
11. Hospital facilities were seen by contemporary observers to be inadequate particularly in poor or isolated areas as evidenced by the interest of a number of private foundations in the 1920s and 1930s.

12. The influence of a developing specialization on the hospital and of the hospital on special practice is an extremely important part of hospital history, but one that has been on the whole neglected by historians.


14. Hill-Burton did specify conditions, but they seem not to have greatly constrained institutional politics. The intra-institutional effects of externally supported research have been significant but are difficult to evaluate.

15. And the carrying out of that imperative has created economic and bureaucratic interests committed to existing procurement patterns and thus another source of rigidity in both areas.

16. The similarities between for-profit hospitals and the great majority of their not-for-profit peers are at least as significant as their differences. Both are prisoners of the same attitudes, expectations, technology, and funding realities and must pursue a good many parallel strategies.

21 THE HOSPITAL AS MULTIPLE WORK SITES

Anselm Strauss, Shizuko Fagerhaugh, Barbara Sucjek, and Carolyn L. Wiener

A useful way of conceiving of the hospital is as a large number of work sites. A walk around the different floors and sections of any fairly large or complex hospital gives one an astonishingly varied visual experience. Over here is the X-ray department—familiar to us all—with its huge mobile machines, its shielded area where the radiologist or X-ray technician pulls switches while the patient lies or stands immobile under or in front of a machine, having been carefully positioned by the technician, while other patients are lined up in a nearby area, usually in

wheel-chairs, each waiting to be worked on. Not far away is the cardiologist's terrain, where a single patient is hooked up to a complicated cardiac monitoring machine, operated by another kind of technician: the patient is sitting, standing, or walking on a treadmill machine, the technician is carefully operating the equipment and keeping an eye on the patient; meanwhile, a physician is looking at the unwinding printout, interpreting what the patient's heart is doing during his or her performance. Down in the basement is the central supply department; no patients are in sight, but low-salaried personnel are doing numbers of tasks related to sending supplies up to the clinical wards.

Upstairs, on the main floors of the hospital, are a variety of wards, each visually and often spatially different to the visitor's quick glance. The postoperative recovery room is heavily staffed with highly skilled nurses who carefully, minute by minute, monitor their relatively few and initially unconscious patients, who in turn are hooked up to multiple machines. Nearby is the intensive care unit (ICU) with its relatively few beds, with patients largely nonsensetive who are relatively exposed to each other, its battery of machines for monitoring each patient's vital signs, its one-to-one ratio of nurse to patient, its floating population of easily accessible physicians, its auxiliary specialists like respiratory technicians, its frequent patient crises and quick gathering of staff for fast action. In the cancer ward, the work pace is much slower ("we take our cues from the patient"): some patients are dying, others are there for X-ray treatments or chemotherapy and are suffering from varied degrees of physiological and psychological distress—so the nurses are doing much comfort care (medical and psychological) with most patients, while working on their own threatened composure and over-involvement with the patients.

In short, a hospital consists of varied workshops—places where different kinds of work are going on, where very different resources (space, skills, ratios of labor force, equipment, drugs, supplies, and the like) are required to carry out that work, where the divisions of labor are amazingly different, though all of this is in the direct or indirect service of managing patients' illnesses.

Decades ago the hospital was much less differentiated. Of course, there has long been a division between surgical and medical sections, though in many hospitals in developing countries there often is little difference to be seen between such sections. The hospital included servicing departments like X-ray and pharmacy but had nothing then like the complex array of wards that reflect today's explosion of medical specialization or the immensely varied chronic illnesses found in the contemporary hospital. If one focuses only on the clinical wards, however, it is easy to miss the similar explosion in the number and variety of support and servicing departments like transport, physical therapy, respiratory therapy, nutrition, sa: ene even a
tion, safety, equipment repair, bio-
engineering, echotherapy, EKG, and
even a full-scale clinical laboratory
for doing the host of diagnostic tests
ordered from the various clinical
wards.

22 THE NURSING HOME INDUSTRY

Charlene Harrington

The nursing home industry is a
multibillion dollar business in the
United States, characterized by rapid
growth in profits and large chain-
owned corporations. Nursing homes
were a cottage industry until the
early 1960’s when they began to ex-
and with the infusion of public
funds from Medicaid and Medicare.
By 1980, there were 23,000 nursing
homes in the U.S. serving 1.4 mil-
ion residents, mostly old and dis-
abled [1].

The industry, while private in na-
ture, is effectively a public program
defined by public policies, particu-
larly by the Medicaid program. De-
mand for services is artificially gen-
erated because of a lack of public
program alternatives and favorable
reimbursement public policies which
benefit the nursing home industry.
While state and federal government
regulate the industry, the effective-
ness of regulatory activities in pro-
tecting the consumer is question-
able, where poor quality of care is
commonly found. Older persons are
forced into such facilities against
their will, where the facilities serve
as agents of social control over those
who are frail, poor, without family
supports, and unwanted. While

some observers argue that the entire
structure of the nursing home in-
dustry requires radical change, the
politics and economics of the current
case reinforce continued expan-
sion of the industry and the use of
institutionalization as a primary mo-
dality of treatment for the frail aged.

Quality of Care

Serious questions must be raised
about the appropriateness of institu-
tional care as a treatment for many
aged. In nursing homes, the resi-
dents tend to lose control of deci-
sions about their treatment and their
daily living activities. Institutionali-
ization makes it more difficult to sus-
tain family ties and social relations-
ships. The morale, health status,
and functional capacity of individu-
als placed in institutions frequently
deteriorate. And many older people
spend their last years in such facili-
ties against their will. The aged have
a general fear and loathing of institu-
tional placement.

source: Readings in the Political Economy of
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Co., Inc.