HABITS OF RELATIONAL COMMUNICATION;
AN ETHICAL PROBE INTO MODERN ORGANIZATIONS

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AN ETHICAL PROBE INTO MODERN ORGANIZATIONS

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ABSTRACT

The topics, ethics and ethical behavior, have been raised throughout history as issues of central importance to human coexistence. Recently, these topics are being discussed in conjunction with organizations, in general, and medical settings, in particular, as issues fundamental, but unceasingly problematic for those of us functioning within these contexts. In spite of the variety of fields that have broached the subject, ethics and its application to modern existence has repeatedly been limited.

What has been missing in these approaches is the direct application of Aristotle’s and Gandhi’s contention that ethics is empirically inseparable from our action. If true, the place we need to look is at our actual behaviors in relation to each other (i.e., everyday relational communication behaviors). The present research attempts to do just that.
The setting for the research was a medical organization. The method of data collection was qualitative (observation and interviews). What was observed were human communication behaviors. The focus was on an interactional level. Glaser and Strauss constant comparative methods was used to analyze the data.

What was sought were "patterns of interaction." What was found were 31 patterns, 22 categories, 13 hypotheses, 5 research questions, 3 binds, 1 corollary, and 2 process mechanisms which were restated as 47 "allowable" behaviors. The translation of redundant relational communication behaviors into "allowables" are the results of the present research. It is but one step in a progression to the expression of behaviors as manifest principles.

The present research did not judge behavior to apply established ethical principles to medical practice or organizational existence. It was the initial test of an adjustment in ethical research to a concrete empirical communication focus, implying for communication an additional conceptual level, and for all of us a glimpse at what may prove to be characteristic ways we interact in modern society.
CHAPTER ONE

THE RESEARCH GOALS

Introduction

An organization is not a reified entity (Pacanowski & O'Donnel-Truillo, 1981), but a social institution. "The term is but a shorthand expression for a particular form of on-going relationship" (Watzlawick, Beavin & Jackson, 1967, p. 27). Organizations are human beings participating in the process of the constructing (Weick, 1969; Berger & Luckman, 1966), and ordering of social relations (Weber, 1946). The form this ordering takes has increasingly been what Weber (1946) refers to as legal-rational bureaucracies. It is a form of human association which promotes predictable behavior over spontaneous human action limiting the discretionary choices allotted to individuals (Selznick, 1969; Reardon, 1981). It is an attempt to structure human relationships in a hierarchical fashion designating allowable actions and interactions by designing and adhering to elaborate systems of rules (Weber, 1915; Selznick, 1969). It is a
humanly constructed system whose effect on the individual
is thought by some to be comprehensibly counterproductive
to the "habits of action" (Aristotle, Ethics) that are the
prerequisites for "democratic" society (Wolin, 1969;
Lakoff, 1973). Modern organizations are associations that
tend to undermine the political influence of the
individual (Lakoff, 1973). They inhibit the development
of the functional sense of community (Hershey, 1970;
Silver & Geller, 1978; Rich, 1983). They reduce the sense
of individual responsibility for actions in relation to
others (Silver & Geller, 1978), and they interfere with
the exercise of critical deliberative choice by

However, juxtaposed to these potential concerns is
a competing, and, for many, compelling argument that these
legal-rational bureaucratic forms of human association
have proven adaptable to a multitude of purposes--
economic, social, and political (Emmet, 1966). Though
considered rigid in their conception and structure, they
often prove to be flexible in their application (i.e., if
the rule doesn't fit, change it). Most important, they
are extremely effective as methods of getting things done
(Perron, 1973). Due in part to their effectiveness, an
idea closely allied with the "apparent reasonableness" of
doing things efficiently¹ and the human tendency to defend
the existing view of reality (Schon, 1971), this form of organized human activity has become the "characteristic feature of contemporary (Western) society" (Emmet, 1966, p. 183), and at present is the most prolific and predominant form of human association in the modern world (Weber, 1915; Emmet, 1966; Lakoff, 1973). It has become the context within which we spend most of our time relating to others. Both in spite of and because of its success, there is a growing concern that the pervasiveness of this form of human organizing "increasingly impinges on the way we live our lives" [Emmet, 1966, p. 183 (emphasis added); Schon, 1971]. The fact that this impingement is an issue of concern, if not problematic, has been dealt with in organizational theory either as a concern for the individual within the "organization" (Perrow, 1973), or more recently as a discussion of the political ramifications of these forms of social order in a democratic society (Wolin, 1969; Selznick, 1969; Lakoff, 1973; Michels, 1982). Both these formulations, the exercise of authority within organizations and the distribution of power within and without, are aspects of an even more fundamental issue, the social construction of reality, the human structuring of human interaction (Berger & Luckman, 1966; Weicks, 1969). What kinds of relationships are we constructing and maintaining in our
modern forms of social order (Pearce, 1978; Berman, 1980; Rich, 1983)? What ways do we interact with one another in a society inundated with bureaucratic forms of association (Rich, 1983)? These questions are distinct from the internal and political orientations mentioned above. For beyond issues of power and efficiency, how we choose to interact with each other is a normative question, a question of ethics (Aristotle, *Ethics*). Our habits of interaction are an expression of the social values by which we consent to live.

We are "community-building animals" (Laski, 1929, p. 17). We associate as naturally as we breathe (Kaufman, 1978). But the realities of modern organizational existence begin to make even the casual observer wonder what kinds of social relations we are constructing. How do we treat each other in "organizations"? What do we say? How do we act? How do we interact? What kinds of relationships do we jointly participate in in these rule-bound hierarchical organizing processes? These are not idle questions. If Aristotle (*Ethics*) is correct, ultimately our actual habits of behavior are the true location of our ethics, and the test and expression of our morality.

How we live together and on what basis we choose to do so peacefully has been the subject of philosophical
discussion for centuries (Plato, The Apology; Aristotle, Politics; Locke, 1869; etc.). The "Other" is a part of reality that cannot be ignored (Laing, 1969). For the individual perspective the concept of self requires either "consensual or conflictual validation" (Gouldner, 1962, p. 44). On the interrelational level, issues of social order (Locke, 1689; Berman, 1980) and perceptions of social reality (Berger & Luckman, 1966; Weicks, 1969) are inexorably involved. And ultimately, how we behave toward each other is the expression of ethical choice (Aristotle, Ethics). What we value is expressed in the ways we behave toward one another and is embedded in the communication behavior that is the observable manifestation of those relationships (Watzlawick et al., 1967).

Conspicuously absent from organizational theory is comprehensive consideration of the nature of the relationships we are beginning to increasingly live by. There have been conceptual abstractions of organizational behavior such as "power," "leadership," "informal," "formal," etc., but these abstractions as suggested earlier, have primarily been in reference to either the individual or the social system as a whole. Seldom is the focus of concern the relational implications of our behavior or the fit of that behavior with what we believe ought to be the way people treat one another. We need to
look again at the actual behaviors that constitute the ways we interact in organizational contexts. For if Berger and Luckman (1966) are correct, it is through interactions with others that we construct and maintain the social institutions we participate in. It is these actions, in the presence of another, these relationships [i.e., interactions] (Reusch and Bateson, 1952) which suggest that it may be reasonable and appropriate to extend Aristotle's (Ethics) focus on "habits of action" as a location of ethics to "habits of interaction" as an equally legitimate location of ethical concern. If so, we need to look more closely at our habits of relational behavior for they constitute an ethical component of modern organizational existence. We need to make the effort that Berger and Luckman (19567) suggest it will take to bring these everyday communications realities of organizational existence to more conscious awareness. By looking at how we actually behave in relation to one another, we can introduce an additional perspective from which to examine the normative implications of these prevailing forms of social interaction. It is a perspective that may provide a glimpse of the characteristic ways we interact in modern society. This interactional frame of reference may lend itself to the
future consideration of whether this is how we wish to continue to live with one another and ourselves.  

The Problem

Laski aptly expresses our present situation:

We are in the midst of a profound . . . crisis. . . . in dispute among us is not only the ultimate character of the relationships between [human beings], but . . . the system of values to which those relationships give birth (1943, p. 346).

Laski's (1943) statement is in reference to the social, economic, and political ramifications of World War II. The issues raised continue to be equally poignant today. Even Laski (1936) was no stranger to the pivotal nature of the implications of the corporate realities of modern society. The issues were raised in the Nuremberg trials as existing authorities attempted to come to grips with the relationship between individual action within an organizational context and ethical behavior (Neave, 1978). Emmet (1966, p. 183) states it clearly when she says that the impact of organizations is "a much more important feature (to modern times) than the controversies between socialist collectivities and individual enterprise." She echoes Weber's (1915) concern that the legal-rational form of organizing would eventually become the predominant value system.
As stated earlier, the issues confronting us in our organizational existence are relational. The assumptions embedded in Laski's (1943) statement are important to clarify in the attempt to grasp the dimensions of the modern predicament. Laski's (1943) reference to crisis implies that fundamental questions are at issue, and that at least potentially there are "fundamental changes . . . occurring" (Lakoff, 1973, p. 235). The full nature of these changes is not known, but of central concern is the nature of the relationships that will emerge.

This focus on relationships is based on an even more fundamental assumption. The assumption is that our relationships (our behaviors in relation to one another) are integrally tied to questions of value.

For Laski (1943) as with Aristotle (Ethics), the nature of human relationships is not a given, but instead is subject to debate and human choice. "Order and human society . . . (are) not a matter of spontaneous conformity" (Emmet, 1966, p. 7). With the exception of certain conditions, our behaviors are voluntary (Aristotle, Ethics). We construct the kinds of relationships we will jointly participate in (Berger and Luckman, 1966; Weick, 1969).
It appears that it is through communication that we not only establish relatedness (Ruesch and Bateson, 1951), but construct these relationships (Watzlawick et al., 1967). The very nature of that communication is inseparable from the nature of the relationship (Gibbs, 1961). Our relationships are constructed, articulated, and discoverable in our verbal and nonverbal behaviors in the presence of others (Watzlawick et al., 1967).

But to focus on behaviors (observable piece of human communications) need not, if Aristotle (Ethics), Laski (1943) and others are correct, leave us in an unbridgeable gap between the empirical and the theoretical. For Aristotle (Ethics), our "habits of action," while for Laski (1943) our habits of interaction are the location if not the source of the ethical dimensions of our existence. Our habitual behaviors toward others both in general and in particular are fundamentally tied to values while simultaneously subject to inquiries about whether what we are doing is what we ought to be doing (Aristotle, Ethics). What "is" can logically be separated from consideration of what "ought" to be while what we do and what we value are empirically inseparable (Emmet, 1966; Aristotle, Ethics). Because they are inseparable, it is by focusing on how we actually
behave toward one another that we will begin to articulate the values by which we live.

At a time when we appear "... not to hesitate to spoil our surroundings and human associations for the sake of efficiency in acquiring power and wealth." (Dubois, 1968, pp. 1-2) our "... morality is problematic." (Emmet, 1966, p. 1). At such times, it seems advisable to emphasize the study of ethics in relation to the realities of the predominant human institutions. To do this, it is first necessary to attempt to articulate a relationship between behavior and ethics.

The Relationship Between Everyday Behavior and Ethics

For Aristotle (Ethics) human behavior is the focal point of ethics. Ethics concerns "the conduct of our lives ... what we should do and from what we should refrain" (Aristotle, Ethics, p. 64). He presents an argument which appears founded on the belief that there is a fundamental relationship between behavior and ethics. The nature of this relationship has been a point of contention in a number of intellectual fields, in a variety of ways. But the fundamental tie between values and human behavior as presented by Aristotle, and reinforced and extended by modern social and communication theories, suggests compelling conceptual connections
between ethical concerns, action, everyday life and modern "organizations." Not only is everyday human activity connected to ethics (Pantham, 1983), it is just this connection which suggests that a primary focus in the modern study of ethics needs to be the activities of human beings in organizational contexts. To clarify this contention, it is first necessary to attempt to articulate Aristotle’s (Ethics) presentation of the three ways action relates to ethics, suggest how these relationships may tie into the realities of organization existence, and then specify which "habits of action" (Aristotle, Ethics) are of central concern to a study of the ethical dimensions of "organizations."

Like Aristotle’s Ethics, the orientation of the present study is not to determine "What goodness is" (Aristotle, Ethics, p. 93). What is under consideration here is, rather, where to focus our attention when applying ethics to modern organizational existence. Aristotle’s (Ethics) suggests that we must focus our attention on "... the problem of ... our actions ... [as] it is these that actually determine our dispositions" (Ethics), p. 93. This paper will contend that if we are to consider at some future time whether we are acting ethically, we must first, employing Aristotle’s focus, look closely at our behavior in the modern processes of
organizing (Weick, 1969) that dominate our lives (Emmet, 1966).

Aristotle (Ethics, p. 93) argues that ethics is "not theoretical." By this he appears to imply that, if moral principles were not ultimately translatable into action, they "would be useless" (Ethics, p. 93). If considerations of goodness did not apply to the making of "good human beings," which means humans who behave in accordance with conceptions of human "excellence" (Aristotle, Ethics, p. 92; Rich, 1983), what meaning would they have? Both deliberation and choice are essential, but thought alone is not enough. "The most important moral norms . . . 'are not cloistered virtues,' but are to be discovered and formed through the ordinary activities of life" (Pantham, 1983, p. 176). Ethics is integrally tied to action, everyday action. In this context, action is the end and the expression of the values we formulate.

Founded on the belief that "moral virtues are not engenered in us by nature" (Aristotle, Ethics, p. 91; Laski, 1943; Kohlberg, 1980), Aristotle's conviction is that goodness is learned, and more specifically, learned by doing. "We become just by performing just acts, temperate by performing temperate ones . . . " (Aristotle, Ethics, p. 91). Actions are not only the end and the
expression of values, but, in fact, they are the "only method [of learning] in the moral sphere" (Kohlberg, 1980, p. 77). There is not the "smallest likelihood of any [human being] becoming good without doing . . ." good (Aristotle, Ethics, p. 98). Again, actions are of pivotal concern. Virtue is acquired through the exercise of appropriate actions, (i.e., by actually behaving ethically). Both to be ethical and to become ethical, our behavior must be ethical.

However, Aristotle's (Ethics) concern is not with random virtuous acts. "Moral goodness . . . is the result of habit" (Aristotle, Ethics, p. 91). It is not the single performance of virtuous acts, but their repeated performance which is the source of virtue. It is through our habits, our patterns of behavior, that our values are to be realized and recognized. Ruesch and Bateson (1951) also argue in favor of a strong connection between habits and values. In fact, they suggest that the values are habits that have become so reflexive that the relationship between cause and effect, between stimulus and response, can no longer be distinguished. Be that as it may, what seems to be indicated is that the patterns of behavior that we develop are of prime interest in the study of ethics.
Embedded in Aristotle's (Ethics) emphasis on "habits of action" is a third connection between behavior and ethics. When discussing the relevance of human actions in relation to ethics, Aristotle describes what resembles a chain reaction. He suggests that a linked effect exists between the nature of recent action, the disposition it produces, and a resultant proclivity of both the behavior and the disposition to produce in their wake like actions. This characterization of the effect of present action as predispositional in regard to future action is remarkably akin to Gibb's (1961) work on the proliferating effects of defensive and supportive communication behavior. Not only are our behaviors an expression and measure of what we value, but for Gibb (1961) as apparently for Aristotle (Ethics), the very nature of this same behavior will directly effect the character of behavior to come. It now seems reasonable to suggest that our actual behavior is fundamentally tied to considerations of ethics. It is through human action that we learn, exercise, and promote human value (Aristotle, Ethics). It is also these fundamental connections between action and ethics which, in modern times, suggests "organizations" as a central focus of concern in any modern study of ethics.
Organizations: The Primary Location of Everyday Habits of Interaction

Organizations are most often described as purposive and goal oriented. This "purposeful" activity is discussed and studied in organizational theory from the underlying assumption that this form of organizing is the preferred method of ordering modern civilization.3 These arguments include beliefs that the methods of creating legal-rational bureaucratic relationships between people constitutes a bulwark against "complete individualism and disorder (Barnard, 1938, p. 242), and includes convictions that by increasing productive power and hence, material wealth and consumption, we are automatically making the world a better place in which to live (Smith, 1776; Taylor 1916). There are, however, strongly held counterarguments that modern society represents "many intellectual and ethical setbacks," and that the solution is not the creation of "more wealth and power" (Dubois, 1968, pp. 2-3). The issue for Dubois (1968), like Argyris (1978), is that there exists considerable discrepancy in modern existence between "espoused" values and our actual behavior. This is a belief that there exists a significant degree of hypocrisy if you compare what we value to the actual "social indifference ... destruction of scenic beauty ... waste of natural resources ...
and threats to health created by [the] thoughtless technology" (Dobois, 1968, p.2) we practice. The question is not as Charles Barnard, Adam Smith, and Frederick Taylor might suggest: "What are these methods of organizing saving us from?" But instead, "What, in fact, are they doing to us?"

There are at least two parts to the consideration of this latter question, and they both involve ethics. One part involves applying standards of excellence and preferred behaviors to what is actually happening between people in organizations. It is hoped that this work will facilitate such an effort, but, before that can be approached realistically, what is needed, first, is a close look at how we actually behave in organizational contexts without the conceptual restraints of the traditional orientation toward organizational theory. This paper is designed to concentrate more fully on this necessary initial effort. There is no attempt here to make organizations more functional for management or present definitions of efficiency. Part of the effort is, in fact, to side step the prevailing assumptions that span of control, chain of command, specialization or unity of direction are the most reasonable methods of organizing. The present paper is instead based on a shift in primacy of assumptions. Preceding questions of the necessity or
desirability of these organizing methods needs to be ethical considerations of the actions prescribed or produced by them. This effort will be focused on investigating what we are actually sayings and doing in relation to each other in organizations, based on an underlying belief that our behaviors represent an empirical ethic. Our behaviors are representative of the values by which we live, though not necessarily the behaviors we will continue to choose as expressions of what we value. To begin to participate in this investigation of modern ethics is to concentrate on characteristic modern behaviors. To do this, it is logical to investigate and identify patterns of behavior in organization contexts.

At this point in the discussion, it is hoped that the fundamental relationship between action and ethics has been reasonably established. However, the connection between action and "organizations" may need further clarification.

"Large organizations are probably the most characteristic feature of contemporary society" (Emmet, 1966, p. 183). These organizing processes are "action generating" mechanisms (Starbuck, 1982, p.3). Action is their central concern and avowed public purpose.
Organizations are methods of getting things done (Perrow, 1979). As basic as action is to the existence of "organizations," what is even more significant to the present discussion is that this method of organizing human action and interaction has pervaded all aspects of human effort (Emmet, 1966; Schon, 1981). The sheer fact of this intrusiveness not only places organizational context in a position (as stated above) to increasingly impinge on the ways we live our lives (Emmet, 1966), but it makes it the source and location of the "everyday activity" to which Gandhi (Pantham, 1983) refers for both the discovery and formulation of values. In addition, it is not just the magnitude and pervasiveness of activity connected to organizations which suggests a linkage to an Aristotelian orientation to ethics. There is currently an inseparable bond between these human institutions and "habits of action" (Berger & Luckman, 1966).

Lakoff (1973, p. 233) argues that a "fatal weakness" in organizational theory has been the persistent treatment of organizational processes "as though they were the problems of logic instead of problems of social relationships" (p. 233). The importance of this distinction and the characterization of organizations as social contexts will become more apparent as we proceed.
What is pertinent here is that apparent "in every social situation continuing in time" is the existence of human institutions (Berger & Luckman, 1966, pp. 55-56), and "organizations" in particular (Weick, 1969).

"Habits of action," and, more accurately, "habits of interaction" [as implied by their interlocking reciprocal nature (Weick, 1969)] within institutional contexts involve issues of control and human conduct. Embedded in these patterns of human behavior are instructional implications designating which actions will take place and by whom they will be performed (Berger & Luckman, 1966). This closely parallels Weber's (1946) description of bureaucracies. "Habits of interaction" are both prerequisite to and characteristic of modern organizational contexts. Given that "organizations" are a predominant location of modern habitual human action and interaction, the character of those "habits of interaction" is a proper focus for considerations of the ethical dimensions of organizational existence. Under these circumstances, it is "of no small importance what . . . habits we form" (Aristotle, *Ethics*, p. 92) in these modern organizing processes.

Implied in the shift in reference from "actions" to "interactions" is an extension from Aristotelian focus
on acts to interacts, from attention on the individual and his/her actions to the interrelational implications of their habits of behaving, and a shift, with the help of communication theory, away from the consideration of the intrapsychic to an emphasis on the observable interactional contexts. It is a shift which has gained support of late. "What was previously attributed by psychology to individuals now reveal themselves more and more as complex relationships and interactions" (Watzlawick et al., 1967, p. 22; Berger & Luckman, 1966). Intentions aside, our actual behaviors are the raw material that we present and are presented with, to cooperatively construct our relationships.

These relationships and interactions are the main concern of ethics (Emmet, 1966, Kohlberg, 1980; 1981). If Rest (1979, p. 20) is correct, "mortality . . . involves social interaction and does not concern individual values that do not affect other people." With this shift in focus, ethics, to paraphrase Aristotle, (Ethics, p. 66) concerns "those who regulate their impulses [toward others] in accordance with" and accountable to concepts of human excellence.

Relationships: A Central Concern of Ethics

Kohlberg (1980) contends that ethics involves
issues that can be divided into three categories: the "good life," the "good person," and the "right action." Again action is a prime focus of ethical considerations. To explain this even more fully, incorporating and extending Aristotle's (Ethics) argument that values find their expression in human behavior, a brief characterization of these categories is helpful. According to Kohlberg (1980), considerations of the "good life" and the "good person" approach the realm of religion. As such, they tend to be primarily intrapsychic interpersonal issues. The epitome of this characterization is exemplified by the life of the stoics, whose efforts to attain the "good life" and embody the "good person" were a personal concern not unimportant, but more inwardly directed than outwardly (McDonald, 1962). However, interestingly enough, these intrapsychic issues will need to find their expression in the "right action." The third category is a combined one, for "rightness" is a matter of perception and action is observable. But not only observable, it is the behavior itself, whether verbal or nonverbal, that impacts on others.

There is an impressive contingent of scholars who suggest that, in large measure, this impact, the potential social ramifications of action, is the primary focus and concern of ethics (Laski, 1943; Frankena, 1963; Rest,
1979; Kohlberg, 1980; Pantham, 1983). For Kohlberg, ethical principles are the end point of a natural . . . development in social functioning and thinking . . . and are ultimately universal constructions of human actors which regulate their social interaction (1980, p. 27).

For Rest (1979), ignoring his distributive bent, morality is a cooperative enterprise, and for Laski, (1929, p. 24) "Good is social . . . or it is not good at all." It is this orientation to ethics, the emphasis on ethics as a social phenomenon, that directs attention toward interactions and relationships.

Ethical considerations are age-old concerns that emanate from the realities of human association. If humans were isolated, self-sufficient beings, considerations of the correct action would have no meaning beyond survival. Since this is not the case and we have set aside concern for what constitutes the "good life" and the "good person, " the right action becomes a concern significant only in relation to others. Issues of justice, fairness, honesty, beneficence, etc., are interrelational issues. They concern how people behave toward one another.

Even Frankena (1963, p. 26), who describes ethics as a branch of philosophy devoted to the consideration of "morality, moral problems and moral judgments," defines
the subject matter of morality as "consideration of the
effects actions, motives, and traits . . . have on the
lives of persons or sentient beings." And more
specifically:

. . . not only the effects on ourselves or the
agent in question (always a person or group of
persons), but also, and perhaps primarily, the
effects on others who are likely to be affected.
This consideration of others when they are
affected may be direct or indirect, but it must
be ultimate or for its own sake, not prudential
or instrumental (1963, p. 25).

Not only is the substance of ethics social, between
people, but the interrelational consideration is more than
acknowledgement of the existence of others. Implied in
Frankena's (1963) statement is an obligation. The
obligation is to consider one's actions in terms of those
people they may affect. Our behaviors, once perceived as
affecting others, constitute a relationship (Ruesch &
Bateson, 1951). This relationship extends beyond the
boundaries of inevitable effect to "likely" and "indirect"
(Frankena, 1963). And like Laski (1943) Frankena's
rejection of convenience or usefulness as a legitimate
relational criterion suggests again that the nature of the
relationship is of prime concern to ethics.

In light of the discussion thus far, it seems
reasonable to define the territory of ethics as
interrelational phenomenon, and focus on action and
relationships as the logical starting place for a consideration of the ethical dimensions of organizational existence. For some, this may appear to be a limited perspective in relation to classical definitions of ethics. Consideration of human excellence, as Kohlberg (1980) suggests, can extend beyond the interrelational focus. But this narrowing has been done intentionally and is not intended to have a limiting effect. By highlighting the relationships we create as the central concern of ethics, the intention is to increase, where possible, clarity of focus, and by doing this to provide a useful vantage point from which to consider our present "habits of interaction."

The Reconnection of "Is" and "Ought"

To concentrate on actions, even limiting the inquiry to interpersonal behaviors, reintroduces issues that have long been contested in discussions of ethics. The controversy is formulated in two oppositions: "is" versus "ought," and "behavior" versus "cognition." They are issues contested in philosophy, sociology, and psychology in the attempt to grasp the complexities of a subject, ethics, which Aristotle argues by its very nature permits only "limited precision" (Ethics, p. 65). If, as Aristotle (Ethics, p. 65) suggests, "we must be satisfied
with a broad outline of the truth," this does not mean we cannot function or that our considerations are ultimately irrelevant (though they may prove to be so). Within the confines of a recognition that the empirical and logical connections we make abound in contingencies, we can proceed "for things are known in two senses: known to us and known absolutely . . . " (Aristotle, *Ethics*, p. 67).

The opposition, "is" versus "ought" according to Emmet (1966), is a controversy which takes place between sociologists and philosophers. Emmet (1966, p. 2) argues that the sociological approach to the study of ethics is a "comparative newcomer," but that the application of sociological method to inquiries about ethics seems logical and promising since "whatever else ethics may be about, it presumably has something to do with how people live together" (Emmet, 1966, p. 2). This approach, however, is confronted with the purely logical problems raised by the philosophical distinction between what "is" and what "ought" to be (Emmet, 1966). The argument revolves around the concern that "no decision about what ought to be done can be logically drawn from any statement about what in fact happens" (Emmet, 1966, p. 2). This is true on one level. But to consider them completely autonomous on all levels simultaneously is to imply that reality has no moral value. Admittedly, no uncontested
universally known value has been established, but that is not the same as saying that human action can exist separately from ethical implications. To confuse these two, is a mistake made by those who extend the recognition that humans assign different values to similar behaviors. "Is" versus "ought" is a theoretical distinction with empirical significance, but it is not at the same time an empirical reality. Human action is always humanly perceived, either by the actor or others, and hence is always within a context. Though it may be "necessary to be able to distinguish [where possible, if possible] between factual description and approvals" (Emmet, 1966, p. 19), it is never possible to sever ethics and human action completely. Though you may not know at any given moment what value to assign a behavior, that is not the same thing as saying that the behavior has no valuative implications. In contrast to those who argue that inability to assign a particular value can be logically extended to imply no value, I would suggest that, to the contrary, it implies that human behavior is instead inundated with values. Again, there is acknowledged relativity of ethical codes between societies, individuals, etc., but "to understand another point of view . . . [does not] lead in principle to its approval" (Emmet, 1966, p. 18). In that sense the value of actions
is neither relative nor situational. It may be that behavior examined without a contextual referent gives no absolute indication of value, and in fact is likely to appear mad (Watzlawick et al., 1967), but human actions are always performed on some level within some humanly conceived and perceived context. Human perception is always "in relation to a point of reference" (Watzlawick et al., 1967, p. 27). The reality is, by agreement or whatever, that societies, groups, and persons exist (in the sense that they have an impact), or at least valuative choices have been made so that we can function as if they do (Laing, 1969). Each represents a context. Within these contexts the value of a human action can be ascribed, for neither the actor nor the human perceiver nor persons affected can perceive outside of some context (e.g., Laing, 1969). Particular actions may not imply a universal value, but that action in relation to either universal, societal, or personal principles implies some value system. Allied with the Aristotelian relationship between action and ethics, what is implied is that what we are actually doing, our behavior, is imbued with ethical implications. Our behaviors at all times are appropriate, inappropriate or irrelevant to some set of values.

To concentrate on the behavioral realities of modern organizational processes is not an exercise in
"situational ethics" which argues that values are so tied to the context, hence so relative to circumstances, that it prevents the application of ethical principles (Johannesen, 1983). Quite the contrary, instead of a situation ethic, organizational processes are situations to which ethics inherently apply. Ethics emerges as a consideration at the point that people interact. Again employing and extending the Aristotelian view, people's "habits of interaction" are a primary location of ethical concerns. As stated earlier, the legal-rational bureaucratic form of organizing is a method of "building social processes out of behavior" (Weick, 1969, p. 3). Gilligan's 1982 work on the ethical orientation of women, considered a challenge by Flannagan (1982) and an extension by Kohlberg (1982) to cognitive development branch of ethical study, takes seriously the consideration of relationships, humans interacting, as a central ethical concern and legitimate orientation from which to investigate ethics. The patterns of interrelational behaviors that emerge are inseparable from considerations of value. How we behave in relation to each other on an ongoing basis is an expression of the values by which we live, is a method we develop the values by which we live, and promotes similar behaviors which tend to perpetuate those values.
The attempt here is to observe the interrelational behaviors (i.e., communication behaviors) in an organizational context as a potential expression of existing or changing relational values, and by increasing awareness of the relational realities of this particular context, to help prepare the ground for others to make more evaluative judgments in terms of universal, societal or personally held ethical codes. It is generally agreed that individuals behave differently when participating in groups than they do when they function alone, but "organizational behavior" is not a unique form of human behavior (Weick, 1969). As suggested earlier, the pervasiveness is uniquely modern, but what is referred to, and unwittingly reified as "organizational behavior," is in reality people behaving and interacting (Weick, 1969). There is nothing that exempts it from accountability to moral considerations. Theoretically, organizational theory may attempt to strip, through job descriptions, the "position" (i.e., boss, worker, etc.) of personal characteristics (Weber, 1946), but it is an illusion to think that a position described as such-and-such, and actions prescribed by rules divest the person of either the necessity to act individually (Rich, 1983) or the responsibility for those actions.
Focusing on behavior in the consideration of the ethical dimensions of organization existence is also not a return to what Rest (1979) calls the "Radical Behavioralism" of Skinner over the competing Cognitive theories of moral development. Nor is it implied support of the "soft" version of Social Learning Theory (Rest, 1979), which, even with the recent introduction of intentionality into the formula, suggest moral development is stimulated and promoted predominantly by rewards and punishment (Wren, 1981). As suggested all along, there is value in a perspective that relates morality and behavior. However, to focus on behavior is not to reject cognitive theorists' strongly argued counterposition that SLT's emphasis on limited "cognitive complexity" devalues the significant role played by thought and cognitive processes in moral development (Wren, 1981). Nor is it to reject the likelihood of Kohlberg (1980; 1981; 1982) and others' suggestion that ethical choice represents complex thought processes requiring sophisticated levels of differentiation (Kohlberg, 1980; Jensen, 1983).

"Behavior" versus "cognition" is a controversy which contests the issue of predominance. It is an either/or formulation which may not be necessary to resolve in order to proceed constructively. Whether thought precedes action (Loasby, 1976), actions predate explanations
(Weick, 1969), or they occur simultaneously (Kohlberg, 1980; 1981), it is ethical choice manifested in action or purposeful lack of action which gives social significance to the cognitive process.

It is possible to focus on behaviors without eliminating the elements of choice and deliberation. With rare exception, "moral conduct [i.e., behaviors that are the concern of ethics] implies choice" (Aristotle, Ethics, p. 118). Though there are persistent feelings of powerlessness in modern existence (May, 1982), if Aristotle (Ethics) is correct, part of the solution and a strong disclaimer to the legitimacy of these perceptions lies in the realization that the "actions we initiate ourselves, whether they are good or bad, are voluntary . . . . Where it is in our power to act, it is also in our power not to act" (Aristotle, Ethics, p. 91). For Aristotle (Ethics), voluntary behavior does not hinge on awareness of universal principles or even awareness of choice options. Instead, the only significant ignorance is ignorance of the particulars "of the circumstances and objects of the action" (Aristotle, Ethics, p. 114). The most important particulars are "the circumstances of the act and its effect" (Aristotle, Ethics, p. 115). The first is a contextual knowledge of the action. The second is a relational concern, for the issue of effect concerns
questions of whom or in relation to whom. Again, action and relationships are the main focal points of ethics. These are, in this case, the essential ingredient for voluntary behavior (Aristotle, *Ethics*).

The relationship between action and values, and the declaration of interactions as a prime focus of ethics are the recurrent themes in this rationale. They are themes which are important because they expose the vital connection between what we say and do in relation to others, and what values we express or, at least, what we are perceived to value. For the person on the receiving end of the effect, an empirical distinction between the act, the effect, and the values of the actor is difficult to establish. Put another way, any disclaimer of the effects in the name of a belief in higher values holds limited validity for the one who has been hit by the working end of a cattle prod. The attempt here is similar to Putnam's (1983, p. 202) description of the Radical-change theorists' "commitment to praxis." The effort is to facilitate "the convergence of thought and action as a means of transforming existing conditions" (Putnam, 1983, p. 202). The emphasis on the relationship between action and ethics is a statement about the inevitable and desirable proximity of thought and behavior. It is an
attempt to reiterate that what we value and how we behave are closely allied and need to be.

It must be stated unequivocally that to argue that ethics involves the consideration of others does not in any way imply that group norms take precedence over individual values or ethical principles. Others may attempt to extend it in this way, but that is not what is being argued here. To say that how we treat each other is an ethical choice is not to say, as organizational development theories appear to propose, that group consensus is the pivotal principle. Instead, it is a reminder that our behaviors carry with them ethical implications which need to be taken into account. How we behave toward others should not be exercised, and cannot be dismissed lightly. We need to look at how we are actually relating in this organizational existence before we can begin to evaluate if, according to our values, we are acting ethically or are capable of acting ethically within this context (Silver & Geller, 1978).

This introduces an additional issue which again targets "organizations" as the focal point of concern. It is not a newly raised issue, and centers on the concern about whether these organizing processes in fact inhibit our ability to recognize, entertain, and/or make ethical
choices. The concern has been introduced in number of ways. As Loasby (1976, p. 84) argues, these organizing processes create a context in which "problems which need different handling may not get it. They may not even be recognized as different problems or indeed recognized at all." McKenzie's (1977, pg. 209) concern is that, even though ethical concerns tend to serve a common interest of making behavior more predictable, "the common interest cannot serve as the basis on which larger group behavior can be organized." For him, "organizations" dwarf the influence of the individual to such an extent that an individual's efforts in defense of a "public good . . . border on insignificant" (1977, p. 209).

If, in fact, actions and relationships are the major components of both ethical considerations and voluntary action, then the work of Silver and Geller (1978) has considerable import. They argue that the rule-bound hierarchical organizing processes by which we have chosen to live alter perceptions of actions and diminish the sense of responsibility for one's action in relation to others. They

. . . transform the meanings of one's actions and the locus of responsibility for one's deeds. . . . main factor insuring high levels of organizational efficiency is the fragmentation of action (i.e., division of labor) [and] often a dehumanization of the relationship between the
agent and the person affected by his action (1978, p. 125).

If this context alters both our perceptions of action and relationships, what becomes of our ability to act voluntarily or our ability to recognize where ethical choices exist (Rich, 1983)?

The concern goes beyond altered perceptions. Johnstone (1982) suggests that actual changes in our behaviors toward one another are occurring. Like Laski (1943), Johnstone's (1982) is a concern about the nature of the relationships we are constructing in modern civilization. He describes "organizations" as an ends-means context which denies the "Other" an opportunity to creatively participate in a dialogue. This, he says, is a mediating step in a progression to no communication which is for Johnstone (1982) the principle ethical issue in a technological society.

The mechanism for the construction of both context and relationships is communication (Berger and Luckman, 1966; Weick, 1969); and if Weick (1969) is correct (as described in the introduction), the concept of organizations as a unique context is an unnecessary "reification"—a reification of what is more constructively and accurately conceptualized as humans interacting. This constitutes the fundamental assumption
underlying the present research paper. This assumption is that "organizations," which have previously and continue predominantly to be looked at as a unique contextual reality, are in fact human beings interacting (Weick, 1969). Accepting that as a correct assumption, "organizations" need to be investigated from that perspective. Accepting as well that it is our "habits of interaction" which constitute the ethics by which we live, the work of Watzlawick et al. (1967), Ruesch and Bateson (1951) and others suggest a focus of communication behavior as the raw material of these interactions.

**Communication as the Logical Focus in the Search for Modern "Habits of Interaction"**

The search for habits of behavior, and particularly habits of relational behavior, is a focus that implies a central connection to the discipline of communication. When considering "individuals . . . in their interaction with other human beings, the vehicle of this interaction with other human beings . . . is communication" (Watzlawick et al., 1967, p. 259). Communication is the channel of human interaction. Verbal and nonverbal behaviors are the media through which human relatedness is conveyed and observed (Reusch & Bateson,
1951; Watzlawick et al., 1967). "To be interested in communication therefore becomes synonymous with assuming . . . a viewpoint and interest focusing upon human relations" (Ruesch & Bateson, 1952, p. 6).

This connection between human relationships and communication is further emphasized in the work of theorists like Knapp (1974) and Gibb (1961), to name a few. A shared, underlying belief manifested in their respective works is that communication behavior is integrally tied to the creation, maintenance, and altering of relationships. In fact, Gibb (1961) as well as Watzlawick et al. (1967) argue convincingly that the very nature of the communication itself is foundational to the ensuing relationship.

Though some communicologists acknowledge the possibility of an intrapersonal dimension to communication, the "impossibility of seeing the mind 'at work'" (Watzlawick et al., 1967, p. 44) has led some researchers of relationships to "disregard the internal structure and concentrate on the study of . . . observable communication behaviors" (Watzlawick et al., 1967, p. 44). In line with this reasoning, in the work of Watzlawick et al. (1967) issues of intention, motive, etc., are submerged in favor of conceptually logical explanations of
the relationships between behaviors, effects, and frames of reference. For Watzlawick et al. (1967, p. 22), communication behavior is not merely conveyance, but rather, it is the "observable manifestations of relationships." It is the relationship.

Which behavior is communication behavior? How is it to be separated from that which is just behavior? According to Watzlawick et al. (1967), the distinction is not a relevant one. "All behavior in an interactional situation . . . is communication" behavior (Watzlawick et al., 1967, pp. 48-49). The impossibility of not communicating (Watzlawick et al., 1967) is the contention that all observed behaviors have potential relational significance. "Every act has its . . . social implications" (Panham, 1983, p. 175). But what does it mean that these observable communication behaviors are the manifestation of a relationship? Watzlawick et al. (1967, p. 51) argue that "... any communication ... implies commitment, and therefore defines the sender's view of his [her] relationship with the receiver." What we say to one another is indicative of and specific to that relationship (Buesch & Bateson, 1951; Watzlawick et al., 1967; Rawlins, 1980), and, in that sense, it is inherently definitional. Rawlins (1980, p. 4) expands on this by saying that it is "from individual expressions [that] actors construct [the]
underlying patterns" of relationships. For him (1980, p. 4), "any expression . . . is an index . . . a document of previous understandings . . . of a particular underlying pattern in a relationship." Embedded and implicit in the observable manifestations of interactional communication are the underlying logics of the relationship. If Bateson (Watzlawick et al., 1967) is correct, these behaviors also represent an empirical indication of the present state of the relationship. It is these observable pieces of communication behaviors which are the logical focal point in the search for modern habits of interaction.

The discussion so far has centered on relationships as a general category, but might the investigation of relationships in an organization context require different assumptions? Again, according to Weick (1979), this is not necessary. As noted, he argues that what is often referred to as organizational behavior is nothing more nor less than human being interacting. Implied is that principles and assumptions applicable to the research of extra-organizational relationships are also applicable to intra-organizational relationships. The richest source of information about the realities and dimensions of human interlocking behaviors in organizational contexts is more likely to be revealed by
research that focuses on communication at the relational level (Weick, 1979).

Modern organizations are the location of everyday social interaction (Emmet, 1966). This "institutionalized world . . . is experienced as objective reality" (Berger & Luckman, 1967, p. 60). However, it is through language that we order and objectify these social experiences (Berger & Luckman, 1967). Inseparable from the reciprocal interlocking behaviors (Weick, 1969), which are characteristic of these organizing processes, are the communications foundational to these ongoing relationships. It is by communicating that humans also resolve, however temporarily, the uncertainties that could divert, modify or undo (Weick, 1969) these social orderings. It is through language that we maintain these institutional realities for what becomes "habitualized is the communication process" itself (Berger & Luckman, 1967, p. 58).

Summary

The rationale, to this point, has attempted to establish the reasonableness of identifying relational communication behaviors in a modern organizational context as an appropriate focus for a modern study of ethics. This contention hinges first on a conceptual shift. The
shift suggests that the traditional purview of ethics, *habits of action* (Aristotle, *Ethics*) that impact on others (Rest, 1979; Kohlberg, 1980, 1981; Gilligan, 1982; etc.), with the help of communication theory can be logically and reasonably reconceptualized as relationships. The second cornerstone of the thesis is that modern organizational contexts are the logical locations of characteristic modern habits of interactional behaviors. Both aspects lend themselves to the argument that as observable manifestations of a relationship (Watzlawick et al., 1967), as the expression of the history and logical progression of the relationship, and as the mechanism for the process of organizing and maintaining these modern social orders (Berger & Luckman, 1967; Weick, 1969), communication behaviors are the local place to focus attention in an ethical probe. What were sought were "patterns of interaction." They will yield the beginning of an empirical picture of the ethics we live by, and communicationally what will emerge is a third level of communication. Not only are Watzlawick et al.'s (1967) content and relationship levels inherent in communication behavior, what is present as well is an ethical level to communication. For in addition to the literal translation which is the content level and the implied positional proximity which is the relational level, there exists a
third level. Implied, particularly in repeated communication behaviors is "what is allowable," the ethical level of communication.
CHAPTER TWO

METHODS

Introduction

What will be presented in this chapter is a description of whose "habits of interaction" were investigated, what methods were used, and the rationale behind these choices.

Setting

The location of the research was a small chronic hemo-dialysis center. Hemo-dialysis is a medical treatment used on people whose kidneys apparently no longer function. It is a treatment that requires a portion of a person's blood to be diverted outside the body so that it can be passed through a filter. The present state-of-the-art requires needles, tubes, and a machine to pump and monitor a person's blood and the shifting pressures that arise in the system. The process removes chemicals and fluid directly from a person's blood, and can be performed with apparently minimal ill
effects. However, the procedure is always potentially life-threatening. The lack of kidney function is usually permanent and requires treatment every few days to maintain life. Since the need is chronic, ongoing centers exist around the country to provide treatment.

This particular hemo-dialysis unit opened in 1983. It is privately owned and directed by three doctors (two of whom work with the unit; the third is a practicing nephrologist at another location), and a non-physician partner. Originally, nine people came to be dialyzed. At the time of the research, there were 32 patients coming for treatment. The 13-person staff consisted of five RN's and six technicians, one person designated as social worker, and one in a secretarial role.6

The unit is open six days a week (Monday, Wednesday, and Friday for 15 hours and Tuesday, Thursday, and Saturday for 11 hours). Patients come for treatment either two or three times a week for two to four hours (determined on an individual basis). They are scheduled at regular intervals and are assigned to one of five shifts on which to be dialyzed. Three different groups are run consecutively on Monday, Wednesday, and Friday, and two shifts on Tuesday, Thursday, and Saturday. The staff works shifts of six to twelve hours. Routinely, the
two resident doctors come to the unit individually approximately once a week.

The unit is set up in a ten-room suite in a medical office building located in a residential area (both apartments and houses). The dialysis itself takes place in the largest and most central room in the suite. Six dialysis machines and six lounge chairs are arranged in a semi-circle along the outer wall of the room. There is a concentric semi-circular counter used by staff as a desk when they are not working at the treatment or moving in and out of the other rooms for stock and equipment care. Both researchers observed from this desk. Most of the staff and patient's time is spent in this central room.

**Rationale for Choice of a Medical Setting**

Human effort in the area of medicine represents a "particularly appropriate target population for this study" (Albrecht, 1982, p. 833). The four central concepts of this present research are those of prime concern in providing and receiving health care services. Relationships, communication, ethics and organizations are increasingly recognized as concepts central to everyday functioning in a medical setting (Travelbee, 1971; DePolito, 1983), relevant to the development of
constructive interaction between "provider and receiver" (Thompson, 1984, p. 27), and the appropriate issues to be addressed if the existing and persistent barriers to humane care are to be overcome (DePolito, 1983).

Ideally, the role of medical professionals is "perceived . . . as a relationship" (DePolito, 1983, p. 5), for seldom do the decisions made or the dilemmas faced in the health care field occur "in isolation; they occur in the context of a relationship with clients, with colleagues--with organizations" (DePolito, 1982, p. 5). Of growing concern is the "impersonalization of health services (DePolito, 1980, p. 5). It is both a relational issue relevant to medicine (DePolito, 1982) and a communication concern in a technological society (Johnstone, 1982). It is argued in both cases that of central importance is the nature of the relationships we create. Not only are everyday medical issues relational, Health Communications' focus on effective communication, obstacles to communication, and the potential curative value of communication (Thompson, 1984) lends support to an approach to research in medical settings which includes both relationships and communication, implying an interactional perspective.
The interactions involved in receiving and providing health care are a particularly appropriate focus for the study of ethics. Humans in these settings create conditions in which organizational goals and professional values come into direct conflict (Albrecht, 1982), providing what Berger (1982) describes as the clearest possible circumstances for observing the dynamics of ethical dilemmas.

Rationale for Choice of a Chronic Hemo-Dialysis Setting

The chronic nature of the setting is particularly suited to a search for "habits of interaction." Patterns involve redundancies (Watzlawick, et al., 1967) and interactions over time represent the most potentially fruitful environment for their emergence. These patterns of behavior are in fact "varying degrees of repetition or redundancy from which tentative conclusions can be drawn" (Watzlawick et al., 1967, p. 37). The redundancies characteristic of relationships, the contents of our habits-of-interaction, are more likely to be visible and "incipient in ... a social situation continuing over time" (Berger & Luckman, 1966, p. 53). The chronic nature of kidney disease and its treatment plus the schemes devised to coordinate staff efforts and patient treatments tend in these centers to place approximately the same
people in proximity over time. This allows a researcher to observe relational redundancies.

Methodological Rationale: A Shift in Focus and Method

To date, organizational health research and health communication research in general have repeatedly been characterized as "much less systematic than . . . (considered) in social science" to be rigorous (Thompson, 1984, p. 2; Georgopoulus, 1975; Salem & Williams, 1981). However, this does not undermine the central issue raised, "the emerging ethical dilemmas facing" those who provide and receive health care. The conceptual addition this paper makes to the contention that the issues facing health professionals and patients are ethical is that the ethical dilemmas to which they refer are in reality embedded in everyday relational communication behaviors. As described earlier, ethical considerations emerge from the realities of coexistence. It is what we say and do, our communication behaviors, within the context of our relationships which are the expression of the source and the promotional material for what we value. This represents a shift in focus for ethical research, and a methodological change as well.

As promising as the connections between medicine and ethics, communication and ethics, and philosophy and
social science theory, and research may be, a discussion of the limitations of these existing approaches is needed. This discussion will serve to reinforce the underlying arguments of this paper that a more concrete empirical base is both possible and desirable in the struggle to apply ethics to modern existence, and that the initial effort must be a search for theory. These issues are most clearly addressed in a review and analysis of method.

In what ways does the shift to relational communication patterns constitute a methodological change? What has been characteristic of modern efforts to broach the subject of ethics and its application? In spite of the diversity of fields (social sciences, medicine, philosophy, etc.) represented by those who have addressed the issue, their efforts have been limited to three basic approaches. The identifying characteristics of these approaches have been: (1) a discussion which clarifies and elaborates the question to be answered (e.g., how to balance competing services, etc.); (2) research which is a discussion and extrapolation of responses to hypothetical dilemmas; or (3) an effort which focuses on the principles to be applied to a particular situation (e.g., utilitarianism, beneficence, etc.).
Kohlberg used "semi-structured interviews" (Rest, 1979, p. 76), Rest (1976, p. 76) used "subjects' discussions of prototypic stimulus statements," and Piaget questioned children about a marble game as the main apparati of their data collection procedures. Self-report and suppositional issues aside, their interests and efforts were directed toward indexing cognitive development (Rest, 1979), and cognitive "structuring tendencies" (Rest, 1979, p.76). What is being addressed in the present work is not the structure of ethical thinking or even the content of ethical thought. What is being attempted here is an exploration of the human interactional, interrelational conduct in a modern social context. It is an attempt to look at how we are presently behaving. What is missing in the previous approach is the direct application of what Aristotle (Ethics) and Gandhi (Pantam, 1983) contended. Ethics is empirically inseparable from our actions. If this is true, then the place we need to begin to look is at the behaviors we enact every day when we interact with other people. We need to explore our actual behaviors in relation to one another. It is in these everyday relational communication behaviors that we can begin to identify the "habits of interaction" by which we presently live.
An additional complaint about health communication and organizational health communication research, in particular, is that the research has tended to be based on hypothetical relationships (Salem & Williams, 1981). This study will attempt to look at the everyday relational realities of participation in a medical organizational context, for "... as long as actual behavior is not fully understood, the recommendations of normative research may be irrelevant, confusing, or even harmful" (Brunsson, 1982, p. 31). This research is but a preliminary investigation of how we actually behave in relation to each other, i.e., what kinds of relationships we create, and in which we participate within modern medical organizational settings, and an exploration of the nature of these relationships as they are expressed through interactional communication behavior. However, this research effort is not an attempt to evaluate behavior or apply ethical principles in medical practice. Instead, it is an attempt to extend the focus of potential ethical research by bypassing the question usually addressed, "How do we apply ethics to modern existence?," and asking the more rudimentary questions, "Are there characteristic ways we interact in modern society, and if so, what do they appear to be?"
Choice of Method

The transition in thinking about communication has been from a representative model that involved the linear, one-directional, passive reception of a message (Laswell, 1948; Shannon & Weaver, 1949) to a picture of an ongoing process which emerges through the continuous active interplay of actors and their perceptions (Barnlund, 1968). This progression toward a transactional view of the realities of communication has involved a shift in focus from act to process, passive to active participation, and from simplicity to complexity. Included in this transition are the efforts of Ruesch and Bateson (1951), Watzlawick et al., (1967), and Pearce (1978) to focus on behavior (i.e., communication behavior) as not only just a skill to be learned and employed, but, also, as a mechanism for the demonstration of social realities (Berger & Luckman, 1967; Weick, 1969). To investigate interactional behavior in particular, requires that the method "reflect the complex interactive texture . . . that so obviously occurs in real life" (Rawlins, 1980, p. 17). Rawlins (1980, p.16) suggests that, in relational research, the method should allow the participants to "speak for themselves." Ethnographic research suggests strongly that qualitative methods tend
to be best suited to the complexities of natural settings (Lofland & Lofland, 1984).

But the choice of qualitative versus quantitative method does not hinge on the complexity of the subject matter. The decision turns on the issue of intent, on the major purpose of the research (Glaser & Strauss, 1967). The primary choice that will dictate method is whether to emphasize the verification of established theory or whether to embark on the generating of new theory (Glaser & Strauss, 1967). The first emphasis suggests a quantitative method while the second implies a qualitative orientation. Since there is little or no theory concerning relationship between ethics, relational communication, and organizational contexts, and only the beginnings of hypotheses and theory on the nature of interpersonal communication in organizations (Muto, 1983; Browning, 1973), the logical choice is the need to generate theory. Even the addition of a medical setting suggests that more is needed than a foray in search of characteristic modern behaviors. Salem and Williams (1981), Thompson (1984), and Georgopolus (1975) all criticize the atheoretical nature of existing research. What is needed is a search for substantive concepts, categories, and theory.
The choice having been made about which effort to emphasize, the discussion then turns to method. If Rawlins (1980 pp. 14-15) is correct in his assessment and summary of the methods and rationale used in his research on friendships, the implication for this study is that quantitative method,

... the partitioning of relational behaviors for the purposes of quantification and correlation, and the application of methodologies that constrain the nature of the findings [will] unduly hamper the development of the theory.

Quantitative methods dictate the isolation and limitation of variables and relationships to be studied. Implied but never stated is that theory building requires more flexibility than this method allows. With these considerations in mind, the choice that remains is which qualitative method to employ.

When formulating theory, Starbuck (Lakoff, 1973, p. 233) argues that "meaningful insights and intimate familiarity with the referent situation are at least as important as logical rigor." He continues by saying that what is most essential is to avoid both "empirically relevant, but logically inconsistent theories, and logically taut, but empirically irrelevant theories" (Lakoff, 1973, p. 233). The method that appears to hold the most promise for bypassing these obstacles is Glaser
and Strauss' (1967) constant comparative method. It is a method designed particularly for generating theory, and specifically for generating theory directly from the data itself, minimizing the pitfall of empirically irrelevant results. It is also a method where the logic emerges from the method itself. The constant comparison of difference and similarity tends to mitigate against the illogic of "comparing noncomparable" data (Glaser & Strauss, 1967, p. 50). In addition, Glaser and Strauss (1967, p. 32) contend that this method "renders quite well the reality of social interaction and its structural context." In defense of this contention, this method for the "discovery of . . . grounded theory" (Glaser & Strauss, 1967, p. 1) has been successfully employed twice as an approach appropriate to researching organizational communication (Muto, 1983), and interpersonal behavior in organizations (Browning, 1973).

Collection of Data: How The Constant Comparative Method Was Employed In This Study

The method used for collection of data was participant observation. As Muto (1983, p. 33) suggested in her thorough and convincing job of elucidating its strengths and weaknesses, "the advantage of this method far exceed the limitations." The attempt was made to
employ Muto's (1983) particular version of participant observer as both observer and confidant with calculated liberties in initiating contact, and expression of personal opinion limited to topics outside the organization. This method seemed well suited to Starbuck's (Lakoff, 1973) directive concerning familiarity with setting as well as facilitating both the unobtrusiveness of the researchers' presence and the willingness of subjects to reveal information that may not be immediately observable (Muto, 1983)

Patients and most of the staff were informed by the head nurse before the research started that a researcher/observer would be coming, and introductions were initiated by her as the research began. The dialysis nurses, technicians, patients, and/or doctors were observed as they went about their daily tasks and interactions. All the observing was done in the large dialysis room. The observers were stationary and centrally located, sitting behind the semi-circular counter. A single researcher observed four hours three days a week for three weeks; two researchers observed simultaneously for three days in sessions of four hours, three hours and three hours.
Interactions were recorded on file cards as they were observed. Participants who were letter and number coded were noted by their designated code. An attempt was made to write down verbatim the verbal content of the interactions as they occurred, but summaries were used when the volume was too great to record by hand. Nonverbal behavior was noted and included when possible. Within 24 hours the cards were reviewed and, periodically, additions were made from recall where sufficient certainty was present.

After all the observations had been completed, interviews were conducted by both researchers over a day and a half. Staff interviews tended to be group or individual. Patient interviews tended to be individual or couples. The length of the interviews ranged from one-half hour to two hours. The questions used in the staff interviews are compiled in Appendix A. Patient interview questions are to be found in Appendix B.

Muto (1983) recommend the use of unstructured interviews as a complementary source of historical and contextually relevant information. Rawlings (1980, p. 31) suggests that soliciting "both persons' views" of the relationship is a rich source of information concerning the "underlying coherences of relationships." Due to the
interactional focus of this research and the necessity for separate interviews, the interviews were constructed to attempt to illicit metacommunicational responses. Issues which surfaced in the analysis of the observations were presented as open-ended questions (See Appendices A and B for list of questions). The hope was (1) to clarify and elaborate the issue; (2) to identify staff and patient perspective as a check on researcher subjectivity; and (3) to add a metacommunicative character to the information being gathered, providing a more direct connection between the interview material and the observed materials. In this context, the interview materials were used as commentary.

An additional concern of Muto's (1983), and one frequently lodged as criticism of qualitative research, is the issue of intersubjectivity. The use of two observers and the participant perspective of the interviews were employed as a partial solution to this problem. In addition, a reliability test on the coding procedure (i.e., a major process in the analysis of data) was constructed from interactional data gathered by the same researchers in six hours of participant observation at an entirely different hemo-dialysis unit. The details of its construction and the results will be addressed in the
Results chapter. Before that, it is important to understand the method used for the analysis of data.

Analysis of Data

Muto (1983) used Browning's concept of an incident as her unit of analysis and defines it as a search for "complete thoughts or complete acts of behavior" (Muto, 1983, p. 55). However, this definition can be employed both narrowly and broadly. The narrow interpretation involves limiting an incident to a single idea or action, while the broader use includes a series of message exchanges around a central theme. Muto's (1983) application of the narrower version of incident in her research tends to filter out the relational communication in favor of a focus on the communication content of the individual messages. It seems more appropriate for this research to employ a broader definition of incident as the unit of analysis. As such, this definition of incidents will be more in line with the work of Watzlawick et al. (1967) which characterizes interpersonal communication in terms of the internal logic between statements and responses. For an incident to retain its interactional relevance it must involve, at the very least, an exchange,
a statement, and a response, even if the response is silence.

There were two initial groups of data. All of a series of message exchanges that appeared to constitute a complete interaction, i.e., from initiation to termination of interaction, were termed and coded as an "episode." The other grouping retained the label "incident," and included those exchanges within an episode that clustered around a single theme, idea or act. Episodes were identified as they occurred and numbered consecutively. Incidents were identified as episode were reviewed, and then bracketed and numbered consecutively within the episode.

Using Glaser and Strauss (1967) and Muto (1983) as guidelines, a four-step method was employed:

1. Comparison and coding of incidents and episodes in a search for all possible categories.

2. Comparison of coded incidents and episodes within a single category and the subsequent emergence of the properties (memos) of that category.

3. Comparison of episodes within a category with that category's memos leading to the
identification of not mutually exclusive patterns, tendencies, and hypotheses.

4. Delimiting, a process of reducing the volume of data by organizing it in two ways.
   a. Identifying the central concepts through recognition of underlying uniformity.
   b. Classifying and coding compared incidents as either repetitious information which is discarded, further clarifications of existing categories or data which suggests new categories of concepts.

To elaborate, Step 1 involves the comparison of each incident and episode to all previously compared incidents/episodes to find the similarities and dissimilarities that lead to the identification of categories. Categories were developed initially by grouping together episodes with common properties. All incidents/episodes were coded according to every category within which they applied. If in the comparison process "no similarities [were] apparent, a new category [was] developed" (Muto, 1983, p. 50). While the identification of categories continued, both a list of the categories and a list of all episodes coded under that category were constructed.
Once coded, Step 2 began. In this step, all of the coded incidents/episodes within a single category were compared with each other. What emerged from these comparisons of the content on the verbal and nonverbal behavior were memos (the properties of the categories). These memos were the apparent characteristics of the communication behavior within a category. In Step 3 each episode within a category was compared to the emerging memos. This comparison produced patterns, tendencies, hypotheses, corollaries and potential research questions. While Step 3 was in progress, the delimiting process of Step 4 occurred. Repetitions were deleted, similarities between categories were noted, and those with obvious similarity were collapsed into single categories or incorporated into subcategories. Incidents/episodes whose conceptual content had been saturated (i.e., thoroughly reviewed and coded) were set aside. As categories were collapsed, those remaining were compared in an effort to identify existing relationships and produce a more cohesive reconstruction of the concrete communication behaviors observed and analyzed. As the comparisons were made, the results were recorded and are presented here in Chapter 3.
CHAPTER THREE

RESULTS

Introduction

One of the dictates of the use of constant comparison is that no attempt be made to confine concepts to mutually exclusive categories. This lack of exclusivity is, in fact, the source of richness encouraged. The results obtained come in multiple forms that emerge from the interplay of concepts and often retain the remnants of the overlapping. This is not a sign of incomplete application of method, but the source of the relationships between concepts that suggest a more coherent reconstruction of the dynamics at play in the setting. The results are 22 categories, 13 hypotheses, 5 research questions, 3 binds, 1 corollary, 31 patterns, 3 process mechanisms, and 47 allowables.

Each of the 22 categories is presented in 2 parts: (1) the property (i.e., communicative characteristics) by which that category can be recognized, and (2) a summary.
of tendencies, patterns, hypotheses, allowables, etc., that suggest themselves in the analysis. After the 22 categories have been presented, the results will be listed in tables according to the form they take.

An additional word of explanation needs to be made about the summary characteristics designated as "allowables." Allowables are not results in the traditional sense, but are extrapolations. If, as suggested in the earlier discussion, how we actually behave is indicative of the ethics we live by, one way to attempt to clarify the latter is to state what is occurring as if it had participants' explicit or tacit consent. It is these restatements that are included under the heading, allowables. Their implications will be explored further in Chapter Four (Discussion).

The attempt to assess the reliability of the results was constructed in a particular way. Observations were conducted at two separate outpatient hemodialysis centers. The data collected from the first center was analyzed as described in the preceding chapter, and is presented below. The recorded episodes from the second center were not further analyzed, but were instead used as the data for a reliability test with which to assess the intersubjectivity of the categories.
Reliability

The reliability tested at 66%, 56%, and 72%. A list of the 22 categories and their properties were given to a third party non-researcher along with 20 of the 63 episodes recorded from the second center. The selected episodes were chosen by asking an additional impartial person to select 20 numbers between 1 and 63 by computer using a random program. The instructions given were to list for each episode all the categories that it appeared to fit into logically. The results of this were compared to a similar coding of the same episodes by this researcher. The number of categories selected by the non-researcher that matched episode for episode with those of this researcher were noted and counted. This number was divided by the total number of categories coded by this researcher resulting in a reliability in the first attempt of 66%. What followed was a discussion between the two researchers about potential ambiguities in the descriptive properties of the categories. After this further clarification, 10 additional categories were selected, coded, and treated as described above. The results were a reliability of 56%. A third test was performed by still another third party non-researcher who coded (as described
above) 15 of the 63 episodes selected again randomly, and a reliability percentage of 72% was obtained in this test.

Results

Category #1

QUESTIONS/ANSWERS

Property: These interactions are characterized by inquiries (spoken or implied) and the responses to them.

Summary: It is one of the three major forms of verbal communication in this setting, and often comes in a series of question/answer, question/answer, question/answer. Questions can be constructively viewed as blanks to be filled, and answers as attempts to fill them. With that in mind, there appears to be awkwardness when a question is not matched with an answer:

S-2: "How are you, Eddie?"
P-1: "Ugh." (No further response)
S-2: ". . . your heart test--it was good!" (with forced energy and enthusiasm.)
P-1: (Partial smile)
S-2: (walks to opposite side and checks chart);

and, oddly enough, an awkwardness when too many blanks are created, even if most have answers:

S-4: (Answers phone and calls out): "Donna!"
S-7: "What?"
S-4: "Phone's for you."
S-7: "Who is it?"
S-4: "Some man."
S-7: "Tell him he has to wait a few minutes."
S-4: Makes no comment, walks away from phone, a minute later walks back, and picks up phone: "Hello? She's busy. You want me to take your name and number?" (Then) "Donna, it's your son."

S-7: "Is he at home?"
S-4: "I don't know. He didn't say."

Allowable #44: It is allowable to attempt to minimize disturbances. 7

Allowable #45: It is allowable to attempt to minimize disturbances by matching.

Hypothesis #1: In this setting, a question without an answer is an imbalance.

Category #2

"HOW ARE YOU?"

Property: A verbatim inquiry,

S-4 to P-1: "Are you okay?"
P-1 to S-4: (Gives a thumbs-up sign)

or a question pursued indirectly in an attempt to measure or obtain information about the present condition of another:

S-3: walks over to P-3 and takes a blood pressure reading.
P-3: has eyes shut and does not respond.
S-3: walks to machine, writes down blood pressure and walks away.

Summary: "How are you?" is clearly a question, but its centrality to the setting and the complexity of
its uses suggest that it is important enough to consider as a separate category.

The complexity of this question comes from its versatility of form ("How are you?" "Are you okay?" "Are you comfortable? Hot?", etc.; meaning ("Hello," "How do you feel?" "Do you need help?"); and the multiple relational levels that can be implied (social, personal, and professional). This complexity suggests three potential research questions:

1. How are distinctions made between the forms, meanings, and relational implications?
2. What, if any, confusions arise from this versatility?
3. Are the ambiguities employed to serve any purposes?

The interest in the intricacies of this question stems from the fact that it appears that interactions frequently revolve around the asking of this question by staff and/or patients. For example:

S-3: "Hot?" (Repeats)
P-1: (Waves hand as if no trouble)

Or:

D: "How ya doing, Paul?"
P: "very well."

Or:
S-3: "Your stomach's upset? . . . What were you thinking about? Your pressure went back up." (They laugh).
S-2: "Don't make yourself sick."

However, the responses sought are limited, and dialysis-related:

S-2: "You okay, Mable?"
P-17: "I'm ready to get off."
P-18: (Laughs).
(They both laugh). (S-2 goes back to what she was doing).
P-18: "Ready to get off here."

This is also suggested in one of the patterns which emerged from the data.

Pattern #1: The sick tend to inquire further about a non-sick's negative response to "How are you?" than the non-sick do of a sick person's negative response to the same question. For example:

P-6: to wife of P-9, a non-patient (not known to be sick): "How're you doing?"
P-11: (wife): "Not so well."
P-6: "Me, too. Me, too."
(A discussion).
P-11: "Got chiggers."
P-6: "Yeah? They puff up like knots. I put alcohol on it. Itch to make you crazy!" (Discussion continues, switching to kids and poison ivy).
P-6: "Some people are more immune."
P-11: (Walking away)
P-6: "Hope your chiggers go away."
P-11: (Turning back and smiling): "Me too." (Goes)

Allowable #1a: It is allowable for the nonsick to not request details about a sick person's statement of complaint.
Allowable #1b: It is allowable for the nonsick to describe their problems in detail to the sick.

This pattern of selective listening or selective participation in conversations with the sick about feeling badly seems so strong that even the sick do not pursue the response of the sick to "How are you," particularly if it is negative. The exception to this is when patients are on the machine, and again specific responses are sought:

P-10: "You look better than Friday."
P-6: "I know. Friday I was sick."
P-10: "I know. I know."
P-6: "I was sick."
P-10: "I know, I know."
P-6: "God knows, today I'm not feeling so swift."
P-10: "But Friday you were looking bad."

It appears that the two major concerns addressed by staff when they ask a patient "How are you?" are (1) What apparent physical sensations are you experiencing? and (2) Do you need help? These questions are variously related and often juxtaposed as will become apparent in the discussion of category #3 (Subjective/Objective).

What is particularly interesting about the first concern ("Tell me what you feel") is that for me to ask "How are you?" means that I do not know. Implied is that you are privy to some information that I can obtain only through you.
Hypothesis #2: Medicine at times is a cooperative venture.

Category #3

SUBJECTIVE/OBJECTIVE

Properties: These interactions are characterized by the use of, and the request or search for, readings from "objective" measuring devices (blood pressure, scales, EKG's, blood tests, etc.) and/or statements of the patient's subjective feelings. More often than not, a comparison between them is sought and/or implemented.

Summary: If staff wish to evaluate a patient's present condition ("How are you?") or when staff intervention is thought to be required ("Do you need help?") , what is sought most often is a comparison between the implications attached to the readings of the measuring devices and how a patient describes his/her subjective experience. Both appear to be used cooperatively to come to some working conclusion about how to proceed.

As suggested in the summary of Category #2, it is likely that there is information that can come only from the other person. The importance of the subjective contributions to the proceedings in this setting is seldom
acknowledged, but it is most clearly felt when it is absent.

P-12: Has been asleep for about an hour.
S-7: Seems worried, wakes him, brings over scales and weighs him.
S-7: (To everyone in room): "P-12 would sleep so hard, he'd be a prune and never know it."
(Everyone laughs).

Losing too much weight while on the machine is potentially life-threatening, and the laughs are hesitant. Implied in S-7's statement seemed to be a concern that if the patient remained asleep (not alert), not only would he or she be unaware of the impending danger, but the staff would be as well. In terms of what is likely to happen, patients who are in trouble and asleep usually wake up before they seize, but this sequence gives staff very little warning and, consequently, very little time to react. Patients' alertness to what is happening to them appears to be considered useful information, and is indirectly acknowledged as important. This contention is supported more substantially by the implications of Category #8 (Reminder of Limitations).

However, as helpful as subjective information is considered to be, interesting patterns emerge when there is a mismatch between it and objective tools' interpreted readings.
Pattern #2: When there is a mismatch, previous experience of the staff is included as a factor--often the deciding factor.

Allowable #2: It is allowable to employ experience as a valid source of information.

Pattern #3: When objective experience suggests a problem but a patient says there is no problem, the nurse will administer treatment for the problem. For example:

S-3:  "Hot?"
P-1:  (Waves hand as if no trouble).
S-3:  "I just gave you something." (Gets a compress and puts it on P-1's head).
P-1:  (Groans as if to say, "This is unnecessary").

Or:

S-1:  "Ready, Jen?"
P-4:  "I guess."
S-2:  "You could stay for a while . . . with all that weight on."
P-4:  (No response).
S-2:  "You really could stay for a while."
P-4:  (No response).

Allowable #3: It is allowable to make treatment decisions on the basis of numbers read from measuring devices.

Pattern #4: When a patient suggests that there is a problem, but objective measures imply differently, no treatment will be given or initiated;
(During take-off procedure)
S-2: "Get weighed?" (Being close to target weight is one of the indicators of a good dialysis and stable patient.)
P-3: "Don't feel well."
S-2: "Sit there 'til you feel better. No rush."
(Goes and busies herself with machine . . . returns to help P-3 stand as he is apparently having difficulty with his legs.)
(After weighing, patient still feels badly. S-2 walks away to do other things.)

Allowable #4: It is allowable not to implement treatment in response to someone's expression of discomfort if there is no apparent "objective" corroboration.

Hypothesis #3: The implications of objective measures and/or staff experience take precedence over patients' subjective expressions.

Relational implications: In pursuit of understanding "How are you?," how you feel is less important than how I (staff with tools) judge you to be.

Category #4

VIGILANCE

Property: Interactions that indicated extended awareness beyond what immediately occupied attention. Such behavior was often accompanied by inquiries (direct or indirect) into the nature of the behavior observed or
intrusion into the discussion overheard or decision being made. For example:

(S-4 and S-5 discuss methods of setting up albumen treatment on P-8.)
S-2: "That's how we did it last time."
(S-4 and S-5 continue.)
S-2 (Repeats): "It worked."
S-4: "Did it?" (Looks at S-5.)
(S-4 and S-5 drip it from the bottle as S-2 suggested.)

Summary: It appears a dialysis unit is a perpetually monitored zone. Not only is verbal and nonverbal behavior accessible to all in the room, what is said and done is constantly under surveillance.

This vigilance can be characterized in two ways. Its routine form involves periodic inquiries:

S-3: "You okay, Bobby?"
P-1: "Um hmm . . . ."
as well as responses to known stimuli. For example:

S-4 is on the phone
P-8's machine beeps
S-4 notices beeping and instructs P-8 as to how to stop it.

Or:
P-3 throwing up--no one notices
S-3 looks up and over at P-3--says nothing, seems unconcerned. Goes back to working on taking P-4 off the machine.
P-4 is known to make noises like that without being in distress.

Its extended form is characterized in the interviews as an awareness of behavior. From the episodes it also appears
to be a consciousness of the discrepancies which take the form of either changes in behavior, (i.e., characteristic behavior):

P-17 leaning over knees as if in trouble. Noticed by S-4.
S-4 goes over and asks if okay.
No response
Gets blood pressure cuff.

Or:

P-8 walks to scale.
S-7 makes a face.
S-4: "What's wrong?"
(No verbal response.)
S-7 to P-8: "What's your weight?"
P-8 tells weight.

and/or awareness of independent behavior (i.e., unexplained behavior). For example:

P-18 walks out of back room.
S-1 (Half playfully, half threateningly): "What were you doing back there?"
P-18 (Pauses): "I just got a shot."

Or:

P-7 walks out of back room working intensely at something.
S-4: "Sam, what are you trying to break?"
P-7 keeps working with pliers and clothes hanger without replying. S-4 continues to watch.
S-7: "He's making a plant hanger."
(S-4 stops being occupied with it.)

Or (a few minutes later):

S-4: "What's he doing, that's what I want to know."
P-6: "Making hangers for plants."

There were no reciprocal inquiries by patients of questioning staff movements or challenging their behaviors
during the observation, though there were points at which patients extended permission to visitors to move freely. Free movement seems to present some form of challenge which requires permission:

A salesman follows S-1 into unit from outer office to talk to S-2. As he discusses the advantages of his blood pressure cuffs, he moves to a cuff hanging on the wall, then stops.

Salesman: "May I?"
S-2: "Certainly."

Allowable #42: It is allowable for certain people in certain places to challenge others' independent behaviors.

This began to suggest the justification for both the challenge and the hesitancy centered on the concept of property, (i.e., the issue of ownership.)

In conjunction with the idea of ownership, the various degrees of involvement by staff (open challenge) and patients (extending permission) suggest the usefulness of a concept of levels of ownership. Neither staff nor patients legally own the suite or anything in it, but in relation to each other and to total strangers, they exhibit behaviors suggesting varying degrees of territoriality. And in the presence of the doctors (the real owners), even the staff began to monitor and restrict their own movements.
Allowable #41: Unver certain circumstances, it is allowable to act as if you own something when, in fact, you do not.

Allowable #43: It is allowable to respond to those challenges as if they were legitimate.

The persistent exception to this was the unchallenged patient initiated behaviors which were of immediate and recognizable assistance to staff. This suggests another potential explanation for the challenges to some and not other independent behaviors.

Hypothesis #4: One of the mechanisms for maintaining an "organization's integrity" is to challenge independent behavior and thereby, perpetuate and promote expected designated behaviors.

Hypothesis #5: Challenging independent behavior is a means of socialization.

Category #5

PROBLEMS/SOLUTIONS

Property: This category is characterized by interactions that involved the recognition and definition of unresolved issues. For the staff, it focuses on issues of how to proceed, and attempts to define "just what the
nature of the disturbance is." For patients, the
questions are basically the same, but the search is for
people who have information rather than answers to the
unresolved questions.

Summary: The most poignant description of the
plight of patients are the words of a blind diabetic in a
long conversation with her husband and the social worker
while she was on the dialysis machine. She is P-2a, her
husband is P-2, and the social worker is S-8:

S-8: "Did you ask why?"
P-2a: "We tried."
P-2: "They get their back up."
S-8: "I know that . . . I know that . . . In
the end you have to say, 'I won't have it
[i.e., the test].'" . . .
P-2a: "I would have if I'd known what he was looking
for. I don't think he [the doctor] knew. I
don't understand what's happening."
S-8: "You need to know what your questions are and
keep asking until you get answers. (Pause)
Some doctors won't be cooperative."
P-2a: "You can ask, but it's like he doesn't know
what going on either."
(P-2 talks about something.)
S-8: "I think you're right. Business does
contaminate the service. Beyond that I think
you can carve out some kind of care that
you're pleased with."
P-2a: "... hard to know what to do until you've
been through it." . . .
S-8: "But if you refuse, the patient can't be
forced to do it. Say to the doctor, 'You
might be right. Thank you for telling me why.
But I refuse.'"
P-2a: "You figure they know more than you know."
P-2: "You need to trust somebody."
(P-2a explains the conflicting information.)
(S-8 explains again that patients do have a choice.)
P-2a: "Yeah, well, I don't know . . . there is a
problem."
S-8: "You're just trying to be responsible. How about if I give you information on patient groups--give you names of representatives. Would that information help you?"

P-2: "We'll have a big meeting with everybody there."

P-2a: "Big problem--there's no one person."

S-8: "Ultimately, there has to be."

P-2a (Laughs): "But how do we find them?"

The underlying questions seem to be who knows what's going on, who is responsible, and how do you find them?

For the staff, the problem is the opposite. Interactions tend to indicate it is the nurse who is considered, and expects him/herself to be, "the problem solver"--the source of the answers.

Pattern #5: Patients tend to present staff with the raw material of problems rather than solutions even when it is not necessarily within the nurses' abilities to control or when the patient can easily learn to make the same correction. For example:

(A machine is beeping.)
P-8 thinks it is hers and adjusts the dials as before. Smiles as if proud of herself.
S-4 looks over.
P-4 machine beeps and she says: "I didn't do it."
S-5 walks over to adjust the machine.

Or:

P-7: "It's hot in here."
P-8: "Think it's hot?"
S-4 (sheepishly): "It was cooler this morning."
Allowable #5: It is allowable to expect others to provide solutions.

Pattern #6: Both patients and technicians tend to present problems and solutions hesitantly. For example:

S-5: "Which one do you want to set up?"
S-4: "Either one. The machine has to be turned?"
S-5: "I don't know them well enough." (Looks at something; asks) "Right arm?"
S-4: "Either one. It doesn't matter."

Allowable #6: It is allowable for some to venture opinions cautiously.

It is difficult to tell which came first, "Nurse as problem solver," or others absenting themselves from the decisions. But no matter what the order, these behaviors seem to reinforce each other. In the interviews, this "need to be the one who knows" was described by an RN as important both as an issue of safety and as a source of reassurance to patients. It also creates for staff a considerable amount of pressure to know, and discomfort when they do not know. This results, as described in the interviews, in a struggle to appear as if they knew what to do or what was wrong, even when they did not. For example:

P-2: "Can I ask a question?"
S-3: ". . . so busy gabbing . . . ."
P-2: "I know." (Continues to ask question.)
(S-3 hesitates.)
P-2: "Come on--you're an advanced graduate."
S-3: "Well—coat line with heparin."
P-2: "Well..."
P-2a: "All I can say is if I need to use gelfoam, someone's in trouble."
P-2: "What causes venous pressure to go up?"
S-3: "... might be... and...
(unintelligible)."
P-2: "I know how to do that."

Or:

S-7, S-4, and S-5 are all facing each other; they discuss a question raised by P-8.
S-7: "They go by her chemistry. Doctors give orders, we can't just change it."
(S-4 and S-5 go to P-8's machine and talk to her about it.)
S-7 repeats what she has said earlier.
S-4: "Be careful about what you eat. Eat when you should on your diet."

Allowable #40: It is allowable to act as if you know something as long as you don't claim to know (when you're not sure).

Allowable #46: It is allowable to promote solutions and answers over questions.

During the observations attempts were made by the social worker to argue in favor of an increase in the level of patient participation in the decisions and solutions sought. But no matter how eloquently argued, the change in behavior is feared by both patients and staff.

S-8: "That's not a complainer. You're becoming an advocate. I saw you do it. I think you are an advocate."
P-2: "Well, I'm not going to change."
S-8: "You mean you'll become a better advocate."
P-2: "Maybe there's more to this than everyone realizes."
S-8: "I agree, and you all as patients can do something about that--write a letter. Their power are their numbers. I see that as your group. You have to get organized. Talk among yourselves. I'll help you organize.
P-2: "See what happens."
S-8: "Okay." (Walks away.)

As stated in the properties, the focal point of problems/solutions is how to proceed and how to define the picture. What tends to be presented and pursued in response to this search is Information (Category #6) and Explanations (Category #7).

Category #6

INFORMATION GIVING

Property: Interactions are characterized by both inquiries and statements that dictate what to do (actions) or describe occurrences that are taking place or that have taken place.

Summary: One of the characteristics of information giving is that it can be handled routinely.

P-6 has eyes closed.
S-5 takes blood pressure.
P-6 still has eyes closed
S-5 finishes with pressure and says something to P-6.
P-6 opens eyes.
S-5 walks to machines.
P-6 puts chair back,
as if what to do and what is happening are understood, or non-routinely where the exchange is a series of questions/answers in pursuit of a picture.

It is possible for both to come into conflict as well:

S-5: "Which one do you want to set up?"
S-4: "Either one. The machines have to be turned?"
S-5: "I don't know them well enough. (Looks at something and asks) Right arm?"
S-4: "Either one. It doesn't matter."

Setting up machines is a routine event in a dialysis unit, and yet, S-5's question about what to do is challenged by S-4 and her understanding of picture (i.e., how the machines need to be arranged). Suggested is that the abstract picture of what ought to be takes precedence over the issue of what to do (i.e., what to do depends on the picture).

Defining the picture also appears in a more limited form, asked or stated as "Is this or that the case?"—the case being a smaller piece of the picture. For example:

(Phone rings and P-7 answers it.)
P-7: "Is S-1 here?"
S-7 and S-4: "No."
(P-7 finishes conversation and hangs up.)

Unlike explanations, information giving tends to openly acknowledge available options, however, requests
for information can be a search for an explanation.
Category #7

EXPLANATIONS

Property: Interactions which present causes or evaluative interpretations are explanations. Often they are a response to an unasked or unresolved questions or an exchange that would remain uncomfortable without some clue as to why the exchange or the issue is being pursued in this manner. For example:

S-2 (giving P-4 normal saline solution): "Don't want you driving if you don't feel well."
(P-4 just looks at her.)
S-2: "Get up when you feel like it."

Summary: Explanations are most often in sequential conversations (Category 16--issues raised and reraised over time) which suggest they may be responses to unresolved or at least presently unresolvable issues. It is a response more frequently used by staff than patients.

What repeatedly accompanied patient inquiries about how a patient in the hospital was doing was the staff response "Not well" or "She's not likely to be back" and then almost invariably, without prompting, the staff would attach an explanation implying the probable causes for the patient's present condition. There were multiple questions about Duffy, a patient who was in the hospital
when we came, and had not returned at the conclusion of observation.

Allowable #32: It is allowable to talk about people when they are not there.

When staff were questioned by patients about how Duffy was, they answered, "not well," and then immediately followed the statement with an explanation, "What do you expect at 82?" This explanation was only and repeatedly used by staff. Even when staff themselves ventured beyond explaining into the more individual/personal reasons for his decline—statements like "discouragement that he was unable to do what he used to" (which in itself is a dangerous quality of life argument overused to explain why death is desireable and good)—and "It's too bad he couldn't have done better longer" receive little or no comment. It may be argued that understatement can be a powerful indicator, but the persistent lack of response to these expressions of feeling is enough to question the effect.

Explanations are not the same as solutions, though they may often be used as if they were. Like citing Duffy's age, they are employed as if they remove lingering questions which in reality remain since causes are not
always known and often only suspected, and evaluative statements are judgement calls, as well.

It is important enough to repeat that explanations, unlike information, tend not to acknowledge alternatives openly so they are usually presented as "the cause" rather than as a "possible cause." Used this way, obscuring questions that might be usefully pursued, they have the potential in a medical setting to short circuit inquiries into causes.

Hypothesis #6: Explanations are employed as a response to an inability, momentary or otherwise, to understand what is happening.

Hypothesis #7: Explanations can obscure the pursuit of causal questions.

Category #8

REMINDERS OF LIMITATIONS

Property: Interactions tend to highlight what one cannot do, cannot have, cannot prevent, and cannot help.

Summary: These interactions seem to be initiated predominantly by staff. However, when the circumstances arise, reminders can be directed toward staff and patients without any apparent discrimination. It is the
circumstances that prompt the use of these reminders of limitations that are intriguing.

Pattern #7: If a statement is made by a staff member or patient about feeling reassured, they will immediately be presented with a reminder of a limitation.

For example:

S-2 (Doing paper work--coping chemistries for P-1): "It's nice to see something work."
Researcher: "Is someone getting better?"
(S-2 explains that P-1's blood count was down, she was given Deca D and her count went up.)
S-2: "Oh."
S-7: "What?"
S-2: "P-1's protein is down, but her BUN is back to what it usually is."
S-7: "I told her to be careful of her potassium level."
S-2: "That's right. This is the season that P-1 eats high potassium foods."

Or:

S-5 walks up to machine while writing on chart.
P-10: "How is it?"
S-5: "34."
P-10: "Holding steady."
S-5: "You haven't aged a bit."
P-10: "Didn't you know I'm ageless?"
S-5: "Yeah, let me know how." (Walking away.)
P-10: "I wouldn't recommend dialysis."
(S-5 stops to listen and meets P-10's eyes smiling.)

Allowable #7a: It is allowable to attempt to undercut a person's feelings of reassurance.

Allowable #7b: It is allowable to undercut a person's feeling of reassurance without warning or explanation.
Allowable #37: It is allowable to be disconfirming.

It would seem logical that the effect of this behavior would be to introduce uncertainty on some level. When people feel uncertain they tend to be more alert. If this is accepted as a reasonable progression then these attempts, in fact, may be a mechanism for keeping people alerted to the dangers of the situation. Theoretically, it is staff who are designated the task of being aware of dangers, so why include patients in this effort? If the contention in Category #2 is correct, that only the patient has certain information, and in Category #3, that subjective awareness is important as a precursor/support to objective evaluative tools, it then becomes important for the patient to remain alert. Again, patients are enlisted in the effort to provide care (i.e., to keep them alive).

Hypothesis #8: One medical assumption is that only if you are constantly wary (worried), will you be alert enough to respond.

Another aspect to this pattern is that the statements of reassurance were made after reading objective measures. As suggested in Category #3,
objective measures are given precedence over subjective statements. But this pattern suggests that not even objective measures are allowed to produce reassurance. What may in fact be happening in this pattern is an acting out of the belief that there is no way of knowing with absolute certainty. This understanding is then reinterpreted and acted out as a prohibition against reassurance and, coupled with the belief that wary patients and staff equal supportive members of the effort, reassurance, no matter how momentary, cannot be permitted.

Category #9

SYMMETRICAL, EQUAL ASYMMETRICAL, AND UNEQUAL ASYMMETRICAL INTERACTIONS

Property: These exchanges frequently begin with a verbal assault (i.e., a one-up statement) and are responded to with an equal response; an equally strong, but non-threatening response; or no response at all.

Summary: Symmetrical responses in this setting tend to be insults and criticism (veiled or open). Not only are they equally aggressive, the statement and response tend to mirror each other in subject matter as well. For example:

P-6: "Go clean up."
P-7: "No."
P-6: "He's like a stubborn child."
S-4: "We could use a pizza."
P-6: "P-7 will get it."
S-4: "I'm only kidding."
P-7: "Do you want it?"
S-4: "I'm just kidding." (Starts washing the counter.)
P-7: "Look at that cleaning. I can't wait to get home."
S-4: "P-7, you're wasting your breath."
P-6: "You're just ignoring it."
(P-7 laughs.)
S-4: "Did you hear, you guys, that it's going to be 100 degrees?"
(S-4 continues cleaning while talking to P-7.)
P-7: "Are you bucking for a raise?"
S-4: "You know I clean every day. P-7, what do you want me to put about you in my book? P-6, what do you think?"
P-6: "Naughty, naughty boy."
S-4: "No change? No change?"

Or:

(In an earlier conversation S-7 told S-2 that she was wrong. Ten minutes later, they discuss P-6.)
S-7: "What did he come off at?"
S-2: "85.5, 0.5 above target weight."
S-7: "His target weight is 68.0."
S-2: "Okay, 68.5."
S-7: "Good. I gave him 700cc when he got dizzy."
S-2: "Yeah, but that related to his heart, not his target weight."
S-7: "Oh . . . ."

This is similar to Gibbs' contention that communication behaviors produce in their wake like behaviors. But potential corollaries emerge as assaults are met with equal asymmetrical or unequal asymmetrical responses.

Corollary to Gibb: Not only do behaviors breed
like behaviors, but some forms need to breed like behavior to continue to exist.

Pattern #8: If the assault is met with an equally aggressive response, the tendency seems to be as Watzlawick et al. (1967) contend, to continue or up the ante. This appears to be true particularly after the attempts on the parts of either or both the participants to compromise have been rejected with another symmetrical response.

A long sequence of conversations between a husband and staff member began with the question, "What are you doing?" It ended after a number of attempts to compromise. After the highest level of spiraling symmetrical responses in this setting, a threat with dialysis tools or procedures was used.

S-4: "I'm talking to old P-7."
S-7: "I heard that 'old P-7--put that in the book: Old P-7 was here."
P-7: "Who are you talking to?"
P-7: "She thinks she's talking to you."
S-4 (Holding up a needle): "P-7, I'll pierce your ears."

Allowable #8a: It is allowable to respond to aggression with aggressive behavior.

Allowable #8b: It is allowable to increase the level of assault if attempts to decrease fail.
Pattern #9: When the assault is met with an equal asymmetrical response it tends to be genuinely humorous. However, its effect on the assault is limited. The response to the equal asymmetrical response is to redirect the assault elsewhere. For example:

S-2 (Cutting and pasting EKG): "How do you do this?"
(S-7 walks up.)
S-2: "I didn't see this."
S-7: "I did."
S-2: "I would have panicked earlier."
S-7 (Smiles and pauses): "But P-8 didn't care."
S-2: "No he didn't."
S-7: "All he cares about is that sometimes his heart goes thump-thump."

Allowable #9: It is allowable to continue an assault even in the face of attempts to defuse it.

However, unlike the two responses above, an unequal asymmetrical response, seems to produce behavior which suggests this corollary, i.e., when a verbal assault is met with a refusal to participate in the conversation in the presence of another, it seems to create conditions which focus attention on the assault and the assailant, forcing a retraction or the end of the assault. For example:

P-3: "What time is it?"
S-8 (Harshly): "I just told you."
(P-3 makes no response.)
S-8: "Huh Robert" Huh, Robert?"
(P-3 makes no response.)
S-8 (Quietly, with half a laugh): "I'm not very nice am I?"
An asymmetrical response is not the same as a complementary response to verbal assault. Though they both may stop the assault, it is on a different basis. A complementary response tends to reinforce the assault as an effective technique, while no response forces the assault to stand alone with nothing to pair it off with—no match, no balance.\(^8\)

Category #10

"THIS IS SERIOUS"

Property: These interactions have two distinct characteristics, both of which focus on behavior rather than content. One form they take is the persistent verbal pursuit of an issue. The second is characterized by the acting out of a serious demeanor (absence of playfulness and a tense, calm, alert, but waiting posture):

(P-8's heart is beating very irregularly.)
The staff are aware of it. A discussion in the outer office away from the patient was characterized by a sarcastic comment: "16PUC's--that's nothing" (nervous laugh).
Back in room where patient is all staff are working on setting up for the next shift of patients. They appear to be in no rush.
No one looks at P-8.

Summary: The issues that are most serious in this setting are those which threaten life.
Pattern #10: If something is considered serious but not immediately life-threatening, the behavior of staff is relentless verbal pursuit. It is routinely obvious in discussions of medicines and diet. For example:

S-2: "Amphagel--how much are you taking?"
P-3: "You said eight, S-2."
S-2 (Irritated): "But are you taking them?"
S-2 to S-8: "They think his key problem's its cause of phos."
(S-2 and S-8 discuss phosphorous and its effects on nerve condition.)

Allowable #10: It is allowable to ask the same question over and over if it is for a good cause.

Pattern #11: If, on the other hand, what is happening is immediately life-threatening, instead of pursuing the issue verbally as before, staff literally act out the seriousness of the situation.

It is as if they have gone on military alert. They become quiet, tense, and waiting. It appears to be a functional alertness though there is an accompanying rigidity which approaches emotional catatonia. Staff tend to appear calm and make absolutely no eye contact with the sick patient. As observers entering mid-problem, it was impossible to tell from the staff's behavior who the sick patient was. Even later when the sick patient joked about
how he was going to proceed, staff remained alert, listening, but participated on a limited basis:

S-2: "Do you want to call your wife from here and tell her."
P-18: "No, I'm going home first and then they can mess with me. Not old P-18. He's filling his belly before they get him. (Pats his belly.) I got me a half dozen crabs at the store and I'm going to have them. Then I'll go."

(S-2, S-6, S-4, S-1 give no response. Noticeable pause.)

S-2: "After you get really feeling bad." (Looks away.)

(P-18 kids some more with no response from staff.)
P-18 (Walking toward door): "Have a good weekend."
S-2: "You, too."
P-18: "I will." (He leaves.)

S-1 to S-2: "Do you think he'll go?"
S-2: "After he goes home and eats something."
S-1: "Men are so stubborn."

Allowable #lla: It allowable to act out the appearance of calm in a crisis.

Allowable #llb: It is allowable to reduce the variety of interactions to a minimum in a crisis.

Allowable #llc: It is allowable to reduce responses to a minimum in a crisis.

In fact, the only person who would respond was another patient who chuckled and peeked at him, something no one else had done.

Quasi-hypothesis: One way to know you are really sick if you're in a medical setting is to observe that no one will make eye contact with you.
Hypothesis #9: People who are perceived to be dying are treated as though they are almost invisible—as if they were already dead.

Pattern #12: Dying and death are serious and require different behaviors than usual.

Allowable #12a: It is allowable to not respond or initiate humor around dying people.

Allowable 12b: It is allowable to not make eye contact with a dying patient when talking to them and to minimize it with others in the vicinity.

Research question: Is humor considered inappropriate in the presence of the dying. With what effect on the dying?

Category #11

LIMITING RESPONSES

Property: These interactions are characterized by attempts to interact (i.e., statement, questions, comments) followed by one of three responses: (1) no response at all; (2) a response only if a new topic is raised; and (3) a response which indicates inability to proceed, usually a logically inappropriate response.
Summary: No response is an unwillingness to participate and takes the form of not talking:

S-2 takes P-3's blood pressure, takes off the cuff, folds it and puts it on the desk. S-2 then goes to P-1, takes cuff off, puts on P-3 and takes blood pressure.
P-3 at first continues to snore, then shifts and snoring ceases.
S-2: "Same with both cuffs. I was hoping it wouldn't be."
P-3 is snoring again as she walks away.

Or:

P-13: "Hi, S-71"
(S-7 walks up to chair.)
(S-3 holds P-13's sights.)
(S-7 walks away having made no comment.)
(P-13 closes eyes.)

It appears to result in a hampering of further attempts to interact.

Unlike not talking, the second type of limiting responses are not refusals to interact totally, but are indicators of any unwillingness to participate in the direction the conversation is going.

Pattern #13: Patients often give limited responses to attempted play.

Allowable #13: It is allowable not to respond to others' attempts at play.

Pattern #14: Staff frequently exhibit limited responses of feeling even to other staff.
Allowable #14a: It is allowable not to request details about statements of feeling.

Allowable #14B: It is allowable to provide minimal or no response to statements of feeling. For example:

S-1: "He scares me. He makes me nervous when he's so upset--his blood turns dark and he turns gray."

Or:

S-1: "She was 82 years old and had been on dialysis a few months. Her sister was 90... She couldn't garden. All the things she liked to do she couldn't do. It is so sad. How could you expect her to do well? It's too bad she couldn't have done better."
(S-3 only murmurs.)

At times, they seem inappropriately limited responses to whatever statement was made:

P-5 is leaving and stops at P-3's chair to touch his shoe.
P-3 is apparently not feeling well and has recently been gagging. Asks how P-5 was.
P-5: "Best can do."
(Not much response from P-3.)
(P-5 signals "good," and exits.)

At other times, they appear appropriately limited:

P-6: "It's starting to ease up a little."
S-2: "Sitting here in neutral doesn't do a whole lot."
(P-6 leans back in chair.)

Again, they are merely a lack of pursuit of the issue raised, not a refusal to interact. However, they tend to cause disturbances in the flow of conversation. These
disturbances tend to force a new direction of the conversation is to continue.

An exception to this seems to be in routine behaviors:

P-6 has eyes closed.
S-5 takes his blood pressure.
P-6 keeps eyes closed.
S-5 finishes blood pressure and says something to P-6.
P-6 opens his eyes.
S-5 walks to machine.
P-6 puts chair back.

This suggests a potential communication signal for routine behavior. That is, one sign of routine behavior is limited responses which cause no apparent disturbances.

The third limiting response is best categorized as ignoring the obvious. It represents neither a total nor limited refusal, but an inability to continue. The disturbance to the conversation is quite observable and usually takes the form of an inability to understand what was said, or a logically inappropriate response, and seems to occur frequently when the response received was unexpectedly inappropriate. It appears to require some form of translation if the conversation is to continue.

For example:

P-10: "P-6, we're holding a contest on this newsletter."
(P-6 looks up from newsletter.)
P-10: "The one who finds the most mistakes wins."
P-6: "I think, you."

"
P-10: "I'll tell you later."

These, like Category #14, seem to represent both intentional and unintentional conversation steering mechanisms.

Category #12

DISTANCING

Property: These are interactions within which participants literally increase the physical distance between them or conversationally increase relational distance.

Summary: Physical distancing is usually a spontaneous move. But, in an environment where one feels obligated to stay, neither staff nor patients maintain attempts to increase physical proximity:

P-5: "It was infection that killed him . . . the medicine."
S-2 (makes no eye contact with P-5 and turns away from the machine): "That's the way it is."
(Moves quickly to the sink--now ten feet away rather than one foot away): "Immune suppressives do that."
(P-5 looks up sheepishly and nods understanding.)
(S-2 moves back to machine next to P-5 and continues working at machine again, but facing machine not patient.)

The distancing that is maintained over time is relational distancing. The dialysis unit is a setting in which RN's appear to be seeking different relationships
than patients. From interviews, it appears that the relationship sought with patients by RN's is not an intimate one, "certainly not family." One source of this is a dictum-laden fear of getting too close to patients. It was a repeated statement in the interviews that "in school, you were told you had to protect yourself," which is clearly difficult in a setting where "you see them [patients] more than your family" and collecting personal information about patients is considered necessary to understanding what is happening physically. In fact, it appears that staff know more about patients on a personal level than is obviously observable in the unit where, in front of patients, they tend to discuss patients by their chemistries, dietary indiscretions, and other dialysis-related behaviors.

On the other hand, patients (and apparently technicians as well) speak in a way that suggests they have fewer prohibitions against forming attachments. "We're like family" is a reference to a form of relationship where the commitments are life-long, which on one level represents the truth of the matter.

The topic of relational distancing when discussed by the staff in the interviews was closely and openly allied with the issue of sickness. Underlying statements
Like "These people are sick" are issues of death and the pain of loss. In fact, it appears as if pain of loss has been reinterpreted to mean the pain of caring too much. In reality, though related, they are not exactly the same issue. One can be afraid of losing someone and still care. But to feel that "caring too much" is the source of the problem is a dictum for implementing relational distancing.

It appears that there are a number of interactions characteristic of this setting that alone or in conjunction might discourage the formation of deep personal attachments between staff and patients. The primary relational distancing mechanisms are as follows:

1. symmetrical play (Competitive)
2. reminders of limitations ("hitting the sore spots")
3. repetitive conversations (stalled)
4. alliances (when the primary one is staff to staff)
5. limited response to expressions of feeling (limited sharing)
6. inclusion/exclusion (promoting and distancing)
7. schooling (in fear of being too close)
Hypothesis #10: In response to fear or fear-producing situations, physical distancing will decrease as relational distancing increases.

Category #13

ATTEMPTED PLAY

Property: These are symmetrical interacts usually accompanied by some disclaimer (smile, laugh, averted eyes, change in tone, etc., that it is not meant to be taken seriously).

Summary: This is the only category where participants' comments were in direct opposition to the researchers' interpretation of what was observed and analyzed. With one exception, both interviewed staff and patients characterized the behaviors designated here as "attempted play" as positive, helpful, and necessary. Patients' description of these symmetrical interacts characterized them as a diversion from an otherwise thoroughly depressing situation. For staff, this "kidding" was a useful response to boring routine, improved the atmosphere, and jogged patients from their depressions. The one exception to this description came from a patient whose demeanor was quiet and who tended to observe and seldom, if ever, participate. His response,
when asked about the kidding was, "... at first it gets on my nerves, but you get used to it."

In opposition to this overwhelming positive participant interpretation, a closer look at the dynamics suggests that more is going on. It is true that the interactions involved in attempted play are the main conversational exchanges outside of questions and answers and sequential conversations. In that sense, they may, in fact, be welcome and serve on a relational level of contact. But the seriousness of the topics, the symmetricality of proceedings, and ultimately the effect on those who do not participate suggest that an unqualified acceptance of the majority perspective is not realistic.

The issues raised in the "kidding" are topical and serious for both staff and patients. Staff to staff pursue topics like lack of support, fear, fellow stumblings, and panic. Staff to patient kidding includes ridicule, threats with procedures (keeping someone on the machine, sticking with needles), reminders of limitations (i.e., age, limited freedom), requests to stop demanding so much and "For God's sake, don't get sick." Patient to staff kiddings tend to be about pain, mistakes, ineptness, and seem to raise the questions "Are you hurting or
helping?," "Are you skilled or inept?," and "Will you be there when I need you?"

The method, as stated before, tends to be predominantly symmetrical:

S-1: "Fathead Ed [P-1]."
(P-1 signals fat and points to his behind.
(S-1 doesn't understand.)
(S-3 translates, smiling.)
P-4: "That's not the half of it."

Or:

P-4: "How's the socks?"
P-2: "No holes today."
P-14: "That's cause he's with his sister. When are the chili dogs going on sale?"
P-2: "Maybe July"
P-14: "That's cause the roof leaks."

which is a "hard ball" way to be playful and which might tend to be relationally distancing and, in that sense, helpful and necessary to the dictum about not caring too much.

Pattern #15: After an apparent bout of playfulness, one of the participants will ask the other for a favor.

Allowable #15: It is allowable to request a kindness after a competition.

This form of interaction seems to have a profound effect on those who do not participate. It becomes clear from the interviews with staff that patient participation
in "attempted play" behaviors is not a neutral issue. Active participation by patients is interpreted by staff as a signal of patient improvement, adjustment, acceptance of their condition; while lack of involvement is considered an inappropriate affect. As a result, nonparticipating patients have less contact with staff and are more easily overlooked: For example:

P-19 is one of the very quiet people. Doctor is making rounds. P-19 looks interested as doctor approaches. Doctor: "P-19, you're okay." (Does not look at P-19). Phone rings and doctor leaves to take the call and never returns to P-19.

Or:

S-3 answers telephone and takes message. She turns and walks toward P-3 but stops halfway there. (Loudly): "P-3, that was your mother, again. She called to remind you that after you're done, she's at your grandmothers." S-3 returns to position prior to phone call. P-3 makes no discernible reply.

Allowable #35: It is allowable to treat people who do not/choose not to participate in characteristic cultural behaviors differently from those who participate.

Allowable #36: It is allowable to label nonparticipants as maladjusted.

A person who chooses not to participate also runs the risk of being judged maladjusted (a relationally distancing label just shy of insane). The relational
message is that "you will participate when we want you to do so." But the bind for nonparticipants is not just that they may be labeled. Since speaking in this setting is automatically public, and public behaviors are targets of opportunity for playfulness, there is a potential bind for those who find this form of play undesirable.

Bind: One cannot speak without participating and one cannot remain silent without becoming more invisible. Under these circumstances, it is difficult to know how to help oneself.

This approaches a double bind when the apparent realities of staff's pursuit of relational distancing are added. For even if you do participate, you are not assured of the relational commitment.

Bind: If you do not speak, you will be subject to relational distancing; if you do speak, you'll be subject to relational distancing.

Category #14

FOCUS/REFOCUS

Property: This pertains to the introduction of a new topic or a shift in emphasis as a response that
appears to alter the direction of behavior, conversation, and/or attention.

Summary: The introduction of a new topic or new emphasis to a conversation can have a profound effect.

Pattern #16: Focus/refocus can stop behavior:
  \[\text{S-1: } "\text{I want to stick this (a needle) right in you} \quad \ldots \quad "\]
  \[\text{P-7: } "\text{You'll stick yourself. Better watch what you're doing. I watched you."}\]
  (S-1 laughs, rolls back.)
  (P-7 jokes about something related.)

Allowable #16a: It is allowable to change the subject without warning.

Allowable #16b: It is allowable to try to stop behavior by redirecting someone's attention.

Pattern #17: Focus/refocus can confound the issue and temporarily side-track intended behavior:

  \[\text{P-6: } "\text{P-7, get your work done?"}\]
  \[\text{P-7: } "\text{Uh-huh."}\]
  \[\text{S 4: } "\text{P-7!}"\]
  \[\text{P-7: } "\text{I cleaned the plants. It's on the floor. She won't tell me where the broom is."}\]
  \[\text{S-4: } "\text{P-6, he left plant debris all over the floor!"}\]

Allowable #17: It is allowable to try to confuse someone by changing the subject.

Pattern #18: Focus/refocus can change the
direction of the conversation.

S-5: "Well sure, you're off and running. Don't go too far--the bloodlines are short."

(P-9 says something while reading.)

S-5: "You're welcome."

Allowable #18: It is allowable to attempt to influence the direction of the conversation you are participating in.

Oddly, this is the underlying mechanism in both reminders of limitations and reassurances. It is also clear that it is an occurrence that confronts staff members perpetually in this setting, altering the direction of and demands for behavior changes. These communication behaviors, like limiting, symmetrical, equal asymmetrical, and unequal asymmetrical responses, suggest the concept of a steering mechanism for directing and redirecting communication.

Category #15

INCLUSION/EXCLUSION

Property: These are interactions characterized by attempts to enter an established conversation.

Summary: This category seems to pivot on two ideas: (1) interrelational behaviors which imply
distinctions, and (2) the specific distinctions of private and public.

Allowing a person to participate with or without resistance is potentially an interrelational mechanism for maintaining a distinction between people. In a conversation between staff members the patient who was just talking to the central figure in this episode is forced to struggle to be accepted as a contributing member and basically never succeeds:

S-1 to S-2: "Do you think apartment insurance is a good idea?"
S-2 (Nodding): "Yes."
P-5 (Who has been talking to S-1): "Good idea."
S-1: ". . . all my clothes."
S-2: ". . . your clothes are worth a lot."
(Teasing.)
(S-1 makes no verbal or facial response.)
(S-2 looks down and away.)
S-1 to S-3: "What do you think?"
S-3: "The apartment's not in my name."

Allowable #32: It is allowable to talk about people when they are not there.

Pattern #19: Patients permit staff members to enter conversations unchallenged.

Allowable #19a: It is allowable to enter some conversations after they have been initiated.

Allowable #19b: It is allowable to enter some conversations without having been invited.
Pattern #20: Staff members tend to exhibit either limited responses or no responses to patients' attempts at inclusion in an established conversation.

Allowable #20: It is allowable for some people to challenge others when they attempt to enter some conversations.

Pattern #21: Patients' attempts to enter conversations between staff members are infrequent and made hesitantly.

Allowable #21: It is allowable not to challenge other people's behaviors or to do so hesitantly.

If the mechanism for creating the perception of a distinction involves behaviors of inclusion or exclusion, one distinction being promoted is that between public and private.

On one level, public/private is a distinction which hinges on the issue of sharing. That which I know and will not tell you is private. It is a distinction not easily maintained in this setting for everyone can hear most things said and see most behaviors as they are enacted. In that sense, it is a very public place. On
top of that, what often happens communicatively is that private issues are made public. For example:

P-13: "Come on in, Butch."
P-2: "I brought my mother with me."
P-13: "Bring her in."
(A young woman enters.)
P-13: "How come she's so pretty and you're so . . ."
P-2: "Look like my father--the milkman."
S-2: "It's his sister."
P-2: "My unmarried, older sister." (With emphasis.)

Or:

P-6: "Where are your socks?"
P-7: "I didn't want to get them dirty."
P-6 (To researcher): "Put that in your book."

The following episode appears to be a symmetrical response suggesting that switching private issues to public is not always a welcome occurrence.

P-7 (Talking about Swale): "They don't know what did it."
S-2: "They think it was an aneurism."
P-7 (Not looking at S-2, disbelieving): "Is that what you heard?"
P-6: "It's sad to see an animal die."
(P-7 talks more about the horse.)

A further complication is that in this culture, feelings tend to be considered private information, but in this setting, "How are you?" is part of the public domain, creating a logical bind for patients.

Bind: Defense of personal boundaries contradicts the defense of continued physical existence.
Research question: Is there a loss of sense of self with the blurring of lines between public and private?

An aside: The exposure of private information outside medical settings usually occurs in intimate or family relations which may address the issue of the patients' views of staff as family.

Pattern #22: When a previously uninvolved and uninvited person attempts to enter into a conversation already in progress, the original conversation ends shortly after the unsolicited contribution has been made.

Allowable #22: It is allowable to discontinue the interaction when someone enters uninvited.

This pattern may be an attempt to retain some territory for the private domain. This is suggested because the content of the conversations that dissolved did not suggest the existence of an intimate exchange that could not sustain the inclusion of another. It can be argued with some validity that staff behavior against patient inclusion is, in fact, a similar mechanism. Since the information exchanged is basically always exchanged publicly (i.e., within earshot of others), a distinction
(private) can be made by maintaining control over who is included and who is excluded from participating.

The pattern does not seem to need to support a staff/patient distinction to defend a dichotomy between public/private. It is a line staff seem to draw clearly for themselves, and one that appears to be reinforced by another inclusion/exclusion pattern.

Pattern #23: Staff and doctors tend to talk amongst themselves about patients within patients' hearing without including them in the conversation.

Allowable #23a: It is allowable for some people to talk in front of others without including them and without being challenged.

Allowable #23b: It is allowable for some people to discuss a person in front of that person without including them and to do it without being challenged.

Allowable #23c: It is allowable to be the person talked about and make no response.

Allowable #33: It is allowable to talk in front of people as if they were not there.

Allowable #37: It is allowable to be disconfirming.
Category #16

SEQUENTIAL CONVERSATIONS

Property: A series of episodes around a repeated topic are considered a sequential conversation. They are not necessarily consecutive, but are content-related to previous conversations.

Summary: These sequential conversations, like question/answer and attempted play, are a predominant form of communication in this setting.

A pivotal characteristic in these serial conversations is whether they are completed or not completed. Some progress to completion like the following series:

P-4 to P-3 (After weighing): "You got a ride home?"
(P-3 makes a nonverbal response.)
P-4 (As if disappointed): "Oh."
Turned out later that P-3 accepted P-4's implied offer.

(P-4 has been off machine five minutes.)
P-3: "Be with you in a minute, P-4."
P-4: "No problem."

(P-4 walks closer to door, passes P-3's chair and waits.)
(P-3 puts on his brace, tapes site up.)
P-4 to P-3: "Anytime."
(P-3 stands up and follows P-4 to the door.)
P-4 to unit: "See you next Saturday."
Others appear never to be completed and continue to resurface as unresolved issues.

There are also content repetitious conversations which literally repeat the same questions to the same people. When done socially, it is at least relationally inert as in this example where the exchanges initiated by P-13 to P-2 are repeated:

"Is your roof leaking?"
"When do hot dogs go on sale?"
"Do your socks have holes."
to which P-2 (increasingly impatient) replies:

"I don't want to talk about it."
"Some time in July."
"Not today."

When done by staff and directed toward patients about medicine, etc., it is argued in the interviews to be the exercise of a serious function, "informing the patient." Intent aside, the effect of repetitive interactions may well compete with the hoped-for results.

Two sequential conversations are worth noting in detail, the first for the potential pattern it suggests; the second for its topic and persistent recurrence. The first example:

Staff: "Are you okay?"
Patient: "Don't worry."
Staff: "Are you okay?" Are you okay?"
Patient: "Don't worry."
Staff: "Are you okay?"
Patient: "Don't worry. Am I okay?"
Staff: "You're not dead yet."

A patient, after repeatedly being asked how he is, begins to wonder, but his inquiry does not pay off. The second example is a repeatedly raised issue deserving the subcategory "Let me out of here." It is an issue which surfaces for patients about the time to be taken off the machine. It is equally poignant for staff when patients are being put on the machines. The most repeated and prolonged sequential battles between staff and patients focus on the issue of patients' being taken off the machine early. The repeated requests and refusals for early take-off times seem to be followed by extended symmetrical battles suggesting the seriousness of the issue. For staff, the desire to "get out of here" takes the form of impatience with lateness at put-on. In this episode they act out the seriousness of the issue and a willingness to endure the discomfort rather than delay their time of departure:

P-10: "You haven't eaten lunch yet. Go ahead. We're not going anywhere."
S-7 (with emphasis): "We don't want to stay here 'til nine o'clock.

"Let me out of here" is a major concern for both staff and patients.

Allowable #: It is allowable to have repetitious conversations.
Category #17

"YOU'RE WRONG"

Property: This category is characterized by a conflicting piece of information presented in response to a statement by another person. The response challenges the validity of the previous statement. For example:

P-9: "I knew you were pretty, but I didn't think you were good."
S-4: "P-9, you know I am." (Disappointed and more seriously than kidding would indicate.)
P-9: "I guess I did."
(No more is said. No eye contact.)

Summary: It appears to be an exchange which surfaces in response to issues of reasoning, not in response to actions. It tends to be applied to the details of issues, often ignoring or bypassing intent of the statement; but it usually is powerful enough to delay or stop the conversation.

Category #18

SICKNESS

Property: These statement are definitional and are characterized by references to the degree of a patient's illness, and the relationship of those properties to other expectations.
Summary: The comparison of observed communication behaviors around the issue of illness appeared to be saturated by the categories "This is serious," "Distancing," "Fear," "You're not dead yet," and "Supportive behaviors." However, what emerged from the interviews was a related dichotomy intriguing enough to pursue conceptually. This dichotomy has to do with staff perceptions of the degree of a patient's illness. For example:

S-8: "These people are sick." (Said with an emphasis and sadness that focused on the seriousness and life-threatening nature of their condition.)

S-4: "These people aren't sick. (Pause.) Not like people in the hospital. These people aren't sick."

The first perception appears to emphasize a person's apparent proximity to death or at least the distance from some concept of wellness. The second definition of sick seems instead to pivot on the degree of observable and functional incapacity. The first definition is enlisted as an explanation of fear of loss, and implied as a justification for relational distancing. The second was tied to issues of patient dependence and independent behavior.

Taken literally, the dichotomy looks like "They are sick"/"They are not sick," and can be combined in a
question "Just how sick are they?" Left unanswered, it represents the expression of ambiguity about the nature of chronic illness and, by implication, the role that medical personnel play. If proximity to death and severe observable incapacitation are the variables which define sickness clearly, then longer term illnesses where deterioration increases incrementally present an ambiguous circumstance.

Hypothesis #11: Medicine as yet has no clear or functional way of defining the relational implications of chronic illness.

It appears that, in general, patients are considered either too sick to be close to or not sick enough to be taken care of. On a relational level, patients appear to be thought of and treated as if they were seriously ill, while on a functional level they are instructed to behave as if not seriously ill.

Category #9

REASSURANCES ("YOU'RE NOT DEAD YET")

Property: These are interactions where expressed concerns, fears, or negative descriptions of one's own present circumstances illicit the suggestion or the attempted forcing of a reconsideration of the complaint.
Summary: If the observations made in this research are characteristic, reassurances tend to be disconfirming. In this setting, they come in the form

"Look on the darker side:")

S-3 (At P-3's machine): "Feel better?"
(P-1 looks worried.)
S-3: "Don't worry--it's still ticking." (Joking while taking blood pressure. This after having asked him twice if he was hot and giving him a cold compress while "reassuring" him that she had given him something not more than two minutes earlier);

"Look on the brighter side:")

S-2: "How long does it take to check on an air conditioner?"
P-4: "About an hour."
S-2: "Could be worse,"

but, if nothing else, "Look anywhere but where you are looking." If they are, in fact, disconfirming, they too will tend to promote relational distancing. In a setting where feelings of reassurance appear to be considered counter-productive to vigilance, disconfirming reassurances are not illogical. Rather, they may be the intermediate step in behaviors which appear to get progressively more disconfirming the sicker a person becomes. That is, if you say you are fine, your certainty of that must sustain itself against the persistently asked question, "How are you?" If you say you do not feel well, you may find yourself confronted with the reassuring response, "It could be worse." However, if you are
certifiably sick, the relationally disconfirming behavior becomes accentuated as eye contact becomes minimal and responses are limited to information giving.

Category #20

SUPPORTIVE BEHAVIOR

Property: These interactions include behaviors or verbal inquiries, responses or statements, which appear to aid patients or staff at times when assistance might be needed. They include unsolicited assistance as well as apparent alliances.

Summary: What is distinct about this category from "How are you?", "Vigilance," and "Reassurances" is that when the behaviors are highlighted as supportive, they suggest new concepts. One such concept is unsolicited intervention. This appears as a specific form of including oneself in the flow of events in an effort to identify and provide aid at specific moments and points. The majority of staff assistance is provided in this way, where the identification of need is the result of staff overture. Unsolicited assistance tends to be predominantly a staff behavior. Though patients will respond genuinely and immediately to any request for assistance, they seldom offer it without permission. The
second concept to emerge was the existence of alliances, the strongest of which appears to be a staff to staff alignment.

Pattern #24: Attempts by patients to gain support of one staff member against another, even in symmetrical play, are usually met with no response. For example:

P-7 (Holding a piece of tape): "S-5 put this on S-4."
(S-5 does not respond.)
(S-4 is at sink.)
P-7: "Come here, S-4."

Allowable #24a: It is allowable to attempt to construct alliances.

Allowable #24b: It is allowable to refuse to reply to or comply with a request for alliance.

The second strongest alliance appears to be patient to staff.

Pattern #25: Patients tend to align themselves with staff over spouses. For example:

(From the sequence about the plant hangers.)
P-6: "He [her husband] is like that at home. Tell him he made the mess--clean it up."
S-4: (That's what I was thinking.)

Further, they tend to reject offers of alignment from other patients if it suggests a challenge to staff:
P-10 (Walking in late): "I'm here, I'm here!"
S-4: "You're late."
P-9 (Joking): "We can't have this."
(P-10 makes no response.)
P-9 to P-10: "Hi,"
(P-10 makes no response.)

Allowable #25: It is allowable to align oneself with the one who can save you even if it flies in the face of social convention.

Staff complained in the interviews that the ultimate alignment is between patients and doctors:

P-12: "Doctor didn't come in today."
S-3: "You didn't miss much."
P-12 (Laughs): "Oh, Dr. McCafferty's okay."
S-3: "I know."

and that patients cannot be depended upon to support staff efforts to challenge doctors even when it would benefit the patient. What is remarkable is that in spite of these alliances, patient spouses, and staff, when pushed, identify their primary loyalty as belonging to patients and patient care.

Category #21

FEAR (A Subcategory of Distancing)

Property: This category is characterized by interactions which include the topic of fear or in which distancing behaviors are produced, evident, or requested.
Also included are interactions where distancing behaviors produce expressions of discomfort.

Summary: Fear as a topic of discussion is limited. If it is discussed, it is raised among staff or among patients, but it is seldom discussed between the two groups. "They do not allow you to be afraid here" was one patient's description of how the staff are reassuring. The relationship between distancing behaviors and fear is distinctly different for the sick and nonsick.

Pattern #26: In the nonsick, fear producing distancing behaviors toward the sick.

Allowable #26: It is allowable to respond to fear with distancing.

Pattern #27: For those who are sick, it is the distancing from people who are perceived to be able to help which produces fear.

Allowable #27: It is allowable to consider proximity a source of reassurance.

Pattern #28: The staff's acting calm in the face of sickness is considered functional (i.e., "Don't frighten the patient"), while patient calm (i.e., lack of
demonstrative fear) runs the risk of being characterized as lack of concern.

Allowable #28: it is allowable to label the same behaviors performed by different people as being different behaviors.

Hypothesis #12: At times of immediate threat to life, those behaviors initiated by staff to be reassuring may, in fact, be fear-producing.

Category #22

OFF BALANCE/ON BALANCE: HOMEOSTASIS

Property: These are interactions where statements or behaviors involve the creation and reduction of some level of tension. Furthermore, they appear to require the application of an appropriate response to the initial tension producing behavior if this is to occur. For example:

S-1 walks in.
P-5 (In very serious tone): "There have been 15 calls—all very angry. They all said they'd call back."
S-1: "Yeah."
(P-5 doesn't crack a smile, winks at researcher.)
(S-1 walks out of office.)

Or:

S-4: "This place is a mess."
(P-15 starts talking about woman again.)
S-4: "She's got the piano—that's what I'm saying. You know this woman? Who is she?"
P-15: "Yeah, she's a nut."
S-4: "Do you know her?"
P-15: "Yeah."
S-4: "Have you heard from her?"
P-15: "Not a word."
S-4: "I didn't know you sold pianos in your store. How much profit do you make?"
P-15: "A fair profit."
S-4: "Be more specific."
P-15: "$600."
S-4: "I have a piano, it's a long story, I should sell you—grand console."
P-15: "Nice piece—good thing."
(They argue about P-15's profit)
S-4: That's highway robbery! How much do you want? If someone said they'd give you $1200, how much do you want?"
P-15: "$1500."
S-4: "$500! I paid $1200 three years ago and you get $200 more than I do."
P-15: I've got employees to pay, overhead, etc."
S-4: "You'll get this and I'll get this and we won't give him anything."
P-15: "I'm like a doctor—a rip-off artist. I want $400. How much do you want?"
S-4: "$1000. What percentage are you getting?"
P-15: "Hey, I'm doing you a favor."
S-4: "You're getting a good 30%. I don't like the sound of that."
(To S-2): "Can I trust him with a piano?"
S-2: "I'd put it in the paper, say you want $1500."
(Later)
S-2: "You know what? I got the pang. I said anything over $2500 you can have. You want $1000, so ... ."
S-4: "But this guy might get a really good deal."
S-2: "So you'll get your $1000."
S-4: "He'll charm them."
P-15: "I'm a charmer."

Summary: This category is abstracted from other categories and appears along with distancing, vigilance, and responding as one of the four major activities occurring in this setting.
Pattern #29 (Off balance): People are frequently forced to deal with, or force other to deal with, some form of discomfort (i.e., "You're wrong," symmetrical play, questions, problems, etc.).

Allowable #29: It is allowable to create in others some degree of discomfort.

Pattern #30 (On balance): When subjected to this discomfort, people tend to seek an appropriate response.

Allowable #30: It is allowable when subjected to discomfort, to seek to relieve it.

Pattern #31: When appropriate response has been found, the seeking is reduced.

Allowable #31a: It is allowable to seek balance predominately in response to discomfort.

Allowable #13b: It is allowable to seek understanding predominately in response to discomfort.

The methods of restoring balance, i.e., homeostatic mechanisms, used in this setting appear to be:

1. symmetrical responses,
2. providing information or explanations to questions,
3. solutions to problems, etc.

But the underlying dynamic is a matching process. The match is of apparently logical entities: a problem with a solution, an insult with an insult, a dilemma with a decision. An interesting speculation is that an apparently logical match is sufficient to restore a sense of balance. If the matching counts more than the content, i.e., if any reasonable answer to a question reduces the tension sufficiently, the merits of that particular case may not receive careful consideration.

Allowable #47: It is allowable to promote balance over understanding.

Hypothesis #13: Balance takes precedence over understanding.

The results are summarized in Tables 1-6. Table 1 presents the categories, Table 2, the patterns, Table 3, the hypotheses, Table 4 the process mechanisms, and Tables 5 and 6 are the allowables.
TABLE 1

The Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Category #1</td>
<td>Questions/Answers</td>
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<tr>
<td>Category #2</td>
<td>&quot;How are you?&quot;</td>
</tr>
<tr>
<td>Category #3</td>
<td>Subjective/Objective</td>
</tr>
<tr>
<td>Category #4</td>
<td>Vigilance</td>
</tr>
<tr>
<td>Category #5</td>
<td>Problems/Solutions</td>
</tr>
<tr>
<td>Category #6</td>
<td>Information Giving</td>
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<td>Category #7</td>
<td>Explanations</td>
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<td>Category #8</td>
<td>Reminders of Limitations</td>
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<td>Category #9</td>
<td>Symmetrical, Equal Asymmetrical, Unequal Asymmetrical</td>
</tr>
<tr>
<td>Category #10</td>
<td>&quot;This is Serious&quot;</td>
</tr>
<tr>
<td>Category #11</td>
<td>Limiting Responses</td>
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<tr>
<td>Category #12</td>
<td>Distancing</td>
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<td>Category #13</td>
<td>Attempted Play</td>
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<td>Focus/Refocus</td>
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<td>Category #15</td>
<td>Inclusion/Exclusion</td>
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<td>Category #16</td>
<td>Sequential Conversations</td>
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<td>Category #17</td>
<td>&quot;You're Wrong&quot;</td>
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<td>Category #18</td>
<td>Sickness</td>
</tr>
<tr>
<td>Category #19</td>
<td>Reassurances (&quot;You're not dead yet&quot;)</td>
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</tbody>
</table>

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Category #20: Supportive Behavior
Category #21: Fear
Category #22: Off Balance/On Balance
## TABLE 2

### The Patterns

<table>
<thead>
<tr>
<th>Pattern #1:</th>
<th>The sick tend to inquire further about a nonsick's negative response to &quot;How are you?&quot; than the nonsick do of a sick person's negative response to the same question.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pattern #2:</td>
<td>When there is a mismatch of subjective and objective information, staff experience is included as a factor--often the deciding factor.</td>
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<tr>
<td>Pattern #3:</td>
<td>When objective experience suggests a problem but a patient says there is no problem, the nurse will administer treatment for the problem.</td>
</tr>
<tr>
<td>Pattern #4:</td>
<td>When a patient suggests that there is a problem but objective measures imply differently, no treatment will be given or initiated.</td>
</tr>
<tr>
<td>Pattern #5:</td>
<td>Patients tend to present staff with the raw material of problems rather than solutions even when it is not necessarily within the nurses' ability to control or when the patient could easily learn to make the same correction.</td>
</tr>
<tr>
<td>Pattern #6:</td>
<td>Both patients and technicians tend to present problems and solutions hesitantly.</td>
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<tr>
<td>Pattern #7:</td>
<td>If a statement is made by a staff member or patient about feeling reassured, they will immediately be presented with a reminder of a limitation.</td>
</tr>
</tbody>
</table>
Pattern #8: If an assault is met with an equally aggressive response, the tendency is to continue or up the ante. This appears to be true particularly after attempts on the parts of either or both the participants to compromise have been rejected with another symmetrical response.

Pattern #9: When an assault is met with an equal asymmetrical response, it tends to be genuinely humorous. However, its effect on the assault tends to be limited. The response to the equal asymmetrical response is to redirect the assault elsewhere.

Pattern #10: If something is considered serious but not immediately life-threatening, the behavior of the staff is relentless verbal pursuit.

Pattern #11: If, on the other hand, what is happening is immediately life-threatening, instead of pursuing the issue verbally as before, staff literally act out the seriousness of the situation.

Pattern #12: Dying and death are serious and require different behaviors than usual.

Pattern #13: Patients often give limited responses to attempted play.

Pattern #14: Staff frequently exhibit limited responses of feeling, even to other staff.

Pattern #15: After an apparent bout of playfulness, one of the participants will ask the other for a favor.

Pattern #16: Focus/refocus can stop behavior.

Pattern #17: Focus/refocus can confound the issue and temporarily side-track intended behavior.

Pattern #18: Focus/refocus can change the direction of the conversation.

Pattern #19: Patients permit staff members to enter conversations unchallenged.
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Pattern #31: When an appropriate response has been found, the seeking is reduced.
<table>
<thead>
<tr>
<th>Hypothesis #1:</th>
<th>In a medical setting, a question without an answer is an imbalance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypothesis #2:</td>
<td>Medicine at all times is a cooperative venture.</td>
</tr>
<tr>
<td>Hypothesis #3:</td>
<td>The implications of objective measures and/or staff experience take precedence over patients' subjective expressions.</td>
</tr>
<tr>
<td>Hypothesis #4:</td>
<td>One of the mechanisms for maintaining an &quot;organization's integrity&quot; is the challenge independent behavior and thereby perpetrate and promote expected designated behaviors.</td>
</tr>
<tr>
<td>Hypothesis #5:</td>
<td>Challenging independent behavior is a means of socialization.</td>
</tr>
<tr>
<td>Hypothesis #6:</td>
<td>Explanations are employed as a response to an inability, momentary or otherwise, to understand what is happening.</td>
</tr>
<tr>
<td>Hypothesis #7:</td>
<td>Explanations can obscure the pursuit of casual questions.</td>
</tr>
<tr>
<td>Hypothesis #8:</td>
<td>One medical assumption is that only if you are constantly wary, will you be alert enough to respond.</td>
</tr>
<tr>
<td>Hypothesis #9:</td>
<td>People who are perceived to be dying are treated as though they are almost invisible—as though already dead.</td>
</tr>
<tr>
<td>Hypothesis #10:</td>
<td>In response to fear or fear-producing situations, physical distancing will decrease as relational distancing increases.</td>
</tr>
</tbody>
</table>
Hypothesis #11: Medicine as yet has no clear or functional way of defining the relational implications of chronic illness.

Hypothesis #12: At times of immediate threat to life, those behaviors initiated by staff to be reassuring may, in fact, be fear-producing.

Hypothesis #13: Balance takes precedence over understanding.
TABLE 4

Process Mechanisms

A. Relational Distancing Mechanisms:
   1. symmetrical play (competitive)
   2. reminders of limitations ("hitting the sore spots")
   3. repetitive conversations (stalled)
   4. alliances (when the primary one is staff to staff)
   5. limited response to expressions of feeling (limited sharing)
   6. inclusion/exclusion (promoting and distancing)
   7. schooling in (fear of being too close)

B. Homeostatic Mechanisms:
   1. symmetrical responses
   2. answers (i.e., information/explanations) to questions
   3. solutions to problems
   4. decisions for dilemmas
   5. favors to competition

C. Conversational Steering Mechanisms:
   1. symmetrical, equal asymmetrical, unequal symmetrical responses
   2. limiting responses
   3. focus/refocus
4. "You're wrong"

5. reassurances
### TABLE 5

**Allowables**

<table>
<thead>
<tr>
<th>Source Pattern Number</th>
<th>IT IS ALLOWABLE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>a. for the nonsick to not request details about a sick person's statement of complaint.</td>
</tr>
<tr>
<td></td>
<td>b. for the nonsick to describe their problems in detail to the sick.</td>
</tr>
<tr>
<td>2</td>
<td>a. to employ experience as a valid source of information.</td>
</tr>
<tr>
<td>3</td>
<td>a. to make treatment decisions on the basis of numbers read from measuring devices.</td>
</tr>
<tr>
<td>4</td>
<td>a. not to implement treatment in response to someone's expression of discomfort if there is no apparent &quot;objective&quot; corroboration.</td>
</tr>
<tr>
<td>5</td>
<td>a. to expect other to provide solutions.</td>
</tr>
<tr>
<td>6</td>
<td>a. for some to venture opinions cautiously.</td>
</tr>
<tr>
<td>7</td>
<td>a. to attempt to undercut a person's feeling of reassurance.</td>
</tr>
<tr>
<td></td>
<td>b. to attempt to undercut a person's feeling of reassurance without warning or explanation.</td>
</tr>
<tr>
<td>8</td>
<td>a. to respond to aggression with aggressive behavior.</td>
</tr>
<tr>
<td></td>
<td>b. to increase the level of assault if attempts to decrease fail.</td>
</tr>
</tbody>
</table>
9  a. to continue an assault even in the face of attempts to defuse it.

10  a. to ask the same question over and over if it is for a good cause.

11  a. to act out the appearance of calm in a crisis.
   b. to reduce the variety of interactions to a minimum in a crisis.
   c. to reduce responses to a minimum in a crisis.

12  a. not to respond to or initiate humor around dying people.
   b. not to make eye contact with a dying patient when talking to them and to minimize it with others in the vicinity.

13  a. not to respond to others' attempts at play.

14  a. not to request details about statements of feeling.
   b. to provide minimal or no response to statements of feeling.

15  a. to request a kindness after a competition.

16  a. to change the subject without warning.
   b. to try to stop behavior by redirecting someone's attention.

17  a. to try to confuse someone by changing the subject.

18  a. to attempt to influence the direction of the conversation you are participating in.

19  a. to enter some conversations after they have been initiated.
   b. to enter some conversations without having been invited.
20 a. for some people to challenge others when they attempt to enter some conversations.

21 a. not to challenge other people's behaviors or to do so hesitantly.

22 a. to discontinue the interaction when someone enters uninvited.

23 a. for some people to talk in front of others without including them and without being challenged.

b. for some people to discuss a person in front of that person without including them and to do it without being confronted with a challenge.

c. to be the person talked about and make no response.

24 a. to attempt to construct alliances.

b. to refuse to reply to or comply with a request for alliance.

25 a. to align oneself with the one who can save you even if it flies in the face of social convention.

26 a. to respond to fear with distancing.

27 a. to consider proximity a source of reassurance.

28 a. to label the same behaviors performed by different people as being different behaviors.

29 a. to create in others some degree of discomfort.

30 a. when subjected to discomfort, to seek to relieve it.

31 a. to seek balance predominantly in response to discomfort.

b. to seek understanding predominantly in response to discomfort.
### TABLE 6

**Allowables Suspected from Other Results**

**IT IS ALLOWABLE TO:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>talk about people when they are not there.</td>
</tr>
<tr>
<td>33</td>
<td>talk in front of people as if they were not there.</td>
</tr>
<tr>
<td>34</td>
<td>include certain people and exclude others in conversation.</td>
</tr>
<tr>
<td>35</td>
<td>treat people who do not/choose not to participate in characteristic cultural behaviors differently from those who do participate.</td>
</tr>
<tr>
<td>36</td>
<td>label nonparticipants as maladjusted.</td>
</tr>
<tr>
<td>37</td>
<td>be disconfirming.</td>
</tr>
<tr>
<td>38</td>
<td>respond in limited ways to expressions of feeling</td>
</tr>
<tr>
<td>39</td>
<td>have repetitious conversations.</td>
</tr>
<tr>
<td>40</td>
<td>to act as if you know something as long as you don't claim to know (when you're not sure).</td>
</tr>
<tr>
<td>41</td>
<td>under certain circumstances act as if you own something when, in fact, you do not.</td>
</tr>
<tr>
<td>42</td>
<td>(for certain people in certain places) to challenge others' independent behaviors.</td>
</tr>
<tr>
<td>43</td>
<td>respond to those challenges as if they were legitimate.</td>
</tr>
<tr>
<td>44</td>
<td>attempt to minimize disturbances.</td>
</tr>
<tr>
<td>45</td>
<td>attempt to minimize disturbances by matching.</td>
</tr>
</tbody>
</table>
promote solutions and answers over questions.

promote balance over understanding.
CHAPTER FOUR

DISCUSSION

Relationship of Results to Goals

One goal of the present research has been to apply a more concrete focus to ethical research. This was attempted by extrapolating form apparent patterns in actual behaviors, those behaviors, which by their very persistence are empirically allowed behaviors, and by implication represent the ethics we live by. The results suggest that this approach holds promise. To work from concrete behaviors deemphasizes the focus on a priori decisions about how people ought to behave by encouraging an ex post facto investigation of principles implied in our actual behaviors. This shift in redundancies in communication behavior emphasizes what exists over what might be, what actually happens over what is thought should happen. What is important to recognize is that this shift in focus highlights actual behaviors not as preferred ethics, but as the existing one.
The emphasis on existing values as expressed through actual behavior broadens the scope traditionally employed in modern ethical research. Instead of investigations that tend to probe those areas which are problematic, the present appears to hold some promise of a more inclusive perspective, existing social values.

As stated earlier, according to Aristotle (Ethics), existing social values are to be found in everyday "habits of action." This was then extended to include more recent thinkers' definitions and reconceptualized as "habits of interaction." The progression from patterns of behavior to statements of values is taken but a single step in this research. Ultimately, it may be possible to abstract underlying principles from patterns of concrete behaviors, but for now, the allowables as listed retain their direct reference to concrete behaviors. And for the purpose of this research effort, it is reasonable that they should.

The effort was made to locate, where possible, characteristic patterns of everyday interactions, and, if necessary, to attempt to raise to a more conscious level aspects of our daily interactional behaviors that, as Berger and Luckman (1966) suggest, may be taken for granted. This was an effort based on the belief that what
would emerge from observations of these everyday behaviors
would be patterns which are the behavioral manifestations
of the values we live by. In modern times, this
contention constitutes a reconnection.

But what does the reconnection of behavior and
values have to do with communication? What do allowables
have to do with communication theory? They appear to
constitute a perspective as yet unaccounted for in
communication theory—a perspective that suggests the
possibility that all communication behaviors may have an
ethical component. For if, as argued here, ethics are
manifested in behaviors, what we allow ourselves to say
and do in relation to each other raises issues distinct
enough from the relational level of communication to
warrant special emphasis. To limit our interpretations of
communication behavior to its content or proximal
implications is no longer sufficient. If communication
behaviors, particularly interrelational redundancies,
imply something about values, it would be reasonable to
construct a conceptual tool to direct awareness toward
this apparent ethical dimension of communication so that
we may more comprehensively consider the communication
behaviors we allow ourselves in relation to each other.
A third focus for research is the continued exploration of process mechanisms. In conjunction with the investigation of characteristic modern behaviors, it would be useful to attempt to begin to identify interactions that appear to play some role in helping humans perpetuate these patterns. For instance, in this research relational distancing is identified as a characteristic behavior. Once identified, what began to emerge was the appearance of specific types of interactions that promoted the activity of distancing. Along with the identification of specific interactions, research on the internal dynamics of particular processes is needed. Again, using distancing as an example of a process, this research would begin to investigate what is being accomplished and how it is being accomplished.

The results obtained in the research are not generally characteristic of organizational research. This is due not primarily to the communication focus, but rather to one of the underlying assumptions of this research, Weick's (1967) contention that organizations are in reality humans interacting. Working from this assumption, the research was designed from an interactional perspective, bypassing presently accepted conceptualizations of the human activities assigned as organizational. This relational focus appears to
encourage results that begin to elicit information about existing human interactional processes. These results are more in line with modern thought about the complex nonstatic nature of human existence.

The results that may or may not be specific to medicine suggest a setting where the major forms of communication are limited and repetitive, questions/answers, attempted play, and sequential conversations, and where the overriding activities, vigilance, distancing, balancing, and responding are responses to fears and discomforts. As dismal as this summary appears to be, what is also embedded here on another level are efforts to relieve, assist, and support.

Limitations

There are three limitations involving method. The first is the tendency of all qualitative research to be affected by the subjective orientation of the researcher. There was a tendency for this researcher to focus on problem areas and to note discrepancies above compatible behaviors. It is not clear if this was a function of the unobtrusiveness of compatible behaviors or the researcher's orientation in pursuit of the research goals.
The second problem involve the application of the method. This tool two forms. Coding, though attempted at various times, was never done simultaneously on a sustained basis as suggested by Glaser and Strauss (1947). Nor did the analysis keep pace with the observations enough to implement a second directive which suggested that the researcher returned each time with questions to answer at the observation site from the analysis of the previous day's observation.

The third methodological limitation is one that was noted during the analysis and appears to be inherent in the method itself. The concepts suggested by the initial comparisons are in relation to these concepts. There is a built-in delimiting effect on the likely directions of the analysis. Considering the richness of the data, this limiting effect is almost welcome, but its existence needs to be acknowledged.

In terms of the goals of this paper, in the identification allowables, two mistakes were made. First, when extrapolating the allowables from the patterns of behavior noted, this researcher, due to an oversight, neglected to note any "habits of behavior" that, by implication, were not allowed. This may well be an issue that needs to be raised in future research that focuses on
actual behavior as the source of data and ethics. "How do you identify the behavioral prohibitions or taboos?" The second limitation in this area was that the extrapolation of allowables from patterns was not always immediately obvious and at times were forced. The allowables were numbered by the patterns they evolved from to permit others to compare the results and decide which of the allowables, if any, are contrived.

Metacommunicational design seemed to make the interview material more immediately applicable to the observations. However, the interviews with patients were too few and less systematically conducted than the ones with staff, making them more uncomfortable for patients and producing less than a logical progression in the flow of the conversation. Also some of the key figures in the observation were unavailable at the time of the interviews, reducing opportunities to speak with nonparticipating members particularly.

In terms of the intersubjective reliability of the categories, the results of the tests are at present ambiguous. What is encouraging is that the best results were from the literal translation of the categories with no exposure to the research setting. However, it is clear that it was a mistake to wait until the reliability test to implement discussions on ambiguous categories. It
would be preferable in future research to involve both researchers in the construction of categories and to maintain an ongoing dialogue. It would be advisable during the entire process to subject the results of this dialogue to periodic reliability tests performed by a third party nonresearcher.

**Future Research**

The present research has attempted to begin the exploration of actual behavior as a focal point of ethical studies. This first effort concluded at the point of identifying some allowable behaviors that are part of modern social existence. From here two directions suggest themselves. The first involves the accumulation of more information (Glaser & Strauss, 1967; Muto, 1983; Cusella, 1984). This suggests that what is needed is research that seeks to identify modern habits of interaction over time, and across contexts. This is recommended in hopes of amassing a body of knowledge from which comparisons can be made and patterns of patterns identified in an attempt to promote comprehensive reconstructions of the interbehavioral realities of modern existence.

The second direction involves the pursuit of higher level abstractions. This can be done initially as
a content analysis of allowables, but to retain their empirical connection and avoid the construction of logical but irrelevant abstraction, content analysis should be limited to first level abstractions.

One potential empirical source of data in this effort is research that elicits participants' rationales for the existence of specific allowables. This application of interpretation and intent to allowable behaviors holds the potential for abstracting inwardly, possibly toward an understanding of the underlying principles in these habitual behaviors. This direction holds the possibility of eventually abstracting principles from behaviors, an interesting twist to the present practice of applying principles to behaviors as a delimiting mechanism.

As described earlier, it begins to appear that behaviors can be interpreted from at least three conceptual vantage points (content, relational, and ethical). The thrust of this research effort has been to probe the ethical possibilities in communication behavior. What can and needs to be pursued as well, are the relational implications of these habits of interaction.

Even from a communication perspective, which is for some, by definition, relational, there have been
persistent conceptual difficulties in attempts to draw relational conclusions from observed communication behaviors. Using patterns of interactions as a starting place, it is possible to suggest both behavioral and cognitive approaches to future relational research.

One thing implied by the concept identified in the present research as conversational steering mechanisms is that replies are pivotal to the direction a conversation progresses. If, as suggested, communication behaviors are indications of the present state of the relationship (Watzlawick et al., 1967), it may be useful to suspect and focus on replies as likely relational steering mechanisms. Using not just a reply alone, but a reply in relation to previous comment(s) or a reply to a reply as the unit of analysis, it might be possible to investigate replies as behavioral commentary on relationships. An effort in this direction might take us beyond the one-up, one-down, and one-across relational implications of behaviors.

"Habits of interaction" may well enhance the opportunity to research a cognitive perspective of relationships. Using people's actual habits of interaction as the stimulus for eliciting participant commentary on existing relationships provides an empirical base for cognitive relational research—a base from which
to investigate the perceptual dynamics of actual relationships.

A third focus for future research is the continued exploration of process mechanisms. In conjunction with the investigation of characteristic modern behaviors, it would be interesting to continue to attempt to identify interactions that appear to play some role in helping humans perpetuate these patterns. For instance, in this present research "relational distancing" is described as a characteristic behavior. Once identified, what began to emerge was the appearance of specific types of interactions that occurred in conjunction with the activity of distancing. To continue to identify these conjunctual interactions is one part of the study of process mechanisms that needs to be done. Another focus that might shed some light on social process is to attempt to study their internal dynamics. This research would probably involve designing methods to attempt to uncover what it is that these processes accomplish, and the interactional and perceptual triggers that help them accomplish it.

As stated earlier, the present research is based on Weick's contention that the concept "organizations" is a reification of human interactions. Considering the
unique perspective it offers, it is recommended that more research be conducted on "organizations" from an interactional perspective. Three concrete suggestions for research proposals that would employ this perspective directly or indirectly are:

1. What behaviors are challenged, by whom, in what ways, and with what behavioral effects?
2. What interactions define the concept of property?
3. What perceptions do minimal-participants have of organizational culture, and their relationship to participants?

It would be helpful as well to do future interactional research on "organizations" both within specific industries, and across varied "organizational" contexts.

Research that might further probe the present results are:

1. Investigate the construction, destruction, and avoidance of alliances by attempting to identify the issues around which alliances appear to surface, and those issues around which they appear to dissolve, in medical settings.
2. Clarify the interplay between uncertainty and vigilance. Investigate the relational
implications of uncertainty as the driving force in good care.

3. Investigate potentially contradictory patterns of interaction within a medical setting (i.e., distancing/supportive behaviors, attempted play/this is serious, limiting response/sequential conversations) to identify the interplay where and if there is any.

4. Identify the sources of fear in a medical setting, and distinctions between the interactions characteristic of different sources.

Conclusions

The persistent emphasis on patterns of interaction is not to suggest that there is only one valid approach to the study of human ethics. Nor is it being proposed, as yet, that a focus on relational communication behavior is the richest source of material, though the results suggest as much. What is being argued most vehemently is that the inclusion of a perspective that highlights actual behaviors is a necessary and long overdue adjunct in efforts to apply ethics to modern existence.

The present research begins to investigate the ethics we practice, our habits of interacting.
Traditionally, the ethics we claim to espouse have been the focal point of ethical probing. But our espoused ethics may or may not match with our behaviors. If they don't, there exists a discrepancy between our preferred ethics and the ethics we live by. Clarification of the actual discrepancies has too long been ignored.
In order to give full credit to others for their contributions, I feel it is necessary to acknowledge the sources of ideas other than published or unpublished manuscripts. Therefore in this work, people will be acknowledged in footnotes for the ideas they have suggested either in conversations or unwritten class lectures. The concept of the "apparent reasonableness" of efficiency was first presented to me by Dr. Daniel Rich in a class on organizational theory in 1983 at the University of Delaware. It is an idea which suggests that if we are going to do something, why not do it efficiently? It is a question which tends to limit consideration of what can legitimately be considered a cost, and generally has the effect of overshadowing detailed consideration of the human costs of efficient behavior.

2 How we choose to treat one another and ourselves is for Dr. Daniel Rich one of the fundamentally important questions for organizational theory.

Again, acknowledgements go to Dr. Daniel Rich who described this concept in 1983 lectures on organizational theory.

4 The " " to off-set certain words is used not as a quotation, but as a reminder that these words are the reified expression of humans interacting.

5 Dr. George Borden made this suggestion during an informal discussion about religion in 1984.

6 The language and quotation marks used in identifying the participants are an attempt to demystify or dereify the titles to make it easier to visualize what is being observed as humans interacting.

7 The majority of the results designated "allowables" were extrapolated from "habits of interaction" categorized as "patterns." The presentation of these "allowables" in the body of Chapter Three will be in sequential order. The remainder of the "allowables were extrapolated
predominately from summaries or examples of communication behaviors, and will be presented in proximity to their sources. However, I was able to do this only by breaking the sequential order.

8A more detailed discussion of limiting responses is found in Category #11, and the issue of matching is explained in Category #22.
REFERENCES


Jensen, A. D. *Conversation and consultation about a paper for an organizational communication course,* unpublished, 1983.


Rest, J. R. Development in judging moral issues. Minneapolis: University of Minneapolis Press, 1979, 3-47, 146-158.


APPENDIX A

Interview Questions to Staff

1. How long have you worked here?

2. What made you apply for a job in dialysis?

3. What are your responsibilities? (That is, what is your job here?)
   a. What are the patients' responsibilities?
   b. How do you feel when patients do something that is not their responsibility?
   c. Are there things they are not supposed to be doing?
   d. How do you react when they do any of these things?
   e. How do you let patients know they have done these things?

4. We have noticed that you kid around a lot.
   a. Are there some people you kid with more than others, or is everyone the same?
   b. Why do you kid around?
   c. How do you decide what topics to kid around about?
   d. How can you tell that this is helpful?

5. Is there any particular kind of relationship you are trying to maintain with patients? With staff? With doctors?
6. How sick are these people?
   a. Do they ask for sympathy?
   b. How do you know when someone really is sick?
   c. How do you react when someone really is sick?
   d. How independent can they be?
7. As medical professionals, what are you trying to accomplish?
8. How do you know when things are on an even keel?
   a. What will knock things off?
   b. What do you have to do to get them back?
9. There seems to be a lot of pressure at put-on and take-off—what is that about?
10. How important are vacations to you?
11. What kinds of things do you talk about with patients?
12. What sort of communication problems do you have with patients? With staff?
13. We have noticed that often there is more than one thing happening at once. How do you handle that?
14. Do you act differently if a doctor is around? How so? Why?
15. How do you know when a patient needs help?
   a. How do you decide what to do?
16. Who supports whom around here?
   a. Who can you depend on for support?
APPENDIX B

Interview Questions to Patients

1. Is this the first place you have been dialyzed?
   a. How is this place different?
   b. What do you look for in a dialysis center?

2. What are the biggest problems you come across?
   a. Do you have any problems communicating with the staff?

3. There is a lot of kidding going on here.
   a. How do you react to the kidding?
   b. How can you tell that it helps?
   c. Does it ever get on your nerves?

4. What are the things that you are supposed to do when you get here?

5. Are there things you are not supposed to do while you are here.
   a. How do the staff react if you do these things?
   b. How do you know what you are allowed and what you are not allowed?

6. How do you ask for help when you need it?
   a. How do staff members react when you do?
   b. Do you ever get help you don't need?

7. What kinds of relationships do people develop here?
a. What kinds of relationships do you try to develop with the staff?

b. How do you do this?

c. Is your relationship with the doctors different?

8. What makes you most comfortable here? Most uncomfortable?

9. Do you feel support from the staff?

10. Is there ever a problem with people feeling or being considered disloyal?

11. What does it mean to be sick?