

Chapter I

CONTINUITIES IN SYMBOLIC INTERACTIONISM

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ILLNESS TRAJECTORIES\*\*

A distinction central to the analysis presented in this paper is that drawn between a "course of illness" and an "illness trajectory". The first term offers no problems to the reader since everyone has experienced an illness, which did not merely appear but developed gradually over time, getting worse and the perhaps clearing up. To the knowledgeable medical, nursing and technical staffs, each kind of illness has its more or less characteristic phases, with symptoms to match - and often only skilled "intervention" will reverse, halt or at least slow down "the progress of the disease". Course of illness is, then, both a common sense and professional term. In contrast, trajectory is a term coined by the authors. It refers not only to the physiological of a patient's disease but to the total organisation of work done over that course, plus the impact on those involved with that work and its organisation. For different illnesses, the trajectory will involve different medical and nursing actions, different kinds of skills and other resources, a different parceling out of tasks among the workers (including perhaps kin and the patient) and involving quite different relationships - instrumental and expressive both - among the workers.

A concept like trajectory is necessary for sociological understanding of illness management. It protects the researchers from being confined by the perspective of the health workers themself-

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\*\* Editorial note: The paper is an excerpt from a larger text by author.

ves-minimizes the dangers of simply appreciating or criticising the "natives" as judged essentially from within their own framework. At the same time, this concept is rooted in close observation (seeing, hearing, interviewing) of health workers and so hopefully does justice to their viewpoints. So much so, that those studied ought to recognize themselves in our account of them and their work, and not disagree with the major thrust of that account - a requisite for our kind of research. But the concept is above all a means for analytically ordering the immense variety of events that occur - at least with contemporary chronic illnesses - as patients, kind, and staffs seek to control and cope with those illnesses. Of course all work - industrial, commercial, artistic, domestic - involves a sequence of expected tasks, sometimes routinized but sometimes subject to unexpected contingencies. It may be that "trajectory" fits the organization of those kinds of work also.

But there are two striking features of health work shared only with certain other kinds of work. One consists of the unexpected and often difficult to control contingencies stemming not only from the illness itself, but also from a host of work and organizational sources as well as from biographical and life style sources pertaining to patients, kin, and staff members themselves. A second and crucial feature of health work is that it is "people work". The product being worked on, over - or through! - is not inert, unless comatose or temporarily nonsentient. Two things follow: 1) the patient can react and so affect the work, 2) the patient can participate in the work itself, that is be a worker. The latter point is equivalent to saying that the product is not only worked on or over but also sometimes with. As will be seen, both major features (contingencies and people work) of illness trajectories affect the various specific kinds of trajectories, and differentially so along their various phases. Taken together, both features insure that trajectory work harbors the potential for being complex and often highly problematic.

Further sources of problematic complexity;  
chronic illness and technology

Two other sources - the prevalence of chronic illness and associated technologies for dealing with it - make for complicated and often highly problematic trajectories. In brief, their combined impact is as follows. Some kinds of technology (like the machinery, drugs, and various procedures used for kidney dialysis patients) are producing new trajectories (P l o u g h, 1981). Until the health professionals gain experience with the novel twists and turns of the illness, also with it and the regimen's impact on other bodily systems, and the organization of work to manage all of that, the resulting trajectories can be difficult indeed as the history of dialysis treatment has shown. At the other end of the age scale: babies saved in the sophisticated ICNs\* may develop disabilities and systemic illnesses - some not known until somewhat later - that are not necessarily "curable"; and their extent is still not at all known (see W i e n e r, et al. 1979).

Improved technology has also produced what might be called a "stretchout" of trajectories. By this we mean that although the technology (for example, open heart surgery) keeps ill persons alive, and may even improve them symptomatically, they then face uncertain futures regarding both the physiological consequences of the surgery, drugs, etc., including drastic impact on other bodily systems - and in the organization of work to manage regimens and attendant life styles. Even without the creation of such related physiological disturbances, trajectory stretchout poses new medical, organizational, and biographical problems: for example, the diabetics who, now living longer, encounter end-of-the-trajectory complications that neither they nor often their physicians dreamed of.

Since many patients suffer from multiple chronic illnesses (whether related systemically or not), their respective regimens need to be balanced carefully or else there are physiological aftermaths, which result in unexpected and sometimes uncontrollable kinds of physiological, and so work-related trajectory, develop-

\* ICN - Intensive Care Nursery.

ments. (We offer a case a few pages below, which serves as a poignant illustration). Sometimes the balancing is hampered by lack of knowledge of, say, the side effects of new drugs or even older ones used with a given patient; or by the staff's own focus on a primary trajectory to the virtual exclusion of others regarded as secondary; also of their lack of knowledge that the patient has other illnesses.

Advances in half-way technology utilized in the service of managing difficult chronic illnesses result in unexpected contingencies during the acute illness period - as when experimental or relatively new drugs, or familiar ones used with specific patients, produce unexpected physiological occurrences that amount essentially to new phases in the illness and its attendant work. Surgical nurses have remarked to us about avant-garde surgery that in postsurgical phases it is difficult even to assess "what is going on" and to what degree the surgery has been "successful". Because "everything is so new", they literally do not quite know what to expect or how to evaluate it. Complicating much trajectory work, also, within the hospital especially is that new microphases and new stretchouts bring in the services of multiple departments, involving the work of their respective technicians and specialists, some of whom are struggling with new phenomena.

The hospital staffs increasingly recognize that patients need to be taught requisite skills for handling drugs, equipment, and for doing various therapeutic procedures when at home. So something else is being added to the trajectories, in the last days or hours before the patient leaves the hospital. In the days or weeks afterward, the patient may be visited and worked on by visiting nurses, social workers, respiratory therapists and other kinds of health professionals.

It is easy to see that the complexities of trajectory work are added to by the host of new specialists (medical, nursing, technical) who are working on the patient's illness and having to relate to each other and to each other's work. These health workers are in various degrees experienced or inexperienced. Worse yet, since many specialities are quite new, their practitioners are essentially finding their way in their work on the patient's illness.

In a very real sense, contemporary medical efforts are producing not only new chronic illnesses and phases of illness - and

the associated trajectory work - but are producing new kinds of chronically ill people. They are predominantly older persons of course, but also include the ICH "graduates" - sometimes referred to by staff as "damaged goods" - and in fact people of all ages. Naturally, the interplay of life cycle and life styles with the purely physiological conditions is immensely varied; said another way, so are the trajectories.

Trajectories, routine and problematic:  
case illustrations

Despite all the conditions that further the problematic character of trajectories, of course many are relatively routine. Certain illnesses and their possible developments are well-known; so are the impacts of therapy as well as the requisite resources and organization needed to control those illnesses. In the pages below we shall be discussing trajectories that run the full range from quite routine to highly problematic - "out of control totally" or partly "out of control". It should be useful for readers who are little acquainted with hospital work if first they are provided with some images of trajectory work through the presentation of two case illustrations drawn from our research. The commentary on these cases will be minimal: just enough to highlight a few features of trajectories and trajectory work that will be addressed in later pages.

1. We begin with a case that illustrates such phenomena as: 1) multiple trajectories, 2) emergency ("acute") hospital care, 3) initial steps in diagnosing or mapping of a major trajectory ("heart failure"), 4) the complexity of the division of labor, including that among trajectory-managers; also among various technical specialists drawn from different departments, 5) the several kinds of work involved in trajectory management.

The patient, Mr. Einshtein, was hospitalized for possible congestive heart failure. He had had an myocardial infarction eight years previously when 57-years old, but had since lived quite a normal life except for self-administered medication to control angina. Einshtein had recently experienced much more angina, but

attributed it to the action of cold weather (which had always affected him somewhat), for he had been on an extended visit to Australia during its winter season. His chronic bronchitis was also "acting up", for he was coughing up much more phlegm daily than usual. (Before hospitalization he did not realize that his increased coughing was so intimately tied up with a malfunctioning heart). Ten days before hospitalization, he had a checkup by his internist who discovered, through a routine blood test, that he had mild anemia. A barium x-ray was then ordered to check for possible blood loss in the colon. The internist awaited this report before moving to his next diagnostic tactic of taking a bone biopsy. Meanwhile, the internist knew that the patient had appointments the following week with both his cardiologist and his respiratory specialist. Besides the anemia, a possible cardiac flare-up and difficulty with his lungs, Einstein had, some months before, developed such severe neck pains that he now could only sleep sitting up, despite being put on home traction by an orthopedist.

The cardiologist and the respiratory specialist, seen on successive days, both suspected congestive heart failure (a heart "gallop" and considerable edema had now appeared), and so hospitalized him speedily. For three or four days he was given intense, virtually emergency care. A host of laboratory tests were ordered - Einstein giving freely of blood, urine, and so on - EKGs were taken at the bedside, he was sent to be x-rayed and then for an echocardiogram procedure. Cardiologist and respiratory physician worked closely together, each in his own province, but essentially the lungs took immediate precedence. So the lung problem was attacked by giving antibiotics, and by utilizing the services of physiotherapists and physical rehabilitation technicians who trooped in and out of Einstein's room, giving mist treatments, bronchosil treatments, and pounding Einstein's rib cage area in an effort to loosen his phlegm and clear his lungs of it. All those respiratory treatments went on undiminished - and ultimately had a successful outcome - during the the two weeks of his hospitalization. After the first days of emergency treatment the respiratory physician moved into the background - the cardiologist moving into the foreground - evincing this by manner and less frequent face-to-face monitoring of the patient.

Einstein's cardiologist was actually new to this case, had

indeed never seen him until just before the hospitalization - Einstein having switched from another cardiologist. One reason for Einstein's choice of this cardiologist, recommended by the internist, was that he reasoned that all of his physicians (internist, cardiologist, respiratory specialists) could work together for each was associated with the same hospital and knew one another. During the first days of hospitalization, the cardiologist awaited the results of various tests including the echogram both to verify the suspected congestive heart failure and to locate which section of the heart was most affected and with what degree of damage. He attacked the edema with a diuretic, but within three or four days changed to a second diuretic when it became clear that Einstein's body had overreacted to the first one. Meanwhile the nurses were making frequent checks of the patient's blood pressure, which was quite low and unstable, while keeping careful watch over his urine output. When the diagnosis of congestive heart failure became clear, then the cardiologist moved to the forefront in the patient's "management". He informed Einstein of the diagnosis, agreed to by all three physicians involved in the case; he put him on isodil (to prevent angina) every three hours; and explained that a couple of days later he was going to treat the heart failure with a drug (apresoline) which by affecting the vascular system would allow, because of the lessened resistance, the heart to function more strongly. He explained that if this worked, then the dosage of apresoline eventually would be increased. Patient and physician eventually discussed the impossibility of predicting accurately "how far back" the patient would come: a wait-and-see attitude was necessary, and indeed it would be many months before the outcome would be known. The cardiologist also explained the necessity of cutting down on sodium, to lessen edema, and had a representative of the dietary department visit with the patient and explain the low-sodium diet.

Meanwhile apropos of his neck pains the patient was doing some trajectory management himself, as well as making some operational decisions, which affected at least temporarily the cardiac and lung trajectories. He requested pain medication so that he could sleep at night, and was allowed it. He asked for a large chair and several pillows, and each night surprised each new night nurse by sleeping in that chair; only at the very close of his hospitaliza-

tion did he discover, through experimentation, that he could now sleep fairly comfortably by raising the movable bed so that his head was about eighteen inches above normal sleeping position. Most evenings he requested back rubs from whatever nurse was on duty, and they were cheerfully given, in part no doubt because he accompanied each request with "at your convenience, when you aren't too busy".

Einshtein's pain management occasionally interfered with the respiratory management; or said another way, sometimes he made choices in favor of the former at the possible expense of the latter. For instance, proper placement of his body during the rib-pounding, and stimulation of his lung area called for having, on the mobile bed, the lower part of his body raised above the upper part - but since this increased his neck pain markedly, he persuaded the physical therapists to do their work while he lay flat. Again, he was supposed to "posture", lie on his side and cough, but sometimes he delayed posturing, or omitted it, because lying down just hurt too much. Paradoxically he also learned how to attack the immediate respiratory problem - coughing up the phlegm, which was sometimes very difficult or wracked him - by putting together bits of information garnered over several days of querying the seven or eight different respiratory technicians who arrived at his bedside. Nobody thought to actually coach or query him about possible difficulties in coughing - he was just supposed to do it. The wracking cough of course interfered with the cardiac regimen of resting as much as possible, so by better management of the coughing he was, in however minor a way, contributing to better management of the cardiac trajectory.

Once he played a more prominent and visible part in the cardiac drama. The cardiologist had cut down drastically on the diuretic dosage because it was contributing to too low a blood pressure; but hours later a nurse gave the old, stronger dosage. Einshtein, groggy at the time, did not immediately notice the familiar pill, but minutes after swallowing it queried the head nurse - who got flustered, called in the intern, who in turn apologized for the error and ordered an IV, explaining that it would be necessary now to counteract the diuretic with a twenty-four hour intravenous drip.

About four days after hospitalisation, Einshtein's internist

reported the barium x-ray was negative and did a bone biopsy to check out another possible source for the anemia. And he ordered iron pills to counteract the anemia. Einshtein would continue to take this medication for many months.

The internist, long familiar with his patient, assured him from time to time that the cardiologist was on top of things. The cardiologist also contributed measurably to relieving Einshtein's anxiety by relatively unhurried visits, clear explanations, and after several days by responding to questions about potential progress and limits to complete recovery, anticipated posthospital phases, expected length of the recovery period, and questions during one session about the possible effect of congestive heart failure on longevity. The cardiologist also carefully explored the patient's life style and expressed a wait-and-see attitude about whether and how much it would have to be altered. In fact, though he did not reveal his suspicion, he had real doubts about how much recovery was possible. Einshtein discovered this only three months later through his internist who told him that the cardiologist was happily surprised at the rate and degree of recovery.

As the day of leaving the hospital approached, the cardiologist carefully explained to Einshtein the home regimen to be followed, answered questions about alternative treatments considered and reasons for discarding them; he also explained how the drug therapy would be altered depending on "how things turn out", for the next weeks would be essentially an experimental, drug juggling period. The chief respiratory therapist turned up and talked about home mist treatments. A physical therapist taught Einshtein a set of breathing exercises. A dietician carefully explained the rules of a low sodium diet, leaving a list of sodium values found in ordinary food and loaning a book on "cooking without salt" that might be useful. The intern - who had taken a deep interest in this case and had been clearly instrumental in some of the daily operational medical decision making - dropped in for a ceremonial farewell. Then Einshtein's wife - who had performed many functions while he was in the hospital, and would do varied trajectory work in the months to come - called for a cab and took him home.

There he would be subject to the cardiologist's provisional program of juggling drug dosages and would carry out the respiratory regimen faithfully. As for his management of the neck pain:

he requested his internist to recommend a reputable acupuncturist; also switched to another orthopedist, who recommended physiotherapy. Within two months, Einstein's neck pains had so diminished that he was able finally to posture properly, and sleep lying down so that he could get the full measure of rest required by his cardiac condition.

2. Next is a case illustrating a trajectory which is highly problematic from everyone's point of view: physicians, nurses, patient. Some features of this case that stand out are: 1) the multiple trajectories, 2) the multiplicity of trajectory managers and the confusion over "coordination" of their efforts, 3) the numbers of medical and technical departments drawn upon as resources, 4) the sheer difficulty of predicting outcomes of the medical interventions and the difficulty of deciding which to utilize, 5) the patient's active role both in reacting to staff decisions and making her own daily decisions, 6) the cumulative impact on everybody: including frustration because of great difficulty in gaining and maintaining control over the various courses of illness, anger and upset over the patient's "uncooperative" behavior, conflict and resulting anger among the staff members themselves, plus dismay and upset over the "dying" issue.[...]

#### Complexities of organizing therapeutic action

The complexities of organizing therapeutic action derive mainly from two sources. The first is the problematic character of so many trajectories. As will be noted directly below, if the illness course is well understood and no untoward contingencies arise, then the stereotypical picture of a single physician instituting therapeutic plans and having them carried out successfully is a realistic picture. If the trajectory is problematic, however, then that classic image of medical work can be very far from accurate. The second source making for the complexities of therapeutic action is the amount and range of tasks plus the organization of those tasks, so that even relatively routine expectable trajectories can develop unanticipated complexities around organizational issues. These in turn can profoundly affect the organization and efficacy of

therapeutic action. In the next pages, some of these complexities will be discussed.

Trajectory management is relatively routine for courses of illness that turn out to be relatively standard - they are all well known, the physician and staff members have had much experience with them. Hospital wards are equipped to handle routine cases with some efficiency, using standard operating procedure: the needed machinery is on the ward, the desired medications are on hand or easily obtainable, the nursing staff understand the procedures, the head nurse has had much experience in coordinating the scheduling and timing of various resources or services needed from other departments. Indeed each ward tends to have what we would term its characteristic "shape" (Strauss et. al., 1964), for it has its characteristic types of illness, which are handled there - and though complex, the requisite tasks are well understood and their larger organization relatively worked out. An example would be that of a recovery room for postcardiac surgical patients, where the latter are initially in parlous conditions, where the clusters of tasks require highly skilled nursing and physician staff, but where the routines are well laid out even for handling emergencies, and the organization for all that is nicely coordinated. The chief physician, as the main trajectory manager, can count on all that organizational machinery for handling - hopefully without undue hitches - his anticipatable routine case, through the first days of postsurgical recovery. By contrast, if a patient is placed on a ward into whose shape he does not fit at all - that is, the staff have little or no experience with his illness, have no experience with the equipment used on him or with medications ordered for him - then the routine trajectory turns into a nonroutine and, also, often highly problematic one. Worse yet, "difficult cases" become even more problematic under these "out of shape" conditions.

Cases that are, on diagnosis, viewed as potentially problematic will require a more complicated order of task organization and coordination. To begin with, the physician may not be able to foresee clearly the course that the illness will take, or perhaps its rate of development, with or without medical intervention. Or the disease course may be relatively recognizable, but the impact of experimental drugs or procedures (old ones not being effective) are not well known. He can, anyhow, visualize some of the tasks

to be done and rely on the ward personnel to carry them out, but they and he know or suspect that other resources (specialists, departments, treatments) may have to be called upon as unanticipated developments occur to supplement the more usual standard operating procedure of the ward. In extreme cases whole clusters and sequences of tasks are unanticipated, and a great deal of ad hoc organization is required to get them decided upon, and to get them done.

To back up a bit, however, the initial diagnosis leads the physician in charge of the case to considerations of medical intervention, of treatment. Here again, modern medical technology - however "half way" - is likely to offer several initial therapeutic options. Breast cancer, for instance, can be treated with surgery, radiation, chemotherapy; and there are several types of each, and they can be used singly, in combination and in different sequences. Which options to choose? The physician's experience may lead him to one choice or another; so may his medical or social ideologies; his sets of belief about surgery or particular kinds of surgery, or about various drugs or machine treatment, or his more socially tinged convictions about womanhood and about sexual relations. Considerations of cost, convenience, availability, speed of impact, skill, risk, discomfort, psychological impact on the patient will also be balanced.

In managing more or less standard cases, the physician will not need to search for viable options, since he will know most of them. For more problematic cases, he may institute a search for options other than those he has already had experience with, utilizing literature and collegial consultations. Housestaff may be involved in both the search and the decisions about which options shall be tried. Typically the physician will anticipate certain outcomes from medical interventions, some undesirable (drug side effects) and will alert the nursing and will alert the nursing and physician house staff to monitor for those effects and, if they appear, to stand ready with counter measures.

However, there may also arise some of those unanticipated contingencies discussed earlier. When, they appear, the responsible physician may not have ready options to utilize as counter measures. Again, he may institute a search for options, or housestaff (even nursing staff) may press alternative courses of action on him. So while one physician may make the option decision, others

may also be involved in that decision. Moreover, at these unexpected option points whoever is present may sometimes need to make strictly operational decisions, needing quickly to choose one or another option without consulting the physician providing that the danger to the patient is perceived as great and immediate. In that sense, the trajectory management is further diluted or - necessarily - shared. (One example is the incident in case when the cardiac patient discovered the nurse's error concerning his diuretic medication, alerting then the head nurse, who in turn called the intern who made a quick decision to counter the potentially dangerous contingency with an intravenous drip).

Each new contingency, whether large or small, requires some choice of alternative lines of action in order to get the trajectory into the best possible manageable order: i.e., to keep the gyroscopic shaping of the trajectory as successful as possible. Again, we say "trajectory" rather than simply refer to the illness course, because so much more is involved than the illness itself. For example, the physician may not only order a procedure changed but request that a skilled, or a specifically skilled person, carry it out. Moreover, at crucial option points, several persons with somewhat different stakes in the case may be weighing, and pressing their respective views on, various possible options.

One important implication of that last sentence is that under conditions of contemporary hospital practice, it is not always a simple matter to say who is in charge of managing the trajectory. In routine cases, the principal physician is primarily responsible for visualizing the trajectory: for ordering, evaluating and acting on diagnostic tests; for laying out the lines of work that need to be done; for utilizing the ward's organizational machinery. However, when the course of illness becomes problematic, when things get out of hand, when other physiological systems go awry, when other chronic illnesses impinge on the primary one - and even begin to take priority - then the trajectory management begins to get shared with other medical specialists. These specialists may disagree or their orders may conflict, so that problems of "coordination" can play havoc with house staff and not incidentally also with patient care. Lack of coordination amounts to a blurring of the division of labor, with untoward consequences then flowing from unclear or disagreed upon conceptions of responsibility.

On the other hand, the specialists may work well together, sharing in the shaping of the trajectory. It is important to understand that with complex trajectories, this shaping, which involves a complicated division of labor, may be parceled out not only among several specialists, including a psychiatrist, but may also involve the efforts of kin. Patients themselves may enter this process at key option points, entering as intensely interested parties or being invited in by the physicians, who may even press them to make certain decisions when the options are very risky, or their potential psychological or biographical impact are great. But they may enter as intensely interested parties who weigh the option criteria differently from the physicians. Their own option searches may lead them to propose and even to insist on consideration of alternative options. One patient with severe respiratory disease whom we followed closely in and out of the hospital was astonishingly and successfully assertive in his own trajectory management, pressing his physician repeatedly on all kinds of issues: but one of his major controlling strategies was to know the whole range of pharmaceutical possibilities and to utilize them with or without his physician's knowledge.

An additional complication is that precedence in the trajectory management is directly affected by the existence of multiple illnesses. As the case of the cardiac patient illustrated, when the lungs were under control and the cardiac condition was specifically diagnosed, then the management shifted from respiratory to cardiac specialist; while the internist stayed in the background managing the minor and noninterfering condition of anemia. If, however, the illness that brought the patient into the hospital impacts on another - or starts another - then the first can drop into a position of secondary importance, at least for a while, the other taking precedence. Usually that means the chief trajectory manager, until illness priorities change again, will be another medical specialist.

One feature of highly problematic trajectories, especially when there are a plurality of highly interested parties or even of trajectory managers, is what might be called trajectory debates, which involve not merely technical but also ideological issues. As the trajectory (or trajectories) goes badly awry, many voices are heard, some *soto voce*, but some loud and clear, expressing different views

on why the illness is out of hand, why the new symptoms or illness have appeared, what alternative lines of action ought to be taken, who ought to be brought into the act and who pulled out, and so on. In every highly problematic trajectory whose unfolding we have watched over the years, we have observed this kind of debate. [...] The debate encompasses not only the medical specialists, but most of the ward's personnel - sometimes right down to the nursing aides who may express themselves publicly too - and the arguments and attempt at persuasion take place in conference, at the nursing desk, in the corridors, and inevitably, since the patient is involved, passionate arguments occur in the sick person's room too. Since particular decisions about options at critical junctures points can profoundly affect the shape of the trajectory (and the patient's life!), it is well to think of those decisions as, in the profoundest sense, potentially very fateful. [...]

#### Trajectory phases, arc of work, and task sequences

Since trajectories extend over time, they have phases. The physicians's and staff's trajectory scheme includes visualisation of some of those phases: more accurately for routine than for problematic trajectories. When the trajectory manager anticipates these phases, he or she has in mind certain things that will need to be done per phase, beginning with the diagnostic period and moving along through various therapeutic steps. The physician in his or her trajectory scheme visualizes what might be termed an arc of work: that is, the overall work that needs to be done to control the illness course and get patient back into good or sufficient enough shape to go home. The arc of work may not be completely visualised by the physician, and indeed the physician may hold in abeyance precisely what further work is required until after initial steps are done, until "we see how things work out" - until the actual phases are known. Under those conditions, the total arc of work will evolve more slowly, as the trajectory manager senses or calculates what needs to be done next. And in problematic trajectories that go quite awry, even temporarily "out of control", the total sequencing of work may be known only after the case is finished. (The case of Mrs. Price, the lady with lupus, exemplifies the

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evolution of unanticipated phases, unanticipated sequences of work, and an arc of work that could only be known post hoc).

At any rate, during each phase it will be decided that certain things need to be done: monitor cardiac output, get another x-ray done, continue the dialysis sessions, monitor the postsurgical condition, and so on. Any point at which it is decided to do those things, we call a trajectory point sequence. The term is apt because at each point a different cluster of tasks is required; they will change partially or totally at the next "sequence point". But the term is less important than our recognition that the cluster of tasks (Hughes, 1971, calls them "bundles of tasks") have both a sequential ordering and an organizational base that allow their being carried out.

The physician ordinarily does not concern himself with the organizational and operational details of carrying out "the orders": the supervision and articulation of those tasks fall under the province of various technicians and nurses, and where specialized tasks are done (like x-ray or brain scanning) also of other medical specialists. If there is some defect in organizational arrangements, then there will be difficulty in adhering to the sequence and its timing - as will be illustrated below. The resource base includes the proper skills, sufficient wo/manpower, appropriate equipment, necessary drugs, enough time, and so on. Some of the resources will be allocated to and be found on the ward itself; others must be drawn from other departments and sometimes from outside the hospital itself (like repair services for equipment or, more implicitly, the electricity to run equipment). [...]

#### Concluding remarks

In closing this paper, we shall underline a few points already alluded to. First, and in relation especially to the cases just discussed, it is noteworthy that trajectory work may require or involve some among several different kinds of work. They include: comfort work, clinical safety work, machine work, composure, biographical, and other kinds of psychological work (subtypes of what will be termed "sentimental work") - plus the work of coordinating (articulating) all of the many tasks involved in the total arc of

work. These may have higher or lower priority depending on the trajectory and its phasing.

Second, trajectory work of whatever species involves the organization of resources. This is why trajectories cannot be conceptualized as pertaining only to the physiological course of an illness or involving only medical-nursing and other technical tasks. Even the construction of an effective intensive care nursery or intensive care unit for adults, for instance, can involve the work of an imaginative or at least competent architect who can, to quote the comments of one of them, design an "appropriate spatial environment" for the personnel's work. As the discussion in this chapter should have made clear, the organization of resources is a matter that involves both a multiplicity of resources and a complexity of organization for their utilization.

A third point touched on but not especially emphasized in the above pages is that work on trajectories can have significant consequences for the various participants. True, some trajectories are relatively uneventful, so that the experiential and biographical consequences are minimal, especially for the personnel. But even with routine trajectories, there can be consequences for some persons since work relationships are directly related to the illness trajectory with which they are all involved. However, when trajectories - of any kind - become problematic, then the impact on working relationships can be visibly great, whether deleterious or beneficial. And in some instances, the impact on staff members is more lasting, having consequences for their immediate or long-lived self regard. The concept of trajectory is especially useful in thinking about the experiential and identity impact of work in hospitals because it brings out the evolving character of that work and work relationships over the course of the entire "case".

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TRAJEKTORIE CHOROBY

Artykuł prezentuje nowe podejście w badaniach losów pacjenta dotkniętego chorobą chroniczną, znajdującego się w nowoczesnym szpitalu wyposażonym w skomplikowaną aparaturę medyczno-techniczną. Autor proponuje nową kategorię analityczną w badaniach interakcji, a mianowicie koncepcję "trajektorii". Koncepcja ta, wyprowadzona z tradycji symbolicznego interakcjonizmu, umożliwić ma syntezę różnorodnych danych, które zbierane są w trakcie drobiazgowych analiz interakcji, a także ma chronić przed przyjmowaniem jednego, dominującego punktu widzenia w takich badaniach.