# 2 Two illustrations

After that long introductory discussion, a "methods" book would ordinarily move directly to presenting in concrete detail the initial steps of research procedure – in this instance, the coding of data. We shall not do that yet. Readers who are eager to get quickly to the procedures can skip the present chapter, returning to it later. But it is placed here for those readers who need some overall visualization of the spate of terms discussed rather abstractly in the preceding pages.

There are two reasons for placing the material given below at this precise point in the book. The first is to give some sense of how a grounded theorist operates with data, since that style of analysis is somewhat different than other modes. Thus the analyst–teacher will be seen developing theory by using both "real" and experiential data, making constant comparisons, discovering and naming categories, suggesting possible theoretical samples to be examined later, emphasizing all of the elements in the coding paradigm, and raising a host of theoretically informed questions. The second reason for presenting this material here is to give a more concrete sense of how grounded theory is taught in research seminars, providing thereby useful imagery before readers are plunged into the technicalities of coding, memoing, and so forth. Indeed the teaching of grounded theory rests on collaborative work by the seminar participants (although sometimes it is strongly guided by the instructor), and is designed to facilitate thinking about and analysis of data in free if disciplined ways. (See also Chapters 4 and 14.) This chapter, in other words, sets the stage for the "how to do, and how it is done, and what the products look like" demonstrations of the next chapters.

Each of the two cases presented illustrates features of the general style of analysis outlined in the opening chapter. It consists of the transcript of a session of a seminar on qualitative analysis, participated in by graduate students in sociology (two of whom were also trained nurses). These students were about one year into their graduate training





and two months along in their training in qualitative analysis. The second case will further show the instructor at work, this time doing a microscopic analysis of a short interview.

## A class session: pain management

The seminar discussion was focused on the phenomenon of pain management, for the instructor was then doing research on this topic (Fagerhaugh and Strauss 1977). Using it as a springboard for teaching about theoretical sampling, comparative analysis, the generating of categories and the labeling of them, the analysis of dimensions, tactics, etc., he is drawing on his research knowledge as well as on the experiential knowledge of the students. As a teacher, he is purposely very active, since he wishes, as speedily as possible (and since this is only the second session of the seminar): (1) to demonstrate how rapidly initial data – even *experiential data* – can begin to generate theory (about pain management) through coding, theoretical sampling, and comparative analysis; (2) to illustrate *how* these operations are carried out; also (3) he is not concerned with exploring at great depth any given comparison in this particular session, but rather with showing the variety of analytic strategies that are available for carrying out generation of theory.

This case illustration, unlike most of the others in this book, will be presented without detailed commentary of what is transpiring, analytically speaking, throughout the session as it proceeds phase by phase. Here, though, is an overview of some notable things that occurred. There was open coding, which resulted in a number of categories and terms for them (assessing, balancing of priorities, pain expectations, inflicted pain). In relation to those categories, the teacher showed how to find numerous comparison groups, suggesting theoretical sampling. Some exploration was made of conditions, tactics, dimensions, interactions, consequences. There was much emphasis on variation, including how to potentially qualify an interesting hypothesis. So the open coding was already leading to some conceptual density, through exploring possible relationships between categories.

As for pedagogy: The teacher explicitly emphasized and elicited the use of his own and students' experiential (research, personal, professional) knowledge qua data. He converted data into questions, categories, hypotheses, dimensions, consequences, etc., and had the students beginning to do that also – by giving examples, by requesting, by raising

questions, by stimulating the students. When the students made comments or offered data which combined two or more issues, he then sometimes clarified by making analytic distinctions. He suggested also when memos could be written and why. He set "next directions" for discussions, or shifted the discussion into new paths (not wanting to go into much analytic depth for any point). He gave summaries and recapitulations occasionally, along with small lectures (lecturettes) on various elements in the grounded theory style (e.g., a little data and then analysis). The teaching style itself emphasizes the provisional nature of open codes, with the corollary that the researcher can correspondingly be relaxed, even if the analytic session is intense and intellectually demanding. A key feature of this kind of teaching of analysis is the raising of generative questions for discussion: expecting that students will be able to respond intelligently, not merely because they are intelligent and can think logically, but because they have experiential data in which to ground their answers – and need not be afraid to do so, once they get over shyness in front of the teacher or their classmates.

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The instructor began by saying that the seminar could use informants to begin building its theory, since two members of the seminar were nurses. "They have data in their heads. We can regard what they say as the equivalent of initial field observations." He urged the nurses to say something based on their own experiences. One said that hospital nurses have a problem in "assessing pain," although it is necessary to do so. Why? "Because it is related to the nurses' actions" with regard to patients.

Instructor: "So, we have to ask how they go about assessing pain; that is, what *assessing tactics* are used. But first, let's ask *what* they assess." The class quickly came up with such items as: the kind of pain, its intensity, its bodily location, its duration, its progression over time. The instructor called these *dimensions*. He added: "Next time you go into the hospital, if you were studying this, you would keep an eye open for other kinds of dimensions. But let us suppose that for the time being we just write a memo, noting down what dimensions we have thought of. Later we are going to see if it works out or not. Meanwhile, there is no point in getting anxious about whether they will or not. But the memo tells us that now we have an inquiry: What other dimensions are there, and will they be relevant to building a theory?"

Then he turned to the tactics of assessment, asking: How do nurses go about assessing pain? Jan, please give examples." Jan replied that the assessing nurse "will compare this patient with past cases." Instructor: "Let us theoretically sample by asking what happens in two contrasting cases – the nurse is quite experienced (say she has been on the ward a long time) versus a nurse not very experienced (say she is new, at least to this kind of ward). Now you *can look* for each kind of situation and observe what happens. Or, if you don't want to immediately, then write a brief memo about it and do it later."



Jan offered, as a second assessing tactic: getting a description from the patient of what it is like, using a question-and-answer technique. Instructor: "How many dimensions does she hit?" Also, we can theoretically sample: "What happens when you get a patient who isn't articulate, and can't give her good answers?" Seminar members: "How about semicomatose patients? Little children?" Instructor: "We have to ask what nurses do under those conditions. All these questions lead us to inquire about (as potential conditions) variations in persons, styles, tactics, etc., as they relate to *pain assessment*. We can see that assessment is an important category for studying pain management, and its properties will guide our next steps in searching for data."

The instructor then asked one of the nurses about what happens when a patient continually complains without seeming to have much cause to – the hospital nurses discounting the complaints, but then the patient insisting that the pain is getting more intense. The nurse answers, "It may depend on the patient's reputation among the nurses." The professor comments: "Then, it is not just pain assessment done only 'in the present,' but it can be done in the context of *mutual experiential careers* (that is, these persons have been around each other for a while)." He continued: "Let us theoretically sample then. Suppose they have no mutual careers whatever! Suppose they have a very long one. Suppose they have had mutual careers, and there was no pain – but now there is? Or there was always a lot of pain, through the whole trajectory? (Compare this with a patient they like or don't like.) Well, we could go on with this kind of sampling, along the notion of mutual careers, but that is enough to make the point now."

A student excitedly says: "Look, when sometimes someone comes into a clinic with an overdose of barbiturates, sometimes there won't be as great an effort to relieve the pain, because they assume somehow that then the pain will show him he shouldn't do this. And once, my mother, having a child at a hospital, was told that it was *necessary* for her to suffer during childbirth!"

Another student, stimulated by the foregoing, notes that when people come in for gonorrhea treatments, the staff may stretch out the treatment for twenty days, giving the patients a painful shot each day, as a form of punishment. They are supposed to learn via the pain.

Instructor: "I hear you saying two kinds of things. We've moved to – When is pain *not* relieved? The second is: When is pain actually administered? You now have another set of memos to write, which have to do with, Under what conditions, when pain is discovered by the professionals, do they manage the situation so that the pain will go on? You can break that into two: when pain is inflicted by the professionals and when it is not. There are, for example, many treatments and tests where it is necessary to give pain to get the job done. Professionals can also try to maximize or minimize the pain: with the gonorrhea treatment and a disliked patient they are maximizing it. And the nurses will tell us that there are situations when pain is desirable because it makes good diagnosis possible. So now we have a series of distinctions: pain for *diagnosis*, pain through *negligence*, pain for *punishment*. There also is the situation where a cancer patient's pain is not relieved fully because the staff withholds medication, believing they need those drugs in reserve for 'near the end.' So now I have introduced the idea of *pain trajectory* as a condition for not minimizing pain." (We had touched on trajectory before.)

The instructor then summarizes the major points touched on thus far, adding that, "We have not done much yet. We have done a little coding, sampling, and a little comparative analysis; and have memos that can either cover a couple of sentences or some pages. We could follow through where we have just brushed by: thus, the question of negligence as a condition for giving pain or for not relieving it much. We could explore that whole area. We could look further into the giving of pain through diagnostic tests: You can look for situations where the inflicted pain is unexpected by the patients, or where they are warned or understand there will be pain; or where the hospital personnel themselves are surprised. So you can lengthen particular memos, adding to them, as you either think through these matters from data in your heads or as you latch onto them in the field. But concerning what's in the memos, for each point, you can theoretically sample by asking: Who do I ask about this (interview), or go and observe? Then you can actually interview or observe these people. You can also theoretically sample by turning the initial query upside down. We have been looking at pain assessment. What about where assessment is virtually nonexistent? For instance, I trust the person very much, so when she tells me of her pain, then I don't doubt it. ('I have a headache today,' my wife says.) But where there is little or no trust, then canny assessment tactics prevail, as in the hospital. So you now write a memo on this type of assessment tactics. If you haven't enough experience with that (i.e., data) or you want more immediately, then observe or interview."

"For instance," the instructor says, "let us ask one of the nurses in the class." From one of the nurse students, he gets three canny tactics in short order: the staff gives placebos; the staff asks trapping questions; they pop their heads in the patients' doorways to catch them unawares. Then the instructor added: "Let us stay for one more moment with pain assessment, but do a flip-flop. Suppose a patient doesn't admit to as much pain as he has! We could ask our nurses about that, too."

Rather than pursuing that path, he suggested that next they pick a specific ward, say a surgical unit. He sketched out something of the typical passage of patients through such a ward: pre-op, surgery, then post-op. If one looks at the post-op phase and walks around a surgical ward, he or she would observe that some patients were temporarily closer to leaving the hospital and some were closer to their surgical operations: "like trains traveling along a railroad track." However, since the patients may have gone through different types of operations, their post-op phasing might be comparably different: hence, they are on multiple tracks. Say there are ten tracks and thirty patients: What would that suggest?

The class grasps his point and answers, "Different *expectations* concerning the steps of recovery." The instructor asks them to disregard the patients' expectations and to focus on the nurses' expectations. From the class discussion there arises the idea of *patterns of recovery*, with possible associated pain. Thus, operation #1 might give much early pain but then a quick drop in it; whereas #2 might give minor pain, but long lasting. The instructor: "Look now at the comparisons you are making that are useful for fieldwork. You can look at them as they appear on the ward. Or you can look at any one patient immediately after an operation, and watch a pattern emerge through the next days. It follows that



if expectations of nurses match the recovery course (i.e., it is fairly routine), then that pain management will be fairly routine in the sense that they know what to do to relieve it (however much work is involved). Let us say the pattern was: at first, terrible pain; then, mild dropoff; then, no pain at all, but with the big concern being an increase of the patient's weight and strength. Now, how do you theoretically sample that pattern of recovery?" The class discusses doing it by phase, though it might take several weeks to pin down the pattern by following several patients. The instructor: "As you did that, you would begin to get the crisscross of things like energy, weight, liveliness. What else?" he asks. Student: "You could sample by nurses and patients; how they handle each phase. You could find the range of the nurses' tactics and how the patients responded to the tactics." Instructor: "And you could watch the variety of tactics also; some nurses might use predominantly one or a few tactics, and so on. Most likely you would find nobody who would do the same thing all the time."

Instructor: "Any other kinds of sampling?" Student: "You could ask if the priorities are on weight as over against pain? If there is a priority on relieving pain, then they would sedate more – which would maybe cut down on appetite." The instructor remarked that it was likely that this would be relatively a minor issue with most surgery patients, but it is a major consideration on the cancer ward (which he had studied). Let us call this *priority balancing*.

A student remarks that one surgical patient might look at another and say, "That's where I was yesterday." This comment leads to discussion about patients' comparing notes; also to nurses telling patients, "See, that's where you will be in three days," as they point to other patients. But there are other wards where patients can't so easily make such comparisons. Instructor: "Now you can theoretically sample – you can look for (or stumble on), in your fieldwork, patients who are in single rooms and so can't easily compare themselves to other patients."

The instructor says that they ought to think of another theoretical sample where a patient "breaks the pattern" of surgical recovery that they have been talking about. "Now we will see the crosscuts of intensity and duration: Think of a patient who appears to have no pain at all after the first day of the post-op period, but she keeps saying she has pain, and goes on saying that for another seven days." The class agrees that the nurses' reaction would be that, "There's something wrong." The instructor adds: "Yes, and now the suspicion game would scarcely take place, however much they suspected her complaints before." A nurse adds: "They might think something else was going on (physiologically)." Instructor: "*Now* suppose that she shows pain visibly on the day of alarm. Then comes great concern, diagnostic work, calling in consultants, and so on. So inadvertently we have theoretically sampled again. First, it was to break the pattern. Now we have sampled again – her pain is also visible; as over against her continued complaints, but it is invisible."

He then lectures: "So, at every step you're asking about opposites, variations, and continua. Sometimes in actual research you don't follow all of these leads – it is just too exhausting. But sometimes a phenomenon just forces itself on you from the nature of what you are seeing or hearing, day in and day out. Or you see something on one day and on another something fits in with it. But

at every step *this* is what you are doing. That is why you don't want to rush out and get a lot of data, because you would get submerged. You get a *little* data, then you stop and *think*! At virtually every point in your initial fieldnotes or interviews, you must do this kind of thing."

The instructor then began to recapitulate the ground they had covered in the last minutes and mentioned multiple patterns of recovery. Then he remarked that we might imagine what would happen if on a given ward all the patterns were evinced simultaneously, on a given day, all patients being in great pain but one patient was not – what would happen to him? Clearly, he would get rather little attention unless he was judged critically ill. "So we can vary the picture further with a little imagination." Suppose one imagined a patient who was recovering "on schedule," but then she began to evince considerable pain when she oughtn't to? Probably the staff would discover that the pain comes from a source other than lack of recovery, like an infection ("or a pair of scissors," someone quipped).

Another student remarked that before we had been talking about nurses' expectations about the duration of pain. What would happen if the two didn't match, as when a patient started with extreme pain but then it just kept on? It wouldn't be just breaking the pattern but "going into another category, for there they are no longer uncertain about the duration. The nurses then probably would go into another whole set of feelings and actions toward that patient." The instructor said: Now you are in the situation of "pain certain, etiology unknown." The student followed up with: "And for that the nurses have been trained, so there will be a momentary shifting of gears but then they will go into another set pattern." "Good," the instructor said, "now we have a word for that: the *shifting of gears*. Now we can raise other kinds of shifting of gears; like shifting upwards or downwards in seriousness of pain. So you write a memo on that and maybe that is all you do with the item for a while, until you see more incidents of that kind, or see it occur on another ward. Realistically, if incidents and memos keep occurring, then you begin to think it is important as a phenomenon." The student who originally raised the issue: "You ask, Under what conditions do the nurses shift gears – like if the patient calls attention to this continued serious pain."

A student suggests the idea that, "From what we've been saying today, what is really important is the assessment; once the assessment is made, the treatment somewhat naturally follows." The instructor answers that this is an hypothesis, "but suppose that I say 'yes but' – and pick a theoretical sample where you get a situation in which an assessment of pain is made and treatment follows, but then we look for a situation where an assessment is made but you aren't sure what the treatment for the pain should be? Under what conditions would we expect to find they don't know what to do despite assessment? Because we might just qualify your hypothesis that way." He added that now we could turn to the nurses in the class for an answer, since they were so full of experiential data. A nurse answered with the illustration that a patient was assessed by a staff nurse as having a sudden pain that needed relieving, but for which there was no prescribed medication or physician's order.

The student who had spoken previously objected, saying that the staff nurse actually knew what to do, she wasn't uncertain in the sense we had spoken of



before. The instructor broke in, saying that the *legitimacy* issue was being raised: "That is, who is allowed to kill off this pain legitimately; and the nurses are not allowed to do this, except on a doctor's instruction – that is, delegation." (Another student gave an anecdote about being in the hospital, and suddenly needing medication, but the nurse refused to give her any without a doctor's order.) After an animated confusion of tongues, the instructor said: "Look, we have at least two things going. Let us be clear analytically. First, there is the patient's tactic when no legitimate agent is available. Second, the nurse cannot act because he or she has not been legitimated. They both pertain to the same category of legitimacy. So we now have a new memo about who can give pain killers and under what conditions. For instance, I can give myself aspirin for pain at home, but if I go into the hospital, they take it away – I'm not even allowed to use my own aspirin. The only persons who are allowed to give drugs there are legitimated or delegated agents. So here is an entirely new dimension, and it is entirely understandable why it hasn't come up until now, because probably on surgical wards the phenomenon doesn't strike the eye very easily. But to return to the question raised before and my responding query: Could there be conditions under which the staff could make the pain assessment but not know what the proper treatment was? You, Larry, are assuming they always would, on the analogy that if you have a headache, then you take aspirin."

Larry answers that he believes assessment also entails treatment, and that if the nurse has faith in the treatment she will assume she won't be punished for using it with a patient in dire pain, even though she has not been given orders to use the medication. "Ok," the instructor replies, "pain management always involves where the pain is, how long it has been going on, its intensity, and it involves calculations about how much medication, what kind, how it is acting or how fast acting, etc. But the game I wanted to play with you now is that of possibilities – based on your own experiential data. One works out possibilities even if you can't find immediate examples of them, provided you *do* have that data. (Usually you eventually do find them in the real data.) You say, 'Under what conditions would you expect to find . . . ?' Our example was one where they can assess the pain adequately, but don't know how to treat. What we had previously been talking about was *standardized* pain, and now here is *unstandardized* pain." Larry responds with the situation where the staff feels they need more tests to determine how to treat. The professor says, "Yes, but there is still another possibility. That is where they can assess pain to their own satisfaction, but they don't know how to manage it because the appropriate treatment would disturb some important physiological function in this particular patient. So they are hamstrung. They are balancing priorities (now I happen to know it is true, because you see it with people who are dying) . . . . Anyhow, that is a possibility. You always try possibilities even if they seem not too likely; and you write memos to that effect. When you actually hit them in the field or in interviewing, then you will recognize them!" (A nurse speaks up and gives several varied examples of that particular logical possibility from her own experience as a nurse.)

There was a long silence. The instructor then pointed out that at least two paths could be followed now. (He warned them never to be too anxious, since it didn't much matter which one they followed – they could come back to the

other eventually, assuming this was a genuine inquiry. They had the whole hospital available plus their own aches and pains.) "First, given the dimensions we have now got memos written about these; we can follow any and all of them up, and anywhere in the hospital – via the kinds of sampling questions we have been asking." (For example, it could be asked under what conditions someone doesn't have to legitimate, and what would happen; or when one is one's own legitimator and then comes into the hospital; and vice versa, when one is suddenly on one's own after a spell in the hospital?) The second path is to just pick another locale where somewhat different things are likely to happen: thus on another ward the patterns of pain, the pain trajectories, etc., will be somewhat different. You can go to another kind of ward, to a nursing home, you can turn your attention rather to what goes on at your own home, or you can take some pattern like that associated with arthritis and interview many patients with arthritis. This kind of nonrigorous, or related, theoretical sampling is analogous to going to the library and deciding to go to the reference section and just start skimming through the books in that section, just to see what happens, because you feel you are bound to find something interesting that you didn't necessarily anticipate.

"It does make a difference whether you follow the locational path or not, so we will do it both ways to show what happens. Let us first take the locational path, perhaps visiting a pediatrics ward, and there looking for pain and pain management. You have in mind all the categories we have already discussed today. But you aren't going to restrict yourself just to them – you are going to leave yourself wide open for anything new. One new phenomenon that you will find, I know, for instance, is that on pediatrics the staff must very often take into account the child's parent. The parent, here, can intervene for the child patient in matters of pain relief. (For an adult patient, someone might intervene also, but that is not so likely as on a pediatrics ward.) Let us keep that in mind. But now, Fran, can you describe the type of event where pain is a problem that one sees on pediatrics?" Fran describes a young child with leukemia who has lesions in his mouth, so that feeding becomes a painful process and there is danger of infection; but he must be fed. Instructor: "So here is *pain inflicted* by staff or parent on a very young child; but it is *necessary pain* in the sense that feeding must go on for survival. OK – tactics?" The two nurses and rest of the class begin to list the tactics (aside from the obvious avoidance of pain through intravenous feeding): Give bland foods, give him foods he likes, give him constant encouragement, the mother does the feeding, give him rewards (like ice cream) for suffering the inflicted pain.

Instructor: "So now we have a new, important category: *pain inflicted for the good of the patient*. Here it happens to be by food, but it could be by tests or treatment. So let us try each one of these now. How do they handle pain that accompanies treatment?" The class offered: distracting, having her participate in it as an event, saying to her, "Soon it will be over." The instructor: "You see how *dense* your analysis is becoming. But analytically, not anecdotally. You can say, for instance, 'It will be over soon,' because the pain duration is short, or because you can tell the child, 'It is necessary,' or because you promise her it will only happen once, or because it is not really too frightening. If you are going to do it every day, then you have another kind of problem. Or if it is the



kind of treatment where the pain begins mildly and then increases, then you have another kind of problem that probably will be handled by different interactional tactics. Every one of those possibilities you might like to be on the alert for, or you might just happen to come across during a day's observation."

"Now," he continued, "you can see why parents are so important on Pediatrics – just in this matter of pain management and relief. And that runs into the issue of trust. That can be theoretically sampled: What happens, for instance, when a child has been trusting, and then you give him a shot that hurts him terribly? And what about a painful treatment that he can see works out right away against one that he can't see work immediately? Or what about something like an application of iodine which he is familiar with, so he knows it is a short pain if only he can get through it, as against one whose efficacy is invisible to him? And how do you explain to a young child about a test, that it is not a treatment but that it is necessary to find out what is wrong with him so they can help him? That is one additional step upward in abstractness. So you watch the tactics associated with giving that test, for they probably will be a little different than with a treatment per se."

"Then you flip-flop your sampling: You look now for treatments and tests that *don't* cause pain, in order to make necessary comparisons – to see the similarities and differences." A student suggests: "A parent may not be necessary during painless treatment or tests." The instructor continues: "Or, you look at situations where the kid might be frightened but actually no pain will be inflicted. So you are theoretically sampling in terms of what is absent. For a dimension like fright with pain – now you take pain away and see what happens in an actual case of that. All that kind of *microscopic sampling* you can do. Or you don't bother with finding those situations, but you run across them and observe them. Then you realize that something different is going on that is well worth noting and thinking about. In short, you can't just study pain, but must study all the penumbra of events around it. You will see it, anyhow, but you must build it into your analysis." Student: "This is probably what happens when people think, anyhow; it makes ordinary thinking explicit." Instructor: "Yes, explicit but theoretical sampling drives this kind of thinking to its limits. You realize rather quickly where your holes are."

He added that while he had been trying to show the class how to do theoretical sampling and find comparison groups, he would also suggest that it doesn't take a genius to do this kind of work. Some people do it better, more efficiently, and can operate on more abstract levels. And of course, one learns to do it faster and better. A student hazards that the genius part is, "How far to take it and in what direction. You can't check out everything!" Instructor: "I also feel that it is temperamental. You cannot allow yourself to be too compulsive – following every last lead, dotting all 'Is,' and crossing all 'Ts.' Also, when you see you are not getting anywhere with a given line, you drop it and move on to something else. If, for example, you can't figure out a legitimacy angle, leave it in your notes, and move to something else. If you are totally blocked, go off to the park or somewhere else where it's fun to be, and then come back refreshed!"

Student: "So, it's not a question of finding out the truth, but *which* truth. Whatever you find out, it will be true and it will be valid. What you leave out

may not be interesting or important to you, but later may be important to somebody else." Instructor: "And if your theory is sufficiently comprehensive and dense – as we say in the *Discovery* book – their work then can fit right into it. It is just a matter of systematically integrating your theory. And that is how theories are built up. If anybody argues that, 'I didn't see what you saw,' then you say – 'of course not, you went in with a different frame of reference, or went to observe pain management, say, on a different ward. But if you, on the other hand, follow me step by step, you will certainly see what I saw.'"

## Coding through detailed analysis

The next set of materials foreshadows the extended discussion of codes and coding in the following chapter. Again, there will be no commentary on the materials, but here too one can see the same experienced instructor–researcher carrying out an analysis. This time it is based on a detailed scrutiny of data, done line by line and also paragraph by paragraph. He had been given a one-page interview, also reproduced below, by a graduate student in sociology, some time after a conference between them (see the précised version of the conference, Chapter 7, Case 5). The central theme of the student's research seemed then to be this: crucial contributions made by parents to the physical survival of their babies and young children, who had been born with severe congenital heart conditions. The student had had little expereince with coding, for he had been unable to attend the research seminars because of the constraints of his position, working as a social worker with the parents at a medical center where the babies were born and given medical treatment. After scrutinizing the interview, the instructor conveyed his coding results (and associated queries) on the telephone, while the student took careful notes.

Probably it is not necessary for readers to understand the details of the reported analysis, except to understand that the instructor's focus is on parental monitoring and assessment of danger signs – something he was much sensitized to by his own research on clinical safety work done in hospital settings – along with considerable work done on the *biographical-time* conceptions of chronically ill persons, derived from a study of those patients and their spouses (see Chapter 9). Although he brought that knowledge and sensitivity to the interview data, he did not bring the concepts of monitoring and assessing to the data beforehand. Rather, he examined the interview, word by word and line by line, coding as he went. Note again the theoretically informed questions, the suggested hypotheses, the potentially useful categories, the dimensions, possible conditions, consequences, and so on. All these are provisional, offered by the instructor to the student–researcher as guides to focus his analysis and further data collection.



### *The interview (by Aaron Smith)*

The parents installed a very sensitive, high-frequency intercom in the baby's and their room. It was kept on at all times. They wanted to hear her breathing and to know that she was OK.

*M.:* We did what we had to do, there was no other choice. When we first took her home, we seldom slept, at least, not too soundly. They (the doctors) told us to watch her and not let her get excited; so we played a lot with her until she fell asleep. They told us to look for reactions, so the only way we could do that was to stay up with her. Lucky for us, she slept a lot, but it didn't help because we were afraid that she would die and we would be asleep. We took turns sleeping and then sitting with her. This lasted for two months. I don't know how we did it, but we did.

*F.:* It was hard to work all day, sleep for three hours, and stay up the rest of the night and go to work the next day. We did what we had to do – no other choice. We got to know her very well and at times we would wake her up, just to see if she was alive. That might sound silly to you, but we understood that she had a serious heart condition, and needed watching for any signs and symptoms of changes that would mean trouble. We called the doctors at the slightest change in anything. Our doctor was kind and didn't seem to get upset by our frequent calls. I don't care if he had, we would rather be wrong than sorry.

*M.:* I got the idea about the monitor from the smoke detection device. I talked to a friend about it, and we went in search of a sensitive intercom system that could hear it. She scared us once or twice when we didn't hear her and both of us ran into her room and she was turning her head over. That scared us.

*F.:* She's been back to her own doctor three times in the first two weeks we had her home. We also brought her to the emergency room once in that period. She was cranky and irritable and we just wanted her checked. She was fine each time, but as my husband said, we'd rather be wrong than sorry.

*M.:* She's three months old now. We've turned the intercom off. We're a little calmer, too. We don't watch her as much or as close as we did. We know more about her heart now than we did when we first went home. I'm sure we didn't learn anything that we hadn't been told, we are just better able to hear it now. Her heart hasn't been fixed – we're still waiting and hoping that those damn symptoms won't show up. I guess we do still worry, that sledgehammer is still over our heads.

*F.:* I guess it will always be. If things don't change one way or the other, we'll have to wait it out and see what happens. I guess we've had it easy compared to other families we've heard about, but it really hasn't been easy, overall, for us. I guess each situation is by itself in terms of what it means.

*Analysis and queries (by the Instructor)*

*M.:* "*We did what we had to do, . . . no other choice.* . . . The doctors told us to watch her and *not let her get excited.* . . . They told us to *look for reactions*, so the only way we could do that was to stay up with her. . . . We were afraid that she would die and we would be asleep. We took turns sleeping and then sitting with her. This lasted for two months."
*Instructor's response:* The parents shouldered responsibility for the child's survival. They assumed an active role (saw themselves as taking on this role); saw themselves as having no choice – what is choice about? Moral obligation and/or the child's survival, the child is theirs and no one else's.

When the doctors said not to let the child get excited, what did they mean? It's dangerous, it's serious? The doctor's comment, "not let her get excited," suggests it's an action under the voluntary control of the parents; they could stop it if they liked, it was up to them. There were three possible responses to that: (1) prevent it, get rid of it altogether; (2) look for reactions suggesting its occurrence; (3) stop her as she becomes excited.

The doctors gave the parents instructions. What did they tell them as the process for keeping the child alive? Watch her. What's involved in that watching? All day, part of the day, when she's asleep? When she's awake?

Specificity – What did they tell them? Intensity – how did they tell them?

sternly?
eagerly?
casually?
nicely?
excitedly?

Do they tell them how to do it and what to *assess* for?

"The only way we could do it was to stay up." An active role of the parents, their job; they couldn't delegate it to someone else (e.g., grandparents, teenagers if any, older children, etc.).

"Lucky for us, she slept a lot" – Was she in less danger when she slept, yet they were afraid she would die in her sleep? Double whammy. Is there an element of ambivalence here? Stay awake to get cues to be alert or could they take a chance, get some sleep themselves but run the risk of her dying while they were asleep?

For how many months was this their life? Was anything else in their lives? – this emergency, crisis division of labor, this ceaseless burdensome existence, where their negligence could have been fateful as far as their child's survival.

*Central issue. Monitoring*, labels for categories of monitoring.

*F.:* "It was hard to work all day . . . and stay up the rest of the night and go to work the next day. We did what we had to do – *no other choice.*"
*Instructor's response:* An interminable two months, scheduling living activities. Parents accumulated tiredness and fatigue. How did they stay alert and be tired at the same time? Where does this lead? How do you juggle this? Does some cheating on monitoring take place?



There's a great deal of anxiety going on – being familiar with the cues. They continued to wake her up to see if she was alive. There is a discrepancy here.

What do they understand about their child's condition – What's their imagery? That she has a serious illness?

What do they know as a result of their monitoring activities? If she doesn't improve or change, is she getting worse? If she seems as though she's getting better, is she getting better?

*First-order assessment.* Parents do their own assessing, evaluate the situation based on their awareness of the child's condition. Partial, sometimes, half-time, all the time – When does monitoring take place? How do they know what to monitor?

There is a discrepancy between lay (parents') and professional (physicians') knowledge, between the message and information given and the message and information understood.

However, what happens when their anxiety gets too much or too great for them?

*Second-order assessment.* Apparently, after some deliberation they call the doctor. They would rather be wrong than sorry. They do juggle their awareness activities.

The doctors are back-up assessing agents. Parents are careful that they do not disturb, upset, or scare off the doctor – cautious in their approach to him.

Their use of the intercom as a second-level assessment agent – they used one machine no one told them about. It is not a medical device; they devised it; the doctors did not tell them to use it. Why not?

The telephone was also used as part of the backstopping activities.

*Third-order assessment.* Taking the child into the doctor's office, the parents give information to the doctor, maybe in answer to his inquiries; he may have found the information significant or may not.

After 2 months, the crisis passed – monitoring slowed down. Their assessing was less frequent. How long? How much space between assessments?

They turned off the intercom.

*Dimensions.* How often did they monitor her? How closely did they monitor her?

They said that they've learned more technical things. What? Are they saying if they knew then what they know now, they would be less tense? Don't know. Would they have been calmer? Would they have monitored less? We don't know. They still worry, though calmer. It is still a fateful situation.

Time:
*Work time* (relationships):
a. monitoring and assessing
b. turn taking
c. marital relationship
*Survival time*:
We'd better get it in time or she will die.

*Intervention time*:
Stop problems before they begin.
*Appropriate act and appropriate time*:
If you don't act right now or at the right moment.
*Time to act*:
1. parents, directly – emergency room
2. parents, indirectly – telephone
3. doctor, indirectly – telephone
4. doctor, directly – sees child

*Time – fateful*:
Future is always part of the present. Time is very important.
Time in relation to the last 3 months – biographical. In the proximate future, it will always be part of the present.
Parents – wait it out; it may be cured or improved.

*Monitoring* and *assessing*:
Quite complex – What is the relationship between the two?
Words and labels (gives categories).
Crisis division of labor as done by parents in their monitoring and assessing activities.

*Illness time* and *activity time*.
Patient work in high relief; parents enter into work field with/for child.

*First-order doctor work*: Doctor's diagnosis and warnings, instructions, etc.; division of labor, lay (parents') role and professional (doctor's) role.

*Second-order parent work*: Assessing the child's condition and state, monitoring responses, reactions, overall awareness of child's present state.

*Third-order doctor and parent work*: Parents bring child to clinic; child examined, doctors ask parents questions; parents answer to best of their knowledge and awareness; solicited and unsolicited information.

*Fourth-order parent work*: Back stopping; physician called if cues suggest something the doctor should be aware of; contacts primarily via (indirect) telephone.

*Fifth-order parent work*: Will bring child to emergency room or take to local doctor or into outpatient clinic; contact is direct.