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THE DESCRIPTIVE TYRANNY OF FORMS

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ABSTRACT

The sociology of formal bureaucratic process offers evidence of pervasive organizational rationality, from the proliferation of rules to rule-use. In this paper, data from human service settings are interpreted to show that the treatment overemphasizes rationality over moral considerations. Focusing on the paperwork of "people forms," we argue that form-completers are not only "artfully" rational in their efforts, but, in the context of moral consideration, feel tyrannized by their actions because of what they believe to be the truths of matters otherwise known. Two related aspects of the organization of form-completion are considered: (1) descriptive demands and (2) the justifactory and moral contexts of the practice of form-completion. The theoretical rationale for the shift in emphasis is addressed throughout.

From Weber (1958) and the Frankfurt critical theorists (Held 1980) to recent interpretive and political scrutiny of "good" organizational practice (Garfinkel 1967; Zimmerman 1969; Erikson and Gilbertson 1969; Douglas 1971; Edelman 1977; Prottas 1979; Collins 1979; Lipsky 1980; Altheide and Johnson 1980),

formal bureaucratic process has been described, analyzed, and criticized. Weber was pessimistic about the prospect of a pervasive bureaucratic apparatus shackling human relations. Horkheimer and Adorno (1972) saw widespread evidence of what critical theorists call "instrumental reason," a form of organizational intelligence where means become ends and social rules confront participants as reified objectifications commanding action (Held 1980, p. 66). Garfinkel and other ethnomethdologists have detailed some of the fine structure of formal people-processing and shown how "artfully" productive of rules and applications its participants are, how bureaucratic due process is not simply a matter of putting rules into effect but a matter of constituting their meanings.

The sense of tyranny in bureaucratic process has varied. Some, like Weber, saw an organized domination over daily human affairs, where the concrete truths of experience are rationalized into institutional fictions. His sense of tyranny was personal, external to a vision of diffuse organizational rationality. Ethnomethodologists are inclined to approach bureaucratic procedure more benignly, cooly examining the rationally constitutive features of everyday life. Tyranny here is analytically eclipsed by the "natural attitude" (Schutz 1970; Mehan and Wood 1975), in which people are understood to take the objects and structures of everyday life for granted rather than being exasperated by them.

However varied the approaches, bureaucratic tyranny makes sense only against a presumed disjunction between realities and appearances, between what are stated or assumed to be the actual truths of matters processed or described in formal organizations, on the one hand, and their reported by-products, on the other. Sociological concern with the interactive minutiae of bureaucratic process focuses so intensely on the rational production of appearances that people's related sentiments about the contrast between appearances and concrete realities are shortchanged. To put it terms of descriptive practice and circumstance, what might be called the context of justification overshadows the context of moral consideration: circumstances whose members orient to rational people-processing and paperwork are emphasized over circumstances of outrage with rationalized appearances. From labeling and ethnomethodological theorists (Scheff 1966; Perrucci 1974; Pfohl 1978; Buckholdt and Gubrium 1979; Cicourel 1968; Zimmerman 1969) to less microscopic analyses of formal bureaucratic process (Freidson 1970, 1975; Collins 1979), it is regularly suggested that what gets done under organizational auspices—while perhaps a matter of hard work—is expedient and/or rationally rule-like, an emphasis denigrating the occasional moral concern for what information reported does or does not represent. The attempt to make visible the cognitive underside of formal organizations has inadvertently revealed a wholly "artful" world of rational appearance production (Johnson 1977a,b).

This paper presents data to reveal the nonrational, moral quality of paperwork and is limited to the descriptive assumptions or demands of "people forms." People forms are standardized papers that become documented descriptions of clients "in need," reported to be in various stages of recovery or care by service providers. Following Goffman (1974), the analysis assumes that experience is not simply known or conveyed to others, but takes on its meaning within descriptive frames or contexts. In line with Garfinkel's (1967) suggestions and work, the artfully rational method by which form-completion gets done is described as occurring in a context of justification. In addition, the paper aims to make visible the response of those concerned to the consistencies and contradictions between what they claim to know about clients and what they are requested to document, which is refered to as the moral context of form-completion. Adapting Garfinkel's (1967) coinage, we show that while people are not "cultural dopes," neither are they "moral dopes" standing mute at the margins of everyday responsibilities.

Two related aspects of form-completion are considered. First, forms in general, and their items in particular, are examined for descriptive demands, categorized as chronological, stylistic, and interpretive. Descriptive demands are not explicit documentary requests but refer to the reportorial expectations assumed to underlie acceptable organizational description. Second, the artfully rational and moral aspects of form-completion are highlighted in their separate contexts.

THE APPROACH AND THE SETTINGS

The data on which this paper is based were gathered over a decade of fieldwork in human service settings. A recent aim has been to discern how those engaged in paperwork, called "form-completers," experience the moral meaning of their work in relation to the lives they service. This requires that we conceive of them, alternately, as constructors and arbiters of their affairs, as both cognitively and morally active.

Data are drawn from three kinds of human service setting: the nursing home, residential treatment center, and the physical rehabilitation hospital. Each setting presented staff members with a variety of forms pertaining to clients and their treatment. (With a few exceptions, such as a patient or family questionnaire, to be completed by the patient or his agent, forms were dispatched by staff.) Observations of encounters with forms and form-completion were initially part of an intensive study of the differential worlds of care and treatment in a nonprofit nursing home (Gubrium 1975). In that setting, much form-completion took place at nurses' stations, in staff members' offices, and in patient care conferences. Further observation was undertaken in the course of studying the social organization of care in a residential

treatment center for emotionally disturbed children (Buckholdt and Gubrium 1979). At the center, forms were completed in classrooms, cottages (children's dormitories), in psychiatric and multidisciplinary team conferences, as well as in staff members' offices. The nursing home observations were extended to five other facilities of varied ownership (Gubrium 1980a,b). The final observations were part of a study of the place of audience in accountability, and descriptive practice in a physical rehabilitation hospital (Gubrium and Buckholdt 1982). There, forms were encountered in therapeutic areas like the occupational therapy clinic and the physical therapy gym, in utilization reviews, staff members' offices, and at nurses' stations.

THE DESCRIPTIVE DEMANDS OF FORMS

Chronological Demand

Forms demand description framed in terms of unidimensional, typically unilinear, timing. The chronological demand assumes that events reported can be aligned according to clocktime, one event following another, and that the events reported are points of time in the client's experience. Revised reports are assumed to reflect more accurately what actually occurred in time past, not the current or future need for particular pasts.

Commonly, first in chronological order are intake forms, which include so-called "face sheets" listing background information. Intake forms are likely to contain vital statistics, family and personal histories, problem histories, and current health data. There usually is detailed information provided about client insurance and related financial matters. Responsible parties, such as family members and private physicians, may be listed.

Ideally, *before* the client begins his or her course of treatment, a care plan is formulated. The ideal is often compromised by the encroachment of other internal business or by external pressures such as fluctuating referral cycles. For example, in the residential treatment center studied, multidisciplinary team (M-team) placement and treatment recommendations sometimes were completed as long as one year after the child was referred to the center because M-teams were "too busy," the result of a need to catch up with an unexpected number of transfers. Despite the practical, multidimensional timing suggested by such events, unidimensional temporal glosses were applied in both documentary readings and the interdocumentary adjustment of form information.

After the client's plan is completed, forms deal with two kinds of therapeutic or custodial events. Most forms pertain to events scheduled within a formal treatment and evaluation regimen. For example, in the rehabilitation hospital studied, occupational (OT) and physical therapists (PT) completed periodic

range-of-motion assessments. Various therapists, including OT and PT, also kept track of the patient's mental status, such as whether the patient continued to be "motivated." In the residential treatment center, each child's treatment team (including a social worker, special education teacher, child care worker, and select specialists such as speech therapists and psychologists) was responsible for completing semi-annual narrative reports on the child's progress at the center, which were submitted to county welfare departments. In the nursing home, daily "notes" on select aspects of patients' physical and psychological functioning were written on each work shift.

Another kind of form reports extraordinary events considered notable, but unpredictable. For example, in residential treatment, children periodically "blow up" or "flood out" emotionally to display uncontrolled activity such as swearing, spitting, running about, fighting, and screaming. Blow-ups might be dealth with by placing the child in isolation (in a control room) to "cool down" and to "get a hold of himself." A form, called a "log," is provided for the purpose of specifying the reason a child was placed in the control room, who placed him, and the times placed, checked, and released. In nursing homes and hospitals, so-called "incident reports" document extraordinary and risky events not part of the patient's daily regimen of treatment and care. A form used in one nursing home defined an incident as "... any happening which is not consistent with the routine operation of the hospital or the routine care of a particular patient. It may be an accident or a situation which might result in an accident."

In completing forms, staff members expect to convey what they know about treatment, care, and progress as if they had a beginning, midpoints, and an end. In turn, the unidimensional timing signalled in the dating of forms demands the same chronological reading. It is taken for granted that temporally anomalous bits of information are errors in an otherwise uniform, unilinear timing, not parts of distinct and separate chronologies.

Stylistic Demand

Forms also carry a stylistic demand. One type is that form-completers descriptively comply with mutually exclusive categorizations. For example, hospital incident reports typically contain an item asking for information about the patient's "condition before incident," the acceptable options specified in labeled boxes or blanks to be checked. On one form, the alternatives were: "normal," "senile," "disoriented," "sedated," and "other." The form compelled form-completers to accept the descriptive irrationality of checking both "normal" and "senile," even though it was known that, in certain cases, some staff members considered the patient in question to be senile while other staff members believed the patient to be relatively normal.

Another type of stylistic demand is for professional, diagnostic writing. It is most time-consuming for forms requiring narrative description. The semi-

annual reports compiled by social workers in residential treatment, which were based on treatment team input, were written in a style not altogether evident in the team deliberations preceding their completion. Indeed, even when terms used in completed reports were identical to those heard in staff deliberations, it was by no means certain that the meaning of the terms in the context of the completed report was equivalent to what it was in the context of deliberating over what to include in the report. For example, a team's sarcastic use of the term "pica," a condition of unnatural craving for inedible objects, could not be presented sarcastically on forthcoming forms or in narrative reports, even though sarcastic usage was routinely part of momentarily serious questionings of the substantive reality of the condition. When the term appeared on forms, it was a sober, clinical label given to an actual behavioral problem.

Interpretive Demand

Finally, forms present an interpretive demand. While the everyday practice of service provision comprises a complex and unfolding array of social relations, treatment technologies, and custodial contingencies, forms demanded completers to interpret ongoing treatment experiences to reveal only that which was clinically or professionally appropriate.

One type of interpretive demand is that form contents refer to clients', not others', needs. It is understood, for example, that reported incidents are, in principle, events in the lives of patients. While staff members might be mentioned in the information conveyed, staff involvement is presented in a reactive or ancillary fashion. An aide might be reported to have calmed down an elderly female patient who, as noted by a nurse, became "combative and abusive and destroyed a chair in the cafeteria." Because the incident is taken to virtually belong to the patient, the nurse is compelled to describe the aide's role in the incident in terms of how the aide responded to the incident, not in terms of how the aide's attempt to claim the patient played a part in provoking the very thing it aimed to control.

The demand that form contents be about needs in the client's world implies that contents are not about form-completers' own needs. For example, when a form requires a staff member to evaluate the patient's "mental condition," the staff member is expected to more or less convey what is known about the condition itself, not reflect an occasional opinion that a mental condition is impossible to define separate from the circumstances in which it is encountered. Concerning a mental condition, a staff member once suggested the latter option in commenting, "I don't think I can really say because it depends so much on circumstances, doesn't it?" Because the item in question demanded a description of the patient's mental condition, not a form-completer's confusion over it, it required a staff member to set aside his or her own sense of its complications and present the condition as a feature of the patient's life. Even

incomplete forms were taken, in principle, to be about client characteristics inadequately described. All told, it was assumed that a form does not, in its own right, produce client needs, but at best, objectively conveys needs that are part of the experience of those undergoing treatment.

It was expected that the information provided on forms should pertain to the *individual* client whose name appears on them, not client roles, networks, or other social extensions of personality (Gubrium 1979). For example, a form requesting information about the patient's progress in the last two weeks of rehabilitation—like that conveyed in the ubiquitous S-O-A-P notes (*s*ubjective, *o*bjective, *a*ssessment, *p*lan) completed by hospital therapeutic staff—requires staff members to describe, to "soap," what they know about two weeks' events in terms of how the individual patient responded to treatment. The fact that what appears on forms following a name are individual characteristics and not the name of a role, a group, or a network is more than mere bureaucratic due process. It reflects a cognitive demand whose fulfillment reproduces individual due process.

In the rehabilitation hospital studied, social workers completed what was called a "social service initial interview" shortly after the patient was admitted. The completed written interview was placed at the front of the patient's chart. The interview had several sections: rehabilitation goals; a description of the support system; the client's former roles in the family or community; the impact of the disability; educational, vocational, avocational information; financial resources; discharge plans; identified problems; and social service goals. Information entered was based on what the social worker gleaned from incoming documents and from interviews with both the patient and select family members or other responsible parties. Whatever the social worker came to know about the patient from these sources and however the information was presented to her, it was framed and assembled in such a way that the individual named on the written interview summary was understood to be the principle subject of description. Goals, for example, were for the patient, not for family members nor for the staff. Even when it was noted on the interview summary that family members had goals for rehabilitation, it was presented as a family's goals *for* the patient's rehabilitation.

While it might seem obvious that goals listed or described are for the patient named, it was by no means clearcut in practice. The form, its items, and their related interpretive demand required form-completers to generate goals for the patient, goals that completers might otherwise believe to be irrelevant to, or only marginally connected with, the patient's formal treatment regimen. Still, whatever the relationship between goals and problems in practice, in constructing adequate form entries, social workers "artfully" assembled patient-oriented goals in writing, tailored as individualized accounts. Seemingly trivial features of the form, such as the client named, the client-oriented sections, and the persistent reference to the "client" within each section's

narrative, concretely conveyed a clear message about whose problems the goals pertained.

A second type of interpretive demand is to present *existing* conditions, however recently discovered. Client needs and problems are portrayed as having more than momentary existence, least of all an existence as short-lived as the time it takes to complete forms or assemble reports. An existing condition, of course, suggests that it had a course of development, which, in turn, requires form-completers to work up an historical sense of what is described (cf. Gubrium and Buckholdt 1977). There are regular means by which to refer to the history of problems and needs. For example, it is fairly common for a form to require a description of the so-called "onset" of a problem. A variety of "histories" are taken, from the history of a recently discovered educational deficiency that "was there all along" but unrecognized (Garfinkel 1967; Raffel 1979), to the history of a chronic emotional disturbance and the regular medical histories taken at the rehabilitation hospital studied, the narrative contents of which are guided by a suggested "order of recording" printed on their respective forms.

Typically, written problems or needs are past-oriented. The exceptions to this were prognostic statements presenting potential problems or needs based on what is known of the history of a client's problems and his current need status. Yet, while seemingly future-oriented, prognostic statements are made in relation to existing needs and problems.

A third type of interpretive demand is that conditions for which information is requested be describable. Only a limited number of "don't knows," "unknowns," or blanks can appear on forms. It was not clear what the overall limit was, the precise tolerable amount of missing information tied to particular form-completers' and form-readers' estimates of what could be "let go" in individual cases. What was clear is that whatever was left blank or said to be unknown was taken to refer to missing client information resulting from shortcomings like a lack of current evaluations, subjective information, client cooperation, and reliable observers. Whatever the limit, the demand mean that form-completers, in some way or other, glossed over the constitutive, interpretive details of their own activity in the form-completion process, omitting the "intentional" outcome of the request for description in its own right as a descriptive resource (Schutz 1970).

THE PRACTICE OF FORM-COMPLETION

In the settings where form-completioen was studied, it was evident that staff members were not wholly cool and "artful" in meeting chronological, stylistic, and interpretive demands. On occasion, as they considered the relation between what they believed to be appearances and what they took to be realities, they

expressed marked irritation with deadlines, the need to "put things in a certain way," and paperwork in general. At the same time, though, such sentiments about the demands of form-completion described tyranny, form-completers did, by and large, organize their wares to complete acceptable reports. In the remaining sections of this paper, the tandem practice of both rational artfulness and moral consideration is highlighted.

The Tyranny of Unidimensional Timing

Consider the justificatory and moral contexts of chronological demand. Unidimensional timing is challenged by a complex daily world of timings, temporal usages, and related moral considerations. A special education teacher is expected to take the time to enter on a control room log the reason she places a child in isolation. But the child, like others, has his own presumed sense of timing in acting out, which the teacher takes into account in deciding whether she shall even attempt to isolate him. For example, the teacher considers how long it will take her to "drag" a disruptive child to the control room, who may scream and kick at the alleged injustice. Knowing the child as she does, she wonders whether she can afford to ignore other matters to take him away from the classroom? There also is the timing of the teacher's assistant, who might prefer to go on a scheduled break rather than assume impromptu control of the class in the temporary absence of the teacher. There is pressure, too, to complete the day's lesson plan lest the teacther get more hopelessly behind than she already is, especially behind another teacher whose progress is a source of constant comparison with her own.

The rehabilitation hospital studied presents further chronological complexity. Within a few days after a physically disabled patient is admitted, his or her needs and cares are evaluated by the treatment team in a utilization review conference. Conference proceedings center on the progress notes written by each member of the team and read to participants. The notes are based on information gathered by each team member about the rehabilitation status of the patient in particular areas, such as the level of care and treatment required in physical therapy or in nursing. As presented in the review conference, the notes convey information about events in the various treatment areas, not the timing of conference proceedings as such. Subjective and objective data about a disability, assessments of treatment required, and treatment plans are descriptions of things ostensibly known about the patient before their presentation in conference. However, the common knowledge that conferees presented their notes in a certain order allowed later presenters who had not taken the time prior to the conference to complete their notes, to do so while a conference was in progress. The contents of later presenters' notes were formulated, in part, to rationally coincide with material presented by earlier presenters. Although progress notes were depictions of the patient's existing

and past disability status, or estimates of the future based on what already was known, the notes were constructed and presented in practice within a completely different timeframe, in this case, the routine sequencing of the proceeding itself. When such practical timing was infringed upon by the demand for unilinear description, form-completers typically expressed exasperation with related paperwork.

Flexibility in certain deadlines allowed staff members to literally "see what happens" in the course of progress for individual clients before a commitment was made in writing to a particular description, especially when whatever was committed to writing was a source of immediate or imminent accountability. In practice, this served to make time virtually flow backward. Completing some forms too quickly could place a preventable chronological burden on form-completers in that what was written, on being made public, had to square with forthcoming but unpredictable events best described *after* the fact.

Relevant here was the behavior modification program in the residential treatment center studied, where staff members completed a variety of "point charts." The charts hung in a public place, making them available for immediate inspection by any child or staff member who wanted to know how the child was doing on his program. Children earned points for specific good or appropriate behaviors throughout the day, which could be exchanged for valued items or activities.

Take the following scene and conversation between two staff members (child care workers) in one of the cottages at the center. The two were in the process of awarding morning points for the boys in their charge. (All proper names here and throughout have been fictionalized.) The children had left for their classrooms. The workers considered each boy's particular program and how well the boy had met his current goals for select periods of the morning. At one point, the workers discussed Robby's behavior, who was on a cottage program to "reduce silliness." Robby was to be awarded a point for not being silly during breakfast and while doing his assigned morning job. One of the workers, Mike, commented:

> You know, Bob [supervisor], I'm not sure it's a good idea to give him his morning points right now. Especially Robby. You know what he's been like since yesterday: zooming one minute and pouting the next. He's really off the wall lately. I'd say we should hold off a while.

Bob responded that what Mike had seen was probably correct and that it should be reflected on the point chart. Bob added that if Robby was acting silly, he should not get his points, "that's all." Bob continued:

> I don't see why we shouldn't fill all these out right now while we have time. I hate to leave all these until later when things get harry. One of us'll just have

to do'em all and I haven't kept my eye on all the little shits. Let's just get'em done, okay?

Mike then explained his hesitation:

> I know. I know. But you know that tonight is car night [Boys are driven to an activity of their choice for the evening by staff member] and I'm taking them swimming—I think. But I can just see it now. We give Robby his morning points, He was okay this morning. And he'll come in here after lunch and look real close at what he got and, of course, that little sucker'll know that he did well enough to go out [on car night]. You know how he'll take advantage of that and act up. You know what he's like. He'll just get under my skin a little bit, just enough to piss me off but not enough for me to keep him here. You know how he uses the damn system. He'll just sit tight knowing that he's got his goddamn points and it's right up here in black and white. I say that we should just conveniently forget to fill his in—and all the others too—just for breakfast and job points. That way he can't say he's being picked on and I can see what happens. Look Bob, if you think things are going to get out of hand, why don't we put their points—all except Robby's—in my notebook for now and I'll record them all later when I [winks] have time.

Bob understood Mike's problem and proceeded to determine points for all the boys except Robby, the points recorded privately for the time being. Yet, in moral consideration of charting, Bob paused and commented disgustedly:

> I know what you mean, man. That happens to me now and then. These damn charts can really do you in. Ya use'em to control the kids but I've seen how the [charts] can really kinda control you sometimes. It's like putting your foot in your mouth. Once you put something down and the kids see it ... you know how they see it too ... it's too late. They'll [kids] turn the tables on you and yell and scream that "I got my points!" Like that. Shit, you can't win. You've just got to play it cool or these kids'll run all over you. They're real con artists.

Later, when Mike did record all the points on the chart, it would appear that what was being awarded was for behavior that was manifested that morning. In particular, Robby's morning points, while seemingly determined and recorded as a belated consequence of earlier conduct, would be assigned retroactively in relation to how appropriate Robby was as the time approached for car night. As forms, the point charts showed little or no evidence of the work that entered into articulating the timing of ongoing practice with unilinear chronological demands, nor form-completers' awareness of, appearances and what they believed to be reality.

The Tyranny of Style

Style presents its own travail to form-completers. One setting where style was a regular justificatory issue as well as a common moral consideration was the nursing home patient care conference. As part of care management and accountability to regulating and funding agencies, nursing homes are required to formulate individual patient care plans. Plans are revised periodically (at least every six months) to reflect the developing care status of the patient. Each plan is entered in detail on a care plan form and usually placed in the patient's chart, where it is readily available for consultation.

Staff members routinely considered how to formulate the plans during patient care conferences. As far as this was concerned, conference proceedings were divided informally into two fairly distinct portions. The one usually occurring first involved the identification of patient problems, the selection of treatment approaches, and the setting of care goals. The later portion was the consideration of how to actually "write up" the problem, treatment approaches, and care goals identified.

Conference participants brought diverse experience with patients to the proceedings. For the nurse, what was known about life on the floor emerged out of the harmony and tension of both managing work and seeing to patient needs. Other participants—dietitians, activity workers, occupational therapists, administrative nurses, and social workers—encountered patients directly or indirectly within the confines of their respective offices or particular service areas. The director of nursing, for example, might indirectly "know"a patient by way of floor nurses' and aides' complaints about him. While a social worker did not usually witness the ongoing affairs of a patient on the floor, the social worker was likely to be acquainted with the patient's recorded social service history, his financial profile, and his performance in an intake interview.

The diverse experiences were an important, yet complicating background for the need to write a rational and unified care plan for the patient. It was evident in conference proceedings that what might be identified, say, as a patient problem by one staff member might be taken to be nonexistent by another. "Identical" problems could, upon extended consideration, become contradictory ones. Behavior originally discounted as troublesome could, upon someone's urging to "come up with at least something that might be a problem if we don't keep an eye on it," develop into a potential problem (Gubrium 1980a).

It also was evident in conference proceedings that participants had varied means of describing what they did, and did not, consider to be patient problems. What at one moment a social worker called "sporadic melancholia," at another time she spoke of as the patient's "up and down blue funks." What was said to be a male patient's "schiziness of late" was assigned concrete meaning in terms of how the patient acted whenever a certain aide was working.

Conference descriptions combined a wide range of official, unofficial, clinical, slang, faddish, and traditional expressions for patient problems.

Yet, despite the experiential and descriptive diversity, there was notable homogeneity in what appeard in writing on the care plan forms. Inspection of written plans showed that the problems identified, treatment approaches selected, and care goals listed were remarkably few and straightforward. Various patients seemed to have virtually the same set of problems, similar means of treatment, and identical goals. How did this come about?

At some point in each planning conference, a staff member, usually the one chairing, asked how participants wished to present what they had more or less agreed upon. This spawned the second portion of the proceeding, whose focus was how to convey in writing what had been, until that point, a matter of discussion. The second portion was signalled by a variety of expressions, from the direct question "How do you want to put that?" to combinations of the question and possible answers, like "Well, shall we say that his problem is 'disorientation with periodic verbal abuse and combativeness?" and "Let's say 'chronic undifferentiated schizophrenia.' Okay? How's that sound?"

The second portion of the conference was distinct from the first in its stylistic aim. The first portion was understood to be an open discussion—a thrashing out, as it were—of patient problems and care management issues as participants saw them. In contrast to this, at stake in the second portion was how to present problems, approaches, and goals on paper as readers might best receive depictions of them. As it turned out, this meant that the patient described in the proceedings often had little or no resemblance to the patient described in writing.

Form-completers worked at what they believed to be the distinct stylistic demands of forms, generating new, but standardized content for the description of care and its planning. They argued forcefully over the best way of putting things, over how "professional-sounding" certain expressions were, and about whether the style in which form items were answered would "pass inspection" or would later make them unnecessarily accountable for realizing what they had written. Some participants sometimes suggested that their separate care planning areas, like nursing as opposed to occupational therapy, were unrecognizable on paper in terms of the distinct services and problems called for. Other participants claimed that problems, as written for one service area, sounded too much like those appropriate for another one.

Not only did participants work at stylistically correct description, they occasionally decried the validity of the outcome. When stylistic considerations got mired in detail or shortchanged for a lack of acceptable ways of putting things, it was not uncommon for someone to literally damn the need to complete forms, forms said to be, as one nurse put it, "full of fancy rot that don't tell you anything about what's really going on." Yet, with a change in context, participants recognized that what might be "fancy rot" from one

perspective was the documentary basis of formal accountability from another. Accordingly, this nurse added with resignation, "But we all know it has to be done. Right? So let's go to it and get it over with or else it's our necks. You can't blame'em [inspectors] though. They've got their job just like us."

Form-completers were prepared for meeting stylistic demands. There were standardized ways of "putting things," some of which were suggested by the forms themselves. Others stemmed from the professional knowledge of certified service providers, and yet others learned from veteran form-completers. There were differences among form-completers in their individual stylistic acumen. In the service settings studied, certain staff members were recognized for their commond of style. They seemed to readily know how to "put things." They were sometimes even marvelled. Referring to a certain social worker, a physician at the rehabilitation hospital studied once commented at a utilization review, "She's just a beaut' with the words. They all fall for it."

The Tyranny of Individualistic Interpretation

Interpretive demand further challenged, and morally burdened, form-completers. Consider the demand that form contents be about care-relevant events in the individual patient's world. The demand led form-completers to orient to what they knew about patients, staff members' work, and outsiders' actions, as ancillary, not constitutive, features of patient's condition, care, and custody.

The following episode illustrates the practice of individualistic interpretation. On an early afternoon in one of the nursing homes studied, a female patient, Mary, approached the nurse's station on her floor. The charge nurse was charting as she chatted with an LPN (licensed practical nurse). Mary asked the LPN for a cigarette. Patients' cigarettes and other smoking materials were kept in a drawer behind the station and distributed and monitored by the staff. There were well-known rules about when and where patients were allowed to smoke in the home, in line with fire regulations.

The LPN turned to the patient and assured her, "Just a second, Mary. I'll be right with you, okay? I want to finish what I'm doing." The patient muttered audibly, "Witch! All she's doing is gabbing. I want my cigarettes. They're mine!" The LPN glared at the patient and said nothing further as the patient abruptly turned away and sat in a chair next to the station. (Neither LPN nor patient were particularly fond of each other. The LPN believed the patient to be a demanding complainer; the patient saw the LPN as uncaring and flighty.) Several minutes passed as the LPN gossiped with the charge nurse, which Mary overheard and derided to another patient seated beside her.

As the gossip continued, the two patients complained to each other about the LPN's "selfish attitude" and "stupidity." The LPN twice warned the patients to "cut it our" and to "wait til it's your turn." At one point, the charge nurse

stood up and asserted, "Look Mary and Sara]the other patient]. I've been listening to your crap long enough this afternoon. Just you keep your comments to yourself." With this, Mary jumped up, again demanded her cigarettes, and shouted:

> I've been sitting here and she's [the LPN] gabbing. She's not working. I can hear you talkin.' I got two good ears. You're talkin' about her [LPN's] boyfriend— that creep she hangs around with. Well, damn it, I don't give a fart about that. I want a cigarette and I'll get it myself!

As the patient walked behind the station toward the cigarette drawer, the LPN turned to stop her, pulling the patient's sleeve. The patient yelled at the LPN, "Let me go! Get your paws off my arm!" The charge nurse then stood to restrain the patient, holding her by the other arm. The patient screamed and swore about her rights and the brutality of the staff as the LPN and charge nurse begged her to calm down and not get so "agitated." Yelling and tussling, the patient bumped her hip into the corner of the station and screamed in pain. As the patient staggered, the nurse and LPN helper her to a chair where she sat quietly, whimpering about her treatment and bruised hip.

About twenty mintues later, at the behest of the charge nurse, the LPN completed an incident report. As the LPN recorded the patient's condition before the incident, she explained to the charge nurse and the observer:

> I'd say Mary was pretty disoriented. I can't put "normal" because Mary is normally confused about her cigarettes. She's getting pretty senile but I'll put she's disoriented and explain that her confusion resulted in inability to control herself ... her balance ... and she lost her balance and bruised her hip ... or something like that.

The charge nurse then commented that, of course, there was more to it than that but what the LPN planned to do was adequate. In good humor, the charge nurse noted:

> You know, when you think about it, we're just as guilty. If it hadn't been for us [charge nurse and LPN]talking to each other, Karen [the LPN]might have just gotten the cigarettes and nothing else would have happened. Right?

The LPN responded:

> Yeah! Sure! I can see your point. Things are always going to be like that. But she [Mary]did get confused. What do you want me to put down? That I did it? I didn't push her into the desk. Look ... do you want me to fill out this report or not? Let's not get all complicated about it. Okay [reciting]"Mary was confused. She got agitated as she got up from her chair and lost her balance and bruised

her hip on the nurse's station." That's what happened ... anyway, that's what I'm going to say.

The charge nurse assured the LPN that what the LPN planned to write sounded "just fine."

It was evident in the rather commonplace events surrounding this incident that both the nurse and LPN recognized, in their own way, the difference between what they experienced with the patient and how they expected to describe it in the incident report. Being "just as guilty" suggested that the incident was as much a staff affair as it was an "extraordinary" event in the patient's institutional life. Yet, completing the form required a description that interpreted the incident as a patient, not a staff, or collective, event. The completed report would provide readers with a patient-oriented portrayal of what happened, thereby warranting any subsequent patient-centered action in the matter.

Interpretations were not only individualistic, but personally historical, too. The completed details of the preceding incident report, for example, would describe an incident in Mary's institutional life and how select aspects of her recent mental state (namely, her progressive disorientation) led to the incident. In turn, the incident was described and would subsequently be read as an understandable *consequence* of Mary's disorientation. If mentioned at all, the interactive details and substance of the cigarette/grabbing episode would be a mere background for a sequence of events with Mary cast as its starring agent.

The biweekly progress notes completed in the rehabilitation hospital studied also required treatment team members to convey a personally historical sense of the patient's continuing rehabilitation. Whatever was described in the most current note as the subjective and objective aspects of the patient's rehabilitation status was "worked up" in relation to descriptions contained in previous notes. The common practice was for a team member to write a note only after reviewing ("checking our") previous notes he or she had written. For example, before a physical therapist wrote a progress note on one of her patients, she made sure that, as one therapist put it:

> You check what you've said already to make sure you're connecting what you say now with what you said before. You'd look pretty stupid if you say the patient has never made progress and in the note you wrote two weeks ago you said he was making progress. It'd sound real dumb. So you kinda compare so that things jibe together and sound like whatever is happening has been kinda happening all along. It's a pain but ya can't just say what's happening. You've got to show some kind of progress—like it's happening or it's not happening, or like it's always been happening, but, like, maybe we just found out about it. So you kind of try to connect things back with what you said before.

Beyond this, staff members (especially occupational and physical therapists) compared each other's old progress notes before they completed new ones in the service of interdisciplinary consistency in describing the course of patient progress. In effect, both as individual therapists and as team members, staff constructed patient historicity out of temporally diverse patient facts, serving to convey degrees of progress in what was reported (cf. Gubrium and Buckholdt 1977).

As noted earlier, form-completion assumes that individual client problems are objective and describable. While staff members occasionally reflected on form-completion, they regularly and dutifully stopped asking themselves or each other questions about what it was they were doing with words, got on with description, and completed the forms. Still, on numerous occasions, the assumption was put to test.

Take the psychiatric conferences in the residential treatment center studied. Conferences served as the professional forum for the review of each child's progress in the last six months, the results of which were reported in a semi-annual written review and sent to the child's county welfare office. As in utilization reviews and patient care conferences, participants in the psychiatric conferences occasionally debated the meaning of some aspect of a client's conduct and care. Assessments and professional judgments were questioned, which, in turn, generated alternative assessments and suggestions leading to further questioning. Series of questions raised over the meaning of client conduct and care sometimes spiraled into meta-questioning. For example, in a typical episode, when one participant challenged another's conclusions about the progress of a child who was on a swearing-reduction program, a third participant took issue with the basis of the disagreement. This was challenged further with someone discounting the validity of the third participant's charge. Indeed, it was not uncommon on such occasions for rather abstract, tacitly epistemological, arguments and assertions to unfold and emerge over the validity of evaluatory knowledge in its own right, separate from the matter of whether a particular child or adult under review had or had not made progress.

In their own way, participants of the psychiatric conferences knew and reminded each other that general questions had to be settled or ignored before more particular ones could be taken up. They also recognized that the abstract regression of their questions and related deliberations could easily get stuck in the pursuit of epistemological issues to the detriment of concrete description, the latter being their immediate responsibility. In the preceding example, after fifteen minutes of conversation over the validity of varied basis for making evaluatory judgments, a special education teacher reminded other participants that, while she found what was being argued interesting, it could not help but lead them farther afield. When a consulting psychologist added, "If we don't stop questioning everything, how're we going to ever decide anything?" he, too,

implied that concrete description demanded epistemological closure, that describability required form-completers to cease pursuing questions about description itself. As a social worker once succinctly put it, "Let's stop agonizing about the 'hows' of it all or you'll never finish it."

Because forms require description, not analyses of, or challenges to it, form-completion obligated staff members to work at settling upon some descriptive stance, something not revealed on forms or in reports themselves. Participants who refused to agree on a descriptive stance, in the long run came to be known as "difficult to work with," "too philosophical," or something less benign. On occasion, the pursuit of questions of describability ended with a warning like "let's not get too abstract" because, it was pointed out, "we have to finish these [forms or reports] some time." On other occasions, warnings were harsher, like those suggesting that a "too philosophical" or "impractical" staff member not be given a chance to speak or even to participate in proceedings anymore. Thus, in interpersonal relations, form-completion ran up against description itself as tyranny.

DESCRIPTIVE TYRANNY

There is a common view of description which holds that, ideally, description can be precisely representational of whatever if describes. Accuracy is its hallmark. The view underpins the descriptive and accountable demands of forms. It is assumed that the contents of forms, in principle, are about the objective topics and matters of which form items request information. In practice, however, it is evident that the demands of forms are not descriptively neutral. We have seen, for example, that forms do not merely request information, but information about individuals embedded in personal histories of need, care, and custody. Like other demands, this one requires form-completers to do something other than just be precise in their paperwork, namely, to be precise about assembling individualistic accounts of configurations of experience.

While form-completers occasionally bemoan the immediate contradictions between what they claim to know and what a form descriptively demands, expressions of resentment and complaints are reflections of the general descriptive tyranny of forms. Or course, descriptive tyranny is tied to the routinization and standardization of all questioning, in or out of human service. It is the concrete side of "instrumental reason," a persistent, but typically undocumented "trouble" of organizational membership (Emerson and Messinger 1977). To standardize questions is to beg the ongoingly constructive and meaningful flow of everyday life, to gloss over the way its members experience its objects and events (Gubruim, Buckholdt, and Lynott 1982). Description that attempts to reflect the latter necessarily spoils descriptive

efficiency. At the same time, it reveals description's intentional quality (cf. Habermas 1971). In their own ways, form-completers are aware of the latter. In the face of descriptive demands, their awareness recognizes tyranny.

Physically, forms are mere pieces of paper. Ostensibly, they ask fairly simple and straightforward questions of those completing them. But their simplicity belies demands on the experience and knowledge of those who complete them. To attach an individual's name to an account of conduct may, on the face of it, seem trivial. Yet it does require form-completers to sort out—to work at—the contingencies and emerging meaning of their institutional knowledge and to assign them individualistic value, to describe what they know as features of the more or less isolated lifeworld of the person whom the form is reputed to be about. Such transformations are not produced by mere puppets of bureaucratic demand but, rather, through frequently wide-awake, rational, often irritating, sometimes agonizing, encounters with the tacit press for disjunction between appearance and reality.

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