

for society (e.g., Paradis, 1985). As such, an analysis of hospice must look beyond both micro- and macrolevel arrangements to reveal the processes through which these levels interconnect in hospice work.

Negotiated order theory provides a social-psychological perspective that has proven to be a successful means of accomplishing this kind of understanding; it is an appropriate framework for perceiving the processes through which daily work life and its larger social environment relate (e.g., Strauss, 1978; Strauss, Schatzman, Ehrlich, Bucher, & Sabshin, 1963). In this article, data from an ongoing research project on hospice are presented within the negotiated order framework. Examining the data through such a perspective sheds light on the relationship between relevant social structures and the daily interactions that go into hospice work. The focus of this article is on the nuances and complexities of a primary strategy used by hospice practitioners to accomplish their work—tactical socialization.

Method

This exploratory research followed the basic tenets of participant observation. I varied my emphasis to be on participation as observer and observation as participant as the situation required (see Bruyn, 1970; Gold, 1958). The initial and overarching research question was, How do hospice practitioners define and then accomplish their work? I gained initial entree, through the executive director, to one hospice organization in 1991, and extended research in that organization led to other research through people who changed affiliations over time. Through this process, I gained access to data on several home care programs and one free-standing inpatient facility. In the interest of confidentiality, these organizations are referred to by one name, Eastern Hope Hospice, and pseudonyms are used for employees.

Sample

The form of sampling I used was determined to a great extent by the methodological approach, the research topic, and the spe-

cific organizational contexts and is considered purposive and representative (Becker, 1970; Strauss & Corbin, 1990). That is, participant observation among hospice workers who provided both inpatient and home-based care led me to the discovery of data that can be considered typical of a broad range of hospice programs (with appropriate qualifications discussed in the Discussion and Conclusion). In many respects, all members of the Eastern Hope staff were the subjects of the research; in particular, this included the executive director, clinical directors, admissions directors, the clinical coordinator (for inpatient care), volunteer coordinators, the medical director, nurses, nursing assistants, social workers, chaplains, volunteers, physicians, and various administrators. Whether individually or in groups, these people were continually informed of my status, allowing informed consent to be an ongoing, informal process (Broadhead, 1984).

Procedure

Once initial entree was gained to these settings, I began qualitative data gathering by taking in the holistic nature of the setting and slowly letting that social world inform and guide the research focus (Glaser & Strauss, 1967). Because entree into research settings is more a process than an event (Broadhead & Rist, 1976), I was required to gain rapport with the setting's participants while remaining an objective "outsider" (Trice, 1970). Therefore, my emphasis in gathering data at each setting of the present research was initially on observation and gradually moved toward greater participation. I entered the 12-hr volunteer training program at each of two settings (the home care program in 1991 and the inpatient facility in 1992) to become initiated along with other outsiders; after completing this training, I requested entree to various meetings (e.g., the volunteer support group and the interdisciplinary clinical team) before requesting and conducting formal interviews. After about a year of attending meetings and conducting interviews among this organization's home care staff, I joined a nurse and social worker for a day apiece of visiting patients, and our conversations about what was seen, said, and done were tape-recorded during car trips between residences. After about a year of attending meetings and conducting inter-

views at the inpatient facility, I became a fill-in volunteer, working a total of eight 4-hr shifts. After these 2 years, I began participant observation (e.g., attending team meetings and an admissions interview) and formal interviews with staff at a third hospice setting and conducted interviews with various staff working through other hospice organizations.

All formal interviews were tape-recorded, semistructured, guided conversations that ranged from about 15 to 75 min in length. Thus far I have conducted interviews with 8 volunteers, 3 volunteer coordinators, 6 nurses, 4 social workers, 3 chaplains, a grief counselor, the inpatient administrative and clinical coordinators, 2 clinical directors, 1 medical director, and 1 executive director. In addition, videotaped interviews with 5 patients and 10 staff, collected by one organization for promotion and training, have been made available. I have also carried out approximately 165 hr of participant observation over the course of almost 3 years.

Data Analysis

I used the constant-comparative method of analysis (Glaser, 1992; Glaser & Strauss, 1967; Strauss & Corbin, 1990) to organize the frequency and distribution of properties during analysis. In this method, ongoing analysis of observational data produces meaningful patterns and conceptual categories that guide further observations and interviews. This method of analysis helps to ensure the reliability of research findings and foster replication (Becker, 1970). Also, one of the advantages of ethnographic research is that its subjects are studied as they are participating in and constrained by their real-world setting. Together with the technique of presenting subjects with and soliciting their comments on significant research findings, this helps to ensure that the data are true reflections of the subjects' world. In the present research, validity has been further enhanced by the triangulated approach of comparing observational and interview data with organizational records (e.g., Kirk & Miller, 1986; Webb, Campbell, Schwartz, & Sechrest, 1966).

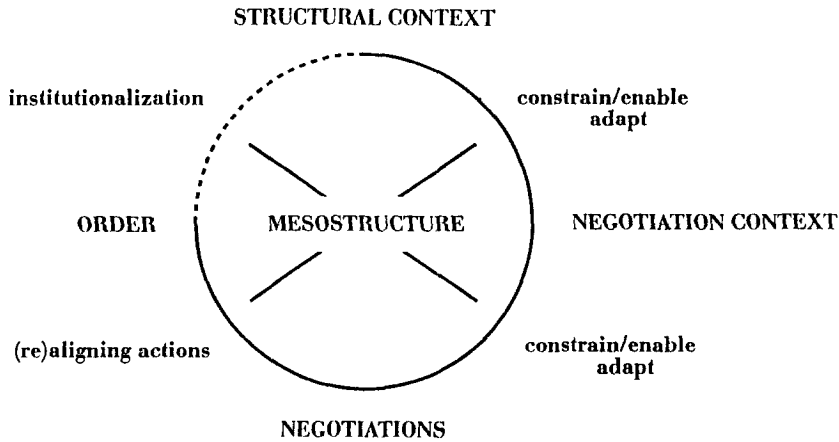


FIGURE 1 A model of negotiated order. This diagram has been revised from Mesler's (1989) summary and depiction of negotiated order theory.

Results

As the initially broad research focus narrowed and meaningful patterns appeared in the data, connections between the larger (macro) social environment and the daily (micro) processes of hospice work suggested the need for an analytic framework that would organize these connections and accommodate an understanding of hospice as a social movement. I considered negotiated order theory, which has been used successfully to reveal important micro–macro linkages an appropriate choice (see Maines, 1982, 1991). The analytic framework provided by this theory reflects the classic sociological emphasis on the social–structural forces that shape individual lives and provides a way of understanding the processes through which individual lives shape the social structure as well (see Figure 1).

Briefly stated, consideration of the macro-level social environment, referred to here as the *structural context*, takes into account the existing, institutionalized aspects of social life (e.g., politics, economics, religion, education, and organized medicine) that constrain people or enable them to adapt within intermediate-level social settings, or *negotiation contexts*. The ways in which these intermediate-level negotiation contexts adapt similarly provide the parameters within which the micro-level interactions, or *ne-*

gotiations, of each settings' participants are enabled or constrained. Thus, a setting's participants (e.g., hospice workers) negotiate with each other and others (e.g., patients, families, and hospital and nursing home staff) to align their actions and establish a working, albeit dynamic, sense of *order*. Although typically tenuous initially, the more this order persists, the greater its potential to become institutionalized as part of the structural context.

Figure 1 reveals how this theoretical framework accommodates the dialectic nature (thesis–antithesis–synthesis) of social movements. That is, the dominant way of defining a situation (thesis) that exists within the structural context not only enables or constrains actions within negotiation contexts, but often highlights or even generates alternative definitions (antitheses) among groups. People within these differing groups (e.g., civil rights groups, women's rights groups, environmentalists, and hospice workers) often negotiate to establish a working order within the existing contexts (structural and negotiation). To the degree that this new order is accepted and persists, it has a chance of becoming institutionalized (represented by the discontinuous line in Figure 1), wholly or in part, within the structural context (a synthesis, itself a new thesis). Data are presented in this framework, and the major negotiation strategy—tactical socialization—is elaborated in the section on negotiations.

The Structural Context

As with any social movement, understanding the social environment out of which hospice evolved is significant to understanding its potential for success. Simply stated, as many introductory sociology students learn, "Socialization for death is almost nonexistent in the United States" (Robertson, 1987, p. 136). In courses on death and dying, this subject is often expanded on with an analysis of the factors that have gradually lessened people's familiarity with death and dying, such as increased life expectancy, decreased infant mortality rates, decreased contact among the generations, the development of life-extending medical technologies, and the displacement of death from the home. This evolution toward "invisible" death—people dying in insti-

tutional settings surrounded by technology rather than family and friends—eventually became the soil in which seeds of dissent began to take root in the U.S. and other Western societies. Among the manifestations of dissent were the publication of books such as Kübler-Ross's *On Death and Dying* (1969), the development of the right-to-die debate, the growth of death education, and the hospice movement (DeSpelder & Strickland, 1992; Mor, 1987; Paradis, 1985; Stoddard, 1991). The term *hospice* originally applied to places that offered hospitality to people on religious pilgrimages and refuge to the poor and infirm (e.g., Cohen, 1979; Mor, 1987; Stoddard, 1991; Torrens, 1985). Contemporary hospice is more a philosophy than a place (Corr & Corr, 1992); in fact, a philosophy of *care* most distinguishes hospice from the dominant medical model's emphasis on *cure*.

Whereas the dominant medical model is perceived as giving up on patients once cure is no longer possible, hospice maintains that care for the patient is most needed at this time of life. Using an interdisciplinary team approach, hospice provides palliative care, the treatment of symptoms rather than disease, through some mix of the following personnel: the patient's personal physician (and/or the hospice medical director), a nurse, a nurse's aide, a social worker, a physical therapist, a pharmacist, a dietitian, and a volunteer helper/companion.¹ With a member of the family or other loved one serving as the primary caregiver for the patient in the home care setting, the goal of hospice is to empower the patient and family to achieve the highest quality of life, with the patient in control of the remaining time together (Koff, 1980; Mor, 1987; Stoddard, 1991; Zimmerman, 1981).

Dr. Cicely Saunders has been given credit as the person most responsible for the modern hospice movement. She was, for example, the moving force behind the opening of St. Christopher's Hospice in Sydenham, England, in 1967, and the inspiration for the first free-standing U.S. hospice in New Haven, Connecticut,

¹It should be noted that the construction of hospice teams varies considerably within hospice organizations. For example, physical therapy, pharmacy, and dietetics were provided on a consultant basis in the hospice settings studied in the present research. Also, the concept of family includes many loved ones often not legally related, and family members are often discussed as both receivers of care from the interdisciplinary team and givers of care as part of it.

which first offered services to patients in 1974. Since these auspicious beginnings, thousands of hospice programs have developed around the world (Stoddard, 1991), and, according to the National Hospice Organization (1993), approximately 1,900 hospices were operating in the United States by January 1993. Most U.S. hospices began out of a groundswell of community support on a predominantly volunteer basis and grew to increase their proportion of paid staff (Paradis, 1985; Stoddard, 1991).

Negotiation Context

Eastern Hope Hospice is one negotiation (in this case organizational) context that developed in a northeastern urban area within the structural context just described.² It began as a volunteer home care hospice program initiated by the interest of a few of the area's citizens in the early 1980s. Over the course of the present research, Eastern Hope carried a home care patient census of between 30 and 65, with a full-time, part-time, and per diem paid staff of 25–90 and about 25–60 volunteers. Although the hospice team originally served most patients in their homes, the proportion served in nursing homes had grown during this research to between one fifth and two thirds of the existing home care census.

The inpatient facility opened in the late 1980s in a relatively poor neighborhood of the city to specialize in the care of AIDS patients. Eastern Hope purchased a residential building and had it remodeled into approximately 8,000 square feet of living space containing 18 patient beds, with administrative offices on a separate floor. As is typical of inpatient hospices, the architects and interior designers were instructed to provide a homelike atmosphere, and their success is evident upon entering the facility. For example, almost all the rooms were designed to be private so that patients could decorate them with personal belongings and have the intimacy with loved ones that this experience engenders. A cozy, bright dining area was placed adjacent to a large, modern

²The organizations studied went through several major changes in staffing (e.g., mergers and mass staff resignations) during the present research; descriptions of organizational size and constitution reflect the ranges observed.

kitchen, and a skylit family room in the center was furnished with a sofa, chairs, tables, a television, books, magazines, and games. Although the practitioners in this facility specialize in the treatment of people in the end stages of AIDS, other patients also have spent their last days here when home care was not feasible, and the 24-hr nature of inpatient care has required a full-time, part-time, and per diem paid staff of 55–60 and an average of 50 volunteers.

Negotiations

The staff at Eastern Hope find the vast majority of the local population, laypersons and medical professionals alike, in need of socialization to death as a part of the life process. This means that their patients, patients' families, physicians, nursing home personnel, and so forth need to be educated to the hospice philosophy. Thus, Eastern Hope's practitioners have adopted a central strategy in their interactions (negotiations) that is conceptualized here as tactical socialization.

The concept of socialization generally refers to a process through which people acquire personality or learn the ways of their society (e.g., Henslin, 1993; Robertson, 1987). *Tactical socialization* has been used to conceptualize a process that is a more deliberate and active attempt by some people to alter others' perceptions of; feelings about; and, consequently, behaviors toward some aspect of their social world (Mesler, 1989). This is more formal and deliberate than socialization is generally conceived to be, yet less formal than what might be referred to as education.

At Eastern Hope, some systematic, formal teaching situations are arranged by the volunteer, clinical, and management teams (e.g., volunteer training, in-service programs for other institutions, and benefit galas, respectively), but most tactical socialization is conducted through a deliberate but informal process of daily work-related interactions. This socialization begins with Eastern Hope's own staff and extends to include each patient and family unit and all the other organizational personnel with whom they come in contact. Eastern Hope's various efforts at tactical socialization are described in this section.

Negotiation with Staff Like working in other organizations, working in hospice requires some training into the ways and means of this work world. Because hospice generally recruits its medical employees from training and/or practice in the dominant medical model, and recruits all of its employees from the larger structural context described, socialization to the hospice ways of palliative care and patient control is a major prerequisite for this work. The volunteer training sessions I attended identified this as an important transition that some would probably not make successfully. Clara, a director of clinical services (for both home and inpatient care) was a nurse with 11 years of hospice experience. She remarked on a number of occasions how difficult it was to get her nurses to make the transition from curing disease to caring for people. She acknowledged, however, that it is not clear-cut.

There's no crystal ball. I've had patients go on who were so sick you'd say they'd be gone in two weeks, and they've had some really good quality time of three and four months. . . . Like if a patient gets pneumonia and they really have some quality time left, we treat the pneumonia. It's palliative. The nurses have to be good at assessment, as to how much time the patient has, how much quality time.

Sue, one of the nurses at the inpatient facility, talked about the ambiguities of the hospice philosophy in this regard.

I mean that's so easy for me to say: We don't treat people. But we have. I think part of the reason that we have, and we have treated various things, lies with giving the patient control over some of the care. . . . [Patients] have said, I don't want to die of pneumonia. [Pause] We don't do it all the time; it takes some discussion with the patient: "If you don't want to die of pneumonia, how do you see yourself dying?" . . . [But] we don't do blood transfusions. If your blood counts go low, you're going to die of anemia. . . . It's so hard to draw that line between what's aggressive and what's not.

Clara also elaborated a bit later on the subject of patient control, that is, allowing patients and their families to live (and die) in circumstances that sometimes do not meet the staff's values and normative standards.³ She commented,

³The difficulty of socializing staff was more evident in the home care setting than in the inpatient setting. This makes sense, because the home care staff worked on a one-

People bring their own ideas into [hospice care]—"we should do this." [Shrugging her shoulders with both palms up] Why? Why should we do it? . . . I mean the Social Service Department gets that all the time. They say, "Catherine, what are you going to do about this? This is so-o-o terrible."

Catherine, the chief social worker for home care, independently commented on this in an interview. We were discussing two patient/family situations: (a) an alcoholic cancer patient whose son was concerned that she used alcohol as her palliative drug of choice and (b) a bedridden cancer patient who refused all alternatives to remain home with his wife, who, despite much "teaching" by the staff, seldom changed his soiled diapers. Catherine said,

There's one home health aide who has a real problem with this, and I really lose my patience with her. [Imitating] "That situation isn't safe." . . . It's real important to me that all of our nurses do not try to change families, to make it "safe." If she wants safe situations, [she should] go work in a hospital where you can control things.

Team meetings typically consisted of assessing patient situations regarding the balance of these issues: quality time, treatment of symptoms versus disease, and patient control. Clara discussed her attempts to hire new staff on the basis of sensitivity to these issues but used a novice nurse as an example of the bottom line:

Regina is the youngest one on the staff, and she has the least amount of experience. But over the last year she has learned a great deal. . . . [At one point] I had asked her to leave because I didn't think she had it in her, and then she turned it around within six months.

Negotiation with Patients and Their Families. As the quotes in the preceding section suggest, effective socialization of staff is significant to their success in socializing patients and families as to what hospice does. For example, one criterion for being a hospice

on-one basis with patients and families, often independent of each other, whereas the inpatient staff worked in shifts, with several people having daily interactions regarding each patient's care. Also, the jobs and work hours of the home care staff were more dependent on the patient census and, thus, less stable than the jobs and hours of those staffing the 24-hr inpatient facility.

patient is selecting palliative care over medical treatment. This means that patients and families are asked to sign a form that places patients on permanent Do Not Resuscitate medical status, so that calling 911 is something home care patients and families are socialized by hospice staff not to do. When asked to express the hospice philosophy in her own words, Catherine responded,

It's not just about taking care of people. It's about empowering and enabling people to take care of each other. And it's about helping people to confront the medical establishment and their own fears of death, to the point [we'll say] "don't just do something, stand there." It's helping them to wait it out, to not have this need to do something, call 911, rush to the doctor. You know? Just really being patient. And understand that dying is happening, and is going to happen, and don't mess with it. I don't mean hasten it . . . but to be comfortable with what's happening, because no one ever really is.

Talking about the nurses' responsibility in this regard, Clara said

[They] have to be able to be comfortable talking to families of patients. . . . They have to learn how to teach these feelings, how to take care of these patients.

John, one of the nurses at the inpatient facility, summed up the task of tactical socialization for hospice in the context of empowerment, that is, teaching dying patients and their families what it means to take control of the last days of life.

People don't live with control. . . . A lot of people don't have the educational base, and the sense of personal responsibility for their own health and their own bodies, just because they're not trained to do that generally in society, in this kind of society, where that's kind of contracted out to the medical world. . . . The frame of reference is go to someone else for them to fix it, like a VCR, because it's too complicated for you to fix. . . . But then suddenly people are dying; they're at the low point, in many of the cases, of their lives . . . in terms of dementia in some cases, in terms of predementia in some cases, or malnutrition, or any number of horribly complicating things, pain. And all of a sudden people are looking to them to take control and responsibility of how they want to live the rest of their life with this terminal disease. That makes hospice very complicated, because you have to start right away with education.

Negotiation with Others. A criterion for entering Eastern Hope's home care program is having a primary caregiver available to provide the bulk of care. However, because approximately 80% of U.S. deaths have been displaced from people's homes to institutional settings (DeSpelder & Strickland, 1992), identifying patients who meet this criterion has meant expanding hospice's traditional concept of home care. Together with the inherent instability of a hospice census, it only made good business sense that Eastern Hope align itself with nursing homes. Here, however, tactical socialization to the hospice philosophy has confronted the dominant medical model head on, every day, for each patient, with all the nursing home staff. Thus, tactical socialization in these settings has become more formal, taking the form of in-service education programs; nursing home staff learn that they must take the primary caregiver role for a patient recognized as dying and that they need to be as comfortable as possible with allowing death to occur. When interviewed, a chaplain serving as coordinator of nursing home services spoke about this relatively new challenge for the hospice team:

The point is, they are the primary care giver. You know, we can walk out; they can't. . . . It's very different in an institutional setting, because you're not just dealing with the family, you're dealing with the whole—not only one shift of nurses and aides, but everybody, three shifts. So it's a lot. It's not easy, and we're learning as we go along. I mean, hopefully . . . we can come up with some better ways to help the staff at these institutions to deal with hospice and use us to the fullest. Right now they're still kind of [saying] "What are you all about?" Or it's the other way. "Oh, we expected you to be here and hold Mrs. Jones's hand all the time. Why weren't you here? I thought hospice took care of the dying." Really, I get that a lot. "You mean you won't provide 'round the clock nursing?" I say, not unless it's a crisis, no. So, we have a lot of education to do in the nursing homes. And they're just coming on board, so it'll take time.

Tactical socialization of the medical community in general is of overwhelming concern for the Eastern Hope staff. In particular, the staff are constantly trying to socialize physicians to what they consider a more realistic assessment of patients' prognoses, to recognize a terminal condition, and to allow patients some quality time to live and tie up loose ends with family. During the

course of the present study, the length of stay in Eastern Hope's programs averaged around 2 weeks for inpatient and a little over 1 month for home care, despite the criterion of a 6-month prognosis. In addition, sometimes even traditional hospice care at home requires a period of hospital care, either for more intense pain/symptom control or as respite for the primary caregiver. Clara provided some good examples of the economic and psychosocial implications of poor socialization when discussing the understandable but lamentable reluctance of some physicians to let go:

It takes a lot of education of the staff in hospitals. . . . We have a contract with City Teaching Hospital, and you can see somebody getting in there as a hospice Medicare [patient] and those interns going to town ordering all those wonderful, costly blood tests. And their patient is terminally ill; he's on a hospice program. And when you tell them what they just did they say, "Oh!" [As if talking to an intern] "This means your hospital is going to eat that \$500. You know, when the patient came in you were told symptom control only; this is a hospice patient. Please check with the medical rec [records] room." I think if the doctors were more realistic about some of these people they really can't help anymore, they would give them more quality time if they would leave them alone. We have brain tumors that they start radiating; they give them ten treatments and the patient is off the wall, and never comes back to his old stuff. . . . That's what hits you. That's what makes the job frustrating.

On Hospice's Order and Institutionalization

As may be apparent, the implicit daily understanding (order) being negotiated by hospice participants is an attempt to fill the cracks, as it were, in the bricks and mortar provided by the formal definitions, rules, and regulations of the structural and negotiation contexts. If the dynamic nature of this daily operating understanding becomes static and accepted, for example, becoming part of the formal definitions, it can be said to be institutionalized. Here the experiences at Eastern Hope Hospice fit into the larger structural context of hospice generally. That is, for Eastern Hope personnel and others like them, order involves socializing staff, patients, families, and the immediate medical community to some

mutual understanding of what it means for patients to become the agents of their remaining days, with as little interference as possible from the encumbering manifestations of disease and treatment; the tenuous nature of this process was described earlier. The larger task for hospice workers is to have this understanding become accepted within society, that is, institutionalized.

Some years ago, hospice leaders identified numerous roadblocks to the institutionalization of their movement, for example, the need for money, regulatory agencies, and organizational structure; society's lack of adequate socialization for death; ignorance of hospice care; and the issue of euthanasia (Cohen 1979). In great part through tactical socialization, hospice practitioners have been negotiating some of these roadblocks, such as the need for money, regulatory agencies, and organizational structure, with relative success. In the United States, for example, the National Hospice Organization was formed in 1977 and was instrumental in drafting legislation to make hospice care reimbursable under Medicare, as well as gaining hospices accreditation through the Joint Commission on Accreditation of Hospitals. Medicare benefits for hospice were granted in 1982, mainly on the basis that it would reduce the high cost of dying in the United States. Voluntary accreditation standards went into effect January 1, 1984, and private insurers have been making hospice benefits available to their clientele since (Mor, 1987).

Despite this success, several roadblocks remain, including society's lack of adequate socialization for death and ignorance of hospice care. That is, while hospice people negotiate their daily tasks within the relatively stable order of hospice practice already established, tactical socialization of the society to a different perspective on death and dying must address several complexly related constraints that still exist.

The problem for hospice is that the apparently clear-cut distinction between life and death is actually fraught with ambiguity. For example, successful negotiation for third-party reimbursement addressed one roadblock—monetary instability—but it also created another—the potential for the business of hospice to compromise its philosophy. In the case of Eastern Hope, as third-party monies became available, the administration increased its paid staff and other organizational overhead. This transition

brought the challenge of maintaining a larger census to support it, which meant tactical socialization of more staff and then the identification and referral of patients by area physicians and nursing home staff. Although successful in gaining organizational growth, their efforts also have brought on board an increasing number of people whose socialization to the hospice philosophy is less than complete. Perhaps the clearest indication of this trend is that patients are being admitted to Eastern Hope on numerous medications that were prescribed to treat their disease. A drug use review of patient records by an independent pharmacist revealed numerous cases, a prime example being a woman in her 80s with three terminal conditions (breast cancer, kidney failure, and congestive heart failure) who was admitted on 12 medications, one of them (epoetin alfa) costing an estimated \$400 per week. When veteran hospice staff attempt to have some or all of these patients' medications discontinued, family members, physicians, and even novice hospice staff say, "But that will kill them." Clara summarized Eastern Hope's dilemma: Her desire is to refuse patients admission until she can adequately discriminate between palliative and treatment medications and have all of the latter discontinued, but she has not been granted the power to do this because it would jeopardize an already tenuous census. This business decision is costing them, because hospice must pay for all patient medications out of a fixed, per diem third-party reimbursement.

Although many of Eastern Hope's staff sought employment there for its relative size and stability, they have also expressed dismay regarding the compromise of philosophy that has been occurring. As Clara put it, "When Medicare and Medicaid came in, hospice went out the window." Moreover, the generalizability of this situation has been suggested by other observers of the U.S. hospice movement.¹ For example, when the transition to third-party reimbursement got underway in the early 1980s, the director of education and training at the National Hospice Organization reflected on the significance of this change, saying,

¹The generalizability of hospice's business/philosophy dilemma must be qualified to some extent by the evolution of U.S. hospice reimbursement, which may be significantly different from elsewhere, for example, countries in which a national health care system is already in place.

“Hospices which are able, consciously or not, to make a transition to seeing the program as a business are the most likely to succeed” (Mor, 1987, p. 17). However, a survey of 48 midwestern hospice programs conducted during this same time period found that those “that did not seek third-party reimbursement were truer, both in philosophy and practice, to the original hospice philosophy” (Mor, 1987, p. 17; also see Cummings, 1985).

Institutionalization of hospice will depend, in great part, on the tactical socialization of all newcomers to the philosophy of hospice, so that the socialization of society toward a greater acceptance of death will occur.

Discussion and Conclusion

Negotiated order theory has provided a framework for placing the daily working interactions (negotiations) of practitioners in one hospice organization (negotiation context) within its larger social environment (structural context). As noted earlier, the representativeness of the Eastern Hope organization and generalizability of these findings are enhanced by the fact that data were gathered from several organizations that provide a wide array of services to a broad-based patient population. They are also enhanced by workers' reflections, like those presented earlier, on the efforts of the movement as a whole. Where hospice is practiced in contexts similar to those studied in the present research (structural and negotiation), people's experiences are likely to be similar to the experiences reported herein. However, as in most ethnographic research, both the representativeness and generalizability of the results are qualified by the ways in which the research setting is dissimilar from others of its kind, for example, Eastern Hope's urban/suburban location surrounded by teaching hospitals in a northeastern state, its federal and state accreditation, its free-standing inpatient facility, and its relatively large paid staff. On balance, however, I believe the present findings will ring true for many of the people in contemporary hospice work.

In the preceding section, the current order and the constraints that jeopardize institutionalization were emphasized. It is

also important to understand how, in the dialectic of negotiated order, daily negotiations through tactical socialization might find success within society as a whole. In the remainder of this section, I discuss the implications of tactical socialization in this regard.

First, one of the chronic problems for analysts of social movements is determining what success means (Turner & Killian, 1957). Even the life course through which social movements are said to pass reflects this ambiguity; institutionalization is not necessarily the final stage, because it often involves bureaucratization and loss of movement toward goals (Henslin, 1993; Robertson, 1987). Analyses of hospice as a social movement, therefore, meet with similar problems. Some might consider the federal accreditation and reimbursement hospice now enjoys indications of success for the hospice movement, acceptance of a new perspective on death and dying, and new advantages for hospices' clientele (e.g., Gamson, 1990). Yet, as has been suggested, accreditation and reimbursement may have been gained as a matter of business more than through a change of perspective, and it is that affiliation with business that appears to threaten the philosophy of individual hospice programs around the country. Thus, determining at what point the hospice movement might be considered successful depends on what it intends to accomplish.

One of the best discussions of the goals of hospice as a social movement has been provided by Paradis (1985). Paradis showed that from the outset, hospice provided a specific focus to the early discussions of death and dying, giving dissenters from the dominant medical model a righteous indignation toward the invisible death that had evolved in the context of that model. However, because invisible death had evolved as the result of a biomedical technology that had been pursued and achieved as progress, there was no clearly identifiable enemy at which the dissenters could point the finger of blame. This made it difficult to rally immediate support from the larger society. What hospice people attempted to do, then, was create an ideal of caring against which to compare the reality of dying in technological isolation. The earlier quote from John, the inpatient nurse, suggests the complexity of the task.

Americans tend to think of their bodies as they do other objects, like VCRs; when something goes wrong, they take them

in for repair. Goffman (1961) described this as the practitioner–object–owner mindset and wrote eloquently of its ramifications in medicine. Stated simply, people are socialized into the mindset that their bodies are machines that periodically need repair by those learned in biomedical technology; if cure is unavailable, that is, the prognosis is terminal, there is not much that these specialists can do for the machine. The problem is, as Goffman pointed out, these body/machines are occupied by a self that goes on living under whatever circumstances exist. Thus, tactical socialization to the caring philosophy of hospice also asks people to redefine the relationship between their bodies, their selves, and society. If this is the hospice movement’s ultimate goal, it needs to assess the power of tactical socialization to accomplish it.

Tactical socialization of staff new to the hospice philosophy can be perceived as an important, specific responsibility for each hospice organization, preparing individual personnel for their work. As suggested earlier, however, the degree of success at this level of socialization has great significance for success at the next level—socialization of those outside the hospice movement who are involved in each case: patients, their immediate family members, and their medical care providers. At this level, the primary goal of tactical socialization is to improve the situation for each patient. Where tactical socialization is not so case specific, as when hospice personnel provide in-service training for those working in hospitals or nursing homes, the goal is more diffuse; certainly, it is to provide better care for hospice patients in these settings, but it is also to promote the caring philosophy of hospice generally. What is interesting is the fluidity with which the influence of tactical socialization can flow.

For example, when provided on a case-specific basis to a patient and his or her immediate family, socialization could reach to extended family and friends. When provided on a case-specific basis to a family physician or during in-service training to various hospital or nursing home personnel, tactical socialization may affect them not only as the health care providers, but also as family members, friends, and colleagues. Thus, the levels at which tactical socialization works are myriad and potentially concentric, and the goals likewise range from improving specific patient situations to redefining care for the dying as a whole. Stoddard

suggested the hopeful nature of the hospice point of view in the latest edition of her classic work *The Hospice Movement* (1991):

Wherever it goes, if its intent is clearly stated, it will tend to work its gentle, stubborn, persuasive way. Within the hospital its presence brings subtle changes that will help to alter our entire society's attitudes about death, and thus about those who are dying. With hospice home care groups proliferating, and freestanding hospices appearing here and there as communities within community, its healing transformations are now coming about even more rapidly. (p. 216)

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