This article is based on the findings from a discourse analytic study which critically explored the language of mental health nurses, and detained sexual offenders, in relation to pornography in one high-security hospital. It recognised previous empirical investigation, and pro-feminist theorising, into mediated representations and male sexual violence, but situated the research process in a forensic nursing context. Decision-making about access to, or restriction of, commercial sexual literature, as a component of therapeutic intervention and offender management, reveals tensions between service-user rights and treatment goals. The aim was to access nurse and patient talk in a specific culture. Semi-structured interviews with eighteen nursing staff, and nine patients, were used to co-construct accounts of pornography, sexual offending, and treatment. Findings suggested collective male talk textured the environment, promoted gendered inequality, marginalised female nurses, and undermined rehabilitation. Shared discourse enabled male staff and patients to relate to each other as men, while maintaining distance through constructions of otherness. Discussion focuses on discriminatory discursive-practices, where men’s talk about pornography and sexual violence embodied gendered knowledge/experience and contributed to a toxic culture.


Physical restraint of people experiencing mental health problems is a coercive and traumatic procedure which is only legally permitted if it is proportionate to the risk presented. This study sought to examine the decision-making processes used by mental health staff involved in a series of restraint episodes in an acute care setting. Thirty nurses were interviewed either individually or in focus groups to elicit their views on restraint and experience in specific incidents. Four factors which influenced the decision to restrain were identified: contextual demands; lack of alternatives; the escalatory effects of restraint itself; and perceptions of risk. While some of these factors are amenable to change through improvements in practice, training and organisational culture, nurses viewed restraint as a necessary evil, justified on the basis of the unpredictable nature of mental illness and the environment in which they worked.


A multifaceted legal landscape now shapes the delivery of health and social care in England and Wales. Fundamentally, treatment is only considered to be ethically acceptable if a competent patient agrees to it. Only decisions made with capacity are viewed as autonomous and valid, with patient autonomy being viewed as a core principle of medical ethics. In common with many other countries, the circumstances in which treatment may be given without consent are regulated by several distinct legal frameworks. These legal frameworks have been developed to protect the interests of patients who are being treated, for whatever reason, without their consent. Their importance lies in the fact that their primary goal is often justified under the guise of safety rather than therapy; Of course, coercion may be used to provide therapy, in particular therapeutic medication or other interventions. It must also be
recognised that coercive powers imposed by the state for therapeutic purposes can be misused even for benevolent reasons. While chemical, mechanical and physical restraint, particularly in the field of mental health as forms of coercion are subject to considerable scrutiny, it is much rarer to find discussion of the more subtle forms of coercion which exist in general medicine. The purpose of the legal frameworks is not only to specify the nature and limits of treatment without consent, but to define the populations to which the frameworks apply. Increasingly, these include populations in settings such as acute hospitals, nursing and residential care homes. This paper focuses on care provided in an acute setting and questions whether legal safeguards can protect the interests of patients. The paper also examines the extent to which legal frameworks can limit the exercise of medical discretion.


The paper suggests that the qualitative methods have an important but, to date, largely overlooked role in veterinary science. The paper highlights the contribution of social science to animal studies and in particular to the interaction between humans and animals. It also suggests some methodological approaches.


This paper explores the role of parents of children with gastro-oesophageal reflux in managing their children’s health. It draws on the findings of a qualitative study that looked at the way in which treatment decisions are made in a joint surgical-medical clinic and which showed that the parents of children referred to the clinic play a crucial role in the development and execution of treatment plans. Using Habermas’s theory of communicative action, we show how the parents develop an in-depth understanding of the condition and its treatments, combining ‘objective world’ medical knowledge, ‘social world’ norms and understandings and ‘subjective world’ experiential knowledge. We argue that in engaging with different forms of knowledge and with the treatment decisions made in the clinic the parents reason and act in a more or less communicatively rational way. The model of the joint clinic enhances the potential for communicative rationality to develop through its more than usually dialogical approach to decision-making that places emphasis on the parents’ expertise and incorporates it into the development of treatment plans. As might be anticipated, however, the clinic also provides much evidence of strategic rationality at work, on the part of both clinicians and parents.