

Risk Management in the Wild

Cultural Dynamism against the Unknown
in the Ward Life of a Mental Hospital in Japan

Interdisciplinary Cultural Studies 7

2007

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Introduction

The notion of risk and risk management is now spilling over from academic discourse to everyday economic activities. Risk appears to hide at every corner of our society, from internal corruption of a private company to environmental hormones; and we are obliged to analyze and manage it as precautiously as possible. The rise of the notion of risk management partly derives from large scale technological accidents such as Chernobyl or chemical plant accidents (cf. Perrow 1984; Reason 1997), and the notion of risk management has been deeply influenced by the engineering definition of it. Its basic tenet is that risk can be neutrally assessed with the use of scientific tools of analysis, with which the probability of the adverse event can be estimated quantitatively to be then managed in line with such calculations (cf. Golding 1992; Renn 1992; Funtowicz & Ravetz 1992).

Yet the notion of risk management's neutrality has been seriously challenged by a number of pioneering works, such as Douglas and Wildavsky (1982) on cultural foundation of risk perception, and Wynne (1987) on the regulators' and scientists' confusion over the definition of risk and its assessment in the case of hazardous waste. Bringing together these criticisms against the engineering notion of risk, Jasanoff commented on the 'two cultures' of risk analysis of engineering and social science, and proposed how to bridge them with the emphasis on the possible contribution of anthropological and sociological approach for adding complex and contextual nuances to the engineering understanding of risk (Jasanoff 1993).

Turning our eyes towards public health, similar trends towards risk management have been propelled by different reasons. Heyes found an explosive rise of the notion of risk in Medline: from 1985 to 1991, 100,898 references were made to it, while in contrast it was 29,870 to cerebrovascular disorder (Hayes 1992). Aside from concern

for risk in health care and for lifestyle risks to personal health such as smoking (Lupton 1993; Hayes 1992), medicine related litigation has contributed to the rising risk consciousness in medicine (Heyman 1998: 2 ; Sanfillipo & Robinson 2002)

A similar trend is now underway also in Japan, where the number of litigation in health care has doubled from 352 in 1990 to 767 in 2000, and is increasing (Okada 2005). The news coverage of medical accidents are also highly visible, and new academic societies related to medical safety have been established in recent years such as JSHCM (Japan Society for Health Care Management) or JSQSH (Japanese Society for Quality and Safety of Health).

In overwhelmingly quantitative studies of risk in medicine, Heyman (1998) underlined the essential ambiguity of the notion of risk in the context of medicine, where risk has not been regarded negatively all the time when patients were concerned. This ambiguity is most clearly seen in the balance between the autonomy of the patients and the staff's effort for their safety. (Heyman & Henriksen 1998:95; Corkish & Heyman 1998: 221). Heyman et al pointed out that specialists on children with learning difficulties once regarded risk as favorable and even referred to it as 'the dignity of risk' (Heyman, Huckle & Handyside, 1998: 211).

This paper will elaborate the very ambiguity of the notion of risk in the context of psychiatric wards in Japan during the period just before such notions of risk management started to flourish. Here the term risk management in the wild is temporarily defined as showing both the ethnographic sense of describing the risk management practice *in situ*, and the nature of the observed practice that was less formalized than the subsequent introduction of formalized methods of risk analysis. Twisting a terminology of Goody on literacy (Goody 1977), *domestication* here means the increasing influence of the engineering notion of risk which has been promoted by government policy, and this paper tries to see ward life just before such systematic domestication began.

The once rich ethnographic studies on psychiatric wards, particularly in post-war US (Stanton & Schwartz 1954; Caudill 1958; Goffman 1961; Perry 1966; Stotland & Kobler 1965) have faded largely due to the transformation of psychiatric policy in major advanced countries (cf. Grob 1994; Mansell & Ericsson 1996; Shotter1997). Although similar trends have been promoted in Japanese public health, mental hospitals in Japan are still playing

a pivotal role where the classical tradition of ethnography on psychiatric wards is an ongoing reality¹. The purpose of this paper is to describe non Anglo-American case studies in psychiatric anthropology (cf. Carpenter 2000; Comelles 1991; Gaines ed. 1992, esp. Nomura 1992) within the context of risk analysis and risk management.

For this purpose, I will introduce two mutually related theoretical frameworks. The first is the notion of distributed cognition most eloquently promoted by Hutchins, in his seminal ethnography of naval navigation (Hutchins 1995). One of the main themes of his analysis was the socially and materially distributed nature of cognition, where the crew's collective activities were coordinated via a variety of networks of communication, information and tool use, in response to changing environments.

Having not explicitly underlined the notion of risk management, his case studies were nevertheless filled with such aspects, like the ship's possibility of grounding on rocks, and he described vividly the way of managing risk *in situ*, such as the recovering process from the malfunction of a certain tool by organizational redundancy where each sections' overlapping area could support the other part in crisis (Hutchins 1990).

However, in spite of the richness of material, Hutchins left a couple of questions unanswered. Among those was the nature of constraints which influences how the organizational sections collaborate via cognitive tools. This I call the problem of cognition/law (Fukushima 2001; cf. Bourrier 1999), and here ~ /law means both legal and socio-cultural constraints such as regulatory constraints of manuals which may curb the best practice, or organizational culture which restrains its member from taking proper decisions. This will be one of the focal points of this paper.

In compensating the weakness of Hutchins' approach, the study of High Reliability Organizations (HRO) by the Berkeley research team of K.Roberts, G.Rochlin, G. La Porte and others will be referred to. The HRO studies were a collection of qualitative field studies of high risk organizations with high safety performance, such as air traffic control towers, aircraft carriers in the Navy, and nuclear power reactors (Roberts ed.1993; Weick & Sutcliffe 2001; Rochlin 1989). Among impressive findings, a distinctive characteristic was that these organizations are very flexible in shifting the decision-making authority to adapt themselves to rapidly

1 Asai ed. 1996 reviews the Japanese mental health in the international perspective. As to the concise history of psychiatry and mental health policy, see the editor's introduction (Asai 1996). In brief, the number of mental hospitals and that of inpatients continuously grew from around 50's up to 90's, and in 1993, mental health policy started to shift to community care, accompanied with the gradual decrease of the number of hospitals and patients. Attention should be paid to the fact that the majority of the mental hospitals are privately owned so that a nation-wide policy to close them down like in Western countries was hard to practice.



changing environments. Another example is the redundant way of communication to scrutinize risky information multi-dimensionally akin to Hutchins' case (LaPorte & Conslini 1991). Furthermore, the problem of cognition/law was analyzed in the studies of nuclear reactors where the staff were forced to balance between the appropriate way of managing risk and abiding by the complex regulations, which were in place to determine the level of safety there (Schulman 1989, 1993; Bourrier 1996).

This paper tries to synthesize these two approaches with a case study of psychiatric wards. Three points will be focused upon. First, the way the staff of psychiatric wards perceived and identified possible risks that should be managed will be analyzed ethnographically. Here the emphasis will be on the analysis of the distributed and collective nature of risk perception, especially on how staff perceived the tacit signals of the patients (cf. Polanyi 1966; Fukushima 2001).

The second point is concerned with the tools of risk management and its actual execution. Once consensus on risks was reached, there should be tools and devices with which to eliminate them. There were a couple of such tools in the face of perceived risk, such as possible violent behavior, yet in the context of medicine and psychiatry, such measures can always be contested as to their effectiveness and legitimacy (cf. Cutcliffe & Barker 2002; MacKay et al 2005). Further resources of risk management were personal contact, medication, and particular places like observation and isolation rooms. But these multiple devices had their intrinsic limits in both technical and moral (or symbolic) senses, and this would lead to problems of the actual application of risk management which will be analyzed.

The third point is the blurred boundary of negative and positive risk, and its consequence for the application of risk management. The point here is that the subtle balance between negative and positive risk is a dynamic process where an ethnographic gaze is required for proper understanding. This balance is also related to the cognition/law problem mentioned above, as optimal measures to prevent risk in the ward life were not necessarily carried out due to the complex relation of restrictions on these measures. I will show that the organizational ward culture restricted the staff's decision making in the face of impending risk in complex ways.

Research site and method

The setting for this research, Hospital X in Tokyo and has about 500 beds in closed and open wards. The research took place from the end of 1994 for half a year at an open ward, and from 1996 to 98 at both the open and closed wards. I visited these wards maximally once or twice a week, mainly on the day of the ward meeting.

At the time, each ward had about 10 *tatami*-rooms where 6 or 7 patients lived together. At the center of each ward was a nurse station, an observation room annexed to it, doctor's rooms, a bath, and isolation rooms in closed wards. The patients' daily activities were organized according to a fixed schedule and during the daytime, a lot of time was spent on occupational therapy in another building.

A weekly ward meeting called *kanfa* (from English conference) was one of the most important resources for this study. The ward members, such as the ward doctor, nurses, a social worker, an occupational therapist, a pharmacist, a dietitian and a clerk gathered together to discuss the problems related to ward life.

The *kanfa* usually started with the introduction of new patients. Then reports from paramedicals were followed by reports from nurses, each of whom was responsible for a room for approximately six patients. There were differences in the style of the *kanfas*, between doctors and between open and closed wards. In the latter, reports tended to be brief and formalized while in the former, the discussion tended to be long on a limited number of chronic patients. The following case studies come from observations from such wards.

Case one: Everyday collective devices for perceiving signs of possible risks

I begin my analysis with a possible case of suicidal intention (*jisatu nenryo*). Suicide was one of the gravest risks that the ward staff were facing, and the following record of a *kanfa* shows the way in which the staff analyzed data and diagnosed collectively. The difficulty of this case was that the patient, Mr. K, was poor at communication so that staff were forced to guess from circumstantial evidence whether he really had suicidal intentions².

(26, Aug, 94)

① A, doctor of the ward: Mr. K seems to be fatigued but I don't

2 For transcribing and translating the following segments of conversation, details have been changed to avoid the identification of the patients and the staff.

know why. As he cannot describe his condition through words, we have to guess how he is now. I wonder if his bad condition may derive from the fact that his family told him that he might have to leave the hospital. Well, I told him to hang on to that thought, but I am worried because I saw him dashing to a window and trying to throw himself out and he hung on the rail at the window. Occasionally he acts impulsively and it's scary.

② Nurse H: Last morning he said that he hated his life, and he looked discernibly dejected. So I once tried to put him in the observation room, but he usually leaves the room within 5 minutes. I am worried about him too.

③ Dr.A: It's true that he hates the observation room, but it's impossible to watch him in an ordinary room.

④ Head Ns : Well, his problem is serious.

⑤ Ns H: His family said that he had called them frequently about his ill health. But it seems that they do not know that Mr K met his sister. I am also wondering what he should do about the occupation therapy.

Then Ns S, who was in his charge, gave a crucial piece of information which actually determined the cause of the discussion.

⑥ Ns S: If I suggest him to have a rest, then he answers ' well, no, I am not tired'. [.....] His footsteps were *pata pata* [pitter-patter] as usual. When his footsteps are *pata pata*, he is in good condition. Actually when he was in a bad condition last time, his footsteps were like *suuuu* [silently], and I could not hear them. So I suppose he is in a good condition. Actually he says he does not feel tired. [.....]

⑦ Dr A: As he claims he's been sleepy, I have reduced the medication. I wonder if his ill condition may have derived from my reduction of medication last month. I am not quite sure about the relation. So I will try to restore that.

⑧ Head Nurse: Well I believe he has not been so ill.

As the head nurse of the ward concluded that Mr K was not so ill, the search continued on a different track of thought; at first it was a sort of sociology of family. After talking a bit about his family, the head nurse presented her interactional analysis of the human relations in the ward.

⑨ Head nurse: Well, I would say, people may pet, or bully or make fun of Mr K. If he pronounces a word then other patients say 'shut up'. Mr M often complains that Mr K is too noisy; he repeats the same thing again and again and people feel he's annoying. But

actually he's not bullied. He is simply made fun of.

⑩ Ns I: When he was in charge of the meal, he had something going on with Mr L. Was it the reason?

⑪ Head Nurse: From the group of Mr L and others, Mr K is thought to be a bit annoying.

⑫ Dr. Well I suppose it will be critical for him when he will no longer be looked after by others, then.

The record shows how the staff assessed the possible risk of suicidal intention collectively. The doctor was not quite sure about Mr. K's condition, so that nurses added verbal clues about his desperation (②), and his family's testimony of his frequent reference to his ill health (⑤). The course of the conversation changed with Ns S's self-made diagnostic criteria focusing on the sound of the footsteps (⑥). *Pata-pata*, an onomatopoeia, can be translated as pit-a-pat or pitter-patter, in contrast with *bata-bata* or *dota-dota*, the latter with the nuances of heavier sounds of walk. So *pata-pata* is an expression of light sound reminding us of relatively light weight. The other expression *suuuu* usually shows a quiet movement, showing that Mr K slid his feet along without liveliness. Ns S concluded that Mr K with his footsteps was in good health and this was accepted by the other staff. A nurse later explained to me that Mr K impressed the staff by banging the doors and the noisy sounds of his walk when in good health, so this onomatopoeic diagnosis was understandable to them too.

If he was in good condition, then what is the cause? Reduction of the medication (⑧), the role of his family, and then came social interactionism (⑨–⑫). The head nurse suspected the possible intervention by Mr. L, who was thought to be manipulative, but there was no decisive clue for that. In conclusion, the staff seemed to assess that the suicide risk was not very high in this case.

As the resources for medical diagnosis were limited, other various sources were fully mobilized; ranging from medicine to naïve-sociology. These different perspectives were accumulated rather smoothly, but this time could not draw a very focused picture of his recent instability. Here one of the characteristics was the relative lack of technical jargon. Nr S's onomatopoeic description were easily accepted as the '*evidence*' of his being not quite ill in contrast with cases in American mental hospital in 60's-70's where psychoanalytic jargons caused serious trouble among the staff (Stanton & Schwartz 1954; Stotland & Kobler 1965). The heterogeneous judgments were

smoothly combined and such commonsensical descriptions were seamlessly intertwined with the doctor's medical judgment.

So in conclusion, the risk of a suicide attempt did not seem to be impending, despite his impulsive outlook. In fact it was only this time that his serious threat to suicide was discussed. But in terms of risk management, this discussion also revealed serious lack of proper tools. His impulsive behavior needed to be observed continuously, but as ③ shows, the staff could not contain him in the observation room and the isolation rooms later described were not appropriate for preventing suicide.

Case two: the shifting nature of risk management and risk taking

The second case will show a different type of risk management involving a patient, Mr. M, who had drastically lost weight. Just like the case above, it was difficult to find reasons for his weight decrease. At first the cause was thought to be purely medical, and the staff treated it as such. Then they gradually changed their diagnosis and the initiative was transferred to nurses and thus the nature of risk management also changed diachronically.

At first, the staff pragmatically tried to let him eat. This strategy, however, collapsed when he started to reject medication. The ward doctors admitted that they needed to overhaul the treatment policy by stopping all the medication provided to him. The other staff did not comment much on the change of strategy. The radical overhaul appeared to work and the patient subsequently started to regain weight. The peak of the crisis seemed to have passed. Yet his strange behavior continued and the staff started to think that there might be something more than the physiological reasons behind it. His strange behavior persisted and included acts such as entering the isolation room with his underwear down to his knees.

At first, the staff suspected that his behavior had an element of hysteria, a rare diagnosis of which they were not quite certain. As the following conversation shows, after the impending risk of weight loss, a new theme came to the surface.

The ward staff discussed Mr. M's diaper and the doctor suggested that he should be out of the ward when he had enough time. (5, Feb, 1997)

- ① Dr B: He has become a bit like a baby recently
- ② Ns F: He's dependent (*izon-teki*).
- ③ Ns D: Yes, Indeed.
- ④ Dr B: Well, then he will grow up, I suppose (laughter). You know, if he is a baby and dependent, naturally we wish he will grow up (laughter). Well, we have to accept his *amae* to a certain degree, And then gradually we wait for his full growth (laughter).
- ⑤ Ns F: But the difficulty is to what degree [we accept]
- ⑥ Ns D: To a *certain* degree?

The new theme was his *amae*. *Amae* is a Japanese term of psychoemotion which became well-known through the extensive semantic analysis by the Japanese psychiatrist Doi, who emphasized that this term shows one of the key elements of Japanese mentality. *Amae* can be loosely translated as dependency, but as Doi showed, this has more positive connotation unlike its corresponding English word, dependent (Doi 1973)³.

The staff began to regard Mr M as *amaete-iru* (showing tendency of *amae*). Describing someone's behavior as *amaete-iru* usually has a critical nuance, as in the person behaves childish, *too* dependent etc. Mr. M's behavior was thought to be a sort of regression to that of a spoiled child who sought to be cuddled like a baby (①④). The staff accepted this framework and the treatment strategy changed from risk management to that which was similar to disciplining a spoiled child.

Being suspected as *amae*, his unintelligible behavior kept on and the ward doctor openly confessed that he did not understand the patient's motive. The following record shows how the staff was at a loss about his intentions. (25, Mar, 1998)

- ⑦ Dr B: it's good that he's in good condition. Has he been eating these days?
- ⑧ Ns F: Today he took orange juice.
- ⑨ Ns I: Well, he does not participate [in ward activities]. When he comes here [to the nurse station] he simply lies down...
- ⑩ Dr B: He was sprawled out here(laughter)
- ⑪ Head Nurse: Yes, he was down here even today!
- ⑫ Ns. I: Well, he was appealing to something but I don't know what it was.
- ⑬ Dr B: If he does not bother others, It may be better letting him down here.
- ⑭ Ns F: He is down where it bothers people.

3 *Amai* as adjective means sweet in terms of taste, and permissive in terms of one's attitude. *Amae* is a noun and describes a mental state of dependency, unrealistic expectation and so on. *Amaeru* as a verb means to be dependent, but rather positively.

- ⑮ Dr C: Didn't he get up again when you did not say get out?
- ⑯ Head Nurse: Yes, indeed, he would get up by himself.
- ⑰ Dr C: I watched him going to toilet and his footsteps were firm.
- ⑱ Ns I: We are at his beck and call.

After the visible risk of weight loss managed by the doctor, the staff had gradually come to understand that there was something more behind this, when his strange behaviors came to the surface of the staff's concern, which was dubbed as *amae*. Compared to the first case where the mobilization of all the possible resources was simultaneous, in this case two different waves of thought came to the surface one after another in line with the change of the perception of the nature of the risk. In the first case, the very nature of suicidal intention was the focus of the mystery story (Brown 1993) while in the second, the loss of weight was such an evident symptom that the staff could concentrate on its *visible measurability*, with risk management policy confined to medicine and nutrition.

Things got complicated when his strange behavior became the focus of collective diagnosis. Then the new idea of *amae* came to the surface with the initiative of the nurses' more commonsensical judgment. As the doctor's joke on his *amae*, followed by an explosion of laughter shows, describing him in terms of *amae* had a very cynical connotation, compared to describing his case technically as regression in psychoanalytic sense. This is an interesting case where the ambiguity of the notion of risk is becoming visible, which will be discussed further below.

Meaning of tools in the face of the risk of violence

Now we will focus more on the second point, i.e., tool use in the context of risk management. In the ward life, there are a couple of observable adverse events that can be labeled as risk, like eruptions of violence, squabbles among the inmates, attempts of assault on the staff and so on. Aside from the cases shown above, the category of high risk patients could overlap with that of difficult patients, including criminal patients. Among them, the staff were aware of the condition of those related to violent behavior. As the condition levels of the patients could not be quantified like vital indexes, everyday observation of their behavior was required to avoid an undesirable incident.

One of the major tools for managing the risk of such problematic behaviors could be medication. If these problems are diagnosed as caused by the worsening condition of a patient, these should be dealt with changes of drugs both in kind and amount. But in this context, tacit organizational culture of a ward exerted influence upon its general policy. Medication could be a tool used as a sort of chemical straitjacket by tranquilizing the patient's behavior. But how far the staff should treat a patient in terms of risk management depended upon the situation and the ward policy for treatment.

The dominant understanding of the staff, either said or unsaid, was to avoid patients from being drowsy due to major tranquilizers. However, this shared understanding, while certainly commendable as a basic policy, had its own drawbacks. Although it was true that the staff did not like *over*-tranquilization, what exactly it meant to be 'over' was in fact situationally determined. As the following case will show, when a patient showed exceptional sensitivity to the normal dose of psychotropic drugs, the meaning of 'over' became quite problematic. Here the tacit assumption about the desired condition of a patient began to exert its influence on risk management policy.

The second major resort for risk management was isolation rooms. A closed ward had 5 isolation rooms, which in Japanese are called *bogo-shitu* (literally: protection room), or in Japanese medical jargon, *Zelle* (from German, meaning the cell). The staff usually paid serious attention to violent behaviors giving almost uniform treatment to patients responsible for such acts by putting them into an isolation room immediately.

I witnessed a number of occasions when the staff rushed to the place where a violent act, usually a small quarrel, occurred. In the worst situations, to avoid possible risk, usually male nurses were summoned to the scene. Arriving at the scene, questions were asked in a brief but stern way, and the person in question was requested to go to an isolation room. The entire procedure would resemble that of an arrest of an offender by the police, if it were witnessed without knowing its background.

The official discourse of the staff at this point, however, was varied and a bit confused. One of the most often stated 'reason' to put a violent patient into an isolation room was to calm the patient down. But things became less persuading in the quite frequent case of violent quarrels, when the staff reached the scene and the dispute had already been settled and the patient had returned to a state of calm.

Behind this determined attitude of the staff concealed the message that violence was not allowed in the hospital. So this swift procedure was intended for the patient to learn the lesson against violence in the hospital, or, more forwardly put, to punish them.

The very ambiguity lies at this point. For the isolation room to function as a risk managing device, it should work as a learning tool for patients to understand 'why' they were put there. The following cases will show that this is far from reality, and this also leads to show the ambivalent nature of these risk managing devices.

Case three: a difficult patient and the limit of tools.

There were a couple of cases thought to be difficult by the staff where this dilemma came to the surface. Mr N was one of these cases: when he was frantic, no bundle of male nurses could stop him. The greatest worry of the staff was the security during the night as the number of the nurses on night shift was too few. His symptoms also drew concern for the staff as his delusion seemed to develop steadily and he often claimed that members of staff had attacked him. This could provoke a defensive reaction on his part and he would attack staff in retaliation. So the staff was usually fully alert as to his reactions.

Yet his case, as well as other examples not shown here, revealed the limited availability of the practical tools of risk management. In fact some of these patients had a rather idiosyncratic sensitivity to major tranquilizers so that the standard dose made them drowsy and inactive. Here the risk management policy was confronted directly with the organizational culture which tacitly prevented the staff from overdosing, as the staff did not like such drowsiness, though, in terms of dosage, theirs was the average dose for other patients.

Without medication, the staff realized that there was not much to be done to control such violent tendencies for the riskiest. Therapies, either recreational or occupational, were mainly for reinvigorating inactive patients and not effective for curbing developing delusions. The ward doctor's medical in-depth consultation did not seem to be successful at all. At the kanfa, the doctors often reported how they avoided requests from such patients to be discharged from the hospital.

Nurses also found them hard to communicate with. A nurse

in charge of Mr. N witnessed that this technique of conversational soothing did not work well with patients of his ilk, “because the more I try to soothe him by talking calmly and patiently, the more agitated he gets, and his own excitement further stirs the emotion. It’s like a vicious circle”. Thus once in a kanfa, the doctor wanted the occupational therapist to treat the patient, but the latter talked back saying not to expect too much from the therapy. As a result, the staff adopted the strategy of changing the level of the patient’s restriction of behavior to create the impression that the patient was gradually freed from the ward.

Case four: the moral basis of isolation rooms

The very last resource of managing the risk of violent acts was the isolation room. The multiple uses of the isolation rooms are well documented in Uchimura & Yoshizumi (2002) and in Hospital X, similar problems were observed. These rooms were usually fully occupied by heavily ill (and often difficult) patients, staying there for a long time. Managing these rooms in order to have a space for acute patients was one of the daily chores of the ward staff.

The ambiguous nature of the role of isolation rooms can be seen from its very name. *Hogo-shitsu* (lit: protection room) is ambivalent in the sense of who is protected from whom. The following case thus reveals this problematic aspect of it as a major risk managing tool. Mr. O was often put into an isolation room because of his repeated violent behavior. He exploded again and this time he hit a couple of inmates so strongly that one of them had their teeth broken. In a kanfa, the ward doctor expressed his doubt if the patient understood the meaning of being put there, to which nurses agreed. (3, Sep, 1997)

- ① Dr B: About Mr. O, you know, how many times in this year already...
- ② Ns T: He hit Mr. A and Mr. B and...
- ③ Ns S: What shall we do if he’s out of the isolation room?
- ④ Dr B: We have to put him back in, then.
- ⑤ Ns S: Well he lost memory and now again he’s got more distanced from his family. We cannot ask them to accept him. We cannot request too much of his family [followed by minute explanation of what he did to his inmates]

- ⑥ Dr B: Next time we should prescribe a deposit injection or something. But we cannot control him with injections only. [..... this was followed by a discussion on how long he would be put in the isolation room]
- ⑦ Ns T: Shall we say to him that as his stay in the isolation room will be long, he should take care of the laundry? (laughter) He will hit me (laughter). You said it, he would say. I am scared.
- ⑧ Dr B: Then I will say it to him this week.
- ⑨ Ns T: OK.
- ⑩ Dr B: The reason why he will have to stay for a long time is the protection of others. It is not really to cure his own illness. To prevent others from being damaged.
- ⑪ Ns B: Well, you know, I would say that he cannot reflect on his actions, or it's his symptom
- ⑫ Dr B: It's his illness..

In this fragment of conversation at the kanfa, the staff discussed the possible measures against his violence. Two possibilities, such as sending him back to his family (⑤) and medication — deposit injection — (⑥) were thought to be ineffective. So the isolation room would be the last resort and the patient was expected to stay there for a long time (⑦). From ⑩ to ⑫, this is a rather rare, but blunt discussion of the role of the isolation room, not for treatment but for security of others. I believe that these statements rather openly admitted the ambiguous nature of the isolation room as the learning device for patients. It is true that in some cases, it was reported that a patient learned the lesson of being there, but in this case, this did not happen.

Case five: the reflected meaning of the isolation room

In contrast to the case above in which the role of isolation rooms was conceived of as risk managing and disciplinary tool, the following discussion will show the staff's reaction to such a formulation. This was the year when a series of violent rows in the whole hospital occurred and subsequently long discussions on how to deal with such situations were held. The doctor repeatedly emphasized that the staff had to demonstrate to the patients that violent acts were absolutely forbidden. But the ambiguity of the use of the isolation room vis-à-vis this motto was clarified in the case below (7, Oct, 1997)

① Head Nurse: What should the nursing staff do about this [case of violence]? A duty doctor may ask, 'usually what would you do in this case on this ward?', Sometimes I feel like answering, 'well, if he is in such a condition now, it's OK [not to put him in an isolation room]', but at the same time I think it's very important to fix the framework of 'violence is absolute forbidden', and I believe, in any case, it's not acceptable to resort to violence. It is not that we punish, but at least we have to make it clear that we the ward staff think like that. [...]

② Ns F: It's true that we don't like to use isolation rooms except for the worst cases....Well, but violence or other things are absolutely ...If we have used measures like injections or straitjackets in the observation room, and we have succeeded to a certain level of management, but if a real fight occurs, and if both are responsible, then I believe they should be put in an isolation room even for a week. The point that I like to stress is that in the case of Mr. P, I cannot easily say that he should be in the isolation room.

③ Dr. A: Well, you know, these duty doctors change everyday, and each doctor has his own standard of judgment, and we cannot say that 'if there is a quarrel, everyone should be put in the isolation room'.

④ Head Ns: No, we can't say that. But at least it should be demonstrated that in this ward violence is absolutely forbidden.

This is a fragment of a meandered discussion on the dilemma between the motto of anti-violence in the ward and the hesitation of using the isolation room as a punishing tool. Even though the doctor resisted the idea of putting someone into the isolation room in a quasi-legal response to violence in this discussion, in other cases the same doctor was reported to order to put violent patients away almost *immediately* after a squabble.

In comparison with Dr B in case four where he stated so clearly that isolation rooms were for preventing further victimization of other inmates, Dr A above did not like such blunt formulations; at the same time, he did not deny the disciplinary function of them for communicating the message that violence was not allowed. In fact, the function of an isolation room was delicately balanced between a tool of isolation for treatment and one of explicit punishment like a prison cell. It is here that the ideal of treatment and ward culture shown above prevented the staff from a sort of full scale risk management, as shown in the case five, the very meaning of isolation room was occasionally under reflective scrutiny, through which the

4 For describing patients' worsening condition close to a violent outbreak, eye looks were often picked up and described as *metsuki ga kowai* (scary eye looks) or *me ga sankaku* (eyes are triangular) in line with the above mentioned footstep diagnosis.

policy intended for maximum security was actually not allowed.

Discussion and concluding remarks

Assessing and managing risk is a very complex cultural behavior. The points of this paper are concerned with analyzing it in the everyday context of ward life. Concerning the first point of the distributed and collective nature of risk perception, I have shown in the first and second case a couple of different patterns of mobilizing possible information to analyze the distributed nature of risk perception, the range of its mobilization, and its relation with group dynamics among staff members.

Attention should be paid to the importance of the situational diagnostic criteria in the form of onomatopoeic mimicry of the footsteps, facial expression and eye looks⁴ shared and understood by staff of different professions, in contrast with, say, some of the troubles with the isolationist nature of the psychoanalytic language observed in classical monographs on mental hospitals in postwar US (Stanton & Schwartz 1954; Caudill 1958; Stotland & Kobler 1965). In this context, Barrett's ethnographic account of the language used by the psychiatric team in an Australian mental hospital showed a rich repertoire of similar colloquial expressions such as 'not with it', 'out of his tree', 'high like a kite', 'off', for describing the degree of patients' conditions (Barrett 1996: 147-8) or 'stropy', 'quiet', 'fragile' about to go off' in cases of violence (Barrett 1996: 82).

A large amount of these expressions is interculturally translatable and Barrett tended to emphasize their solidarity-making function among the team (Barrett 1996: 167). As it is hard to deny such a 'function', I will add emphasis to their cognitive, situated nature, which is essentially parallel to the cases studied by researchers on situated cognition, such as street mathematics in Brazilian child traders or arithmetic in grocery shopping, which were far from the orthodox arithmetic principles taught in school, yet were shown to be very effective for practical purposes *in situ* (Nunes et al. 1993; Lave 1988). Risk perception in the wards was deeply based on this situated nature of cognitive activities.

The second point of tool use was most clearly pointed in the case of violent behavior of patients., A couple of preventive measures could be mobilized against violence in the wards, such as medication,

therapy, observation and isolation rooms, but in each case there was a sort of ambiguity in the sense of its practical effectiveness and ethical legitimacy. I found that the very use of these tools was deeply restricted by the background hypotheses of the ward staff as to the expected condition of patients. To articulate this point, I will cite an interesting dialogue between the heads of two leading reformist hospitals in Japan in the 60's (Senba & Ishikawa 1983). In this dialogue an interesting episode was introduced: the staff of each hospital mutually visited and observed everyday practices in the other and found they were quite different. In one hospital, it seemed that too much emphasis was put on inspiring patients' participation for events in hospital, which the visitors found too artificial. In return, the other hospital was found to be too quiet. Group activities of the patients were minimal as compared to the first hospital, and generally the impression was one of stagnation.

The differences came from the background hypotheses held by the staff about the ideal image of the patients, which can be tentatively labeled as the organizational culture of a ward or a hospital. In this sense, the staff of Hospital X largely shared the former's understanding, i.e., preferring reinvigorating the patients to letting them rest. In the context of cognition/law, it was not explicit rules or manuals but this organizational culture that exerted influence upon the way the various tools of risk management were used. In the cases shown above, the use of medication and isolation rooms was repeatedly problematized in line with such tacit understanding.

This complex restriction to the tool use is deeply related to the third point of the dual aspects of the meaning of risk. As has been pointed out, risk taking rather than risk management was once thought to be more important in the areas related to education and welfare. Even in the case of violence, maximal risk management was not really the option of the ward staff, and the use of the isolation room was tainted with ambiguity as to whether it was for punishment or education.

The second case was a good example to shed light on the Janus-like aspect of the notion of risk. Judging someone either to be medically ill or to be *amae* makes a difference in the staff's understanding of the nature of risk. Diagnosed as the former, the staff would tend to avoid negative risk, but as the latter, they would encourage the patients to *take* risk for learning to be more autonomous (meaning more adult). In fact, the situation resembles

the cases of children with LD (Heyman, Huckle & Handyside 1998: 211; Corkish & Heyman 1998: 221). The difference, then, is that in the case of my study, the change of the understanding of negative and positive risk was applied to the same person and organizational dynamics of the staff changed diachronically in line with the change of diagnosis.

Such complex relation between cognition and organizational dynamics in the ward life invites us to compare this case study with these of HRO's with high safety performance. One of their important findings was that a smooth shift of organizational style from a rigid hierarchy during ordinary periods to the temporary delegation of authority to the bottom that actually performed the risky task occurred in times of crisis. The Berkeley team believed that it was such smooth shift of organizational structure that was thought to be one of the most important sources of the high reliability of such organizations (LaPorte & Consolini 1991).

This kind of shift can be also observed in the wards, especially in the first and second case, where the change of the diagnosis on the patient from a medical to a more psychological perspective corresponded with the way the collective web of diagnosis was mobilized, and with the shifting of the initiative from the doctors to nurses or paramedics. This flexible shift was one of the features that allowed ward staff to collaborate smoothly according to the changing conditions. But as I have to point out, this smooth shift was not always guaranteed and in some cases, such a shift could develop into a rather clear confrontation between these two modes. As far as I observed the activities of the ward staff, noticeable rifts among the staff were very limited in number, while medical and more commonsensical judgment on a certain patient differed sharply among the doctors and the paramedics.

So it is not the smooth shift of organizational collaboration that makes a difference between the HRO cases and the psychiatric ward, but is the very understanding of risk and safety that differs substantially. This is where the wisdom of the HRO studies is not directly translatable to the research in medical anthropology where the very notion of safety i.e., low frequency of accidents, should be counterbalanced with the contestable nature of the 'risk' of the ward.

In other words, the HRO's made it a rule to search intensively for the 'cause of the possible accident' without much self-reflective regarding on the meaning of risk because it was so self-evident, while

in the psychiatric ward, the search of the 'cause' was more limited, accompanied with occasional self-reflection on the meaning of risk in the ward. This is probably the very nature of risk management in medicine at large and psychiatry in particular, which requires both the intensive search of the cause of the troubles *and* self-reflective search of the situated meaning of risk as such. This double requirement, however, may cause continuous difficulty in practicing risk management in such contexts, as the very strategy itself may meander according to the change of the meaning of the target itself caused by the continuous self-reflection of its situated meaning.

Now the meaning of risk management *in the wild* is ready to be elaborated. Here *the wild* means 'less domesticated' by the engineering notion of risk and risk management, which seems to exert more and more influence upon the expanding empire of risk analysis. The period of my research was appropriate to observe the less domesticated form of risk management as the tools of risk analysis and specialized staff like for example the safety manager was yet to be introduced to ward life. In part, *the wild* means a sort of impressionistic and colloquial way of risk perception and communication which was rather smoothly amalgamated with the more professional, medical judgment and discourse.

The other aspect of the risk management in the wild is the fundamental ambiguity of the nature of risk and risk managing tools in psychiatric context. Unlike the engineering notion of risk in which the target is clearly definable in the case of the HRO's, the very notion of risk and tools in ward life is always contestable in practice. Furthermore, the second-order reflection upon the meaning of risk might jeopardize the first-order practice of risk management, as the former could destabilize the very target of risk control, and might paradoxically even increase the very risk through self-reflection.

Consequently, *domestication* can be defined in a couple of ways. Superficially, it signifies the introduction of a quantified notion of risk calculation with risk analysis tools. It is still uncertain if this leads to the elimination of the impressionistic and colloquial way of risk perception and communication, but one of the imaginable changes may be that the essential ambiguity of risk in the medical field may be replaced with non-contestable, manualized notion of risk and safety where the instability of situational definition of risk can be eliminated.

The sign of such a domesticating process is reported elsewhere

5 Such a tendency is most clearly seen both in the Government policy and the development of the societies concerned with medical safety. One of the often observed scenes at the conferences of such societies is the lectures of the specialists of risk analysis and safety mainly from such industries, usually believed to have developed more systematic methods of risk management vis-à-vis health care.

6 This research was supported by Global Communication Center of the International University of Japan and the department of nursing of the Hospital X. My thanks are to the patients and the ward staff, especially two Head Nurses of the wards for their support and comments, to Fabio Gygi of the University College of London for his helpful comments, and to Toby Moseley for kindly correcting English.

in researches on medicine. A couple of ethnographic accounts of recent development in American psychiatry showed the undeniable impact of managed care (Robins 2001, Kirschner & Lachicotte 2001) or even Wal-Marting process where the pressure for OTPs (Optimal Treatment Plans) and strategies of resistance by the staff was described (Donald 2001). This process of standardization has begun to show both similar and different effects on the scene of Japanese medicine and psychiatry⁵.

Similar processes in Japanese medicine are often regarded publicly as promising, because if the risk managing process is more rationalized, it is thought that patient's safety will be increased. But this type of understanding clearly misses the important aspect of risk management in medicine and psychiatry, which is the fundamental ambiguity of the situated meaning of risk in such a context, and the possible danger if that was substituted with the simplified and formalized definition of risk borrowed from airline or nuclear industry.

In this sense, how far and what kind of conflicts emerges in the process of the domestication of risk management in the wild by the engineering notion of risk remains yet to be seen. But I don't believe that it will be a sort of unilinear process of rationalization, as the task of domestication requires to translate the self-reflective practice on the meaning of risk *in situ* into the form of manuals and analytical tools. I am not quite sure whether this is a simple case of contradiction in terms, or a case of successful dialectical *Aufhebung* of contradiction. But at least I like to underline that the very ambiguity of the notion of risk in the ward life is at the same time the very strength of the psychiatric practice, as it relentlessly requests reflection of the practitioners about the very meaning of what they are doing, which I have tried to describe in this paper⁶.

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