

The Bleary-Eyed (But Disciplined) Patient:

Late Night and Early Morning Awakenings and Foucault's Disciplinary Power in a Healthcare Panopticon

Author: Darren Choi
Program: Political Science (Honors)

ABSTRACT: It is an old adage that when one is staying at the hospital, a sleepless night will follow. Hospitals are notoriously difficult places to sleep in. This is due to a variety of factors, but one of the primary ones are the late night and early morning disturbances caused by nurses and other medical professionals who are taking measurements and vital signs from the patient. Explaining why this occurs requires an understanding of how the hospital is organized as an institution. To meaningfully talk about the nature of the hospital as an institution, we then must ask fundamentally political questions (with political answers). Thus, I draw upon a Foucauldian theoretical framework to critically examine the hospital as a disciplinary institution. Through this framework, we shall find that the hospital's organizational impetus for a "perpetual examination" is what drives hospital sleeplessness. While the perpetual examination is not borne out of malice and is usually vital to the health of the patient, understanding this process helps us understand why hospitals are so difficult to sleep in. Without rejecting the processes of hospitalization wholesale, this understanding of what drives hospitals as political institutions helps us begin to improve them; helping patients sleep is one place to start.

KEYWORDS: disciplinary power, healthcare, hospital, Michel Foucault, panopticism, sleep, wellness

Introduction

There is an intuitive positive relationship between sleep, health, and healing. When we are sick and injured, we instinctively seek sleep and rest. Thus, it is a strange contradiction that hospitals – spaces dedicated specifically to health and healing – are notoriously difficult places to sleep in. While there are many reasons why a hospital patient might find it difficult to sleep, the most obvious are the late night and early morning awakenings by nurses and other medical staff. These awakenings are so common that one might resign themselves to thinking of them as an inevitable reality of hospitalization that can only be alleviated, not prevented. However, a closer examination reveals there is a political explanation for the interruption of patients' sleep, which lies in how we conceive of and organize the hospital as an institution. Late night and early morning awakenings are not just an unfortunate reality of hospitalization, but a direct consequence of medicine exerting disciplinary power through a “perpetual examination” of its patients.

As can be seen from the term “disciplinary power,” I will be drawing from the concepts of Michel Foucault, and specifically the concepts outlined in his work, *Discipline and Punish: The Birth of the Prison*. Foucault (1977) was concerned with how the modern-day prison exerts power on individuals and how that power is utilized in the name of “reform.” From this, he drew broad conclusions about how power is exerted throughout our society. Among the many key concepts that I will draw from is Foucault’s “panopticon” (a famous prison concept that I will explore in detail later). This panopticon is represented in hospital organization, reflecting medicine’s impetus to constantly observe and surveil every one of its patients. While the perpetual examination is not born out of malice and is often to the benefit of seriously ill patients, having a greater awareness of how hospitals are organized will allow us to understand why we cannot sleep there; when conscious of the disciplinary impetuses created by the hospital, individuals within the institution can adjust hospital processes and individual behaviours to reduce patient awakenings. With such an understanding in mind, we will assuredly be able to improve the health and wellbeing of hospital patients.

Hospitals’ Sleep Problem

“O sleep, O gentle sleep, Nature’s soft nurse, how have I frightened thee...”

King Henry IV, Henry IV, Part 2

Shakespeare, in his history, *King Henry IV, Part 2*, writes of the lamentations of a sleepless King. The

Bard of Avon’s claim that sleep is “Nature’s soft nurse,” reveals that he, like us all, knows of sleep’s healing nature and the negative effects sleeplessness has on our health and wellbeing. While claims such as “sleep is the best medicine,” “I’ll sleep it off,” and “you’ll feel better in the morning” are clichés, they are natural assertions to make. When we are sick, we gravitate towards our beds in search of rest. If we are injured, well-wishers and doctors alike encourage us to “get some rest.” Although this connection seems somewhat intuitive, there are also numerous studies within the medical literature that demonstrate the direct benefits of sleep on our health and healing (see Alvarez and Ayas (2004); Evans and French (1995) for a couple of examples).

Given sleep’s importance to health and healing, one might think that within the hospital, where the most serious illnesses and injuries are treated, ensuring patients get sufficient, high-quality sleep is of utmost importance. Unfortunately, most hospital patients find themselves in a similar situation as King Henry: bleary-eyed and wondering why sleep “no more wilt my eyelids down.” Hospital sleeplessness is not some oft-repeated myth; medical discourse is acutely aware that the “[q]uality and quantity of sleep in hospitalized patients may be sub-optimal and negatively associated with many hospital-related factors...” (Wesselius et al. 2018, 1202).

The possible causes of sleep disruption are numerous and well documented by medical literature. Two good examples of these medical analyses are Grossman et al. (2017) and Wesselius et al. (2018). Sources like these cite numerous factors present within the hospital that contribute towards hospital sleeplessness. Various external lights and noises are obvious potential causes of sleep disruption. Medical reasons are another potential factor: certain medications, pain, or discomfort can keep a patient awake, for example (Wesselius et al. 2018, 1204). One of the most significant factors, however, are the nocturnal and early morning awakenings by nurses and other medical staff. Wesselius et al. (2018), in their study of various hospital-related factors contributing towards patient sleeplessness, found that twenty percent of patients surveyed cited awakenings by hospital staff as a disturbing factor (1204). Medical tests, vital sign measurements, and responding to alarms are the most prevalent reasons for late night or early morning awakenings by hospital staff (Grossman et al. 2017, 303–4). Regardless of its prevalence within these surveys, these awakenings by staff are certainly the most infamous and widely disliked source of sleep disruption as nurse Theresa Brown (2011) notes. Brown laments that, due to hospital practices surrounding the

aforementioned tests and measurements, “[f]or hospital patients, the nurse is often the dreaded voice crying ‘Sleep no more!’” (Brown 2011). Given the role sleep plays in promoting healing, hospital sleeplessness is an obvious problem. One common solution offered by hospitals is sedation and medication (Schumacher et al. 2017). The ubiquity of this approach is somewhat unsurprising. As Matthew Wolf-Myer (2012) notes, disordered sleep is usually dealt with by a medical, pharmaceutical approach in our modern era (156). When one is in the house of medicine, one might expect that any disorder, even if it is iatrogenic (i.e., related to the course of medical examination or treatment), will come with a pharmaceutical solution. This is not to say that medicine is fully beholden to pharmaceuticals when tackling hospital sleeplessness. For example, Birdja and Ozcan (2019), within the context of medical literature, recognize the problematic nature of the overuse of pharmaceutical solutions to hospital sleeplessness; they explore how redesigning soundscapes in a hospital can be conducive towards patients’ sleep.

While approaches such as Birdja and Ozcan (2019) may acknowledge that hospitals are “sonically covered, noisy environment[s],” and attempt to find non-pharmaceutical solutions, they do not answer the more fundamental question of the cause of patient awakenings (4). Sedating a patient or redesigning hospital soundscapes alleviates sleeplessness; they do not address the imperative for nurses or other medical staff to wake up their patients in the first place. Explaining these awakenings requires an institutional analysis of how our society conceives of and organizes the “hospital.” To analyze the fundamental bases of one of the key institutions of our society is a fundamentally political question. Why is the hospital organized the way it is? How have political forces – governments, institutions, beliefs and ideologies – shaped our modern conception of the hospital. It is only after we address these wider political questions that we are able to return to our specific question of sleeplessness and hospital awakenings. *Foucauldian Discipline and the Hospital*
To find our explanation, I turn to Foucault and his concept of “discipline.” Foucault frequently invokes medicine and the hospital in his work, from *The Birth of the Clinic* to his lectures on the architecture of the modern hospital (Gutting and Oksala 2018; Lambert 2013). Most useful is his characterization of the modern hospital as a “disciplinary institution” and how medicine exerts “disciplinary power.”

Foucault (1977) asserts that “prisons resemble factories, schools, barracks, hospitals, which all resemble prisons” (228). What does a hospital have in common with a

factory, barracks, or prison? For Foucault, all of these institutions exert “disciplinary power” on their subjects (i.e. they are “disciplinary institutions”) through complex systems of surveillance. “Discipline” is one means by which power can be exerted and the behaviour of individuals regulated. He identifies three “simple instruments” through which disciplinary power is exerted: hierarchical observation, normalizing judgement, and the examination (Foucault 1977, 170).

Firstly, Foucault argues that there is great power in observing somebody (170). Through systems of “[h]ierarchical, continuous and functional surveillance,” we create multivalent power relations across the entire system; from this, “the apparatus as a whole... produces ‘power’” (177). Importantly, hierarchical observation ensures that disciplinary power is both “absolutely indiscreet,” as it creates constant and omnipresent observation, and “absolutely ‘discreet,’” as these systems largely work in silence (177). Foucault also notes that the architecture of the modern hospital is organized around hierarchical observation “to render visible those inside it” (172).

Another key tool of disciplinary power is normalizing judgement, which seeks to impose certain, precise norms on individuals (183-4). “The Normal” is an important force that imposes limits on behaviour; in our case, the “Normal” was “established in the effort to organize a national medical profession and a hospital system capable of operating general norms of health...” (184). A disciplinary institution, such as a hospital, seeks to reform its subjects by ensuring they conform to certain norms or standards and acting when those norms or standards are not met (Gutting and Oksala 2018).

Finally, the examination is a combination of hierarchical observation and normalizing judgement. An examination observes an individual to correct behaviour that falls outside of “The Normal,” “establish[ing] over individuals a visibility through which one differentiates them and judges them” (Foucault 1977, 184). A medical examination is an excellent example of this process: a doctor elicits information about the health of their patient, then changes the behaviour of the patient by treating them. Moreover, Foucault notes that the modern hospital has been organized “as an ‘examining’ apparatus” (185). He chronicles the development of the hospital into its modern form, where there is a “ritual” of a patient receiving regular, rigorous, and constant visits from doctors, so that the patient may be examined (185-6). Thus, the modern hospital has been built around this process which “transformed into a regular

observation that placed the patient in a situation of almost perpetual examination” (185-6).

With this in mind, hospitals’ institutional drive for a “perpetual examination” of their patients is best represented by Foucault’s analogy of the Panopticon. Philosopher Jeremy Bentham imagined a prison in which every inmate was in a separate cell, unable to see one another, but visible to a central tower monitoring them. The power of this model lies not in the observer in the central tower, but from the fact that inmates do not know if they are being observed or not. Thus, they must behave as if they are being monitored at all times, creating an internalized authority that controls their behaviour (Gutting and Oksala 2018). Foucault (1977) used the Panopticon analogy to describe modern society as a “disciplinary society,” but he also uses it to describe disciplinary institutions (209). In a lecture on the hospital, Foucault argues that, for an institution to exert disciplinary power, “[i]t is necessary to keep [individuals] under surveillance to ensure activity takes place all the time and submit them to a perpetual pyramid of surveillance” (as cited in Lambert 2013, 41). Foucault (1977) observes that the panoptic model is “polyvalent in its applications; it serves to reform patients, but also to treat patients...” (205). We can see the reflection of the Panopticon within the modern hospital driven by the logic of perpetual examination. A patient must remain “disciplined” – in the sense that they are conforming to the medical “Normal” – and thus, constant, hierarchical observation must occur. One might argue that a hospital, which requires an active observer to be monitoring at all times, is a poor Panopticon. However, whether there is an observer or not, we see the internalization of power through surveillance in a hospital. Beyond basic self-preservation, we can imagine that a patient is disinclined to perform an unhealthy behaviour (in the sense that they are acting in a manner contrary to their overall health and healing) because they know they are being observed; a lack of “discipline” would trigger a response from the observer. Without a doctor or nurse in the room, the patient internalizes the disciplinary power of medicine and polices themselves. Thus, we see that the hospital is designed and organized along panoptic lines, to facilitate the constant surveillance of those within its walls. Only then can medicine exert its disciplinary power – observing patients and imposing normalizing judgment through its perpetual examination.

The Hospital Panopticon and Patient Awakenings

It is through this model of medicine exerting disciplinary power, the panoptic model of organizing

perpetual examination, that we can explain late night and early morning awakenings. As I noted earlier, it is often the processes of medical examination that drive nocturnal awakenings: blood draws, measurements of vital signs, and response to alerts send by observing technology (Grossman et al. 2017, 303–4). For medicine to perpetually examine all patients at all times, a bevy of sleep-disrupting processes must occur. The nurse enters because of the panoptic logics of perpetual examination; no matter the hour, a patient must be observed, measured, and monitored to ensure that they are maintaining “discipline.” Sleep manifestly does not factor into this logic; despite the deleterious effects of sleeplessness on a patient’s health and wellbeing, sufficient high-quality sleep is not a part of the hospital’s processes of perpetual examination.

A skeptic would likely reject this description as needlessly negative. One might argue that “Patients losing sleep is an unfortunate phenomenon, but it is an inevitable by-product of processes designed for the good of hospitalized patients. ‘Perpetual examination’ merely refers to the tests and monitoring that are vital to the health of the very sick.” In this context, Foucault’s perspective seems irrelevant; what does it matter that medicine is exerting “disciplinary power” and perpetually examining its patients if it is for their health? Importantly, this description of the hospital does not presuppose that “perpetual examination” is a negative logic that should be eliminated or that the panoptic nature of the hospital is born out of some sense of malice on the part of medicine or doctors. Léopold Lambert (2013) notes that disciplinary processes are not “necessarily driven by a sadistic class seeing dominion over another... [t]he hospital is exemplary in this regard, as discipline is applied for its subjects’ own good, namely their health” (15). It is obvious that, in many cases, continuously observing a sick patient is beneficial or even vital to their health. A patient that requires a prompt response from doctors and nurses to changes in their health will appreciate the “perpetual examination,” even if they find themselves sleepless as a result.

Solving the Patient Awakening Problem(?)

I have used Foucault to conduct an institution-level analysis of the hospital and explained late night and early morning awakenings as originating from within the logics of the hospital as a disciplinary institution. What, then, is to be done with this explanation? Is there significance to a Foucauldian description of the hospital to solving the sleeplessness problem? While the idea of the “perpetual examination” does not reveal some malicious, intentional process causing patient awakenings within the modern hospital, it

does demonstrate where the problem originates. This understanding demonstrates that the processes of hospitalization itself – namely, the panoptic processes of perpetual examination – are the root causes of late night and early morning awakenings of patients. Nurse Brown recognizes this as well (although, as an on-political theorist, she arrives at this conclusion through her own knowledge, as opposed to Foucault). She cites the collection of laboratory tests, vital sign measurements, and other processes of medical examination as one of the primary reasons nurses must awaken their patients (Brown 2011). Meanwhile, solutions we see within the medical literature, such as sedation or the redesign of hospital soundscapes, seem to alleviate but not address the issues created by hospital processes. For example, neither solution seems particularly effective if one is deliberately jolted awake by a nurse seeking a blood sample. Our problem, I have found, lies within the institution of the hospital itself.

However, while we can assert that there is an institutional cause behind the problem of patient awakenings, it seems silly to tear down an institution as vital as the hospital to resolve that problem. Despite the drawback of patient awakenings, the disciplinary processes of the hospital are, in general, rooted in a concern for the health of patients. Moreover, it would be tremendously difficult to radically reform hospitalization away from perpetual examination and it is difficult to say such reform would not have serious deleterious effects on the health of the seriously ill. Rather, we can think of individual-level changes and adjustments to the processes of hospitalization such that patients are not needlessly awakened. Doctor Kunal Sindhu (2018) offers an excellent example of the type of approach a greater understanding can motivate. Sindhu questions the necessity of one of the key processes of perpetual examination – early morning blood draws taken from patients. He notes a motivation remarkably similar to the idea of perpetual examination, noting that “fear of missing a laboratory abnormality that could have been fixed... provides a powerful, if inappropriate, incentive to [perform regular blood draws]” (para. 7).

Consequently, I would argue that with this Foucauldian explanation in mind, individuals within the institution of the hospital can adjust the processes of perpetual examination to minimize sleep disruption. This could be a nurse adjusting their schedule to allow patients to sleep or an administrator reforming policy such that early morning medical tests are minimized. Another example could draw from Foucault’s argument that architecture is a key part of the hospital’s ability to exert disciplinary power (Lambert 2013, 15). One might

imagine a theoretically-minded hospital architect, cognizant of how disciplinary processes disrupt patient sleep, adjusting their design to allow for perpetual examination that minimizes patient awakenings. Thus, while the idea of eliminating perpetual examination within hospitals is absurd, given its importance to the health of patients, a critical examination of its processes by individuals within the institution can help tackle the root cause of patient awakenings. Rather than just alleviate the symptoms of hospital sleeplessness, we instead might enhance the very processes of hospitalization itself and emerge with tangible improvements in the health of patients.

Conclusion

Foucault’s analysis allows us to understand the origins of late night and early morning awakenings are the processes and structure of hospitalization itself. As the modern hospital has evolved into its current form, it has created an organizational impetus to perpetually examine its patients. Within this logic, every patient must be constantly and continuously surveilled, to ensure they maintain “discipline.” This impetus is reflected in the panoptic organization of the hospital and the processes that ensure every patient is always being surveilled. The exertion of disciplinary power within a hospital is not necessarily a bad thing; a “disciplined” patient is most likely a patient that is following the expert advice of their doctors. There is an unfortunate side effect, however: processes of perpetual examination, however beneficial, are usually disruptive to patients’ sleep.

However, while patient awakenings can be attributed to this institutional level explanation, solving the problem is more complex. It is absurd to simply reject the processes of hospitalization wholesale to solve the problem of patient awakenings; these processes exist for the benefit and health of patients. Rather, a Foucauldian analysis of the hospital should be applied in a more subtle manner. The objective is to address how the processes of hospitalization cause hospital sleeplessness to improve the health and wellbeing of hospital patients. This analysis underscores the importance for individuals within the hospital to be cognizant of the institutional forces shaping their choices, and critically examine, adjust, and adapt the processes of hospitalization to minimize patient awakenings. Such a critical lens can ensure that the sickest among us receive the sleep they need within the institution where they are brought to rest and heal.

Work Cited

Alvarez, Gonzalo G., and Najib T. Ayas. 2004. "The Impact of Daily Sleep Duration on Health: A Review of the Literature." *Progress in Cardiovascular Nursing* 19 (2): 56–59. <https://doi.org/10.1111/j.0889-7204.2004.02422.x>.

Birdja, Dilip, and Elif Özcan. 2019. "Better Sleep Experience for the Critically Ill: A Comprehensive Strategy for Designing Hospital Soundscapes." *Multimodal Technol. Interact* 3 (36). <https://doi.org/10.3390/mti3020036>.

Brown, Theresa. 2011. "Need Sleep? Stay Out of the Hospital." *New York Times*, September 7, 2011, sec. Health. <https://well.blogs.nytimes.com/2011/09/07/need-sleep-stay-out-of-the-hospital/>.

Evans, Jane C., and Diana G. French. 1995. "Sleep and Healing in Intensive Care Settings." *Dimensions of Critical Care Nursing* 14 (4). <https://doi.org/10.1097/00003465-199507000-00005>.

Foucault, Michel. 1977. *Discipline and Punish: The Birth of the Prison*. Translated by Alan Sheridan. New York: Pantheon.

Grossman, Mila N., Samantha L. Anderson, Aelaf Worku, William Marsack, Desai, Ambrosio Tuvilleja, Jacqueline Ramos, et al. 2017. "Awakenings? Patient and Hospital Staff Perceptions of Nighttime Disruptions and Their Effect on Patient Sleep." *Journal of Clinical Sleep Medicine* 13 (02): 301–6. <https://doi.org/10.5664/jcsm.6468>.

Gutting, Gary, and Johanna Oksala. 2018. "Michel Foucault." In *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta, Spring 2019 Edition. <https://plato.stanford.edu/archives/spr2019/entries/foucault/>.

Lambert, Leopold, ed. 2013. *Foucault. The Funambulist Pamphlets*. Brooklyn, New York: punctum books. <https://punctumbooks.com/titles/the-funambulist-pamphlets-2-foucault/>.

Schumacher, Laurence, Maria Dobrin, Damien Tagan, Annelore Sautebin, Anne-Laure Blanc, and Nicolas Widmer. 2017. "Prescription of Sedative Drugs During Hospital Stay: A Swiss Prospective Study." *Drugs - Real World Outcomes* 4 (4): 225–34. <https://doi.org/10.1007/s40801-017-0117-6>.

Sindhu, Kunal. 2018. "Are All of Those Morning Labs Really Necessary?" *KevinMD.Com*. February 18, 2018. <https://www.kevinmd.com/blog/2018/02/morning-labs-really-necessary.html>.

Wesseli, Hilde, Eva van den Ende, Jelmer Alsm, Jan Maaten, Stephanie Schuit, Patricia Stassen, Oscar de Vries, et al. 2018. "Quality and Quantity of Sleep and Factors Associated With Sleep Disturbance in Hospitalized Patients." *JAMA Internal Medicine* 178 (July). <https://doi.org/10.1001/jamainternmed.2018.2669>.

Wolf-Meyer, Matthew J. 2012. *The Slumbering Masses: Sleep, Medicine, and Modern American Life*. Minneapolis: University of Minnesota Press.