Discourse, organisation and the surgical ward round

Abstract
The surgical ward round is examined as an organisational strategy entered into by surgeons to enable particular claims about the success of surgery to be validated.

The paper reports ethnographic data from UK surgical wards which suggest that surgeons organise the discourse of their interactions with patients around three themes: physiology, wound condition and recovery/discharge. These themes are surgeon-centred, and are organised to deny patients access to the agenda of these encounters.

Within a post-structuralist and postmodern framework, these strategies of discourse organisation are understood as techniques of power. Surgeons privilege discourses which support their claims to be healers, denying those which focus on the necessary injury which surgical resection causes. The paper argues that the 'ward round' is a mythical structure constituted as an organisational strategy to counter challenges from patients to their hegemonic discourse.

Introduction
Statistics of surgery suggest its significance – at least in terms of quantity – as a form of medical healing. In England and Wales over three million people are treated as surgical in-patients each year, with a further 700,000 as day cases. The waiting list for surgery stands at approximately 600,000. Over seventy thousand surgical beds are available under the National Health Service (NHS), and more than five million people attended as new out-patients at surgical clinics (HMSO 1988). These figures indicate that the experience of surgery, of being a surgical in-patient and undergoing the unusual techniques of healing which surgery has developed – asepsis, anaesthesia and of course the very invasive procedures of surgical resection itself – is extremely widespread. While the specialty is subject to regular scrutiny from public health and psychological perspectives, this is not the case in the recent sociological literature, with the exception of a handful of writers and researchers (Atkinson
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1981; Bloor 1976; Bosk 1979; Burkett and Knafl 1974; Flood and Scott 1978; Goffman 1974; Katz 1984; Knafl and Burkett 1975; Millman 1977; Silverman 1981; Travis 1985). The material in this paper is drawn from a project which set out to document the social processes involved in surgery, by means of ethnographic fieldwork in a number of NHS hospitals during the late 1980s (Fox 1992). The data was collected by the author, who joined surgical ward rounds at two general hospitals during an extended period of fieldwork, and also conducted interviews with patients hospitalised for surgery.¹

Many of the episodes of co-presence involving surgeons and their patients occur with the latter as silent – sleeping or heavily doped – individuals, unable to offer their version of what is happening to them as they undergo the experience of surgery. Under these circumstances, surgeons have it mostly their own way when it comes to defining what surgery is, and I have documented elsewhere (Fox 1988, 1991, 1992) the discursive strategies of surgeons and others which constitute the world in which these silent bodies play a central, if uncommunicative, part.

At other times, surgeons and patients interact with both parties conscious. Clearly in such situations, patients as conscious human agents have the potential to affect the content and the course of these interactions, and consequently the possibility also to influence the discourse within which these interactions occur. Tuckett (1985) has suggested that we can understand the interactions between doctor and patient as a ‘meeting between experts’ – both parties possessing authoritative discourses upon the patient’s body, one by dint of ownership, the other through professional status. So when patients are conscious, surgeons are no longer the only ‘expert’ present, and to sustain their authority (in the sense of being able to demonstrate their ‘expertise’), they will have to deal with possibly contrary definitions of what surgery is about, how patients are to be categorised, and the extent of surgical ‘success’. Studies of medical treatment (Bloor 1976; Roberts 1985; Silverman 1981; Strong 1979) indicate that doctors do not willingly give up their authority concerning sickness and healing. Oakley’s (1979) example of a doctor’s unwillingness to admit a mother’s ability to recall the size of her own family when it contradicted his record, illustrates the struggles for discursive hegemony which occur in these interactions.

Taking this authority and power as the focus, in this paper I examine the ways surgeons manipulate ward-round interactions with their patients to their own advantage – to constitute and sustain their (surgeons’) perspective on surgical healing. The proposition which I will make is that ward rounds can be understood as an organisational strategy entered into by surgeons to achieve discursive hegemony. Within organisation studies there has been a recent interest in post-structuralist and postmodern approaches² to explaining organisation (Clegg 1990; Cooper and Burrell 1988; Parker 1990; Reed 1989). Post-structuralism has led to a radical re-
thinking within social theory of the nature of power (Foucault 1970; Lyotard 1984; Game 1991), and it is to this framework for analysing power that I have turned here. Cooper and Burrell (1988:92) suggest that post-structuralist studies of organisation require:

a shift away from a prevailing definition of organization as a circumscribed administrative-economic function (the organization) to its formative role in the production of systems of rationality. . . . Weber made us see modern organization as a process which emblematized the rationalization and objectification of social life, and it is to this process that the current debate returns us, but with a fresh twist which directs our attention to the concept of discourse . . . (by which is achieved) the continuing mastery of the social and physical environment.

The distinctive character of such an approach is perhaps worth exploring. Structuralist, both functionalist and marxist, perspectives reify 'organisations' as things, treating the structures they uncover as sui generis realities (Silverman 1985: 79–80). For the post-structuralist, so to do is to confuse the model or method of social analysis with organisation itself: if you look for a system, you will find one (Parker 1990). Interactionist and phenomenological perspectives on organisation have explored how the social world becomes routinised in practice through actors' taken-for-granted assumptions about their environment, while ethnomethodologists seek to show how actors use organisational rules to validate their activities. These perspectives have this in common with postmodern social theory: they reject the notion of organisational structure as reality. But whereas for traditional idealist approaches rules and routines reflect consensus, negotiation and shared world-views, in the postmodern study of organisation, routine is not the outcome of a shared world-view, but the opposite: the imposition of control and constraint by the empowered, through techniques of power mediated by discourse. The postmodernist project is to deconstruct such apparent shared views, to seek out instability (Lyotard 1984: 53). Echoing such sentiments, Parker (1990:9) suggests that:

If we are to look at organization . . . in this way we must be continually recognizing the impossibility of the formal structure. The myth of structure is simply one of the ways in which social life is continually constituted. Instead the postmodern organization theorist must (attempt) to uncover the messy edges of the mythical structure, the places where the organization process becomes confused and defies definition by the discourses that are used within it.

What this means in terms of understanding surgical ward rounds is that one starts not with the assumption that the ward round is 'there', constituted through the social roles of surgeon, nurses, patients etc, or through a shared perspective which manifests as routinised activities, but
that in fact there is no ward round, that the claim that a ward round has occurred or is still occurring is a myth, a consequence of what Bourdieu (1988) would call the ‘doxic modality’ of discourse – that is, the aspiration to inspire belief in the truth of what is being said or done. The ‘ward round’ is a discursive strategy entered upon by particular agents for their own reasons. The concern of the postmodern social analyst is not primarily with the minutiae of the outward manifestations of activities which are carried out during this discursive strategy, but with how these activities – the fictive ‘ward round’ – serves discourse, and what is driving that discourse.

To add some substance to this radical position, it would be helpful to explore in slightly greater detail some elements of post-structuralist and postmodern social theory. It is clear from what has been said previously that from this position, social life becomes far less deddable than the structuralist would assert. Post-structuralism admits of no rational, unified human being, possessing a fixed identity. Instead, as Clegg (1989: 151) has argued:

Membership in a category, as a particular type of subject, is regarded as the effect of the devices of categorization. Identity is seen as always in process, as always subject to reproduction or transformation through discursive practices which secure or refuse particular posited identities. Identities . . . are always relational . . . always defined in terms of difference, rather than as something intrinsic to a particular person or category of experience.

Fluidity of identity, and of relations between actors – in particular, their power relations – means that social organisation must similarly be relational, and consequently also be continually subject to challenge or disruption. Foucault held this position, rejecting the idea that power struggles can ever be won finally and absolutely, or that power can be ‘held’ by a state or a class; and instead arguing that techniques of power never resolve struggles over control and domination. Rather, power achieves its effects through continuous strategies, such as surveillance and assessment of individuals in the prison, clinic and asylum (Foucault 1976, 1979, 1980). Resistance to these tools of power merely demonstrate the necessity of such disciplines for the production of docile bodies (Clegg 1989:153).

Organisation then, is understood in the postmodern view as a response to challenges or threats to power, to ‘knowledge’ or to hegemonic discourse. The contribution of another post-structuralist, Jacques Derrida, may be invoked at this point. Derrida showed (1978) how meaning, and the ability of signifiers to signify, is subject to constant slippage, as a consequence of the impossibility that language might supply (in the search for meaning) a referrent other than another language element. For those who seek power, or in an organisational context wish to promote their
interests over those of others, there can thus be no final resolution, no final claim to speak 'the truth'.

Derrida's purpose is to show that rationality and rationalization are really processes which seek to hide the contradictions at the heart of human existence. . . . What motivates the call to organize is the recognition of a discursive 'gap' which organization serves to cover up . . . the world of commonsense structures is the active product of a process that continually privileges unity, identity and immediacy over the differential properties of absence and separation (Cooper and Burrell 1988:99-100).

In this precarious world, social practices will tend to undermine the discourses which informed them. The authors of discourse, those who draw their power (or their doxic modality, if you wish) from such a discourse, respond by organising, by augmenting discourse such that objects are set in relations of meaning to each other which will resist challenge. There is consequently a tendency for organisation to become ever more complex, as the relations of meaning – while being more and more firmly embedded in discourse – also become more prone to threat from rival discourse. In this situation, the strategy in the short-term is to encompass the rival, although this, of course, only puts off the evil day. This, it may be noted, is an interesting re-formulation of Weber's 'iron cage' of bureaucracy. For a discussion of this in a situation of rivalry for hegemonic discourse between surgeons and health service management, see Fox 1991.

So, from a postmodern perspective, the 'ward round' is an attempt to organise interactions between surgeons and patients. The data which is reported in this paper examines the fine detail of the techniques used by surgeons to sustain hegemonic discourse, the continual threats to this discourse from patients, and the strategies they adopt to cope with these challenges. The objective of the paper is to explore – with the assistance of the postmodern perspective of organisation as response to challenge, what is the character of the power struggle which is waged when surgeons and patients meet: what surgeons feel they have to lose if they fail to sustain hegemonic discourse.

The structure of the paper is straightforward. Firstly, I report the ethnography. Then in a discussion section, I examine the character of the discourses used by surgeons on ward rounds. Using the post-structuralist analytic strategy of 'deconstruction' assists this exploration, making present what is denied in this discourse, the ambiguity of surgery itself. I conclude by considering how the use of a postmodern approach has enabled the micro-processes of medical power to be opened to analysis.
A note on validity

Postmodern social theory elides any distinction between truth and ideology (Bauman 1988; Kellner 1988), and while for some readers this is tantamount to the ultimate relativistic sin, leaving social analysis devoid of claims to scientific validity, there is a developing school of postmodern ethnography which celebrates this elision, taking the opportunity to abandon the querulous claims of the social analyst to objectivity, and offering as the intention of ethnography, not 'representation' but 'evocation' (Tyler 1986). Evocation, in my view, offers a far weaker claim to describe reality than representation. Thus I would offer to the reader, not the truth about ward rounds (or even 'ward rounds'), but an evocation of these situations, an intimation of how power is distributed during these interactions, how the 'truth' about surgical healing comes to be told, and by whom. In this way I would hope to be more honest about how this paper makes its own claims to truth. (For an interesting discussion of how traditional ethnography does this, see Atkinson 1990). It also means that the relationship between I, as author, and you, as reader, is much closer than might be the case in a modernist academic paper. It means that I must be open about my closure around particular commitments. One of those commitments is to an exploration of how surgical patients might increase their control over their treatment, for – as these pages will suggest – the post-operative patient is virtually as constrained by discourse while conscious as s/he is by anaesthetic while unconscious. Another is to the developing project of a postmodern social theory. Other commitments – for instance to a gendered analysis, or to a particular programme for my personal academic career – are more or less clear. The deconstructionist reader may uncover these commitments in the text which follows.

The surgical ward round

Surgical ward rounds can be very rapid affairs. If a consultant surgeon has seen her/his patient at an out-patient clinic, s/he may leave pre-operative admission entirely to junior staff. Most conduct a round, but these pre-operative rounds are often cursory. Similarly, most surgeons visit their patients during the evening of the day they have undergone surgery, when they have been moved from the recovery room to their ward or to the Intensive Therapy Unit (ITU). These are also brief, the patients usually being still very drowsy or asleep as an after-effect of the anaesthetic, or of post-operative analgesia; the round primarily consists of a short report from the junior staff of the surgical firm on each patient's post-operative physiological status.
Subsequent post-operative rounds are more leisurely, as the patient is usually capable of some interaction. The 'routine' character of medical ward rounds has been noted in the sociological literature (Atkinson 1981; Davis and Horobin 1977). The timetabling of ward rounds into the overall structure of the hospital day has also been described (Roth 1963; Zerubavel 1979). I am unenthusiastic over this description, for reasons outlined in the introduction. To speak of 'routine' is to obscure the non-routine character of individual encounters, which exist within a framework of great uncertainty as to clinical outcome. In terms of the day-to-day content, these occasions are constituted from fragmentary elements of social practice, so as an alternative to perceiving the 'routine' in the ward round, it is reasonable to analyse 'ward rounds' as highly structured acts of organisation. My intention is to demonstrate through the ethnographic data reported how this act of organising enables surgeons to set the agenda for their interactions with patients.

Occasionally, a patient is not included directly in a round at all, except perhaps to receive a greeting from the consultant. An end-of-the-bed resume of the clinical assessment from the junior staff does not develop into surgeon/patient interaction before the round moves on. Such cases are rare on post-operative rounds, as patients usually make progress quite quickly on surgical wards, and so judgements of condition have to be updated since a previous ward round, and interaction is necessary. The usual course of these interactions is very tightly controlled by the surgeon, having the effect of defining and categorising patients according to criteria which surgeons set out. Unlike the situation in the operating theatre, where alternative definitions of patients by anaesthetists and nurses can affect the activities which surgeons can undertake (Fox 1991, 1992), on the wards there is only the patient to offer an alternative, and the patient is in a vulnerable and disempowered position relative to the surgeon. Sometimes, a more articulate patient may gain temporary access to the agenda, sometimes with the co-operation of the surgeon, and occasionally without it, as will be seen below.

These challenges are rarely successful in upsetting the surgical discourse, and in the coming pages I examine the minute-by-minute strategies used by surgeons to counteract and disempower patients who try to set the agenda. Surgeons organise these interactions in many ways which serve to rhetorically mark their power: they walk or process around the ward while the patient is confined, undressed, separated from fellows with whom s/he might form a counter-culture of patient-centred discourse (cf. Roth 1963). They use various props: screens, white coats, notes which patients cannot see. Yet the necessity of linguistic interaction can still threaten this whole edifice, and I wish to show how surgeons focus on a number of themes which enable them to control the discursive framework of this interaction. I include examples of discourse where challenge is avoided absolutely, where the challenge is unsuccessful, and one or two
examples where the surgeon is in severe danger of losing discursive hegemony.

In the following pages I have used a loose categorisation of surgical discourse within three general themes. The first theme concerns the physiological condition of the patient, as judged by staff from clinical tests, physical examination for clinical signs and enquiry to the patient as to her/his subjective experience. The second theme focuses upon the condition of the surgical wound and its dressing, while the third theme concerns prognosis – the extent to which the condition for which surgery was undertaken has been resolved, on the stage to which a patient’s recovery has progressed, and upon a projected discharge date from the hospital ward.

These themes are all surgeon-centred. The first is the most surgeon-centred, relying heavily on technical analysis. The third is the least, involving the possibility of patients having some input into the decisions reached. The three themes are hierarchical also in the sense that in the case of the patient who is showing signs of ‘recovery’, the first theme will be succeeded by the second, and the third will succeed the second.

**Theme 1: the discourse on patient physiology**

Prior to interaction with a patient, a consultant surgeon usually spends some time in discussion with the junior surgical staff, in order to familiarise her/himself with developments. Registrar and house officer wait at the entrance to the ward for the arrival of the consultant, while the staff nurse waits at the nursing station with the trolley containing the files on the patients in the ward. Moving to the first patient on the round, the nurse retrieves the relevant file and passes it to the consultant. These notes and the report of the house officer provide the consultant with the information s/he requires, only after this will s/he greet the patient. After any direct interaction with the patient, which may entail verbal commentary or discussion and/or physical examination, there will usually be a further period of inter-staff discussion. In both these periods, much of the discussion concerns the patient’s physiological condition, and will involve reports of tests, monitor printouts and proposals for further tests or medication. These tests are all problem-oriented: they define the patient in terms of her/his forthcoming operation, or her/his response to it:

Patient $H$ had been admitted for repair of inguinal hernia and fistula, and his GP had written to say that because of a history of ischaemic heart disease $H$ was not suited to general anaesthesia. However this information contradicted the opinion of a surgical consultant who had assessed $H$ as suitable for a general anaesthetic on the occasion of an operation four years previous. To square this contradiction, tests were
being carried out on H in order to make a decision about the form of anaesthesia to be adopted. It thus appeared inappropriate to devote more than the briefest moments with the patient, as no decision had been reached. The consultant and junior staff discussed the possibilities for some time, standing some feet from the end of H's bed. The preference of the consultant was for a general anaesthetic if possible.

Occasionally, these discussions on physiology spill over into the surgeon-patient interaction during the round:

Patient B had had surgery to remove a tumour of the gastro-intestinal tract. During surgery, the tumour had been found to be disseminated, and during the extensive operation to remove as much as possible, B had had a cardiac arrest. He was conscious but poorly.

Mr D: (to junior staff and researcher) Despite what we've done he seems to be getting better. How is his . . . (a long discussion on technical details of the patient’s metabolism ensues, including reports on tests and suggestions of further tests and action to stabilise the patient’s condition.

The house officer introduced the problem of the surgical wound, which was leaking as a consequence of having been very rapidly closed following the cardiac arrest on the operating table. The discussion now focused upon this problem, and the relative advantages of different forms of skin sutures and staples were debated among the staff. After about five minutes Mr D addresses the patient: 'How are you Mr B? Are you feeling less sick now?'

Patient B: Yes, less sick.

The interaction with the patient in this extract appears to be an afterthought, but in fact it continues the theme of the physiology of the patient, whose self-report of his condition is used to make a decision concerning future management of the case. The discourse does not develop into a more patient-centred theme with an emphasis on recovery (Theme 3). In the case of Patient B, the nature of his condition (an advanced malignancy) may have precluded this deviation. In other patients, however, where there is a more positive evaluation of potential outcome and recovery, especially on the part of the patient, a discourse on physiology initiated by the surgeon can lead to conflict of interpretation. In the following case, an inter-staff discussion of a patient's physiology concerning lack of bowel function as a result of a road traffic accident is continued in the first exchanges of surgeon-patient interaction:

Mr D: Hallo, Miss F. (sits on edge of bed) Have you passed any wind yet? (Because he is a gastro-intestinal (GI) surgeon, Mr D has an interest in post-operative flatulence as a clinical sign of GI function.)

Patient F: No. Can I take this (oxygen) mask off?

Nurse: (sharply) No, not yet.
**Mr D:** You can take the mask off when you can breathe, when the bruising on your lungs has gone down. We are going to give you a couple of suppositories which will get you unblocked, because your bowels are bruised too; that will reduce the swelling here, and that'll make your breathing easier. (To researcher) I said she was going to be a difficult patient.

Here the patient has sought to subvert the discourse on physiology into one on recovery. Mr D's usual way of asking about post-operative flatulence was more folksy: 'Have you passed any wind out of your tail-end yet?' The question thus framed offers a more patient-centred interpretation, and it is usually concerned with Theme 3 (recovery/discharge). In the case of Patient F, who was admitted with a silent abdomen, the wording was not intended to indicate a significance other than within the surgeon-centred discourse on physiology. The subverting of the discourse away from the surgeon's discourse, and necessitating a long explanation in terms of Theme 3, is demonstrated by the comment to the researcher at the end.

The discourse on physiology is a surgeon-orientated technique for categorising the pre- or post-operative patient. Pre-operatively, the patient's physiology is a sign which determines the patient as a suitable case for surgical treatment. It will consist of the whole gamut of symptoms and clinical signs, plus possible investigations or biopsies conducted in the pre-operative period. All these have the purpose of categorising the patient as a surgical case, and once the categorisation has been made, then future activity is clear and unquestionable. If the discourse on physiology does not confirm that right, interest in a patient is quickly lost, as in the case of Patient P, who was originally admitted for a cholecystectomy, but after tests is now to be transferred to a medical ward, to be treated non-surgically:

In a very brief discussion at the foot of the bed the transfer to a medical ward is confirmed by the house-doctor.

**Mr D:** (addresses patient) How are you today?

**Patient P:** Not too bad.

**Mr D:** We're just waiting for Dr X (medical consultant) to fix you up. It'll be Thursday (the next day), or maybe Friday. (already moving away) Then you'll be all sorted out. Goodbye.

**House officer:** It's Friday.

**Mr D:** (uninterested) Friday, is it?

The discourse on physiology is also the most suitable for pre-operative rounds, as it enables progress towards surgery to move inexorably. The following extract is of interest in that it suggests how vulnerable ward-round organisation can be to alternative interpretations.

**Mrs A:** Where is Dr S (registrar)?

**Staff Nurse:** He's looking at Patient X.
Mrs A: He's taking his time, that fistula need not take him so long. Ten minutes, that's a long internal examination. (1)
Dr S: (arriving at the staff group) It's just a small hole in the rear wall.
Mrs A: Will you do it tomorrow afternoon?
Dr S: Yes, I'll try.
Mrs A: In that case put it down for me, and I will do it myself. (2)
Dr S: No, I can do . . . .
Mrs A: . . . . It's just that word 'try' that I do not like, Doctor S. I don't like it at all. (later, to me) I do not like Doctor S, he is rude to the patients. The trouble with Dr S is that he cannot speak the Queen's English. (3)

Patient X's fistula has the effect of categorising her as a suitable case for surgery, and Dr S's painstaking examination seems to Mrs A unnecessary, interrupting a discourse in which there is an 'obvious' need for surgical intervention. Mrs A resists any such interruption by (1) imputing sexual misconduct to Dr S; (2) threatening to deny Dr S's access to the patient and (3) commenting on his ethnic background. By these techniques, Dr S's deviation from the script does not pose a threat to Mrs A's discourse on surgery as a true system of healing, or her own right as surgeon to conduct the operation.

Post-operatively, the discourse on physiology is similarly concerned with guaranteeing the surgeon's right to have intervened to heal the patient. In this extract, a patient is being told what has been done during the operation, but the conversation develops into a series of re-definitions of the patient:

Mrs A: Hallo Miss E, we sorted everything out for you, we've taken the (fallopian) tube, but the ovary is still there as usual.
Patient E: You left the ovary?
Mrs A: Oh yes, we never take the ovary. (1) So everything's fine (2); but come and see us when you are trying for a baby, as you only have one tube now . . .
Patient E: I don't want a baby.
Mrs A: (to nurse) Fix her up with contraceptives, the sheath. (3)
Miss E: I thought I'd use an IUD.
Mrs A: No, I don't want you on IUD or mini-pill, use the sheath and foam. (4)

The surgeon first confirmed that despite having removed a fallopian tube, by leaving the ovary intact she had not interfered with the patient's normal female hormonal balance, and thus her femininity (this was emphasised by Mrs A to the researcher as of great importance during a number of similar operations), and goes on to say that she is 'fine' (1, 2). A second re-definition occurs when Mrs A suggested that Miss E will
fulfil the role of mother in due course. When the patient denied this desire, the surgeon turned away from her, and spoke about her in the third person to the nurse, commenting on a need for future sexual regulation (3). Finally, there was a return to the discourse on physiology with a comment which referred to the patient’s new status as a person with an impaired reproductive system which could be affected by contraception (4).

This re-definition of patients is a significant feature of the discourse on physiology when used post-operatively, and hence this theme in ward-round discourse is extremely valuable in evaluating the ‘success’ of surgery. However, sometimes the theme is unsatisfactory, and in these circumstances re-definition is not possible. Mrs O, a very old patient who has had a cardiac arrest on the operating table, does not offer the surgeon the usual rights to categorisation via the discourse on physiology:

Mrs O was a very small woman virtually obscured by a mass of high technology equipment placed around her bed: monitors, a complicated three-way drip and ECG equipment, all of which had been erected post-operatively by the medical (as opposed to surgical) staff, who had become involved following the arrest. Mr D stopped some way back from the end of the bed with his junior colleagues.

Mr D: That’s a very impressive array of tackle. (The word ‘tackle’ is used derisively, and the others smile.)

Mr D approaches the patient who mutters unintelligibly.

Mr D: You’re doing fine.

Mrs O: Nnnnnnnnnn . . .

Mr D holds her hand and tries to make eye contact beneath the oxygen mask. When there is no response, he turns to the equipment, and after looking it over starts to fiddle with one of the taps attached to the drip. After a few seconds he turns away.

Mr D: (to housedoctor) Here’s a bit of IT [intensive therapy] for you.

Housedoctor: I’m enjoying it.

Here the equipment represents an unsatisfactory discourse on the patient’s physiology, firstly because it was erected by non-surgical staff, and the patient is now no longer a surgical problem, her main sickness now being a consequence of the cardiac arrest. Nor does the patient respond to Mr D’s bedside manner, which would enable an alternative discourse to be invoked. Consequently Mrs O’s continued presence on the surgical ward is anomalous, she is ‘matter out of place’ to use Douglas’s (1984) term, and Mr D’s last comment suggests that the Intensive Therapy Unit (ITU) is the right place for her, rather than his ward.

When patients intervene in the discourse on physiology, the possibility is that the theme is subverted in a way which is unsatisfactory from the surgeon’s point of view.
Mrs F had had an ectopic pregnancy, and had a fallopian tube removed as a consequence.

*Patient F:* I have a list of questions which I wrote down, because I was a bit hazy when you explained before the operation. (Surgeon Mrs A nods) What exactly have you taken?

*Mrs A:* We have taken your right tube, that's all.

*Patient F:* Not the ovary?

*Mrs A:* We never take the ovary, so you have two good ovaries.

*Patient F:* So will this make it difficult for me to conceive? (1)

*Mrs A:* No you can produce an egg every month, same as before.

*Patient F:* But I will only have a chance every other month? (2)

*Mrs A:* No, just the same, you have both ovaries.

*Patient F:* But one is not connected to anything... (3)

*Mrs A:* No... we can't just say which one will produce an egg each month. (4)

In this sequence, the questions at points (1) (2) and (3) force the surgeon to admit that the operation has not returned the patient to the status of 'normal' fertility, and is forced at (4) to fall back on the randomness of ovulation as a response, thereby at least avoiding being allocated the moral status as potential scapegoat for a future infertility. At this point, Mrs A hurriedly departed, preventing any further questions.

By the nature of the major surgery carried out by some surgeons, a number of their patients end up in the Intensive Therapy Unit following their operations. In ITU the physiology of the patient becomes the concern of the ITU nursing staff and anaesthetists. Ward rounds include post-operative visits to the ITU when a consultant has a patient there. The discourse on physiology is unsatisfactory in these circumstances, and interactions down-play the involvement of the surgeon in care, substituting a kind of empathic mood.

After rounds in the male and female wards, there was a visit to Intensive Therapy to see Patient J, who had haemorrhaged during an operation to excise a tumour in the abdomen, and had barely survived. The visit consisted principally of a discussion between Mr D and the duty anaesthetist on the patient's physiological condition, which was giving extreme cause for concern. Mr D then turned to patient J and offered a few words of encouragement to the patient. The latter appeared extremely frightened by his circumstances, and responded by gripping Mr D's hand. Mr D seemed to derive comfort from this, but on leaving the ITU he was subdued. He asked the researcher 'Have you ever been in one of these places before? Just think what it's like for J.'

The ward round thus ended on a sombre note, with the inability to use the post-operative theme of physiology as a marker of the success of surgery in the case of J.
In these last three extracts, the discourse on physiology has not supplied the re-definition of the patients as 'healed' which the surgeon seeks. The problem for the surgeon is that surgery does harm (through resection, and the adverse effects of anaesthesia) at the same time as it reduces illness, and that it can have serious consequences for patient fitness. In the extract documenting Mrs F and Mrs A's interaction, it can be seen how direct patient intervention into the discourse on physiology can become problematic if not carefully controlled. For this reason, surgeons usually confine themselves to the other themes in their interactions with patients. In the next sections it will be seen how surgeons use strategies to control discourse in situations where patients have a greater input.

**Theme 2: the discourse on wound condition**

The second theme in ward round discourse, while concerned with the physiological outcome of the surgical intervention, is differentiated from the previous theme on a number of grounds:

1. It is consequential upon the surgery, not upon the condition of the patient in a wider sense.
2. It is a marker that surgery has been carried out, that the patient is no longer in the pre-operative state.
3. It is a theme upon which nursing staff and possibly the patient have an input.

Wound condition therefore plays an intermediary role between the discourse on physiology, which objectifies the patient, bracketing her/his social and individual characteristics, and the theme of recovery and discharge (theme 3), which more explicitly recognises the patient as possessing a social position, and one which soon will remove the patient from the surgical space. This theme in discourse – of the condition of the surgical wound – refers back to the operation, but in so doing acknowledges that the patient is no longer in her/his pre-operative situation, and that healing has taken place.

Inspection of the wound is a regular part of the post-operative ward round. If the round is within the first forty-eight hours after surgery the dressing will be the one put on by the surgical team at the conclusion of the operation. The consultant may take the opportunity to remove this dressing on the round:

Patient C has undergone surgery to remove an ovarian cyst. The surgeon Mrs A is seeing her the day following.

*Mrs A*: Hallo Mrs C, we have sorted out your problem for you. Let us have a look at your tummy.

Staff nurse and junior doctor pull curtains around, Mrs C is laid flat, and the dressing is removed.
Mrs A: Yes, that's OK. You will not have much of a scar there. (1)
Patient C: Thank you. When can I go home.
Mrs A: We'll see you on Monday. (2) (To nurse) Can I have a (type of dressing) please.

Consultant and housedoctor dress the wound with gauze and lengths of plaster.
Sometimes the task of dressing the wound is left to the nursing staff, while the ward round moves on; in these cases the original dressing is only partially removed, sufficient for the consultant to see the wound. Inspecting the wound provides an opportunity, as in the previous case, to refer back to the operation to indicate its 'success' (1). It can also enable discussion of issues of recovery and discharge to be aired. However, in the case of Mrs C this is deemed an inappropriate development of the discourse, and, with the patient flat on her back, the issue is sidestepped (2). In the case of Miss A, a young patient who has undergone a minor operation, the wound inspection is used to promote the discourse on discharge:

Mrs A: (looking at case notes, speaking to house doctor, but across the patient) I think Miss A can go home today. Can we just have a quick look, doctor. . . . How are you feeling?
Patient A: OK.
Mrs A: looks at the condition of the surgical wound.
Mrs A: Well you can go home today, have you someone coming?
Patient A: Yes.
Mrs A: Well that's OK. Sort that out will you, doctor?

This extract demonstrates how the discourse on the wound still enables a distancing from the patient: although the patient is involved, the most significant interaction is between surgeon and other staff, not with the patient. This differentiates this theme from the theme of 'discharge', where the discussion between surgeon and patient is the central focus of discourse. When discharge is not imminent, the discourse on the wound allows an interim and partial normalisation of the post-operative patient:

Mr D inspected a wound dressing on the lower abdomen of Patient M, an old man treated for a hernia four days previously.
Mr D: Your wound is healing well Mr M. I want you to get about a bit. You can have a bath, but try not to get the dressing wet.

The patient can now bathe, signifying normal behaviour (although in order for Mr M to avoid wetting the dressing will require him to have a very shallow bath indeed!)

Sometimes this theme is used to subvert possible difficult questions by focusing specifically on the detail of the wound, as opposed to the underlying condition for which surgery was undertaken:
Patient N is an unhappy looking woman who has had surgery for carcinoma of the lower bowel, she is sitting on her bed, and appears to have anticipated the round as an important event: she has put make-up up on.

Mr D: (to researcher) This one is a bit of a hypochondriac. She has no colon left, and her urine comes into a bag too. (He sits down on the bed, but no move is made to examine the patient.) How is the ileostomy?

Patient N: It's much better, at least this one works.

Mr D: Good.

Patient N . . . (tries to ask a question, but Mr D has moved away and has initiated a conversation with the housedoctor.)

Mr D: We'll see you on Tuesday.

The importance of the wound in referring back to the operation is seen in the following case in a dramatic way. Patient S had been recovering from an abdominal operation when unexpectedly her wound burst. Despite this disaster, the discourse is constituted in such a way as to continuously refer, often in technicalities beyond the patient, to the 'successful' outcome of the surgery.

Patient S is sitting in an armchair – she is looking quite distraught.

Mr O: Hallo, Mrs D; well we were going to send you home yesterday weren't we, thank the god almighty we didn't.

Patient S: (quietly) No.

Mr O: Well we just don't know why this happened, there's no infection, no haematoma, nothing at all to cause this. You were up and walking . . . ?

Nurse: Yes she was walking about, and went to the lavatory and was straining, and then . . .

Mr O: . . . Yes I hear there was small intestine hanging out. Well, you've had a nasty time, and we'll keep you in for ten days.

Patient S: (aghast) Ten . . . days . . . ?

Mr O: Yes, but there's absolutely nothing the matter inside, we don't know why this happened, so we'll keep you in for ten days.

Inspection of the wound is a moderately frequent occurrence on post-operative rounds. The main concern is with infection, and this needs to be quickly identified. When there is satisfactory healing, no great deal is made of wound condition, and it appears that this discourse is used only when the final theme – on recovery/discharge – is inappropriate. Sometimes, as has been seen in the extract reporting Miss A's interaction above, the discourse on wound condition becomes a discourse on discharge: not only has the surgery been successful, but also the injury caused has been quickly resolved and on both counts the skill of the surgeon is demonstrated.
The discourse on the wound is thus a way of referring to the 'success' of surgery, even when the more obvious marker of success, discharge - which of course is a strong indicator of success, is not yet a possible topic for interaction, perhaps because of the severity of the surgery, complications, or the lack of fitness of the patient as a consequence of the ordeal of surgical trauma. Wound condition is thus used as a means of avoiding moves into a discussion of recovery/discharge in circumstances when the surgeon would be unable to offer a positive response. This suggests the paradoxical character of the surgical wound, and its attractiveness as a theme in surgical discourse. The wound is a marker which is metonymic with, which stands for the surgical operation. It is the physical sign that surgery has taken place, yet at the same time it de-centres attention from the resection, itself no longer visible. When there is still underlying pathology, discourse either remains in the theme on physiology, or enters the theme of wound condition in such a way as to draw attention from the underlying condition (as in the case of patient N, whose bowel carcinoma has not been resolved finally by surgery). When pathology has been resolved, the injuries inflicted must also be allowed to heal, or the success of the resection could be compromised, as in the extract documenting the burst stitches. The 'success' of wound healing is used discursively to suggest the 'success' of surgery, before the latter can be assured. The modulation of these two approaches to the theme of wound condition is part of the organisation of discourse which constitutes the ward round as a strategy for the disposal of post-operative patients.

The healing of the wound leads in time to the opportunity for the third theme of the ward round to be introduced, in which discourse looks not back to the operation, but forward.

Theme 3: the discourse on recovery and discharge

Discharge from hospital is a topic which most patients seek to put at the top of the agenda of the ward round. This can place them in opposition to surgeons during ward rounds, and a number of techniques which are used by surgeons to subvert this attempt have already been documented. However, the theme is one which will be instigated by surgeons at a time suited to them. The authority of the surgeon extends throughout the post-operative period, in her/his ascribed moral right to determine an appropriate date of discharge. The surgeon declares how well the patient is recovering, and may or may not suggest a discharge date. When a date is fixed the pleasure on the part of the patient which derives from this decision, in conjunction with the authoritarian nature of the discourse on recovery and discharge gives the air of a benevolent despotism to these interactions.
In the immediate period following an operation, the surgeon may choose to make statements to the patient about how s/he is recovering, without mentioning any possible discharge:

Patient G, an old man, had had an appendectomy, and the removal of a tumour from his abdomen discovered during the surgery. Mr D is cheerful.

Mr D: We will have you up in three weeks, and by then we will know what it is that we took out.
The patient appears to accept this version, although it provides no information about the tumour.

Patient H had a stone removed from the bile duct, and although still very jaundiced is very happy that her operation is over. Mr D is concerned to discover the reason for the stone, and is asking a range of questions about the patient's family history. He allows the conversation to be subverted.

Patient H: (looking at the gall stone which he has in a jar by his bedside) Where was it?
Dr D: It was in the little tube that links the gall bladder to your intestine.

Patient H: Will it come back.
Dr D: It's possible.
Patient H: Was it to do with my diet?
Dr D: (laughing) No. Just wait till the first time you see ice cream or cream.

In both these cases the patient is supplied with information which confirms that s/he is recovering, and while the operation supplies the hook for the conversation, the emphasis is upon the future. When the patient expects to be considered for discharge, this emphasis becomes central, but now a further element is added to the discourse. Up to now, the surgeon's locus of activity and concern has been limited to the patient's body. Now, this area is widened, to include the patient's future biography, and her/his position within society - explicitly her/his home and familial arrangements.

Patient T has no post-operative problems, but her circumstances are slightly unclear.

Mrs A: Hallo, Mrs T, well I think you can go home.
Patient T: Go home today?
Mrs A: Yes I think so, where do you live?
Patient T: In (district) . . .
Mrs A: . . . near, yes . . . have you someone coming?
Patient T: Yes my husband is coming.
Mrs A: Yes ring him to tell him to come this afternoon, and we'll see you in a week for the stitches.
Patient $W$ is an old man who has had a major resection for gastric carcinoma. Mr $D$ plans to send him home if he can be looked after.

*Researcher:* Are you sending him home to die?

*Mr $D$:* Oh no, I *think* I’ve cured him. Cancer of the stomach is not that difficult to treat, although in the long term prospects are not good. (Moving over to patient) Who’s going to look after you when you get out?

*Patient $W$:* (smiling) You tell me when I can go, and I’ll arrange to be looked after.

*Mr $D$:* (smiling) That’s right . . . but seriously though . . . ?

*Patient $W$:* Well my sister. She’s older than me of course, but . . .

*Mr $D$:* Well someone to cook for you?

*Patient $W$:* Oh yes, that’ll be alright.

*Mr $D*: Make a clinic appointment for next Wednesday and you can go home now.

*Patient $W$:* When?

*Mr $D$:* As soon as you can arrange it.

*Patient $W*: (pretends to get out of bed) Well I’ll give a ring now . . . (very pleased) Thank you.

*Mr $D$:* (joking) At least we’re not sending you for convalescence, terrible place, worse than here. If you go for convalescence you don’t need convalescence.

In the latter example Mr $D$ uses a search procedure in order to find excuses for discharging the patient, and the joking relationship enables them to cast off a previous relationship which had been orientated toward the operation and the patient’s illness. Despite the strange definition of ‘cured’ used by Mr $D$ (recognising the likelihood of metastasis), and with the recognition that further informal care is needed by this old man, the discourse re-constitutes $W$ as ‘healed’.

While surgeons utilise search procedures to assemble a case for discharge, patients’ attempts to supply such information when the surgeon has decided against immediate discharge founder. Patient $Z$ was an old lady who had had a major gynecological procedure, and whose recovery had been slower than expected:

*Mrs $A$:* Hallo, Mrs $Z$, I think you can go home on Monday.

*Patient $Z$:* On Monday, not today?

*Mrs $A$:* No, I think we’ll keep you in till Monday. (To house-doctor)

*Doctor,* can you listen to her tummy. Where do you live *Mrs $Z$?*

*Patient $Z$:* In (district).

*Mrs $A$:* On your own?

*Patient $Z*: Yes, but I’ve arranged for my sisters to come over to me . . .

*Mrs $A$:* . . . Yes. (To house-doctor) Does that sound OK?

*Housedoctor:* Yes, it’s OK.
This extract indicates that despite the more ‘patient-centred’ orientation of this theme, surgeons still set the agenda on recovery/discharge, as with the other themes. There is an apparent conflict for the surgeon here. On one hand, s/he must take into account the weakened state of the post-operative patient. On the other, discharge is evidence of the new status which the post-operative patient holds, and therefore is an attractive option for the surgeon. The following extract indicates one way in which the discourse on recovery was utilised to resolve this conflict. Mr D’s ward round had arrived at Patient Y, who had developed a slight pyrexia (raised temperature):

Mr D: (to patient, looking at chart) Hallo Mr Y. Well we want to send you home, but I don’t like that raised temperature. (1) Patient Y: No. Mr D: I don’t know what can be causing it. We’ve cultured the wound and there’s no infection there. I just don’t know what’s causing it. . . . Are things ready for you to go home? Patient Y: Yes, my wife can come and collect me today. Mr D: Can you go to bed, and she can look after you? Patient Y: Yes. Mr D: I don’t like that raised temperature. (2) Phone your wife and you can go home now. Patient Y: Thank you very much.

Mr D uses the phrase ‘I don’t like that raised temperature’ twice in this short interchange, but whereas at (1) the meaning imparted is that the raised temperature is possibly a complication which should be resolved before discharge, at (2) it has changed its meaning, and now the pyrexia is an annoying detail which is preventing the return to home and the categorisation of healed. Mr D’s dislike of it means he can ignore it and thus allow the patient home!

It is of course the prerogative of any patient to discharge her/himself against medical wishes. Despite this, surgeons behave as if they can control the movement of the patient. Using the discourse on discharge is a further way in which surgeons mark themselves as the people who can define post-operative patients. The decision on discharge is the final act in the process by which a patient has passed through the surgical enterprise. A surgeon has defined her/him as needing surgery, now a surgeon has made the definition of the patient as no longer needing the benefit of surgical healing, of being healed.
Discussion

The ethnographic data reported here suggests that during interactions with patients, surgeons seek to constitute two foci in their discourse. The first is the operative procedure itself (or its marker - the wound). The second is the status of being healed. The discourse on recovery/discharge is the most forward-looking, focusing on the new status of the patient as a success of surgical healing. Where patients have not progressed to a stage where this discourse is possible, their progress is assessed in terms of physiological condition (the removal of sickness) and wound condition (one marker of the reduction in fitness caused by surgical injury). Both of these discourses choose their own ground upon which to evaluate surgical 'success': the resection itself and the recovery of fitness lost as a consequence of the operation respectively. Patients who threaten to become aberrant, such as Mrs S, whose wound had burst, move back from the discharge discourse to one on wound condition, or move sideways out of the surgical gaze, as with the patient who was to be treated medically or in the case of the patient who arrested on the table, who was marginalised and re-categorised as a medical or IT problem.

So the hierarchy to the three themes concerns 'surgical success', with recovery/discharge the most clear-cut in terms of 'success', followed in turn by wound condition and physiology. The latter is the most surgeon-centred, and denies patient input to the greatest extent. At no time during the fieldwork was the physiological detail of a case ever discussed with a patient, except occasionally in terms of return to normal function post-operatively (e.g. ability to have a normal sex-life or eat normal diet.) Perhaps significantly, this is the discursive theme where the patient might have the greatest opportunity to contest the surgical conclusions, as an 'expert' on how their body normally performs. The discomfort and pain, immobility and depressed bodily functions offer quite different messages as to their nature of what the process of resection has achieved. Similarly, with the wound, the gross insult which has been inscribed on the surface of the skin during surgery is something upon which a patient might be expected to have some comment. However, in these areas, the patient is not permitted to supply an input. Only when it comes to discharge may a patient participate in the discourse.

Even here the kinds of inputs expected of a patient are limited. Surgeons make decisions on discharge by means of searches for relevant information on home arrangement: if a patient presses the right buttons (someone to collect, carer - preferably female - to look after the patient), then discharge will be eased. Any opinion a patient has on her/his discharge is not even elicited, let alone taken into account.

Post-operative ward rounds thus demonstrate surgeons at their most authoritarian. Despite the cases documented here in which there is resis-
tance by patients to surgeons' discourse, only one patient was seen during the fieldwork even briefly to successfully set an agenda for the interaction, and she had to write down her questions in order to ensure they were answered. In this case, Mrs F (the patient with the ectopic pregnancy), demonstrated how a perceptive question could shake a surgeon's claim to authority, which had sought to constitute surgical 'success' in terms of the continuity of the patient's reproductive capabilities. This authoritarianism would suggest that for surgeons the post-operative period is an anxious time, during which their ability to define their work as success is most open to alternative definition. As revealing here, are the silences. There is no discussion with patients, once surgery has taken place, of the pre-operative state, or of details of the operation, or of physiological prognosis. For patients who are moving satisfactorily towards discharge, all the talk focuses on the future, and the new condition that the patient will possess as an 'ex-surgical patient'. For those who have not yet achieved this stage of progression, the discourse is guarded, focusing on very specific objectives such as the attainment of stability or the healing of the surgical wound. Patients who do not permit any of these discursive themes to be developed may be marginalised. In cases where no possible definition of success is possible, there is silence.

The ward round is thus a tightly controlled strategy for organising interactions between surgeons and their patients. It was noted earlier how surgeons range their props to orchestrate these encounters. Foucault's analysis of pan-opticism - the technology of the disciplinary gaze - suggests how such practices of surveillance and control contribute to the creation of people as subjects of discourse (Foucault 1979, 1980). Whether these props contribute significantly to the discourse of surgical power or not, resistance to this power is possible, as a surgical ward is not a total institution, and subjection is open to challenge. These challenges must be faced directly, and the spoken discourse of the surgeon will be a significant focus through which the rival perspectives of surgeon and patient will be channelled. Hence, as I hope this ethnography has demonstrated, the most tightly controlled element of the ward round is what may be said, by patients in particular. Patients are disruptive elements - a threat to the organisation of interactions, and capable of challenging an otherwise secure discourse on surgical healing (secure to the extent that all the principal agents share this discourse). Only once they are well on their way out of the surgical space are patients permitted to have any say concerning what has happened to them.

Thus far, it has not been spelt out precisely what are the grounds upon which alternatives to surgeons' discourse might be based. I have argued elsewhere (Fox 1992) that it is the opposition between surgery as a healing process and surgery as a (necessarily) injurious procedure which constitutes a problem for surgical discourse, and that in recognising this opposition (which is by no means in open view) one can start to
understand the complexities of the relations between surgeon, anaesthesiologist, patient, nurse and manager during surgery. The data reported in this paper suggests that for patients, having survived resection to return to the ward, this opposition remains central.

The postmodern perspective on power as constituted by 'knowledge', by the discursive strategies by which the powerful can claim to speak the truth about something, places language at the centre of the analytical stage. Derrida's (1978) perspective on the way discourse creates this claim to be true focuses on absence, on 'gaps' in texts, discontinuities, spurious or questionable claims to authority. Post-structuralists are wary of such rhetorics (Flax 1990:38), and the technique of 'deconstruction' enables investigation of discourse through the reversal of this process of silence or absence. By such deconstruction, the ideological claims of a text are exposed, the very things which the author of discourse would deny come to be seen as the bedrock without which the discourse would founder.

Turning to the paradoxical nature of surgery as both healing and injury, one can see these as poles of an opposition: one in which surgeons (obviously) prefer - and wish to emphasise - the proposition: 'surgery as healing', even though it is in fact the injury which defines surgery as a distinct method of intervention, that is, the definition of 'surgery' depends upon resective injury. But by negating this negation (surgery as injury), by careful discursive procedures, the surgeon concentrates attention away from this injury, to sustain a definition of the post-operative patient as a success of surgery, and of course in the process, the definition of her/himself as a successful and powerful healer. Despite a patient's doubts or physical suffering as evidence to create a different definition of what has been done to her/him, the surgical discourse achieves its version of events. The discursive strategies of the ward round are organised so as never to leave the surgeon open to a threat of alternative definition. When the situation is at its most grim, as with patient J in IT who may not survive, there is silence, a grasped hand, a recourse to pure Will in the face of defeat.

Deconstruction (see Figure 1) allows us to see how this negation supplies the surgeon with the definition of healer, and denies the injuries which her/his 'healing' cause. The Will just mentioned is a will to power. Throughout the high-risk strategy of surgical healing it is this will to power which guides the surgeon. Post-operatively, her/his denial of the injurious nature of this enterprise, her/his strategies to avoid definitions based on this pole of the opposition, are the means by which the risks to the patient do not also become risks to the authority of the surgeon to carry out healing.

Reading the case-reports in this ethnography indicate just how much uncertainty enters into the surgical enterprise. ‘Success’ seems a very difficult term to define in many of the cases. In some, surgical outcome is fairly straightforward, and in these perhaps the previous analysis seems a
little overblown. But surgeons take more risks than other healers, by the
nature of their enterprise. Elsewhere I have documented some of the dis-
asters they cause when surgery goes wrong (Fox 1992). What I am argu-
ing in this paper – as elsewhere – is that it is because they are skilful not
only at the business of resection, but also in managing discourse that they
can claim high prizes in terms of authority and prestige. The techniques
of surgery provide powerful markers for the treatment that surgeons
offer, in a way which is less obvious in non-surgical medical interven-
tions. So long as the focus is on the good that surgery does, not upon
the injury, then surgeons can reap the benefits of their powerful healing
technique. The discourses used on ward rounds illustrate one way that
focus on good is sustained.

Position: Surgery has healed the sickness of the patient
Negation: Surgery has led to injury of the patient
Negation of negation: Patient physiology, wound condition and progno-
sis all indicate that healing has occurred, that surgery is successful, and
the surgeon is a healer.
Deconstruction: The surgeon has organised post-operative interactions
so as to sustain silence over the injurious nature of surgery, and its
threatening relations of meaning for surgical authority.

Fig. 1. Deconstruction of discourse on the post-operative patient

Conclusion

The surgical ward round is a strategy adopted to organise a set of social
practices which require interactions between surgeons and patients post-
operatively. It has been seen that organisation of ward rounds ensures
that a very highly controlled discourse is sustained, with few opportuni-
ties for patients to intervene or to introduce their own agenda for the
interaction. While the organisation of surgery within the operating theatre
itself has undergone a modicum of democratisation, with surgeons no
longer able to act as petty dictators (Fox 1991, 1992), on the wards this
model of the surgical hierarchy is still alive and well, with patients firmly
constrained. Virtually every element of organisation which constitutes
these interactions within the framework of the ‘ward round’ seeks to
ensure that the surgeon’s discourse remains unchallenged. Even if a
patient does find a way to subvert this discourse, s/he is one among a
multitude, to be passed over, an element which discourse silences, in
favour of a more compliant alternate.

I have sought to demonstrate the power of this organisation of interac-
tions. Central to this organisation are the three discourses on physiology, wounds and prognosis. If it appears that I have glossed over elements of the round concerning physical arrangements, the processions and the rhetorics of white coats and curtains which other writers have emphasised, perhaps that is because they seem far less significant than these discursive frameworks. Perhaps indeed they have masked the significance of the highly controlled interactions which occur when surgeons and patients meet on the wards: the gaze of surgery has far less to do with the ceremonial or the gross appurtenances of the hospital routine, and much more to do with the ways surgeons speak the truth about surgery as a powerful technique of healing. This paper has shown how this truth comes to be told when surgeons meet their post-operative patients. It is also told in those statistics which began this paper, in the heroic and the novel surgical technique (McGlew and Robertson 1981), and the portrayal of such heroism in the media (Karpf 1988); in the allocation of merit awards (Department of Health 1990), in the claims of five-year survival rates (McNeil 1978), in the willingness of our acquaintances to speak about their operations.

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Notes

1 The data was gathered as part of my doctoral research undertaken at the University of Warwick in the late 1980s. Some material gathered during an earlier period of fieldwork while a student at Bedford College is also reported. I am grateful to the staff of the hospitals concerned for access and assistance throughout the fieldwork.

2 These terms are sometimes used interchangeably in sociological writing. I prefer to use 'post-structuralism' to refer to the social theoretical position which locates power as constituted through language, while using 'postmodern' to refer to a commitment to this analysis, and the consequent abandonment of modernist social theory, with its notions of truth, rationality, the individual and social structure.

3 Dictionary definitions provide the simplest understanding of this 'chaining of signifiers', and the failure to achieve any final resolution of meaning. An extreme example would be the description of the kidney as a 'bean-shaped organ', while a bean is described as a 'kidney-shaped seed'.

4 This is of course an act of organisation, whereby I try to persuade you to the truth of my ethnography! See my earlier comments vis: postmodern ethnography; also Atkinson (1990).

5 This is an attractive thesis in terms of an explanation of the relative stature of differing medical specialties. The power of hi-tech equipment to bolster the status of a medical specialty would support this proposition, although as has been seen in this paper, surgeons disdain such showy markers of 'healing' when it does not belong to them.
The ward round is of course an organisational form which is common to most hospital specialties. It would be my proposition based on the conclusions reached here that each specialty develops its own themes of discourse, which may be more or less successful in terms of constituting treatment as 'successful' and the medics as 'healers'. A comparison of these would be extremely interesting, and might contribute further information on the 'league-table' of medical status.

References

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