Human Relations
DOI: 10.1177/0018726708098085
Volume 61(12): 1775–1802

SAGE Publications
Los Angeles, London, New Delhi,
Singapore and Washington DC
http://hum.sagepub.com

The social meaning and function of food rituals in healthcare practice: An ethnography

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ABSTRACT

This ethnographic study was undertaken to build a picture of physiotherapy practice through prolonged observation. Several building blocks of the therapists' culture were created one of which was the negotiation and meaning of food rituals in the practice of a team of physiotherapists in a UK National Health Service hospital. Interviews were carried out following the observations to gain the therapists' perspectives in an open critical exploration of assumptions and ideas. The analysis was iterative and followed a systematic recognized ethnographic approach. The findings revealed explicit and implicit meanings of the food rituals. Explicitly they were instrumental in sustaining continuity and a strong sense of harmony. They were seen as a morale-booster, a key ingredient to mark departures and a powerful component of the therapists' break time. They underpinned a need for cohesion within an environment of constant change. Implicitly, they were a vehicle to expose tensions and a catalyst for isolation. Food rituals, for this team, reduced the anxiety and stress, which unpredictability, a hallmark of clinical practice can engender. By hiding their concerns in rituals, the team members were able to avoid a real confrontation with issues of authority and hierarchy that underscored these activities. They also maintained the continuity of a professional tradition and contributed to a strong sense of professional autonomy which can smooth the pathway to inter-professional collaboration.

KEYWORDS continuity ▪ ethnography food rituals ▪ exclusion ▪ healthcare practice ▪ hierarchy ▪ inclusion

Introduction

Background

This study explores how some aspects of the practice of a group of healthcare professionals are made explicit through their food rituals. Healthcare organizations are said to be different in certain key aspects from many others in the industrial and service sectors due to the fact that they have a social role and have to individualize collective services (Sheldon, 2001). Therefore insights gained from other organizational studies cannot easily be transferred to a healthcare context. Most importantly, according to Sheldon (2001), healthcare organizations are dominated by strong professions that have the power to constrain or enhance change for the total organization. One could say therefore that many healthcare practices are hidden beneath this mantle of dominant practice. Brooks and Brown (2002) observe that the anthropological category of 'tribe' is a useful metaphorical descriptor for these professional groups. The authors suggest that tribalism is ingrained within the National Health Service creating rich breeding grounds for ritual activity. In their study, which utilized observation and interviews to explore the symbolic significance of ritualistic ceremonies in an NHS hospital, Brooks and Brown (2002) conclude that some ceremonial rituals serve to safeguard professional autonomy and others encourage change.

Eating food in a hospital setting can be perceived in a ritualistic sense as an intrinsically multilayered and multidimensional activity with social, psychological and symbolic dimensions (Holtzman, 2006). Drawing on Turner, one of the most prominent ritual specialists in anthropology, this ethnographic study explores the food rituals of a group of physiotherapists in an NHS hospital to investigate the role and function of these rituals in the everyday life of these health professionals.

Anthropology and ritual

Turner (1969), a symbolic anthropologist described ritual as a social phenomenon, the way in which persons of a particular culture must interact if there is to be any kind of social life; it is social and periodic. He sees two inherent functions of ritual. First, it has an expressive function communicating certain lay values and cultural orientations and second, a creative one which creates or re-creates the categories through which people perceive

reality. Each ritual, according to Turner (1969), contains a ritual symbol which not only has an ideological meaning but also stimulates desires and feelings. Food is significant in many ritual ceremonies. Douglas (1999), a structural anthropologist, comments that if food is a code the message it encodes will be found in the pattern of social relations being expressed. The message is about different degrees of hierarchy, inclusion and exclusion, boundaries and transactions across the boundaries (Douglas, 1999). According to Douglas (1999) meals as opposed to drinks parties express friendship. They are structured social events which are ordered in scale of importance. A meal 'distinguishes order, bounds it, and separates it from disorder' (Douglas, 1999: 240).

Perhaps the most important contribution Turner made to the field of anthropology is his work on liminality, believing the liminal stage to be of fundamental importance in the ritual process. From his early work on ritual society emanating from his five-year study of the Ndembu tribe of Zambia, he conceptualized the phenomenon of a ritual space 'liminality' (1969: 95) borrowing and expanding upon Van Gennep's (1960) earlier work on liminality, thus ensuring widespread usage of the concept. Turner (1969) defined this as a social space that is, 'betwixt and between the original positions arrayed by law, custom, convention and ceremony' (p. 95) – in other words, an unstable and unstructured place with no routines or rules and whose participants are undefined with no rights or obligations.

Contemporary studies have challenged this 'Turnerian Paradigm' (Sturdy et al., 2006). Sturdy et al. (2006), drawing on interviews and observations in a Western European business organization, evoked Turner's concept of liminality to apply the notion of a 'liminal space' around a food ritual. The authors investigated evening meals attended only by those 'outside' an organization, in this case clients and consultants. Those who dwell in liminal spaces include temporary employees who move between organizations and hence constantly encounter different processes, rules and routines which can be assumed to be unsettling. However, far from being isolated from either organizational or other social routines the authors found elements of organizational hierarchy and functional divisions in the performance of the meals supplemented by other deeply engrained routines and norms associated with dining and sociability. The authors conclude, therefore, that there is potential for liminality as part of the make up of everyday society and this might be revealed by developing an analysis of its use through a more relational view of power.

Power was a theme in Rosen's (1985) study of the annual ritual of the 'agency breakfast' held in an exclusive hotel for members of an advertising agency. It followed a well-known routine of self-congratulation, awards,

slide shows, all set within a soothing environment of soft music and 'haute cuisine'. This, according to Rosen (1985), symbolized a strong influence on the practice of the employees by communicating a particular message aimed at maintaining a particular power order whose purpose it was to hide the disorder and chaos underlying the culture of the agency. Thus, using this perspective, organizations are patterns of shared symbols and meanings which need to be interpreted to be understood.

Food rituals and healthcare organizations

Modern times are posing a major set of challenges for the way healthcare practice is thought about and organized. Unpredictability, constantly adapting to new situations and responding to the needs and preferences of patients characterize modern healthcare such that everyday clinical situations can be seen to have no easy and unambiguous solutions. The search for certainty may result in ritualistic behaviour. Holland (1993) set out to investigate if ritual existed as part of the cultural system of nurses in an NHS ward setting. The findings of her ethnography indicated that traditional knowledge and practices inherited by nurses from their education and practice experiences are perpetuated as ritual and that, as part of an overall healing system they are essential for ensuring that order is maintained in hierarchical structures and divisions.

Brooks and Brown (2002) postulate that successful organizational change in a General Hospital can be achieved through the elimination of those rituals that reinforce or preserve the negative aspects of professional and work group autonomy. Examples of this are the procession of 'hand maidens' waiting upon a surgeon, and each clinical profession's insistence on collecting the same personal data from patients. Conversely, the encouraging of rituals that reinforce positive aspects is likely to achieve more flexible, team-orientated changes such as cross-collaboration in patient care and more flexible team roles. Contemporary healthcare delivery relies on effective cross-boundary working and professional collaboration, with, for example, nurses, psychologists, occupational therapists, doctors and physiotherapists all having an input in the management of a single condition. Most conditions, especially those of a chronic nature, are multidimensional phenomena that cut across professional boundaries. Most commentators agree that 'boundary-spanning' occurs successfully when there is trust, reciprocity and mutual understanding between professionals (Currie et al., 2008; Tjosvold et al., 2005). Brooks and Brown (2002) maintain that rituals of preservation serve to preserve demarcation between groups and detract from multidisciplinary team working, multiskilling and aspects of patient-centred care.

It is questionable if food in a healthcare context can ever be seen in a strictly realist sense because even discussions on managing its delivery to patients can also become a metaphor for the managing of social order. Pearson et al. (1997; Pearson, 2003) explored the roles and responsibility of serving food to patients, designating it 'domestically orientated' work and a 'non-nursing' duty. This supposed downgrading of the process of giving and receiving food not only creates a hierarchy but gives a message that meals are provided within a context of rules governing work and, in particular, are time-bounded (Pearson, 2003). The reason for this 'demotion' of mealtimes in hospitals appears to be that technical cure-orientated interventions, reflective of the biomedical model of health, are more highly valued (Pearson, 2003).

If patient mealtimes are given such low priority it would be interesting to explore health professionals' perspectives on their own mealtimes. In part, this was answered by Rogers (2004), who suggested in a study exploring nurses' perspectives towards their meal breaks, that many nurses revealed in their logbooks that taking a break would jeopardize patient care and/or make it difficult to complete their assigned tasks before the end of the shift. It appears that this strictly materialist construction of food permeates the experiences of both caregiver and those in their care. The common factor between Rogers's (2004) findings and those of Pearson (2003; Pearson et al., 1996) relate to notions of 'time thrift' and 'appropriate work'. Those controlling the circumstances of delivering meals to patients and the organization of the nurses' meal breaks arguably hold a belief that meals should be consumed in as short a time as possible with minimal disruption to the main task of delivering and performing the technical tasks. It appears that food in this context is seen as 'non-work time' implying that it has a liminal existence. This echoes a comment in Czarniawska and Mazza's (2003, as cited by Sturdy et al., 2004) study by a client to a consultant, 'going to lunch already, are we now paying you also for mealtimes?' (p. 274).

In essence, concretizing the process of eating food fails to see its social significance as the medium for improving social interaction for both patients and health professionals. This echoes Van Gennep's (1960) observation that eating together is a rite of incorporation, an inclusive activity that confirms a bond between those who are participants in the activity. This was demonstrated in the nurses' perspective in Rogers's (2004) study which at a macro-level reflected a system that demeans meal breaks. But perhaps there is a deeper meaning to demoting the eating of food to the sidelines, which is to avoid social interaction and the possibility of a social relationship. When Davies and Snaith (1980) introduced a family style meal service for institutionalized patients they discovered that conversations and helpful behaviour increased not only between patients but also between staff and

patients. One important factor instrumental in this was that this style of communal eating reduced the social distance and hence proved to be a vital element in promoting interaction. Habeeb (1973) came to similar conclusions after observing patients' interactions with staff over food and found that nursing practice may be improved to promote better patient care by re-defining eating in a hospital as a social event as well as part of medical therapy. Researchers have long been interested in this and Menzies Lyth (1960), in her seminal study on containing anxiety in an NHS hospital, observed that work practices were organized to encourage greater social distance in the belief that if the relationship between nurse and patient were close the nurse would experience increased anxiety when the patient was discharged or died. Although not specifically researching ritual, Menzies Lyth (1960) revealed a system of defence mechanisms nurses had developed against anxiety. She claimed that nursing hierarchies and ritual practices were thought to protect the nurses from the anxieties provoked by human suffering even though the reverse was found. Similarly, Goldbloom (1999) maintains that many healthcare practices serve to reduce the level of anxiety or at least prevent it rising.

The aim of this study was therefore to investigate if the elements discussed so far exist in therapists' food activities or if they reflect Pearson's (2003; Pearson et al., 1997) findings that food should be consumed in as short a time as possible with minimal disruption to the main task of delivering and performing the technical rational work.

Hence this study explored how the therapists' food rituals were created and negotiated through their conversations and their role and function in the organization of their practice. Utilizing some of the perspectives in this introduction it would be interesting to reflect on the relationship of the food rituals to the social order in the team, the possible paradoxes within the rituals and how they symbolize team values, beliefs and actions. It is in the activities of the teams that physiotherapists gain their professional identity and it is in the unpicking of the mundane, that is 'to render the familiar strange and the strange familiar' that this process may be revealed (Agar, 1986).

Methodology

Ethnography was chosen to describe and interpret the characteristics of this particular healthcare setting capturing the multiplicity of voices. Ethnography is broadly speaking a method, or set of methods, which involves the ethnographer participating in people's lives for an extended period of time, watching what happens, listening to what is said and asking questions,

in other words, learning from them (Hammersley & Atkinson, 1995). It is particularly suitable in the exploration of practice because ideas of 'process' that is, a series of changes by which something develops, are crucial to understanding the world of healthcare (Robinson, 2001). If one were to single out the unique aspect of ethnography it would be the importance of context. Bateson (1979: 15) states, 'nothing has meaning except it be seen in some context'.

It is generally agreed that ethnography originated from two main sources, anthropology and sociology, and the two traditions are irrevocably enmeshed and juxtaposed because they have used similar methodologies (Delamont & Atkinson, 1995).

This study would recognize many of Geertz's (1973) (a symbolic anthropologist) arguments that ethnography is not simply a matter of presenting a body of facts; it is much more to do with the author's ethos, with the power of his or her presentation (Olson, 1991). He refutes the notion of the objective researcher, preferring a deliberate self-reflexivity within a situation. This article includes the perspectives of the therapists and explored the researcher/researched relationship within a process of researcher reflexivity. In a sense, the very idea of the researcher being reflexive frees him/her to write accounts which are open about their limitations and partiality and acknowledges the complexity of the world and the difficulty of presenting it in words without sacrificing coherence, or clarity (Hammersley & Atkinson, 1995). As a consequence, there are moves to produce ethnographic texts that replace the 'monologic' mode with more 'dialogic' forms in which the text allows for a multiplicity of voices (Atkinson et al., 2001). Ethnography describes and interprets the characteristics of a particular social setting with the intention of capturing cultural diversity and the multiplicity of voices.

Methods

Reflexivity

A reflexive stance towards taken-for-granted knowledge will mean that the therapists' knowledge claims and the author's for their practice and the practice activities themselves, will be open to scrutiny. Taylor and White (2000: 35) define this as 'epistemic reflexivity' in which we subject our own knowledge claims to critical analysis. The therapists' construction of their food rituals will not be seen as a mere reflection of an unproblematic reality. Cunliffe (2003) commenting on reflexive inquiry in organizational research defines participant reflexivity as asking participants to reflexively account for

their practices. It necessitates participants to be active in the creation of meaning, and authoring voices in generating knowledge.

Ethnography sanctions a reflexive approach by the researcher. It contends that researchers cannot separate themselves from their accounts and are part of a circularity in which they are included in their own research. Situations are neither totally familiar nor totally strange and the researcher's insider–outsider status changes at different points in a research project and is different with different groups and different individuals (Allen, 2004).

Reflexivity involves an immediate, dynamic and continuing self-awareness and demands acknowledgement of how researchers co-construct their research findings with their participants (Finlay, 2003). My relationships with the team and those I encounter in the study will be central to this account and crucial to the quality of the data collected. It is considered important for the researcher to make his/her values and any a priori knowledge known so that any biases can be exposed. However, as Cutcliffe (1999) argues, it follows that there is a requirement for me to know myself and I am left wondering to what degree do I know myself, what is the extent of my self-awareness?

In summary, the aim of reflexivity is to make explicit my emerging assumptions, as well as the situational behaviours which will shape the findings. In this way, these features will complicate and enrich the task of not only constructing interpretations of participant responses, but also to subject these to further scrutiny by the reader of the account (Jorgenson, 1991). Linstead (1994) comments that language is the central element in creating accounts which are constitutive of the world rather than revelatory of its essence. Hence all accounts are partial and persuasive versions of reality. My reflections and my dialogue will be presented in connection with the different food rituals.

Participants

Ethnographers who are not already part of the setting they wish to study have to gain access. In this study, permission was given to the researcher by the physiotherapy manager of a specialist NHS hospital to give a presentation to her physiotherapy staff. This resulted in one team of therapists self-selecting themselves.

These therapists, Rachel, Catherine (the two senior therapists), Julie and Sue (the two junior therapists) were known as the rehabilitation team. They offered a three-week in-patient rehabilitation programme which focused on global functional goals. The patients' needs were highly complex with high disability scores.

Ethical approval was given by the local Ethics Committee for a six-month period of observation (plus two further months to follow up any outstanding issues) and informed consent was sought prior to the study and before every observation. On average, two days a week were spent in the department for a period of approximately six months. This depended upon the need to follow up activities, plans and subsequent events.

Data analysis

The analysis used a two-way iterative process between the fieldnotes and the transcripts of the conversations between the team themselves and their interactions whenever they came together both formally and informally. In addition to these two sources, interviews were carried out between the researcher and the therapists that highlighted both the researcher's and the therapists' thoughts in an open critical exploration of assumptions and ideas. Each observation over the six-month period of observation was scanned and marked off into sections, given a code and then cross-referenced to the fieldnotes and follow-up interview. The subsequent observations were similarly coded. Commonalities and comparable codes were sorted and grouped together. This process is analogous with the constant comparison method (Glaser & Strauss, 1967). Codes can change through the emergence of new codes within new data offering new insights and experiences until a stable set of codes based on the full range of data emerges (Hammersley & Atkinson, 1995). I also reflected on my ideas and intuitions that emerged as a result of my immersion in the teams' day-to-day practice and formed some tentative preliminary concepts of what was going on in this social setting. This is affirmed by Cutcliffe (1999) who states that qualitative researchers make decisions during their data collection based on intuitive knowing as they engage in the field setting and seek to understand the data being collected. From this coding of their talk, I formed categories of meaning which began to fit into certain patterns of behaviour that represented this team's activities. This was the beginning of the emergence of the building blocks of the team's culture. At this stage, I formulated questions to frame the building blocks more accurately. I continuously involved the therapists in dialogues to check, or challenge our understanding.

Activities related to food emerged as one of the main building blocks of the team's practice. Further analysis contextualized and analysed the situations in which food was the focus. From this analysis, evolving and repeating patterns of eating food were revealed and following Turner's (1969) definition of a ritual as social and periodic these were categorized as rituals.

As the professional lives of the therapists unfolded each ritual represented an evolving theme such as cake days and the leaving dos. All ethnography involves the narrative form and thus these events contain a series of happenings, often with a beginning and an end point or resolution that are linked and contextualized. This according to Atkinson (1992) is 'like working with the whole cloth rather than constructing an account like a patchwork cloth' (p. 460).

Results

Cake days, seen as a morale-booster

Traditionally, Friday was cake day in the physiotherapy department. Rachel told me that cake days had been in existence for many years, always on a Friday, when the therapist, whose turn it was, would bring in cakes for the others. This was confirmed when the therapists were seen early on a Friday morning scurrying into the kitchen and removing small bowls and plates to put the cakes on. Every Thursday the team wrote a list of the sort of cakes they preferred: Battenberg biscuits, cheese snacks, or home-baked cakes. The person whose turn it was would ask the others what they would like and get responses such as 'let's not bother with chocolate cakes, let's go for grapes' or 'how about Battenbergs, or jammy dodgers'.[1]

Rachel, one of the senior therapists, commented that cake days were taken very seriously and there were no compromises on quality. As if to emphasize this she said:

> the story goes that B at one point forgot to bring her cakes and went down to the nearest garage and bought some and the team was so incensed when they saw these garage cakes that they made her drive all the way down into the village at lunch time, to Sainsbury's [supermarket] to buy proper cakes.

One of the juniors justified the economic cost of buying 'proper' cakes:

> I usually spend about 8 quid [pounds] on my day, good cakes are quite expensive but it's worth it and besides it's only once a month . . . or so.

Evaluating the food was seen as an important part of the process, perhaps indicating this activity was perceived as something special, a treat as opposed to a duty. The team looked forward to cake day as a reward for their hard work and took care in its implementation and showing enough

commitment to its purpose. Rachel was observed to say on several occasions 'keep going, it's nearly Friday, cake day!', reinforcing the concept of reward for hard work. The notion of food as a treat for demanding work extended to others. As Sue commented when asked what happened to the food left over on a Friday, 'the weekend staff consume it, it's their treat for having to work at weekends'. Cakes were seen as relieving the pressures in their working lives. It was a mutual collaborative activity and an observable genuine collegiality suggesting mutual social support.

Communally eating cake served as a ritual which nurtured the staff in the face of their job-related stresses and the conversations with the team exposed several implicit reasons for the fairly elaborate and time consuming procedures around this ritual. Rachel felt that in learning to care for each other and be sensitive to each others' needs they would in turn learn to care for their patients who were often very complex and at times demanding. Their patients had not only suffered pain for several years, but many had also had several unsuccessful operations. Rachel described themselves as being their patients' 'last hope' and 'struggling against all the odds'.

It also became apparent that the team was one which only had two fixed points (Rachel and Catherine, *the two seniors*), and otherwise only members who passed through on a six-monthly rotational basis (Julie and Sue, *the two juniors*) and were there by default at the time of the study. Cake day could therefore be seen as an investment process of showing care and consideration for each other whether they are permanent or passing through.

It became apparent that Julie and Sue (the two juniors) had to adopt the food preferences of the two permanent members of the team (Rachel and Catherine); they joined for their six-month rotation stint as the food identities of the teams did not change. Julie commented:

> the team leader on the paeds[2] team always eats very healthy food [she's following the Rosemary Conley diet] and the senior therapists on the musculo-skeletal[3] team are known as 'party animals' and are often out at night clubs, or parties on the day before cake day, I'm sure their allergies are more related to how they feel on Fridays.

She added that she was happy with Rachel's and Catherine's preference for certain types of cakes on this team 'and after all I am only here for six months'. This again exposed the temporary state of the juniors in the team who did not have the same decision-making power and knowledge about the implicit meaning of the ritual as the two seniors.

No-one questioned the fact that the cake day rituals were led by the senior therapists and the willing participation of the juniors in terms of

providing and sharing cakes symbolized their commitment to the team's practice, hence the distress when 'petrol station cakes' were provided. It is generally held that organizations seek to socialize newcomers so that they will conform to prescribed norms and values, perform their roles efficiently, and exhibit commitment to the organization (Van Maanen & Schein, 1979). The junior therapists fitted into a professional social system that has been decided by their profession, according to their experience and its traditions and customs.

It was through the team's conversations about cake day that aspects of their practice were made explicit. The ritual of cake day gave an impression (to the observer) of the team's sense of belonging, a sharing of concerns, a feeling of value and providing practical assistance for each other. Food can be an instrument in the creation of a social alliance, a tool in the deliberate construction of social solidarity (Meigs, 1997).

Food, in this instance, also functioned to identify group affiliation. The eating behaviour of the juniors was determined by their need to conform to the group's standards which had significance for the group in relation to other groups and was maintained in accordance with its needs. The food produced for cake day, ideologically, appeared to represent team solidarity and boundary forming and gave the team, spearheaded by the senior, an identity.

Another event which, similar to the cake days, followed the same well-tried familiar pattern and placed food at its centre was the occasion to mark a colleague's leaving. These events were celebratory but represented a way of coping with loss.

Leaving dos

There was a tradition in the physiotherapy department of celebrating a colleague's leaving with a lunch, or more rarely, a breakfast. Food was copious and special with a considerable amount of forethought and preparation, which involved the whole staff in collaborative co-ordinated activity. During the period of the eight-month study six members of staff left. These were mainly the more junior grades. According to Julie and Sue they 'preferred to leave rather than go on endless rotations'. Rachel explained:

> the leaving meals are traditional at this hospital, the recipient can choose what kind of lunch, or breakfast they would like. Usually there's a big sheet hanging on the door of the fridge everyone uses it for coffee . . . tea whatever . . . it would say M's leaving lunch/breakfast and announce that it is to be Indian, Italian, English, etc. Usually the person

> closest to that person organizes slots such as . . . pizza – one two three, etc. spaghetti . . . makes a list of all the things that are needed and all we do is go to the fridge and sign our names. You then see it all the time, every time you open the door, so you won't forget.

The leaving dos were celebratory but paradoxically may have acted as a defence mechanism, which is a psychological strategy to cope with reality in order to shield the therapists from undesired emotions and conflicts because they were, in effect, vehicles for farewells. When one therapist left, Rachel said:

> it was quite painful . . . we were left behind . . . we had nobody to do her job . . . lots of people have left us in the team . . . it is one of the most difficult aspects for us in the team . . . this instability . . . that when people perceive things to be not coming up to scratch, or morale being low, they just leave.

This comment was said with great feeling and confirmed that farewells had particular significance for this team. Historically, people had left because of the high demands of their very needy patients. The unchanging ritual of the leaving dos appeared to act as a defence against loss as well as celebrating the good fortune of the person leaving. The established investment in maintaining the ritual could be seen in the way the organization swung efficiently into action. The events themselves were full of hilarity and fun with the departing person being subjected to some outrageous acts. These were for example being thrown into the pool, or alternatively put into a wheel chair, wheeled outside and submerged in all the left over food.

Ostensibly to the observer these acts promulgated maltreatment but in effect they were not as they seemed. Rachel remarked that the more the person was liked the more outrageous they were because they were a sign of great familiarity and warmth. She felt that this also represented how difficult those who were left behind experienced the departure. These activities could be likened to the outrageous rituals performed on stag nights to a prospective groom and reflected in rites of passage. Van Gennep (1960) maintained that rites of passage have three phases: separation, margin and aggregation. Rites of departure are intended to make the break gradual and this was evident in the build up to the leaving meal. The first phase, separation, found resonance in this study and comprised symbolic behaviour signifying the detachment of the individual in the social structure. The marginalized phase was presented in a comment by the therapist who was leaving:

> during my leaving do I felt as though I had already left, the people around me were talking about things they would be doing in the future and I suppose I was also thinking of my next move, it was as if I wasn't there.

Those leaving were in essence liminal entities who were, according to Turner (1969: 95), 'neither here nor there; they are betwixt and between the positions assigned and organized by law, custom, convention and ceremony'.

In terms of this study, the physiotherapy department and the hospital organization was structured, differentiated and hierarchical. Liminality represents unlimited possibilities and arguably may be perceived as dangerous by those in charge of maintaining structure (Turner, 1974). With this interpretation the outrageous acts carried out on those therapists leaving might appear as acts of envy that the person leaving is either free from the constraints of the organization or anger that they leave behind work that has to be done by those left behind. A manifestation of this freedom was demonstrated by the ritual of the 'exit interview' in which the one leaving is invited to express their feelings about the organization. The exit interview allowed for personal agency as opposed to conformity to a powerful collective identity. This also echoes Sturdy et al.'s (2006) comments that liminality is a potentially disturbing and yet liberating creative and productive place to be by virtue of its location beyond 'normal' practices.

This state therefore creates double-edged possibilities of increased creativity (Sturdy et al., 2006). However, liminality cannot be permanent unless the therapist shuns social structure altogether and accepts its lack of stability. More often it is a transitory condition (Turner, 1977, 1982) and therapists move on to other jobs.

The leaving rituals could be seen as a re-shaping, or a drawing together of the team left and breaking the bonds with the individual leaving. The leaving meal, marking the loss of a therapist from a team, may be likened to funeral breakfasts. Van Geneep (1960) likens this rite of re-shaping (or in his term, rite of incorporation) to the meals shared after funerals whose purpose is to reunite all the surviving members of the group with each other, in the same way that a chain which has been broken by the disappearance of one of its links must be rejoined. Holtzman (2006) on the theme of funeral breakfasts perceived this ritual as constructing an arena for celebrating and forgetting through food.

The leaving dos represented sadness and loss but also a potential threat to cohesion and this was behind a façade of elaborate food and fun to the extent of some outrageous behaviour. This façade was recognized by the senior, although it was uncertain how much the juniors were aware of its

purpose. While a constant change is to be expected in a young workforce, mainly working in training grades, it added to the sense that practice was unpredictable and transient in spite of the stabilizing activities. I was struck by the fact that in a team who put such effort into the leaving activities there was no special marking, or induction, for the new juniors who joined them each six months, apart from inviting them to the processes legally required through clinical governance. They were, however, invited to the end of rotation meal given by the team for those moving on, and so the separation of these juniors could have obscured the incorporation of the newcomers, to ensure the succession in an undemanding way. When I raised this, the team seemed to be unaware of its implications as a possible way of disguising constant change.

Relaxing and eating

At approximately 12.30 pm each day most of the therapists congregated for lunch. At least 20, at any moment, sat around the large airy pleasant staff room. All had either brought their lunch from home, or purchased it in the cafeteria in polystyrene boxes. They ate a mixture of salads, sandwiches and soft drinks. Some used the microwave or oven to prepare their food. The staff room had a quality of an 'extension' from home. It also seemed that it was the place where friendships were forged between the team which had the potential to increase their solidarity in their practice.

The therapists discussed subjects other than work, even though it was one of the few times when most of them were together, apart from the general staff meetings. The conversations could be categorized into current affairs, holidays and an evaluation of each other's food.

Food was subjected to a teasing debate and the behaviour that emanated from this was a kind of rivalry between the therapists. In such an inconsequential activity as lunchtime, so much could be learnt about the team. Their food preferences could indicate their religion, or country of origin, how they spend their holidays, their interest in the outside world and their personal life.

The staff room had a high place in the team's priority for privacy and the Rachel commented:

> apart from when there is an emergency, it is the only place that we are not disturbed by patients, it's our inner sanctum.

This space echoes Sturdy et al.'s (2006) description of a liminal space where the regular routines of the formal organization are suspended. Hierarchy did

not appear to be evident as senior therapists and junior therapists mingled and exchanged stories of their private lives as equals. This was a space where the regular routines of the organization were suspended as it became apparent that the therapists used this time to 'swap' their weekend and evening emergency and on-call duties. The accepted routine of doing this formally was suspended as a new routine was opened up.

However Turner (1977, 1982) saw liminality as a temporary condition and there were some therapists, the agency therapists, who occupied this space and fitted this description. Interestingly, although hierarchy was suspended between the other therapists the agency therapists were not given this privilege.

Food as a sign of 'otherness'

During the lunchtimes two therapists were observed to be apart from the rest, not joining in the conversation, tasting other therapists' food, or seemingly not knowing anybody. They were both listlessly looking at magazines and eventually, sensing their mutual isolation, began to talk to each other. The inquirer only seemed interested in talking per se as opposed to finding out about his colleague. They were agency therapists, that is, they were taken on by the hospital to deal with a short-term recruitment problem. It became obvious that the downside of being an agency therapist is the transitory nature of the employment. In this instance, food was a sign of the 'otherness' of their status. These lunchtime food activities thus contributed to the exposure of who was part of the, 'family' and who was on the outside.

Rachel said that, on the whole, the permanent therapists felt slightly bitter about the higher salaries received by the agency staff although conceded that they were expected to be 'workhorses' and could not attend any of the training in-services.[4] They also could be dismissed without notice although this was reciprocal. They were, however, necessary because of the shortage of senior physiotherapists in NHS hospitals. This gave an understanding about the team's commitment to the well-being of the whole group, rather than self-interest. I perceived the team resented their non-participatory role and appeared to ostracize them. Turner (1969) defines marginality (or liminality) as slipping through the network of classifications that normally locates people in positions in cultural space.

It does appear that even in this liminal space where the rules of the organization are suspended that other rules of exclusion and inclusion are manifest. The basic social convention of inviting strangers to partake of food was flouted in this lunchtime example. The agency therapists paid the penalty of not investing fully in their profession.

In contrast to those predictable occasions when food was used as a morale-booster, boundary forming, a way of coping with loss and socializing, it was also a vehicle to expose tensions between the team. The way they were dealt with revealed important perspectives of the relationships between the team.

Food expressed as a disorder within the system

Food may provide an opportunity for group members to express and work through conflicts that could be less amenable to direct verbalizations (Mishna, 2002). The state of the kitchen and the adjacent staff room was beginning to cause concern. Plates and utensils were left unwashed or just left in the staff room with abandoned food congealed onto them. Upturned coffee cups had stained the carpet.

One lunchtime in the staff room, the junior therapists were discussing, with some trepidation, the problem with the kitchen, as there was a sharp note from the manager on one wall. The note said:

> people are using the kitchen with a total disregard for anyone else. There is food left around and unwashed plates. Someone left the sandwich maker on last night and there was a real danger of fire, it was too hot for the fire blanket as it had burnt into the casing of the new toaster on which it was resting.

The microwave had been taped up with hazard tape because it was deemed a health hazard and Rachel said:

> it was absolutely filthy and one wonders really what goes on in people's houses, disgusting was not the word, there was also half eaten, smelly, bits of food were found underneath chairs. Food was half eaten, left on plates, abandoned, become smelly, decayed, unpleasant and inedible.

The manager was initially very unhappy about making the kitchen an issue because of his problems with retention of staff.

> don't forget that the staff may become disgruntled if they feel that the kitchen issue is a form of criticism . . . Everyone is working to their limit and it may be that the kitchen is a symptom of their disgruntlement with everything!

However, it had become more serious and forced him to make it an important part of the agenda of the general staff meeting. He announced:

> There are two options open to you, one is to completely improve, or to stop using the kitchen altogether, but remember if you stop using it there would be no cake days.

In many ways, the manager was reinforcing the idea that an authoritarian approach was the only one to follow and underpinned Gergen and Thatchenkery's (1996) contention that if only one version of the truth is assumed the result is hierarchy and oppressive forces within a culture. An alternative perspective was provided by Julie and Sue who said they saw the lunchtime as a whole hour for relaxing and chatting whilst they ate and did not want to incorporate queuing and washing their dishes in that time. There was a stark contrast between, on the one hand, an image of conviviality and pleasure, and on the other, disregarding colleagues' well-being. This highlighted how food can, in one situation, symbolize a reward and in another act as a disciplinary tool, as in closing down the kitchen.

However, the disruption to the smooth running of the kitchen was not in vain because it allowed for the expression of a voice of dissent, which made the team and the whole department reflect on their behaviour and exposed underlying concerns, less amenable to direct verbalizations, which needed to be addressed. The chaos in the kitchen was a form of aberrant activity within the system and may have been a form of protest against the hospital or the department, a collective message about coping with ever-demanding waiting lists without being shown any appreciation.

The juniors were expected to operate in some instances at a mechanical level indicative of a low level of activity. For example, they performed many of the routine administrative tasks. As a result these were often perceived as demands as opposed to self-selected activities and resistance (as shown by their conversations) ensued. Perhaps, knowing their objections would upturn an idealized image as demonstrated by 'cake days' the only way the juniors could express their dissatisfaction was in aberrant activities such creating chaos in the kitchen. These aberrant activities were in effect a form of dis-identification with the culture of the team which momentarily gave the juniors a sense of power to do the unthinkable, although the punishment was the abolition of the cake days. This though was a double-edged sword because these implicitly served as a form of professional socialization and thus a tool in the service of the team's hierarchy.

Discussion

Reflexive researchers recognize oppositional logic as implicit and actively explore the paradoxical relationship between presence and absence. A picture of contrasts emerged from the analysis of the food rituals of the team of therapists. Food as a vehicle of exclusion and inclusion presented a duality of two inseparable yet mutually constitutive elements. They were not mutually exclusive; they were two integral components of the process of creating a picture of this team's practice. Their complementarity reflected the complexity, uncertainty, instability, uniqueness and value conflicts that are increasingly perceived as central to the world of professional practice (Schön, 1987). The teams' patients were complex with very tangible needs. Some were able to become assertive risk takers focusing on problem solving, however, others did not conform to the predicted pathway of the rehabilitation programme and therefore could not be defined in terms of the expected outcomes. Hence the team's search for hard facts and certainty to underpin their practice was further juxtaposed by this prevailing instability.

To counteract this unpredictability, 'cake day' was a tradition; it had been in existence for many years. Each ritual, according to Turner (1969), contains a ritual symbol which not only has an ideological meaning but also stimulates desires and feelings. The cakes were attractive and special and the therapists looked forward to eating them and when they ate them, collectively, expressed delight and pleasure. Practice, therefore, in this one regular event could be perceived as attractive and pleasurable.

Ritual sustains the unity of a culture; it is embedded in and is essential for ensuring that order and continuity is maintained in a much wider social context (Holland, 1993). This kind of ritualized behaviour can easily reduce the anxiety which unpredictability, a hallmark of clinical practice, can engender. The team's practice, so acceptant of unpredictability when being with their patients, found it very difficult to cope with this part of their practice which had to do with their own interrelationships. Always doing things the same way (cake day on a Friday, elaborate meals for leaving dos) appeared to create an impression of some order. If this ritual was to be changed in its sequence, for example, cake day on a Monday, a leaving do without the usual planning, some soothing effect of the ritual might be lost. A change in the sequence of rituals is linked to anxiety and hence a detractor from team practices (Goldbloom, 1999) and the team seemed to know this implicitly in their careful and precise preparations of these activities. Everyone and everything concur to sustain this sense of continuity in the midst of discontinuities and this was clearly evident in this study. Cake day may appear to the serious minded a frivolous ceremony but by exposing

its symbolic meaning the complexity of some aspects of physiotherapy practice was revealed.

One discontinuity that everyone was aware of was the temporary status of the juniors in the team who passed through on a six-monthly rotation. This cyclical process of juniors arriving every six months presented a dilemma for the team. This is in contrast to literature that focuses on self-chosen teams purposefully making sure the right person joins the team and the wrong one stays out (Belbin, 2003; Hackman, 1990). Researchers discuss the importance of selecting a team with the right balance of skills and personalities, but the reality of healthcare practice is often that the professionals with whom one must collaborate are the people who just happen to be there (Headrick & Wilcock, 1998). Given these challenges, there appears to be a greater need for activities that foster collaboration and teamwork. In many ways although this ceremony could fall into Brooks and Brown's (2002) definition of a ritual of preservation that asserted individual membership of one profession it allowed a sharing of concerns and the possibility of considering alternative perspectives to reduce tangible experiences of anxiety that occur in healthcare contexts. This could thus be seen in psychoanalytical terms to function as a container of anxiety unlike the ritual practices described by Menzies Lyth (1960) which clearly did the opposite of what was intended. Thus a possible way forward to increase communication between the many professional subcultures in a hospital environment might be to create occasions where meals can be shared routinely to promote social relationships. Following the examples of Davies and Snaith (1980) and Habeeb (1973), who defined eating together as a social event this could challenge the modern preference for 'technical rationality', which supposes a simple hierarchy with knowledge and theory at the top and practice at the bottom which cannot account for the messy problems practitioners face in their day-to-day practice (Schön, 1983, 1987).

It became apparent that the impermanent juniors had to adopt the food preferences of the two influential permanent members of the team they joined for their six-month rotation period as the food identities of the teams did not change. The very nature of their impermanence indicated constant change and possible danger to the team and the carefully orchestrated cake ritual controlled by the seniors responded to this. According to Douglas (1966), Van Gennep (1960) saw society as a house with rooms and corridors in which passage from one to another is dangerous. Danger lies in transitional states because transition is neither one state nor the next. The juniors were constantly in a transitional state thus the continual change could be perceived as threatening and destabilizing to the senior members of the team. Nevertheless, on the surface the ritual of cake day gave an impression (to the

observer) of the team's sense of belonging, a sharing of concerns, a feeling of value and providing practical assistance for each other. It echoes Van Gennep's (1960) observation that the ritual of eating together is a rite of incorporation which constitutes the confirmation of a bond. It was seen as a life-preserving space as opposed to a liminal one.

The cake day was an important vehicle in the professional socialization of the juniors and arguably could have been specifically designed to instruct them in the attitudes necessary to perform their role (Van Maanen & Schein, 1979). It was a collective endeavour not an individual one because social life, to a large extent, is responsible not only for an individual's experiences but also for how these experiences are interpreted (Clouder, 2003). Individually, the team members were very different, but gained their conformity in belonging to the practice of the team in pursuing the same endeavour. The majority of the novices in Clouder's (2003) study of professionalization in health and social care had become aware of certain essential traits (such as 'learning to play the game' and a 'need to act in accordance with expectations') that they perceived had shaped their performance to varying degrees. Cake day could therefore be seen as an investment process of showing care and consideration for each other whether they are permanent or passing through but more importantly a process of assuming a professional identity.

The leaving dos, although a stable feature in themselves, represented a potential threat to cohesion and the anxiety of this appeared to show itself in childlike pranks. Those leaving according to Turner (1969) were liminal entities in the middle stage of Van Gennep's (1960) rites of passage, the liminal stage. As they become separated from an existing social order their status was socially and structurally ambiguous and offers the realm of possibility (Turner, 1969). This was evident in the exit interview which allowed for personal agency rather than acquiescence to hierarchy. In many ways this could give those leaving a sense of being able to make a difference to the established order as they have no fear of any reprisals or negative consequences as a result of their comments. The suspension of formal codes associated with the organization for those leaving thus had the potential to act as a safety valve for dissatisfaction without any reprisals (Fleming & Spicer, 2003). They may also hold a belief that their words will be heard and perhaps acted upon by the organization. Likewise Sturdy et al. (2006) refute the idea of liminality as being without structure as they found the suspension of rational organizational routines provided an important space to test the political dynamics of the organization.

The purpose of the elaborate meal ostensibly was to wish the person on their way and to show appreciation for all their work but at a deeper level its purpose might be one of affirming those who remained. Van Gennep

(1960) in his study on death rites saw the meal as primarily re-shaping those left behind and likewise Holtzman (2006) perceived the funeral breakfast as constructing an arena for celebrating the memory of the deceased both as a way of remembering their legacy and forgetting them through food. This echoes both the purpose of the exit interview which followed the celebratory leaving do meal as influencing those left behind and also the impression gained by those leaving of being invisible when witnessing conversations during their final days.

The staff room represented a liminal space where ostensibly hierarchy was suspended as the therapists interacted as equals. However, the suspension of accepted routines allowed the therapists to create their own routines such as swapping their on-call duties and the conviviality afforded by both the space and the ambiance that accompanied their lunch breaks facilitated this process. However, even in this liminal space professional hierarchy was present. The lunch time food rituals were used by the team to exclude outsiders, such as the agency therapists in a very basic way. The paradox, in the team's practice, was that they chose the tool for demonstrating exclusivity from the same tool box they referred to for their inclusive growth activities, indicating how they saw these two as ends of the same spectrum. This was an unexpected occurrence in a study in which food, as a nurturing vehicle, was paramount. Food rituals can have a powerful role in symbolizing exclusion and even in the liminal space of the staff room other deeply ingrained routines can occur. Meigs (1988, 1997) explored how exchanges of food are linked to bonds of social alliance and solidarity and the agency staff as deviants or pollutants could not contribute to the driving force of cohesion and were therefore ostracized. Douglas (1999) states that pollution beliefs of a culture are related to its moral values, thus the agency staff's refusal to invest in the values of the team was perceived as polluting.

Food rituals were one way in which continuities were sustained and in which an ambience of cohesion was created. Inevitably, there were breakdowns in the familiar pattern, such as the disorder in the kitchen. Food, used in this way, evoked intense conflict and made some of the team's feelings explicit. It was arguably a symbol of collective resistance against managerial control. The boundary of the accepted structure of the ritual was crossed and it could not control the ensuing danger. The effect of this was an increase in hierarchical authority of the organization. The situation, generally so convivial and enhancing became one of disorder and required the organization to reveal itself. This reflects Rosen's (1985) premise that if members become aware of the political outcomes of social dramas power structures would be laid bare. The authors assert that social drama is the instrument through which social order is reinforced, and through it social control (Rosen, 1985).

Food rituals as symbols of emotional nourishment were used by the team to enhance rapport, group cohesion and emotional well-being. When they broke down into disorder as shown by the chaos in the kitchen the juniors' disgruntlement was uncovered. Douglas (1966) maintains that disorder spoils ritual; it also provides the material of ritual. The ritual is a limited selection of actions from options and thus disorder by implication is unlimited. Disorder has enormous potential and therefore symbolizes both danger and power. When the ordered lunchtime ritual was abandoned the disorder exposed the juniors' unhappiness and their concerns were at least heard. Frequently, the tension between a valued aspiration as shown by the philosophy of the cake day ritual and the constructed reality of the lives of the team produced dilemmas. The disorder in the kitchen revealed an authoritarian approach adopted by the management. The irony was that they banned the very tool (by closing down the kitchen), which fostered the professional socialization of the therapists and revealed the difference between the concerns of the institution and the professional concerns of the therapists.

A collective identity was important for the team, as a means of projecting a united front to their colleagues within the physiotherapy department, their patients and other health professionals but the degree to which each member had ownership of the team's philosophy varied. The food produced for cake day, ideologically, appeared to represent team solidarity and boundary forming and gave the team, spearheaded by the seniors, a team identity. In orchestrating the team's food rituals the seniors were in control of the disorder both outside themselves and within their own minds. Douglas (1999) contends that whenever people are aware of encroachment and danger the boundary is emphasized, it is more than a negative barrier of exclusion, it bounds the area of structured relations within which ritual rules apply. However, in modern healthcare it is important to transcend professional boundaries and work collaboratively with other health professions but equally important to 'metaphorically' have a 'home' where members can support each other and reduce their anxiety. This is part of professional socialization which plays an important part in novices internalizing and integrating the physiotherapy profession's worldview into a personal worldview (Richardson, 1999).

This finds resonance in the boundary activity defined by Menzies Lyth (1988) who states that an aspect of human development in the individual is the establishment of a firm boundary for the self and others where realistic and effective relationships and transactions can take place and within which a sense of one's own identity can be established. It may be conjectured that the food rituals of the physiotherapy team orchestrated by the seniors asserted effective control over the boundaries that in turn had a positive

effect on the development of the juniors' identity. They gave a strong sense of belonging to what is inside, of there being something comprehensible with which to identify. They gained a sense of their professional identity through secure containment in a small intra-professional team first and only then connect to the whole healthcare organization and relationships with other professional groups. Mechanisms of belonging were therefore important and their activities reflected the degree to which they would eventually gain promotion and progress to permanent posts. Cook and Wyndham (1953) commented that there is a tendency for distinctive cultural groups to develop and preserve characteristic patterns of eating behaviour. Group conformity is required as one means of establishing identification with the leader and at the same time demonstrating the separateness of the group from other groups (Cook & Wyndham, 1953). This may have resulted in a more defined cultural tradition of working, which would survive despite individual members leaving.

Effective rehabilitation can be complex requiring the expertise of more than one profession. It is a multidimensional phenomenon that cuts across professional boundaries, physiotherapists, nurses, psychologists, occupational therapists, doctors all have an input into its management. Brooks and Brown (2004) maintain that rituals of preservation such as rituals of belonging and continuity reinforce professional boundaries thus preventing successful multidisciplinary team working. Currie et al. (2008) also suggest that another detractor is the hierarchy of the various professions within healthcare with doctors at the apex of the organizational pyramid. These both conspire to prevent what is known as boundary spanning roles which allow different healthcare professionals to enter into collaborative decision-making and the acceptance of equally valued non-hierarchical roles within a multidisciplinary team.

It would thus seem that ceremonies such as the cake days, the leaving dos and the lunchtime rituals could be perceived as exclusive and reinforcing the therapists' professional boundary. However, paradoxically it may not be possible to achieve the hoped for collaboration and multidisciplinary teamwork critical to organizational performance and success until health professionals have achieved a strong sense of their own professional autonomy. Thus the food rituals on the one hand could be construed as rituals that detract from interdisciplinary team working but on the other hand could facilitate it. This was borne out by Rafferty et al. (2001) who surveyed 10,022 staff nurses to explore the relationship between interdisciplinary teamwork and nurse autonomy and found that those nurses with higher levels of autonomy also exhibited higher levels of teamwork. This conjecturally suggests that a strategy that begins by reinforcing intra-professional

teamwork could create a positive environment that facilitates inter-professional collaboration. Logically it would seem that the allied health professions can only transcend the hierarchy of different health professional groups when they feel secure in their knowledge and competency. Rituals such as those described in this study could therefore be implemented as a leadership approach to cement individual professional teams and prepare them for the 'swampy lowlands' of clinical practice where situations are seldom cut and dried (Schön, 1983). They created a sense of affiliation and acceptance of the responsibilities that professional commitment demands.

Conclusion

In this ethnographic study of the food rituals of a team of physiotherapists areas of practice, made up of many small events, were revealed which, over time, had a forceful influence on practice. The inner workings of the team's practice found a visible release in the various rituals they defined themselves by. These were regular and hence typical aspects of their workings with each other and were used to impress on others, and themselves, their identity and nurtured their professional socialization. The same ritual would be inclusive and nurturing for the, 'in-crowd' (the team) and, at the same time exclude the outsiders. Food as a ritual symbolized different patterns of social relationships. They encapsulated and reflected wider social processes that might otherwise remain hidden such as serving as a coping mechanism to maintain continuity in the face of constant change. Food rituals delineated boundaries and controlled danger but at the same time permeated liminal spaces in which their presence facilitated the establishment of new routines. Food rituals were identified as an enhancer to the team as well as a restrictor within the hierarchy of the organization. This study suggests that inter-professional collaboration can be achieved by affirming a strong sense of professional identity and food rituals re-enforce this by supporting and emphasizing a process of professional socialization. The ordinary life of this team of physiotherapists, as told in the language of their everyday activities, on the surface seems very straightforward, but by exploring their rituals a complex picture of practice emerged.

Acknowledgements

The authors would like to acknowledge the contributions of Dr Barbara Richardson and Dr Barbara Steward to this article and to thank the physiotherapy team who so generously agreed to take part in this study.

Notes

1 Jammy dodgers are jam biscuits.
2 The paeds team were the team of therapists who specialized in the care of children.
3 The musculo-skeletal team were the team of therapists who specialized in musculo-skeletal disorders.
4 The in-services were educational sessions run by the senior therapists who were experts in their particular fields.

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