



A shared zone of ignorance: Considering practices of seeing and unseeing in and around nursing stations in two psychiatric wards

Holger Højlund and Thorben Simonsen

abstract

The notion of ignorance has become a central topic in social, political, and organizational research, with scholars thus beginning to explore the distribution and strategic uses of not-knowing (Gross and McGoey, 2015). Claiming that ignorance involves making decisions on what should be seen or unseen (Otto et al., 2019), they are calling for insights into the intermediary states produced between knowledge and non-knowledge in practice. Answering this call, the present article empirically details how practices of seeing and unseeing take place within and across the transparent architecture of a newly built psychiatric hospital in Denmark. Drawing on participant observations and interviews with nursing staff, we examine the role that spatial and material circumstances play in the situated production of ignorance. As such, we consider how the mutual visibility afforded by the transparent design of a nursing station in an inpatient setting produces what we suggest is 'a shared zone of ignorance'. Inspired by the work of German philosopher Peter Sloterdijk, this article extends current understandings of how ignorance is 'tethered to the spatial' (Frickel and Kinchy, 2015: 175).

Introduction

Yes, well, here we have this Dovecote [the nursing station] where there are glass partitions all the way around, which lets us see the patients. We can't always hear them when the door is closed, but we can see what's going on just outside. They can also see us. I don't think that this is always an advantage. Sometimes we have really sick patients where we experience that they – almost daily, in every shift – are staring in at us, which can be disturbing and uncomfortable. Sometimes I also think that patients may feel the same way, because sometimes we, too, when sitting at our computers and such, peer out: what's actually going on? (Nurse, interview, 2017)

Many contemporary designs feature glass partitions as a means of opening up spaces and enabling new orders of visibility (Pile, 2005; Pors et al., 2019). Using the case of a newly built psychiatric hospital, in this article we explore the transparency and mutual visibility such developments afford – more specifically, how the material circumstances of an inpatient setting animate the production of what we suggest is *a shared zone of ignorance*.

Architects generally see the transparent architecture and flexible spatial organization of hospital settings as giving staff and patients a sense of safety, security, and accountability (see Connellan et al., 2015; McGrath and Reavey, 2019; Simonsen and Duff, 2020). Countering these expectations, however, we show how this focus on transparency and flexibility co-produces acts of ignorance in ways that render ignorance an important part of hospital wards' daily socio-dynamics.

Focusing on how transparent settings shape the relations between nursing staff and patients, we investigate the implications of these dynamics, asking how nursing staff working in and around nursing stations conduct practices of seeing and unseeing. Starting with this research question, we scrutinize how nursing staff experience, react to, and manage the mutual visibility intrinsic to transparent design. Precisely because nursing stations are so central to staff-patient interactions (e.g., Andes and Shattell, 2006; Jovanović et al., 2019; Riggs et al., 2013), we seek to establish how the sense of constant co-presence engendered by glass-walled and hence transparent nursing stations shapes hospital ward socio-dynamics such that a shared zone of ignorance is produced. By thus delving into how co-present staff and patients interact, how they see and unsee each other in this setting, we

contribute to the literature on spatial design and hospitalization and on the way professional practices are shaped by a given architectural design (Connellan et al., 2013; Curtis et al., 2007; Jovanović et al., 2019).

Historically designed as alternative spaces for managing those deemed deviant or mentally troubled (Topp et al., 2007: 1), psychiatric hospitals have at times literally removed psychiatric patients from the public eye, separating them from society and othering them from rationality (Foucault, 1961). This transposition has given rise to a collective ignorance of their very existence, as witnessed in the Victorian era asylums of early modernity, where spatial modulations and geographical exclusions were used to connect ignorance to place (for an analysis of early modernity, see Frickel and Kinchy, 2015).

However, the architecture of psychiatric institutions has changed dramatically over the last 50 years (Nord and Högström, 2017). Today, psychiatric facilities emphasize the importance of openness, transparency, and visibility (McGrath and Reavey, 2019), thus spatially, materially, and symbolically challenging the very possibility of ignorance. Nothing is to be hidden, neither psychiatric practices nor the hospitalized patients. The clinical gaze described by Foucault as constitutive of modern medical practices (Foucault, 1973a; 1973b) seems to have expanded to render staff and patients in contemporary facilities mutually visible. This expansion has served to institutionalize the expansion of a panoptic mechanism whereby everybody sees everybody. Such full visibility creates conditions under which nursing staff and patients put self-imposed restrictions on their self-appearance and mutual observations.

In the following, we first discuss approaches to ignorance, then outline our data production methods. Next, we introduce the hospital site and analyze the empirical data. The article ends with a discussion and conclusion on our findings concerning transparency and ignorance.

Approaches to ignorance

Scholars studying ignorance consider knowledge and non-knowledge in relation to a diversity of topics, from racism, gender, and economy, to

management, media, and philosophy, to mention just a few (Gross and McGoey, 2015). For scholars of management practices, selection structures in evidence-based management (Knudsen, 2017), self-inflicted ignorance in accounting and performance management (Essén et al. 2021), and multiplied ignorance in communication (Knudsen and Kishik, 2022) have been important matters of concern. These scholars see knowledge as a managerial problem of objectivation and measurement – only information which is measurable appears as visible knowledge (Butler et al., 2020), while other information appears as noise (Kahneman et al. 2021). Despite the importance of these insights, management is primarily investigated as communication or through texts, with much less attention directed towards the importance of material circumstances for management and how the management of knowledge and non-knowledge is accomplished in and through everyday practices.

Although we share an interest with these scholars in studying management practices, rather than focusing on communication, we direct our attention towards the importance of the physical setting for the interactional management of knowledge and non-knowledge in practice. We further explore how this, in turn, produces a shared zone of ignorance. Also, while others have previously studied ignorance in healthcare (e.g. Essén et al., 2021), we contribute with novel insights about the psychiatric setting, where the interactional management of knowledge and non-knowledge is an important aspect of how nursing staff and patients handle their constant co-presence.

Hospital ward spaces are functionally differentiated into sub-areas, and these areas constitute shared spaces in which nurses and patients must manage different kinds of knowledge and ignorance. With the words of German philosopher and sociologist Peter Sloterdijk, managing such knowledge and ignorance can be termed ‘practices of immunization’. Practices of immunization are not strange or unfamiliar in other settings, but rather quite normal. Sloterdijk (2016) has done numerous studies and describes how a shared separateness, co-isolation, and a need to be immunized from the outside world suffuse in different spheres of everyday life, from intimate enclosures to more distanced venues. In this respect,

hospital settings and practices of immunization conducted in these spaces are particular expressions of more general features of living in modernity.

Before detailing Sloterdijk's approach to ignorance, we will first present other approaches to the topic. When it comes to ignorance, some studies focus on the atmospheric and sensory conditions required for sociality in organizations (Kanyeredzi et al., 2019), including conditions that stimulate the senses of smell (Riach and Warren, 2015), hearing (Brown et al., 2020), and sight (Otto et al., 2019). In hospitals, for example, acts of care are related to using the senses. Management of sense stimuli shapes how staff practice care when, for example, deciding what to acknowledge and to ignore.

Other scholars have studied organizational sociality related to 'the interface between inner and outer environments' (Bakken and Wiik, 2018: 1109) and to the 'geographies of ignorance' (Frickel and Kinchy, 2015), using these perspectives to investigate the spatial properties of ignorance, how ignorance is localized, and how domains of imperceptibility (*ibid.*: 180) can be mapped across space and place.

Going back to Sloterdijk, he has compellingly worked with the notion of spheres as sites for ignorance. The notion concerns how participants in different socialities form fragile compromises in order to separate between an inside and outside of their interactional encounters. In other words, spheres demand attention, protection, and generative work from the people inhabiting them. From this perspective, a psychiatric hospital can be seen as a sphere of very controlled sociality, a place intended to help uphold a fragile co-sociality. The psychiatric ward is a place fundamentally functioning as a protective membrane that immunizes against not only dangerous outside shocks but also inside disturbances. The spatial and material circumstances mediate and shape the manner in which staff and patients interact. The architecture of the ward premises how they see and unsee each other, how shared zones of ignorance are produced. One can talk about the psychiatric hospital producing spheres of shared separateness in which 'dwelling becomes an ignoring machine or an integrous defence mechanism' (Sloterdijk, 2016: 504). There is a fragile co-isolation related to hospital atmospheres (e.g., Brown et al., 2020; Kanyeredzi et al., 2019).

Patients situated in a hospital participate in a micro-sociality where sensory management (Sutton and Nicholson, 2011) takes place. Thus, patients find themselves in a situation of co-isolation where they must live in close proximity with fellow patients, only to be separated by shared walls that obstruct their visibility and lines of sight unless constructed of transparent material like glass. In institutionalized settings such as hospitals, co-isolation is a fundamental premise of co-habitation – a distinct form of being as togetherness.

Being as togetherness implies a four-place relationship because it describes the existence of somebody with somebody and something in something. (Sloterdijk, 2017: 159)

Patients and staff manage seeing and unseeing as part of this being as togetherness. A ward is a space at once separated and shared in which staff and patients manage ignorance. Here, we should note that, in our approach, ignorance concerns not unethical acts of disregard for others, but the production of shared circumstances of selective attentiveness. A fragile state of being, togetherness entails constant efforts to immunize the sociality of being together against situations that endanger it. Acts of seeing and unseeing are part of this work.

Method

Before introducing the hospital setting and our empirical findings, we would like to explain how we gathered the empirical data, which is based on ethnographic material collected by Thorben Simonsen between 2016 and 2017 in two inpatient wards at a newly built psychiatric hospital in Denmark (Simonsen, 2020). Although some of this material has been reported on elsewhere (Simonsen and Duff, 2021, 2020; Simonsen and Højlund, 2018), our conceptual approach differs because it is animated by our empirical interest in uncovering the situated production of ignorance. We have narrowed our focus to nursing stations, a space other scholars have shown as fundamental to mental health facility design (Connellan et al., 2013) and psychiatric practice (Andes and Shattell, 2006; Jovanović et al., 2019; Riggs et al., 2013; Shattell et al., 2008). This sharper focus enabled us to confine our investigation to interactions and reactions in and around the stations.

Our initial observation that the life of a ward primarily occurs at nursing stations also drove our choice. To explore the relationships between the material properties of the nursing stations, their location, and proximity to other ward spaces as well as examine the mediating role stations play in staff-patient interaction, we have mainly drawn on data obtained from participant observations of work taking place in and around two nursing stations. By conducting observations in this way, the second author, who did the empirical observations, was able to interact and engage in informal conversations with both staff and patients. This movement between staff and patient spaces thus gave insight into the various lines of sight afforded by the stations' transparent design.

To support the observations, seventeen semi-structured qualitative interviews were conducted with staff to obtain accounts of how they found working at the nursing stations and experienced their placement, transparency, and importance in relation to the surrounding ward spaces. The interviews with healthcare staff, including auxiliary nurses, care workers, and physicians, were most relevant to our study, but the architect, the project director, and hospital management were also interviewed. Three interviews were conducted with head nurses, one with a head physician, five with nurses, three with auxiliary nurses, and one with a care assistant. To identify the various seeing and unseeing practices, we centered our analysis on the daily work procedures and routines as well as the everyday challenges of juggling patient care and administrative work. The empirical material gained from the staff interviews helped us account for nursing staff's (re)actions to the transparent spatial and material circumstances. On closer analysis we also examined issues such as patient encounters and the distinctions made between important and unimportant inquiries. Our interest lay in everyday stories about how the nursing staff acted inside and outside the nursing stations, as such stories, descriptions, and accounts of everyday life in the wards – combined with participant observations – enabled us to consider the situated production of ignorance and, by extension, to conceptualize the organizational space as a 'zone of ignorance' within which the circumstances for work and care fundamentally differ from other care contexts. We are now ready to enter the hospital site.

The hospital site

In autumn 2015, about 650 employees from five psychiatric facilities in the Zealand region of Denmark were relocated to a brand-new psychiatric hospital in the city of Slagelse. The hospital was a high-status project with 194 beds, an emergency reception, outpatient treatment functions, and facilities for research and education. Transparency pervaded the hospital building, with the widespread use of glass partitions blurring the boundaries between outside and inside. Large window sections created porous passages and lines of sight never seen in Danish psychiatric facilities. The interiors were designed as open, furnished spaces with clean surfaces, and the outdoor areas included small gardens and benches.

Within the hospital site, each inpatient ward was a microcosmos designed for treatment and psychiatric work, with recovery being a key design rationale. Karlsson Architects and Vilhelm Lauritzen Architects, who won the architectural competition, stated a principal aim of the design as being 'to create unity between culture, structure, behavior and bricks. [Because i]t is our belief that the value of the physical framework is expressed through the activities that a building supports' (2010: 43).

Importantly, the architecture served to enable treatment that would help patients walk around the hospital building and thus gradually learn to cope with visibility and transparency, in both a practical and a wider social sense. With a hierarchy of spaces, the design is meant to offer patients varied places in which to recover.

Inside the hospital

The hospital has six wards, with nursing staff organized in teams to share responsibility for each one. Every ward has a centrally located nursing station where the teams meet to coordinate and perform tasks as well as have collegial exchanges. Formed as a glass cube, the individual stations project a sense of openness and availability and are strategically located and designed to give patients a sense of safety because they are in visual contact with and physical proximity to staff at all times. Being nested within the common spaces, the stations foster a constant sense of co-presence between

staff and patients. The glass walls also maximize surveillance over most of the given ward space, providing visibility not only to the adjacent communal space, but also into the ward's inner courtyard and far end.



Figure 1. Nursing station – © Karlsson Architects/VLA. Photo: Jens Linde

As the picture illustrates, visibility is completely pervasive at the nursing station, as its design is totally transparent but for a ribbon of slightly frosted window film inscribed with poems by a Danish writer. The thin line of poetic impenetrability represents an exception in the otherwise shared circumstance of total transparency. The design is premised on visibility as being fundamental to practices occurring both inside and outside a nursing station. Staff are able to quickly intervene in episodes such as undesirable, disruptive, or violent behavior, but the visibility also animates staff to interact with patients. Patients can see all work situations occurring within the stations, and staff are thus exposed to patients' gaze. The nursing staff interviewed report that the transparent circumstances make concentrating on tasks difficult, whether they entail attention to administrative work, the safety of colleagues, or patient care. Brown et al. (2020: 1550) draw similar conclusions about the continual interruptions staff experience at nursing stations, a finding that the participant observations of our present study

support. In the following we take a closer look at the everyday life of the inpatient wards to see how nurses conduct practices of seeing and unseeing when situated in and around nursing stations.

Seeing is knowing

The nursing stations are at the very heart of the common area. They can only be accessed through three respective solid doors, but other than this single sign of impenetrability, the stations send signals of inclusiveness. The glass design creates a sense of openness. The transparency of the glass walls in an immunological sense provides to the wards a well-lit, visible environment conducive to a sense of safety and security for patients and staff alike. Nursing staff mention the feeling of having an overview.

Yes, yes, yes, I almost always place myself on this side [facing the common area], because then I can see out. During a nightshift I always sit so I can look out. I don't like to sit with [my back turned], so I don't have an overview. In that sense you can have an overview without being out there [in the common area], you might say. (Nurse, interviews 2017)

Because staff observe their surroundings while doing administrative work tasks, they are not fully engaged with the activities going on outside in the common area: the 'seeing' conducted by staff is restricted to what they from professional and practical considerations find necessary. Watching over the patients is integrated in their administrative engagements, so to speak. As such, the nursing staff have to manage their administrative work with face-to-face interaction and patient engagement – a well-known dilemma among others in psychiatric practice, such as the balance between care and control (Mullen, 1993; Curtis et al., 2013; Tucker et al., 2018).

From a patient perspective, seeing is not knowing, as only with a distanced gaze through glass walls can a patient sense what is happening inside a nursing station. Still, the glass walls allow patients to feel visible and thus safe, which is a general rationale applied in psychiatry (Brown and Reavey, 2016: 287). From a design perspective, the glass walls of the nursing station function as a security design intimately incorporated into the building.

Conversely, the nursing stations serve as a safety measure that allows staff to withdraw from patients. The stations afford a direct line of sight in almost

every direction, providing an overview key to the staff's clinical work, as staff observe patients as a means of knowing how they are either progressing or regressing. In this respect seeing has both a therapeutical aim and a preventive rationale. Indeed, not only can staff do the fundamental clinical work of documenting patient behavior but they can also swiftly intervene if irregular, disorderly, or unwanted behavior is observed. Nursing staff thus exercise a kind of social-prophylactic gaze, as their clinical gaze can be said to be anticipatory. Seeing is related both to knowing the current status of individual patients and the ward's social order and to forecasting and maintaining an overview that keeps staff ahead of events while also retaining a distance and, thus, a sense of security. 'You want to be able to see what you're going out to', as one nurse put it. (Field note 30. 01. 2017)

The glass walls enable an expanded two-way panopticism with no invisible tower guards, just nurses and patients on the same level. The transparent circumstances forestall any hidden social interaction among patients, who cannot enter each other's rooms, so all activities become visible, accessible, and available to be made someone's business. Patients essentially cannot create spaces out of sight, away from staff interference. Indeed, in a transparent inpatient setting any action, any private conversation, can become someone else's business.

When all parties feel monitored

The interviews and observations have shown that not only patients, but also the nursing staff feel monitored. As two nurses reflect:

So they can sit and look at us all the time, and I can sit and keep an eye on them, and we have some patients that sometimes ask "why are you always laughing at me from inside the office?" for example, right? And just last week we had two patients that were severely psychotic who placed themselves in front [of the nursing station] and looked directly at us, and that was actually, I mean, that made it pretty hard to work when you constantly feel like you're under surveillance. No matter where you are in the building, right, someone is keeping an eye on you [...] I mean, it's actually uncomfortable to be watched the entire day. (Nurse, interviews, 2017)

In this excerpt, the nurses do not reflect on their own surveillance practices, but articulate how patients through their observations intrude on the

nurses' personal and professional spaces. The nurses find themselves unable to ignore the eyes of the patients, or, more precisely, the fact that they might watch them, which makes the nurses feel under constant surveillance. As such, the mere possibility of being watched is what is hard to ignore.

Conspiracies about conspiracies

Among nursing staff, there is a constant awareness of conspiracy-making among patients. They know that conspiracies are related to distrust and therefore are not suitable for the atmosphere in the ward. A nurse explains how patients produce stories about nurses' talking about patients during meetings. Inside the nursing station, the nursing staff is visible, but not audible, thereby leaving patients to interpret what is going on and thus produce what might be considered conspiracies or misinterpretations about the situation. Several versions of the misinterpretation theme emerged in the interviews with the nursing staff, thus indicating that these reflections are turned into their own conspiracies, with staff conspiring about what patients might be conspiring about.

Circumstances of full visibility but auditory insulation, create room for stories to exist – a semi-transparent sphere overloaded with contingency. Contrary to the architectural intentions, the nursing stations animate storytelling practices among inhabitants on each side of the glass walls. While the physical boundaries between the nursing stations and the common areas are visually accessible, the glass walls are soundproof, thus rendering what is discussed inside the nursing stations to speculation. 'What are they talking about – what are they saying about us?', one patient rhetorically proposed during observations, while another patient confronted staff more directly, asking, 'Why are you always laughing at me from inside the office?' The observations and interviews show that staff take issue with allegations and false impressions coming from patients' seeing but not hearing. Staff repeatedly come to assert and legitimize their actions inside the nursing stations, because the uncomfortable feeling of being observed make them conspire about conspiracies.

Impression management

The mutual visibility afforded by the hospital design make nursing staff consider how they conduct themselves while inside the nursing stations, because their conduct is confronted by not only patients, but also their own professional standards. Such impression management can be explained as an effort to immunize themselves against exposure to patients' gaze. One nurse offers reflections about the importance of body language and gesturing:

All those gestures you make ... they [the patients] can easily follow [them]; sometimes I think about our hands because ... but we do that when we speak, right, we do all kinds of things ... you need to consider what you're doing, differently than you're used to. Before, you would think, "well, the office is our private sphere where we ..." ... I mean, this won't go any further, but it just isn't that closed anymore, is it? Because now there are windows all the way around. So, you need to think twice about what kind of gestures you make. (Field note 03. 08. 2017)

Staff is obviously put on display, with the patients cast as an audience and the nursing stations constituted as a stage. The glass design animates efforts among nursing staff to immunize against outside disturbances through impression management. As a practice developed to take control over what is supposed to be seen and thus known and supposed to remain unseen and thus ignored, impression management serves to manage the nursing stations' transparent space. Each staff member hopes to gain control over the surrounding space and manage critical complaints from patients' about professional conduct by reconsidering appearances when inside the nursing station. Staff are often confronted with patient accusations that their conduct is lazy and unprofessional. As one nurse explains:

I regularly experience, maybe once or twice a week, patients saying the same sentence over and over: "You just sit on your asses in the nursing station." Occasionally it might be true because we don't come out [of the nursing station] enough, but sometimes when we're obnoxiously busy and need to use quite some time on paperwork, well, then it gives the incorrect impression that we're just sitting at the computer all the time. (Nurse, interview, 2017)

Although, as the above staff member says, such an accusation perhaps represents an inadequate understanding of the psychiatric hospital's daily activities, the absence of visibly identifiable and understandable activities is

not tantamount to laziness. Administrative work inside the nursing stations often consists of seeking information from or adding it to computers – a form of clerical work that patients tend to interpret as expressing laziness, even though staff are also tasked with being available as a safety back-up for colleagues if a patient behaves unexpectedly. Availability is important, and the mere visual presence of staff is considered a safety measure. Put more provocatively, staff experience that patients are ignorant about nursing work and that many less easily interpreted tasks animate rumors about laziness. For this reason, nursing staff feel an urge to appear busy and, thereby, to conduct impression management or simply to hide in plain sight.

Hiding in plain sight

The constant visual exposure animates staff to develop ways of hiding in plain sight and engage in practices of tactful inattention and of unseeing patients. Unseeing patients is a kind of preventive practice made possible when nursing staff place themselves at their work stations. This practice was observed on multiple occasions during fieldwork. Here, one nurse offers her account of such practices:

Sure, you can hide by pretending to be doing something important. It's not like you make an active decision about hiding. I just think, the more workstations, the easier it is to sit down at a workstation and look like you're working, where in reality it might be more important to be doing something else, right? (Nurse, interview, 2017)

As the nurse reports, pretending to be doing something important signals unavailability to patients. Performing such an act might be considered an overt strategy not only to immunize oneself against interruption, but also to obtain momentary relief from the demanding social interaction with patients. On such occasions, the nursing station simultaneously offers the needed refuge and necessitates the performance of busyness, that is, of doing the particular work of ignoring patients while being well aware of their presence. Hiding in plain sight requires effort; one must unsee patients when seen, avoid eye contact in order to stay focused on other tasks or, indeed, establish a space of momentary relief. As one nurse reports, 'Everyone needs room to catch their breath, a place to find relief, right?' Avoiding visual encounters with patients is a way to avoid requests for

further contact and communication. This practice of unseeing takes place as a particular form of impression management, a protective performance occasioned by the inspection from the patient's gaze.

Negotiating availability

Data from interviews and observations support the finding that negotiating availability is an ongoing task for nursing staff working under circumstances of transparency. Patients consider the individual staff member available simply if present, as this nurse reflects:

The big difference here, is that everything is completely transparent, which means that patients can actually see us all the time, which also means that they think that we are available all the time, which also means that we never really get any peace or can consider ourselves unobserved. (Nurse, interview, 2017)

This issue spurred nursing staff to compel patients to have specific reasons for making their inquiries, thus animating them to negotiate the legitimacy of each encounter. These negotiations obviously occur in the doorway between the nursing station and the adjacent patient environment, with patients seeking visual contact or vocally requesting an audience with staff. Encounters between staff and patients predominantly take place in this space, making it one of the wards' busiest sites and an important point of convergence with 'let's just say 90% of all contact taking place in that doorway [...] from short conversations to longer conversations', as one nursing staff member puts it (Nurse, interview, 2017).

Patients seeking, requesting, demanding, wanting, or needing something happens frequently, and nursing staff often express their irritation with such inquiries, particularly blaming the glass walls for giving patients a 'false sense of [staff] availability', as one nurse explains. Staff generally see patient requests as a point of irritation or distraction, and often deny such requests on the formal grounds that the given patient is not their direct responsibility on that day. However, staff also find being available to patients important, which often gives rise to issues regarding what might be called 'door management'.

Although security regulations for a psychiatric hospital stipulate that doors to nursing stations be kept closed, the central doors to the stations are usually kept open except during meetings, conferences, or other activities requiring privacy. Patients display frustration when the doors are closed, some knocking on them anyway, while other patients understand that staff is unavailable. As one patient notes, 'When they close the door, it's sort of like it's a forbidden area' (Field note, 04.08. 2017).

Reaching agreement on availability is an ongoing effort among patients and staff, especially due to the transparent circumstances. The doors are the material manifestation of this struggle about agreement. A nurse explains:

Ah, one of the reasons that our office door is always open is because we actually want patients to feel that we're available, right, so a closed door does not invite to anything. An open door [on the other hand] does that in a completely different way, so, in that way, we want to be exposed because we're here to take care of patients, but that isn't the same as [saying] that we don't sometimes need to be able to talk behind closed doors. (Nurse, interview, 2017)

Negotiating availability is a daily task when a glass and open-space design signals openness. Staff are faced with the task of managing and communicating when they are available to patients. Each and every negotiation affirms an 'us' and 'them' between staff and patients. This hierarchal reproduction counters the intentions of the transparent design, when it comes to both the nursing stations and the ward in general. Under conditions of full visibility, closed doors tangibly enforce a boundary between an inside and an outside. Whereas a brick wall is mute, glass doors speak, to rephrase a formulation from Simmel (1994: 7).

Discussion

The findings presented in the previous sections demonstrate daily life in and around the nursing stations in psychiatric wards. The following table lists six practices of seeing and unseeing in a shared zone of ignorance.

Practices of seeing and unseeing	A shared zone of ignorance
Seeing is knowing	The nursing staff react to the known. Observations are made to conduct control and intervene if necessary
When all parties feel monitored	The nursing staff and patients feel surveilled by each other
Conspiracies about conspiracies	Here, the unknown takes precedence over the known. Rumors are produced on both sides of the glass wall.
Impression management	Staff react to the feeling of being observed, and as a consequence engage in impression management
Hiding in plain sight	The nursing staff feel called to act as if they are busy – in order to protect themselves from criticism, they perform a kind of disengaged professionalism
Negotiating availability	Staff and patients have a shared responsibility for the social life of the ward, here the doors play a symbolic function in negotiating availability of staff

Table 1: Practices of seeing and unseeing

We assume that staff and patients alike have a basic right to ignore the ‘outside’, also when this outside is inside the institutionalized setting of a hospital. This basic right is confronted by the transparent architecture of the hospital, and practices of seeing and unseeing go against the intentionality of the building. As practices of immunization, however, the seeing and unseeing is important to inhabitants of the hospital. In the hospital studied, the nursing stations are designed to promote staff-patient encounters, to combat us-and-them hierarchies between staff and patients, and to encourage openness. The stations are designed to support staff practices and help demystify the work of everyday psychiatric care. However, our findings point to some of the challenges related to managing the porous boundaries between staff and patient spaces under circumstances of full visibility. Nursing stations are usually designed with high degrees of visibility (Joseph

and Rashid, 2007), but our findings show that daily life in psychiatric wards involves the situated production of ignorance. For example, patients react like ignorant persons when they observe staff but cannot hear them inside the nursing stations, which leaves the patients feeling in the dark about the actual content of the conversations inside. The glass walls both reflect and refract patients' ignorance, thus making it clear that not everything is transparent and leaving patients to speculate about what is going on behind the nursing station's closed doors.

Psychiatric hospitals are designed to be immune systems that support the recovery of vulnerable human beings. Recent hospital designs are fundamentally premised on transparency. Our findings suggest that some degree of invisibility and, hence, ignorance are crucial in wards. Through interviews and observations, we have learned about the dynamic relations between nursing staff and patients in the daily practices of seeing and unseeing. The hospital studied is built from principles of so-called healing architecture. As a particular immune or life-support system whose transparency constitutes and 'explicates' (Sloterdijk, 2017; 2016) the hospital's fundamental *raison d'être* (Simonsen and Højlund, 2018), such setting, thus, calls for particular forms of boundary management (for boundary management in other institutionalized settings, see, e.g., Borch 2014).

Nursing stations and patient spaces constitute an inside and outside to each other. As separate but fragile worlds, or bubbles, as Sloterdijk would say, the nursing stations and patient spaces are shared spaces of co-habitation, but also fenced through glass walls that simultaneously separate and demarcate life forms and tie them together. Infrastructures of visibilities enable a simultaneous sense of safety and are therefore 'explicated' in the designs of psychiatric hospitals. Ignorance management, however, is as a necessary part of professional behavior in hospital settings and should be focused upon in further research.

Our findings furthermore indicate that in the busy hours of current hospital life, ignorance is related to staff rejecting patients' interruptions, which staff must understandably do to get administrative tasks done. However, every hospital has a certain, distinct monotony for patients, an atmosphere

saturated with a sense of boredom, because so little is going on. Interruptions become distractions from this ennui. Transparency further seems to amplify a peculiar feeling among patients whereby they feel observed, yet ignored. In our study, this feeling was most prevalent among patients who were near to the nursing stations: they initially regarded themselves as seen and afterwards ignored, which could sometimes make ignorance seem like an act of rejection.

In psychiatric hospitals, observing is done with the eyes, but observing also entails other senses. In our study, nurses talk about being sensitive to the ward's atmosphere in order to make professional judgements, prognoses, or calculations regarding future situations. The nurses speak about listening in an anticipatory manner – a preventive listening of sorts – that entails being alert to sounds of little significance in themselves, but that indicate that a problem is brewing. In this instance, one of Brown et al.'s (2020) key findings support our own, namely that nursing staff manage ward atmosphere by utilizing multiple senses and entering into negotiations with patients in order to 'take the ward's temperature'. Stations can be understood as a kind of immunity system in the inpatient wards, as they must function to immunize themselves against conflicts among patients plus immunize staff's administrative work against patient disturbances.

We invite further micro-investigations to be done on immunizations. Staff momentarily create a space of relief from patient interaction and/or maintain a position of distance despite the obvious proximity. The fragility of inhabiting such a space amplifies the need for work that manages the tensions between care and containment, for which reason our study adds empirical insight to existing research (e.g., Curtis et al., 2013; Tucker et al., 2018) identifying such challenges in contemporary psychiatric settings.

Our findings have demonstrated how staff and patients deal with a shared spatial problem of inhabiting transparent spaces in which affects and temperaments are easily transmitted. Builders and architects should take closer account of reactions to the transparent designs used in institutionalized settings: the sometimes subtle, yet paramount 'conduct of the eyes', the delicate practice of impression management, the loud accusations of laziness. For psychiatric hospitals built on principles of

transparency, ignorance might be considered an important, even necessary aspect of professional practice. In our findings the nursing staff prominently utilize their capacities for both ignorance and attentiveness in their practice. Ignorance and attentiveness are not dichotomous, but rather managed in combination, with both being drawn on in the everyday work of the nursing staff. A staff member might have to ignore a request, deny an appeal, or postpone a possible encounter in order to be available for another work task. Our data elucidates how distinctions between presence and absence are unsettled and how nursing stations' transparent architecture thus creates atmospheres of unfulfilled expectations.

As Berger claims (1972: 9) the reciprocal nature of vision is undeniably fundamental, but the importance of sound in relation to immunization should not be overlooked (Sloterdijk, 2016). In our case, the fact that the transparent circumstances allow visual contact makes this contact the main sensorial and shared affect, whereas sounds and smells remain (somewhat) contained behind the glass walls. Our findings add insight into how surveillance practices can also be reversed in psychiatric settings (Salzmann-Erikson and Eriksson, 2011; Simonsen and Duff, 2021), but we have also explored and contributed to the importance of the visual in the experience and management of atmospheres, especially the visual aspect of such management (e.g., Kanyeredzi et al., 2019; Tucker et al., 2018). Other senses can be studied further. Listening practices, for example, seem especially relevant, their being critical to how staff orient themselves to a hospital setting, as Brown and colleagues have also shown. In this light, one might consider conceptualizing ignorance in terms not only of 'looking away', that is, of redirecting one's focus of attention, but also of 'shutting one's ears' and enacting a particular form of sonic agency (Brown et al., 2020).

Conclusion and further research

The term 'a shared zone of ignorance' captures the key point of this article. Transparent architecture leaves both patients and staff with an immense interpretative work to be done. A situation of double contingency, with the glass walls rendering many formerly invisible aspects of the staff's work visible to patients, are solved by daily practices of ignorance: the patients

can observe the staff, and the staff, in turn, observe patients observing them. Often the information gained through observation is ignored, but nevertheless has implications for behavior. As our data clearly shows, being visible to the gaze of patients animates staff to engage in a variety of unseeing and hiding practices. From the present study we hope to inspire further research into the materialities of contemporary hospital buildings. The use of glass walls provided a specific answer to the somewhat rhetorical question posed by Bakken and Wiik (2018: 1111): how can ignorance be observed? Actual practices of seeing and unseeing are animated for example by glass walls. Ignorance is indeed tethered to the physical spaces of hospital settings. As such, ignorance and space are entangled (Frickel and Kinchy, 2015), and further empirical research can be done into the work of managing circumstances of shared separateness and co-presence in institutionalized settings such as hospitals.

Critically embracing Sloterdijk's notion of shared separateness, we suggest further critical investigations into hospital milieus where patients spend some or much of their lives in an institutionalized dwelling. In such a setting, patients intersect in shared spaces but must also live individual lives, simultaneously differentiated and kept apart but nevertheless alongside each other because those everyday lives are enclosed in institutionalized spaces. Facilities designed with glass and therefore with high levels of transparency expose patients to a sociality that is not only part of their treatment, but also central to how they appear as individuals. In hospital settings, like any other settings, for that matter, practices of seeing and unseeing may function as important means of immunization. As we have shown, however, under circumstances of pervasive transparency and mutual visibility, such practices also produce a shared zone of ignorance, at once productive and problematic and, therefore, to be taken into consideration in the development of future designs.

references

- Andes, M. and M.M. Shattell (2006) 'An exploration of the meanings of space and place in acute psychiatric care', *Issues in Mental Health Nursing*, 27: 699–707.

- Bakken, T. and E.L. Wiik (2018) 'Ignorance and organization studies', *Organization Studies*, 39: 1109–1120.
- Berger, J. (1972) *Ways of seeing*. London, England: British Broadcasting Corporation and Penguin Books.
- Borch, C. (2014) 'The politics of atmospheres: Architecture, power and the senses', pp. 60–89 in C. Borch (Ed.) *Architectural atmospheres: On the experience and politics of architecture*. Birkhäuser.
- Brown, S. D., A. Kanyeredzi, L. Mcgrath, P. Reavey and I. M. Tucker (2020) 'Organizing the sensory: Ear-work, panauralism and sonic agency on a forensic psychiatric unit', *Human Relations*, 73: 1537–1562.
- Brown, S.D. and P. Reavey (2016) 'Institutional forgetting/forgetting institutions: Space and memory in secure forensic psychiatric care', E. Weik (ed.) *Institutions inc*. London: Palgrave Macmillan.
- Butler, N., H. Delaney, E. Hesselbo and S. Spoelstra (2020) 'Beyond measure', *ephemera*, 20: 1–16.
- Connellan, K., M. Gaardboe, D. W. Riggs, C. Due, A. Reinschmidt, and L. Mustillo (2013) 'Stressed spaces: Mental health and architecture', *Health Environments Research and Design Journal*, 6: 127–168.
- Connellan, K., D.W. Riggs and C. Due (2015) 'Light lies: How glass speaks', *Communication Design Quarterly Review*, 3: 15–24.
- Curtis, S., W.M Gesler, V. Wood, I.H. Spencer, J. M Mason, H. Close and J. Reilly (2013) 'Compassionate containment? Balancing technical safety and therapy in the design of psychiatric wards', *Social Science and Medicine*, 97: 201–209.
- Curtis, S.E., W.M Gesler, K. Fabian, S. Francis and S. Priebe (2007) 'Therapeutic landscapes in hospital design: A qualitative assessment by staff and service users of the design of a new mental health inpatient unit', *Environment and Planning C: Government and Policy*, 25: 591–610.
- Essén, A., M. Knudsen, and M. Alvesson (2021) 'Explaining ignoring: Working with information that nobody uses', *Organization Studies*, 1-23.
- Foucault, M. (1961) *Madness & Civilization: A history of insanity in the age of reason*, Bo. ed. New York: Vintage.

- Foucault, M. (1973a/2008) *Psychiatric power: Lectures at the collège de France 1973-74*, New York: Palgrave Macmillan.
- Foucault, M. (1973b) *The Birth of the clinic: An archeology of medical perception*, Bo. ed. New York: Vintage.
- Frickel, S. and A. Kinchy (2015) 'Lost in space: Geographies of ignorance in science and technology studies', pp. 174-182 in M. Gross and L. McGoey (eds.) *The Routledge international handbook of ignorance studies*. Routledge.
- Gross, M. and L. McGoey (eds.) (2015). *Routledge international handbook of ignorance studies*. Routledge.
- Joseph, A. and M. Rashid (2007) 'The architecture of safety: Hospital design', *Current Opinion in Critical Care*, 13: 714–719.
- Jovanović, N., J. Campbell and S. Priebe (2019) 'How to design psychiatric facilities to foster positive social interaction: A systematic review', *European Psychiatry*, 60: 49–62.
- Kahneman, D., O. Sibony and C.R. Sunstein (2021) *Noise: A flaw in human judgement*. Hachette Book Group, USA.
- Kanyeredzi, A., S.D. Brown, L. McGrath, P. Reavey and I.M. Tucker (2019) 'The atmosphere of the ward: Attunements and attachments of everyday life for patients on a medium-secure forensic psychiatric unit', *The Sociological Review*, 67: 444–466.
- Karlsson Arkitekter/Vilhelm Lauritzen AS, 2010. Konkurrenceforslag.
- Knudsen, M. (2017) 'From evidence-based management to management of non-knowledge', *Emergence: Complexity and Organization*, 19(2): 1-8.
- Knudsen, M. and S. Kishik (2022) 'Multiplying ignorance, deferring action: Dynamics in the communication of knowledge and non-knowledge'. *Social Epistemology*, 16(3): 344-359.
- McGrath, L. and P. Reavey (eds.) (2019) *The handbook of mental health and space: Community and clinical applications*. Routledge.
- Mullen, P.E. (1993) 'Care and containment in forensic psychiatry', *Criminal behavior and mental health*, 3(4): 212–225.

- Nord, C. and E. Högström (2017) 'Introduction', in Nord, C. and E. Högström (eds.), *Caring architectures: Institutions and relational practices*. Cambridge Scholars Publishing.
- Otto, B., J.G. Pors and R. Johnsen (2019) 'Hidden in full view: The organization of public secrecy in Miéville's *The City and the City*', *Culture and Organization*, 25: 91–103.
- Pile, S. (2005) *Real cities: Modernity, space and the phantasmagorias of city life*. London: Sage.
- Pors, J.G., L. Olaison and B. Otto (2019) 'Ghostly matters in organizing', *ephemera*, 19: 1-29.
- Riach, K. and S. Warren (2015) 'Smell organization: Bodies and corporeal porosity in office work', *Human Relations*, 68: 789–809.
- Riggs, D.W., C. Due and K. Connellan (2013) 'Duty stations and the regulation of space in mental health wards: A South Australian case study' *The Australian Community Psychologist*, 25: 78–93.
- Salzmann-Erikson, M. and H. Eriksson (2012) 'Panoptic power and mental health nursing-space and surveillance in relation to staff, patients, and neutral places', *Issues in Mental Health Nursing*, 33: 500–504.
- Salzmann-Erikson, M. and H. Eriksson (2011) 'Latent or manifest observers: Two dichotomous approaches of surveillance in mental health nursing', *Nursing Research and Practice*. <https://doi.org/10.1155/2011/254041>.
- Shattell, M.M., M. Andes and S.P, Thomas (2008) 'How patients and nurses experience the acute care psychiatric environment', *Nursing Inquiry*, 15: 242–250.
- Simmel, G. (1994) 'Bridge and door', *Theory, Culture & Society*, 11: 5–10.
- Simonsen, T. (2020) 'The spatial organization of psychiatric practice - A situated inquiry into "healing architecture"', PhD Thesis. *Copenhagen Business School*. <https://doi.org/10.2307/j.ctvpj7b7z.9>.
- Simonsen, T. and C. Duff (2021) 'Mutual visibility and interaction: staff reactions to the "healing architecture" of psychiatric inpatient wards in Denmark', *BioSocieties*, 16: 249–269.

- Simonsen, T. and C. Duff (2020) 'Healing architecture and psychiatric practice: (re)ordering work and space in an in-patient ward in Denmark', *Sociology of Health and Illness*, 42: 379–392.
- Simonsen, T. and H. Højlund (2018) 'Rummets grammatik - Helende arkitektur i psykiatrien', *Politik*, 21(2): 22–42.
- Sloterdijk, P. (2017) *The aesthetic imperative*. New York: Polity.
- Sloterdijk, P. (2016) *Foams: Spheres volume III: Plural sphereology*. Los Angeles: Semiotext(e).
- Sutton, D. and E. Nicholson (2011) 'Sensory modulation in acute mental health wards: A qualitative study of staff and service user perspectives', report, *The National Centre of Mental Health Research*, Auckland.
- Topp, L., J.E. Moran and J. Andrews (eds.) (2007) '*Madness, architecture and the built environment: Psychiatric space in historical context*'. London: Routledge.
- Tucker, I.M., S.D. Brown, A. Kanyeredzi, L. McGrath and P. Reavey (2018) 'Living "in between" outside and inside: The forensic psychiatric unit as an impermanent assemblage', *Health and Place*, 55: 1–8.

the authors

Holger Højlund, PhD, Associate Professor, VIA University College, Aarhus, Denmark. His research covers areas such as welfare technologies, health partnerships and care professionals.

Email: hmeh@via.dk

Thorben Simonsen, PhD, Researcher, The Danish Center for Social Science Research. His research interests converge around different problems relating to space and place, organization, digitalization, and health/care.

Email: thsi@vive.dk