (here), do they?"

(Lounge, fourth floor):
Anna Yovich: Do they have something doing downstairs?
Aide: I don't know what they have down there, hon.
Anna: I think they have something.
Aide: I don't know, I just got back.
After the aide leaves, I tell Anna and Mae Olney that the birthday party is being held on the second floor, in the auditorium. They say they both would like to attend, and I take them one at a time by elevator downstairs.

(Discussion with Rhoda about Mae Olney):
"She is beginning to accept the fact that she is in the nursing home. She is coming out of her shell; she's coming down to bingo. We try to encourage her: every Tuesday we make sure she gets down to bingo. I'll make sure she is taken down to the birthday party this afternoon. She was in a wheelchair, and now she's walking with a cane. She just needs someone to watch over her. She says she wants to go down daily for activities, but the nurses don't get her there. She's alert, she could tell the nurses if she wanted to. But she hasn't made that commitment."

(Field notes):
Yovich, Olney and McGeorge are near the elevator closest to the fourth floor nurse's station. They are all in wheelchairs. A nurse passing by asks them what they are doing there, and McGeorge says that they're going to the second floor (Pavilion). An aide walking with the nurse asks them what's doing down there, and they say they don't know, but there'll be some activity. The aide walks away; I walk closer to the women and tell them that news and discussion group is being conducted now. . . . As I leave, the aide walks by and McGeorge says that it's news and discussion. The aide asks Olney if she's interested in going to that, but then answers the question herself: "You interested in that? You're not interested in that."

(Interview with Mrs. Gibson):
SJS: Do you go to Mass every day?
Gibson: If I can, and I get very angry if I can't get there.
SJS: What would be a reason you wouldn't be able to get there?
Gibson: If I'm not dressed in time to get there, and it just blows my mind and I'm angry for the rest of the day. It seems to me that they give precedence to physical therapy and I don't think that should be in a hospital or in a Catholic institution.

(Fourth floor of the Main Building):
I enter Mrs. Palatino's room to ask her why she didn't attend the celebration for Father's anniversary in the lounge. She tells me that no one came to get her. She says she knew nothing about a celebration, but wishes someone had told her.
(Near the fourth floor elevator):
I tell Anna and Mae to wait for me, that I will take them to
the chapel to see the May procession.
Mae: If it wasn't for this young man, I wouldn't know about it.
Anna: See, I told you I heard something (e.g., on the loudspeaker).
Mae: This man is a godsend.
SJS: Not a godsend. I'm just trying to help if I can.
Mae: Nobody told us about the procession.

As these citations from the field notes indicate, the ward staff
members' expectations for their charges to a very large degree shape the
extent to which they are allowed to participate in off-the-ward
activities. There is a lack of information flow to many residents, and,
as suggested by one of the resident informants, the priority given to
medical over social routines at SFH legitimates this (also see Chapter
IV).

There is some indication that becoming an active at SFH is a long-
term goal shared by residents and staff; it is not seen as immediately
possible. This conclusion is derived from my notes on observations of
the health care team meetings and the nurses' summary reports on the
patients. There a distinction is drawn between long-term and short-term
therapeutic and rehabilitation aims. My interviews with various staff
members revealed that, in handling the adjustment of incoming patients,
priority was given to the establishment of various medical programs over
resident-resident social contacts. One of the directors of activities
indicated that she waited a month or more before meeting new residents
and making an activities program assessment. The following comments
made by a nurse about introductions to new residents support the
position that an activities assignment and peer social contacts were not
a priority at SFH:
(Interview with Cynthia):

SJS: How do you handle new admissions?

Cynthia: Try to calm some of the fears. You know they're petrified. I like to direct the questions to the patient unless the patient is really out of it.

SJS: What else?

Cynthia: Try to make them comfortable in the new environment. Show them the room, where they'll be sleeping. And introduce them to the aide who'll take care of them. Almost always you start a new patient asking them if they want to go to Mass. You tell them this is home. You're constantly reassuring them, "It's your apartment." If there's therapy involved, we make an appointment right away.

One of the residents who was discharged from SFH, Mrs. Gill, had told me and one of the social workers on the first day of her arrival that there was a friend from her home community residing in the nursing home. Prior to her discharge, Mrs. Gill was taken to visit her friend living on another floor only once. Several of the residents who might have been asked to attend the activities program either died or were discharged prior to their meeting any long-term goals of the staff (e.g., Mrs. Gill, Mrs. Frake, Mrs. Foley).

To summarize, the data have made it clear that residents at SFH are divided by the staff into actives and nonactives, and that these categorizations are not immediately related to ward placements. Although staff members do acknowledge that not all alert residents are participants in the activities program, one consequence of being a member is that the individual is given an excuse for leaving the floor during the day, and an opportunity to interact with peers and with members of the staff. Furthermore, the actives are treated by the others as if they are the most alert residents of the facility. Various rules guide their behavior. Their conversations, in that they eschew complaints and negative comments, reflect the status the alerts enjoy at SFH. It should be reiterated that the stated purpose of the activities
group is not for resident socialization or recreation, but to provide an opportunity for the patients to feel productive. One apparently unintended consequence was that this context provided residents with an elite group of peers and with special contexts for interaction with staff members (both on the floors and off).

Clearly, one implication of being defined as an active (or not) is that this establishes and governs limitations or constraints on information flow. Specifically, there are different channels of information from staff members to residents (and among the residents) regarding life within the institution, social relationships with and the identities of specific staff members, and events outside the home. There is a cyclical nature to the relationship between the rules for information passage and the typology of residents. Those who are considered actives are those who are told about and encouraged to attend the daily arts and crafts program; once there, they are provided with a certain interactional context with staff members which promotes certain feelings of pride, usefulness and prestige; their participation in activities and their interaction with staff members further provide them with information about and invitations for additional social programs.

Residents Who Remain on the Floors

The majority of residents were not told about the various programs, or, at least, were discouraged from attending. They spent the bulk of their days on the floors, complaining about the lack of diversions away from those they considered senile. As we will see, spatial allocations and staff attitudes made it almost impossible for these residents to form consistent interactional groupings on the floors. Emphasis in this
discussion will again be on the communicational implications of (1) particular section slottings, in association with (2) whether or not one gets defined as an active.

Each residential slotting decision at Sisters of Faith Home can be seen to provide for a number of "outcome" (career) options which are not predictable from the floor/room assignment itself. SFH ostensibly patterns or defines careers around individual patient trajectories, rather than ward-specific ones. Each floor is internally structured around a variety of divergent pathways. Furthermore, all but one of the sections of SFH are alloforms of each other, i.e., they are so patterned with reference to each other as to be maximally equivalent. For these two reasons, I found it necessary to search beyond ward placement to examine other interaction contexts and dimensions by which residents might be distinguished. In a sense, the same typology of residents exists at both SFH and PH: confused (senile, disoriented), alerts, and transition patients. However, one difference lies in the behavioral criteria used for making these judgments. In their most dogmatic statements, SFH staff members claim that all the non-senile residents undertake active careers in the nursing home. Less dogmatically, the staff suggests that some alerts do not participate in the activities program, but that they are halfway house type patients. More specifically, alert residents who do not participate in the activities program are considered "incompetent" vis-à-vis certain institutional standards. In this section, more perspective may be provided by the description of messages that are exchanged with those patients who are non-actives and so pass their days on the floors.
Staff members discourage residents from spending the day in bed. As one nurse informant indicated, "We encourage an active life." As noted, those residents who are labelled actives usually leave the floors soon after breakfast, and return during the day only for meals. There is no central meeting area either allocated for or implicitly appropriated by the non-active residents similar to the activities room for actives. There is no room specifically called the "living room" at SFH, although each floor does consist of two "lounges" or "solariums." Those individuals who do not attend the activities programs remain on the floors except for morning chapel services, physical or speech therapy, or for a visit with the social workers. These residents remain in their rooms all day, watching television "alone" or, quite literally, just staring into space. Occasionally they walk or wheel themselves on an endless back-and-forth tour of the corridors, or they sit in one of the floor lounges. Only the active residents are permitted to travel the elevators on their own, and the others are thus effectively confined to their respective residential floors.

These residents indicate that the majority of their interpersonal contacts are likely to come from the staff. Indeed, even when asked if they had made friends with other residents, the non-active residents were likely to refer to staff members (as were other patients—see Chapter IV):

(Discussion with Mr. Hayward):
I ask him if he's made any friends at SFH and he says he thinks he's met some people he can consider friends. Interestingly, he says that staff members must initiate all interaction and friendship, that "the patients shouldn't do it first."

(Discussion with Mrs. Gibson):
She says she likes living in the Pavilion, and when I ask her
if she's made many friends with the residents, she says that she has gotten to know many of the nurses fairly well.

Also note that in the following, residents complain that there are no places at SFH where they can meet other residents, and, moreover, there are no people with whom they can converse:

(Third floor):
I run into Rhoda who tells me that she's going to visit a new resident, and asks me if I want to come along. I say yes and follow her. Rhoda introduces me to Evelyn Pound, forty-two-year-old female, suffering from MS. Evelyn is in a wheel-chair with special padding, a high back and an outstretched platform for her legs. Her hair is cut short, almost like a man's crew cut. She talks in a slightly creaky voice, staccato, reminiscent of other MS patients I have seen (at PH). Rhoda introduces me to Evelyn, and I briefly tell her why I am at SFH. She says it's good to see me. I ask her how she likes living at SFH, and she says everything is fine except for the fact that there are "no yakkers" in her room. Rhoda asks her what she has been doing the last few days, since her arrival, and Evelyn says she is going to start physical therapy, that she doesn't want to lose the use of her right arm. Rhoda asks her if she has any use of both hands for her to go to activities and she says no.

(Field notes):
I am sitting with Catherine McGeorge and Mae Olney in the fourth floor lounge. We are seated in a semi-circle in the middle of the room, and all around us are gerry chairs, wheelchairs, etc., some piled on top of the others. The television is playing in one corner of the room. Catherine complains that they no longer are allowed to eat in the downstairs cafeteria or in this lounge: "It was nice when this was the dining room. It was so nice and cute. Now they turned it into like a rec room, you need a place to sit. But there's no one who sits here. They're kinda just scattered all over the place. I think it's a storage room." Catherine says that she can't get a cigarette whenever she wants one (from the nurses), and Mae says she has the same problem. Catherine says she wishes she could go to the nursing home where she was originally staying because there were plenty of activities there: "They have parties and dances going on. All they have here is bingo, and they have an occasional party. I like the bingo, I win every time I go. (pause) I don't like this. You can't do anything you want. It's like a prison. I'd go to the Presbyterian Home, I don't care, I'd go. One of the ladies went there. They have dances." Mae Olney turns to me and tells me she lived at a rehabilitation center before moving to SFH, and she prefers the former: "Everyone was so friendly there and they kept you busy all
day. You had no time to complain. They were sicker, but they gave us more things to do. There's just sitting and the television here for me."

(Discussion with Cassie White, a resident of the fourth floor):
"What are we gonna do, talk all day? There's really not much to say to each other. Besides, all the roommates I had, only one wasn't senile."

(Discussion with Anna Wortz, in the second floor solarium):
"Why didn't I foresee some of these things. I wouldn't say I'm stupid, but we just don't know how to foresee what will happen to the senses. My eyes, you know I can't see any more. I have the nervous condition, and I had the (cataracts) operations, but it wasn't successful. I came here on the thirteenth of March in 1979, a few days before my ninety-first birthday. I was born in eighty-eight and I came in seventy-nine. I'm not quite here two years. . . . I have nothing to relate except that there's nothing around here but senile people. That's not very complimentary. I have just one desire, and that is for the good lord to take me home to my people."

Residents further suggest that they avoid or dislike staying in certain areas of the home because of the sights there. For example:

(Interview with Mr. Hayward):
He asks me to shut the recorder off, which I do. He says he wants to tell me something, and that, even though he trusts me, he doesn't want his voice linked to what he is to tell me. I say that I understand. He tells me that, since they suspended eating privileges in the cafeteria, he has been eating in his bedroom, not in the solarium. I ask him why, and he says that too many of the other residents in the solarium are sloppy; they drool, they spill food over their trays and those of others. They eat with their hands: He graphically tells me that he has seen residents taking handfuls of meat or potatoes and putting it in their mouths. . . . The conversation changes to visiting people in their rooms and he says: "I never go into people's rooms, I don't know why. I never noticed it till you asked me. I guess a person has a right to privacy." He says that what friends he has, he occasionally sees in the hallways when he takes his "walk" (pedals his wheelchair), but he admits: "There's not too many places to meet people."

(Third floor of the Main Building):
Mary Bach, a third floor patient, walks up to Cynthia, near the third floor nurse's station. She is very agitated, her hands are shaking, and there are tears in her eyes. Her voice is very tense. She tells Cynthia that she can't take it any
more, that she can't take her new roommate. She asks Cynthia how they expect her to eat in her bedroom while the aides are taking her new roommate "to the bathroom" (i.e., put the woman on the commode). Cynthia puts her arms around Mary, and gently rubs her back while saying to me that Mrs. Stephens, formerly a Pavilion patient, was placed in Bach's room. She agrees with Bach that the aides were insensitive to put Stephens on the commode while the others in the room are eating, even if the screen around the bed is closed. Mary Bach says her daughter is coming soon, and if she doesn't want her to stay she won't.

(Fourth floor solarium):
I turn to Catherine McGeorge, who is sitting near me, near the small round wicker table on the left side of the room (as one enters). I ask her how she is doing today, and she says that she is very disappointed with SFH: "I was told there were all nice ladies here, but Mae's the only one. All the others are a little off. Look what she (points to a resident opposite us) does: banging; 'honey, honey, honey' all day." Catherine says she previously lived at a residence for elderly women, but that when she had a heart attack and then was hospitalized, the administrator of the home told her she would have to move: "It just wasn't a nursing home. They told me I was sick and I needed a nursing home. Mrs. McFey recommended this place. If I'd a known, I don't--It's all mental people here on this floor. I guess all the floors. Pestered you all the time. The men there (points to the other end of the solarium) curse, they bang; he can curse and lay you down. There's one over there who sits and catches flies with his mouth open, it's upsetting."

These last citations are important because they indicate one apparent consequence of the lack of a ward system. Specifically, there is no differential coding of activities or routines on each of the various sections. For example, at People's Home, the residents were aware of the meaning of bodily restraints; they associated them with certain sections of the facility and staff judgments of residents' behavior. Such was not the case at SFH, where I never once heard residents discussing the fact that someone was restrained. Although staff members at SFH indicated reasons similar to those at PH for restraining individuals, there was no indication that this was in any way patterned differently for the various sections:
(Discussion with Pat Anderson, LGPN, third-Pavilion): "We usually need them if they're in wheelchairs and they don't know it, if we think they're gonna get out. We watch the doors to the elevators, so if they can walk around we let them. . . . Is there any difference between floors? If they need them, they use them."

Similarly, no difference was found—either through my observations or through interviews—to indicate that consistent distinctions were drawn regarding where residents should eat their meals. For approximately the first three months of field work, residents were given a choice of having dinner (the noon-time meal) either in their rooms or in the staff/visitors' cafeteria. The former meant that the standard-menu meal tray was delivered to the floor for each individual, whereas the latter enabled the residents a wider choice from the cafeteria line.

Interestingly, it was the residents who had no other means of leaving the floors during the day who tended to choose this second option, and who were resentful when (beginning with my third month of field work) they were required to eat on the floors:

(Interview with Mr. Hayward):
Charles: They (had) it set up where those who wanted could go down to the dining room and have your meals. Were you here then?
SJS: I was here for a few weeks when that happened and then all of a sudden you no longer were able to go down there.
Charles: Many of us were disappointed when they cut that out because it was a little diversion.
SJS: Do you know why they cut that out?
Charles: No. I don't know, but I don't think it interfered with anything, really. I think they simply got the idea that this present set-up would be more desirable. It didn't work out that way. It was nice down there, we enjoyed it. It was something different for me everyday.
SJS: Did you go down with a few people you know or did you meet them down there?
Charles: It was pretty much the same crowd. People coming in were invited down and there might have been thirty-five who used to go down there. That doesn't seem like many so maybe that's why they cut it out. I think more people should have been encouraged to go. You have a choice more or less. If you didn't like what they had that particular day you could have a
sandwich and many times I used to take just a bowl of soup and maybe a sandwich with it and those who liked two or three cups of coffee or tea could have it, or they could have milk instead of coffee. Under the set-up now, you just have to take what they bring up. If you don't like liver, well, you just don't eat it. If you don't like fish, same thing, but down there those who didn't like fish might have chicken or roast beef or something else that they had, so we liked it and we just hope they'll go back to that same system because it was nice.

Two interesting aspects of eating meals on the residential floors need to be mentioned, both of which reflect the fact that minimal distinctions were drawn between residents on this issue. First, no territories were specifically established to separate residents into, e.g., "senile" and "non-senile" groups. Residents were wheeled into (or escorted to) one of the two lounges on each floor or allowed to remain in their rooms as determined by the staff; moreover, they were required to sit at tables of the staff's choosing.

(Middle solarium, fourth-Main):
An aide walks in to tell the women they'd better go to the other lounge if they want their lunch: "Well, you ladies better get a move on it. You know you eat up there. Sitting there pretty, you better get." Catherine begins to stand and says, "Alright, alright, we're going." In a low voice to Mae, she complains that last week they ate in this room. Also: "Mae, they're gonna sit and make us wait over there another thirty minutes."

It was not uncommon, given the diversity of patients on each floor, for one patient to be quietly eating his/her meal while a second patient poked through the food, spit at it, etc. (see below).

Second, I could discover no consistency to the seating arrangements in the lounges (either during meals or any other time) from meal to meal, from day to day. Staff members indicated to me the importance of "straight lines" and placing residents according to the delivery schedule for the food wagons:
(Discussion with Sally, nurse's aide on fourth floor):
"You have a lot of them eating in there (the two lounges). We set the tables up to coincide with the trucks. All the people get first lunch, or second lunch, sit together. This way, we're not running around the tables."

There is some indication that staff members also viewed meal time as another context for the servicing of patients, and not necessarily as an opportunity for peer social contact. Residents were thus not permitted to choose whom they wished to eat with, but rather were seated with whom a particular staff member at any one time decided:

(In the second floor lounge nearest the nurse's station, just after noon):
One of the aides wheels Anne McGrath into the lounge. Anne smiles as she sees Ruth Hancock sitting at a small square table by the right corner of the room, and says to the aide: "Over there, I'll sit there with Mrs. Hancock." The aide continues to wheel Anne to the long rectangular table in the middle of the room; after she has done this and secured Anne's brakes, she says: "This is all the same. Your tray'll be up soon."

(Corridor of the fourth floor):
Mae Olney and Anne Yovich are being wheeled down the corridor by the two aides, who tell them they should have started toward the "lunch room" twenty minutes ago. Mae Olney and aide enter the lounge (furthest away from the nurse's station) first, followed by Anne and the second aide. Mae is placed at a rectangular table with five other women, which leaves no space for Anne, who is placed at a circular table in the middle of the room. After the two aides leave the room, Mae pedals herself away from the rectangular table and toward Anne's.

As noted, the slotting decision does not in itself determine the likely and appropriate interaction contexts residents encounter. Moreover, residents from varying functioning levels may be found in similar situations—the lounges, the bedrooms, the corridors. This fact appears to have a significant impact on the definition of self which the institution fosters for residents. In specific, those residents who are not invited to join house-wide activities during the day can be observed...
to question their placement and hence their own sanity, apparently as a result of the patients they come in contact with. I observed that this questioning on the resident's part often led to a self-doubting, and a bitterness towards staff members, because it was assumed that the latter considered the resident to be senile. In this regard, it is important to note that one element consistently absent from staff discussions with residents and with visiting family members (especially during the initial admissions interview) is information on the reasons for a particular room assignment.

(Fourth floor lounge):
Mae Olney: It's quiet here today. The men, they speak all the time. It's usually all noisy. Y'know, they're crazy. I like it this way. Y'can listen to the TV. (pause) I wish they'd move that lady. She's in my vision.
SJS: Do you want me to do it.
Mae: Would you? You better not, I don't want you getting trouble. (to Catherine McGeorge) I told you what I told the nurse, nurse's aide. I said 'What do you feed them, crazy pills?' There's one man here, his wife's dead three years, and he thinks I'm his wife. He wants me to come into his room. I don't do it. He calls me Myrtle. (laughs)
Catherine: (to me) The men all here are senile. (to Mae) So we're here on the floor with all senile. They put us with a bunch of senile. They don't have 'em on the second floor. They got carpeting.
Mae: You pay more money down there. I'd pay it. Well, you're senile and I'm senile. Well, I'm not senile. I'd be better off if I was.
Catherine: Well, they c'n think it, but we're not.

(Interview with Jess Palatino):
SJS: And what do you do in the afternoon?
Palatino: I work here in the afternoon. They (her family) keep me busy. My granddaughter just had, no, I just got two new great-grandchildren. Boy, then a girl. I'm making them some things. Thank god, I'm active. Or else you lose your mind.
SJS: How are the people on this floor?
Palatino: They're nice, but you have the ones who are--. It's a shame when they get that way. I get depressed. I wonder how they get that way. Geesh, I say, why do they get that way. It's terrible to see them. I really feel so bad I don't know what to say. That's why I go downstairs. And that's why I do this (holds up her crocheting). Keep myself
busy. I don't want to go senile. My family don't want it.
SJS: So you think activities is good?
Palatino: I can talk to people. They're not all senile
down there. Louisa, she says why don't you come down (i.e.,
to a first floor bedroom). I tell her she's gotta look. She
don't want me staying up here. "Why'd they put you with
seniles?" she asked.
SJS: Well, it's good to see that you're busy.
Palatino: I keep myself. And you too, that's what I say to
you. I wish they'd put me in the kitchen, though. I'd do it.
I don't like the meals they got here. (pause; Strunk's
screams from across the hallway are heard) Imagine. Listen to
that. That's pathetic. A lot of times I say, "I wonder what
done it, I wonder what done it." The first time I heard her
I thought she was an opera singer, maybe she was. I thought
it was someone on television.

(Third floor of Main Building):
Nurse Zeak enters the room where Mrs. Foley (a new
resident) has been placed to check her blood pressure. Mr.
Foley, the daughter-in-law, and I are standing outside the
room.
Foley: This must be the Medicare floor.
Daughter-in-law: Yeah.
Foley: There are four beds (i.e., in each room).
SJS: Most rooms in this building have four beds.
Foley: Is this the older building?
SJS: Yes.
Foley: I guess that's why they put us here.

Staff members do recognize the problems that result from
integrating patients:

(Discussion with Rhoda):
"Someone who's orientated talks to a confused person and
believes what that person says. I found it happen quite a
few times. Or you put them together in the same room, and
the confused person is blurring out at night with language
they probably never used in his entire life. And the one only
one who's really hurt by this is the alert patient. Martha's
deteriorating as she's taking care of her (Agnes, her roommate).
The nurses said she swatted her one day because Agnes did some­
thing she told her not. She's becoming more disorientated, she's
regressing to when she was a mother."

Staff members also recognize the implications of a patient's not being
defined as an active:

(Interview with Cynthia, LGPN, about Helen Nunnely, a third-
Main resident):
"When she first came in she wanted to get involved. She
wanted to maybe teach ballet or do a show. I brought my daughter in and I didn't tell her anything, and she started to do the various positions; I didn't tell her anything, and she (Helen) named all the positions. She's not a woman you can cut down to nothing, and then expect her to go on."

Nevertheless, no efforts are made to remedy this. Since transfers are not often instigated for the purpose of bringing residents from different functional levels together, this option does not exist as a consistent means to remedy the problem for patients. Furthermore, as discussed above, there apparently does not exist a differential coding of spaces (except for activities room versus residential floors) which could be used by the staff to separate residents and allow them "a place of their own."

The proximity that residents share with each other often makes it impossible for them to avoid interaction with "seniles," and, more importantly, to establish any social distance from them:

(Fourth floor solarium):
Rose Rank, a hematoma patient, begins playing with some of the food and a small paper cup on Mae Olney's tray.
Rose: Can I have that?
Mae: Yeah, you can have that always (To me: laughs) I wish they'd take you away.
Rose: Can I have some of that?
Mae: No, you can't. You had your dinner.
Rose: I'm getting some bread in that. From her. (She points to the woman to her left with her head.)
Mae: No, you're not. You already ate it.
Rose: I must be blind.
Mae: You're not blind, Rose. Remember you tried giving it to me, and I didn't want it. You ate it.
Rose: Boy, you're not being very helpful.
Mae: How can I help you, Rose?
Rose: You could give me, you don't have to keep.
Mae: I don't know how to help you.
Rose: You at least can give me what you get.
Mae: That's mine, Rose. I gotta eat too, y'know. I eat to live and I live to eat.
Rose: (to man in a wheelchair to her right) Mister, you have a long pair of pants, huh?
Mae: He can't hear you. (to Joe) Something about a long pair of pants.
Rose: He don't have to hear it. I wanna know about the pants.
Mae: What?
Rose: If you got a long pair of pants, then they can take the others. (pause) Dear God, help me, dear God, help me.

(Fourth floor lounge):
I sit in between Joe, in his wheelchair, and Mae Olney, in a gerry chair. As soon as I approach Joe, he says to me: "Three and one make four, right?" I say yes, and then ask him how much four and one make. He says five, at which point I take out a five dollar bill to show him. He looks at it, and then tells me to put it away; he says that the dog will tear it up. Mrs. Strunk is chanting, humming, screaming, etc. in one corner of the room. Mae asks me: "I wonder if the doctors ever figured out what makes a person like that?" and Joe says to me: "I like that singing"... Joe asks me if I am cutting the price of the other man. I say no, and he says I'd better not, because he was able to sell the machines for thirty-five dollars... Mae calls me and tells me that before I buy anything from Joe, I should talk to Julie, the nurse who was sick last week, who has blonde hair. She tells me that Joe tried to sell Julie a car, until she found out that he still owed a lot of money on it. Mae winks at me. I tell her (in a questioning manner) that she's joking, of course. And she says: "Oh, no. I'm just telling you the truth." I walk away from Mae wondering whether she really believed what she said or not... Mae tells me that she has got to leave the room, that Strunk's "singing" is annoying her.

In some cases, the patients expressed the view that arbitrary and infantilizing rules were placed on their behavior because of their placement near confused residents:

(In fourth floor solarium):
Jane Hogan is attempting to smoke a cigarette, and one of the evening aides is trying to stop her:
Jane: I feel as if we're being punished.
Aide: No, we're not trying to punish anyone.
Jane: Y'know, it's my only pleasure.
Aide: I know, dear, but look, we're not saying you can't smoke, but it's the others, they don't have it all, and so they don't know any better.
Jane: Would you call Richmond Rehabilitation Center? Would you? See if they'll take me back. It was better over there. (Starts crying)
Aide: No, now dear, listen, we're not saying that it's your fault, but, y'know, there are others here, and we're afraid they might grab it, and put it in the trash basket. Boom they blame you.

Jane: Oh, I understand now. So, I can have it.

Aide: But, you'll have to wait for the nurse. No, hon.

(Jane takes out her lighter and begins to light the cigarette.) Oh, geesh, how do I do this tactfully? (The aide leaves the room, presumably in search of the charge nurse. Although I remain in the room another fifteen minutes, the aide does not return.)

Finally, as noted in the discussion in the previous section, information flow to these patients is limited, and apparently does not provide them with knowledge of contexts for interaction with non-senile patients, and with staff members in a non-task-related manner.

These examples deserve reexamination in the light of the general concern with the overall recruitment system at SFH. The lack of spatial or interactional separation of patients seems to reduce the possibility of the formation of special interaction groupings. The fact that there is an absence of groups identified by either staff or residents further serves to justify, and, at the same time, provide evidence for the institutional claim that all residents are individuals. This emphasis on individualism apparently functions to keep residents dependent on the staff for whatever focussed interaction and conception of their place at SFH are occasionally made available; as noted, many of the non-active residents (and some actives) refer to staff members as their only "friends."

One does not find an audition etiquette at SFH by which residents could exclude others from conversation or even from co-presence. One possible reason for this is that the staff members' assemblage of heterogeneous resident types does not provide a basis or justification for acceptable resident exclusions. I frequently heard the non-active
residents bemoan that they had "come down to this," that is, that they were now required to live with crazy people or other non-equals. In this respect also, it was difficult for the non-active patients to create and sustain a "we-they" attitude toward others at the facility. The lack of a ward system seemed to work against the establishment of separate interaction contexts. The only activity which apparently was able to establish an identifying context was limited to a certain number of patients. My data indicate that the non-active residents complained about their placement with those they considered confused. However, since the complaints were not reinforced or acted upon by the staff, feelings of self-doubt were apparently created instead of a superior attitude.

Summary

The present chapter provides data on assignments/reassignments at Sisters of Faith Home which contrast with those discussed for People's Home. SFH is a nursing facility located just outside Philadelphia's city limits. It is owned by the Catholic archdiocese and operated by a community of nuns known for their work in the field of medicine, the Sisters of Faith.

The current administrator of SFH stressed the importance of being of service to the larger community as one influence on the organization of the admissions procedure and on the organization of residential positions. SFH applications are made for a type of bed and room, but not for a particular place. Because of the existence of a wait list individuals can apply for a spot on the list. Admissions are eventually made from this list. This list takes precedence over immediate entry to
the facility. SFH feels obliged to admit all individuals who qualify for placement. The wait list is said to provide family members with some assurance that an admission will eventually be made, and that all admissions are handled fairly (i.e., on a first-come basis).

The administration prefers to bring a new patient into the facility as soon as a bed is made available. There is apparently only minimal concern for making "appropriate" or "matching" assignments. The ostensible aim of this type of admissions procedure is in the direction of being the greatest service to the community. The facility attempts to admit a patient without regard to matching ward-specific restrictions. This is seen to speed up the process. At one time, the head administrator considered a plan for increasing the number of public assistance entrants which would have filled beds left vacant by M.A. patients with public rather than private paying individuals. Although this scheme was eventually abandoned for financial reasons, this points up SFH's view of its mission.

SFH consists of six residential floors in two connecting buildings (three building sections), but, as suggested above, none is specifically allocated for a single patient type. The chief administrator had established guidelines which encouraged the mixing of confused and non-confused patients. The organization of mixed bed slots was instituted ostensibly in order to continue a tradition established by the administrator's predecessors of not separating individuals whatever the criteria. Consistent with the expressed ideal to be as much help to the community as possible, Sister Marie attempted to bring patients needing institutional care into the facility as soon as a bed opened up. With such an ideology, limitations on matching patients with wards would be
inappropriate. The one attempt occasionally made in matching was that of fitting incoming patients' medical and psychological diagnoses to those of the available roommates (i.e., room-matching rather than ward/section-matching). An "oriented room" at SFH, for example, is not a room which has historically been set aside for alert residents, but is one for which the current occupants are considered alert. The staff members stressed the equivalence of the residential floors for purposes of slotting decisions, however, and the consideration of roommate-matching was not consistently applied or adhered to.

The ideal of the organization of the sections into equivalently functioning units shaped criteria and procedures for reassignments. Transfers at SFH are as likely to involve intra-ward changes as they are inter-ward changes. In this regard, the social workers and the nurses indicated a belief that transferring off a section was not a necessary consideration for a reassignment. Consistent with an emphasis on the importance of treating patients as individuals, personality conflicts between patients were cited by staff members as a common rationale for voting for a transfer. A second situation associated with transfer decisions concerned the changing health status of patients. Reassignment was seen by staff members as an opportunity to reactivate or remotivate a failing patient, especially one who was no longer benefitting from his/her current slotting. Attempts were also made on occasion to match residents with similar functional levels or medical diagnoses through the transfer route. This usually occurred when residents and their families complained about the initial assignments (more specifically, about roommates) and requested transfers.
A number of problems seemed to be associated with the above organization of residential positions. First, without the benefit of a system which continuously slots the same individuals to the same floors (or rooms), i.e., a ward system as described for People's Home, there is not likely to be any consistency at SFH in the nature of or expectations for a room over time. As indicated by one nurse, "alert rooms . . . don't stay that way too long." The gradual importation of confused patients into rooms occupied by those regarded as alert--for initial assignment and for transfer purposes--resulted in a change over time in the character and definition of rooms.

The absence of a ward system has another consequence which reveals itself in the patterns of staff-patient and patient-patient relationships. Residents at SFH are divided by the staff into actives and non-actives. These categorizations are not immediately related to ward placements. Staff members acknowledge that not all alert residents are participants in the activities program. However, one consequence of being an activities member is that the individual is given an opportunity to leave the floor during the day, to engage in some productive activity, and to interact with peers and with members of the staff in a relaxed and friendly manner. Participation in the various programs in the activities room was taken by the residents as a sign of their prestige and their alertness vis-à-vis others in the facility. Activities staff personnel at SFH held specific assumptions about those who should be encouraged to attend the various programs and those who should be excluded. Such criteria existed despite the apparent mandate of equality of residents laid down by the chief administrator. Only
those residents who were regarded as physically adequate and capable of being productive were invited to activities. From the staff's viewpoint, the activities room was not a context for socializing, but rather one in which patients demonstrated and contributed productivity.

Those residents not invited to activities remained on the floors during the day; they were subjected to the staff's discretion with regard to those others with whom they came in contact, where they were seated during the day, knowledge about home-wide events, and so on. No spatial distinctions were seen to have been drawn for the various residents who were required to stay on the floors during the day—either by the residents themselves or by their caretakers. Residents who appeared to me to be most alert indicated that the majority of their interpersonal contacts were likely to come from the staff. They often referred to the latter as their only friends at SFH. These residents bemoaned the fact that they came into regular contact with senile patients and that (based on their limited information store) there were no activities or contexts for them to meet with other alert patients at the facility.

In brief, the present chapter analyzes a second system for organizing assignment/reassignment decisions in a nursing home. Sisters of Faith Home patterns residents' careers without regard to ward location, but rather in terms of the labels "active" and "non-active," a division based on an "individualistic" ideal.
NOTES

1 See Berger (1963) on the issue of biography construction; also Chapter V above.

2 O'Rourke refers to his aunt's handicaps, but he stresses that she is independent, i.e., she won't "be a bother." The exact reverse tactic (stressing dependence) would have gotten the aunt admitted to SFH, with the identical medical diagnosis. This assessment is based on my observation of several other mildly retarded patients, who had lived in institutions for most of their lives, and who were capable of self-feeding, bathing, etc. Their SFH medical records noted, however, such medical conditions as diabetes, and, more importantly, contained a doctor's certification indicating the need for supervision.

3 Lucille Nahemow (personal communication) points out that this is generally a distinguishing factor between proprietary (private) and voluntary (church-affiliated) nursing homes.

4 Interestingly, midway through this study, John Stevens expressed to me much the same attitude as that expressed by Sr. Marie:

(Interview with John):
"I don't think we should have one floor, it's like a leper colony, if there's any prospect, if it's reversible and they come in very confused, I don't think it's good to tag them as confused and put them on the third floor for the rest of their lives. We're learning that with a lot of them it's reversible. That floor has had the reputation for four or five years. I tried it a few times to change it, but the family members don't really like it. The nurses tell them, 'Your mother's really oriented. She shouldn't be on this floor.'"

5 Originally, Palatino was scheduled for a room on third-Main, but was given one on fourth-Main the day of her arrival.

6 This example is especially interesting because it demonstrates the way in which a label and a social career continue from one institution to another. Mrs. Nunnely is, in this instance, assigned to the type of room suggested by the social worker of a previous nursing home.

7 For purposes of this report, it is sufficient to note the apparent equivalence of the first five members of the equation, but there are complications that should be briefly noted about this type of analysis. First, third-Main could be considered equivalent to the others if we consider the institution's attitude that it should be integrated. Given that third-Main is viewed by the nurses "on the floors" and by the residents as exclusively reserved for senile patients, I have decided to
place it as a nonequivalent member of the equation. But equivalence is always relative to some standard (or analytic level). From a financial perspective, i.e., the differential assignment of public and private pay clients, the following equations would hold:

\[(1M = 2M = 3M = 4M) \neq (2P = 3P)\]

If one takes the residents' viewpoint, fourth-Main becomes an undesirable floor (see transfer section) and so drops out as an equivalent member of the above equation. These contrasting analyses are not examples of mere gamesmanship, but reflect a structuralist position described by Hockett: "Culturally given identifications are not always absolute. Sometimes sameness is only relative to certain criteria, while by other criteria, also operative in the culture, there is difference" (1960:180). See Sigman (1981) for a discussion of the role of a "final arbiter" in such analyses.

By loose criteria I do not mean to suggest haphazard or non-existent criteria. Rather, SFH's system of maximum sectional equivalences served to increase the number of routes or entry positions for admission to the home. Similarly, the appropriateness of individuals to just about every section in the facility increased the number of permissible transfer types (whether or not all were ever used is a separate analysis). In this regard, Pike (1967) suggests that an increase in structure produces increased opportunity for choice.

Note Posner:

Because single rooms are in low supply as they are more expensive to maintain than doubles, it is more efficient, from an administrative standpoint, to move those residents who are the most difficult to get along with, rather than those who cannot get along with them (1974:361).

Posner's field notes describe an incident in which a woman petitioned for a new room, so as to be rid of her incontinent roommate; when a single room eventually became available, it was the latter woman who was moved and not the woman who had originally been annoyed. The situation at SFH is that the "problem" patient is not transferred to a single room, but is placed with roommates again.

On the other hand, an increase in the number of occupants in a facility may dilute dyadal pressure. This needs systematic study (Birdwhistell, personal communication).

Frake had been the subject of an intra-section transfer, but wanted to be moved to the first floor.

In some cases, the individual paying privately requested the cheaper rate:
(Discussion with Catherine Anderson): Irene Mills was originally placed in 215-B and was just moved to 400-B. Irene is on a one-year private pay contract. She was admitted to the Pavilion because she needed immediate placement, but her family wanted her moved to a four-bed unit as soon as it became available.

13. Jane Simon suggests that volunteers are the "backbone" of the activity program. The residents rely on the volunteers to wheel them to the activity room, secure their work projects for them, etc. One resident expressed it this way: "I don't know what they do without the volunteers." It may be suggested that many of the SFH actives were themselves church and civic volunteers, and thus are now continuing on their relationship with church activities with their own volunteers in assistance.

14. These data differ from the findings by Posner discussed in the literature review: "Some residents in the Home who are viewed as relatively competent and unproblematic are pretty well left on their own after admission" (1974:362). However, these data may also be compared with Teski's observations in a retirement hotel, where similar outcomes of identification with staff are noted:

... The important residents gained much of their prestige through the extra respect given them by staff and by their functions as unofficial staff members. Through their contacts with staff they were closer than the other residents to the sources of power, and the extra regard of staff put them in a better position for determining their own activities in a satisfactory way (Teski, 1976:87).

In this regard, note Warner and Srole's (1945) criterion of social status and prestige as the persons with whom one has extended relationships.

15. Leininger (1970) suggests that the taboo on personal topics between nurses and patients is not as strong in Catholic hospitals as it apparently is in nonsectarian ones. Compare the above data with that discussed in Chapter V and Sigman (1979)

16. In a conversation I had with Sister Constance the day before these field notes were recorded, Sister complained that one problem she had with SFH was the way the staff treated residents, i.e., not listening to their suggestions, not asking them for ideas, not allowing them to be independent, etc.
Compare the above data with findings concerning 120 residents of another Catholic facility:

Daily participation in religious group activities was more characteristic of the better adjusted than of the less well adjusted residents (Amen, 1959:341).

Staff resident relationships seemed to be an important factor in the satisfactory adjustment of the individual to the home. This was shown by the fact that the work, attitude, and treatment of the Sisters ranked second only to the presence of the chapel as the most important factor in the maintenance of high morale among the residents as was indicated by their listing of factors in morale (ibid.).

However, note that no one is excluded from activities by the residents; the decision to invite or escort new residents is left to the control of the staff. There seems to be an assumption on the part of the residents that, if one has been brought in by staff, one belongs there. Even though Mrs. Beaty, Mrs. Racer, and Mrs. Balsamo fight about the latter's attitude (see above), she is not avoided by the other residents in attendance at activities, and I never heard anyone question the propriety of Balsamo being a member of the activities program.

Mae Olney had been told about the daily program (reported to me by Sister Rose) and had occasionally been taken down to sit in the room either before or after physical therapy by her nurse's aide. She was not given a work place or storage bin because, according to the activities personnel, she did not have any skills of use to the program. On several occasions, Mae was wheeled into the activities room, but was placed at a table all by herself so as not to disturb the workers.

Note that the onus for being included in activities is placed on the patient.

This interview was conducted just after the invitation to join activities.
CHAPTER VII
SUMMARY AND CONCLUSIONS

This has been a dissertation concerned with the examination of certain social communicational aspects of intra-institutional career organization. It has focussed upon trajectory assignment and maintenance for aging residents of retirement facilities with housing, medical, and custodial responsibilities. Two research sites were selected on the basis of certain differences in organization and clientele in order to best exploit a methodology based on ethnographic techniques utilizing comparative analysis.

Review of the available literature revealed that there has been a paucity of published material on the criteria and procedures for patient assignment and reassignment in medical settings. While the aims of this dissertation concerned with communication are more general than this, the data gathered herein should be relevant to further understanding of assignment procedures and outcomes. It differs in orientation, problem and methodology from Lawton, et al. (1976), for example, whose interesting study indicates that differences in spatial behavior among transferred patients of various floors are a result of the relative number of moves each floor or each resident experiences, and are not associated with the type of patient reassigned. The issue of institutional assignments and reassignments has been examined here from an entirely different theoretical perspective. The aim of this research has been to develop information concerning the social interactional context of particular assignment and transfer decisions. It has,
therefore, dealt with certain of the observable social behavior, direct and indirect, leading up to and following position selections and reselections. The data analyzed in Chapters IV, V and VI have consisted of observational and interview material related to: (1) the criteria used by administrators and/or administrative committees to accept or reject applications to nursing homes; (2) the expressed criteria and procedures which justify and regulate decisions to assign and reassign patients to particular positions (beds) within each facility; (3) patterns of behavior expected of and accorded incumbents of particular social positions by nursing home staff members and other residents; and (4) the changes in behavioral patterns or complexes that signal or are associated with patient "declines" and the decision to transfer patients.

Two skilled care facilities located near Philadelphia were selected as research sites. The two nursing homes, People's Home and Sisters of Faith Home, were selected because they were judged to be confronted with the necessity of establishing recruitment systems. That is, in order to survive each had to continuously fill unoccupied residential positions. Each nursing home to ensure its continuity must organize to meet the recruitment demands occasioned by residents' deaths, discharges, or transfers to different institutional positions. As outlined in Chapter I, it was hypothesized that the two nursing homes would exhibit differing patterned processes for the selection of individuals for entry into the facility, and for the assignment of these individuals to existing social positions. It was further hypothesized that different behavioral expectations and demands would be placed on residents with different positional assignments and in anticipation of or preparation
for positional reassignments. In the discussion to follow People's Home data will be reviewed and summarized in some detail. This will be followed by a contrastive summary of the situation at Sisters of Faith Home.

People's Home: Summary

People's Home is operated as a private and profit-making facility. In apparent consequence of the profit orientation, the directors of this facility aim at making the home maximally appealing to its various customers (potential and actual). The owner and the administrator of PH told me that private nursing homes, by providing a physically appealing building which attracts a variety of types of clients, are able to maintain some competitive edge over other geriatric facilities. The various programs of People's Home aimed at improvement and expansion of the physical plant were designed with the idea of expanding the range of potential applicants. The owner and the chief administrator agree that private nursing facilities draw applicants from a pool of individuals who seek particular services and special facilities for relatives who are to be institutionalized. At PH, the satisfaction of these presumed customer demands is seen to entail the implementation and employment of a ward system which provides the different physical locations of the facility with differing definitions. Thus, each section of People's Home is designated by the administration as appropriate for a different category of patient. The segregation of patients is one of the selling points from the administrative perspective. This segregation enables each patient to commingle with selected peers and to receive treatment from health professionals who specialize in the care of selected types
of patients. Thus, most of the residents and their families when interviewed about the decision to apply to PH referred to the nursing home as primarily a place for meeting and socializing with other people, i.e., as a residential community. The fact that it was a skilled facility received secondary attention.

Several factors seem to account for the administrator's decision to accept or reject an applicant to People's Home: (1) the availability of family funds; (2) the total number and the classification of beds which are available at the time of the application; and (3) the type of patient. Applications to the facility are considered by the administrator only when there is an existing bed vacancy, and when the preliminary descriptions of the applicant-patient provided by physicians, social workers or family members indicate that the individual is suitable for that open position. When a specific bed becomes available, the first individual to apply at that time who is appropriate for occupancy of the bed is accepted. The facility does not maintain, or feel the obligation to maintain, a wait list. Thus, potential residents are allowed entry into the facility only when a match exists between patient characteristics and the available section space(s). Nonadherences to this apparent rule were generally observed to be the result of a low population census, and of the need expressed by the administrator to fill some of the empty beds.

An individual may enter PH through any one of the four residential sections; however the initial slots are not equivalent. Each section of the facility is designed for a different category or type of patient. As noted above, such a ward system is justified on the basis of the need to attract the full spectrum of geriatric patients to People's Home.
"Confused" and "disoriented" patients are assigned "A" or "C/D" sections because of the high staff-patient ratios there as compared to those on "E" or "B." The varying staff-patient ratios are apparently a response to the differing health and supervisory needs of the various patients at PH. In addition to this, the physical plant itself differs among the various sections: "A," "C/D," and portions of "B" have linoleum floors, which are said to be easier to maintain with incontinent residents than are the carpets found on "E." There is more attention paid to aesthetic details (e.g., matching wallpaper, signed and numbered lithographs) on "E" section and on portions of "B" section, where "alert" patients are selected for residence.

In some respects, the most important aspect of the patient-to-section match is seen to be concerned with the potential newcomer's capacity to contribute to and benefit from social life (contact with one's peers) on the particular section assigned to him/her. Assignment to a particular section of the home entails the most likely social group(s) which the new patient will be allowed, encouraged or expected to join. This criterion of matching incoming patients and available beds (and wards) is consistent with the definition of People's Home as a skilled nursing facility as well as a residential community. Staff members recognize that each of the four sections promotes and is guided by different rules for social interaction and peer contact. Moreover, there exist few opportunities and sanctions for extended inter-ward interaction to develop; friendship among the residents is predicated on the staff members' assumption that individuals must be allowed to reside and associate with patients of a similar type. This attitude is, in general, accepted and reinforced by the residents.
themselves who avoid conversation and other activities with residents not from their own section in such places as the living room and the dining room. In addition to this, residents adhere to certain tacit spatial allocations. Thus, they avoid entering territories (wards) outside their own sections in order not to come in contact with the patients there.

The nonequivalence of the residential sections which influences initial slotting decisions by the administrator can also be seen to shape transfer procedures at People's Home. In general, staff members initiate reassignments when a patient is no longer considered suitable for his/her current ward placement. Change is usually viewed by the staff in terms of patient deterioration; there is little assumption that nursing home patients improve. The ostensible aim of a transfer is to select a section of the facility which matches the patient's current medical condition or functioning level. As a result, the general flow of reassigned patients is from the most prestigious sections to lesser evaluated ones in the home.

Several variations on this general rationale of reassigning deteriorated patients can be noted. First, in some cases, assessments (reassessments) of a patient's medical and psychological condition occur immediately upon the patient's entry to the facility. Such transfers are likely when a major discrepancy exists between the staff members' evaluations of the incoming patient and the family members' original reports. However, the majority of transfers are initiated for long-term residents of the facility who are judged unqualified for the existing assignments. It is interesting to note that, although a staff committee exists at PH for monitoring patients' medical conditions and behavior
performances, and for regulating transfers, judgments regarding patient inappropriateness are made by the residents' section peers, as well as by nurses and activity workers. (The structure and possible outcomes of these monitoring interactions will be summarized below.) Finally, relatives of the residents of PH can be observed to encourage particular treatment of residents, both of their own family members residing at PH and of the latter's roommates (real and potential). Relatives outside the facility are acutely aware of the status and prestige system within PH, specifically, how the resident's prestige is dependent upon that accorded his/her section mates. Therefore, relatives negotiate with the administration of the facility for a particular status, either by encouraging particular placements, activities, etc. for their own family members, or by encouraging particular transfers for other patients.

**Sisters of Faith Home: Comparative Summary**

Sisters of Faith Home has organized its system of assignments and reassignments on a different basis. The history of SFH's founding, and, perhaps more important, the current administrator's selective reports regarding this history, indicate an institution-wide perception of a nursing home (this nursing home) as a charity and health-care facility for the aged. It is important to note that SFH does not define itself simply as a domiciliary facility, but rather emphasizes its role as a total-care medical institution. Consonant with this definition of the institution as a whole is an assumption held by the staff members concerning their role vis-a-vis patients. The staff members' behavior can be interpreted as attempting to exhibit an all-encompassing helping attitude. This differs from the impression the PH personnel attempt to
Staff members at People's Home assert that their purpose is to assist the patients in helping themselves and to provide them with a fitting residential setting, not to "serve" them. In contrast, when SFH staff members are asked to talk about their nursing home, they refer first and foremost to the numerous health programs which are made available to patients, and which extend beyond those required by state and federal regulations for skilled care licensure. These expanded services include high staff-patient ratios throughout the home, and extensive social services and religious offerings.

These contrasting data between SFH and PH are consistent with those provided by Marshall (1975), who observes that Catholic nursing homes tend to assume responsibility for organizing all facets of patient care (medical and recreational), whereas private facilities leave certain aspects of this unstructured and in the hands of the patients themselves. It is noteworthy in this respect to recall that SFH residents often refer to the home as a hospital, and tend to attribute more importance to the medical services provided by the staff than to the various opportunities for peer interaction.

A second difference between People's Home and Sisters of Faith Home is that the latter is not based upon a ward system. SFH consists of six residential floors in three connecting buildings; however, none of the six floors is explicitly allocated for a single patient type (with the possible exception of the third floor of the Main Building). Entering patients can be (and are) placed on any floor of the home by the admissions board and the social work department without regard for the patients' medical and/or psychological diagnoses. Although an attempt is made to apportion staff workloads evenly throughout the facility by
a relatively equal distribution of patients, the rules regulating
initial admission/assignment decisions specify that any patient or
patient type can be given any bedroom. Since the outset of the chief
administrator's tenure at SFH, guidelines have been established which
encourage the mixing of "confused" and "alert" patients throughout the
facility.

These assignment/reassignment procedures are justified and
explained by the administrator and other key personnel on the basis of a
conviction that SFH should be the greatest possible service to the
surrounding community. SFH describes itself as obliged to admit all
individuals who qualify for placement, and therefore makes use of a
waiting list which guarantees applicants (and their families) an
eventual place in the facility. The absence of differential ward
criteria is further justified because it increases the number of
possible entry slots for applicants and hastens admissions. Social
workers at Sisters of Faith Home are discouraged from leaving beds
unfilled for more than a few days. Finally, staff members claim that
patients must be treated as individuals. A ward system, from the SFH
perspective, serves only to label and to group patients together.

The equivalence patterning of the residential sections shapes
criteria and procedures for reassignments. The quantitative data
reenforce the observation that transfers at SFH are as likely to involve
intra-ward changes as they are inter-ward changes. The social workers
and section nurses, who are in charge of monitoring the residents'
behavior and deciding on reassignments, indicate that transferring off a
section is not a necessary consideration for a move. Consistent with
the emphasis placed by the staff members on treating patients as
individuals, personality conflicts between patients are cited as reason
enough to justify a transfer.

A second situation associated with transfer decisions at SFH
involves the changing health status of patients. When an individual is
deemed no longer able to benefit from an existing slotting, a room
change may be instituted. Reassignments under these conditions are not
necessarily intended to match the patient's deteriorating health status.
Instead, staff members describe the post-transfer location as a context
which can potentially stimulate and reactivate the regressed individual.

In some cases, "failing" patients are described by the staff as
suffering from and being particularly vulnerable to the character of a
current slotting, which is itself subject to change over time. One
problem acknowledged by SFH staff members is that, without the benefit
of a system which repeatedly assigns the same patient types to the same
residential floors, there is little consistency in rooms over a period
of time. As a result of, e.g., "alert rooms... (not) stay(ing) that
way," it is not uncommon for patients to be given placements which the
social workers initially assume are appropriate, but which ultimately
result in transfers.

Another implication of the absence of a ward system at SFH can be
seen in the rules which guide communication behavior between residents
and staff members, and among the various residents. The data indicate
that room assignment is not as salient for the behavioral treatment of
and expectations for patients as are "active"/"non-active" labels. For
the most part, different codes of behavior are not expected of patients
with contrasting assignments, or of patients who undergo transfers. The
use of physical restraints, tacit permission for patients to wander,
seating arrangements and locations, among other behavior, are viewed by staff members as patterned for particular individuals, not for specific sections.

Both residents and staff members distinguish between those patients who are invited and expected to attend the home-wide activities program, and those who are discouraged from doing this. Nursing and activities personnel maintain that the former, the activities participants, are the alert members of the resident population, and that the latter, the non-actives, are either senile or failing. Both patients and staff accord the most prestige to those who engage in the various programs in the activities room. In part, such participation is considered an opportunity for extended sociable contact with peers within a constructive work context. With regard to staff-patient relationships, active residents tend to engage in more non-task-related interactions with staff members than do the non-active residents. Active residents are provided with more contexts (e.g., afternoon snacks in the cafeteria, etc.) for sociable conversation with the staff. In addition, the flow of information concerning activities, events, and religious programs tends to favor the active patients over the others.

One influence on or adjunct to the differences in assignment criteria and procedures between the two nursing homes may be found in the contrasting goals and assumptions held by each institution. Although People's Home and Sisters of Faith Home are both confronted with the need to establish recruitment systems, the specific systems for assigning and reassigning patients to available beds have developed in a manner consistent with certain other distinctions which can be formulated about the two facilities.
At People's Home there exist contrasting criteria for entry onto and position maintenance within each residential section. This range of criteria is ostensibly created to enable the institution as a whole to attract a variety of patients. It is somewhat paradoxical that SFH also seems able to attract a diversity of clients without the existence of a ward system.\(^1\) Gerontologists and institutional workers acknowledge that voluntary nursing homes, e.g., church-affiliated facilities such as SFH, have less difficulty attracting clients and maintaining a population census than do proprietary facilities, e.g., private ones such as People's Home.\(^2\) This observation may be used to interpret the existence of a wait list in one of the nursing homes studied here, and its absence in the second. However, the differences in admissions and assignment procedures between SFH and PH seem to be the result of the role each institution defines for itself. People's Home perceives its role as custodial and as providing a residential context for aged individuals. The role of this institution is defined in "social" terms, and a resident's ability to "make it" (survive) in the facility presumes acceptance by one of the ward-specific social groups, one of the reasons for entering a nursing home in the first place. In this manner, not only is there the requirement placed on PH of recruitment to fill available slots when admitting new patients, but also there is apparently the requirement of differential recruitment so that the institution can maintain the segregation of a relatively heterogeneous population.

SFH does not justify the absence of a ward system by its ability to attract applicants and patients (as evidenced by the long wait list). Rather, certain other aspects of its self-defined mission are important...
elements to be considered. First, SFH is defined first and foremost as a health care center. The administrative and nursing staff members perceive their jobs as primary caretakers of the patients. Indeed, the patients spend a lot of time in servicing interactions with staff, and there is little emphasis at SFH placed on the providing of contexts for resident socializing (except for the small number of patients defined as actives).

Conclusions and Discussion

There are serious questions raised by this analysis of the procedures and self-conceptions of these facilities. Would the health status of the patients at SFH be improved if they could commingle with similar patients? When posed with this question, the administrator of Sisters of Faith Home points out that there are two "schools of thought" which must be addressed in order to resolve this issue. Referring to the geriatric literature, the administrator noted that the data on the relative benefits of integrating versus segregating patients are ambiguous and inconclusive. A review of the literature supports this conclusion. For example, Natenshon, an architect who was involved in a design project of a geriatric facility, points out that there is little agreement among institutional workers on the advantages (or disadvantages) of segregated living:

It is generally felt that confused or mentally disturbed patients hasten the deterioration of alert patients. At the same time the presence of alert patients slows the deterioration of the disoriented. How much segregation is advisable? Whose welfare is to be considered? On none of these questions was there agreement among the "experts" (1969:62).
Kahana suggests that segregation of patients in nursing homes serves to produce a total institution environment, and that segregation is not always beneficial:

In the majority of institutions for the aged, residents are segregated with regard to age, sex, social class, ethnic background, physical and mental illness. It is assumed that specialized care could be best provided to a very homogeneous group. Yet in fact the institutions are only carrying one step further the isolation of the aged resident from the varied interactions he was used to in the community. The lack of attention to individual needs and the tendency to treat everyone alike have been seen as the very essence of institutional life. Goffman's... concept of the total institution applies to many aspects of institutional living in homes for the aged (1971:55).

Kahana reports on a study she performed which shows that age integration serves to keep elderly patients active and stimulated, although the optimum ratio of geriatric-to-nongeriatric patients in institutions is left unanswered. In contrast, Brody argues for the utility of segregation on the basis of patients' diagnoses:

Experience at PGC indicates that the relatively intact (that is, those who do not require round-the-clock supervision, who are ambulatory, and capable of self-care) should not be mixed with the more impaired. Those who are mildly forgetful can often live with the more intact, depending on their level of functioning. Residents whose impairment is evidenced by marked confusion and severely disordered behavior should be segregated; they require more intensive staffing patterns and create anxiety on the part of the relatively intact (1970:305-306).

One may extrapolate from this that SFH is faced with a choice between at least two approaches to the organization of geriatric facilities. The selection opted for by the administration is on the side of what is justified as a "Christian" orientation: no segregation. This interpretation of SFH recruitment finds support in the words of the administrator who, in her interviews with me, indicates an aversion to the implications of a ward system (e.g., locked wards), and a
preference for carrying on a general policy of integration which is said to have been established many years before by her predecessors.

The differing attitudes regarding the degree and kind of health services found in each institution can also be observed in transfer procedures. As noted above, certain transfers at Sisters of Faith Home are provided for failing residents and are intended to offer them a new and vibrant living context. In contrast, transfers of similar residents at People's Home are most likely to involve movement to a lesser ward, i.e., one which the resident "fits" rather than has to "live up to."

One interpretation of this difference again relates to the definition of its role and its responsibility to patients that each nursing home holds. SFH views itself as a Christian health-care institution, caring for, and, in some cases, rehabilitating patients. While PH is also a skilled care facility, it further views itself as a residential facility constituting varying living contexts. In this manner, reassignments at SFH are made in order to provide ameliorative living arrangements; at PH, in contrast, transfers are initiated with an eye toward furnishing a socially appropriate and minimally stressful environment.

The two institutions similarly differ with regard to their definitions of patient adjustments. When staff members at SFH talk about the adjustment of a new patient, they usually point to the patient's stabilizing medical condition, his/her enrollment in speech and physical therapy, and so on. On the other hand, PH staff members seem to allude to (or stress) two additional criteria of patient adjustment: the newcomer's becoming accustomed to and able to navigate through the physical plant of the facility; and the newcomer's acceptance into one of the ward-specific cliques.
It is not being suggested here that ideological differences between PH and SFH inevitably cause or result in the recruitment systems described. Rather, the present discussion attempts to situate the recruitment differences within a framework that includes the differences between each institution's avowed goals and preferred tasks. It should be pointed out that other differences exist between SFH and PH. As the following data from another study indicate, the potential impact of nursing home size cannot be ignored:

... Administrators themselves in large institutionalized homes may tend to discourage close relationships between nursing home residents and to foster a feeling of dependence and inactivity in their patients. Additionally, the fact that smaller homes are usually converted into nursing homes from large private residences may give these homes a more "residential" tone, where friendships are felt to be socially appropriate. The long corridors and more hospital-like appearance of the larger homes may create just the opposite social psychological feeling among the residents (Curry and Ratliff, 1973:298).

In this study, a small nursing home was one with fewer than forty-five beds, and a large facility was one with over one hundred beds. Sisters of Faith Home is a three hundred eighteen bed facility, and People's Home contains one hundred and sixty beds. The potential influence of these differences in size on each nursing home's organization and routines cannot be assessed in the present study, and is a variable which future research will need to consider.

Apart from the specific assignment and reassignment criteria which distinguish PH and SFH, there are a number of generalizations concerning the two recruitment systems which should be noted. One implication of the data presented in this dissertation is that staff members of nursing homes continuously monitor the medical conditions, and, more important for our concerns, the communication behavior of residents. In the case
of PH, this practice provides the staff with opportunities for ensuring that a sustained match exists between patients (newcomers and veterans) and wards. This monitoring also permits the staff to observe residents' assessments of each other's position assignments and the possible influence residents have on the shape of the careers experienced in the home. In the case of SFH, this monitoring behavior is especially important, not only for assessing particular residents, but also for surveying the character of particular rooms (i.e., in the absence of continuous ward- or room-specific categorizations). These staff observations serve as the basis for further action (e.g., for assigning new admissions to a particular room, for deciding on a reassignment, etc.). To a more limited degree, monitoring of patients during their first few weeks of residence at SFH is used to invite newcomers into the activities groups (or to exclude them from these).

The similarity of these practices to those described by Goffman for total institutions in general is noteworthy:

When persons are moved in blocks, they can be supervised by personnel whose chief activity is not guidance or periodic inspection (as in many employer-employee relations) but rather surveillance—a seeing to it that everyone does what has been clearly told is required of him, under conditions where one person's infraction is likely to stand out in relief against the visible, constantly examined compliance of the others (1961:6-7).

In total institutions there is a basic split between a large managed group, conveniently called inmates, and a small supervisory staff (ibid.:7).

Also:

. . . Minute segments of a person's line of activity may be subjected to regulations and judgments by staff; the inmate's life is penetrated by constant sanctioning interaction from above. . . (ibid.:38).
Goffman apparently sees such surveillance as part of the institution's restrictive control practices, which ensure, in this manner, a definition of self for the inmates which is in accord with the institution's "stripped down" roles. The present analysis suggests something beyond or in lieu of this motive. The monitoring interaction observed here apparently functions, not solely in an attempt to make uniform the behavior of others, but to ensure that the residents' behavior is in line with the expectations for particular status placements and with the total range or repertoire of acceptable behaviors for the institution as a whole. Individuals whose behavior deviates from a particular predictability framework (see below) may be subjected to efforts by staff members (and residents) to get them to conform, but they are also likely to undergo a reassignment which invokes a different patient categorization and a different set of behavioral expectations. In this regard, monitoring of residents' behavior (by staff members and by the residents' peers) may serve a training function, a position maintenance function, and/or a reassignment function.

Birdwhistell (1970) maintains that communicational predictability is a sine qua non for the adaptability and continuity of a social system (also see Bateson, 1972). Further, all social systems attempt to standardize and to regulate the behavior of members, and special treatment is accorded individuals whose behavior is insufficiently predictable to others. The behavior guidelines that are imposed on an incoming patient's conduct and the behavior which is accorded the individual by his/her peers and caretakers may be seen from the perspective of ensuring predictability.
Newly admitted patients interact with their peers and with the professional staff in such a way that the subtle rules which constitute life in that facility become available to the newcomer. Although Goffman has suggested that this type of interaction operates as a mortification or a stripping of the patient's self from "on high," the present data indicate that attempts are made by all institutional actors to train individuals into knowing and adhering to the rules which make meaningful communication possible. Moreover, the individual's transition into the facility and his/her learning of the rules are (at least initially) supported and eased by others. Staff members contribute to the patient's biography subsequent to the initial assignment in an apparent effort to ease the patient's "audition" vis-a-vis the other residents and to ease the patient's acceptance of the assigned position. For example, when Mrs. Ford was first assigned a room on "E" section of People's Home, no restraints were used by the staff to control her wandering. Although this effort failed and Mrs. Ford was eventually transferred to a different section, the initial attempt on the nurses' part was to facilitate Ford's entry into and acceptance by the female clique on "E." Similarly, the director of activities at SFH remarked to me that the first task given to new residents invited to join the program are very simple ones; this ostensibly eases the adoption of the active label by providing the individuals with an initial success.

Monitoring interactions and patient labels also impose standards of behavior on newcomers which they may (or may not) attempt and be able to meet. In their interactions with their peers and with the professional staff, recent entrants to each nursing home are informed—explicitly and
implicitly—how to conduct themselves with various others in the facility. Residents are informed about acceptable/unacceptable standards for certain behavior, as well as the consequences of not adhering to these standards. At PH, residents learn where they are expected to congregate and the conversational rules which govern the interaction. Moreover, they learn what it means to be an "E," for example, and not a "B" or "A," and thus they become familiar with the classificatory scheme guiding social relations. The phenomenon of residents training each other is also clearly evident at SFH where many residents, even on the very day of admission, come to realize the importance of the labels "active" and "non-active," and, in some cases, strive for a particular label to be designated for them. Information about these labels and their significance to social life at SFH is conveyed to recent entrants by the social workers during the admissions interview and by the residents' "welcome wagon."

One means of ensuring social predictability during one's life course in a nursing home, it may be noted, apparently involves the establishment of and adherence to procedures which classify the behavior of others. These classificatory procedures may then be used by institutional members in the determination of particular response patterns and courses of action. Residents are able to find predictability in others (or assign this) through their efforts at continuous monitoring of each other's performances, by labeling the behavior they observe, and by sharing such information with a limited group of others. The novitiate's own behavior initiatives and reactions to the interaction he/she has with others are used by peers and staff members alike in an assessment procedure. The new resident provides
information to others which is used to determine the appropriateness of that person for incumbency of the assigned social position; in part, this information is compared with standardized expectations (entrance requirements) sustaining a particular group's boundaries.

These surveillance procedures enable established persons in the facility to find a category or classification for the behavior initiatives of others, and to use this category in making determinations on the appropriateness, likelihood and desirability of particular kinds of interaction contact with the newcomer. Even the patients isolated on the floors at SFH observe the behavior of their fellows, and make decisions as to the salience, sanity, worthiness of response, etc. of such behavior. One difference between the isolated residents and some of the others studied in this dissertation is that the former are not provided with contexts for sharing or affirming this information with others.

As noted, one aspect of these frameworks of predictability at both facilities is that they are used by all members as guides for determining with whom one can "safely" have focused interaction, whose initiations of social contact are to be discounted, and the range of acceptable behavior (e.g., conversational topics) when there is interaction. The behavior of the residents of both SFH and PH is guided by such procedures even though, as discussed above, differences in the specific behavior exist when the two institutions are compared. At PH, one's ward affiliation largely constrains whom one meets on a regular face-to-face basis, and with whom one is expected to develop friendships. The expectations that are held about a new entrant are shaped by general background knowledge held about a particular section.
The act of position assignment at People's Home may be interpreted to include the placing of a set of expectations which differ for each of the assignment types. After a period of time, during which staff members try to provide for the patient's adjustment to life on the particular section and other patients convey the appropriate behavior rules, the insufficiently predictable individual is considered unsuitable for the particular section assignment and moved.

The procedure operates differently at SFH than at PH. The initial framework of predictability at SFH is not shaped by the first position assignment, but by the subsequent existence of an invitation to the activities program. Given the definition provided by the staff of patients as either active or non-active, a particular course of action ensues from the categorization, and not from a position in a residential section. Active residents avoid extended co-present interaction with those defined as non-active, and frequently disparage staff efforts to include the latter in some activities. Non-active residents tend to remain on the floors for most of the day, usually sitting by themselves in the sun room or in a corner of their bedrooms.

Patient categorizations invoke standards for the behavior of newcomers and also for the behavior of those doing the classifying. This is especially the case at PH when newly arrived patients do not fit the limited ward-specific classifications. When an individual does not or cannot conform to the expectations of the other residents (even after the training described above), then the latter residents share their observations with each other and are apparently obliged to act upon these. For example, patients were observed agreeing upon and/or imposing labels which could then be used to justify particular treatment
to others whose behavior was nonconforming. Individuals who, despite
the slotting provided by the staff, do not meet the audition
requirements for a particular assignment, may be defined as "crazy" or,
more simply, as "not belonging." These labels are shared by the
residents and are used to explain various orders of avoidance behavior
(e.g., conversational exclusions, activity cessations).

Labels which institutional members use for defining the range of
what is considered unexceptional behavior are not all based on ward or
activity assignments. In some respects, those occurrences which have
taken place outside the nursing facility and prior to the patient's
entry into either SFH or PH are as important as what happens in the rest
home. Descriptive labels, predictions of patients' future behavior, and
suggested position assignments and treatment modes are offered SFH and
PH by family members, social workers, and previous institutional records
and charts. For example, at SFH there was observed the continuity of a
label and the associated social career from a previous institution for
an epileptic woman who was considered "disruptive." The initial
placement of this woman on third-Main was justified on the grounds that
staff members there could handle recalcitrant patients. Similarly, the
designation of the "Dr. Johnson syndrome" at People's Home results from
expectations for the patient's behavior conveyed to the nursing home by
family members unwilling to concede the issue of permanent placement.

In brief, both nursing homes studied for the present research
employ various means to categorize residents, and to provide for
contrasting sets of behavioral expectations in association with
particular labels and position assignments. These labels and
expectations may be seen to be under the control of both residents and
staff members. Certain categories are initially assigned by the personnel (e.g., ward designations, activities designations), and the residents' behavior towards newcomers at least initially adheres to the rules associated with the assignment. However, residents were also observed auditioning newcomers, i.e., examining the latter's appropriateness to the assigned positions, and acting upon their own labels if the patients failed the screening.

Both nursing homes evidence prestigious in-groups which avoid contact with outsiders, and whose boundaries are in part defined by their refusal to interact with other institutional actors. The existence of these groups and their relative status are apparently organized at both institutions by the staff members, although, as noted, these groups are sustained by communication rules adhered to by the residents themselves. Given the emphasis at SFH on entering a nursing home "for medical reasons" or "to be sick," it is perhaps not surprising that the status women are those who transcend their illnesses in order to live relatively active lives. Further, prestige at SFH is apparently allocated to those individuals who maintain or develop an attitude of contributing to church-related functions by accepting an invitation to join the daily activities program. On the other hand, since People's Home is partially defined by the residents, their families, and the staff members as a place for establishing new friendships in one's later years, prestige is conferred on those residents who are not loners, who accept the permanency of their placement, and who eventually are included in one of the ward-specific cliques. Paradoxically, residents' participation in formalized activities is not considered by the staff members to be a salient characteristic of the "best" residents, although
an individual's absence from his/her regular recreational events is sometimes interpreted as evidence for the individual's "failing" or "withdrawal."

There is an important implication raised by these observations, especially when they are compared with the prevailing sentiment in the geriatric institutional literature. Goffman (1961) has claimed that total institutions employ mortification rituals in order to standardize the behavior and attitudes of inmates. Chapter II of this dissertation indicates that several other writers have argued for the applicability of these total institution concepts to geriatric nursing homes. The present study indicates that, in addition to processes of uniformity, there may exist in nursing homes processes by which institutional personnel make use of and communicationally elaborate on the differences between incoming patients. In a sense, the same typology of residents exists at SFH and PH: confuseds (seniles, disoriented), alerts, and transition patients. Differences lie in the behavioral criteria used for making these judgments, and in the associated behavioral expectations and outcomes.

Although the rhetoric of the administration at SFH may be seen as an attempt to deny or depreciate the existence of patient groupings and classifications, this institution does evidence practices which serve to categorize and separate patients. To repeat, SFH clearly draws a distinction between active/alert patients on the one hand, and non-active/senile patients on the other. This organization of patients is powerful despite an emphasis on "individuality" as far as initial slotting decisions are concerned. Moreover, such distinctions as are drawn at SFH are coordinated with contrasting behavioral treatment by
residents and by the staff. Such differentiating behavior is similar to that observed at PH. Differences in the behavior accorded patients based on their category were seen in terms of the physical spaces they were allocated for occupancy, their social relations with staff members, etc. It is impossible with a study of only two institutions to suggest that all nursing homes assign contrasting positions, social careers and behavioral expectations to patients. However, it does seem safe to say that once patient categories are established, the continuity of their application to specific patients is maintained (or their discontinuity is signalled) through various orders of staff-patient and patient-patient interaction.

Several additional generalizations about the behavior at both nursing homes studied here can be made. First, there exist similar rules for acceptable friendship groupings based on the status accorded a patient (and accepted or affirmed by his/her peers). For example, as noted above, social relationships at People's Home are largely organized around the patients' areas of residence. A person's status and identity are defined in part by the peers with whom one maintains regular contact. Comparably, behavioral limits are conferred at SFH on the basis of the residents' participation (or nonparticipation) in the various activity programs, and the peers contacted there. Although the alert residents of SFH are fondly disposed towards some of the more confused residents, they were not observed spending much time with them. Instead, the staff decision to bring one's peers into the activities room was used by residents as a basis for assuming the degree of alertness of others and for establishing extended interaction relationships with them.
Second, similar rules can be seen to govern the conversational interaction of in-group members (i.e., within the higher status groups). According to the active residents at SFH, the worst of their peers are those who constantly complain—whether about sickness, feelings of abandonment by their families, or life in a nursing home. The former residents suggested to me that one not dwell on what could not be changed, and instead concentrate on their talk on pleasant aspects of SFH life. The "F" women at People's Home also place a premium on sustaining a positive attitude toward life in the home; they too adhere to rules which minimize disparaging comments or complaints. Moreover, the prestige residents of both PH and SFH can be observed interacting with staff members in a relaxed, sociable and often humorous manner (a style of interaction which appears to be permitted and encouraged by staff members in each institution).

A third general consideration regarding the present data is that the different labels or categories which are placed on patients are seen to be associated with differential channeling of information from staff members to the patients. This is most clearly seen in access to knowledge about the various contexts of interaction, activity programs, etc. available at each facility. The data indicate an interdependent relationship between particular patient position assignments and particular patterns of message flow. Residents who are provided with certain positions are made privy to certain information from and social relations with staff members. This differentially accumulated knowledge among the various resident factions serves to maintain and reinforce the original distinct assignments. For example, SFH residents who are defined as actives are told about and invited to participate in various
programs within the facility as well as in various outside excursions. Their participation in these programs serves to provide the patients with information about additional social activities that are regularly scheduled by the nursing home, and extended contexts for non-task-related interaction with staff members and volunteers. The more a resident attends the various activity programs, and, moreover, the more a resident can be relied on by the staff to attend the activities they plan, the more likely is this person to be given future invitations. The staff members refer to the active residents' participation in social activities in order to justify the original assignments. The active residents themselves refer to their activities participation and their friendly relations with institutional personnel in order to further disassociate themselves from other categories of residents.

At PH, message flow to patients is limited by ward affiliation, although there also exist "open" contexts (e.g., the beauty parlor) where home-wide information can be shared. Residents on a particular ward are told about only certain activities and about only certain physical locations of the total facility. Information boundaries are established through the residents' and staff members' talk as to where one may comfortably and appropriately enter. Nonassociation with institutional members outside of one's ward can be seen to reinforce one's belonging to the ward-specific group and one's seclusion from others at the facility.

Social recruitment has been referred to here as a communicational structure evidencing itself in a behavioral system concerned with the sorting of individuals within a social system and with their assignment to existing social positions (see Chapter I). The present data indicate
that recruitment in the institutional context can be seen to involve processes of position assignment, training newcomers in institution-wide and ward-specific behavioral rules, audition for entry into one of the resident social groups, and position reassignment. The two systems of assignment and reassignment that have been examined here provide for a range of flexibility with regard to the selection of patients' careers. Each institution assigns the individual to a particular slot or position within the facility. While the initial slotting may delimit patterns of appropriate behavior, it does not prescribe the scheduling of movement (if any). Position transfers at both facilities are associated in various ways with patient decline, but they are apparently not scheduled or based on an explicit time dimension, or even the nature of the first slotting. Rather, movement toward and away from different positions in each facility (i.e., the through-time career or trajectory) is based on the individual member's interaction with his/her peers, declining medical and behavioral symptoms, maintenance of appropriate and expected behavior, and so on.

Each residential slotting decision at SFH provides for a number of outcomes (careers) not totally predictable in advance, i.e., not predictable from the floor/room assignment itself. This is because the SFH rhetoric ostensibly defines patients' careers around individual patient characteristics. Each floor at SFH is structured around a variety of divergent pathways: actives and non-actives, alerts and seniles, competents and non-competents may be found on each residential section.

The same flexibility of the recruitment system is observed at PH, where the initial slotting delimits the range of possible careers.
available to residents of that nursing home, but does not in all cases indicate the precise one. The range of acceptable or expected careers for each PH section is narrower than the range found at SFH; this is due to the existence of nonequivalently evaluated residential sections. Nevertheless, floor and room slottings do not by themselves predict all aspects of a patient's career, i.e., the unit of through-time behavior for which a specific room assignment is but a partial moment. To a large degree, the patient's status cannot be seen as being defined or imposed solely by the staff's initial assignment decision. As noted above, a new resident may be assigned a particular position within the facility, but his/her continued incumbency is shaped by subsequent interaction with peers and the latter's evaluations of the former's behavior. Although the contrasting probabilities of movement between specific wards can be noted for PH, actual movements for patients are not scheduled in advance by the staff members. Various patterns of position movement or position maintenance are the result of the training, acceptance/rejection, etc. processes described above.

In brief, the present study has shown that nursing homes apparently confronted with the requirement of establishing recruitment systems for selecting and assigning incoming patients may pattern these in a variety of ways. The particular system that each nursing home studied here has instituted seems to be associated with its assumptions regarding the role of a geriatric facility in the care of elderly patients. Therefore, it is important to note that recruitment systems are apparently patterned not only by the system requirement of functional continuity, but by particular (and contrasting) institutional definitions concerning the place of health providers and skilled care
facilities in geriatric medical practice. Nevertheless, certain similarities were observed for the two recruitment systems, e.g., the behavioral implications of categorizing patients, the presence of monitoring procedures, the existence of standards for patient admissions, assignments and reassignments, the impact of census counts on admission criteria, and the like. Each recruitment system described here can be seen to pattern members' biographies or careers within the institutional setting; each recruitment system provides residents with sets of behavioral expectations and guidelines, and delimits or supports particular staff-patient and patient-patient relationships.

In addition to the differences in size between institutions which may influence the patterning of career options (see above), there are a number of other conditions which need to be considered in evaluating this research. The present data are limited in a number of ways, and these limitations require us to consider the generalizations and conclusions discussed in this chapter as preliminary only.

A first consideration for future research involves more detailed analysis of pre-patient careers and their influence on intra-institutional careers. At what point in an individual's life is a decision for institutionalization made by that individual and/or his/her family members? In general, when and how do society members seek professional help? What contributes to the choice of the particular nursing facilities which families apply to and enter? With reference to the present data, how is it that PH and SFH residents and families can be seen to echo the respective mission and self-definition held by each institution?
The present study indicates that recent entrants and long-time veterans of People's Home reaffirm the institution's expressed goal of providing patients with a living context conducive to peer socializing by suggesting the importance of making friends in a nursing home as one reason for initial entry. In contrast, SFH residents stress the value of an extensive health and social services program as a justification for entering this particular nursing home; this is congruent with the emphasis placed by the SFH administration on SFH's role as a skilled nursing facility. To what extent is there a self-selection process operating here (by individuals, their families, or assisting social workers) and to what extent is this phenomenon the result of a training process (residents emphasize whatever is most stressed by the institution itself)? In this respect, the differing definitions of prestigious/nonprestigious careers discussed above may be associated, not only with the contrasting recruitment systems themselves and the ideologies held by SFH and PH, but also with the differing expectations for social participation brought into each facility by the residents and their families. One limitation of the present study, then, is that it has primarily focused on institutional agents who control recruitment and social careers, rather than on individual choices to allow oneself to be recruited, to enter the institution, and the attendant expectations for life in the institution.

In addition, this dissertation treats the institutional staff members as a relatively stable group, and as primary agents of recruitment vis-a-vis the "clientele." Nevertheless, such personnel are also subject to selection procedures and career patterning; the interdependence and mutual influence of the patients' and the staff
members' life courses should be made part of the observational present of research derived from the present study.

The present research has analyzed different behavior guidelines governing staff behavior and resident behavior based on ward assignment at PH or activities designation at SFH. To a large degree, observations were made and interviews were held with staff members on the late morning and early afternoon shifts only. This choice can be partially justified on the grounds that it was during these times that all staff meetings (e.g., of the transfer committee, the admissions board) were convened, and the bulk of the various patient-directed activities were held. However, there was some intimation by residents at both facilities that parties were held by the evening nurses on certain sections and that a limited number of residents participated. The present study was unable to collect observational data on this phenomenon. In a similar vein, the active residents at SFH discouraged or decried my visits to the nursing home when the activities room was closed (e.g., during weekends and holidays). More systematic observation of these patients when they are not provided with the activities context to separate themselves from the other residents is needed.

The larger temporal dimensions of the present analysis must also be considered. The data for People's Home are based on two periods of field work. Perhaps more important, these data encompass a time dimension of nearly three years. In addition to facilitating my entry into the nursing home for the 1980-81 period of field work, data from the earlier study of People's Home (Sigman, 1979) enabled me to see the long-term impact of transfers on patients. The present data include
descriptions of patients who lived on one section during the 1978 observations, and who were transferred to a second ward prior to or during the more recent research. This extended time frame does not exist for SFH. Although I was able to interview informants at Sisters of Faith Home concerning specific patients who had experienced a transfer and concerning general reassignment criteria, I did not have the opportunity to observe patients' careers over an extended period of time. Chapter VI suggests that becoming an active at SFH is a long-term goal shared by residents and staff, and that the initial priority for new arrivals is given to their various medical needs (e.g., nursing care, enrollment in physical therapy, etc.). This might explain the small number of patients who were invited to join activities during my field work, and the fact that most institutional members who are activities participants have lived at SFH for a year or more. An extended time dimension would enable us to see which of the new entrants are eventually invited to join, and to test for entrance criteria through observation (rather than through retrospective interviews). In this respect, the differences in assumptions about geriatric care which were noted above for SFH and PH may partially be an artifact of the varying observational moments employed for each institution. Both nursing homes express the desire to meet patients' medical and psycho-social needs; it is possible, however, that the differences in meeting these goals exist in terms of the relative importance of the goals over time, i.e., sequential priority, when in a patient's career these goals come to be seen as salient for staff consideration and attention. A follow-up study at SFH could provide the necessary expanded time frame for resolving these questions.
Research is also needed on the recruitment systems of other geriatric institutions and of other medical institutions. In order to more adequately contextualize the present data, studies are needed on career patterning in institutions which do not attend primarily to geriatric patients. Contrast studies are needed on private versus church-affiliated hospitals, rehabilitation centers, and psychiatric clinics. Such data can help situate the present study in a context of more general differences between religious and non-religious medical institutions. The present data also require contextualization in terms of their relationship to other forms of geriatric care in the United States. Future research needs to be directed at the larger interactional context associated with institutionalization of family members, especially at the existence of alternatives to nursing homes. Both PH and SFH apparently assume the inevitability of decline of the institutionalized elderly (see Gustafson, 1972). Ethnographic studies comparable to the present one are needed in order to shed light on staff and family expectations for the participants of senior day-care centers, adult education centers, and retirement communities.

Finally, the applicability of nursing home data to the analysis of processes of social recruitment more generally must be questioned. The above descriptions regarding certain general properties of recruitment, e.g., assignment/reassignment criteria, behavioral concomitants of transfers, are limited by the fact that this study focussed on only two nursing homes. As noted above, the selection of geriatric facilities as research field sites was initially justified on the grounds that these institutions could be seen to be confronted with the necessity of continuously filling vacant residential positions, i.e., social places.
made available by patients' deaths, discharges, and transfers. In addition, the sociological and geriatric literature indicated that nursing homes could be viewed as institutions which process incoming individuals onto a variety of social careers. Nevertheless, and as indicated in Chapter II, social recruitment can be observed to occur in social situations for which formalized committees, governmental guidelines and subsidies, explicit application procedures, etc. do not exist. These include street corner gangs (Whyte, 1955), religious organizations (Suaud, 1975a, 1975b), urban families (Suttles, 1972; Kaplan, 1981), the ranks of the warrior (Linton, 1940, 1942) or deviant (Erikson, 1966) or higher economic classes (Warner, et al., 1944), and the like. While the dual institutional contrast utilized in the present study has proved useful in providing details on recruitment configurations in nursing homes (and the possible influences on the different patterns of recruitment), it is unable to assess directly the possible contribution of these data to the study of recruitment in other group contexts and in other social systems. In this respect, an alternative contrastive investigation might have compared social recruitment in a nursing home with that found in a non-institutional setting.

Chapter II notes that previous studies on social selection and status passage have isolated the following partials or patterned features of recruitment: the necessity for the recruit or novitiate to exhibit status appropriate behavior; evaluation procedures for admitting individuals into the membership of a particular group, social setting, or institution; quotas for filling particular social statuses and an organization of permissible moves between positions; and explanations
and justifications for the status system, the evaluation procedures, and particular assignment decisions. The present data are consistent with these earlier findings. The present research has shown that, for nursing homes, the allocation of responsibility for each of the above activities is distributed to varying degrees across the ranks of the residents and the personnel. At SFH and PH, recruitment was seen to consist of rules for admitting applicants to each facility, procedures for assigning individuals to the available residential positions and training them for appropriate behavioral performances, and routines for monitoring all participants and for deciding status continuations, transitions, and expulsions.

Despite the similarities between previous research and the present data, it must be admitted that certain specific features of nursing homes may limit the applicability of this study. The fact that each nursing home studied here contains a fixed number of residential positions, the continuous occupancy of which is required for each institution's economic survival, and is comprised of at least two distinct populations (residents and staff) who possess differing social resources and physical capabilities, warrants treating the present findings as the contextually-bound data that they indeed are. By necessity, the recruitment partials isolated by the present dissertation need to be cross-referenced with their appearance and functioning in other social contexts (see Chapter III for a discussion of some problems related to "two-body" contrasts). The above discussion on some general features of social recruitment at SFH and PH can be interpreted, therefore, as contributing to an initial etic grid (Pike, 1967). That is, they comprise an a priori terminological system which can be
tentatively employed in and tested on other social settings. This contribution is congruent with Radcliffe-Brown's assertion that "sociological theory must be based on, and continually tested by, systematic comparison" (1958:110). More recently, the necessity of such an etic research tool has been articulated by Hymes in his discussion on the construction of an ethnographic methodology and theory for communicational studies:

For ethnographic purposes, an initial "etic grid" for delineating and "notating" possible types of (communication) functions is needed, and it does seem possible to provide one, by considering the possibilities of focus upon each component in turn in relation to each of the others. The grid so derived has proven adequate to accommodate the various schemes of functions, and of functional types of messages, which have come to my attention. Ethnographic work will of course test and probably enlarge and revise it, just as experience of additional languages has enlarged and revised phonetic charts (1974:22).

The primary concern now must be with descriptive analyses from a variety of communities. Only in relation to actual analysis will it be possible to conduct arguments analogous to those now possible in the study of grammar as to the adequacy, necessity, generality, etc., of concepts and terms. Yet some initial heuristic schema is needed if the descriptive task is to proceed (ibid.:43-44).
Both PH and SFH contain patients who are defined either as "alert," "senile," or "halfway." In this sense, the two facilities are comparably diverse. An issue not addressed by this research is the similarity of the patients at each facility who are given the same classifications.

This information was provided by Lucille Nahemow (personal communication).

An earlier study by Bennett found similar patterns in patients' conversational behavior:

From interviews and resident publications, it was possible to discover some of the expectations that the residents had for their behavior in the Home. The following statements represent some resident norms:

1. A resident should not criticize or complain about it.
2. Not only should a resident not criticize but he should praise the Home and come to regard it as his home (1964:80).

See Chapter II.
APPENDIX:
RESEARCH DOCUMENTS

The following documents were collected during the field work, and are used in the text above:

Document I: SFH calendar and promotional literature
Document II: PH health regulations
Document III: PH promotional brochure
Document IV: PH medical plan guidelines
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