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The ethnographers' shared task with their informants: the eye witness as we-witness or the production of cultures by means of cultures

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Marx, with and through Gramsci, has provided a critical social science to those who followed him, now as always, not fully aware of what they owe both to him directly and to the irreversible change in European and many other cultures produced by him and other 19th/early 20th century European scholars (DERRIDA J. 1994). He used a powerful, deceptively simple, basic methodology with which to analyse social and cultural activity. This was to begin by asking a set of questions related to production in general but also to the production of commodities in particular. He poses the question; what human agencies, singularly and in co-operation, living and crystallised, brought this about. Marx's great innovation (in *Capital* vol. I) did not set out to understand the distribution of wealth in the Nineteenth Century by ignoring the exchange of commodities. On the contrary he realised that that was why they were produced at all. He wrote that it was nevertheless necessary to go through the door marked "No Admittance except on Business" and to study relations of production in order to understand all the processes that commodities represented in their final appearance. This led him to posing further questions:

Who is producing what; (people in what social positions)?

Using *what* resources; (the necessary raw materials, labour and investment)?

With *whom* do they collaborate?

Under *whose* control and ultimate direction is production carried out?

Using *what* means and ultimately for what ends, visible or hidden, or as Merton put it long ago, latent or manifest?

The primary end was the production of commodities, which are not just simple objects, but crystallised, or perhaps in a modern idiom, deep frozen, labour. Their potential value awaited release in exchange and in use.

The most important political and social ends and products were the classes that produced themselves and each other as bye-products. Despite the distortions in sociology textbooks, Marx did not present these social groupings as fixed entities nor even simple processes. They mutually produced and dissolved one another in mortal (yet, at least in the short run, eternal) battles for control. Furthermore, it is not an accident, although it may seem so to an inattentive reader, that Marx's Capital is full of detailed examples of cultural change, difference and inequalities, not least in health and welfare. These are also processes produced by and alongside, the conflict between classes.

The Prussian founder of both pathology and public health, Virchow, discovered part of this independently, by asking what produced appalling Cholera epidemics in Upper Silesia and why it affected mostly Poles and miners rather than German-speaking administrators and settlers. The report to his employers, Bismarck and the government of Prussia, ended his professional paid career and political status but ensured his historical fame.

Gramsci, faced the flowering and first crises of a period when, at least in Europe, class struggle seemed to some to have gone completely underground. It had apparently been exported abroad in the form of violent imperialism and/or buried underneath the surface of an apparently attractive populism. He realised that, for the understanding of manifest and hidden political practice, the study of the production of cultural process, whether artistic or scientific, was not a luxury but a necessity. He made one of his central political themes, the battle over hegemonic ideology, which was at least muted if not latent in Marx. This led him to emphasise the centrality, in struggle and in production, of organic working-class intellectuals, as well as those of the professional upper and middle classes. Anthropologist Kate Crehan (CREHAN K. 2000: 100-105) discusses the complexity of this in the context of Zambian development and illustrates it with well-chosen translations from his prison notebooks.

> «…..it is not that Gramsci rejected Marx's insistence on basic economic relations as the ultimate dynamic of history, but rather that his intellectual project was focused on the question of how at particular historic moments, within certain broad economic parameters, specific political landscapes, with their specific possibilities for transformation, come into being. It may be true that basic economic relations, whether those of feudalism or capitalism, contain within them contradictions which may tear them apart, but just as it is impossible to know exactly when and where the seismic faults created by colliding tectonic plates will produce earthquakes or volcanic eruptions, so too with the seismic upheavals of human societies. And, moreover, unlike the inanimate world of geophysics, the social world depends on human volition for its earthquakes and volcanoes. Gramsci's concern was with how

> the potential energy of the subordinated classes – an energy given by its objective exploitation – could realize itself as a historical force. Holding this force in check, as long as a particular constellation of class forces exists, is the power exercised by the dominant groups. This power however is not simple brute coercion. If it were it would be impossible to understand how small elites are able to dominate large masses; crucial to any long-term domination is gaining the consent of the dominated. One of the most helpful ways of approaching Gramsci's admittedly difficult concept of hegemony is as a way of thinking about the complicated way consent and coercion are entangled with each other, rather than as the delineation of a specific kind of power » (CREHAN K. 2000: 100-101).

In other words, to use the term hegemony is not to offer a descriptive final summation of an object but to pose questions, as other terms in the theory of praxis do, about the continued, but always incomplete, production of reality. Practice is more than merely economic and political, it is also technical and culturally influenced as we shall observe below. It is demonstrated anew, often ingeniously and independently in some sociology, STS and anthropology.

This paper then builds on the work of Marx and Gramsci's followers and others to suggest that the method of critical analysis of production can also be usefully applied to the activity of anthropological scholarship in general, and medical anthropology in particular. As a premedical student, in 1950, sensitised by serendipitous discovery of a then obscure and unknown critical work of Max Gluckman (GLUCKMAN M. 1958 [1942]), as well as by some knowledge of Freud and the formal study of a dialectical Biochemistry, as taught in just pre-DNA Cambridge, I took the step, not unwelcome to my medical teachers, of abandoning them and undertaking postgraduate research with Gluckman in his new Manchester department. In due course, I carried out my own field-work on village life in North and South Wales, in Britain at large, and then into systems of "health care" in Lusaka (Zambia) and in Italy. Thus began, over a period of time (which now exceeds 50 years), the crystallisation of my views that, although we can certainly learn some answers from our forebears, the most important thing, which their writings help to teach us, is what questions to ask and how to ask them.

Gluckman was born in South Africa and did his first research amongst Zulus and others in Zululand, although, by the time I met him he was best known for his later work, even though it was then still largely unpublished at the time, on Law in Barotseland, an area on its conflictual way to becoming the Western Province of Zambia. He was not a Marxist, nor had he studied Marxism in any detail, but the influences upon him included Marx

and Freud, and he fought all his life against racism in his native South Africa and, after he had left it, abroad. We were similar to one another in that neither of us was then a communist but each of us were influenced in various directions by friends who were.

In his study of a bridge-opening ceremony in Zululand he, encouraged by the historian Macmillan and his teacher, Schapera, had courageously attacked the received (non)-wisdom of Malinowskian cultural anthropology and of (Afrikaans) White South Africa that referred to culture as a bounded entity. This would have required him to see the ceremony as culture contact. Instead, he chose to experience it, in its reality, as a process in which people and groups from different cultures were involved with one another, and which produced new forms of interacting cultures for all the participants whether Zulu warriors, Government officials or the anthropologist. He became thereby one of the first social anthropologists, later mightily reinforced by emphatically non-Marxist, mutual contexts. To put it formally, he set the scene whereby an anthropology based on reified essentialism could be replaced, by recognising the characteristics that arise from difference in practice, and by asking the questions that revealed how difference (within similarity) could be produced [(1)]. In order to do this as my title (echoing and adapting Piero Sraffa, one of Gramsci's closest friends) asserts, it has to be the ethnographers' shared task with their informants and their colleagues; the production of cultures by means of cultures. The secret of properly applied ethnographic method is to avoid disguising the subjective as objective by applying to it the falsifying simplifications of questionnaires and the always doubtful, if not overtly, dubious measures of probability theory. The perceptions of the subject are shared, analysed and assimilated. They can and must then be analysed objectively and, if desirable and possible, put to the test of practice.

This task is made the more urgent in that Management Studies applied to health services in the United States and Britain, if not always elsewhere, while it usually ignores the actual findings of anthropologists, medical and general, has practitioners who have appropriated concepts from the field and used them to erect screens not only around the patients' beds but also the doctors' consulting rooms and surgeries.

Vitally important structural analysis is displaced either on to fixed cultural assumptions or on to one-sided individualised vulnerabilities. Situations of inadequate analysis are transformed into ideological cultures of blame that acquire hegemonic but therefore subvertible status. Our task is to question this distortion by means of metaphorical concepts. A first step is to understand how misleading outcomes are produced by their use.

I present here, in brief summary form, three empirical examples of the analysis of such received but unacceptable wisdom:

a) The case of "vulnerable" children for which their carers were blamed for inadequately coping with the total (essentialised) vulnerability of their charges;

b) An examination of the usefulness of Cardio-pulmonary resuscitation (CPR); and

c) The need for "cultural" change in the British NHS arising out of an enquiry into the failure of a particular Children's hospital which led to institutional reform at a national level.

In each case my focus is on the study and the meta-study and on posing the questions set about production outlined above.

The Vulnerability of Children in London

Starting from 'received' wisdom, colleagues and I set out to study the degree to which a group of primary school children in London could be regarded as vulnerable, both inherently as children and by their actions as individual persons, in ways arising from permanent disability, chronic ill health or relatively persistent injury. The participant observing fieldworker, Amber Delahooke (FRANKENBERG R. - ROBINSON I. - DELAHOOKE A. 2000) overthrew, on the very first day of her research, our initial assumptions that health would be the major source of such vulnerability. She observed how vulnerability in the classroom was produced, by whom, and in what way. She soon realised that the interplay between children among themselves and between all of them and teachers and other adults set up a productive system that generated vulnerabilities for all the actors. These vulnerabilities were of differing duration, at different times and in different places. The formal attribution of permanent vulnerability by a legal document (a statement of special needs) more often itself generated in response to so-called "personality or behaviour disorders" rather than to specifically health problems, did sometimes reduce relative vulnerability but in unforeseen ways. It often increased, temporarily or permanently, the vulnerability of other players; teachers, and other children by limiting their rights to respond in what otherwise might have seemed to be constructive ways. The researcher, unusually in investigations of this kind, accepted invitations from the students to visit them at their homes and to accompany them to swimming pools, discos and the like. This facilitated

their attendance by supplying the adult chaperone that they needed. At the same time it enabled her to discover that children seen as predominantly vulnerable at school and by the authorities often exercised considerable power in other contexts. This power sometimes arising from precisely those factors like absent or incompetent parents, jailed or mentally ill siblings, which were seen as giving rise to their long-term vulnerability. When the findings were analysed, we concluded that the presence of children added a productive element to many situations that, in fact, made the production of vulnerability at some time, more likely for most of the people involved. In the same way as Crehan is quoted above as arguing for macro-processes, micro-situations «...contain within them contradictions which may tear them apart, but just as it is impossible to know exactly when and where the seismic faults created by colliding tectonic plates will produce earthquakes or volcanic eruptions, so too with the seismic upheavals of human societies [however small they may be, *comment of the Author*]». (CREHAN K. 2000: 100-101).

The recognition of this, a qualitative finding about process, is very much "common sense" in the Gramscian meaning of that term; it is a making apparent of the embodied knowledge of those involved in particular sociocultural situations. It seems to be natural but is, of course, produced and reproduced within the framework of particular structural practices. Because reformist reformers of public services, like the vulgar political economists rejected by Marx, cannot grasp that quantitative analysis is neither always possible nor ever self sufficient; they continually suggest changes that are ineffective by reason of their failure to recognise the multiplicity of vulnerabilities continually produced and reproduced in dynamic systems. In Plekhanov's famous analysis; accidents are the result of a chain of inevitabilities.

Applied Social Science: medical sociology and the evaluation of resuscitation

As I argue above from *Capital*, vol. I, Marx certainly centred his analysis of early Nineteenth century European capitalism on the discussion of the process of production of commodities, but he showed himself aware, even in that allegedly most abstractly economic of works, that other things were also being produced, including social groupings, ideologies and ill health. The major cardinal sin, with the possible exceptions of avarice and overweening pride, tempting the medical applied social scientist, is to take for granted that it is possible to accept without question, her/his clients' view

of what is usefully produced at the end of a procedure being evaluated or audited. This is literally to short change the client. Nor does one have to apply a political economy approach to perceive this. I have already referred to Robert Merton's distinction between the latent and manifest functions of social action.

More closely related to our own field is Anselm Strauss's and his colleagues' analysis (STRAUSS A. *et al.* 1985) of the patient trajectory, in terms of the different kinds of work needed to shape it and how they are combined and directed in the supposedly acute hospital of his day. One thing that his method revealed, of course, was that most of the patients had chronic disorders and had entered the hospital as a result of their disease being in an acute phase. They left not, usually cured, but either dead or, more usually (except in developing countries or in medical TV soaps) returned to chronic near-manageability outside. Although he and his three colleagues wrote of kinds of 'work', he volunteered to me in correspondence, that 'production' might have been more appropriate. In any case, he used work to mean productive practice and examined each of the productive processes that might occur: machine-, safety-, comfort-, sentimental- and articulation-work, and the work of patients (the last, no doubt needing most patience) and the combined synergic outcomes at which they were aimed and often succeeded in producing. It took four years for the field research alone and another to produce the book. Lack of time and resources (and perhaps will and imagination) have deterred others from following them. It is only very recently, that the Dutch scholar, Annemarie Mol (MOL A. 2002) has, in my view, irreversibly transformed hospital ethnography in particular, as well as social science of medicine in general, and thereby the understanding of how medicine works. She simultaneously reports and analyses her many years of work within the hospital. The innovative and imaginative "duplex" structure of her book perhaps, as she suggests more accessible to ordinary readers in the television age than to conventional text-bound scholars, also enables her to contextualise her work in a wide range of literature. Her focus is «on the way medicine enacts the objects of its concern and treatment» (MOL A. 2002: vii). It is to be hoped that she may succeed where others have failed and shame the majority of practitioners (if such they are?) of medical anthropology and sociology away from the simplistic eclecticism in which they often seem semi-consciously to be drifting. One reality that she impresses upon us, as Strauss *et al.* and Gramsci also did, is that we have to identify and constructively examine (ask questions about) all the relevant practices and not just those that appear to be scholastically (intellectually) respectable let alone universal or commonsensical.

It is salutary in this respect to examine a recent juxtaposition of articulated articles in the Nursing Times (DINGWALL E. - SHUTTLEWORTH A. 2002, RICHARDSON M. 2002) under the respective titles "C(ardio) P(ulmonary) R(esuscitation): is it cruel or is it kind?" and "It's the difference between life and death".

The first of these begins under a heading «Why do we assume CPR should be attempted» by suggesting, partly in reference to Timmermans's controversial book (TIMMERMANS F. 1999), that CPR is one of the great unquestioned practices of modern medicine, it being implied that those who refrain from questioning are especially ethicists who are only concerned if the procedure is manifestly futile or if it has been rejected, preferably in writing, ahead of the emergency calling it into play. It is argued that these (false and misleading) assumptions are based on three principles; the rule of rescue, duty to love our neighbours as ourselves and beneficence/non-maleficence. These principles, it is averred, exist in health ethical codes to the extent that not to observe them is held, by officially (the courts, regulatory professional bodies) enforced British practice, to be a dereliction of the duty of care. The legal position is then hypothesised that although the law is uncertain, courts are likely to take the view that only a decision against resuscitation taken by the sufferer or by someone medically qualified and actually present at the scene can be regarded as valid. This attitude is described as having been overdetermined by allegations of discrimination by lobby groups of the elderly who have forced the National Health Service to impose audited policies on practitioners in the name of a very loosely defined principle of protection of patients' rights.

The next set of arguments is headed «Perceptions versus reality» and is presented as arising from the cultural representations derived from television medical soap operas like ER in the United States and Casualty in Britain. It uses statistics derived from a 1996 study of three such series in the United States to show that CPR was mainly applied to trauma in children and young adults and is portrayed over-optimistically with regard both to its immediate success and its lack of long term damage. In real life it is performed on older patients «whose average age seems to be in the sixties» with short life expectancy; studies suggest that «independent circulation is re-established in less than 30% of patients» most of whom will die shortly afterwards or «suffer significant neurological impairment». Cultural theorists might question the reversion to the injection theory of mass media influence and the implied assumption that viewers are necessarily influenced by percentages rather than qualitative emotional impact of particular instances. I do not however dispute these figures or the quantified

statement that «In the community prospects are even worse». Nor do I think the arguments that follow about the considerable cost of CPR, the ethics of taxation, the non/existence of patient's rights or the author's perceived need for «Reversing the default assumption» are necessarily wrong or even merely seriously misguided [2]. My objection is that readers might be influenced by his title as professor of sociology (and the sophistication he showed, alas without much effect on his listener, in his analysis of culture for the Bristol Enquiry. See below), into believing that he is exercising his sociological skills. My disappointment arises from the fact that he, in fact uses only his (considerable) rhetorical and statistical skills and plays the *advocate* rather than using his (also considerable) sociological and anthropological skills and acting as *analyst*. In order to have done the latter, he would first have had to participate directly or through an assistant in examples of the actual process he set out to study (as Chairman Mao is reported to have put it, perhaps hypocritically, perhaps not, «no investigation, no right to speak»). Second, it was his duty to the administrators and ethicists he sought to serve, to use his grasp of theory to question, if only provisionally, what other products might have been the outcomes of following the procedure, how they were produced, whom by and in whose interests. An example of this is provided in the accompanying article to his, whose writer (RICHARDSON M. 2002) is able to use her embodied knowledge of her own nursing practice to argue that making apparatus and training available to a wider public would not only improve the efficacy of CPR and life-saving measures in general but reduce death from out-of-hospital heart attacks. Some might argue that this was a more effective way of saving money and lives than merely using the method less? Another example of the production of knowledge by studying and asking questions about apparent failing, internally unforeseen, outcomes is found in anthropological studies of hospice pioneers of ultimate non-intervention in the dying process. This eventually produced more comfort for the dying and their relatives, as well as less frustration for nurses and carers unaccustomed to and untrained in active passivity, resulting in premature burnout or breakdown. Once it was noticed that the latter was a bye-product the productive process changes were made in practice. Even at the level of outcome evaluation in all these examples, it is, of course, necessary to ask not only did the patient survive, for how long and at what cost but also at what cost to whom? Dingwall questions rightly, and rightly does not stay for an answer, the cost to taxpayers and those whom postcode rationing or third world status, deprives of CPR, but he does not consider the production of expertise, knowledge about physiological processes, job satisfaction

or the possibility of travelling beyond doing the sick no harm to saving life (if not every life). His advocacy is not only politically ineffective, it is merely (?) common sense, (once again in the Gramscian sense of the hegemonic ideology partially shared with the fortunate nonsubaltern); his analysis of a more totalising, but theoretically informed questioning as a social scientist could have made a difference, although not necessarily in the direction which as a citizen and political animal he might have preferred. At least he would have provided some evidence for the evidence base!

The British National Health Service

My final example leaves the beating hearts of its patients and goes to the abstract, but personalised, heart of the British National Health Service. It considers the questions posed by and answered by a public enquiry into the manifest and literally scandalous failures of a particular children's hospital in South West England (REPORT 2001). The production process of such an enquiry is a complex one. It is obviously significant that it arises out of public clamour about something that has gone manifestly wrong. In this case, there had been a long series over many years of unexpected deaths of small babies undergoing, often unnecessary, cardiac surgery. This, although it was well known first by the Paediatric department and then by all professionals within the hospital, only gradually leaked out to NHS at large. It finally, complicated by the hospital's retention of the children's body parts, led to a call for public enquiry led by affected parents. In the UK, a public enquiry of this kind is called by a Cabinet Minister (Secretary of State), its terms of reference defined (and perhaps debated and/or modified) and the name of its Chairman, usually a senior lawyer, announced in the House of Commons. A selection of what is often "termed the great and the good"; prominent academics and other people well known in public life, are selected to serve. They meet, and guided by the chairman and civil service secretary, decide whom to call to give direct evidence and what submissions to invite from them and others who volunteer. They also issue a general invitation to the public at large to offer to make submissions. After the preliminary phase of taking evidence they then decided to focus on particular issues that they thought should be addressed and invited particular organisations to submit position papers. They then organised subsidiary seminars to discuss these under different headings; the Commission members discussed these and the secretary will have, after preliminary discussion with the chairman, drafted the lines of the report, which

the chairman finalised, polished and presented in his name to the Commission who approved it to pass on to the minister. They produced an interim report on the body parts issue. They then, with official support and encouragement, produced two reports with recommendations not only in order to correct the specific problems of Bristol Royal Infirmary but also to reform the NHS at large. (Learning from Bristol is its title but it is labelled rather grandly as «Presented to Parliament by the Secretary of State for Health by Command of Her Majesty.» It is known informally as the Kennedy Report, one of several as it happens. Officially, it is styled CM5207(1,2). The Government unusually accepted nearly all the recommendations of all three reports except those few that directly challenged the government's existing powers.

Its overall more notable ultimate products were a new national agency to regulate the use of treatments (National Institute of Clinical Excellence - NICE) and a new audit body (Committee for Health Audit and Improvement - CHI) entrusted to the overall direction of the chairman of the enquiry, Sir Ian Kennedy, Barrister at Law and Professor of Medical Ethics, referred to, ironically but virtually officially, as is customary in many public service fields in Britain, as the Tsar of health service reform [(3)]. Its most important product was putting the final touches to his emergence as the major figure in the NHS. Its immediate production was 900+ pages of report, minutes of evidence and appendices all made available on the internet and in print. (REPORT July 2001) At first sight rather surprisingly, the initial findings on the actual issue it was investigating were couched, (in partial agreement with, but also despite the professional sociological protests and excellent expositions of the same Professor Dingwall described above) in somewhat dated, predominantly essentialised, reified but not entirely misunderstood social anthropological concepts. Chapter 22: *The Culture of the NHS* explores the necessity for a series of new cultures of openness, accountability, quality and safety, public service and team work; the last eschewing especially the supposed existing tribal cultures of Doctors and Nurses [(4)]. Its general theoretical product was the canonisation of the honest Thatcherite principle of capitalist populism enthusiastically adopted less openly by New Labour, which can be summarised as «The customer is always right once s/he has been convinced that s/he wants to buy what we want to sell them, defined as the saleable end of what we produce.» Since management's aim in most organisations is to produce a situation in which they organise first commodities and then markets for them, the NHS, it is said, needs reorganisation whose object is providing for the patients who are therefore to be redefined as consumers – it must therefore be a "pa-

tient-centred culture".[5] This idea had given rise to an earlier intriguing illustrated cover and subtitle of a special issue of the "British Medical Journal", *Dancing with Patients*, "BMJ", 319, 18 September 1999, which led to both serious and spoof disapproving comment.

In practice, the Commission and developments from it, consolidated the consumerist ideology that Meg Stacey criticised long ago (STACEY M. 1988: 6 and *passim*), that patients are always patients and ignores that patients as a class are produced by the health system from the raw material of social persons and actors (self-producers). It incidentally, in its caricature of doctors and nurses as warring caricatures of tribes, ignores all the other hospital workers in the way that Strauss *et al.* (STRAUSS A. *et al.* 1985) creatively avoided doing (6). In short it does not analyse the situation in terms of production questions but in terms of consumption answers. This results in culture becoming, as audit (SHORE C. - WRIGHT S. 2000) did before it, not so much a boundary concept (BOWKER G. - STARR S. 1999) that is an example of the shared concepts which mark the relationships between shared but not congruent cultural formulations, as a stop word blurring boundaries. Shore and Wright argue that audit both suffered and enjoyed conceptual inflation and became less useful as it became more influential – both a keyword and a meaningless concept. I illustrate the impact on views of culture in table form:

Commission analysis	Production approach
Unitary	Plural
Managers do not just do tasks; They create/correct culture	Do tasks in a natural way Socially constructed by members
Change organisation "is" to organisation "has"	For workers & patients vital productive resource
Work force is passive reactive recipient of external objective entity, i.e. culture	Are soft targets, good at absorbing & diffusing impacts

The view of culture(s) which emerges from looking at its relations of production is that it is not an object but a continuous and changing process; it is virtually (and in reality) always plural, indeed that is what gives it singularity and uniqueness. This is because it is played out and produced in practices of interaction. Descriptions of it are always therefore provisional which is why its protagonists think it is natural (Gramscian commonsense once more!). Cultures always enact differences between their members as well as the shared identities of their participants. *Vive la differance* Derridean! Like identity, except in crystallized, frozen or fossilised forms, it requires hard work to assert that you have only one culture if you should need to. Such fixed forms for

culture are rituals, symbols and artefacts; and for identity, habitus, memories and again artefacts. These observations do not make applying anthropology to health problems impossible but it does mean it requires creative imagination and that modesty, also required by teachers in general, which forbids dictating answers but rather suggests questions. For anthropologists, doing research is an interesting and hopefully useful, to all parties, way of extending the range of cultures in which they, their subjects of study and their attentive readers are all involved.

Notes

(1) This did not happen overnight and it was not until DERRIDA J. (1994), interestingly in a tribute to the murdered Chief of Staff of the South African ANC, Chris Hani , attempted fully to theorise some of the non-marxist implications of living after Marx. Derrida's non-concept of *différance* is relevant here.

(2) I feel bound to declare an interest as one who is himself in his seventies and with cardiac problems, although I do not think that Dingwall would suggest that either of our chronological ages, some twenty years apart, affect our respective judgements any more than the comparative infancy of his medical journalist co-author.

(3) He is to New Labour's embattled NHS as the United States' 8th Cavalry was to cowboys and ranchers besieged by Indians in the classic Western American Movies

(4) Sections 9 & 10 merit quotation:

9. It is important to avoid caricature when referring to "culture" and to be clear what the word is intended to convey. We take it to refer to those attitudes, assumptions and values which condition the way in which individuals and the organisation work. It is also helpful to bear in mind Professor Robert Dingwall's view (footnoted as Seminar 3 Professor Robert Dingwall, Professor of Sociology, University of Nottingham. Points for discussion) that organisational culture is a complex notion and something that is often resilient to change. One reason for this may be that its complexity lies in the co-existence of competing cultures. This is very much the case within the NHS, where the cultures, for example, of nursing, medicine and management are so distinct and internally closely-knit that the words 'tribe' and 'tribalism' were commonly used by contributors to the enquiry Seminars on this subject.

10. The positive aspects of Tribalism are clear. Tribalism engenders a sense of belonging, a set of common goals, a sense of mutual support. Moreover, competition between various tribes may be beneficial if it creates an environment of creative tension within the organisation. The danger of tribalism, of course, is that where there are numerous tribes it can threaten to undermine the capacity of a large organisation to adhere internally to a set of agreed core values and to represent these values to the outside world. Moreover, when the tribal groups fall out, or disagree over territory in an organisation such as the NHS, the safety and quality of the care given to the patient is put at risk. [Compare Lord LUGARD 1922].

(5) «We recognise that patients are experts in their own right and that includes parents and there must be a culture of listening to them».

(6) see *inter alia* Liz HART's (1991) analysis of the organisation of cleaners the breakdown of which, and their replacement by outside tendering, may well be responsible for the increase of hospital cross infection.

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