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Language practices in caregiving in a South African nursing home: conflict and tension

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Abstract

Very little is known about the manner in which caregiving is interactionally accomplished. The role of language in caregiving has not been directly addressed. In this paper, I argue that language practices are embodied in care and that an analysis of the language practices of caregivers can give insight into the quality of care that is rendered. Based on findings of an ongoing ethnographic study, the effects of a number of different interactional styles in caregiving practices are identified and described. Some caregiving strategies are found to be conflictual, with some verbal strategies de-individualizing and infantilizing recipients of care. The strategies induce a sense of dependence in the recipients, reinforced by the ideological position of the institution, projecting inactivity and a lack of individual autonomy as the norm. Another set of strategies has the opposite effect: care recipients are constructed in discourse which foregrounds their self-actualization in a criminal frame. The criminal frame which is used to describe some recipients is in conflict with institutional discourse which, according to a biomedical model, describes residents in terms of their physiological or cognitive conditions only. I conclude the paper by outlining how sociolinguistic interventions may be implemented in care institutions.

Introduction

In this paper I depart from the philosophical conviction that care is a "communicative act" (Grainger, 1990) and analyse the nature of language practices used in the delivery of care, or in caregiving. The paper is divided into four sections. In the first section, I focus on socoiolinguistics within health-care institutions and explore the role and function of language practices within institutions. In the second section, I report on an ongoing research project in which interactional practices of black nurses in a nursing home for frail older whites in Cape Town, South Africa are documented.

In the third section, I analyse interactions recorded during routine moments of care delivery. The analysis reveals the different and conflicting verbal strategies used when care is rendered and the effects which the strategies have on the care recipients. Although the main focus of the paper is on the level of interpersonal relationships between caregivers and care recipients, the analysis also demonstrates relationships between care practices and broad institutional ideological positions. The final section outlines the role that language analysis can play towards improving the quality of care.

Language in care and ageing

The past decade has witnessed a rapid increase in the number of studies on language and ageing (Coupland, 1997). This sub-area has been referred to by Makoni (1997, 1998) as gerontolinguistics. Unfortunately, to date most of the research into gerontolinguistics has been conducted in European and American contexts. The research reported in this paper thus aims to fill a gap and focusses on language relating to ageing in African contexts. The practice of gerontolinguistics is significant in that it gives insight into the nature of ageing and the institutional contexts in which individuals grow old.

Since caregiving is embodied in interaction, it is unfortunate so little is known about language practices in caregiving, particularly where black nurses care for white elderly residents in long-term care institutions, or nursing homes – as in South Africa. However, the limited knowledge that we have about the specifics of interaction in care is not peculiar to South Africa. Commenting on the role of communication in health-care delivery in Euro-American contexts, Coupland, Wiemann and Giles (1991) argue that while much is known about diagnosis – in some cases, even the reasons for a diagnosis, very little is known about the manner in which a diagnosis and caregiving are interactionally accomplished, on a day-to-day basis and from moment to moment. Studies on ageing in institutional contexts have practical relevance. They play an important role in exposing and critiquing regimes of care which regularly undermine the personal integrity of the recipients of care, which put unrealistic interactive demands on the carers (Makoni & Grainger, 1998).

Language is at the base of the majority of assessments in health care and is central to all forms of treatment (cf. Swartz, forthcoming; Makoni, 1997). Language is also implicated in the definition of psychiatric disorders, such as thought-disordered schizophrenia, Alzheimer's disease and other dementias, which are predicated on miscommunication which is a type of communication in itself. For example, Bayles and Kaszniak (1987: 1) define Alzheimer's dementia in a way that attaches great importance to the role of communication as a "chronic progressive deterioration in intellect, personality, and communicative functioning" (see also McTear & King, 1991). In the few cases in which the role of language in diagnosis is explicitly acknowledged, the construct of the language that is employed is of doubtful theoretical validity – as in the Mini-Mental State Examination (MMSE) which is internationally used as a test of dementia. Some of the items which are purported to test language may be tests of memory rather than of language. For example,

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individuals being tested are asked to spell words backwards or, more recently, to repeat proverbs backwards. Attempts are being made to adapt the MMSE test for use among sufferers who have limited or no Western education.

In the following section, I explore the role of interaction in care, focussing on "veterinary care."

Interaction in "veterinary" care

The term "veterinary care" is used in psychiatry (Kleinman, 1978) to refer to care administered in the absence of "meaningful communication" between a health professional and a patient, and to the behaviour of the patient being controlled by a psychiatrist, or another relevant health professional, such as a nurse, without any resistance from the patient. Although the concept has its origins in psychiatry it is portable. It may be applied to other medical contexts and indeed to other non-medical contexts, such as education (Mohammed, 1998, personal communication). I propose that the concept is most productively utilized when divided into two versions: a strong form and a weak form of veterinary care.

South African health-care services provide numerous examples of strong forms of veterinary care. The majority of South African health-care providers are bilingual (English and Afrikaans), while the majority of their recipients are only proficient in an African language. The strong form of veterinary care thus obtains where the care provider uses a language which the care recipient does not understand. In the study reported in this paper, I demonstrate that in a long-term health-care facility, veterinary care is rendered by nurses who, in this case, speak Afrikaans or Xhosa – languages not understood by the care recipients.

The weak form of veterinary care is also rendered where care recipients speak the same language as the caregivers. Prospects of veterinary care occur predominantly where people "... must negotiate patienthood in institutional contexts but the weight of this burden and implications for failure are that much greater without ready access to the medium of communication" (Swartz, forthcoming). Even if the veterinary care model could be extended for analytical purposes to a large number of medical contexts, there is to date no evidence of the linguistic forms which may occur in care practices. A main objective of my research is to address this question.

The veterinary care approach places some conceptual significance on language practices in care. It is defined by an "absence of meaningful communication" and is thus consistent with the way in which other "disorders," such as schizophrenia and Alzheimer's dementia, are defined on the basis of (mis)communication (McTear & King, 1991). Because the approach attributes some significance to communication, I shall examine in greater detail the construct of communication which is implicated in it and the possible role that it plays. I will also pose what may initially appear to be a bizarre question: Are there any desirable effects of veterinary care, particularly in under-resourced institutions? (I attempt to answer the question affirmatively, with qualifications.)

The problems of communication are most visible when a patient and a health professional do not share a common language; however, the problem does not disappear when the patient and the health practitioner share a common language. Even when caregivers and care recipients share a language, they may attach different "meanings" to the disease. Veterinary care is strongly affiliated to biomedical modes of "reading" disease or condition. It operates on a simplistic model of communication. By defining itself in terms of the absence of "meaningful communication," it fails to seriously appreciate how "untidy and messy" and "subtle and fragile" (Kitwood 1993: 55) communication can be; it is irrelevant whether the messiness is by design or default. A more serious criticism of veterinary care is that it does not adequately appreciate the extent to which meaningfulness is relativistic. It is far from self-evident whether communication which is meaningful to a care recipient is necessarily meaningful to a caregiver. The underlying communication model is a "conduit" one (McTear & King, 1991), or "a morse code model of communication" (Kitwood, 1993: 54), assuming an uncomplicated relationship between "encoding" and "decoding."

The weak form of veterinary care accepts that most individuals, in spite of sharing a common language, are confronted by varying forms of care whereby health professionals may be able to dominate them through the manner and forms of their talk. This leads to a bizarre but perfectly understandable situation in which care recipients may not want to understand the language or the forms of language used by the caregivers. After a thorough review of the literature on medical communication, West and Frankel (1991) conclude that care recipients may construe the use of jargonized medical language as a sign of the doctor's expertise. Faith in incomprehensible discourse may thus be a fairly widespread phenomenon. The converse in placing one's faith in incomprehensible discourse is the feeling that it is not always advantageous to care recipients if the health provider is able to address them directly. The fact that a health-care provider cannot communicate with a care recipient directly, paradoxically provides the recipient with space to comment, at times adversely, on some of the procedures being used by the health provider.

There are hidden costs and benefits in both the strong and the weak forms of veterinary care. The weak form may in fact make it more difficult for care to be rendered to a large number of potential care recipients. If care recipients are properly understood, as Muller (1994) shows, this may well have implications for the amount of energy and resources expended on them. In a context of a hopelessly under-resourced system, it may be better from a resource point of view not to have a mechanism whereby a deficit in the system becomes apparent. An over-stretched hospital may need to rely on veterinary care (the strong version) to maintain the amount of work that it does (Drennan, 1997).

Recent research by Coupland (1997) and others places an important premium on the role of communication in improving the quality of life – and indeed the longevity – of residents of long-term health-care institutions. A systematic study of forms and functions of routine interactional practices during care still has to be made, particularly care of institutionalized elderly persons in South Africa. Internationally, the nature of the routine interactional practices of caregivers has begun to be analysed. The work of Grainger (1990) and more recently of Somera (1997) readily comes to mind.

Relevant empirical research

Grainger (1990) analyses routine practices as a way of understanding how care is practised in nursing homes for elderly persons in the United Kingdom. However, a main difference between the context in which Grainger works and my research setting is that Grainger's study was conducted in a country where tension between different professional groups and care recipients is at least not as acute as in South Africa. Somera's (1997) work is one of a few of these studies conducted in nursing homes in Third World countries. He based his study on an analysis of interaction involving a language other than English – Tagalog, in the Philippines. The study provides an important base for comparison. The main difference between Somera's work and mine lies in the focus of our

analysis. Somera discusses how processes of infantilization take place and the role of linguistic ageism in a construction of relations between caregivers and care recipients. I focus more broadly on a relatively large number of interactional styles, over and above infantilization, including flirting, bribery and instructional mode styles.

Research approach

My study investigates the nature of interactions between caregivers and care recipients, during which nurses conduct routine duties such as bathing, feeding and toileting of residents in a nursing home. The objective of the ethno-medical approach which I use is to investigate the linguistic and cultural dimensions of the care rendered by black nurses to white residents. A "verstehen" approach is adopted to reconstruct the meaning of the care practices, as understood from a nurse's perspective (Ferreira, 1982).

To be as unobtrusive as possible, my two research assistants and I spent time becoming acquainted with the nurses prior to beginning the field work. We visited the nursing home 24 times over a six-week period in early December 1996 and January 1997 to collect the data. We visited the home again in December 1997 and in the early part of January 1998. The aim of the revisits was to investigate whether any major changes had occurred in the dynamics of the relationships between the caregivers and the care recipients since our earlier visits. Permission to involve the residents in the project was obtained from family members. Permission to involve the nurses was sought and obtained from them collectively and individually. The administration of the nursing home formally granted us permission to use the nursing home as a research site.

The nurses were extremely keen to be video taped during the execution of their routine duties, which would give them an opportunity to view their professional actions on replay of the tapes. However, the nurses' interest created methodological problems, not totally unexpected. It introduced an element of "theatricality," which blurred distinctions between natural performance and role play. There is evidence of theatricality in earlier studies which I conducted on first-time encounters between young and elderly black South Africans (Makoni, 1996). In the present study I tried to address the problem of theatricality by conducting interviews with the nurses and playing back the video tapes to them and inviting their comments. The retrospective commentary was intended to investigate to what extent the "theatrical" performance was natural. Methodologically, it became apparent that distinctions between theatricality and natural performance constituted a continuum and were not binary opposites.

The nursing home

Nursing homes in South Africa fall into different categories. Some are organized along ethnic lines – for example, there are homes for Jewish elderly persons, while others are supported by religious organizations – such as the Salvation Army. The nursing home in which the study was conducted fell into the latter category.

When the research was commenced in December 1996, the management of the nursing home was, like many other South African public institutions, in a state of transition and transformation, which included racial integration.

Like similar institutions world-wide, the nursing home is tightly controlled (cf. Sigman, 1986; Nussbaum, 1991). Bureaucratic rules determine when eating, bathing and hairdressing may take place, who may smoke, and how many cigarettes and the brands of cigarettes that are allowed. The nursing home is a typical example of a "total institution" (Goffman, 1961).

The private-public space distinction is a useful construct which complements and extends, and does not replace a nursing home as a "total institution" concept. A nursing home is a private space in so far as the residents live within it. It is a public space in so far as it is a working space for nurses and other categories of health professionals, such as physical therapists, dieticians, and so on (cf. Wilcocks, Pearce & Kellacher, 1987; Van Dongen, 1997). In South Africa security personnel are an intergral part of a nursing home and provide around-the-clock services, protecting the home from persons entering from outside and those inside from leaving the home without permission.

On admission to the home where my study is being conducted, the residents are placed either in a private ward or a general ward. The rate for a private ward is more expensive than that for a general ward. The residents are located on a floor according to their health condition and the severity of the condition. Consequently, residents with similar conditions find themselves on the same floor. There is very little possibility (officially) of a resident moving spatially from one location to another, unless the resident's condition has been reclassified.

Even though residents with comparable conditions may be in the same general ward, they may occupy different physical spaces within it. For example, in the nursing home where my study is sited, three residents referred to by the nurses as the "gang" colonized an area which was their private space and which they did not allow other residents to cross – although they themselves crossed other residents' private space. The residents constructed each other's medical identities differently, depending on the physical space which they occupied. For example, the residents in one part of the home were referred to by other "normal" residents in Afrikaans as "die malletjies" (the mad ones).

Caregivers

The different categories of nurses in the home have different levels of education. In general, black nurses have a lower level of education and occupy lower professional positions than their white counterparts – a legacy of the apartheid regime which has resulted in "a divided sisterhood" (Marks, 1994). A majority of the black nurses only have the equivalent of a secondary-school education. They have limited proficiency in English, which reduces their linguistic effectiveness as carers when interacting with residents in English. Interacting with elderly, particularly dementing, individuals is extremely demanding, even for mother-tongue speakers of English (in this case). Communication with a demented sufferer is "an open-ended and unpredictable behaviour" (Kitwood, 1993: 59). Rippich and Terrell (1988: 140) capture the spirit of interaction with demented individuals more metaphorically when they compare it to "being led across a bridge that suddenly drops into an abyss." Talk by dementing elderly people is construed as "confused," a generic category used to describe different types of linguistic and content characteristics of their speech (Makoni, 1997). Linguistically, their speech is marked by the absence of clear pronominal referents, as the following exchange between a nurse and a resident illustrates:

Nurse: *What happened to your arm, tell me?*

Resident: *This one went up stretches from the bottom. Speed up to the altitude. This is going for the others. It gotta lots of things on top of them. Now it*

goes up there. (Unclear references are underlined.)

The nurses' low proficiency in English leads in some cases to nurses switching into Xhosa or Afrikaans, which the residents may not understand and which may compromise the quality of care that is rendered. Despite their low levels of proficiency in English, they are expected to carry out extremely sophisticated work with limited training. "People are literally taken off the streets and are expected to carry out highly sophisticated work, looking after people with unrealistic demands," as a matron put it.

The nurses frequently suffer from burnout and frustration. Racist discourse in care may be a means of giving vent to that burnout and frustration. The nurses' working conditions are characterized by "sandwiched conflict." At times, they are simultaneously in conflict with management and residents. They frequently express frustration that although racial restrictions have been removed, socio-economic inequalities persist. For example, a nurse complained to me that because of her poor salary, she could not afford to pay R1 000 for 30 tablets of a drug which had just come onto the market, which she was administering to the residents in the home, for a relative of hers who has a similar condition. This created a sense of bitterness in her which may have impacted on her caring practices.

Care recipients

The majority of the 98 residents of the nursing home (33 males, 65 females) are whites. At the time that the data were collected, their average age was 78 (males 76 years, females 82 years). The residents suffered from a wide range of conditions, including multiple sclerosis and various types of dementia. The residents had extremely heterogeneous backgrounds: some had been missionaries, others had been teachers, engineers, etc. They had also grown up, lived and worked in different parts of the world.

The majority of the residents had been admitted to the home at the request of close relatives. They had not come on their own accord and felt betrayed by their relatives. They had, what a matron referred to as, "unmet needs" – perhaps "unmeetable needs" might be a more accurate description.

A few of the residents had voluntarily come to the home because they had felt that they were no longer able to look after themselves. Both groups felt frustrated but for different reasons. The group of residents whose relatives had requested they be admitted to the home felt an acute sense of loss of control. They had to have their intimate needs taken care of by "black strangers." "Some close their eyes when we feed them," a black nurse explained. The group which had voluntarily entered the home was still alert. These residents felt that the nursing home lacked stimulation. The home is "more boring than the Second World War," an alert resident stated. This group also felt frustrated because they were daily forced to confront "the inevitable decay of the physical body." An elderly woman in her nineties, on admission to the home, requested that she not be placed with "those sick elderly people." She clearly was distancing herself from other residents to avoid feeling trapped by her own slow physical deterioration.

Data representation and analysis

Some of the verbal strategies which the caregivers used in their interactions with residents while rendering care to them are outlined below. First, I describe some verbal strategies which the nurses use to gain control over the residents. A major problem which the nurses face is to gain the residents' compliance, which they need to carry out their routine caring duties.

In Extract 1, a nurse attempts to exercise control over a resident by issuing a series of commands. The nurse is operating in an "instructional mode" (Makoni, in press). In the extract the nurse attempts to get a resident to sit up so that she may feed her.

Extract 1

(1) Nurse 1: *Move up.*

(2) Nurse 1: *Move up* (pause) – *please, darling.*

(3) Resident: *I don't want.*

(4) Nurse1: *Carry on.*

(5) Nurse1: *You must move! Move, move up, move up* (pause) – *your pillows.*

(6) Nurse1: *Move up, Mrs S, you must eat now.*

(7) Nurse 1: *Move up – be a darling.*

The nurse is instructing the resident to sit up. She attempts to mitigate the effects of the instructions through the use of a term of endearment, i.e. "darling" – in lines (2) and (7). It is important to note that the endearment term "darling" in both cases is placed after a long pause (0.8 sec in line (2)), as if it was an afterthought. The study data contain numerous other terms of endearment, such as "sweetheart," "my darling" and "lovey," which tend to occur with instructions. The nurse is operating in an instructional mode which complicates her interpersonal relationship when it is challenged by the resident. The instructional mode is potentially face-threatening to both caregiver and care recipient. It is threatening to the caregiver because it makes her feel that she has no control over the resident. When the commands are challenged, as in line (3), the resident refuses to obey the instructions. "I don't want." The instructions are also construed by the resident as an indication that her sense of autonomy is being challenged. "I don't want." When the commands are challenged the recipient feels that she is not in control of her caregiver, which makes it difficult for the caregiver to discharge her routine care duties. To establish control, the caregiver shifts from a instructional mode into a pleading mode. However, the pleading mode is unsuccessful in getting the recipient to comply. The caregiver abandons the attempt and moves on to another resident.

Nurses also use "interactional" bribery to gain residents' compliance. For example, the residents may be offered a number of different favours, such as "a cup of tea" or cigarettes, if they comply. The favours could be withdrawn by the nurses if the residents do not comply. In Extract 2, recorded in December 1996, a nurse is trying to get a resident to come to the table to have her lunch.

Extract 2

Nurse 2: *Mrs D, come over to the table. I'll get some nice lunch for you. If you finish your lunch, I'll give you a nice cup of tea, very hot.*

While Nurse 2 is taking Mrs D to the table, another nurse appears holding the hand of a male resident and assisting him to the table. Nurse 3 talks to the male resident.

Nurse 3: *You are supposed to be here.*

Resident: *Thank you.*

Nurse 2 leaves and comes back after some time when the residents have finished their lunch. Nurse 2 talks to the resident.

Nurse 2: *Thank you, lovey, you can come for your cup of tea.*

Resident: *I enjoyed it, enjoy it.*

The verbal strategy used in Extract 2, in which a resident is promised a cup of tea if she complies, is referred to by Grainger (1990) as "exchange." I prefer to use a more loaded term: reverse bribery. It is reverse bribery, because bribery is conventionally offered by a client to gain services. In this case the individual offers services by simultaneously offering favours to the client, to get the client to use her services. The exchange or bribery strategy in Extract 2 takes place within what may be regarded as a cordial relationship. Reverse bribery as an interactional strategy is consistent with care models seeking to take into account the interests of care recipients, when care practices are negotiated and not necessarily imposed.

When I returned to the nursing home in December 1997, a year later, the exchange/bribery strategy, although still used as an interactional bait, was taking place within a very tense and hostile relationship, as shown in Extract 3. In the extract, two nurses are standing at the door and talking about Mrs D and to her.

Extract 3

Nurse 2: *Where are you going to?*

Nurse 3: *She doesn't like blacks, this one.*

Nurse 2: *Yes, yes.*

Nurse 3: *Terreblanche.*

Nurse 2: *Leave her – AWB.*

Nurse 3: *Sit down, sit down.*

Resident: *Bugger off.*

Nurse 2: *Do you want a cup of tea?*

Nurse 3: *Why are you shouting?*

Resident: *I'm trying to be funny.*

Nurse 2: *Do you hear the noise that she makes, this fat one, getting fat everyday.*

It is quite telling that Mrs D is described as a member of the Afrikaner Weerstandsbeweging (AWB) – an extreme racist conservative group. It is in fact highly unlikely that she is a member of such a political organization. The reference to Mrs D as a member of a racist group is shorthand to indicate that her behaviour is unacceptable to the nurse.

Mrs D and two other residents were now referred to as the "gang" because of the solidarity which they showed each other. The nurses complained that when one member of the gang attacks them the other two join in. One of the nurses showed us the bruises which they got from attacks by the "gang."

At times the residents resisted the verbal strategies used by the nurses. In Extract 4, a group of nurses flirt with Mr S, who allegedly seriously objected to their behaviour. He threatened and swore at them. "Hé, voetsek." The insults and threats only succeeded in eliciting laughter from the nurses, unlike threats from the "gang" which they would take seriously. The threats from Mr S were construed within a "play" frame from the nurses' perspective.

Extract 4

XS: Xhosa-speaking nurse

AS1: Afrikaans-speaking coloured nurse

AS2: Afrikaans-speaking coloured nurse

Mr S: Resident

XS: *Jonga, jonga, jonga.* (Look, look, look here.)

AS1: *Jonga.* (Look (kissing Mr S).)

Mr S: *Hê, voetsek* (swearing).

AS1: *Hy baklei.* (He is fighting.)

Mr S: *Ek gaan vir jou hard stop.* (I'm going to stop you.)

AS1: *Jy baklei, nê.* (You are fighting.)

XS: *Ina manzi uyawafuna amanzi.* (Have water, do you want water, have it.)

AS1: *Drink die water.* (Drink the water.)

Mr S: *Water, nog.* (Give me more water.)

XS: Tries to kiss him.

Mr S: *Ek wil nie soen, meisie.*

AS: Kisses Mr S.

Mr S: *Hê man! Ek sal jou klap.* (I'll hit you.)

AS1: *My klap.* (Hit me.)

Nurses cluster around Mr S and clearly seem to enjoy flirting with him. The institutionalized group flirting seems to have the approval of the management as a care strategy specially tailored to suit Mr S' imagined individual interests.

Another set of strategies which the nurses use are designed to encourage the residents' dependence on them as caregivers, which makes the residents relatively easier to control. In Extract 5 the nurse keeps on directing the same questions to Mr V, to which she already has answers. It is not normal procedure in ordinary conversation between adults to ask questions about which one already has answers. It is only in institutional contexts in which there are clear assymmetrical power relations between participants, e.g. in courts and classrooms, that adults recyle questions to which they already have answers. In the extract a nurse is looking after a resident in a lounge.

Extract 5

Nurse 3: *What car is your wife driving? What car is your wife driving, eh! What car is she driving, a Corolla?* (No response.) *I need to know from you, what car she is driving. Who is coming? I need to hear from you. Can you hear me? I don't know who is here. Somebody is here.*

Wife of Mr V enters the lounge.

Wife: *Did you give him a cigarette?*

Nurse 3: *No.*

Wife: *I promised that I won't give him another cigarette. That will get me into trouble.*

Extract 5 effectively illustrates the possible dangers of including family members in care because an alliance may emerge between the family members and the caregivers against the autonomy of the care recipient.

By directing her questions at the nurse about Mr V, the spouse reinforces the nurse's position, making her husband more dependent on the nurse. In some cases the nurses seem to try to control the residents, or to make it easier to control them by stripping them of their past achievements. If residents' past achievements are taken into account, then their mode of care will be dramatically affected, because some residents occupied higher social positions that do the nurses. "He was an electrical engineer." "He was a teacher."

Interpretation and discussion

The central issue running through the various extracts is that of control. The caregivers try to use language strategies to

exercise control over the residents to make it easier for them to carry out their routine duties. Some nurses prefer to operate in an instructional mode because, normally, "commands" may be given and must be obeyed without question. Commands reinforce hierarchical relations. The residents do not participate in decisions about when to eat, to take medications and to go to bed. The caregivers' absolute authority gives caregivers control and simplifies their work and routine (cf. Somera, 1997). Unfortunately, in the context of my study, the instructional mode if anything has the opposite effect: it complicates the work routine of the caregivers because authority is challenged by the care recipient who becomes highly uncompliant.

The "exchange," or "reverse bribery" strategy seems to work because the residents are offered certain favours if they are compliant. Another predominant strategy which the nurses use is to de-individualize the residents by stripping them of their past achievements, hence rendering the residents easier to control because their past/life achievements are regarded as inconsequential to their current status. This leads to the caregivers' construction of the residents as "part" persons, or non-persons. When care recipients are de-individualized their personal interests do not necessarily have to be taken into account, because "they do not talk back," as a matron put it. Veterinary care models create conditions which encourage psychological degeneration into non-personhood.

Some of the strategies, particularly those whereby the residents are constructed as inactive or dependent, are reinforced by the general institutional culture in which passivity and dependence are reflected by the limited activities which the residents may carry out independently as the norm.

> *The Home is oriented toward the least competent. Although typically one tends to think of the advantages of being competent, a significant structural feature of the Home life is the way in which being a competent member can work against inmates, as such behaviour is, in a very real sense, inappropriate, atypical and unprepared for* (Posner, in Sigman, 1986: 145).

Language practices in the discourse of the carers are at times, in some cases, in conflict with those of the institution. This showed up in the complicated ways in which the carers and the administrators related to the residents in their care practices.

In Extract 3, for example, by describing the resident as a member of the AWB, the caregivers were implying that the resident still retained a level of individuality, albeit one which was unacceptable to the caregivers. The individuality which the caregivers attribute to the residents is in conflict with the official discourse which describes them in terms of their medical condition and reduces them to wheelchair-bound, or mobile diseases: a cerebral sclerosis (case), a peri-neuralgia (case), a renal failure (case). Evidence of a tendency to reduce elderly individuals to their "bodily ailments" as part of bureaucracy and infantilization strategies has been reported in other nursing homes, for example in the Philippines (cf. Somera, 1997).

Implications for intervention

Research into how care is interactionally practised has an applied dimension. In this paper, I sought to demonstrate the complexities and tensions in the caring practices of nurses. I have attempted to demonstrate that care has an important linguistic dimension. Attempts to construct models of care should thus explore the linguistic dimensions of care as well. The linguistic dimension of care, I have illustrated, is affected by and also affects the ideological position of the institution. Interventions in such health-care environments must thus take place at a systemic level, taking cognisance of multiple levels of information.

Nurse education is another level at which meaningful intervention may take place. Nurse education should emphasize that language practices may affect the quality of care which a nurse renders. In the South African context this also entails drawing nurses' attention to the different aspects of language as used by residents and outlining strategies which nurses could adopt to maximise resident co-operation in health care.

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Books received

Health systems

Health systems and aging in selected Pacific Rim countries: cultural diversity and change, edited by Andrew V. Wister & Gloria M. Gutman, Gerontology Research Centre, Simon Fraser University, Vancouver, BC, Canada. 1998. ISBN 0-86491-188-2. Available from the Gerontology Research Centre, Simon Fraser University, Burnaby, BC V58 1S6, Canada. Paper; 146 pp; price US$15.00, Can.$20.00.

This book addresses contemporary issues associated with the intersection of population ageing, health care, and cultural diversity and change through an exploration of the experiences of selected countries from the Pacific Rim. Common themes underlying this volume are the development of services that are sensitive to diverse cultures; transition from primarily curative to combinations of allopathic, holistic and health promotion models of health; and the interrelationship between formal and informal, especially family-based, care of elderly people. Australia, China, Hong Kong, Japan, Korea and Canada have been chosen because they represent countries that have distinct history, culture and organization of health care. They are undergoing population ageing and health transitions at different tempos and they also share a geographic connectedness because of their location on the Pacific Rim.

Technology

Technology innovation for an aging society: blending research, public and private sectors, edited by Gloria M. Gutman, Gerontology Research Centre, Simon Fraser University, Vancouver, BC, Canada. 1998. ISBN 0-86491-183-1. Available from the Gerontology Research Centre, Simon Fraser University, Burnaby, BC V58 1S6, Canada. Paper; 158 pp; price US$14.50, Can.$19.00.

This publication explores issues relating to the development and market expansion of new technologies designed to enhance the health and quality of life of "at risk" seniors. Topics of concern are how to reconcile market imperatives with social and public policy agendas; how to effectively research and market technology to older persons; how to ensure consumer protection without destroying producers' incentives for innovation; and generally how to increase the availability, affordability and use of appropriately designed technology by and for the benefit of seniors.