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Hospitals as total institutions

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Abstract

The image of the hospital is presented to the public as a place of healing. Though the oft-criticized total institutions of the past have been notably dismantled, the totalizing practices therein are now operationalized in the health care system. Through the lens of Erving Goffman, this article offers ways in which health care institutions operationalize totalizing practices, contributing to the mortification of patients and nurses alike in service to the bureaucratic machine. This article examines the ways in which totalizing practices may disrupt the agency of both patients and nurses alike.

KEYWORDS
autonomy, caring, Goffman, total Institution

1 | INTRODUCTION

The image of the hospital is presented to the public as a patient-centred place of healing; a haven for people to recover from injury and disease, receive necessary treatments and monitoring and above all, a safe place to receive *care*. Though the oft-criticized total institutions of the past, including tuberculosis sanitaria and large mental institutions, have been nearly dismantled, the *totalizing* institutional practices embodied therein have, in many ways, found a way to remain extremely present within our actual health care system. Totalizing practices are those in which, through mortification of self, a person within an institution exercises little control, and is essentialized to serve the needs of the institution. Within the commodity-driven health care system in the United States, the corporatization and capitalist-driven heartbeat of health care, as well as a dearth of community and public health resources, has led to the institutionalization of hospitals. These institutions in turn exhibit varying degrees of totalizing practices. In privatized, corporate health care models, the needs and desires of the patient may be incongruent with the productivity of the organization, and various methods of control may be exerted to preserve productive caring operations. The bureaucratic practices, policies, and rules associated with the administration of *care* and *safety* in hospitals may serve as barriers to their oft-espoused person-centred narrative, as well as act against the preservation of the autonomy of patients and nurses upheld by the nursing profession. Particularly, methods of control and surveillance over patients and nurses alike, usually most strictly used on the most marginalized of populations, may result in poorer outcomes for patients and role conflict for nurses. At a time in history in which the US health care system experiences great destablization, there is an opportunity to rebuild. As we examine the past, present, and future of health care, and the nursing profession, it is essential that we both examine and make visible the ways in which these demonstrated totalizing practices may disrupt the agency of both patients and nurses alike. Although totalizing practices impact all participants in the hospital ecosystem, this article presents the ways in which patients and nurses experience similar experiences of mortification. This article examines the ways in which modern acute care hospitals embody Erving Goffman's definition of 'total institution', and the mechanisms by which mortification of self is operationalized behind contemporary hospital walls.

2 | GOFFMAN'S TOTAL INSTITUTION

In society, there are certain organized social groups that promote separation, isolation, and strict monitoring by way of physical structures and institutional rules. In these social organizations exists a

division between those who are supervised and those who do the supervising (Serpa, 2018). In his 1961 book titled *Asylums*, Canadian sociologist Erving Goffman defined such social organizations as total institutions, or 'a place of residence…where a large number of like-situated individuals cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life' (Goffman, 1968, p. xiii). Goffman's identified characteristics that qualify systems as total institutions are those entered both voluntarily and involuntarily, including institutions established to care for people who are presumed to be both incapable and harmless (i.e., homes for the blind and orphanages), institutions for persons deemed incapable of caring for themselves and who may pose a threat to the community (i.e., mental hospitals or halfway houses) and institutions organized to protect the community against what are felt to be intentional dangers, in which the welfare of the people therein is not considered an immediate issue (prisons and jails) (Goffman, 1968, p. 4).

The modern acute care hospital is not explicitly listed as an example of a total institution in Goffman's original text, however, in the early 1960s, the landscape and structure of health care delivery were quite different from today. Goffman did study locations at which health care was provided, however, these institutes have evolved and consolidated into the modern hospital industrial complex. Institutions like tuberculosis sanitaria were largely shuttered by the late 1960s (D'Antonio, 2020). After chlorpromazine© was offered as a promising cure for severe psychiatric symptoms, and most psychiatric facilities were closed without sufficient community-based alternatives. Thousands of people with severe and debilitating mental illnesses were pushed into homelessness, local jails, and often in their times of greatest crisis held against their will in general acute care hospital emergency department or inpatient beds (Ollove, 2016). This drastic evolution of the health care landscape pushed more care delivery away from person-regulated environments, and behind the walls of institution-regulated environments: hospitals. Although several of Goffman's manifestations of total institutions may have been at least partially dismantled in their physical forms (tuberculosis sanitaria, mental institutions, etc.), the relevant social processes are sustained in similar entities. With regard to the hospital environment, many of the intensely isolative processes, in particular, have been subsumed.

Another important characteristic of today's general acute care hospital that differs from the time of Goffman's writing is the dramatic change in incarceration rates and necessarily related models of health care delivery. By the 1970s the United States began a dramatic upward trajectory in imprisonment rates. By 1985, 312 out of every 100,000 residents were incarcerated, and by 2005 that increased to 743 per 100,000 (Wildeman & Wang, 2017). These numbers do not include the over 500,000 persons in immigration detention centres in the United States (Stickney, 2019). In a country where mass incarceration is pervasive, patients in custody are receiving an increasing amount of medical care in hospital settings (Travis & Western, 2014): hospital care accounted for about 20% of prison health care spending between 2007 and 2011. This suggests a necessary collision (or dramatic collusion) of institutions, of which the ramifications are exponentiated by the *totalitarian* characteristics inherent in each. The complex matrix of biopolitical power relationships (Foucault, 1973; Hacking, 2004), and a historic building of panoptic surveillance in health care (Holmes, 2001) has provided for the transfer of totalizing practices from the Goffman's decrepit total institutions of the past, to modern acute care hospitals.

3 | HOSPITALS AS TOTAL INSTITUTIONS

Total institutions are generally characterized by the bureaucratic control of the human needs of a group of people, operationalized through multiple techniques such as mortification of self and a formally administered way of life. Today's general acute care hospitals share many, if not all of the attributes that define total institutions. These similarities are not lost on patients, particularly those seeking services for mental illness, nor on nurses whose very steps may be tracked by hospital administrators seeking to maximize 'efficiency'. As a patient participating in a qualitative study on experiences with mental health care in an emergency department stated:

> And then the security would come in and start yelling at me and holding me down, restraining me. I think it's what was had to be done at the time, but I think the security need to be trained a little better as far as how they handle people. That was, you know, an episode: Me screaming at the top of my lungs. I was screaming. But as a human being, as someone with feelings, even though I was acting irrationally, I actually needed their compassion (Vendyk et al., 2018, p. 593).

3.1 | Mortification of self

To maintain bureaucratic control and efficiency of operations, total institutions specifically require mortification of self. Goffman described that the person comes into such an institution with a conceptualized self-identity that was created, in part, by arrangements in their homeworld (domestic identity). It is through mortification of self that they shed the personhood which served this sense of self and take on the role and identity which serves the institution (identity of *the patient*). The person is stripped of the 'domestic' identity and support provided by 'outside' arrangements, and through 'a series of abasements, degradations, humiliations, and profanities of self' (Goffman, 1968, p. 14), a radical change in personhood occurs. Mortification of self occurs through the dispossession of role, a loss of identity, and a devolvement of autonomy that one holds on the 'outside'. The degree to which the individual is permitted autonomous decision-making also determines the degree to which mortification is complete. Although Goffman failed to deeply investigate the mortification of people other than the 'inmates' of a total

institution (Peshkin, 2001), we see that nurses who work in outpatient or less regulated clinical settings may have greater autonomy over everything from their working attire to when and what they choose to eat while at work than do nurses in strictly regimented acute care environments such as intensive care units, locked psychiatric units, or surgical procedure suites. Similarly, patients with very short hospital stays may not experience the fullest extent of a hospital's bureaucratic control.

Upon entrance to the hospital, one must leave behind the autonomous role one plays outside of hospital walls. Inside the hospital, a person may be becomes a *patient* or a *nurse*, generally cohorted with other similar patients or practitioners, often referred to by their diagnosis or speciality area. The person is expected to take on the newly imposed roles of *patient* or *nurse*, amenably and compliantly receiving or providing the care that is most often determined by someone else to be provided. Suddenly, one takes on the identity of a role: they are a 'COVID patient', a 'psych patient', the 'sepsis in room 3', an 'ICU nurse', the 'scrub nurse', or the 'float'.

The acute care hospital employs specifically constraining techniques to reduce social interaction with the outside world. Goffman described that reduction of social intercourse is built into the very structure of the total institution. Hospitals commonly have various layers of restrictions, increasingly intensifying based on the level of total control institutions assert legally or administratively over the patients being cared for or the nurses ostensibly providing this care. Hospitals employ security officers, or even off-duty law enforcement to guard entrances. Visitation is limited or even restricted by staff. Doors and hallways are restricted to specific personnel, with access abilities preprogrammed into employee ID badges and badge readers on doors—this ensures both that only certain people can enter and exit, and that those entrances and exits are recorded. Institution policy limits the time patients are allowed outdoors or off hospital property if permitted at all, with the risk of expulsion from potentially life-necessitating resources or placement into increasingly restrictive environments should they fail to comply. Similarly, nurses may be required to stay on hospital grounds for extended periods if involved with complex cases, in instances of disaster (natural or human-generated), or when they are the sole provider of a specific type of care for a particular patient. In either case, it is often difficult if not impossible to function in the engaged role a person holds on the 'outside', and once returning to one's normal life, the losses while in the hospital may be irrevocable and painfully lost. For nurses, this became particularly apparent during the COVID-19 pandemic, as many were forced to work long periods without respite only to be unable to return to homes and families because of the risk of transmission. Many reported caring for patients who were even more isolated as the nurse might be the only other person with whom they had even brief contact in a day—indeed, some patients died under these circumstances, deprived of family and other social supports (Walton et al., 2020). Both patients and nurses are obliged to play their designated role within the hospital walls. While for some, re-establishment of roles may be possible once released from the hospital, some may suffer irrevocable losses through missed time receiving education, advancing one's career, or raising children.

Goffman described that upon admission to a total institution, the individual is stripped of their usual appearance and thus suffers personal defacement (Goffman, 1968, p. 20). The patient and the nurse are both, as Goffman described, 'trimmed and programmed' (Goffman, 1968, p. 16); the person becomes an object existing to serve the establishment through processes like providing insurance information, clocking in and out, undergoing various assessments of health-related characteristics, providing an inventory of belongings, and the like. Upon admittance to the hospital institution, one of the first actions is the shedding of 'outside' clothing: patients are placed in a gown that opens in the back and ties around the neck, while nurses may be required to don specific uniforms or protective equipment. The belongings, or artefacts of one's identity, are removed and sent to a safe or placed in a locker for 'safekeeping'. For both patients and nurses, those affiliated with psychiatric care must often relinquish *all* artefacts, including phones and phone cords, under the premises of safety. The patient is assigned a number, and a wristband is affixed, with a barcode that is scanned which provides the staff with information deemed pertinent to the function(ing) of the hospital. The nurse activates a locator badge or pager, ensuring that they can be monitored and contacted throughout the workday according to the needs of the institution. From this point, most patient actions are monitored, including those normally taking place with some degree of privacy, including eating and using the bathroom. Goffman described that movements and postures, or positionings are in fact facets of mortification of self, and this is seen in the restricted physical movement imposed on both patients and nurses. There are a series of degrading postures and patterns of deference required of patients justified on the grounds of necessary medical and nursing interventions, or, safety (Goodman, 2017). Patients are generally required to lie in bed unless supervised ambulation has been approved. For patients not compliant with staying in bed, bed alarms are activated, and the patient may be ultimately restrained to the bed. Ironically, nurses may face similar degradations when ordered to initiate treatments they feel are inappropriate, required to stay beyond regular working hours to 'help', or, from numerous personal accounts, instructed to turn over personal protective equipment to providers deemed hierarchically superior.

Goffman also described that in total institutions, the passage of information to inmates is restricted. This is no different in the hospital setting. Multidisciplinary rounds are most often conducted outside of the patient's room, in which a team of medical professionals discusses the patient's case and plan, without patient input. In some cases, only physicians are included in these discussions—despite the fact that the majority of care activities will be performed by nurses. In a small fraction of cases, the physician actually informs the patient directly of a select few pieces of information regarding the plan for the day.

Despite the generally accepted premise that meaningful partnership with patients and nurses enhances patient care delivery and outcomes, investigation has demonstrated that in fact, very few interactions elicit patient involvement in decisions about their care, and nurses have little autonomy in directing that care (Galbany-Estragués & Comas-d'Argemir, 2017; Redley et al., 2019). Additionally, a patient is often not immediately privy to their own medical record and must go through a process of bureaucratic checkboxes and permissions to access the records, usually only available after the course of hospitalization is complete. While 'open' medical records are becoming of increasing popularity there are ample regulations on patient access to health information. A recent cross-sectional study of US hospitals found that there was widespread noncompliance with state and federal regulation for formats and release of medical records, inhibiting timely access to one's personal health information (Lye et al., 2018). The recent enacting of the 21st Century Cures Act, requiring health care facilities to provide access to personal health information 'without delay', validates the assertion that the processes a patient must endure to access information are tangible examples of restricted flows of information.

3.2 | A formally administered way of life

Persons who engage with the institution of the hospital, especially over extended time periods—whether as patient or nurse, must ultimately succumb to the institutionally managed spheres of activity that generally have clear boundaries when taking place on the 'outside'. This amalgam of social spheres is often surveilled in a panopticon-like fashion, which facilitates self-regulation of behaviour for the purposes of supporting the operations of the organization (Wade, 2016). Goffman's observations on how people behave differently in face-to-face private interactions than when being monitored laid the groundwork for Michel Foucault's work on panopticism (Manokha, 2018). Panoptic surveillance is a means of exertion of power and control, and may in fact cause someone to exercise the sovereign's power over themselves without any direct coercion (Foucault, 1975). Beyond the walls of the institution and the panoptic gaze, normal daily activities like eating, sleeping, toileting, and leisure, are done with some recognizable degree of autonomy, privacy, and in reasonably different locations. In the hospital, life is experienced and monitored, and controlled in the same location by the same central authority for the purposes of efficiency, productivity, and safety—applicable to both patients and nurses. Usual activities of daily life are conducted in the presence of other people and daily schedules and activities are often entirely pre-determined for the efficiency and productivity of the organization. Radiology testing, procedures, mealtimes, periods of rest, quiet time, activity time, and transport from one area of the hospital to the other, are all predetermined and under varying degrees of supervision. Internet access can be limited, preventing patients from communicating with family or friends, and preventing nurses from accessing some kinds of references and resources. Bed alarms notify staff of patients moving in or out of bed, remote video surveillance technology tracks both staff and patient movement, and the practice of placing tracking devices on patient wrist bands as well as on staff identification has become exceedingly commonplace (Bazo et al., 2021; Kanani & Padole, 2020).

In a total institution, there is an echelon of surveillance, where even those doing the supervision are themselves being observed. The mechanism of surveillance dictates the structure and processes of the institution in powerful ways. Controlling workflow and physical spaces that a nurse occupies is critical to maintaining surveillance and productivity. De-centralized nurses' stations have become increasingly popular with hospital renovation and new construction, ostensibly to decrease walking and increase direct patient observation (Design, 2017). An additive effect, however, is the decreasing of nurse interactions, teamwork, and information sharing, causing feelings of isolation (Fay et al., 2019).

Furthermore, both the nurses and patient are directed by and managed within a powerful modern influence of the panoptic mechanism of control: the electronic health record and the many technological modalities that monitor the nurse's performance and productivity as well as the patient's compliance with treatments. The electronic health record requires consistent inputs and outputs that the nurse must manage: a feeding of data which the nurse mines and surveils from the patient, data that are then digested, and output as tasks the nurse must perform by certain times. All of this becomes, '…discrete mineable data points that go on a construct map of the patient experience… and an audit trail for nurses' behaviors, surveillance in absentia… a proxy governing forces that are not necessarily present' (Dillard-Wright, 2019, pp. 1-2). The ever-present and omnipotent panoptic governing of nurse practice can also be found in the locating and pedometric technologies that monitor nurses' steps, track and trends amount of time spent in patient's rooms, and even dictate the amount of resources units receive based on acuity calculators (Miclo et al., 2015). The nurse and patient alike are under the continuous sovereign gaze, serving the productive drive of the institution.

A total institution disrupts the autonomous actions of the individual and degrades the perception that one has self-determination, autonomy, and/or freedom of action. This results in a feeling of impaired agency, the ultimate result of efforts to manage the daily processes of large numbers of people within one setting as productively as possible while expending the fewest possible resources. A nurse, assigned more duties and responsibilities than may be humanly possible to accomplish by a mechanistic health system (Park et al., 2018), needs to ensure that every patient is in their place, non-disruptive of the milieu or the tasks at hand, ready and willing to receive interventions as prescribed. If this is not accomplished, the nurse may face recriminations, poor performance reports, and ultimately dismissal. To preserve the sense of self, the nurses are thus forced to exert authority and even coercion on patients.

Antagonistic behaviour, such as 'acting out' and becoming what is often described as a 'difficult' or 'noncompliant' patient, is not well tolerated (Dudzisnki & Alvarez, 2017). This may be seen

in patients refusing to stay in bed, demanding different food, yelling, refusing to stay in their room, refusing to take certain medications, refusal to participate in therapies—a whole host of behaviours frequently assessed as 'noncompliance' with treatment (Scarlett & Young, 2016). A person's autonomy is further degraded when such behaviours are used as evidence in support of assertions of psychiatric instability, impaired decision-making capacity, and such interventions, and punishments, such as restraints, seclusion, or sedation are used (Beysard et al., 2018).

Goffman argued that identities marked by stigma must be responsible to *manage the self* and be certain to project an image that positively conforms to the institutional norms to gain recognition and protect oneself (Goffman, 1963). The dangers of nonconformity to institutional structures and norms, rooted in white colonizing practices, have been detailed by Black nurses (Jefferies et al., 2018; Waite & Naardi, 2019). The ways in which caring practices are inequitably delivered based on such stigmatized identities as race (McLemore et al., 2018), gender (Rabelais, 2020), and disability (Peña-Guzmán & Reynold, 2019) have been well documented, and provide a further example of the extent to which control and conformity have become ingrained in care delivery.

Goffman (1968) described that in a total institution, compliance must appear to be absolute, or punishment may be swift. In 1995, the North American Nursing Diagnosis Association recognized noncompliance as a nursing diagnosis, indicating that a patient's aversion to a prescribed plan of care and method of care delivery is to be identified, measured, and resolved in order that the nurse has adequately performed their job (Russell et al., 2003, p. 283). This is despite the fact that more recent research has demonstrated that such labels correspond with patients not receiving the same level of support or care as those assessed to be 'compliant', thereby causing harm (Groth, 2017). This 'diagnosis' is highly subjective and arguably wrought with stigmatizing views of who is and who is not deserving of personal agency. It is also fascinating to consider how the hospital institution places this burden on the nurses acting in its interests, and that this is also a self-mortifying function for the nurse. Such mortification is likely to contribute to many known nursing workforce issues such as moral distress, compassion fatigue, reduced job satisfaction, and feeling that patients are not truly being provided the highest standards of 'care' (Delgado et al., 2017; Wocial, 2020). This potentially dangerous assertion of control illustrates the inherent power structures at play.

4 | IMPLICATIONS AND CONCLUSION

This article has provided a description of Goffman's total institution, as well as tangible examples of the ways in which modern acute care hospitals embody and operationalize totalizing practices. We describe some of the many mechanisms by which mortification of self is operationalized behind contemporary hospital walls, as well as the formally administered ways of life for both patients and health care workers that ultimately strips them of autonomous authentic human connectedness while operating under the panoptic capitalist medical gaze. These examples demonstrate that Goffman's total institutions may not have been dismantled, but more so reconfigured to adapt to contemporary conditions (Clot-Garrell, 2021). This reconfiguration illustrates Goffman's assertion that total institutions are in a dynamic state with the society that supports or limits them (E. Goffman, 1968). If societal pressures do indeed have an influence on the extent of totalizing practices, then society, and the nursing profession, may work to reconfigure the institutions in an attempt to reduce the intensity of totalization.

As we move towards a more just health care system, it is critical that we both make visible and examine the ways in which these demonstrated totalizing practices disrupt the agency of both patients and health care providers. With this visibility comes an ethical obligation to subvert totalizing forces that dehumanize nurses and patients alike. To begin, individual nurses must carefully assess interventions administered for the purposes of institutional productivity and advocate boldly for resources and processes that centre patient well-being. As a profession, we must denounce care delivery models which prioritize institutional profitability. We must advocate for systems that centre the communities we are obligated to serve, as well as the safety and well-being of the nurses themselves. Whether or not this subversion is successful in dismantling total institutional control, the act of resistance itself is imperative to self-preservation (McCorkel, 1998). There is a profound necessity for conceptualization and maintenance of our identities distanced from those ascribed by the hospital institutions that employ us; the integrity of our profession and the safety of our patients depend on it.

CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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