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INSTITUTION(ALIZATION), BUREAUCRACY, AND WELL-BEING?

An organizational ethnography of perinatal care within the National Health Service

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Introduction

The NHS is a highly politicised creation. The political left has long regarded it as principal pillar of a socially-conscious ideology. To the extent that it is now an integrant part of British tradition, those at the more conservative end of the political spectrum regard it with a sense of pride, too. However, the NHS has frequently been the subject of bitter critique in terms of its resourcing, provision, and specific purpose. Such critique is routinely invoked to win political points. Equally, spin doctors are often charged with developing campaigns to convince the public that opposition parties are not sufficiently committed to the NHS. For example, at the time of publication there was a frenzy of reports in the British media of Prime Minister Boris Johnson's alleged negotiations with US President Donald Trump to "sell off" the NHS to the Americans. In all probability these allegations were untrue. They do, however, illustrate the public's preoccupation with the NHS.

The point of this chapter is not so much to defend the NHS against the specific criticism with which it is routinely charged, but to bring to the fore the unseen and intangible aspects of its role. This necessitates a shift in mindset; it is not that the NHS needs to be run "more efficiently" as the prevalent counternarrative would have it, but that its institutional character and influences must be properly acknowledged if we are to reflect more meaningfully on the experiences it affords. I urge readers to consider both the hospital and the NHS as anthropological phenomena, rather than socially inert brokers of clinical expertise. To this end, in a (post-) industrial world, hospitals – and organizations more generally – have, to some degree at least, assumed the role of wider kin or provincial community. Organizations are not simply economic expediencies but are principal brokers of shared experience, identity, and existential security.

Reflecting on the ethnographic data presented, I challenge the negative perception of the NHS by suggesting that well-being (of newborn, family, and the wider community) is realised, not just through clinical expertise, midwifery, and caregiving but through the institutional characteristics inherent to health provision within the NHS. Rather than regard the NHS – and

hospitals generally – as a necessary "institutional evil", it is through the very dynamics of the institutional culture they represent that a sense of health and well-being is routinely realised.

Institutions and institutionalization

On the very first page of *Modern Organizations* (1964), the eminent sociologist Amitai Etzioni penned the following:

> Our society is an organizational society. We are born in organizations, educated by organizations, and most of us spend much of our lives working for organizations. We spend much of our leisure time paying, playing, and praying in organizations. Most of us will die in an organization, and when the time comes for burial, the largest organization of them all – the state – must grant official permission.

As an organization theorist and ethnographer I recognise, perhaps more so than most, that organizations have become an integral part of our human geography. But what of *institutions*? In some respects the words organization and institution are synonymous; they refer to common underlying anthropological phenomena. But while the word organization is typically used positively, the same is not always true in respect of institution. This chapter deploys the latter label, in part in a bid to better understand – and challenge – its negative reputation but also because the derivative concept of institutionalization is relevant, too. It is worth stressing that the institution that tops and tails life (in terms of birth and death) for most of us in the industrialised world is the hospital; and in the UK, this is typically an NHS-affiliated hospital.

The words "institution" and "institutionalization" are routinely invoked negatively. Indictment comes from both the political left (consider, for example, the Left's preference for rehabilitation in place of incarceration as a means of addressing crime) and the political right (just try searching "NHS" on *The Daily Mail* website!). The bulk of the academic literature takes a comparable position. The scholarly attitude towards institutions – as distinct from organizations – has been molded by a critical discourse in which Goffman's (1961) "total institutions" and Foucault's (1973) prisons and psychiatric hospitals have become ingrained in the scholarly psyche as representative examples, so much so that Burrell (1988, 1997) suggests that the dark forces of institutionalization are latent in *all* organizations.

Institutions, we routinely tell ourselves, are inherently *dys*functional. But to what degree does this attitude resonate with formal definitions? The Oxford English Dictionary lists three definitions of institutionalization:

1. The action of establishing something as a convention or norm in an organization or culture.
2. The state of being placed or kept in a residential institution.
3. Harmful effects such as apathy and loss of independence arising from spending a long time in an institution.

While the second and particularly the third definition allude to the concept's negative characteristics (which Goffman, Foucault and Burrell all invoke), the first – and *primary* – definition is perfunctory. Indeed, in this primary sense, institutionalization innocuously describes the manner in which we assume the characteristics of an organization – how we are *enculturated*. And this, of course, is an intrinsic aspect of our social and organizational lives. While I have no desire to fall prey to accusations of misplaced concreteness, it is I think fair to say that we almost always think of institutions and institutionalization in terms of the subsidiary definitions,

ignoring the functional – perhaps even positive – aspects conveyed in this primary definition. By way of illustration, think about how the word is assimilated in popular parlance. It tends to be used in very specific contexts. For example, it invokes the ideas of *being institutionalized*, or *institutional racism* or – simply – *bureaucracy*. Indeed, we tend either to assume that institutions have a totalising, oppressing, and alienating agenda or, for the less vociferous, that institutions both rely on and proliferate devitalising bureaucracy. Neither is empirically accurate, and yet such damnation persists. As recently as 2016, Graeber, for example, penned the following: "What the public, the workforce, the electorate, consumers, and the population all have in common is that they are brought into being by institutionalized frames of action that are inherently bureaucratic, and therefore, profoundly alienating. They are the instruments through which the human imagination is smashed and shattered" (Graeber, 2016, 99). Bureaucracies are by no means perfect. However, as we've noted of institutions more generally, it would be a mistake to overlook the fact that the conventional – and almost exclusively negative – perception of bureaucracy represents a convenient whipping boy irrespective of political hue. In *The Case for Bureaucracy,* Goodsell, for example, reflects on the fact that:

> Bureaucracy… is said to sap the economy, endanger democracy, suppress the individual and be capable of embodying evil. It is denounced on the right by market champions and public-choice theorists and on the left by Marxists, critical theorists, and postmodernists. One side of the political spectrum finds bureaucracy a convenient target because it represents taxes, regulations and big government, the other sees it as representing elitism, injustice to the underprivileged, and social control.
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> *(Goodsell, 2004, 17)*

For Kallinikos (2006, 611), too: "The prevailing negative sentiment bureaucracy tends to evoke reflects a crooked… historical trajectory that has been engraved by a variety of socio-cultural conditions and forces that traverse the entire ideological and political spectrum of modern society". The overwhelmingly negative narrative associated with bureaucracy is attributable to at least two erroneous social inclinations, as Vine (2021) has noted. The first of these is our tendency to conflate bureaucracy's pathological extremes with its everyday reality. The second is the perennial misrepresentation of bureaucracy in the arts, specifically in dystopian literature and cinema (everything from Kafka's *The Trial* to Gilliam's *Brazil* have molded our attitudes towards bureaucracy). The problem here is that casting bureaucracy in this way ignores the existential value of institutions. As the celebrated theorist of bureaucracy Max Weber noted over a century ago, institutions provide a sense of routine, security, and predictability. To this end, a counter argument – that institutions may actually be *anti*-alienating – is beginning to gain traction. In recent years, a distinct cadre of scholars has presented data supporting this position: du Gay (1994, 2000, 2004, 2005, 2011), Goodsell (2003), Kallinikos (2003, 2004, 2006), and Styhre (2007) are foremost among their ranks. Interestingly, in many cases these scholars argue that it is actually *post*-bureaucratic endeavours that represent the greater concern in respect of alienation. Indeed, Vine (2018) reveals data that support precisely this: for the subjects of his research the wholesale movement away from the sense of existential identity and ontological security institutions provide was profoundly unsettling.

It is thus against this overwhelmingly negative perception of both institutions and bureaucracy that the NHS is compelled to continually defend and legitimise itself. Notwithstanding the defense outlined, I by no means wish to suggest that institutions are beyond reproach. Clearly not. I simply wish to suggest that a fresh approach to viewing the NHS-as-institution

can be realised by viewing the institutional and bureaucratic aspects of the NHS not as necessary evils, but as important conditioning factors in and of themselves.

Method

I have presented a broad defense of the ethnographic method elsewhere (see Vine, Clark, Richards, & Weir 2018) and do not plan to rehearse this here. However, the ethnography presented in this chapter is rather different; it is an ethnography of convenience, an "opportunistic ethnography", if you will. My daughter, Sophie, was born in 2018 and in the run up to her birth I thought it would be interesting to experience and explore the event through the medium of ethnography. Now, I recognise entirely that this was to be a controversial decision. Would it be disrespectful to my wife? Would it be disrespectful to my new-born? Would it be disrespectful to my wider family? Would it be disrespectful to the hospital? I grappled with the ethics and found sanctuary in Briony Campbell's *The Dad Project* (2009). Through the medium of photography, Campbell documented her father's gradual demise from cancer. When her work was professionally exhibited, she commented that she too had debated whether or not to pursue the project. Ultimately, her father supported her in the decision to do it. Her work won numerous awards and is now a principal part of her father's legacy. Of course, while Campbell's work documented end-of-life hospital care, mine would focus on start-of-life.

My data is presented in the form of edited notes from a diary I kept at the time. True to the ethnographic spirit, I was careful to collect and convey as much detail as possible: in respect of people, processes, and physical environments. As an organization theorist, however, my primary focus was on recording, digesting and interpreting the *organizational dynamics* encountered. The entries in italics are repurposed directly from the diary I kept, and are presented in chronological order. The names of hospital personnel are pseudonymised throughout.

The story

Thursday 4th October 2018

Becky is 38 weeks pregnant. She didn't sleep at all last night and feels itchy all over. We ring the midwife and convey her symptoms. It transpires that she needs to go to hospital for blood tests. Upon arrival there is confusion with respect to the blood forms as by chance there is another Rebecca with a similar surname undergoing identical treatment. The confusion resolved, Becky's blood tests are completed. We're then introduced to a friendly midwife, Nikola, who records the baby's heartbeat and uterine contractions using a cardiotocography (CTG) machine. She suggests that Becky retains the CTG machine straps she's been issued for later tests. "We want to save our NHS money where we can!", she says in a Polish accent. Later, the blood test results confirm that Becky is suffering from cholestasis, a pregnancy-related liver condition. The paediatricians recommend induction because going full term can, apparently, increase the risk of stillbirth. We digest the news. Becky has wanted a natural birth all along. This is a significant deviation from "the plan". They want to admit her on Saturday.

Friday 5th October 2018

It's all happening so quickly. Becky's due date was originally the 15th October and we've assumed all along that since this is her first child, it will be late. We've had building works going on at home in

readiness for the baby and the builders are yet to complete the job. The place is covered in dust. In effect, we now have 24 hours to prepare. The nesting begins. We spend the entire day cleaning the house and doing what we can to mitigate the dust. We keep reminding ourselves that our circumstances are not unusual; do any parents return from hospital to the perfect home? And what about the car? It's filthy. And we haven't yet fitted a baby seat. Apparently the hospital will not let you leave without a baby seat.

Saturday 6th October 2018

We're both exhausted. The house is still a little rough round the edges but the car is packed and we need to go. We arrive at the hospital just after 11am as instructed and head to ward F11. The Ward is opposite The Labour Suite, where Becky will eventually give birth. The Labour Suite is itself next to The Birthing Unit. Becky was hoping to give birth in The Birthing Unit, which unlike the Suite is geared towards natural birthing. Those plans have gone out of the window now.

We're welcomed by a very friendly nurse who shows us to Becky's bed. It's a bit like being at a hotel. Her bed is in a very spacious 6-patient bay. Becky has been given a bed by the window. There's a fully reclining chair alongside the bed – apparently for the "birthing partner". I feel a little uncomfortable saying "birthing partner". I recognise that it is deployed for reasons of inclusiveness (good), but can't help feeling it degrades the father's role somewhat (bad). I sit in the chair. It is permanently reclined which is a bit of a problem since I plan to be writing my ethnographic notes in this chair. Hmmm. I'm conscious about keeping notes – I haven't discussed doing so with Becky, let alone any of the hospital staff. I figure that Becky's got enough on her plate without worrying about what I'm up to. I don't mention it to hospital staff, as what is rather innocuous might suddenly raise concern and take on a life of its own. I figure I'm ok. Am I? Yes, this is fine. I think. We're left alone for about an hour to settle in.

Everything is spotlessly clean. There is an entertainment system for Becky to use, similar to those found on long-haul flights. There is a menu listing various options: internet access, TV, radio, films (including pay per view). There is even a power point for charging mobile phones – hospitals have clearly given up the battle trying to prevent patients and their families from using their phones. A woman comes past with a lunch menu. Shortly afterwards another midwife arrives. She takes various particulars, answers questions and reassures Becky. I don't discuss my feelings with Becky but it's at this very point that I begin to feel the warmth of the institution cradle me. It's a trite metaphor but it really does feel appropriate. A little later, while Becky is eating her lunch, I resume writing my diary in violation of my original intentions to only do so when she's sleeping. "What are you writing in your book?" Becky asks. I hesitate. "About hospital", I respond vaguely. "Ah, yes" she says, "That's how you process everything, isn't it?"

The nurses return to administer the first of two pessaries. I ask Claire whether much is likely to happen for a while. She replies, "No. To be honest, you ought to go home and get a good night's sleep". I leave as I hear Becky and Claire engage in the now familiar – and ostensibly pointless – conversation about whether she's having a boy or a girl. "We don't know", Becky replies, "we want it to be a surprise". "Oooo" Claire says, "I wanted to know with my two. I couldn't bear the idea of getting lots of pink things, only to have a boy".

Sunday 7th October 2018

I wake at home about 9am. I make myself a coffee and phone Becky. She says she's feeling pretty good. We agree that I will continue with the domestic duties at our house before heading to the hospital

for about 2pm. At about 11am, Becky calls and says she'd like me to come in earlier. She's in a fair bit of discomfort. This puts me in a quandary since the house is still not clean. I decide to whip out the Febreze and cut a few corners. I eventually arrive at the hospital for just after 1pm. Becky is experiencing contractions. She's determined to stay mobile and so we walk together to the hospital restaurant. She's breathless and it takes a while to complete the short walk. We're sure to return by 2pm, which is when they need her back. We count the intervals and duration of her contractions and I document the data in a notebook Becky has brought along. A midwife pops her head round at about 3pm to apologise for the delay – she says they're extremely busy. At about 3.30pm Becky begins to get frustrated. The drugs she's been administered are wearing off. "What's the point if they're not going to follow it up as scheduled?", she asks. "I'll have to start the whole process again!" She doesn't mention it but I get the feeling that she's worried about the effects of the delay on our baby. At 4.30pm, she's really distressed. I head to the nurses' station to convey our concerns to the midwives. They are frantically busy. While waiting for a nurse, I peruse the dozens of thank you cards that adorn the station. Without exception, the handwritten messages are glowing in their assessment of their experience on the ward. I eventually speak to the charge nurse. She apologises on behalf of her staff and explains that the delay is down to the fact that there have just been too many high risk patients that take priority.

We hear babies cry elsewhere on the ward – the sound of the "prize" at the end of the journey. My mind begins to wonder. It occurs to me that the sound of a baby crying is not dissimilar to that of an engine starting. Is that an appropriate analogy? The engine starting for the very first time as the car roles off the production line. Goddamnit, why am thinking these thoughts? What use are they? Why can't I be useful?

And then – progress – well, at least for the woman in the bay opposite. Her waters break and she's transferred to The Labour Suite. Becky is the sole remaining patient in the bay. "I'll hopefully sleep better tonight", she says. Every cloud has a silver lining. The midwife walks through the door. "It sounds like you guys have been busy today", Becky says cheerfully. "It never rains… .", comes the response. "It's just horrible thinking how much the wait impacts on everybody… not everyone is as patient as you!" Patients have to be patient, I guess.

Heather comes by at about 6.30pm to do another inspection. She says Becky is a "9" and as a result they could technically break her waters now. "Hmmm", the midwife ponders, "I need to consult with my colleagues in The Labour Suite". Initially, we both assume that this is to seek relevant clinical advice. When she returns, however, it becomes apparent that it is really about operational capacity – without saying this in so many words. No matter. The penny has dropped. Health is like any other industry operating with scarce resources. The upshot is they can't fit Becky in right now. In a strange way, Becky is relieved.

At about 10pm, I head off to a local hotel where I've booked a room for the night. On my way out, I see one of my MBA students at the nurses' station. She too is heavily pregnant. It's a bit awkward. What's the protocol for this sort of interaction? I haven't the foggiest. "Good luck", I say.

Monday 8th October 2018

I text Becky at 7am, as planned. She calls me back a few minutes later to say they have transferred her to The Labour Suite and plan to break her waters shortly. I jump in the shower, check out of the hotel and head to the hospital. Upon arrival, I am greeted with the sight of my wife without underwear, waters broken. She's in a very chipper mood. Grinning, in fact. She's been transferred to her own room now. It feels very comfortable. Sunlight floods in through the skylight windows. It's rather beautiful.

We have been allocated another midwife, Toni and a midwifery student, Olivia. Becky and the two midwifes exchange pleasantries. Over the next couple of hours, we establish a wonderful rapport, trading jokes and anecdotes. As Becky's labour progresses, she shifts into her preferred position for giving birth: on all fours. The midwives busy themselves with various tasks, before positioning another cardiotocography machine adjacent to Becky's bed. They attach her CTG straps to Becky's bump. Silence. What the fuck? The reassuring sounds of the baby's heartbeat are absent.

[MY NOTES ARE INCIPHERABLE AT THIS POINT, FOR APPROXIMATELY HALF A PAGE]

They eventually find the heartbeat. I breathe an immense – and audible – sigh of relief. I study the midwives' faces. They maintain complete professionalism, but it is clear that this was a tense episode. As the heartbeat settles back into a steady rhythm, Toni explains to Becky that while she understands why it is that some women prefer to give birth on all fours, our baby's heart will probably find it easier to do its job in the conventional birthing position. Apparently the conventional position enables easier passage through the birth canal. She's right.

Our baby is born at just after 8pm. She pulls off my glasses at about 15 seconds into life, a trick she's repeated hundreds of times since. The experience is, of course, magical. Later on in the evening, I kiss my wife and new-born goodbye. On my way out of the ward, I notice a poster on the noticeboards: 'EPIC DAD: Restoring the Role of Fathers'. EPIC apparently stands for Encourager, Provider, Instructor and Carer. Wow. That's me now! And this poster is far from alone. The whole wall is plastered with notes of practical advice for new dads and advertisements for local self-help fatherhood groups. In my experience these sorts of notices (in GP Surgeries or Council offices, for example) normally target vulnerable sections of the community. As an educated white male, I'm unused to being targeted in this way. It feels strangely compelling.

Tuesday 9th October 2018

I text Becky at 7.50am and say I am on my way back to the hospital. I haven't slept very well; I was far too concerned about my new-born. I arrive at the hospital just after 9am. Becky hasn't slept well either, unsurprisingly. It is lovely to see them both. I kiss my daughter on the forehead as she sleeps in her crib. It feels unworldly. Becky is struggling with the feeding. Our baby appears to be too sleepy to feed but Becky is worried that the lack of sustenance is compounding the sleepiness: a vicious circle. A nurse called Matilda drops by and Becky explains the dilemma. Though young (early 20s) she's a no nonsense character. Matilda fetches a syringe and instructs Becky to express some colostrum. Matilda then dispenses the contents of the syringe directly into our baby's mouth. As she settles into my arms, we discuss baby names. We decide on Sophie. We both rather like the Ancient Greek etymology.

While Sophie sleeps, I listen to the conversations going on in the adjacent bays. Around one bed, the extended family has arrived and the customary conversation in respect of resemblance circulates. "I think I can see a bit of Robert in the baby's eyes…".. "Oh, I'm not sure, I think the baby looks more like Tristan's Dad". You get the idea. In another bay, a young couple trade insults and expletives. It is a stressful time that is bound to put tensions on already fragile relationships. Eventually, the Dad rings his own father and persuades him to collect them. "I'll pay you for the diesel money", he says down the phone. "It will probably be cheaper than the bus anyway". They apparently agree a rate and tensions begin to subside. A little later, a nurse – who I suspect was privy to this conversation too – drops by and suggests they stay another night in hospital. My suspicion is that this isn't strictly for clinical reasons, but to help ameliorate tensions. In another bay, a

paediatrician addresses another new Dad, explaining that they are concerned about the baby's hips. "You'll receive details on an appointment in the post regarding an x-ray, scheduled for about 6 weeks from now. It is important that you keep the appointment". The Dad looks anxious. "Thing is", comes his response, "it really depends whether or not we can afford to get to the hospital… . we live an hour away and money is tight". The paediatrician empathises and reassures them that they will work out a way to minimise the financial impact.

Listening to these conversations brings home the reality of childrearing for low income families. And it feels particularly difficult to stomach given the fact that throughout this whole day, a professional photographer goes from bed to bed trying to persuade families to fork out for a photo shoot; she is representative of Bounty (a promotions company that provides new mothers with sample baby products; the infamous 'Bounty Pack'). She offers to take photos of your new-born with or without family and arrange prints in an array of sizes, mouse mats and keyrings. The conversation she has with the single mother to the bed next to us is especially revealing: "Would you like a professional photoshoot?" "To be honest", comes the response, "I have a photographer booked to take photos at home". "When is that booked for?", the photographer asks. "Well, that photographer said to call and book it as soon as I'm home and settled". "Well, the thing is", the Bounty photographer replies, "babies change so fast at this age that by the time you get photographed, your baby will have changed and you've lost the opportunity forever". At this point, the din of the hospital drowns out the conversation. Ultimately, I'm unsure whether the new mum succumbed to the pressures of the photographer. I really hope she didn't.

Discussion

The NHS is an institution designed principally to deliver clinical care on a national scale. But interpretation of the ethnographic data presented suggests it can be cast in other significant ways too: as *existentially-secure environment;* as *resource maximiser*, as *broker of community relations;* as *mediator between clinical orthodoxy and cultural contingency;* as *fractional matriarchy;* and as *validating institution*. Each is examined below.

NHS as existentially-secure environment: Bureaucracy is often assumed to be alienating; in practice, however, it is pivotal in realising a sense of security. On the face of it, an NHS hospital is considered to be secure purely in terms of physical security: swipe-card entry, video surveillance and personnel verification. But the sense of security it provides goes much deeper. The hospital perdures beyond the shift of any single member of staff. The concept of "the midwife" is a case in point. The midwife is rarely a single individual; technically it describes an office. Over the duration of Becky's pregnancy, we probably saw over a dozen midwives and yet, routinely referred to this as a distinct role: that of *the midwife.* More generally, the institution – bricks, mortar, and cultural entity – is a constant. It is for this reason, of course, that patients feel so wonderfully cosseted with. A cursory read of the thank you cards that are displayed round the nurses station – and indeed beyond – are testament to precisely this. Yes, the names of specific midwives are noted and individually thanked, but the central narrative presented in almost all of the cards I read is that the entire perinatal experience was expertly managed. In many cases this seems to come as a surprise. Of course, the birth of a child is a cause for celebration; but for many it is assumed that this is *in spite of* rather than *because of* the experience afforded by the hospital. The NHS hospital *is* a community; it serves as host to a complex organizational culture and it is a broker of identity. One is reminded of the film *Shawshank Redemption*. Upon release from prison after a life of incarceration Brooks hangs himself.

Far be it for me to suggest that hospitals are directly comparable to prisons (although as Foucault has famously observed, as institutions they are not dissimilar); the important point is that they serve as vital community and identity workspaces, a theoretical concept developed by Petriglieri and Petriglieri (2010). This is, I think, at least part of the reason the couple in one of the adjacent bays were so relieved when the paediatrician suggested that they stay another night.

NHS as resource-maximiser. I do not purport to suggest that my study represents a systematic evaluation of resource use within the NHS. Nonetheless, my training as a management academic has primed me to evaluate my various organizational experiences in terms of efficiency. To this end, I couldn't help but notice the specific manner in which discourses of resource preservation underpinned the perinatal experience. On the one hand it was clear to see how commercial pressures manifest themselves; the presence – and persistence – of the Bounty photographer was especially unnerving in this respect. But ultimately the Bounty episode represented a side of the operation that was peripheral to the perinatal experience. On the one hand, the presence of the photographer felt invasive; on the other – and notwithstanding the long-term game Bounty is playing in eliciting a sense of brand loyalty, the free products it supplies to new parents (some of whom are extremely cash-strapped) are appreciated. What was clear is that NHS money is being spent in areas that mattered; the various wards associated with perinatal care appeared to be extremely well staffed and the clinical care was excellent. In this respect, commercial considerations remained firmly subordinate to patient care. Resource preservation typically manifested itself in less evasive ways. A very clear example of this was Nikola's suggestion that Becky retain the CTG straps she was issued when we first arrived at the Hospital such that they could be used throughout the perinatal period. It felt especially pertinent that the advice was conveyed in a Polish accent. This was, I felt, a rather nice bringing together of international communities and their shared sense of the value and importance of the NHS, and particularly so in a multicultural climate muddied by the prospect of Brexit. More difficult to discern, however, was the fact that birth partners took on what I refer to in a forthcoming publication as "negotiated nursing". To this end, birthing partners are (a) afforded a sense of involvement, and (b) free up clinical staff to focus their energies on those patients who are either in need of more complex clinical attention and/or do not have familial support on hand. At one point I felt frustrated that I wasn't being useful, but upon later reflection I realised that my role as "birthing partner" was indeed more than to provide proverbial moral support: I regularly made Becky's bed and generally kept house. I brokered discussions between Becky and the clinicians at key moments, particularly when Becky was in a pain or felt anxious. I was even able to assist in terms of recording key medical information, such as Becky's contraction intervals. Now, the extent to which the involvement of family members in this way is a conscious aspect of the operational design isn't clear. My suspicion is that this is done intuitively and, as a practice is implicit rather than explicit. It has, in all likelihood, evolved naturally; the midwife's comment that "not everyone is as patient as you" is, I think, instructive in this sense. The hospital makes judicious decisions taking into consideration the support networks each patient has at their disposal. This approach represents a formidable challenge to the prevalent narrative that institutions and the bureaucracies they spawn are faceless, senseless, and de-individuating.

NHS as broker of community relations. One of the most remarkable aspects of the experience was the fact that it brought together people from very different walks of life. The interaction with families in adjacent bays both prior to and after the birth of our baby was illuminating. In my line of work as a university lecturer I rarely have an opportunity to interact with people from different social backgrounds. In an NHS hospital, you have no choice. Now, this all might sound delightfully patronising but it most definitely isn't intended to. While it certainly brings home the very

different environments and networks of opportunity that babies are born into – even in a relatively affluent part of a developed nation – it was revealing to note how each of us seemed to appreciate and marvel at the hospital experience. We did not hear a single raised voice or complaint trained at the institution or its processes; it was, on the contrary, nothing but praise. And where we did witness tensions, these were inter-familial tensions with regards to personal finances, which the hospital did its very best to help ameliorate. Of course, and as the data show, the NHS is no utopia. The commercial pressures of the photography was, as noted, rather unsettling. But then, I have no doubt that such a measure would have been evaluated in utilitarian terms; the freebies offered to new parents (and the likely financial rewards attributed to the hospital itself) most likely outweighing the negatives associated with the commercial pressure heaped on patients.

Given the sense of community brokered by the institution, it is perhaps unsurprising that it delineates specific topics of conversation, too. One of the regular discursive tropes associated with both antenatal and perinatal experience is regarding the anticipated gender of the child. Initially, this was something I found vacuous and tiresome, even irritating. Eventually, however, I realised that it is not so much that people are genuinely interested in the sex of an unknown baby; rather this particular conversation serves as an anthropological medium. It is not just *something to talk about,* but it is a shared un/known which connects us and reveals something about one another. Becky's interaction with Claire was instructive in this sense. Claire commented that she wanted to know the gender of her second child in advance, because she couldn't bear the prospect of buying pink baby paraphernalia only to discover that she should have bought blue. Now, this sort of justification is unlikely to have had much traction with Becky, as a feminist. However, at the time rather than insincerely concurring or challenging the nurse in respect of gender politics, she rather shrewdly pointed out that where there's a sibling involved (which presumably there was in the case of Claire's second child), that sibling probably wants to know the sex in advance. Moreover, in the case of the clinician-patient dialogue, the conversation about prospective gender serves a second purpose: it has a cultural-therapeutic function. Patients appear to appreciate these exchanges of words precisely because they are *not* clinical; they alleviate anxiety.

It is, then, with these observations in mind that mothers-to-be and their birthing partners who are considering a home birth (or a birth in purportedly more natural environments) would do well to remember that the institution – the hospital – in our case the NHS, is not always an abstract representation of an oppressive patriarchal regime. To the extent that our experience is at least to some degree representative, parents who regard the only advantage of giving birth in a "clinical" environment is proximity to specialist care (should something not go according to plan), would do well to appreciate that the hospital is much more than a mediator of clinical expertise; it is a highly cultural – and enculturating – space. In a world in which ties of kinship and indigenous community have been displaced, it conveys a sense of community; it rekindles relations between different people's perceptions, hopes, and fears that we rarely have the opportunity to experience. For a brief period, at least, everything is taken care of for you; you are cocooned. It is, quite possibly, the closest most of us will get to a direct experience "of the state" at any point in our lives; it is also one of those rare occasions when the institution of family and the institution of the state are brought together.

NHS as mediator between clinical orthodoxy and cultural contingency. Given its clinical remit, it is to be expected that the NHS assumes a role of "safety expert", "educator" (as evidenced through the leaflets, posters and various online facilities) and "formal advisor". What is, perhaps, more noteworthy is that our experience suggests that the NHS is remarkably sensitive to cultural preferences. In the months leading up to the birth, Becky had undertaken extensive research regarding the childbirth process and had been persuaded that the convention of giving birth lying down on one's back was the result of a patriarchal healthcare discourse which puts

control of the patient at the centre of its practice, often without realising it. As such, Becky had envisaged a birth on all fours, which is – apparently – more natural. Or, at least, this is the prevalent bourgeois narrative. Ultimately, Becky's birth plan reflected her desire to give birth on all fours. The midwives were acutely aware of this, and tried to accommodate it. They only intervened – and did so extremely sensitively – when it became clear that this preference may well have been restricting Sophie's passage through the birth canal. To this end, Becky's cultural preferences prevailed until the point at which their presence compromised our baby's safety.

The NHS as fractional matriarchy. It would be disingenuous, misleading, and rather patronising to suggest that NHS perinatal care is "run by women". What is clear, however, is that it might legitimately be cast as a fractional matriarchy: the perinatal institutional experience is one which, on the face of it at least, is mediated through a women-dominated environment. One of the diary entries from the 8th October reveals my own reflections on this at the time:

> Chitchat is something I've never quite got the hang of. This is, a woman-dominated environment. In fact, aside from birthing partners, there isn't a single male member of staff. Nurses, doctors, obstetricians, paediatricians, cleaners, housekeeping staff – all are women. As a result, a woman-centric culture dominates. The chitchat is most likely a technique the clinical staff use to help make patients feel at ease, but it feels natural rather than engineered. Are woman better at chitchat than men? Is it fair to ask these sorts of question?

Beyond observations in respect of conversational dynamics, it was also interesting to note that to some degree stereotypical gender relations appear to be reversed; women dominate the organizational environment while the posters on the wall are dedicated to male self-help groups and fathers-to-be camaraderie.

NHS as validating institution. The unborn baby is inscribed onto the bureaucratic apparatus long before the birth itself. We received the 28-page Pregnancy Notes booklet on our first midwifery appointment, which took place at our GP surgery. The midwife referred to this as "the bible", and it would – apparently – accompany us throughout Becky's pregnancy. Becky was instructed to bring it with her to each midwifery appointment and to any other medical meeting. In this day of electronic communication, the booklet felt rather reassuring. It was gradually filled in as Becky's pregnancy progressed and we completed the midwifery visit schedule. As I've argued elsewhere (see Vine, 2021), documentation or "paperwork" provides a sense of continuity; in this case continuity between hospital visits, different clinicians and other hospital stakeholders. To this end, it is an important bureaucratic artefact: hence "the bible". Upon arrival at the hospital, Becky was required to hand over this booklet. It later transpired that it wasn't to be returned to us. Interestingly, Becky revealed to me that this made her feel rather sad. In its place, however, we received a "My Personal Child Health Record" book, which has since become known as *Sophie's Red Book*. It serves a similar purpose, but focused this time on the infancy period.

The Pregnancy Notes and *Sophie's Red Book* are of course just two examples of how the NHS can be presented as a validating institution. More broadly, it is worth noting that everything is documented: from the meal choices for the mothers, the new born baby's feeding schedule, the decanted colostrum, the baby's weight, visiting hours, staff rosters. Perhaps most important of all, however, is the clipboard that graces the foot of the bed and "travels" with the patient as she moves around the hospital. These, of course, are the medical notes that provide the backbone of the clinical care; they frame it and co-construct its narrative.

Concluding thoughts

In my native field – organization theory – there is an ostensible distinction between "organization" (generally viewed positively) and "institution" (generally viewed negatively). As we have seen, however, this distinction is largely unfounded. Both refer to a common underlying anthropological phenomenon; a collective cultural entity. Institutionalization is rarely – if ever – paired with well-being. In fact, it is often assumed that institutionalization is more naturally paired with "*unwell-being*". As Graeber (2016) notes, institutions are "supposed to be alienating". The data imparted here challenges this portrayal.

It is not so much that we need to take more notice of positive – but often glib – comments about the NHS such as "those nurses work *so* hard", or "they're doing their best with very limited resources". Ultimately, comments such as these simply reinforce a perception that the NHS is a dysfunctional organization that subsists on the basis of goodwill. No, the provision of clinical expertise is just one aspect of healthcare. It is the institution that provides the experience; it is the institution that brokers the culture; it is the institution that affords a rare coming together of different walks of life, of different generations, of different ethnicities. In a secularized and increasingly commercialised existence, experiences such as this offer an invaluable glimpse of a shared purpose. Without wishing to discredit private providers of healthcare who doubtless do a terrific job, the services they offer are crafted in such a way that they afford the "customer" an array of choices in terms of healthcare plans, appointment times, and treatment options. In effect, they endeavour to provide their customers with a sense of control. But is such control necessarily desirable? One of the virtues of the NHS is that it necessitates the relinquishing of our control and this has a desirable existential effect: we feel cradled. To this end, we might feel vindicated in challenging the various adverse connotations of the word institutionalization. Such connotations include incarceration, racism, and – simply - bureaucracy. As an alternative to these negative quips, on occasion the lexicon affords instances of the term deployed in a more positive sense. For example, Brown's (2016) popular book *The Pub: A Cultural Institution*. The word here is understood in a desirable sense; the pub reflects a sense of community, tradition, and kinship. Pubs and hospitals are not dissimilar in these respects but – regrettably – this is rarely acknowledged in the case of the latter. As I pen these words (March 2020), the COVID-19 crisis is just unfolding. Calamitous as it is, one silver lining is that the crisis appears to have rekindled widespread respect and support for the NHS. Perhaps this represents a good opportunity for us to recognise the vitality of its institutional credentials.

And, finally; I wish to reflect on the nature of opportunistic ethnography. The ethnographic account delineated in this chapter can be described as opportunistic in at least two senses. First, it is opportunistic in that I was presented with a life experience and took the decision to interpret it through an academic lens; it wasn't formally arranged. Second, I recorded ethnographic notes both discreetly and only when time permitted (principally when my wife was sleeping and when my assistance – either emotional or physical – was not required). I thus "did ethnography" only when presented with opportunities to do so; I thus had very little control over the data collection schedule. On reflection, however, this experience of "opportunistic ethnography" wasn't altogether different to the more conventional – planned – ethnographies that I have undertaken in the past. Even when properly planned, and with solicited ethics approval, it is off-putting to scribble notes down while the action unfolds in front of you. (This is of course why ethnographers have a reputation for weak bladders; they must regularly scurry off to the toilet to write up their notes).

As this was opportunistic ethnography, there are two pertinent questions we are compelled to address. The first: is this *academic* research? Ethnographers – especially auto-ethnographers – are forced to routinely deflect vitriolic attack (see, for example, Delamont 2007), and I suspect that the notion of opportunistic ethnography will be especially troubling for such antagonists.

But I remain convinced not only that it is academic research, but that it offers insights which alternatives are unable to provide. While a more conventional, etic, positivist approach will have been able to report on broader trends about patient satisfaction, such approaches are unlikely to have yielded the sense of nuance and analytical depth presented here. It is hoped that this chapter has demonstrated to readers that our attitudes to both institutionalization and bureaucracy are somewhat skewed. The NHS – and hospitals more generally – are more than innocuous "providers"; they are cultural entities. In 2017, the British media reported on a man who had refused to leave his hospital bed for two years. Inevitably, the media were savage in their assessment of the circumstances; the man was labelled a "bed-blocker", pure and simple. Now, while his hospital residence clearly doesn't make financial sense, it does – I think – help illustrate the fact that hospitals are communities; they are agents of kin and are hence deeply social spaces. Women are, of course, welcome to give birth at home or elsewhere (my wife flirted with the idea of giving birth in a forest, for example) by way of "recreating" a "more natural" experience. But to what end? In one sense, these alternatives are indeed more natural; in another sense, however, they represent a wholesale rejection of community. We have, it seems, created a bourgeois discourse which tends to regard hospitals and the administration of clinical care as anti-community and anti-natural. This position lacks nuance; it is an over-simplification.

The second question: is this work *ethical*? As opportunistic ethnography, clearly the research could not involve advanced formal solicitation of ethical approval. Consequently, during the review process for this chapter, the editors suggested it might be best to frame the chapter not as research (since the orthodox academic research process necessitates formal ethical approval) but as "a reflective account". I'm perfectly content with this latter label but wish to stress that the distinction between "research" on the one hand and "reflective account" on the other is not necessarily instructive. On the face of it, a strict ethics approval process is desirable. However, there is a body of work that is beginning to challenge this assumption. For example, in their exploration of the ethical practices inherent to ethnography, Fine and Shulman (2009) note that non-disclosure of research intent (in the various forms of "faux-friendliness", "inverse-plagiarism" or "self-censorship", for example) are both inevitable and often ethically *desirable*. This is something that is echoed in Bochner and Ellis's (2016) work on ethical quandaries in autoethnography. Similar conclusions include research by Thomas, Hujala, Laulainen, and McMurray (2018) in respect of what they refer to as "wicked problems". More recently, Vine (2018) has theorised these tensions as "methodological paradoxes". Collectively, this emerging body of work reveals a greater degree of complexity in respect to research ethics than is routinely acknowledged by university ethics approval processes. This body of work raises at least three important points worth considering: (i) exercising respect and sensitivity to participants is, ironically, often only achieved by circumventing official ethics documentation and formal solicitation of approval; (ii) overly-authoritarian ethics approval processes are likely to yield more in the way of "under the radar" operations; and (iii) overly-rigid ethics approval processes significantly thwart intellectual creativity and innovation. I daresay many academics reading this book will have had first-hand experience of this final point.

As noted at the outset of this chapter, I grappled with the ethical ramifications of this research throughout the process, but ultimately found sanctuary in the work of Campbell (2009). Having been through the process myself, has my position changed? No. On the contrary there is a compelling argument to suggest that ethnographic work such as that presented is not only legitimate, but that as trained ethnographers we have an active *duty* to reflect on life events in this manner. After all, we have each had an extensive and privileged education and are trained to interpret social interactions in this way. Arguably, then, there is an obligation that we contribute to the ethnographic record wherever possible. As a colleague of mine once noted, if academic ethnographers reject these opportunities, journalists will embrace them instead. I have no desire

to cast aspersions over the profession of journalism, but I dread to think what a rabid tabloid reporter might cook up in similar circumstances.

By way of summary reflection, then, my wife was right: ethnography *is* how I process things. Ostensibly, it is about academic research; in reality, it has become a way of life. Auto/ethnography is often charged by critics as self-indulgent. To some degree they are right. What is beyond dispute, however, is that it is cathartic.

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