

“MERE SOURCES OF ERROR”: WORKERS, PATIENTS, AND THE  
REDUCTIVE LOGIC OF RATIONALIZED HEALTHCARE

MARNINA NORYS

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*"In consequence of the rationalization of the work-process the human qualities and idiosyncrasies of the worker appear increasingly as **mere sources of error** when contrasted with these abstract special laws functioning according to rational predictions.*  
~ Georgy Lukács, 1023/1971, p. 89, emphasis in original.

## Abstract

This project represents a sustained critique of the reductive logic of rationalized healthcare delivery systems which reduces the individuality of both workers and patients to little more than problems for the system itself. Drawing on social theory and ethnographic data, I show that wherever clients' needs or the caregiver's empathic responses to those needs threaten the efficient working of the system, both are taken as aberrant, as "mere sources of error".

In contrast to this systemic dismissal of workers' empathic responses to the personal needs of patients, I consider the basis in moral philosophy for the view that workers' caring impulses ground morality writ large and are essential in the provision of humane care. Hence, I argue, such feelings should be carefully heeded and cultivated rather than ignored and controlled. I also argue – in distinct opposition to modern managerial logic – that there are strong grounds, both moral and managerial, for less systemic control over caregivers' time and practices. A reduction in central control is important not only because adequate care is time-consuming, but because unstructured time and space are necessary for the development of the sort of caring attitude that is essential for humane caregiving practices. Time and space are also key for the cultivation of *phronēsis*, a form of wisdom that enables one to discern when a system, not a person, has gone wrong, and when efficiency *must* be sacrificed in the name of humanity.

While such reflections apply to healthcare delivery systems generally speaking, the development of morally wise and caring workers is especially crucial for work done with persons suffering from severe and persistent mental illness (SPMI). Because such

persons have been thoroughly marginalized in society, drawing them back into a community of care is essential to meeting their needs. Based on my own ethnographic observations, I contend that the ethos of Assertive Community Treatment (ACT) represents a refreshing departure from the rationalized treatment modalities that prevail in modern psychiatric facilities. The program, however, is becoming increasingly rationalized as it enters the mainstream, bringing pressure for more detailed management of workers' activities. The encroachments that are likely to follow from this intensification of management may well erode some of the most morally valuable aspects of ACT work.

## **Dedication**

I dedicate this dissertation to my mother who has provided me with an unfailing source of encouragement. She is also a living example of a compassionate and fiercely protective nurse who doted on her “preemies” and remained dedicated to the promotion of their individual flourishing for much of her career.

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## List of Abbreviations or Acronyms

ACT .....	Assertive Community Treatment
APU .....	Acute Psychiatry Unit
CBT .....	Cognitive Behavioral Therapy
DACTS .....	Dartmouth Assertive Community Treatment Scale
DSM .....	Diagnostic Statistical Manuel of Mental Disorders
EBM .....	Evidence based medicine
EBP .....	Evidence based practice
FGA .....	First generation antipsychotics
RTS .....	Rational techno-scientific
SGA .....	Second generation antipsychotics
TJM .....	.Theoretical-Juridical Model
SPMI .....	Severe and persistent mental illness
TMACT .....	Tool for Measurement of Assertive Community Treatment

## Introduction

*“We cannot solve our problems with the same thinking we used when we created them”*

*~ Connolly and Rionoshek, 2002, p. 175*

“Alexandra's death, in the end, was much like her life - solitary, troubling and overlooked” (Allemang, 2009, F1). This is how journalist John Allemang leads his story of a woman he describes as forced to live independently in “an indifferent community” and, who, he is quick to add, was dead for a day or two before her body was discovered. As a features writer and columnist, Allemang knows how to zero in on details that will instantly catch a reader's attention, and evoking a painful image of person dying alone and undiscovered for days fits the bill. We feel there's something intrinsically wrong with consigning anyone to a solitary death.

This sense of what persons are owed likely underpins a basic inability to grasp the mindset of workers in US hospitals who reportedly ignored psychiatric patients dying right in front of them. In the first of two incidents taking place in 2008 Steven Sabock, a 50 year old man diagnosed with bi-polar disorder choked to death on medication while nearby workers played cards and watched television. Several months later, at a different psychiatric ward Esmin Green lay on the floor dying, and the only attention she received during her 24 hour wait for a bed “consisted of someone's prodding of her dead body with a foot” reported the *Mental Health Weekly Digest* (2008).

Such incidents tend to provoke calls for more regulations and greater control over healthcare practices and practitioners. In the story above it is noted that “these would

include raising standards and regulatory expectations, and identifying and funding pilot programs to demonstrate best practices in psychiatric emergency, inpatient and community-based care.” Meanwhile, Alexandria’s lonely death caused her sister to conclude that “what we need is a 24-hour care system that’s regulated and controlled, where she’s got security, where she can get her medications administered in the right way, where her day has some shape to it and she doesn’t have to take on too much responsibility.”

A popular assumption is that both Alexandria and neglectful caregivers need better systems of management. No one quoted in Allemang’s article – not case managers, family members, lawyers, or her Assertive Community Treatment(ACT) outreach workers – suggested that a helpful factor would be a greater number of people in Alexandria’s life who, like her family, genuinely cared about her enough to support her and look out for her. This is true in spite of Allemang’s recognition that “if it weren’t for the attention, protection and advocacy provided by her family, whose patience she tested almost daily and whose love she could never quite exhaust, perhaps she wouldn’t have lasted this long.”<sup>1</sup> To show the importance of such obligation, he notes that after helping to clean smeared feces from the walls of Alexandra’s room in a residence for the mentally ill, her sister asked "who's going to scrub the windows and the floors if the family doesn't do it ... You can't stand the thought of your sister or your daughter sitting in that filthy room. You're doing it because you have to do it."

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<sup>1</sup> By all accounts, Alexandra was violent and difficult to deal with. She had threatened her own family members with a knife and was charged for assault after closing a car door on a stranger’s head and made death threats to housemates.

Even living in the kind of facility described by her sister, Alexandria would require people who cared enough about her to poke their heads into her room to see how she was doing and who similarly could not stand the idea of leaving her to languish in squalor. That no one mentioned this very obvious gap in Alexandria's life is probably due to an implicit understanding that this is not something that social institutions are meant to provide. One cannot teach a person to care about another in the same way that one might impart a practical skill such as checking an IV or changing a bandage. We cannot make workers care on demand.

In spite of this implicit understanding, people are still aghast when hearing about a more recent case where inspectors entered a US psychiatric ward for the elderly and found some patients covered in feces. Others were cowering and fearful and several patients reported that the staff were unkind. "At any given time," during the visit, the inspectors wrote, "there were two patients crying"" (Conaboy, 2013). The president of the facility states that "a change in culture among unit staff is paramount," hence managers decided to have workers go through "patient rights training, which included watching a four-minute video on empathy." Such a minimal and inadequate response from the upper echelons suggests that a far more radical cultural shift needs to occur; one that includes both the administrative culture as well as that of workers dealing directly with patients.

The suggestion that more intense management will somehow solve the problem of callous indifference from workers is a little mysterious. Closer monitoring and control over workers' activities may result in a cleaner environment and timelier services, but it

will not cause staff to become more kind. In fact, I argue that exerting more control over the work process is not only ineffective here, but actually contributes to the problem by encroaching on the time and space necessary for bonds between healthcare workers and patients<sup>2</sup> to take root. This is not to suggest that if workers are left to their own devices they are guaranteed to develop care for patients; rather, such moves need to take place within a workplace culture that explicitly prizes caring relationships and idealizes them within the professional sphere.

It is important to realize that the ability to develop a caring relationship hangs crucially on the ability to see and appreciate another person's uniqueness. For example, as a reporter intent on evoking our sympathies, Allemang knows precisely how to humanize his subject. Before he is more than a few lines into the story of her death, he tells his reader that "Alexandra Smith loved animals and showy jewelry, found companionship in coffee and cigarettes, adored Madonna's music and cherished the isolation of her tiny, private room." This information is key and appears at the top of the story because these small biographical details tell us that this is a unique individual worthy of our care. With a similar point in mind, Elyn Saks, a law professor diagnosed with schizophrenia, asks people to "portray [people with mental illness] sympathetically, and portray them with the richness and depth of their experience as people, and not as diagnoses" (2012). As will be shown in later chapters, learning to see others in this way can reconfigure a person's sense of what matters.

Such personalistic forms of knowledge do not carry great value for those working

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<sup>2</sup> It should be noted that through this work I use "client" and "patient" interchangeably.

at an administrative level, even in settings designed to provide professional caregiving. Bureaucrats who manage by numbers are poorly positioned to see clients as individuals. As a result they develop structures that severely constrain workers' ability to meet their clients' needs, a condition that ends by harming the worker as well. Given the frustration that so many workers experience in being barred from meeting patients' all-too-evident personal needs, it should come no surprise that at least some workers resort to dehumanizing patients and become inured to their suffering.

### **Trivializing the significance of relatedness and discourses on power**

When examining the emotional dimensions of social relations, one obstacle a researcher is apt to encounter is a subtle bias within academia and the professional sphere against representing interpersonal relations and feelings as legitimate objects of discourse. One of my informants featured in Chapter Four reveals the inferior status of such information in the context of public discussion. Beth, a nurse with an assertive community treatment team (ACT) was commenting on the influence of her parents on her work. "I guess I learned—this sounds so unprofessional—but to just kind of have a heart for people," she said. On further questioning Beth explained that it was the expression "having a heart" that did not sound professional even if caring about one's clients was important. "I don't think any of us would say that in a team meeting,<sup>3</sup> 'having a heart.' That wouldn't stick to anything." An interesting contradiction is at play here where the affective dimensions of the work are recognized as valuable and important, yet carry little

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<sup>3</sup> As I explain in greater detail in Chapter 4, ACT teams hold daily team meetings to get updated on the problems and progress of a roster of psychiatric patients the team for whom the team provides care.

weight in decision-making, nor should these be made explicit in the course of a formal discussion.

The notion that a prohibition might exist against explicitly endorsing such values within professional contexts is borne out by Joyce Fletcher's work which shows that relational work is often "disappeared" in the workplace (Fletcher, 1998). That is, in evaluating workplace performance, employers and employees alike systematically overlook the value of activities such as teambuilding, mentoring, and offering other forms of support to coworkers. Such activities, finds Fletcher, are neither cultivated nor recognized even though cooperative behaviour and friendly interactions are known to provide the glue that holds organizations together. As Mastracci et al, note, moreover, "emotional labour" or the ability to sense emotions in others and to respond appropriately is an essential skill, yet undervalued in service sector employees (2010, p. 124).

Academia, it would appear, is not a particularly more hospitable environment for discourses on relatedness. Michael Hardt, who has been incorporating the concept of love into his political work notes "in many contexts, especially the normal university context, it's very uncomfortable to talk about love. When I start talking about love, people start squirming in their seats, they think I've been around Italians too long" (Hardt, 2007). While talk of emotions is not well tolerated within certain intellectual spheres, Hardt's example suggests that this attitude may well extend to the topics deemed worthy of scientific investigation. As psychologist Harry Harlow notes

[t]he little we know about love does not transcend simple observation, and the little we write about it has been written better by poets and novelists. But of greater concern is the fact that psychologists tend to give progressively less attention to a motive which pervades our entire lives. Psychologists, at

least psychologists who write textbooks, not only show no interest in the origin and development of love or affection, but they seem to be unaware of its very existence (1958, p. 673).<sup>4</sup>

As the offspring of healthcare workers, where my father was a psychiatrist and my mother a nurse, I have become sensitive to the relational and affective underpinnings of healthcare work. In light of this background, and the consequent knowledge I have gleaned regarding the difficulties of their jobs, I harbour both care and respect for healthcare workers generally speaking, and find myself concerned about their working conditions. This is especially true of mental health workers who are willing to take on what I see as a crucially important role in patients' lives, but one that I myself could only assume with great difficulty. Undoubtedly, this attitude has coloured my analysis here and possibly opens me up to certain critiques. For example, in spite of borrowing from Foucault at certain points, I mainly focus on the emotional caring side of client/patient relations in lieu of a more critical analysis of the power deployed by healthcare workers.

Arguably, ACT teams in particular can somewhat easily be conceptualized as agents of Foucauldian governmentality (Foucault, 1991). Being workers who bring their practice into the community, ACT workers admittedly draw out the long arm of

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<sup>4</sup> Harlow's observations may appear dated, but a more contemporary example of an apparent aversion to sentiment in academic psychology is evidenced in Sebastian Kraemer and Jane Roberts' introduction to a book on attachment theory. In making a case for the importance of personal attachments, the authors note that "there is a serious risk that some readers will recoil from the argument, as if it were merely an invitation to 'love thy neighbor.'" The writers also take pains to distinguish their work from "an appeal to sentiment" stressing that it is "quite the reverse." Attachment theory makes a "serious contribution" they contend and is "hard headed stuff" adding that "if the notion of attachment means anything at all to the general reader it tends to conjure up a rather syrupy picture of loving contentment, such as a mother and baby enjoying each other's company." (1996, p. 6). It would appear that writers are anxious to position their work within the "hard" sciences as opposed to being perceived as champions of soft and syrupy sentiment, talk of which, or so they seem to assume, holds no rightful place in serious discourse.



surveillance into citizen's private homes. Workers also monitor for deviant behaviour, stress self-regulation to clients, and endlessly strive to win patients' compliance with treatment. Moreover, this is all done in the name of imposing a conception of normalcy upon patients' behaviour. None of the data I present here is inconsistent with such a view. However, as I note in Chapter One, such approaches represent well-trodden terrain. I would also argue that analyses of power relations, or examinations of the tactics and strategies used to modify people's behaviour, provides an incomplete picture of the social. For instance, ACT teams, as I shall show in later chapters, not only seek to manage and control clients, but they also aim to know and connect with patients as unique persons, and often seem to establish caring relationships along the way.

Generally speaking, the need to connect and experience care and nurturance are important motivators of human behaviour that stand to become obscured if we are only looking at a field in terms of power relations. This latter sort of theoretical framework, in fact, can cause valuable knowledge pertaining to affective care to recede from view.<sup>5</sup> The

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<sup>5</sup> Feminist philosophers have helped to drive home the point that we're missing something crucial about human existence when we ignore the less strategic and more emotional side of social relations. A short story some use to show this is Susan Glaspell's "A Jury of Her Peers," that was latter adapted into the play "Trifles" (Hedges, 2002). In this story a farmer John Wright has been murdered and some men gather to investigate. Meanwhile, alongside them, their wives sift through very personal clues. Barren furnishings reveal a stingy humourless husband, a half cleaned kitchen tells them of the wife's depression, otherwise immaculate stitching gone awry speaks to them of Minnie's agitation. Then, the dead body of a songbird with a broken neck cinches the deal. They *know* Minnie killed her husband. The song bird, as it turns out, was one of the few things that brought her any joy. Having known the woman for years, they knew how John Wright had stifled her and robbed her of love and care. Concurrent to the women's investigation, the men fruitlessly search for objective evidence of the murder, for instance the murder weapon, while dismissing or completely misinterpreting the same details the women find salient.

Women are always concerned with "mere trifles" one of the men says in the story, which helps to encapsulate the dismissal of the special brand of knowledge the women deployed in search of answers. Another example of this dismissive attitude is Donna Haraway's story about highborn women openly expressing their dismay while Robert Boyle slowly suffocated a live bird at a public demonstration of his vacuum. Boyle's response to this was to hold demonstrations well past the hour when any wellborn lady

value of discourses on power is that these tend to invite critiques of oppressive or coercive social relations. Less, however, gets said about what should exist in place of this. Contributing to an alternative kind of discourse, one that reflects upon ideal social relations, strikes me as equally worthwhile, and hence I aim to do this here. None of this is contrary to critiques of power. Rather, I see it as complimenting such critical perspectives, or ones that so often point the way towards that which divides and conquers. My work, conversely, aims to shed light on factors that stand to strengthen, as opposed to those which dissolve, relationships and communities.

## **Methodology**

It should be evident then that one of my main motivations in carrying out this work was to challenge the kinds of biases that drive talk of relatedness from the field of public, and especially academic, discourse. My primary question was whether rationalized modes of organization tended to squeeze the affective dimensions out of professionalized caregiving, especially within psychiatry, and, if so, what the moral implications might be. Is rationalized healthcare harmful to patients in some specifiable way? And what about the workers themselves? When healthcare is scripted by efficiency algorithms and “best practice” protocols, what remains of the satisfactions of caring for others that likely drew many to their careers in this field? The case of persons diagnosed with severe mental illness is of special interest, given the lack of elementary human

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would be seen in public (1997, p. 27). Rather than entertaining the notion that the women might have seen relations that were genuinely amiss, they were merely excluded from discourse.

community that so many of them experience. Does highly rationalized care respond to this problem or serve only to deepen it further? Questions of this kind call for an interdisciplinary approach that draws on both critical social theory and moral philosophy, applying them in ways that can illuminate the results of observation from the ground floor of practice.

My effort to understand the human effects of rationalization was most informed by the work of Max Weber. Like Weber, I have tried to examine the internal structure of rationalized systems and their general ideological consequences, while prefacing out, to some degree, questions about the particular political interests being served. I also draw to some extent on the work of other well-known critical theorists including Marx, Lukács, Marcuse and Foucault, as all have insights into the effect of highly rationalized modes of organization on social relations.

My own focus, however, is both broader and narrower than that of most of these thinkers. It is broader in the sense that I am not concerned specifically with a capitalist context, but rather contexts that essentially rely upon standardized procedures to administer or medically treat large populations. However, my problem is also more narrowly defined in that I am asking about the negative impact on human relationships that such systems might have. Hence, while critical theory represented a starting point for my enquiries, I present my own formulation of the ideological parallels linking the three dominant forms of rational technologies, which are mass production, bureaucracy and science, as well as the consequences for human relationships in settings governed by these technologies. In order to demonstrate the converging impact of these technologies

on patients and workers in healthcare, I then turn to ethnographic research conducted in both general healthcare settings and institutions specializing in psychiatric care.

In trying to theorize the moral contradictions at play in these settings, I soon realized that the problem had its counterpart in a divide between two very different kinds of moral theory. One of these is the rationalistic, universalist, rule-bound approach to morality that has dominated ethical debate in its various (and often conflicting) forms since the time of Kant and Bentham. This is the type of moral discourse that typically serves to guide and at times justify healthcare policies. The other approach is one that has developed much more recently in the field of care-based ethics, as exemplified in the work of Gilligan, Noddings and Dillon. While rationalistic ethics helps us to understand the moral reasoning behind the standardized procedures that inform most healthcare settings, care-based ethics shows us what those procedures invariably miss: the critical and irreducible importance of the personal encounter between caregivers and patients.

In following these questions from the realm of theory into the arena of everyday life in actual healthcare settings, I wanted first of all to learn about the impact of rationalistic administrative systems on the quality of care as reflected in the experience of patients and caregivers. What harms, if any, seemed to arise from rules that suppressed personal connections between caregivers and patients? I also wanted to know whether workers themselves valued relatedness, and whether institutional settings gave rise to moral contradictions stemming from conflicts between a personalistic ethos and rationalistic demands. It was also important to try to understand what it was about their work that caregivers themselves viewed as morally worthwhile.

To throw light on these issues I began by reviewing a number of ethnographic studies of conventional healthcare in both general medical (Campbell and Rankin, 2006) and psychiatric settings (Rhodes, 1995, Letendre, 1997, Cleary 2004, and Donald, 2001). The results of this review are summarized in Chapter Two. It was in light of this background that I sought to understand the contrasting world of ACT, a more individualized approach to psychiatric outpatients that held out the hope of embodying some of the concerns at the focus of care ethics.

While my decision to study ACT was shaped partly by circumstance and the good fortune of a local ACT team prepared to host me as an observer for six months, I quickly realized that ACT was ideally suited to my research for three reasons. Firstly, a great deal of ACT work is focussed on the long-term maintenance of the therapeutic relationship with clients. Hence, there was reason to suppose that such caregivers would be apt to value relatedness, and might even have something to teach us about an ethics of care not yet fully captured by moral theorists. In such a vein, it was also possible that workers possess a fine-tuned understanding of what is required to form solid relationships. Such insights, in turn, might better reveal existing limitations imposed by institutional frameworks on relatedness, while also further informing work in care-based ethics.

Secondly, ACT developed largely as a response to the shortcomings of conventional systems in providing a decent level of psychiatric care. Insofar as ACT represents a departure from standard psychiatric practice as well as a sustained attempt to provide individualized care, the program design offers an instructive response to the

limitations of rationalized healthcare systems. Finally, as I learned over the course of my research, ACT work is literally spreading across the globe and may well come to represent the future of psychiatric treatment for people diagnosed with severe mental disorders. Hence understanding the program and tracking its development becomes important in appreciating what may be at stake in this transformation.

My approach to ethnographic research has been guided in large measure by the precepts of interpretive phenomenology as practiced by Patricia Benner and others (Benner, 1994, Smith et al, 2009, Lopez and Willis, 2004). This is a qualitative method used to observe a small number of informants which aims to understand another's lived experience in her own terms. Given that ACT teams typically have less than sixteen members, this method was appropriate. Interpretative phenomenology requires the researcher to dwell empathetically and imaginatively in research participants' experiential worlds while engaging in reasoning and analysis that aims to discern their practical concerns and lived experiences. A researcher aims to go in with as few preconceptions as possible in order to allow genuine patterns to emerge.

Due to limitations imposed by the research ethics review board for the ACT team's home institution, and in the name of patient privacy, I was not able to include observations of clients as part of my research. Hence, my observations were largely limited to interactions among workers in team meetings, and these were further supplemented with interviews near the end of my study period. Fortunately the team meetings proved to be an excellent and very natural setting for ethnographic observation,

and the exchanges that took place there turned out to speak directly to the kinds of questions guiding my research.

Given that talk around a boardroom table is necessarily a limited way of revealing value, I also found it necessary to supplement my own observations with the findings of Paul Brodwin (2008, 2010, 2011), an anthropologist whose ethnographic study of an ACT team over two years fortunately extended to observation of the team's interaction with patients in the field.

### **Outline of the Argument**

In my first chapter I show how a worldview dominated by mechanistic logic strengthens an intellectual climate in which relational concerns are devalued. Rational technologies, or assembly-line styled processes, are colonising an ever-broadening share of the human services. One assumption of this dissertation is that rationalized systems are necessarily ill-equipped to accommodate human beings in all their complexity. Inevitably, particular persons each situated within their own unique particular contexts outstrip the resources of mechanistic apparatuses designed to work on a large scale by producing a limited range of outputs. When this occurs, however, the blame usually falls on the person rather than the system.

Along with Georgy Lukács, I challenge the mechanistic logic that reduces persons to “mere sources of error,” and hold that instead we ought to cast a critical eye at the broader machinery that deforms workers in sometimes painful ways. As I shall show, there is a marked tendency in rationalized bureaucratic systems to assume that in the

event of a discrepancy between the system's outputs and the requirements of particular persons, the fault lies with the person rather than the system. The same is true of workers unable to meet the demands such systems place on them.

When we layer what I call the rational techno-scientific (RTS) paradigm<sup>6</sup> onto such assumptions, then complaints of people being served by, or working within the framework of, such systems are apt to remain unheeded. This is especially true if their difficulties stem from concerns about the inferior quality of the human attachments they are capable of forming. As I shall describe at length, a paradigm which prioritizes economism and efficiency, objectivity, quantifiability, and standardization, but which deemphasizes interpersonal concerns, is very much at home within bureaucratic, productive and scientific spheres. Given the convergence of these three intersecting arenas in a wide range of healthcare settings, systems designed in the name of efficiency end up encroaching on the time and the space necessary for personal relationships – in other words, for the “caring” part of healthcare.

In my second chapter, I showcase the human consequences of such influences by looking to ethnographies describing healthcare practices. Here it becomes apparent that the logic that locates persons as sources of error serves to “other” particular kinds of clients or construe them as less worthy of care and concern. Workers’ own empathetic distress, as it pertains to the harms produced by rationalized systems, tend to be minimized and similarly treated as a source of error. Meanwhile in psychiatry we see that

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<sup>6</sup> Rational in this term is meant to capture the emphasis this mindset places on instrumental reason, techno refers to the mechanistic view of nature, and scientific evokes the enormous importance of objective forms of knowledge for this worldview.



discipline becomes a key treatment modality for patients who are themselves quintessential sources of error relative to their rationally prescribed societies.

In Chapter Three I engage in a moral assessment of the modern healthcare environments described so far. First, however, I show the deficiencies of a ratio-centric style of moral theorizing for navigating interpersonal relationships. I then advance a care-based ethics to address the shortfalls of more conventional, and largely academic, ethical approaches. I also introduce a set of practices that will be used later to analyse ACT work, and which some theorists contend can, at minimum, inform a moral agent about the outline of an attitude consistent with care. In light of reflections from an ethics of care it becomes evident that imposing the technologies of mass production onto the provision of human services is intrinsically problematic. Meanwhile, relying exclusively on rationalistic moral theories, and hence failing to heed intensely felt responsibilities occasioned during face-to-face encounters, can create potentially painful paradoxes for workers.

Finally, I seek to challenge the assumption that the suffering workers themselves experience in the course of their working day is a mere source of error. The empathic suffering of workers represents crucially important information for assessing the acceptability of rationalized technologies that we have trusted to determine care. Workers, I conclude, are a crucial first line of defense against systems that have gone morally astray. Ignoring their input and restricting their freedom to respond to others could potentially cause them to become inured to the suffering of their charges, or even the stunt the development of workers' own moral wisdom.

Up to this point, however, I have only been assessing inpatient care. However, ACT, a treatment modality unlike anything that had come before now brings treatment into patients' own homes and communities. As I show in Chapter Four, ACT work represents the vanguard of mental healthcare for those diagnosed with severe mental illness, and is hence an important area for any researcher aiming to provide a complete picture of the state of modern psychiatry. Meanwhile, the very need for this brand of program speaks to the deficiencies of population-based approaches for the provision of adequate human caregiving. At the end of this chapter I also describe the current state of ethical debates around ACT in order to better situate the morally-focused ethnography that follows.

In Chapter Five I depart from standard critique and begin by highlighting certain valuable aspects of ACT work as seen through the lens of care ethics. As Fletcher's work shows, such acts are liable to be "disappeared," hence an analysis of this kind holds value while also showing us concrete examples of those aspects of the work worth preserving. It would appear, moreover, that these morally valuable aspects of the work are achievable in part because workers have the necessary authority, time, and space to carry their work out as they see fit. Despite such positive evaluations of ACT work, I shall also demonstrate that the RTS paradigm constrains ACT work in ways that ultimately cause workers to suffer. Having already argued in Chapter Three that workers' own suffering matters deeply for our moral assessments of caregiving, and this is especially true if this suffering stems from a felt concern for clients' wellbeing, I go on to examine other sources of defeat that ACT workers are prone to experience due to the limitations on their

ability to significantly improve their clients' lives. My own modest proposal to address challenging working conditions is to encourage workers to also employ the space of the team meeting to arrive at a richly intersubjective and more nuanced understanding of their clients.

Having shown how an emphasis upon the values of objectivity and quantification impinge upon ACT work by making an already difficult job more emotionally trying, in Chapter Six I draw my earlier discussions of reification, economism and efficiency as well as standardization back into my discussion to inform a prospective look at ACT work. In this chapter we see that clinical researchers are using the concept of “fidelity” to signify remaining true to an abstract model of ACT. By showing that this model has been designed primarily to achieve cost savings, I suggest that this use of the term departs significantly from an everyday use of the term implying loyalty to and support of a particular person.

In fact in this chapter I suggest that if it becomes standard practice to employ scales devised to measure program fidelity, ACT teams may be altered in ways that erode some of the more morally valuable aspects of the work carried out by the team I observed, a team whose work is not currently subject to such assessments. Based on my arguments from Chapter Three, I conclude that if workers' concerns go unheeded and the “fidelity” model remains unchecked by those situated at the ground floor of practice, we risk seeing ACT workers gradually turn away – like so many in other care settings – from the needs of their suffering clients.

It is important to acknowledge here that this thesis is not about individuals such as Alexandria directly, or even her family. Admittedly, it is vitally important that firsthand accounts of modern psychiatric care come to light and to hear from patients themselves about the quality of the care they receive in modern mass societies. Hence, it is not without reservation that I focus almost exclusively on the situation of healthcare workers in the following chapters. Current ethical restrictions relating to psychiatric patients' capacity to consent, however, represent a systemic barrier for academic researchers interested in unearthing their stories. Moreover, issues related to the appropriation of marginalized voices mitigate against aiming to speak on behalf of persons diagnosed with SPMI. Fortunately, a growing consumer-survivor literature base exists that allows researchers to draw on the voices of clients themselves, and I have employed such work where appropriate in what follows.

Finally, although patients do remain my central, albeit tacit concern, insofar as I strive here to identify and articulate conditions best suited for the cultivation of wise and caring workers who work with people such as Alexandria as well as other vulnerable persons. In psychiatry caring workers who are skilled at cultivating relationships are doubly important, given that a key deficit clients suffer from is an inability to relate to and connect well with others. There is something to be said then for nurturing modern care workers both for their own sake, and for the sake of their clients. To do this adequately, however, will require an understanding of professional caregivers' unique situation if one wishes to grasp how workers can be pulled in different directions by competing demands and how such contradictions cause them suffering. Conflicted and

distressed workers likely do not make the best caregivers. There is a good chance that most people will one day find themselves occupying the role of a vulnerable other within a modern healthcare environment. Hence, we all ignore at our own peril the suffering of workers laboring under the conditions described in this work.

## **Chapter One**

# **Reification, the Rational Techno-Scientific Paradigm and Professional Caregiving**

*“Is it not possible that science as we know it today, or a ‘search for truth’ in the style of traditional philosophy, will create a monster? Is it not possible that an objective approach that frowns upon personal connections between the entities examined will harm people, turn them into miserable, unfriendly, self-righteous mechanisms without charm and humour? ‘Is it not possible,’ asks Kierkegaard, ‘that my activity as an objective [or critico-rational] observer of nature will weaken my strength as a human being?’”*

~ Paul Feyerabend, 1975, p. 154.

### **Two Different Styles of Professional Caregiving**

In her 1995 work on care in an American nursing home, Nancy Foner’s describes two nursing aides with very different nursing styles. Ana Riviera is described as patient, soothing and kind; she is exactly the woman we might hope to see care for our aging parents. Ana stroked agitated residents to calm them, thanked and praised them and in general was caring and respectful towards her elderly wards. For instance, Foner describes the aide quietly feeding “a frail and weak resident, cradling her with one arm and gently calling her “Mama” as she coaxed her to eat” (1995, p. 62). “It’s not just a job,” says Ana. “Some of them are lonely. They have nobody; they need love and understanding” (p. 63). By way of contrast, Foner also observed Ana’s colleague Gloria James taunt, bully and ridicule patients in front of nurses, doctors, administrators and visitors. According to Foner, Gloria’s “tactics at meals were Gestapo-like” (p. 60). For instance, one day she was overheard telling one patient to “shut up and eat you. Eat. You

think I have all day for you?” Later another resident was placed on a toilet and when she complained Gloria “barked” saying “sit there. Just sit. I don’t care what hurts, just sit there. Sit down, don’t bother me about being ready”(p. 61).

After the numerous historical reports of nursing home abuse cited by Foner, it is unsurprising to hear of clients receiving harsh treatment. What may give a reader pause, however, is learning that Gloria was “the nurse’s pet” (p. 58) and favoured by her supervisors. “She received the best evaluation on the floor and had privileges denied other aides. Indeed, when the two nurses were away from the floor, it was Ms. James whom they left in charge” (p. 61). According to Foner, supervisors preferred Gloria because “she was a fast worker. She finished her ‘bed and body’ work early and was punctilious about getting her paperwork done neatly and on time” (p. 60). Gloria’s fast and efficient working style extended to patient care, and she sought to hasten clients’ baths, meals, and apparently, bowel movements, to fit into pre-established routines. Ana, on the other hand, received numerous reprimands, mostly for circumventing bureaucratic protocols. Once she bypassed her supervisor and ordered supplies to reduce a patient’s discomfort, and other times made changes in routines in order to please her clients, prioritizing their needs over the requirements of the system put in place to manage clients. In spite of maintaining “a steady even pace throughout the day,” Ana’s paperwork was not always completed on time and her clients were often late to their scheduled 11:45 am lunch. “These are old people,” Ana explained, “you can’t rush them through, shove them this way and that to wash them. You have to be careful when you move them” (p. 64).

In spite of her empathy and demonstrated concern for the wellbeing of her patients, Ana ran into problems with her supervisor because she undermined the bureaucratic order structuring nursing home operations. “By placing the residents’ sensitivities and feelings before efficiency, she was, in effect, challenging the standards of her supervisor, the archetypical bureaucratic nurse for whom efficiency was all,” argues Foner. “If the rule stated that patients must be dressed in the dayroom by 11:45, then the nurse expected them to be there, even if this meant spending less time on such things as makeup” (p. 65).<sup>1</sup>

As Foner tells it, these sacrosanct routines were derived from procedures implemented to constrain the unrestricted environments of the past that were reportedly rampant with abuse. Tales of such abuse provoked widespread calls for nursing home reform. In the face of a public outcry to reduce the suffering of the elderly, it would appear that highly rationalistic procedures were implemented in a bid to control the behaviour of workers and to manage client care. As Max Weber argues, bureaucracy “is *the* means of transforming social action into rationally organized action” (1923/1971, p. 987, emphasis in original) which perhaps helps to explain why it will tend to be called upon to put new policy into effect. According to Foner, the bureaucratization of nursing home environments was something of a necessary evil insofar as an organized system helps to maintain standards of care and to limit negligence and abuse. She explains further that such bureaucratic operations “are governed by a system of abstract and impersonal rules applied consistently to particular cases. These explicit rules define the

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<sup>1</sup> One of Anna’s patients preferred being made up before leaving her room, which, of course, took time. Performing this extra service for the client had gotten Anna in trouble.



responsibilities of members of the organization and relationships among them. The rules are designed to ensure that tasks are done uniformly, at the right place and right time, regardless who is performing them” (Foner, 1995, p. 54). As such, bureaucratic governance can help to insure that all residents receive consistent, well-regulated care.

An interesting reversal Foner observes, however, is that the very same system implemented to curb abuse also undercuts the provision of compassionate care. This is because as she notes, “at every level of the nursing department, efficiency and organization were valued over compassion to residents” (1995, p. 67). While Foner is probably right in her conclusions regarding bureaucracy’s impact on relational work, her focus is overly narrow. In industrial societies professional care also falls under the sway of two other rationalistic systems: science and mass production. Hence to properly understand the rationalistic forces shaping the culture of modern caregiving, we must examine all three domains.

Hence, in Section I of this chapter, I examine the phenomenon of reification as it occurs in science, bureaucracy and industry along with the ideological implications of this phenomenon. In Section II I examine a set of values that are articulated in these three mutually reinforcing domains as they converge upon the provision of modern healthcare. The value set common to all three includes objectivity, quantification, efficiency and economism, and replication, prediction and control. I shall also note the manner in which a culture of discipline helps to support society’s reliance on rational technologies. In my third section I examine how the rational techno-scientific (RTS) paradigm emerging from the first two sections undermines direct human relatedness in caregiving settings. The

final section will show how and why human connectedness and other relational values are devalued by the relational worldview described here. As a result of the devaluation of caring work, healthcare systems are increasingly designed in ways that encroach upon the time and the space necessary for the development of trusting and nurturing relationships between workers and patients.

Many of the thinkers whose work I shall employ here, including Georgy Lukács, Herbert Marcuse, Michel Foucault and Erving Goffman, tend to concentrate on the authoritarian aspects of reified rational technologies, and show how such structures oppress individuals and quell resistance to current configurations of power. Theorists of a more Marxist bent, such as Lukács and Marcuse, are primarily concerned with the manner in which ideology associated with rational technology reinforces a false consciousness in workers that, in essence, causes them to act against their own best interests. As with Marcuse, my work emphasizes the “overwhelming rationality in this irrational enterprise” (1964/2006, p. 34). What is of special concern for me is seeing how the maintenance of rationalistic systems tends to take precedence over an impulse that probably attracted many to the healing professions to begin with, namely the felt need to reach out to others, to nurture them and ease their suffering. For, as I shall show, the quality of relations between workers and clients is eroded when they are situated within reified organizational structures, and this is especially true in psychiatry given the conflation of discipline and treatment within the field.

Admittedly, a substantial body of nursing literature exists that focusses on hindrances to nurse-patient relationships, because as Joan Liaschenko notes, in nursing

“the relationship is the vehicle for how the work gets done in the first place.” According to Liaschenko, however, “the majority of nurses articulate this relationship almost exclusively in interpersonal terms overlooking the role that macro-relationships hold in the structuring of micro-relationships” (2001, p. 129). As such an examination of the broader systemic factors that help to structure the field in which practitioner-client relations take root represents a modest contribution to nursing literature as well.

## **I. Reification: The Mechanistic Structuring of Healthcare**

Workers entering the field of professional healthcare encounter pre-existing bureaucratic and productive structures organizing their work, as well as an enduring body of assumptions, knowledge and established techniques derived from the sciences, especially the medical sciences. Even if some workers are not medically trained themselves, the odds are that they must answer to someone who has been, such as a doctor or a nurse installed to insure that the care provided is medically sound.<sup>2</sup> With the turn towards neoliberalism, many healthcare administrators are also being encouraged to look to the managerial techniques developed by industry to organize leaner, more cost-effective delivery systems. As Yasin et al note “the new realities of the healthcare marketplace are forcing healthcare decision makers to implement innovative operational philosophies, techniques, and tools that were proven in other industries to enhance the effectiveness of their organization” (2002, p. 268). As a whole, developments in

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<sup>2</sup> As many have claimed (Illich, 1975; Waerness, 1984, Hart and Wellings, 2002; Lane, 2008; Aho, 2008), a great many facets of human existence including mental health, sexuality, reproduction and aging have been medicalized, or have fallen under the purview of medically (i.e. scientifically) trained authorities.

healthcare are influenced by the scientific paradigm and the bureaucratic ethos, as well as by a value system inherent in capitalist mass production.

One feature these three systems have in common is that they are highly mechanistic. Modern bureaucracies and mass productive techniques, for instance, are understood as forms of what Herbert Marcuse calls rational technologies. This is because both rely on largely automated and broken-down assembly-line-style processes predicated on the division of labour, while tasks are determined by pre-established and rationally derived protocols. According to Weber, in fact, a fully developed bureaucratic apparatus compares “exactly as does the machine with the non-mechanical modes of production” (1923/1971, p. 973). As with systems of mass production not only are bureaucracies guided by a mechanistic, or algorithmic logic, but Weber also notes improvements in the speed of operations, precision and continuity are gained at a reduced cost.

Neither Weber, nor Lukács<sup>3</sup> finds such parallels surprising given that both theorists see the mechanistic logic underwriting mass production as entailing its use in other parts of society. Lukács, citing Weber, notes “modern businesses with their fixed capital and their exact calculations are much too sensitive to legal and administrative irrationalities. They could only come into being in the bureaucratic state with its rational laws” (1923/1971, p. 91). Because the capitalist system is predicated on rational

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<sup>3</sup> In examining Weber and Lukács side-by-side various parallels become evident, for instance both remark upon a conception of a judge as a rationalistic “automatic statute-dispensing machine” (Lukács, 1923/1971) or “an automaton into which legal documents and fees are stuffed at the top in order that may spill forth the verdict at the bottom along with reasons, read mechanistically from codified paragraphs” (Weber, 1922/1979, p. 979). Both men also discuss the bureaucratic ethos I shall discuss later. This sort of overlap is unsurprising once one learns that the two were not only acquainted personally, but carried on a life-long dialogue with one another (Tarr, 1989, p. 131).

technologies of scale, it requires an organized, stable, and therefore predictable social environment. Hence, other forms of rationalistic, and mechanistic management begin to take root and dominate various aspects of society.

The mechanistic logic characteristic of these first two systems extends all the way down to our very understanding of reality as revealed by the pursuit of modern science, and especially evidence-based medicine (EBM). As shall become evident, EBM aligns with a mechanistic worldview that envisions nature as a vast mechanism that can be coaxed to churn out her secrets in an orderly and predictable manner. Akin to bureaucracy and modern industry, EBM in particular represents an efficient form of knowledge production oriented to caregiving on an industrial scale.

### **Reified Machinations**

The prevalence of mechanistic systems in the provision of mass healthcare supports Ursula Franklin's contention that rationalized, broken-down technologies, have "spread like an oil slick"(1992, p. 27) in modern times. As Weber writes regarding the modern economic order, it

is now bound to the technical and economic conditions of machine production which today determine the lives of all the individuals born into the mechanism, not only those directly concerned with economic acquisition, with irresistible force (Weber, 1905/1958, p. 181).

Given such a process of acculturation, Franklin may be correct when she contends that "production-based models and metaphors are already so deeply rooted in our social and

emotional fabric that it becomes almost sacrilege to question them” (Franklin, 1992, p. 31).

This sense of naturalness attached to rational technologies as the only proper basis for production and management likely helps to reify such structures, as does the enduring nature of institutions employing such techniques. As Lukács argues, a worker entering into a rationally organized workplace “finds it already pre-existing and self-sufficient, it functions independently of him and he has to conform to its laws whether he likes it or not” and can therefore only “look on helplessly while his own existence is reduced to a particle and fed into an alien system” (1923/1971, p. 89). We enter into a world ready-made along such lines so that, as Marcuse argues, a certain “matter-of-factness” lends itself to the notion “that the machine is the factor and he [the person governed by rational technologies] is that factum” (1941, p. 91). In other words, the algorithmic processes derived from machine logic are necessary and absolute while humans are merely contingent means of facilitating pre-determined ends.

Generally speaking, a rationalistic system is reified when its abstract phenomena and the rules governing such objects’ behaviour are taken to be more real, or of greater importance, than the unique circumstances or individual history of the particular entities described or managed in virtue of such schemes. In what follows I shall identify two kinds of reification, the first of which I shall call “conceptual reification” and the second, “systemic reification.” Conceptual reification refers to the manner in which rationalistic explanatory schemes take on a more substantial reality than the world of everyday experience. In this way abstract objects and quantifiable phenomena come to be seen as

reflecting the underlying organization of the universe. This form of reification is associated with the sciences. The second form, or systemic reification refers to the tendency to see the classifications, dictates and aims of rationalistic systems of management or production as taking precedence over the idiosyncrasies and needs of those being managed or served by such a system. As we shall see, these two forms of reification are closely related.

### **Conceptual Reification**

If Plato's theory of forms is any indication, the tendency to reify abstract phenomena is nothing new to Western thought.<sup>4</sup> Historically speaking, the concept of reification first appears in Karl Marx's discussion of commodity fetishism in *Capital*. In his discussion of commodity fetishism in *Capital*, Marx describes a process where certain contingent regularities in the marketplace come to be taken as objective types of phenomena akin to natural kinds. The phenomena that Marx zeros in on in particular in this discussion is, of course, the commodity. As Marx describes the commodity, it appears to modern men in the marketplace utterly divorced from the productive processes and social relations that give rise to a particular product. This is because all commodities enter the marketplace stamped with a price and are therefore taken to be commensurable

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<sup>4</sup> In the *Phaedo* all that counts as knowledge is knowledge of the forms, or those abstract objects distilled down to their eternal and unchanging essence and of which everything in the world is nothing more than an imperfect copy. For instance, that which is beautiful, Socrates tells Cebes, is so "only in so far as it partakes of absolute beauty" (Plato, *Phaedo*, 100b). As with numbers such as the number two, which derives its meaning from the concept of duality, Socrates explains further, the only way that objects come into existence is in virtue of their "participation in the distinctive reality of that in which it participates" (101c). This shows one then, that the realm of concepts is on Plato's account, that which is real.

and related one to the other. However, value, Marx notes, “does not have its description branded on its forehead; it rather transforms every product of labour into a social hieroglyphic” (Marx, 1867/1990, p. 166). In Marx’s view, the prices assigned to commodities are deceptively simple because they in fact represent a complex historical process that gave rise to systematized market exchanges as well as the amount of “socially necessary labour time”<sup>5</sup> required to produce various kinds of commodities.

The mistake being made by the economists of his day, argued Marx, was to view value as intrinsic to commodities rather than recognizing it as the result of a developing set of historically situated social relations that underlie production and market exchanges.<sup>6</sup> Value then was thought to be something that a commodity *has* as opposed to representing something that men invest into products in virtue of their labour. Economists then take a bird’s eye view of the market that obscures the fine-grained relations underlying production and trade, favouring instead an analysis of abstract quantifiable categories of objects whose values are determined by supply and demand.

“Reflection begins post festum, and therefore with the results of the process of development ready to hand,” remarks Marx, explaining how the market comes to be represented as something akin to mindless matter set in motion by mechanistic laws rather than as a set of social relations. “It is however precisely the finished form of the

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<sup>5</sup> This refers to an average amount of time it takes to produce something, and is something that men come to agree upon over time and the value becomes fixed (presumably until technological advances serve to shorten this amount of time, at which time we’d see this value decreasing).

<sup>6</sup> Customary practises, such as the trading of 3 ounces of gold for a particular amount of iron, for instance, become entrenched over time so that the value as quantified in the weight of the gold comes to appear as an intrinsic property of the iron. Marx also sees “socially necessary labour time” incorporated into the concept of exchange value is what which is an average amount of time required to manufacture a product, and is something upon which producers and buyers come to agree upon over time and in virtue of social practices.



world of commodities – the money form – which conceals the social character of private labour and the social relations between the individual workers, by making those relations appear as relations between material objects, instead of revealing them plainly” (p. 169).

The upshot of this statement is that the formulas devised by thinkers of his day to study the market “bear the unmistakable stamp of belonging to a social formation in which the process of production has mastery over man, instead of the opposite, so that it appears to political economists’ bourgeois consciousness to be as much a self-evident and nature-imposed necessity as productive labour itself” (p. 175). In other words, the regularities of the market came to be seen as a natural state of affairs to which men must adapt themselves rather than representing a system that should be adapted to meet the needs of those toiling under its rule.

### **Conceptual Reification in Psychiatry**

In so far as modern psychiatric diagnoses abstract away from the psychosocial factors that give rise to them, they are analogous to the economic concepts discussed by Marx. With the medicalization of mental illness, various thinkers (Horwitz, 2002, Greenberg, 2013, British Psychological Society, 2011) argue that many diagnoses are mistakenly categorized as discrete entities each sharing biological basis yet to be determined. Bracken et al describe the mindset characteristic of modern psychiatry as the “technological paradigm” in which psychiatrists broadly accept that “mental health problems can be mapped and categorised with the same causal logic used in the rest of

medicine, and our interventions can be understood as a series of discrete treatments targeted at specific syndromes or symptoms” (2012, p. 430).

Given that mental illness is conceptualised as disease, Bracken et al also note that it is generally presumed that patients’ individual contexts, life history and experiences will be irrelevant to diagnosis. As such, these diagnoses may well be akin to the categories formulated by the economists of Marx’s day in that the complex psychosocial factors and social relations underlying certain observable regularities are ignored so that certain forms of distress or behaviour can emerge as distinctive kinds of disease. Drapomania, for example, or the tendency of black slaves to run away, is a favourite historical diagnosis that critics of psychiatry (Greenberg, 2013) often invoke to show how socially unacceptable behaviour tends to get labeled as pathological. ADHD, depression, and generalized anxiety disorder are more modern diagnoses that arguably follow a similar pattern.

In medicine in particular, there is reason to suppose that the rise of evidence-based medicine (EBM) and evidence-based practise (EBP) stands to amplify reification. In essence, explain Bracken and Thomas, EBM represents “the belief that medical practise consists of a number of different discrete interventions that can be compared with one another as to efficacy, cost and safety. Good ‘evidence-based practise’ involves using the interventions that are judged best by ‘consensus’ panels of experts” (2005, p. 168). As such, not only may certain diagnostic categories be mistakenly represented as real discrete entities, but treatments that work for most people so described will tend to emerge as *the* treatment for particular disorders.

## **Systemic Reification in the Workplace: Sources of Error**

The concept of sources of error is key for this dissertation and is drawn from Georgy Lukács' analysis of reified and rationalistic productive systems. Just as reified diagnostic systems abstract away from the particular characteristics and contexts of individual patients, so do such individual factors become secondary to the workings of the rationalized technologies employed for the purposes of mass production and mass administration. What I am calling "systemic reification" is a process first described in detail by Lukács, who starts with Marx's conception of reification and applies it to the factory floor as it were. According to Lukács, reification occurs when the abstract objects and processes internal to rationalised systems for production of administration come to take on greater reality or importance than the individual people implementing that system so that humans rather than the set-up of such systems are apt to be represented as "sources of error" when things go awry. To Lukács' insights I shall add that people served by said systems also stand to be reduced to mere sources of error within the framework of such systems.

It is evident from Marx's work how abstracting away from industrial labourers' gritty and monotonous day-to-day conditions helps thinkers dodge questions about the exploitation of workers, since economic theory seems to presuppose that the value of labour, like other economic concepts are entities subject to impersonal forces such as supply and demand. The operations of the market appear as the product of immutable forces of nature and are treated as such. Following upon Marx's work here, Lukács began

to examine the manner in which the highly organized and precise rationalistic systems underwriting mechanized mass production came to dominate the consciousness of the proletariat as well. As Lukács saw it, such productive processes along with the expected output of the system became reified. This is to say that the abstract system and its generalized categories are taken as givens, or come to take on greater importance than individual workers toiling in the factories. For Lukács, reification occurs when “a relation between people takes on the character of a thing and thus acquires a ‘phantom objectivity,’ an autonomy that seems so strictly rational and all-embracing as to conceal every trace of its fundamental nature; the relations between people” (Lukács, 1923/1971, p. 83).

Similar to the realm of Plato’s conceptual forms then, the meaningfulness of mathematically precise abstract objects gains ascendancy in the workplace relative to the contingent details of historically situated people entering into such systems. For it is just such details that stand to complicate the process of categorization, enumeration and calculation required for mass production. The division of labour within such productive schemes means that workers occupy highly specialized roles defined in terms of their function within the overall work process. Those implementing and overseeing the process, moreover, will aim to control and quantify a worker’s output in order to match predictions regarding the quantity and quality of manufactured products.

Within the scope of these highly organized technological apparatuses, argues Lukács, “the human qualities and idiosyncrasies of the worker appear increasingly as mere sources of error when contrasted with these abstract special laws functioning

according to rational predictions” (1923/1971, p. 89). In other words, qualities in a worker that interfere with the functioning of broader system will tend to be represented as defects. It is the worker who is assumed to have introduced “human error” into an otherwise perfect productive system because the system takes precedence over the needs and abilities of the workers. The onus will then be on the worker to modify and correct herself relative to the demands of the pre-existing mechanized process, rather than adapting the process to accommodate her particular dispositions or needs.

It is important to remember that Lukács was mainly writing about factory labour, especially insofar as he was commenting on Marx. If one extends his arguments to rationalized human services, it becomes evident that the individual qualities of both workers and clients will tend to be represented as sources of error. This is especially true if the dispositions or characteristics depart from expectations derived from rationalized schemes and thereby threaten productivity. In my final section, I take up this further implication of reification in greater detail. Moreover, in my next chapter I provide ample ethnographic evidence of both clients and workers being represented as mere sources of error if the empathetic responsiveness of the former, or the particularities of the latter, impinge upon the efficient functioning of broader workplace machinations.

## **II. The Rational Techno-Scientific Paradigm**

### **A Reoccurring and Mutually Reinforcing Set of Values**

Given then that we are examining mechanistic systems premised on large-scale uniformities, it ought not be surprising to see certain symmetries running through all

three spheres. In examining this triad of influences upon healthcare, in fact, I shall show how certain values are reiterated in each of these domains. A joint examination of these three domains will thus help to reveal how these systems stand in a relation of co-production<sup>7</sup> whereby the systems buttress and shape one another while the three discourses operate in tandem to strengthen a certain basic underlying set of assumptions about what matters. These mutually reinforcing presuppositions, combined with the enduring nature and social embeddedness of the rationalized systems being discussed, loop back to bolster the ideological impact of the overarching value set that I shall bring to light.

### **Objectivity and Impartiality: Just the facts**

A worldview that grants primacy to the seemingly independent workings of industry, bureaucracies or nature, reduces the role of human agency to one of dispassionate observation and intervention. Hence, the bureaucrat observes and carries out ordinances from above, the capitalist observes and tries to improve the bottom line, and the scientist observes and tinkers with the machinations of the natural world, and all three do so more or less dispassionately.

For example, the ideal of a “good” (that is, ethical) bureaucrat is one who applies the rules impartially. Weber argues of bureaucracy, that “it develops the more perfectly,

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<sup>7</sup> I am borrowing the term from science and technology studies. As Sheila Jasanoff holds “coproduction is shorthand for the proposition that the ways in which we know and represent the world (both nature and society) are inseparable from the ways in which we choose to live in it” (Jasanoff, p. 2). This is a paradigm in which practise and the production of knowledge are viewed as intrinsically interrelated spheres of activity that coexist in a dynamic feedback loop where developments in one will tend to shape the other and vice versa.

the more it is “dehumanized,” the more completely it succeeds in eliminating from official business love, hatred, and all purely personal, irrational, and emotional elements which escape calculation” (Weber, 1922/1971, p. 975). As Luther Gulick argues, public administrators “are supposed to be smooth running machines ... transmission belts” (cited in Mastracci et al, 2010, p. 127). Weber, similarly employs mechanistic imagery when he describes the quintessential bureaucrat as a “small cog in a ceaselessly moving mechanism which prescribes to him an essentially fixed route of march” (Weber, 1922/1971, p. 998). Under both descriptions one can see that the behaviour of administrators is determined by the system and as such, personal relationships and unpredictable emotional responses potentially gum up the rationalized systems of which individuals constitute mere appendages. Weber contends, moreover, that the demand for “equality before the law” in the personal and functional sense—hence the horror of “privilege,” and the principled rejection of doing business from “case to case” (p. 982) also help to drive the demand for impartiality in a bureaucrat.

Such requirements for impartiality combine with capitalism’s need for a stable social environment. In line with such demands the bureaucrat sees it as his duty to put personal feelings aside so as to “adhere conscientiously and meaningfully to general rule as well as special directive, even and particularly if, they do not correspond to his own political attitudes. This is appraised as its special virtue by capitalism” (Weber, 1922/1978, p. 1415).

Lukács, moreover, makes an interesting move when he marries Marx’s conception of alienation with Weber’s description of the bureaucratic ethos which

celebrates impartiality and detachment as moral virtues. In *Capital* Marx critiqued factories where the worker is “crippled to the point of abnormality” when he is “transformed into the automatic mechanism of a partial labour.” For Lukács, this disfigurement extends to the very consciousness of the bureaucrat, since “the more elevated, advanced and ‘intellectual’ is the attainment exacted by the division of labour,” the more profound is the crippling of the psyche.

The specific type of bureaucratic ‘conscientiousness’ and impartiality, the individual bureaucrat’s inevitable total subjection to a system of relations between the things to which he is exposed, the idea that it is precisely his ‘honour’ and his ‘sense of responsibility’ that exact this total submission -- all this points to the fact that the division of labour which in the case of Taylorism invaded the psyche, here invades the realm of ethics (1923/1971, p. 9).

Where Taylor adjusted worker’s movements to better accommodate the requirements of the machine, the bureaucratic ethos requires the worker to adjust his moral outlook to accommodate the demands of the abstract mechanistic system of administration.

According to Lukács then, even if an administrative worker’s body remains unaffected by the demands of his work, he is still mutilated by his working conditions. This is because he has internalized the importance of the requirements of the administrative machinery to such a degree that it comes to shape his very moral self.

Hannah Arendt’s remarks regarding the Holocaust touch on this last point of Lukács’ when she notes that

Much of the horribly painstaking thoroughness in the execution of the Final Solution—a thoroughness that strikes the observer as typically German, or else as characteristic of the perfect bureaucrat—can be traced to the odd notion, indeed very common in Germany, that to be law-abiding means not merely to obey the laws but to act as though one were the



legislator of the laws that one obeys. Hence the conviction that nothing less than going beyond the call of duty will do (1976, p. 137).

If we move from the bureaucratic ethos to the virtues expected of a scientist, we shall find that the bureaucrat and the man of science are not so dissimilar. Just as the bureaucrat's own psyche is expected to shape itself to reflect the ideals of the rational apparatus so that detachment and impartiality become part of his very moral code, so does a scientist's integrity depend on bracketing out his own possible biases so that his cognitive faculties mirror nature in an objective and disinterested manner. "Science is cold, hard, impersonal, 'objective'" notes Elizabeth Fee (cited in Code, 1991, p. 35).

Feminist epistemologist Lorraine Code adds that in regards to knowledge "produced in seemingly objective ways,"

Its alleged derivation from detached, pure thought permits it to claim superiority over modes of thought infected with emotional involvement and feeling. Out of this conception of the autonomy of scientific knowledge the conviction emerges that 'real' knowledge must be autonomous, detached from the subjective idiosyncrasies and circumstances of both 'observer' and 'observed'; abstract, independent and depersonalized" (1991, p. 35).

In his capacity as a scientist, a practitioner is expected to strip away any trace of himself from his observations while remaining disinterested in anything but the truth, for as Fee notes, subjectivity is "regarded with suspicion, as a possible contaminant of knowledge production and one which must be governed with stringent controls" (cited in Code, p. 34).

Just as bias might distract a scientist from the pursuit of objective truth, so does partiality stand to deter individuals' rational pursuit of their own objective self-interest under capitalism. There is reason to suppose, moreover, that medical practitioners are, at

least to some degree, influenced by the capitalist ethos given that the Ethics Primer of the American Psychiatric Association states that, “all medical services are dispensed in the context of a contractual arrangement between the patient and the physician.” (2008, p. 84). Writers in Canada (Deber et al, 2005), the US (Andereck, 2007) and the UK (Leavey et al, 1989) have also remarked on the drive to situate patients as “consumers,” thereby reinforcing doctor/patient relations as market-driven entities.

Weber, however, calls the rationalized economic structure underlying capitalism “an abomination to every system of fraternal ethics” (1922/1978, p. 637). This is because relations are determined by a market structure over which individuals have no control, but where the onus is upon each to honor her contractual obligations. Weber notes

There is no possibility, in practise or even in principle, of any caritative regulation of relationship arising between the holder of a savings and loan bank mortgage and the mortgagee who has obtained a loan from the bank, or between a holder of a federal bonds and a citizen taxpayer. Nor can any caritative regulation arise in the relationships between stockholders and factory workers, between tobacco importers and foreign plantation workers, or between industrialists and the miners who have dug from the earth the raw materials used in the plants owned by the industrialists. The growing impersonality of the economy on the basis of association in the market place follows its own rules, disobedience to which entails economic failure, and, in the long run, economic ruin” (p. 585).

As Weber’s account suggests, it is broadly understood that capitalism represents an impersonal system and our obligations to others, can, and sometimes must, be subordinated to the rational pursuit of economic interests. Because we are all trapped in the same system, there is a shared understanding of the manner in which other less rational considerations can lead to economic ruin. Within each kind of system, then, it is both reasonable and acceptable for individuals to distance themselves from the needs of

others. “It’s just business” says the Hooter’s owner to justify firing his pregnant cocktail waitress. “I’m just doing my job,” explains the security guard ejecting the homeless man out into the cold.

### **Quantification: “That is Real Which Can Be Measured”**

It is interesting to reflect upon the common use of the term “it counts” to signify that something matters, as such an expression points to the cultural significance of quantifiability generally speaking. Any outlook that prizes objectivity will also tend to value quantification given that numbers do not lie, as it were, and thereby represent something upon which all rational agents can agree. Moreover, within a public sphere dominated by technologies geared towards mass administration and production, the ability to measure phenomena and their effects is of fundamental importance. Arguably, the importance of quantification finds its roots in scientific thought, is intrinsic to production and carries over into bureaucratic forms of management as well.

On Isaac Newton’s mechanistic worldview phenomena that could not be measured “had no place in experimental philosophy,” a view that, according to Morris Berman, “has been the public face of modern science to present day” (1983, p. 43). The ontological significance of quantification also emerges from Max Planck’s truism “that is real which can be measured” (cited in Heidegger, 1977/1969 p. 169). This shows us that at the most basic level of investigation, anything that fails to lend itself to enumeration falls out of the basic fabric of reality. Planck’s staunch empirical attitude spills out from

beyond the physical sciences and into administrative policy. According to the author of a textbook on health measurement

Ensuring the quality of health measurements is supremely important, because decisions affecting the welfare of patients and the expenditure of massive public funds are based on the results of such measures; and pressure to monitor the outcomes of treatment is virtually universal (McDowell, 2006, p. 704).

Due to such pressures, a multiplicity of measurable constructs have arisen including social health, depression, anxiety, psychological wellbeing and quality of life (McDowell, 2006) all of which are accompanied by instruments designed to assign a numerical value to these concepts. For it is not simply enough to say that people are feeling or living well, in order to be seen as referring to something real it must be possible to assign a numerical value to one's claim.

Psychiatry has seen a long struggle to situate itself as a legitimate science (Scully, 1989, Shorter, 1998). According to psychiatrist David Healy, to this end, a shift occurred in the 1980's that saw psychiatrists taking up instruments such as the Hamilton Rating Scale for Depression in their practice (2002, p. 288). Unlike the scales, timers or thermometers typical of the physical sciences, the instruments meant to take measurements in psychiatry typically take the form of a checklist or a structured interview. While Hamilton did not include specific questions for his scale (McDowell, 2006, p. 371), others, for instance the Structured Clinical Interview for the DSM-IV (SCID) weigh yes/no answers to produce a score indicating levels of depression. Among the questions are items such "in the last month has there been a period of time when you were feeling depressed or down most of the day, nearly every day? (nearly every day? for

as long as 2 weeks?)” and “In the last month have you lost interest in things that you’d usually enjoy? (nearly every day? for as long as 2 weeks?)” (First et al, 1997). Answers to such questions are then weighted against criteria for a diagnosis. In this way, depression, as with other forms of diagnoses, has become, as per the demands of science, a real entity.

With their emphasis on profit, producers are as beholden to numbers as scientists, and bottom-line thinking permeates industry through and through. As noted, the technologies of mass production rely heavily on calculability as a means of controlling output. As Mastracci et al note in fact, within the assembly-line mass productive techniques characteristic of Fordist manufacturing tradition, work was defined “according to what was measurable about a job” (2010, p. 126). Measurable, in this instance, refers to technical competence, or abilities that directly correlate with increased production in clearly quantifiable ways such as increased output or profits. This way of assessing what counts towards good job performance carries over into techniques of administration where, as we see in mass production, “civil service systems are built on a foundation of formal descriptions that specify tangible elements of each job” (Mastracci et al, 2010, p. 128). As with production then, in a bureaucracy unless workers’ activities can be documented, enumerated and turned into a measure, it will hold little meaning.

As Weber contends, at the broader organizational level the existence of “calculable rules is the most important [element] for modern bureaucracy. The peculiarity of modern culture, and specifically of its technical and economic basis, demands this very “calculability” of results” (1922/1978, p. 975). In modern society, the core requirement

for the calculability of results is further demonstrated by the “audit explosion” described by Michael Power wherein public accountability is coming to be equated with a measurable value discernible via a mathematically derived auditing system that will often resemble a financial audit (Power, 1994, p. 13). Decisions about funding, moreover, will often be based on the outcomes of such audits.<sup>8</sup>

Hence, the enduring pressure to produce quantifiable results often prompts institutions to embrace numerical targets. In 1994, for instance, Britain’s National Health Service defined three primary targets: “to improve significantly<sup>9</sup> the health and social functioning of mentally ill people. To reduce the overall suicide rate by at least 15 percent by the year 2000 and to reduce the suicide rate of severely mentally ill people by at least 33 percent by the year 2000” (Sabin and Daniels, 1999, p. 115).<sup>10</sup>

### **Economism and Efficiency**

If quantifiable phenomena are all that is real, while an impersonal ethos carries the day, then instrumental reason takes precedence as the primary mode of reasoning within scientific and technological domains. As Hume argues, instrumental “reason is, and ought only to be, the slave of the passions” (1739/2011, 2.3.3.4) meaning that this

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<sup>8</sup> Wait times for hospitals, scores on standardized tests for students and the quality and quantity of publications for a university department are types of standardised measures that have been devised in order to audit the corresponding institutions (Shore and Wright, 2004).

<sup>9</sup> The fact the NHS did not provide a number suggests that the term is being used in its statistical sense. Statistical significance, moreover, need not be a major increase, but rather represents an level of increase high enough to demonstrate that the effect was not occasioned by mere chance, but was actually a result of an intervention.

<sup>10</sup> Each of these targets is readily amenable to quantification, and arguably, this is precisely why they have been selected. The first can be measured with rating scales, while demonstrating that the other two objectives have been achieved requires nothing more than a tally and statistical analysis of suicide rates.

form of rationality is incapable of generating values. Values are assumed by, and not derivable within, such a schema. Similarly for science, as moral philosophers are wont to remark, one cannot derive an ought from an is, meaning that rationalistic explanations of natural laws do little to inform one's system of values.<sup>11</sup> In a "disenchanted" world that construes the universe as mere matter in motion, it is very difficult to ground questions of value. However, if one's primary concern is to alter numbers in a predictable way, a natural stance to assume is one in which ingenuity amounts to deriving simple and reliable shortcuts to quickly achieve particular ends. As such it ought not be surprising to see economism and efficiency emerging broadly endorsed values.

In fact, it is also worth noting that such values are also as close to rationally derivable ones as could be hoped for within the framework of instrumental reason. Even in the sciences, economism and efficiency are key values reflected in the preference for simplicity in theories (Kuhn, 1977/1998, p. 105) and the celebration of Occam's razor as a means of paring down superfluous theoretical entities. For, as Einstein puts it, "the grand aim of all science...is to cover the greatest possible number of empirical facts by logical deductions from the smallest possible number of hypotheses or axioms" (Einstein, quoted in Norman 2010, p. 50). Admittedly, it is not mysterious how such values might have risen to the surface as primary ones in modern capitalist societies given their role in the tremendous generation of wealth achieved in virtue of faster and leaner productive

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<sup>11</sup> For instance, research aiming to show that sociopathy, for instance, derives from an adaptive trait could not be used to advance the argument that we ought to value the sociopath's behaviour.

systems. Nevertheless, whether the goal is production or explanation, economic constructs with maximum scope are the order of the day.<sup>12</sup>

As Herbert Marcuse (1941/1982) has shown, these unequivocal virtues of capitalist production turn all too readily into a general ideology. Over time those values associated with the technological productive base come to appear as the very embodiment of reason itself. Hence, once efficiency and economism emerge as especially useful tendencies in the context of mass production, these become articulated as social values that rush in to fill the vacuum created in a world dominated by technological rationality.<sup>13</sup>

The neoliberal tendencies that began taking root in the 1980's served only to reinforce the translation of capitalist values into social values. The new neoliberal era, based on the work of economists such as Milton Friedman, was ushered in by leaders such as Brian Mulroney, Margaret Thatcher and Ronald Reagan. According to David Harvey, proponents of the doctrine endorse "Adam Smith's view that the hidden hand of the market was the best device for mobilizing even the basest of human instincts such as gluttony, greed, and the desire for wealth and power for the benefit of all" (Harvey, 2007, p. 20). While consumer choice, which may strike some as the empowerment of regular

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<sup>12</sup> As I shall show in *Chapter Two*, the same can be said of modern moral theories.

<sup>13</sup> Theodore Roosevelt's historical comments about the patriotic dimensions of Scientific Management help to mark the transformation of these instrumental values into social ones. "Scientific management is the application of the conservation principle to production. It does not concern itself with the ownership of our natural resources. But in the factories where it is in force it guards these stores of raw materials from loss and misuse. First, by finding the right material – the special wood or steel or fiber – which is cheapest and best for the purpose. Second, by getting the utmost of finished product out of every pound or bale worked up. We couldn't ask more from a patriotic motive, than Scientific Management gives from a selfish one" (cited in Callahan, 1964, p. 20).



people, is taken to be the guiding principle for social welfare, the neoliberal shift has also resulted in the decentralization of government and a dismantling of the welfare state.

Showing the emphasis being placed on economism and efficiency in virtue of neoliberal theory, Sue McGregor notes further that “this powerful ideology has gained the upper hand, persuading officials, parliamentarians and congress that states are inefficient and private markets are more cost-effective and consumer-friendly. The result is cuts to social spending, including health care” (2001, p. 83). According to McGregor, health systems in the UK, Canada, United States, Australia and New Zealand have been the most strongly impacted by neoliberal policies. She writes

The neoliberal agenda of health care reform includes cost cutting for efficiency, decentralizing to the local or regional levels rather than the national levels and setting health care up as a private good for sale rather than a public good paid for with tax dollars.

According to Thomas Osborne, in the UK both managers and doctors have been coopted to further the neoliberal agenda in health and he cites UK’s 1983 Griffith Report to make this point. A recommendation of the report, notes Osborne is to bring administrative and clinical reasoning into alignment.

What is at stake is an effort to make truth administratively and economically efficient; to make, as it were, an economic rationality function as close as possible to the point of clinical decision itself. All the repertoires of ‘quality initiative’, ‘audit’ and ‘decision analyses’ that now pervade the Health Service also testify to this overlap between clinical and economico-administrative functions (1993, p. 353).

The point here is not the creation of profit, argues Osborne, but to imbue clinical rationality with administrative logic so that values such as economism and efficiency come to guide clinical decision-making.

This blending of clinical and administrative rationality, moreover, is evidenced in efforts to map the techniques of capitalist mass production onto the provision of medical care to make the latter as efficient and economical as the former. According to Kujala et al, a significant body of literature exists that aims to borrow from techniques characteristic of industrial commercial process in a bid to streamline healthcare delivery. Similar to proponents of neoliberalism, Kujala et al celebrate the success of the capitalist system in holding that “with the proper adjustments and conceptual translations, several of the methodologies that have contributed to the enormous creation of wealth in the industrial world can also be applied to health care” (2006. p. 512).

### **Standardization, Prediction and Control**

The sorts of techniques that Kujala et al are referring to involve implementing standardized productive processes within healthcare delivery systems. As in industrial production, administrators are better able to monitor and control resources if they insist that all relevantly similar cases receive identical forms of treatment or, as the medical jargon goes, follow the same clinical pathway. In industry, standardization is not merely a means of achieving efficiency it also affords a level of control that, should, in theory at least, allow for precise predictions. Meanwhile, as Kujala et al’s quote above suggests, the cultural acceptance of the legitimacy of industrial techniques stems, at least in part, from both the profit to be made from, and the dizzying array of human needs that can be met in virtue of, processes yielding uniform outputs.

In general, as much as industrialists, scientists or bureaucrats want quantifiable results, being able to predict the quantity and quality of these results is a key marker of substantive knowledge. Such a stance is not restricted to the physical sciences, as is evident from Goodwin and Guze's famous proclamation in their textbook on psychiatry that "diagnosis is prognosis" (1996, p. 300). This statement implies that the classification of mental illness is utterly contingent upon knowing what effects it stands to occasion and a further natural step is to begin to classify ailments in accordance with the kinds of medications to which a patient responds.

Ontology then, that is, the very manner in which we classify the objects of scientific discourse, relies upon being able to know how to cause each type to occur,<sup>14</sup> while also being able to consistently predict what further effects they will occasion. Not only do such classificatory practises presuppose that the natural world, like a machine, will reliably reproduce phenomena once we set it into motion in the right way, but prediction and control is essential to understanding within this paradigm, since operational definitions largely represent instructions for the production of a particular kind of phenomenon combined with reliable predictions of its effects. As Jasny et al note, in science "replication—The confirmation of results and conclusions from one study obtained independently in another—is considered the scientific gold standard" (2011, p. 1225).<sup>15</sup> Meanwhile, the need for replication can also shape one's conceptual scheme as

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<sup>14</sup> It is worth noting here the fact that precise causal mechanisms cannot be described for mental disorders is an aspect of psychiatry that is apt to draw out charges that either the diagnosis fails to refer to a real entity, or that psychiatrists do not actually understand the phenomena they are describing.

<sup>15</sup> This quote appears in a special edition of *Science* dedicated to data replication and reproducibility, which further attests to the importance of these concepts in science.

is evident in the field of psychiatry. According to Mayes and Horowitz, in fact, one of the reasons psychiatric diagnoses have come to be conceptualized as discrete disease categories in the DSM is because researchers required precisely defined categories in order to be able to produce replicable studies (2005, p. 256).<sup>16</sup>

### **Coalescing Scientific, Industrial and Bureaucratic Interests**

It is not difficult to see science's inherent promise for the harnessing of nature combined with the drive towards replicable processes and predictable outcomes stands to be exploited by industry. This melding of interests, in turn, results in a relationship of coproduction between the two fields. Within the field of health, the rise of EBM and evidence-based practice (EBP) help to demonstrate this convergence of the methods of medical sciences with the purposes of industry.

Regarding the prevalence of EBP Sandra Tanenbaum observes

EBP is ubiquitous. It has a powerful presence in the clinical literature and in plans for improvement of professional education, health care management, and health policy making. One commentator finds that physicians "can't kick over a bedpan without hearing the phrase 'evidence-based medicine' rattle out." EBP is more than a version of health care practice, however. It is a movement, like the outcomes movement before it, of scientists, public officials, private payers, and advocacy groups that seek to establish a new knowledge regime in health services (2005, p. 163).

The kind of knowledge that Tanenbaum alludes to here is primarily concerned with statistical regularities, since EBM is defined as "the use of mathematical estimates of the risk of benefit and harm, derived from high-quality research on population samples, to

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<sup>16</sup> If no one knows what anyone else means when they are conducting experimental research on depression, it will be very difficult to try to replicate findings.

inform clinical decision-making in the diagnosis, investigation or management of individual patients” (Greenhalgh, 2010, p. 4). Under such a paradigm “evidence which accrues from individual cases, from anecdote, from unusual or exceptional cases, these areas are ruled out of order” notes Phil Barker (2000, p. 331). Instead, what counts as knowledge on this paradigm is data showing how most people are apt to respond to a particular intervention.

The same kind of standardized, context-free knowledge that informs bureaucracy and mass production is also the goal of evidence-based medicine. In order to generate data that can be generalized to a sufficiently large swath of the population, in fact, randomly controlled trials (RCTs) have become enshrined as the “gold standard” in medicine (Barker, 2000, p. 331) for EBM and EBP. It is the randomness of a sufficiently large sample that licenses researchers to extend their findings with confidence to the remainder of a particular population. RCTs, moreover, are replicable, double-blind studies that compare treatments against a placebo, or treatments against one another in order demonstrate the efficacy of a particular agent or intervention.

Due to the increasing reliance on EBM Healy argues that “clinical freedom became constrained by algorithms.” Diagnosis amounts to assigning an abstract category to a patient via a checklist, which in turn implies some standard form of treatment. Healy notes that Hamilton, who interestingly never employed the scale he developed in his own practice, commented on this use of RCTs and rating scales saying that “it may be that we are witnessing a change as revolutionary as was the introduction of standardization and mass production in manufacture” (Hamilton, cited in Healy, p. 288).

While industry stands to profit by marketing standardized treatments, EBP also represents a good fit for bureaucracies due to their requirement for control and predictable results. To achieve such ends, administrators can look to science to provide controlled algorithmic processes to underwrite the provision of human services. Perhaps it is the promise of such seemingly guaranteed outcomes that explain, as Latimer et al's observation that within the publically funded Canadian mental healthcare system "there is virtually no limit to the cost of the medications that physicians can prescribe" while other types of interventions are severely limited (2011, p. 525). The growing reliance of psychiatric drugs may in fact, provide evidence of a comingling of interests, since a well-trialed pharmaceutical affords a fixed cost as well as an economical and efficient way of providing treatment complete with precise instructions as to what can be administered and to who in order to generate a predictable reduction in a given construct.<sup>17</sup>

There is also evidence that the need for efficient, economical and predictable outcomes impacts the very manner in which science itself is pursued. Paul Montgomery, who was quoted in a university press release notes

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<sup>17</sup> Even beyond pharmaceuticals, the scientific method can offer administrators standardized processes that lead to predictable and quantifiable results. For example, if we look at a study described by Allan Horowitz comparing psychotherapy to pharmaceuticals, it should become evident how scientific studies can be directly translated into standardized interventions. The study was "was developed to approximate a "pure" scientific experiment with carefully delineated diagnoses, highly standardized treatments, and highly skilled therapists." There were two treatment groups and one control group and researchers "randomly assigned 239 patients with "pure" cases of major depression to one or other of the ... groups. (2002, p.199-200). Importantly, moreover, "to control for factors such as the effect on treatment of personalities of therapists, all groups used a carefully standardized manual with specific treatment protocols." Beyond experimental results, what such a study produces is a documented series of steps in a rigidly controlled process, a process that is controlled for confounding interpersonal dynamics. This means that in theory, anyone can implement said process in order to produce the same results among the target groups. It should be no small surprise that bureaucrats would gravitate towards such methods and begin to insist on EBP in a variety of domains given the need to produce the predictable and quantifiable results that organizations require if they are to justify their existence.

In this era of austerity, policymakers increasingly look for evidence of “what works” to ensure that revenue is well-spent on programmes that address issues such as poverty, mental health, crime, and drug use. Evaluations of these programmes can be expensive. When they are reported fully and transparently, they can help policymakers choose the most effective way to spend public funds; however, readers rely on reports of these studies in academic journals to effectively understand and use the research (Oxford University, 2013).

There is good reason to suppose that “what works” means what will work reliably in any context. This is because Montgomery is commenting on a recent literature review (Grant et al, 2013) that found most of the psycho-social studies sampled failed to adhere to the Consolidated Standards of Reporting Trials (CONSORT) guidelines. CONSORT standards, moreover, are intended to shape reports so that readers may quickly and easily assess the potential for sampling bias and confounding environmental factors in order to better “appraise the validity and generalisability of trials.”

Given that Grant et al recommend further dissemination of CONSORT guidelines, we may increasingly see the administrators’ need for standardization, prediction and control resulting in an increasingly standardized format for reports of scientific studies. Meanwhile the propagation of such guidelines may serve as reminder to researchers about the importance of generating maximally generalizable findings and thereby shaping both the methods they employ and the kinds of problems upon which they concentrate.

Since EBM as well as the rational systems of administration and production are meant to be highly generalizable, it’s no surprise that techniques from one often cross over into the other. Moreover, given that they are interdependent domains with many points of overlapping interests, their requirements often shape one another. This

integration of interests and techniques should also serve to strengthen the ideological impact of overriding value structure reiterated in each domain. Meanwhile, living in a culture steeped in rationalized organizational structures may even serve to subtly reinforce the essentially mechanistic worldview characteristic of the sciences.

### **III. Rational Technologies and Discipline**

One outcome of the drive to control and standardize work processes, is an increased need for workplace discipline, or the management of worker's bodies. This is because tight control of industrial or administrative processes necessarily entails the control of people implementing such protocols. However, it unclear whether the drive towards the rationalization could be sustained were it not for a host of workers who, since childhood, have been trained within disciplinary apparatuses where obedience is celebrated as a primary virtue. Michel Foucault described such a system as a rationalized, hierarchical structure that identifies individuals, then places and monitors their bodies in time and space. Its aim is to instil obedience through surveillance, punishment and reward effected to train individual bodies and thereby optimize their measurable performance of particular functions (Foucault, 1977/1995). Eventually, if such systems are successful, individuals come to internalize the demands placed upon them and in so doing, can be relied upon to monitor their own behaviour and govern themselves accordingly.

The functional roles for which people are trained are largely prescribed by the requirements of the various forms of rationalized systems administering modern life.



Schools, for example, are engineered to adapt individuals to workplace regimens that will one day require them to present themselves for a pre-established period of time, whether this be at an assembly line or a desk, and to obediently perform a particular set of functions as determined by one's superiors. Hence, as with Weber's "iron cage" of capitalism, the vast majority of members living in Western industrial societies have been born into, and are therefore acclimatized to, a world dominated by disciplinary structures.

In Marcuse's view, the imperative to adapt ourselves to predetermined processes in so many aspects of our lives, also impacts upon our conception of social harmony. Having a multiplicity of mechanistic systems dictating so many aspects of a person's life, notes Marcuse, results in a generalized conception of good social relations in which "getting along is identical to adjustment to the apparatus" (1941/1982, p. 144). For instance, Gloria, the more abusive nursing aide Foner describes appeared to get along with her supervisors by meeting institutional demands for efficiency and punctilious paperwork. Just as workers are required to adjust themselves to match the requirements of a mechanized process and thereby cooperatively produce commodities or provide services, more broadly speaking, in a society dominated by various forms of rationalised technologies, Marcuse sees good social relations amounting to obedience to the dictates of rationally prescribed protocols that mechanically govern various aspects of peoples' lives in a mass society.

## **Discipline and Havoc**

To explore the relevance of discipline for psychiatry it will be useful to examine the concept of havoc. “Havoc” is a term Erving Goffman (1969) employed to describe disruption of the social order occasioned by the mental patient, but which I shall expand upon somewhat in what follows. Such disruptions pose a special problem for psychiatric practice that occurs in a society rationally prescribed to the degree we see under modernity.

According to Goffman, psychiatric patients typically call attention to themselves via the transgression of social norms, while the ensuing havoc effected by the transgression creates the need to isolate the person causing the disturbance from his social environment. In his work, Goffman stresses the extent to which social interaction is rule-bound. The rules that guide our behaviour are often implicit, and relative to both one’s social status and particular situation. According to Goffman, a “fine mesh of obligations” obtains in public places and “ensures the orderly traffic and co-mingling of participants” (p. 370). In other words, when everyone knows their place, fluid social relations occur. Hence while Marcuse depicts getting along as adjustment to the rational apparatuses, Goffman portrays it as adjustment to hierarchical social norms.

On Goffman’s view, many, if not all, psychotic symptoms involve an overt flouting of social conventions associated with an individual’s social position within a particular context. “Mental symptoms,” argues Goffman, “are situational improprieties, and these, in turn, constitute evidence that the individual is not prepared to keep his place” (p. 368). According to Goffman often these improprieties are only subject to

informal means of social control such that those forced to interact with a mentally ill person lack any ritualized way to respond to offensive behaviour. Everyone knows to shake the extended hand of an acquaintance at a business meeting, but most will suffer utter confusion and uncertainty when a nude person on a subway approaches them in a similar fashion. There is no telling what a person might be capable of, onlookers realize, when the transgressions of another become grossly apparent and this in turn stands to provoke anxiety.

As Goffman argues

It follows that if the patient persists in his symptomatic behaviour, then he must create organizational havoc and havoc in the minds of members. Although the imputation of mental illness is surely a last-ditch effort to cope with a disrupter who must be, but cannot be, contained. This imputation in itself is not likely to resolve the situation. Havoc will occur even when all the members are convinced that the troublemaker is quite mad, for this definition does not in itself free them from living in a social system in which he plays a disruptive part (p. 369).

Knowing that another person is mad does not free those looking upon displays of insanity because they remain constrained by social norms in their ability to respond. Moreover, the outburst they've witnessed can only serve to remind them that society's bedrock of taken-for-granted social relations is not so stable after all. As Goffman, notes, within families, one who does not know his or her place can seriously undermine other family members' quality of life.

In the case of technologically-administered mass societies, the stakes are raised even higher, and it is not merely one's taken-for-granted social reality, or even the ability of a family to function that depends on all members' acquiescence to social norms. For, any form of technology geared towards mass production or mass administration is

predicated upon the existence of a populace that ‘knows its place.’ Any good terrorist knows that due to the sheer scale of the machinery required to service the masses and the magnitude of its scope of action, the smallest disruptive force stands to become enormously amplified. This is especially true in the case of multiple intersecting systems. Moreover, the very regularity and predictability of rationally prescribed apparatuses can themselves be exploited to maximise one’s impact.<sup>18</sup>

For example, one small piece of malicious code introduced by a single renegade hacker could conceivably cripple networks spanning the globe. The way this is accomplished is by exploiting the very same standardized, logarithmic systems that the hacker aims to corrupt, in order to broaden the scope of the virus’ action exponentially.<sup>19</sup> “Progress and disaster are two sides of the same coin” holds Arendt (cited in Virilio, 2007, p. 15), and as Paul Virilio’s work on accidents demonstrates, the modern conception of catastrophe is often associated with failures in technological apparatuses, such as hydro-electric dams or nuclear power plants, designed to service the masses. Indeed, the more elaborate and grandiose our feats of engineering (whether this be in architecture, production or administration) and the more their organization relies upon rote mechanized processes, the more vulnerable these are to small, but unexpected disruptions.

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<sup>18</sup> Just as James Holmes was able to consult a theatre schedule to select which showing of the 2012 Batman premiere would guarantee him a packed house for his shooting spree, other shooters exploit the predictable school schedules, or, more recently, that of the Boston Marathon in order to amplify the impact of their actions.

<sup>19</sup> 9/11 is another obvious example of this, where the hijacking of a handful of airplanes, and collapse of two skyscrapers shut down air traffic across the globe, shut down the New York Stock exchange, and caused the Dow Jones to plummet (Makinen, 2011, C4). Every passenger who is x-rayed or effectively groped by a TSA agent today knows the effects of this action persist well into the present day.

It may be in fact, that the level of order and organization seen in a system is inversely related to the level of chaos that any one individual can introduce into said system. In a system that is already chaotic, for example, difference, or disruptions will hardly be noticeable. At the height of a full scale riot, for instance, a single rock shattering a plate glass window will have little impact on people's consciousness and will warrant little response. The same act, however, carried out mid-morning in a business district will likely have a much greater impact and cause a far greater disruption.

Foucault's point then, made in his *Madness and Civilization* therefore is well taken, which is that efforts to manage mental illness increasingly intensified along with the dawn of the age of reason (Foucault, 1965/1988). For, in all its unpredictability, insanity stands in opposition to rationality. Due to the pervasiveness and scope of technology, reason's tool to manage the masses, unanticipated happenings hold that much more sway over collective destinies. Mass technologies therefore have a contradictory dual aspect in that they expand the dominion of reason over mass populations while simultaneously amplifying the potential effect of singular, localized and irrational elements. The precarity of a society made so vulnerable to small disruptive forces, and which a post 9-11 audience knows all too well, surely contributes to a growing tendency to isolate, manage and control psychiatric patients who for many, represent irrationality and dangerousness.

## **Discipline and Psychiatric Treatment**

The concept of discipline, then, is especially relevant to psychiatry. As Foucault notes, in the event that people cannot be made to adjust to one disciplinary system, other “isotopic” apparatuses are specially devised to govern and train such “residue” or those who remain unruly and unmanageable. Hence, for instance, highly organized prison systems are created for those who fail to adjust to the legal order, and schools for juvenile delinquents spring up for those who fail to adapt to traditional educational regimens. As for people deemed mentally ill, according to Foucault, they “are the residue of all residues, the residue of all disciplines, those who are inassimilable to all of a society’s educational, military and police disciplines” (2006, p. 54). Alternatively, to borrow once again from Lukács, people suffering from severe and persistent mental illness are quintessential “sources of error” given their global inability to adapt to the rationalized systems that dominate modern mass society. Due to their inability to assimilate combined with the cultural embedeness of disciplinary structures, it should come as no small surprise to see discipline emphasised in the forms of treatment provided for the mentally ill.

Hospitals, in general, are not engineered specifically to train patients’ bodies or to instil discipline. Such institutions do, however, borrow many of the techniques developed from more paradigmatic disciplinary apparatuses including identification, panoptic surveillance, and the careful partitioning of time and space in order to more effectively manage bodies. To treat disease, argues Foucault, a hospital “must be a filter, a mechanism that pins down and partitions; it must produce a hold over this whole mobile,

swarming mass, by dissipating the confusion of illegality and evil” (1963/1994, p. 144).

The treatment of the anonymous masses necessarily involves discipline that orders patients so that, to use contemporary jargon, their diseases might be efficiently “managed.” Open wards demonstrate the manner in which surveillance becomes the norm. Spaces are structured, as with Bentham’s Panopticon, so that a few can effectively monitor many.

When we move into the psychiatric ward, the emphasis on discipline becomes all the more transparent. As Bonnie Burstow and Don Weitz note, many consumer survivors talk of forced incarceration in locked wards where their bodies are immobilized by drugs and where they must earn their “clothing privilege.” The authors add that “inmates are usually stripped of their clothes and forced to wear drab and dehumanizing hospital pyjamas which are invariably made so as to fit nobody at all” (1988, p. 24).

The use of “token economies” takes this form of discipline even further, rewarding desired behaviours with tokens that can be traded for goods or services in hospital as if to reproduce the society’s commodity structure.<sup>20</sup> Furthermore, according to one advocate,

Daily structure is also reinforced with the use of scheduling aids. Every morning patients update a large board in the living room that lists that day’s activities and times. Patients make and keep calendars in their rooms and are strongly prompted to use wristwatches. Activities are scheduled as regularly as possible to enhance routine. Indeed the patients’ day is somewhat like being in school, and patients often call activities “classes.” Far from cringing at this, we try to foster it. If a highly structured setting with bells, attendance records, and monitors is acceptable or even indispensable for us for 12 years of public schooling, why should such

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<sup>20</sup> Although the research cited here is from the 1980’s, the token economy are now seen as an established form of evidence-based psychosocial treatment and is one of 8 kinds of evidence-based practises recommended to treat people diagnosed with schizophrenia (Dixon et al, 2010).

structure suddenly take on an aversive connotation when used with patients who indeed behave like children? School it is, and the more the better (up to a point), where the curriculum is the living and coping skills needed to survive schizophrenia. (Gibson, 1986, p. 13).

As we shall see in the next chapter, hospitals are becoming increasingly high-tech while moving towards the administration of efficient, rationalized, and standardized treatments. Under these conditions, patient compliance becomes all the more crucial considering the number of intersecting rationalized systems that come to bear upon, and which therefore stand to be disrupted in, the course of hospital care. As such, we can predict that an emphasis on the management and control of patient's bodies should only become intensified as care becomes more procedural and algorithmic.

#### **IV. Implications of the RTS Paradigm for Relatedness**

Many of the theorists cited so far appear to be primarily concerned about the oppressive and authoritarian nature of disciplinary systems and rationalized technologies. Throughout the years, moreover, multiple critiques have sprung up that characterise psychiatry as a form of social control (Horwitz, 1982, Showalter, 1987, Conrad, 1992, Szasz, 1998, Chesler, 2005). In terms of the ideological impact of rational technologies, Marcuse makes much of the fact that rationalistic systems emerge as the very embodiment of reason so that dissent is cast as irrationality. While such critiques are important and often well-supported, by now these represent well-trodden terrain.

Arguably, it was not merely a lack of critical thought that lay at the root of the systemic atrocities referred to, for example, in Arendt's work on the Holocaust. In some



way, those involved in the Holocaust found a way to suppress their basic empathetic responses to other human beings in order to focus exclusively on the workings of broader reified systems. If we look to the impact of disciplinary systems, as well as the phenomena of “Othering” occasioned in reified systems, we can arrive at a partial understanding of how such organizational structures work to hinder empathy and mutual understanding in those being governed.

### **Disciplinary Structures and Social Relations**

While Goffman tends to focus on the authoritarian aspect of psychiatric care, at points his work is suggestive of the manner in which an emphasis on discipline, for example, can have a chilling effect on interpersonal relations. As he notes in looking at patients, constant surveillance and the strict enforcement of rules can create a state of “chronic anxiety” so that “the inmate may forego certain levels of sociability with his fellows to avoid possible incidents” (1961, p. 43) because breaking the rules might provoke punitive measures. The same chill on social relations Goffman describes here ought to also hold for interactions between clients of a system, and service workers who are equally constrained by rules. Workers themselves are subject to the anxiety-inducing surveillance and discipline from their own superiors which can only heighten tensions between workers and clients as workers fret over the possibility of causing “incidents” of their own.

Meanwhile, we need only to consider the infamous Stanford experiments to see what happens to human relations when one group of people are delegated to monitor and

guard another group.<sup>21</sup> Sherif Muzafer's classic work also shows that minimal conditions, such as the arbitrary division of children at camp, can result in the formation of concepts of in-groups and out-groups. (Sherif et al, 1954/2000). Other research suggests that people are less willing to attribute distinctively human emotions such as love, hope, resentment or contempt, for instance, to members of an out-group (Leyens et al, 2003). Hence, the manner in which disciplinary systems identify and organise clients and workers relative to one another stands to have a chilling effect on mutual perceptions and group relations.

### **Sources of Error as a Distinctive Form of "Othering"**

Such observations go some way in explaining the process of exclusionary "othering" at play in the nursing home, for example, where Foner reports Gloria's pejorative comments about patients ("a nasty pig," "a pair of dingbats" , "a pain in the butt" and "a dirty disgusting woman. I wouldn't let her into my house") (1995, p. 61). Othering is a concept identified in the feminist literature and according to Lois Weis is a "process which serves to mark and name those thought to be different from oneself" (1995, p. 17). When othering takes on an exclusionary form it causes those marked as different to be marginalized. Typically, the concept has been examined in the context of race, gender and identity (Ahmad, 1993, Fine, 1994, Hall, 1999).

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<sup>21</sup> In 1971 Philip Zimbardo conducted a study in which a number of volunteers were designated as "guards" and others as "prisoner." What was to be a 2 week study had to be stopped after six days when, as Zimbardo describes it "too many normal young men were behaving pathologically as powerless prisoners or as sadistic, all-powerful guards." Although normal healthy volunteers were selected for each group "in less than a week there were no similarities between them" (Zimbardo et al, 1999, p. 202).

Certainly, this is a concept worth exploring as the othering of the Jewish people, where they were characterized as vermin or subhuman, contributed to the ability of Nazi supporters to inure themselves to such people's suffering. The brand of othering I am examining here is quite different from forms identified in most of the literature because it does not rely on any of the usual causes of discrimination, and can stem purely from the set-up of a rationalized productive system itself. For instance, what is interesting about Gloria's brand of othering is that it did not appear to be tied to these more common forms of discriminatory practises. Rather, as Foner puts it "she had no tolerance for patients' resistance, which slowed her down" (1995, p. 60). That is, in all the aforementioned cases, Gloria's disparaging remarks were reserved for residents who interfered with her ability to operate smoothly and efficiently.<sup>22</sup>

Hence, just as worker's idiosyncrasies, including her affective responses, are apt to be represented as nothing more than a source of error relative to a rationalized productive scheme determining their labour, the same can be said of clients who function as objects to be managed and processed by that system. Casting troublesome clients in the terms of the reified system and thereby reducing them to mere sources of error, fixes their status as an excluded other. As for the workers who might tend to view their clients in this fashion, when one is a mere particle, as Lukács puts it, introduced into an enduring monolithic structure, it perhaps ought not be surprising to see a worker identifying with the reified system over and above her clients. This is true even if doing so means that

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<sup>22</sup> The "nasty pig" and "disgusting woman" were being monitored at the lunch table, the "dingbats" were unable to move their bowels and the "pain in the butt" was falling asleep in her chair making it difficult to comb her hair.

clients are othered merely on the basis of having idiosyncratic requirements that elude the system's design. For, it is worth noting that workers who prioritize the needs of individuals over and above the requirements of the system will also tend to be represented as sources of error, and hence subject to othering themselves, perhaps even to the point of getting fired.

For example, according to Foner, "a major blowout" in the nursing home occurred when Ana ordered a pair of special gloves to reduce one resident's discomfort. According to Foner, Ana's "furious" supervisor informed her "you cannot order things for the patient. You can only do what you see in the care plan or you will get in trouble. I have to write it down in the care plan, that is the only way to get things" (1995, p. 65). As Foner explains it, a nursing aide's primary obligation was to follow the care plan to the letter. The supervisor further stressed that without a note in the care plan other workers will simply throw the gloves away, which underscores the point that the plan is all that matters. Fetishism attaches itself to the document in such cases endowing it with the power to direct interactions between persons as though they were mere objects in a process.

This emphasis upon the authority of a reified care plan calls to mind Viktor Frankl's description of a scene from a Nazi concentration camp which he survived. According to Frankl, German soldiers who came to take the sick away used a list and even if a prisoner on the list had since died, his dead body was taken anyway and placed in the cart alongside the living. Frankl writes

the list had to be correct! The list was the only thing that mattered. A man counted only because he had a prison number. One literally became a

number: dead or alive—that was unimportant; the life of a “number” was completely irrelevant. What stood behind that number and that life mattered even less: the fate, the history, the name of the man. (1946/1997, p. 63).

The list, the care plan, these are what must be correct, even if following these rationally derived directives mean that an ailing man is placed next to a rotting corpse or a nursing home client must endure pain and discomfort because a remedy is not marked in her file.

In both cases, we see that for the person being directed by the system, his or her own idiosyncratic subjective responses will tend to represent mere sources of error if such experiences conflict with the outputs specified by the designers of the system. The only way to fit with the broader system will be to distance oneself from one’s own emotions so that they do not alter one’s behaviour. For instance, as Foner describes it “it pained Ana to see the resident uncomfortable and vulnerable to injury” (1995, p. 65).

Apparently she, and others like her, must check their empathetic responses and stifle the desire to help another, if such ‘troublesome’ tendencies threaten to disrupt pre-established nursing home protocols. In my next chapter, moreover, we shall see psychiatric residents explicitly taught to manage their own empathetic responsiveness so as to meet the demands of sped up reified systems. I shall also describe Nurse Trudy, a worker who minimizes the importance of her concern for another because this affective response interferes with rationalistic demands of her workplace.

### **Rational Technology, the Division of Labour and Proximity**

Even if the onus is upon those at the ground floor to work around their emotional responses when these create contradictions, typically they have little say in designing the

systems that organize their labour. As some contend, it may well be Ana's proximity to the woman that causes the aide to experience such an acute empathetic response to her client. "It is possible that decisions that result in suffering are more easily made at a distance," remark Peter and Liaschenko, adding that "it may be morally less burdensome to give the orders than to carry them out or to live closely with their consequences" (2004, p. 221). The division between intellectual and physical labour in the nursing home places Ana and the other aides in regular close proximity to the residents since the former tended all manner of bodily needs throughout the day.

Often it will be the case that the designers of a system stand at a remove from both the people doing actual hands-on work and the people receiving services.<sup>23</sup> For instance, an engineer who designs an especially ingenious and efficient productive system will not necessarily have any inkling of the mind-numbing boredom induced in labourers who are later introduced to carry out the piecemeal tasks prescribed for them. As such, decision-makers in charge of designing the systems that govern hands-on work may largely be spared from having to regularly witness the consequences of their decisions for actual persons because they have little occasion to experience the

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<sup>23</sup> Ethnographic work in the nursing literature may be telling in this regard. According to Austin et al, Jean, a hospital nurse, tells a story she claims "epitomizes" her relationship with managers. According to Jean one evening she was overwhelmed by a maelstrom of simultaneous and intense interpersonal encounters related to the admission of a woman with dementia. Not only did Jean need to calm the patient and the woman's agitated family members, but paramedics jockeyed for attention as well, anxious as they were to leave the scene and return to work. "Amongst the turmoil," remarks Austin et al "Jean was relieved to see her administrator approaching from down the hall. When she reached the scene, however, the administrative officer walked around Jean, saying over her shoulder, 'I'm going home; do your best,' She hurried away" (2003, p. 181).

consequences of systems put in place.<sup>24</sup> In this way, Peter and Liaschenko claim they remain “detached from the implications of choices made and one can view people as ‘just numbers’” (2004, p. 221).

### **Incommensurable Paradigms**

Even if an administrator were acutely aware of barriers to the cultivation of caring relationships in an institution, it is not clear whether she would be able to articulate why this matters in terms of the dominant rational techno-scientific paradigm previously discussed. For, this is a worldview that serves to devalue the importance of our own affective responses along with other relational values. As I have been contending, people occupying managerial or policymaking positions are also subject to a particular kind of ethos that is reinforced in virtue of the re-articulation of several key values in science, bureaucracy and capitalist mass production. The resulting worldview and conception of what counts as real and what matters departs sharply from a standpoint that prioritizes relatedness and “caring work.”

Celia Davies defines caring work as “attending physically, mentally and emotionally to the needs of another and giving a commitment to the nurturance, growth and healing of that other” (1995, p. 18). As Davies notes, such care involves both a

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<sup>24</sup> Interestingly, this division of labour is reflected in the pure sciences as well, with the division between theoretical and experimental sciences remarked upon by Paul Feyerabend. “Many experimenters are suspicious of theory,” remarks Feyerabend. “They think they, not the theoreticians, are in touch with reality” (2011, p. 29). Probably this distrust comes as a result of seeing regular contradictions between theory and practise as witnessed by those with experience working with concrete phenomena. As Feyerabend notes, another class of scientific workers are the “curve fitters” who aim to adjust data so that it conforms with the predictions of the theory. “Often curve fitters abandon ‘raw data’ and replace them with the data suggested by the curve,” contends Feyerabend. As such then, the purveyors of high theory do not necessarily ever become aware of the small and regular discrepancies observed by experimenters.

commitment to sustaining a relationship, and “committed attending,” or striving to understand another well in order to adjust her care plan and environment. However, according to Benner, one must know of more than a person’s physiology to arrive at such an understanding, since it also requires apprehending another person’s “lifeworld,” a term that refers to a particular person’s embodied context as well as the manner in which she attributes meaning to her experience (2000, p. 6). One who is adept in this, notes Benner, will have achieved a state of *phronēsis*, a term borrowed from Aristotle and which refers to practical wisdom. *Phronēsis* is best conceived of as a skill acquired through practise (Little, 2001, p. 39) and mastery is gained when “one’s acts are governed by concern for doing right in particular circumstances, where being in relationship and discerning particular human concerns are at stake and guide action” (Benner, 2000, p. 9).

My point is not that the paradigm of care is clearly at odds with the more rationalistic worldview I have been aiming to typify. For instance, in the nursing home, the kindness and consideration that Ana showed clients was by no means actively dissuaded. In fact, according to Foner, “workers who manage to combine efficiency and kindness are well-liked by their supervisors; inefficient, sloppy and abusive aides have trouble.” I do contend, however, that a relational orientation is incommensurable with the rationalistic paradigm that embraces quantifiability, objectivity and detachment, economism and efficiency, and replication, prediction and control. The reason is that these two viewpoints ascribe meaning in different ways.

In fact, I would suggest that as per Thomas Kuhn’s suggestion in relation to competing scientific paradigms (1962, p. 85), something of a gestalt switch is required to



move from one worldview to the other. Often in the course of a working day one must snap out of it, as it were, and break free of routinized directives guiding one's behaviour in order to attend to another as a person. More importantly, at the level of policy or industry, it is typically not possible to adequately articulate the importance of human relatedness in terms meaningful within a scientifically informed worldview that prizes economism and efficiency, admits only quantifiable and replicable phenomena as real, and insists upon standardized processes to realize goals.

### **The Devaluation of Caring Work**

Although many of those who write about nursing stress the importance of a caring attitude, Barker notes that "one apparent weakness of the concept of caring in contemporary practice is its apparent invisibility" (2000, p. 331). Paul England also argues that, in general, work that requires caring for others, or "interactive service work" typically sees a "pay penalty" relative to comparably skilled jobs (2005, p. 383). Meanwhile, when Goodwin and Guze deign to write about caring work, they remark "good nursing care is very important. A calm, sympathetic, reassuring approach can turn a frightened, combative patient into a quiet, cooperative one" (1996, p. 360). Here, care is not recognized as a way of being able to discern what treatment is most appropriate, as therapeutic in and of itself, nor as an intrinsically valuable and important aspect of any human interaction. Rather, a sympathetic and reassuring approach is only recognized for its instrumental value in providing a means of rendering the unruly patient into a compliant one.

As I have shown, the partiality required to show another care is viewed with suspicion by the bureaucrat, the scientist, and the competitor under capitalism, which begins to account for the devaluation of caring work. As Davies notes for example, “intimacy and the exercise of emotion are not part of the vision that is bureaucratic organization. Formality and distance are seen as the only route to a rational decision.” Davies sees this attitude running over into the impersonal stance evident in the “‘bedside manner’ of the doctor” who “keeps emotion firmly under control. Professionals offer a detached ‘understanding’ when clients, in what can be a highly charged context, frequently apologise for their fear and their tears” (1995, p. 25). Given the pervasiveness of the expectation for professionalism, a concept that is virtually synonymous with a detached demeanour, not surprisingly, an emotional responsiveness in a practitioner will tend be stigmatized. As Benner and Wrubel put it in fact, caring work represents something of “a cultural embarrassment” (1989, p. 325) for nurses.

It is not merely the sense of propriety attached to distant and formal relations that serves to minimize relational concerns in executive-level discourse or policy-making. Care is also difficult to quantify from which it follows that within the discourse of science and technology, it effectively does not exist. Measuring care is difficult because different forms of observable behaviours are required to show care for particular people. Hence the concept is not amenable to any form of standardized measure. In fact standardized, and hence calculable, forms of “care” such as the flight attendant’s smile, or “have a nice day” mechanically uttered by the cashier become the hallmark of indifference due to their rote nature.

Given this antithetical relationship between care and measurement, then, at the level of policy or administration, levels of kindness and consideration shown to clients will tend to fall from areas that are of concern. Moreover, even if it were possible to reliably identify and measure a more kindly approach to a client, it will not be obvious to an administrator how to calculate the value this adds to services. For example, statistically speaking, there is no good reason to suppose that a doctor with a terrible bedside manner will see fewer successes repairing the hearts of patients over and above her more compassionate colleague. Rather, as we see with Ana Riviera, her concern for her client's emotional wellbeing is what interferes with tasks such as bed and body work which are amenable to quantification.

Understanding the importance of replication and standardization provides a little more insight into the question as to why human relatedness and interpersonal relationships represent constructs ill-fitted for the purposes of science and rational technologies. For, just as the quality of interpersonal relationships are difficult to quantify, so are they difficult to replicate, and as such are difficult to control. This is because close trusting relationships depend crucially on the idiosyncrasies of both parties involved, and most relationships are influenced by the context in which they take root.<sup>25</sup> Bonds also change over time so that the same action, take playful teasing as an example, can impact quite differently on a person depending on whether the relationship is new or

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<sup>25</sup> It is not uncommon, for instance, to form relationships with compatriots while abroad yet be aware of the fact that had both parties crossed paths in their home country, it is far less likely that they'd have found a reason to interact. The Capilano Bridge experiment also points to the sensitivity of relationships to context. Findings included the observation the fear and excitement men experienced while crossing a suspension bridge seemed to increase their attraction to a female researcher they encountered on the other side (Dutton and Aron, 1974).

if it has had time to mature and develop. Arguably, establishing trust requires small risks, whether this be a joke, a private revelation, or a just a reassuring pat on the arm.

However, rote standardized systems tend to be risk-averse and favour the tried and true over the new and unexpected. Meanwhile, for a scientist what this means is that it is not possible to observe bonds forming between people under controlled conditions, hence, neither can one engineer rote processes to implement such relationships. For, although it might be possible to replicate conditions that would guarantee a lack of human connectedness, it would be far more difficult to find any well-defined set of conditions that will guarantee bonds forming between any two parties selected at random.

Certain phenomena that matter from an interpersonal perspective are also difficult to parse within the modern rational techno-scientific paradigm. In a world that prizes objectivity, one's affective responses to another, for example, are discounted as a form of guidance as to how to proceed with that person. As Healy notes, in the early days of psychotropic drug trials, "a generation of older, analytically trained psychiatrists could feel the change in the "transference" relationships between them and their patients induced by psychotropic drugs" which in turn lead to further discoveries (2002, p. 288). Nowadays, however, such subjective forms of evidence fall well beyond modern medical science's evidence base and would count for little. Nor, for that matter would a mental health nurse's discovery that stroking the back of an agitated patient's neck would calm him, something she discerned because she had seen his wife do the same. "It is not something they taught me at the school of nursing but it felt right and it worked" (Davies, 1995, p. 21).

As Davies notes, such insights are gleaned in virtue of the “patient, minute and detailed observation that takes place in the sustainedly close relationship that the [healthcare provider] has with the patient” (p. 22). Typically, moreover, such exchanges of information occur in virtue of an intersubjective exchange of meaning that is difficult to articulate on a worldview that stresses the primacy of objective facts that exist independently of an observer. As Feyerabend writes

I meet a friend. In a way I see our whole relationship written in her face. She looks different now from the way she looked to me when I first met her and she will look different again a few years from now. This look is not an objective fact. It does not sit on her face waiting to be discovered by an objective experimental procedure. It is part of our relationship and it involves me in an essential way. It is therefore not a scientific fact though it is more important to me than any scientific fact could ever be. However, it is not ‘scientifically important’ and if science takes over, not socially important either (2011, p. 95).

Such intersubjective meanings are crucial for our intimate relations and are also key for adequately nurturing others. Seeing that a client who loves beauty treatments remains indifferent when she is offered a manicure can be as sure a sign of decline as a blood test for someone who knows the patient well. Sharing a laugh together, or perhaps just learning that a worker and client share a favourite song might build just enough trust so that a client reveals symptoms she’d previously been too uncomfortable to discuss. Understanding what a client values is the only way to infuse her with hope. Meanwhile, simply being able to connect with, and hence trust, a caregiver can be comforting and therapeutic in and of itself.

“Most of us in our home know [the therapeutic value of sociability] instinctively,” argues Richard Titmuss, adding “but somehow or another it gets lost in hospital” (cited in

Waerness, 1984, p. 195). Barker and Poppy Buchanan Barker also allude to the seemingly obvious importance of relational values in posing the rhetorical question

who would consider seeking scientific proof of the ‘value’ of [caring] forms of human encounter – such as friendship, comradeship, loyalty, sympathy or love? These encounters have inherent value. When we experience them, we often are moved to tell others of the power that we experience within those relationships. Only a fool, with perhaps too much money, would commission a study of the value of such relationships” (2000, p. 252).

What makes such research appear absurd is not simply the intrinsic value of relatedness, but also the sheer impossibility of describing relational values in terms the rational techno-scientific paradigm can grasp. Just as it is untenable to replicate and quantify the conditions giving rise to relatedness, so would attempts to examine the concept of care in terms of the values of economism and efficiency appear ill-conceived, if not completely contradictory due to the non-commodifiable status of human care.

As it stands, the drive to care for others pushes back against values such as economism and efficiency and quantifiability. As Lukács argues, under rationalized productive schemes “time sheds its qualitative, variable, flowing nature; it freezes into an exactly delimited, quantifiable continuum filled with quantifiable ‘things’ ... in short it becomes space” (1923/1971 p. 89). It is only possible to generate precise predictions if time is defined in term of quantifiable activities. Once such predictions have been made and entered into calculations regarding the work process, there is a certain imperative upon a worker to stay on schedule. Nurturing, however, takes time and as Karen Davies argues, processes that require caring work operate on their own schedule, making the time required to adequately tend to another difficult to anticipate, while human needs are

unpredictable (1994, p. 279). Unpredictable and time-consuming requirements undermine the standardized procedures in place to improve efficiency while conserving resources, especially human resources.

This is not to say that healthcare provided within rationalistic systems is necessarily impersonal and detached, rather relational values are aspects of services of which “we cannot speak” in terms of the dominant discourse, and hence as per Wittgenstein’s famous truism, “must be passed over in silence.” Due to the invisibility of care within the dominant discourse, connections between workers and clients take root in spite of, rather than in virtue of, the systems implemented to deliver healthcare. This is because with no way to articulate the importance of relatedness, such systems are designed in ways that encroach upon both the time and the space necessary for the cultivation of sustained and trusting relationships between workers and clients.

### **Encroaching on the Time to Care**

If relational values are squeezed out of the dominant discourse, so is the time necessary for the cultivation of human connectedness. Given the devaluation of care combined with the difficulties of advocating for relatedness in ways that are meaningful within the rational techno-scientific paradigm, relational work comes to be treated as a waste. In fact, according to one OR nurse who likes to accompany her patients in the operating room,

this [administrative] person said right out to me, he said, “Well, I don’t see any value in what you do. You need to be in the operating room itself, getting things ready.” He feels that our patient contact is totally unnecessary and he’s not happy with it.

According to Weiss et al, although nurses viewed such activities “as essential to preserving the patient’s humanity and security in a highly threatening, highly technological atmosphere,” managers were looking to eliminate time for them, because they were “viewed as superfluous to the “real” work entailed in the actual surgical procedure” (2002, p. 104). Meanwhile, Weiss et al note, post-operative patients often wake “feeling helpless and confused.” According to one nurse, “sometimes they just want to hold my hand – that’s all they want to do. “I want to hold your hand.” I say, “You can have it for 5 minutes and then I have to run off to the next bed ... we don’t really have the time to give the spiritual and psychological and emotional care that they really want” (p. 106).

A look at managerial literature in healthcare reveals an emphasis on the economic use of time and helps contextualise Weiss et al’s research. In an article on time-based management (TBM) in health, Kujala et al draw parallels between health and industry. “Time,” they say, “becomes a critical measure of competitiveness, comparable to traditional financial measurements,” because, among other reasons, “customers prefer to get their stuff (receive their goods) sooner rather than later” (2006, p. 515). In their article they recommend employing TBM to maximise productive activity within specific spans of time and thereby minimise “patient episode throughput times” or the total span of time encompassing diagnosis through to treatment.

Kujala et al then apply machine logic to the operations of public health services and explicitly liken patients to objects on a conveyer belt.



A patient episode is analogous to a customer order-to-delivery chain in industry; a patient process is analogous to an industrial production process including resources and procedures. Consequently, the focus in healthcare should be on minimising non-value-adding time during the patient episode ... Analogously to the Work in Progress (WIP) measure in manufacturing, in health care we suggest the Patient in Process (PIP) – concept. The focus and unit of analysis in studying PIP should be a patient episode (p. 516).

In order to expedite such abstract PIP objects through the system, Kujala et al suggest dividing up the process into increments of “Administrative time,” “Waiting time” and “Diagnostic and care time.” *Diagnostic and care time* is then further parsed into categories. “*Diagnostic time* includes collecting and analyzing diagnostic information. *Active care time* consists of clinical interventions. During *passive care time* resources are not used actively, but the patient is under observation in inpatient units. *Superfluous time* is defined as “a medical diagnostic and care that is not based on official care process recommendation” (p. 519). As Weiss et al’s work demonstrates, and for reasons I have provided, time spent showing care for or nurturing patients has no place on this list.

### **Encroaching on the Space to Care**

Space, as it is used in this work, refers to allotments of time that are not fully occupied with pre-determined tasks, and hence allows for spontaneous interactions. We see that in Kujala et al’s drive to eliminate waste, they simultaneously aim to cram scarce increments of time with maximally productive activities. As for the nature of such activities, as the authors further note “[a]n application of PIP-concept could provide an opportunity for healthcare managers to insist that medical professionals agree on standard processes, which are easier to manage and control” (p. 519). If Osborne is correct about

the drive to blend administrative and clinical logic, the objective here is to identify cost-effective rote procedures that can be agreed upon in advance by clinicians and managers. Hence, while time to nurture clients is limited, whatever time is spent with a patient will tend to be dominated by pre-determined quantifiable activities amenable to managerial control.

Relationships between workers and individual patients are entirely pushed out of such a conceptual scheme. Within the kind of framework put forth by Kujala et al, for instance, individual patients are conceived of as a mere component of the abstract unit that is the 'patient in process.' For in their analysis Kujala et al "assume that homogenous cases can be identified" (p. 521) to differentiate between different kinds of PIPs, and suggest adult depression, cataract and hip arthrosis among the possible groupings (p. 514). Hence, patients themselves are more or less interchangeable so long as their "cases" match. Intimate knowledge of individual patients has no place on this scheme, and as such, there is no imperative to understand them as persons either to diagnose them or to treat them. Diagnosis amounts to assigning an abstract category to a patient, which in turn implies a predetermined care plan.

Not only does a reliance on standardized forms of treatment undercut any necessity to know a patient as a person, the emphasis on technique also interferes with a caregiver's very ability to respond to a client's personal needs. If the caregiver's attention is fixed upon following a very specific technique and there is an imperative to keep to a strict schedule, it is very difficult to simultaneously attend to the people with whom one

interacts and to be responsive to their needs. As for the effect that the stringent regulation of caregiving work processes might have on care workers, Foner notes

the sheer onslaught of rules has a numbing and demoralizing effect on the caregivers; it breeds cynicism about regulations and, for a few aides, contributes to a tendency to perform the job routinely and without feeling ... One especially bitter and rather cruel aide tried to explain it to me during an interview. "You writing now," she said. "If someone tells you don't dot the i, it would make you tense. She then spoke of the nursing home. "And who suffer? The patient. You scream at a patient" (1995, p. 74).

The effects that systems of management have on workers is key information here not merely for its own sake, but also because clients are affected by proxy. As I have been aiming to demonstrate, the kinds of responses Foner describes here are products of a deeply imbued RTS paradigm and its structuring of the workplace. It is a workplace that squeezes out the time and space necessary both to form human connections, and, as I shall add in Chapter Three, to cultivate rich, nuanced and well-rounded moral practices.

Before doing so, however, we look to various ethnographies to deepen our understanding of the impact of reification and its associated set of values on professionalized caregiving. This will be my task in the next chapter, which will examine the role of reification and rationalization at the ground floor of practice, and especially the part that these forces play in reducing clients and workers to little more than "sources of error." Generally speaking, it is important to ask if modelling public administration after mass production is an appropriate way of providing human services in spite of the obvious efficiencies and cost effectiveness such approaches achieve. Indeed, these very values of economy and efficiency may be little more than ideological reflections of the systems that brought them to prominence.

## **Chapter Two**

### **Rationalized Caregiving on the Ground Floor**

*“What is remarkable as one looks back on this 200-year “history of reform without change” is how consistently those in charge of the system, indeed society as a whole, sought to deflect attention away from the horrors of the present by resurrecting the tales of the barbarities of the past. Indeed, it is perhaps not too much to claim that one of the main ideological tasks of the history of psychiatry has been to manufacture reassurance of this sort, supplying us with a seemingly inexhaustible store of exemplary tales to document the inhumanities of earlier generations and the heroic struggles through which we arrived at our present (relative) state of grace and enlightenment”*

~Andrew Scull, 1989, p. 306.

### **Introduction to the Ethnographies**

Having delineated the co-productive and reiterative set of values rising out of reified productive, bureaucratic and scientific schemes, I now turn to accounts from the ground floor of medical practice to illuminate the way these values lead to the construal of both patients and workers as little more than “sources of error” relative to a reified system. Due to various constraints stemming either from the drive for efficiency or the set-up of increasingly rationalized systems, workers are deprived of the time or the space they require to adequately attend to their patients’ individualized needs. This lack of time and space appears to exacerbate the need for discipline, especially in psychiatry. Perhaps unsurprisingly then, we see workers seeing, or being taught to see, their own empathetic responses to such patients as something to be managed, controlled and even suppressed. Interspersed, in these accounts, however, are glimpses into gaps in these systems, or

small spaces where unexpected connections between workers and clients can take root, the significance of which will emerge slowly as this thesis unfolds.

The first ethnography I examine in Section I was conducted in a general acute care setting in order to demonstrate certain trends in healthcare generally speaking. In *Managing to Nurse: Inside Canada's Healthcare Reform*, Marie Campbell and Janet Rankin (2006) document the restructuring of Canadian hospitals resulting in a workplace that is becoming increasingly technological while sophisticated managerial techniques are being introduced to rationally govern the work process. Although reification stands out as a distinct phenomenon most clearly in Section III, it is also evident in the rationally organized hospitals described by Campbell and Rankin. Their work, however, most clearly demonstrates the ascent of economism and efficiency as primary values in health, as well as the influence of objectivity, quantification and standardization on the organization of the healthcare systems.

After examining Rankin and Campbell's work, in Section II I move into psychiatry and piece together a representation of the state of modern inpatient care. What emerges most clearly from this section is the problematic relationship between rationalized care plans and discipline as this pertains to the treatment of psychiatric patients. As with the general healthcare systems described in the previous section, we shall see that efficiency is becoming a guiding force in psychiatry. Meanwhile objective, and some say dehumanizing, diagnoses are used to generate rationalized treatment plans in order to hasten recovery times.

In my final section I examine Lorna Rhodes' (1991) ethnography of an acute psychiatric unit (APU). Although the rationalized care plans and sophisticated managerial techniques evident in the first two sections are absent from this particular ethnography, Rhodes' work is useful for the manner in which it so clearly isolates the phenomena of reification whereby we see workers wholeheartedly embracing a certain perceived function of the APU. They also take expediency as the guiding principle in their work. The end result of this is that patients become quite explicitly othered, or construed as sources of error. Moreover, while there is a subtle suggestion of this in my first section, in the APU we see empathetic responses to clients overtly construed as sources of error, or a mere hindrance, a mistake, because such responses interfere with productivity in the workplace. There is also evidence of the paradigm shift that can occur when workers begin prioritizing the needs of individual persons over the requirements of the institution. There is reason to suppose, however, that this shift only occurred because space existed in APU that allowed for such unlikely relationships to take root.

### ***I. Managing to Nurse: Rationalizing Trends in Healthcare***

I focus on this account because the writers describe new rationalized healthcare technologies in fine-grained detail, which helps to connect some very specific forms of control over nursing work with the erosion of the quality of interactions with patients. Moreover, their account reveals a subtle example of the relationship between reification and othering, or, in other words, the representation of patients as mere sources of error. We also see evidence of workers representing their own empathetic responsiveness as a

source of error to be modified if such affective states conflict with the demands of their jobs. This latter phenomenon becomes especially relevant in later chapters.

This ethnography of Canadian hospital care was written by former nurses Janet Rankin, who began nursing in 1979, and Marie Campbell, who started in 1959. As shall be seen in *Emptying Beds*, Campbell and Rankin's book shows that the scarcity of resources is an overriding concern for healthcare providers. The former book, however, features an ethnographic account of various forms of rationalized technologies being introduced to both manage hospital workers, and efficiently ration healthcare.

The scarcity that modern administrators face is an artefact of the same neoliberal shift that reduced healthcare funding in the US. After Reagan's funding cuts in the US, Canadians also saw their federal government back away from healthcare when Ottawa cut transfer payments to the provinces. Initially the federal government had covered 50 percent of health costs, a number that was reduced to 10 percent by 1999 (Rankin and Campbell, 2006, p. 25). Hospital closures, mergers and staff reductions soon followed on the heels of these transfer payment cuts. Diminishing levels of service led to calls for healthcare reform to more efficiently utilize remaining funding. In order to accomplish this, policymakers and hospital administrators assimilated managerial processes developed in the private sector in a bid to improve the delivery of public healthcare.

As Campbell and Rankin see it, the administrative culture in healthcare has been overrun by what they describe as "accounting logic" a paradigm that is nicely summed up in a quote from a chair of the Canadian Institute of Health Information: "if you can't measure it, you can't manage it" (Michael Dector, cited in Campbell and Rankin, p. 17).

Such a statement, moreover, evokes Max Plank's "theory of the real" cited in Chapter One, or "that which is real can be measured." As we shall see, in health it does seem that whatever cannot be counted does not count for much at all. As is evident from the authors' description, reified measurements of both nursing labour time and bed utilization, combined with standardized treatments, are key elements in a system that reduces patients to quantifiable pieces of data waiting to be fed into an alien system designed to mend them. All such objective measures and technological apparatus is directed, as ever, at extracting maximum yields at minimum expense.

Although Campbell and Rankin are describing general hospital care, as I shall show in the following section, such technologies are increasingly structuring psychiatric care, while undercutting relations between workers and clients. We also see the intensification of reification, wherein not only is the functioning of the system as a whole given priority over individual patients, but abstract categories derived from statistical generalizations are simultaneously emerging as more real than day-to-day observations. Nevertheless, these reified categories are used to create a system that structures nursing work so rigidly that workers are often forced to turn away from patients' idiosyncratic needs.

### **Economism and Efficiency Trumping Safety and Care**

According to Campbell and Rankin, as early as 1968, the same year that universal health care was legislated into existence, studies were carried out to describe and quantify nursing tasks. The goal of studies such as that done by the Saskatchewan Hospital



Systems Study Group (1968) and the *Report of the Review of the Costs of Health Services* (1970) was to break down the work done by nurses in order to make work more efficient and to cut costs. Already, according to Campbell and Rankin, those undertaking the studies were recommending that nurses were wasteful in the length of time they devoted to patient care. Before the advent of such research aimed at creating an exact science of nursing, and into the 1980's, experienced head nurses were responsible for maintaining productivity and determining adequate staffing levels. During this period, although imprecise, "head nurses' judgements about the intensity of any day's work were the best source of expertise available" note Campbell and Rankin (p. 29) and as such, hospital administrators had little control over labour costs or nursing practices.

When nurses were in charge of allocating time, patients themselves were their top priority. Rankin describes her own earlier training as a nurse

In my own 1970's diploma nursing education I recall being told that my first priority was patient safety. Avoiding risk to patients was always to be foremost in my attentions and plans. Once safety was attended to, I was instructed to attend to patient suffering and to provide comfort. Finally, I was told, I was to attend to efficiency – the most practical ways of accomplishing the work. I had to be organized, sequencing my tasks to use my energy sensibly to make sure I completed the required work in a reasonable amount of time. 'Safety, comfort and efficiency' became my organizing mantra (and likely the mantra of my nursing generation) for making nursing care decisions.

According to Rankin, a tangible shift in the rhetoric occurred over the next 10 years so that when she resumed her studies to upgrade her credentials, efficiency had become the reigning concept in the materials she encountered at school. A course on management was now a core course for a bachelor in nursing science, and during the course she was taught that efficiency was

a vital part of management. It refers to the relationship between inputs and outputs. If you get more output for any given input, you have increased efficiency ... since managers deal with resources that are scarce – money, people, and equipment – they are concerned with the efficient use of these resources” (Robbins, 1984, cited in Rankin and Campbell, 2006, p. 147).

Not only had such materials, as Rankin puts it, “taken on a new ‘business-like’ inflection,” but as she notes in virtue of such forms of interpellation “I was being involved in an efficiency that encompassed broader organizational considerations, in which I was being prepared to participate in various ways” (p. 148). That is, nurses were now being called upon to primarily “nurse the organization” rather than focussing exclusively on caring for patients and monitoring their own practice.

### **The Science of Nursing time and the Set-up of Workplace Machinery**

By the time Rankin was pursuing her degree a more scientific approach to nursing administration had begun to emphasize objective measures for care time. The 1970’s had already seen moves in this direction with research conducted that aimed to precisely describe nursing tasks and classify patients, all with an eye to deriving objective measurements of “patients’ needs for nursing care” (p. 28). In other words the time that nurses took to treat different kinds of patients could be averaged out so as to provide a standardized amount of time that administrators could then use to determine staffing levels. “Once ‘needs for patients’ care could be conceptualized in commensurable terms, hospitals (and their expenditures on nursing care) would be less reliant on individual nurses’ judgements about the amount of care that should be provided” note Campbell and Rankin (p. 28). We can see, moreover, how the shift to more scientific conception of the

work process also moves decision-making out of the hands of nurses on the ground floor, and into the domain of managers working with abstract calculations.

The result of such research has been an increasingly mechanized workplace. The patient classifications the authors discuss here are calculations of average times for discharge for patients suffering from particular disorders. “Clinical pathways” are also implemented, a technology reliant on EBM and which consists of sets of “best practices” that “establish, direct, and record (for monitoring variances) key interventions by all clinical staff occurring at timed intervals throughout a patient’s hospitalization” (p. 67). Precisely described procedures result from this process, which serves to direct nursing work and break down patient treatment into half-hour intervals.

In Campbell and Rankin’s view, nurses have, for the most part, internalized managerial priorities and have taken it upon themselves to keep patients on track, and even monitor colleagues to ensure that they are heedful of clinical pathways.

Adopting the mindset and undertaking the activities, nurses’ work along with the work of other involved practitioners accomplished the standardized length of stay ... The clinical pathway technology organizes nurses to see and accept *as a nursing concern* the goal of [for instance, a] five-day hospitalization for joint replacement (p. 69, emphasis in original).

Thus, as Campbell and Rankin note, “The nurses mindset as developed through clinical pathways ensures an *organizationally correct* course of action” (emphasis in original).

Hence, not only are standardized times established for nursing tasks and patient recovery, but an assembly-line productive model that expedites treatment becomes the norm.

Further instances of rational technologies structuring nursing work include the American MCAP™ program, which is admission, discharge and transfer (ADT) software

designed to maximise bed use. It does this by helping to regulate patient turnover and managing the allocation of beds to promote the most efficient distribution of this resource. With the help of this software, administrators assign incoming patients ‘virtual beds,’ or beds deemed likely to be free when needed and the onus is upon nurses to make it so at the appropriate time.<sup>1</sup>

As a patient placement clerk describes it “We admit people but we [may] have no beds for them. They come in before the bed is ready for them. So, in the system we create this place called SDAs [Same-Day Admits]. They are fictional rooms” (p. 52). The system’s predictions, moreover, are made in virtue of calculations based on the categorization of patients, generalized estimates of nursing time, and treatment protocols previously discussed. Decisions are then made about discharging patients based on rooms that are free only in theory, and, as shall be demonstrated, these fictional rooms become more real than the needs of patients currently occupying them.

Layers of administrative machinery are hence now set in place to ensure patients and healthcare workers alike take a fixed route of march through the system. While a statistically average hospital stay has become a reified measure, and therefore a fixed component in hospital administration, many other aspects of care are also weighed down by all the trappings of bureaucratic protocols so that even minor deviations are rendered complex and time-consuming. Moving a patient, for example, is not merely a matter of gathering up belongings and going into another room. Rather, this involves exchanging treatment information, organizing meal delivery, moving records, medications, and

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<sup>1</sup> One nurse interviewed by Campbell and Rankin noted that she had 3 patients allotted to a single bed one day a phenomena a hospital executive called “110 percent utilization” (52).

equipment. Hence, moves involve “not only the patient placement clerks and nurses, but also ward clerks, housekeeping staff, medical records personnel, dietary clerks and so forth” (p. 60), and are, as a result, highly labour intensive.

### **The Weight of an Inflexible and Demanding Reified Apparatus**

Nursing, Rankin and Campbell contend, is not a piecemeal process composed of broken down parts. Rather, nurses are part of a larger team, and objective measurements of a particular task cannot account for time spent helping a colleague, making allowances for a new resident learning the ropes, unexpected ringing of call-bells or the unavailability of other workers. As Campbell and Rankin note, when a nurse’s work day is divided into half-hour intervals and nursing interventions are mapped out minute-by-minute, being stopped by, or having to navigate around, say, worried family members in the hall, or seeing treatments interrupted by non-patients’ needs all begin to appear as a waste of “precious nursing time” (p. 152).

At the intersection of all these precise calculations and carefully planned interventions lie the patients. As the authors note, the use of the technologies described thus far

assumes that patients have standard needs and staffing levels are determined thereby. That is the dominating feature. The patient classification calculations establish standard amounts of time needed for nursing; staffing decisions made in response to those calculations *require nurses* to act as if their patients’ needs were indeed standard (p. 39, emphasis in original).

In light of the severe time constraints under which nurses already operate, the simplest alterations then can become excessively elaborate and further limit any flexibility on the

part of nurses to work with ‘sources of error,’ or patients whose recovery times exceed the standardized recovery times, or who require something other than what is specified in their clinical pathway, such as a caress, some words of hope, or comfort.

“Ms. Shoulder” provides an example of the manner in which the highly organized system in place impedes a nurse’s ability to respond to unexpected needs. Ms. Shoulder had had surgery to repair a torn shoulder ligament and was due to be discharged at 11:00 am. “Precise discharge arrangements were made well in advance of the surgical procedure during her appointment in the preadmission clinic” note Campbell and Rankin (p. 46). In a bid to make her ‘check out’ time Ms. Shoulder had been struggling to wash herself with one arm immobilized. Nurses observed that she was pale, her skin was clammy, she complained of considerable pain and she began dry-heaving during the preparations for her discharge. Linda, her somewhat harried nurse, was splitting her time between Ms. Shoulder and another incoming patient suffering from a serious leg wound. Because there were no doctor’s orders for anti-nausea medication on Ms. Shoulder’s chart, and presumably there was no time to request the medication, “Linda looked at her watch (and seeing that it was close to 11 o’clock, the assigned discharge time) makes the decision to administer an antacid stating that she ‘hopes it will help’”(p. 48). After this hurried ad hoc treatment, Ms. Shoulder gets out of hospital just under the wire looking “decidedly unwell” and is sent home with a cardboard box on her lap in case she vomits on her way home.

Because she is both limited by both time constraints and a pre-established treatment plan Nurse Linda cannot treat Ms. Shoulder *qua* Ms. Shoulder, or address any

of her particularities. Linda has only enough resources to treat the idealized patient so that all those qualities falling outside this category must be, for the most part, ignored. As Campbell and Rankin argue that “patients marginalized ... when efficiency measures constitute them in terms of their cost-relevant parts. As whole bodies and as subjectivities, they become excess” (p. 173).

### **Bed Blockers as Sources of Error**

Workers rendered powerless to respond to another's need by the dictates of rational technologies and sped-up services may perhaps also assuage such difficult feelings by characterising the patient expressing them as undeserving of care. Based on Rankin and Campbell's description of Alternate Level of Care (ALC) patients, it does appear as though such people tend to be othered by staff. ACL patients are those who deviate from the rationalized schemes devised to heal them, and who require forms of care that are not rationally prescribed. In hospitals contingencies sometimes arise such as a lack of support in the home, that mean treatment cannot be expedited. When this happens, patients are labelled ALC, which is a designation Rankin and Campbell had never encountered in their own time nursing. ALC indicates patients who no longer require acute care, but cannot care for themselves at home and therefore cannot be discharged until there is placement in either long-term care, an auxiliary hospital, or a complex continuing care facility. Through this designation, certain patients are flagged as less of a priority so that those patients who can be ushered through the system at top speed will be attended to first.

ALC is an official acronym, and represents a top-down designation flowing from management to the floor, where it appears on patients' charts. In Campbell and Rankin's view, the term is by no means a neutral one that merely serves administrative purposes. Rather, they contend that this designation impacts upon the way that certain patients are perceived, and that this perception impacts judgments about what such persons are owed. As Ian Hacking argues, "defining new classes of people for purposes of statistics has consequences for the ways in which we conceive of others and think of our own possibilities and potentials" (Hacking 1990, cited in Rankin and Campbell, 15). As Campbell and Rankin note, "applying this framework of cost relevance to actual people through the ALC-designation system requires nurses to think of people in *its* terms" (Emphasis in original, p. 86). In short, ALC-designated persons just are Lukács' sources of error.

To explain, in reality, ACL patients are simply those who must take a detour from routine clinical pathways. Yet, as Campbell and Rankin note, nurses often "failed to be convinced that ALC-designated patients actually deserved their care" (p. 84). When planning out their tasks, many nurses say that ALC patients have to wait, explaining that "they're not as sick as the other patients and I have to decide I have to look after the sick ones first." Another nurse restates the issue as: "I focus on the assessments of the treatments of the acute patients first." Nurses and other workers, also tend to classify such patients as "bed blockers" (p. 86) or "inappropriate" (p. 85). Once again, it is the patient who is presumed to have gone wrong if their presence obstructs the smooth functioning of an abstract system predicated on average, standardized recovery times. On paper the



healthcare apparatus appears to be a smoothly functioning, well-oiled machine. Life, however, has no obligation to conform either to mathematical predictions or the algorithmic depiction of complex processes. Patients have varying levels of cognitive abilities, emotional and physical level resilience, and their own unique mitigating circumstances. Campbell and Rankin however, point to a sensibility held by nurses wherein the shape of the system is what ought to determine who is served by it, which once more speaks to the phenomena of reification. “Patients’ needs, they [the nurses] seemed to be saying, should match what is offered, instead of the other way around” (p. 84).

Workers also actively seek to limit their involvement with such patients. In fact, one nurse admitted to Campbell and Rankin that her colleagues would haggle during morning bed assignment meetings in an effort to limit the number of patients who represented “inefficiencies” due to age, social circumstance or high needs for care. Such patients are problematic for workers because the software used to manage beds also functions as a form of surveillance by generating monthly reports of “off-index” or “lag-days,” and doctors and nurses bear the brunt of responsibility for minimizing these (p. 102). The nurse above describes the effect this has on workers and how it serves to define them negatively.

Each month all the clinicians and the physicians wait with bated breath to see how many ‘off-index’ days we had. The implication being of course that the doctor is a ‘*bad*’ doctor if he has too many off-index patient days and that the clinician on the ward is not doing the job of ‘moving her patients out’ appropriately if we had too many ‘off-index days’ (p. 103).

Importantly, age differentials are not factored into standardized recovery times, and often ALC patients are the elderly and frail. That is, they are patients who typically require longer recovery times and more nursing time as well. As Ana stated in Chapter One, “you can’t rush these folks.” Hence, in spite of being indexed as requiring less nursing labour, ALCs are, in reality, difficult and time-consuming to care for. As one nurse describes it

They take a lot of time because they are old, and most of them are really dependent. I mean, that’s why they can’t go home because they need all this help ... I do use a different mindset with these people. I feel sorry for them. There’s not a lot we can do for them here. Sometimes they stay for weeks, and you can just watch them slipping away. They lose their confidence. We watch them get increasingly withdrawn ... I try to make sure they get up in the chair and have some sort of stimulation. I mean we should be dressing them and everything, but it’s difficult. We’re just not set up for that sort of thing here (p. 84).

The impact on staff that the presence such patients might have does not seem to be something that is often considered. One cannot help but wonder if it is not easier to view such patients as inappropriate and underserving rather than bear the guilt and sympathies incurred in those who must watch them slip away because no one has the time to offer them care.

### **The Management and Control of Nurses’ Empathetic Responsiveness**

Just as the system demands a worker to think of patients in its terms, so will it tend to shape her view of whatever sympathies they evoke in her, especially if such responses run counter to the demands of rational technologies. Given both the scope and the weight of the pre-existing apparatus directing their work, coupled with the prevailing RTS paradigm holding sway over modern administrative practises, a nurse’s own

affective responses must seem insignificant by comparison. One nurse notes regarding an initiative to make laparoscopic gallbladder surgery a same-day procedure: “I think it’s a major surgery and I think they can benefit from an overnight stay. However, if I take on that role, that is the nurse coming out in me” (p. 56).

The speaker here seems to minimize the importance of her own conception of patients’ wellbeing relative to the demands of the organization, because as Campbell and Rankin hold, part of “her job is to override such concerns.” According to Campbell and Rankin, administrators see nurses’ concern for their patients as something to be managed and contained. As in the APU, workers’ concern for patients seems to be construed by administrators as irrational. As one administrator puts it, “our nurses will often find reasons why the patients need to stay, frankly, some reasonable and some unreasonable, but that they do tend to be protective here” (p. 56). In the face of such attitudes, nurses learn to manage their own affective responses in order to remain in alignment with institutional priorities.

Likely, there is some relationship between administrators’ view of nurses’ empathy as a factor to keep in check, and nurses’ subsequent turn away from the face of suffering observed by the authors of this ethnography. Campbell and Rankin’s description of an interaction between nurse Trudy and a patient’s weeping spouse helps to demonstrate how in dismissing the importance of their own emotional reactions to suffering, especially suffering to which they are powerless to attend, nurses may also come to discount the importance of the needs being expressed by another. Trudy had already admitted that the wife of a particular patient was likely “in over her head” when it

came to caring for her elderly, incontinent, yet soon-to-be discharged, husband. Mr. Jones, the patient, underwent major surgery to have his prostate gland removed. His nurse notes that it is day 7, which means that his treatment should be finished according to clinical pathways. Things seem to be on track for his release: his stitches are clean, he is dressed, cleaned up and ready to go until, that is, he wet himself due to complications from the surgery. Now the patient must be changed and put in an adult diaper, and becomes irritable and uncooperative as a result (p. 72).

Standardized allocations of nursing time will fail to account for such contingent events. Given the tight budgeting of time, a hectic and rushed mood is created, leaving Trudy, the nurse responsible for discharging the patient, even less able to deal with what comes next. That is, Trudy must also provide aftercare instructions to the patient's overwhelmed and crying wife. During the conversation between Trudy and Mrs. Jones, the latter admits that even before the surgery, she had been having a difficult time coping with her husband. The nurse herself had witnessed fear, confusion and combativeness in the patient during his hospital stay and could therefore appreciate the wife's situation. Trudy's attention at the time, say Rankin and Campbell, was largely on controlling her own desire to rush through her presentation of post-operative instructions for the wife. Her time here is so crammed with predetermined tasks, that she is incapable of fully concentrating upon and attending to the person before her.

This encroachment on the space that might allow Trudy to treat Mrs. Jones caringly is exacerbated by the encroachment of the time she has to carry out her work. In Trudy's view, taking the time to relay instructions and trying to arrange better homecare

is all she can do for Mrs. Jones. Trudy sees her own hands as tied given that incoming patients required five beds, and only two were free at the time. “It’s already too late, you see” Trudy says regarding the possibility of keeping the patient in hospital longer. “The bed’s already booked ... the pressure is on” (p.73).

As Campbell and Rankin note, the nurse appears to have accepted the requirements of the organization, allowing these to overrule her judgement as a nurse. In their book, Campbell and Rankin are primarily concerned about nurses being forced to work in ways that run counter of their professional standards. However, the situations selected by the writers also involve cases in which normal empathetic responses to another person must be suppressed in order to accommodate the demands generated by the rational technologies dictating treatment. The writers note that Trudy has accurately identified an important aspect of Mr. Jones’ recovery that conflicts the ‘virtual’ representation of care, but the fact that the man’s primary caregiver is overwhelmed and requires nurturance herself does not compute within rationalistic schemes used to generate care plans.

As Trudy’s statement below demonstrates, the nurse downplays the significance of Mrs. Jones’ suffering while simultaneously rationalizing her own inability to respond to the distressed woman

I can’t hang onto him because his wife got teary. So I mean, you just kinda kindly bundle them out the door and keep your fingers crossed that home care will catch up with them, and then you start looking after the next one. And let’s face it, it might feel like hell, but that’s not our job. I mean, it might not look like it’s very caring, but it’s just not an efficient use of resources to hang onto this patient for another night because his wife is having trouble coping. There are all these other patients waiting for surgeries to think about (Campbell and Rankin, 74).

In this statement, Trudy seems to be trying to convince her listener, if not herself, that no real contradiction exists despite the fact that she is standing at the crux of a paradox. That is, she is part of a highly organized system that is designed to heal people, and yet she is precluded by its very design from being able to tend to the individual needs of those, including patients' family members, that she encounters face-to-face in the workplace.

Trudy's own distress, occasioned by her failure to respond to the suffering clearly written upon Mrs. Jones' face, is automatically discounted. This feeling 'like hell' is characterised as extraneous to her proper functioning as a nurse. Trudy's attitude towards her own subjective state is understandable considering the ontological priority discussed in Chapter One that the medical sciences give to objective and quantifiable phenomena. Moreover, as Campbell and Rankin note, more broadly, nurses such as Trudy have constructed their "understanding about competent nursing practice within the scarcity and rationing practices of contemporary health care reform and hospital restructuring." Hence, rather than attending mainly to the person in front of her, "the nurse's job is to think of 'all those other patients waiting for surgery'" (p. 74). This last form of justification will become especially relevant in the following chapter, which I shall begin by taking a closer look at Trudy's dilemma here.

For now I shall note that as the statement "it might not look like it's very caring" reveals the possibility that Trudy's lack of responsiveness might represent a genuine failing is characterized as a mere matter of appearances. It is nothing more than an illusory problem. What counts here is efficiency, and what are real are the demands stemming from rational technologies structuring her work. Hence the moral failing Trudy

experiences simply cannot be what it seems. There would be a significant cost to addressing such a paradox, moreover, given that the statement “I feel bad for Mrs. Jones” would hardly cut it with administrators if Trudy were to try to argue for an extended stay. Hence, the paradox is effectively dissolved by downplaying the significance of Mrs. Jones’ suffering, and Trudy’s own response to it.

## **II. Contemporary Psychiatric Inpatient care**

It might be argued that nurses such as Trudy have not primarily been trained to cope with other people’s emotional distress and that that psychiatric workers take this aspect of their caring duties much more seriously. After all, psychiatric wards are apt to draw people whose primary complaint is psychological distress, even to the point where some will be suicidal. However, if we look at the daily practices of inpatient psychiatry, we see many of the same rationalized techniques being implemented to provide quick and expedient care.

In this second section I aim to construct a picture of contemporary psychiatric practices based on a wealth of ethnographic data primarily found in nursing literature. As the selections from this literature suggest, rationalistic and expedient forms of treatment pose a special problem for psychiatric care because compliance is especially crucial for the implementation of tightly controlled and regimented care plans. As a result of this need for patients’ compliance, we shall see that discipline and control, as well as the use of drugs, persist as enduring aspects of psychiatric treatment and hence perhaps undermining worker/client relatedness. Moreover, given both the cutbacks in nursing

staff and the evidence-based culture that dominates thinking around care, most psychiatric patients also receive impersonal care. Here, too, healthcare workers are often forced to ignore clients' needs, and many suffer as a result.

To start with, it will be useful to describe the nature of modern inpatient psychiatric wards. Mental hospitals today are considerably smaller than the vast asylums of the past (Thibeault et al, 2010) and stays are considerably shorter, lasting weeks or days as opposed to months or years (Cleary, 2003, Quirk et al, 2006).<sup>2</sup> Quirk et al, moreover, have described modern psychiatric facilities as “permeable,” meaning that the abrupt disconnect Goffman observed between the environment inside and the world outside no longer holds. Patients entering mental wards today are generally in close proximity to residential areas and are more able to move in and out of the building during periods of hospitalization (2006, p. 2110).

Generally speaking, moreover, the story being told in the psychiatric nursing literature is the same whether we look at Canada (Austin et al, 2003), Norway (Hummerlvoll, 2001), Australia (Cleary, 2003, 2004), New Zealand, (Fourie et al, 2005), the US (Donald, 2001, Shatell et al, 2003), and the UK (Ford et al, 1998). That is, industrial countries are seeing cutbacks in mental health resulting in staff reductions so that nurses have less and less time to spend with patients. As Michelle Cleary, the author of an ethnographic study of Australian psychiatric nurses, notes

Nurses spoke about the constant pressure to meet the unrelenting demands 'now', feeling 'squeezed like a sponge', being 'pulled in different

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<sup>2</sup> In fact a recent advertising campaign by Centre for Mental Health and Addiction reads: “What you need is a night out” which is meant to capture common uninformed perceptions of mental illness. Below this text is written “or, in some cases, a 21-day stay,” pointing to the trend towards shorter treatment times (Subway advertisement. Toronto, ON. Observed June 27, 2012).



*directions*’ and being ‘*run off*’ their ‘*feet*’. Nurses said they were ‘*stretched to the limit*’ and identified their work as ‘*emotionally draining*’ and stressful. They spoke about feeling ‘*exhausted*’ and being ‘*unable to think*’ by the end of the day. Moreover, abuse of nurses by patients was considered relatively commonplace. One nurse told how she had already been ‘*punched*’ and ‘*hit*’ that morning (Cleary, 2004, p.55, emphasis in original).

As this last statement would suggest, psychiatric nurses deal with a greater number of unruly patients than other nurses and probably see more havoc erupting in the course of their day. Cutbacks and hospital bed closures, in fact, have raised the threshold for conduct deemed worthy of hospital admittance. As a result more acute (Cleary, 2003) and more dangerous (Currier and Allen, 2000) patients are concentrated in remaining hospitals. According to nursing professor Len Bowers, ‘the admission of people suffering from severe mental disorder implies that the ward and its multidisciplinary team are faced with the task of managing behaviour which has been found intolerable in the everyday world outside ... Even within the tolerant environment of the psychiatric ward, the disruption created by some disturbed patients is difficult to manage, and psychiatric nurses talk about these patients as ‘management problems’ (2005, p. 234-235).

### **Rational Technologies in Psychiatry**

However, while patients are more difficult to control, treatments are coming to resemble rational technologies. Campbell and Rankin note that in Canada “even patients experiencing mental health illness are grouped and categorized to determine ‘optimum’ (efficient) lengths of hospital stay that can be defended as evidence based and quality assured” (2006, p. 75). Moreover, according to Alistair Donald, an American psychiatrist

and anthropologist, in the US “madness has become an industrialized product to be managed efficiently and rationally in a timely manner as it passes through the hands of clinic workers” (Donald, 2001, p. 435).

According to Donald, the assumption that mental illnesses are specific biologically-based diseases has led to the view, promoted by proponents of managed care in the US, that “the practical treatment of each mental illness can be rationalized and streamlined and made economically efficient” (p. 429). Hence, for example, anyone diagnosed with major depression with psychotic features is likely to be met with an optimal recovery guideline (ORG), one of a whole series of “rational templates for the treatment of specific illnesses” in which people fitting a particular diagnosis receive more or less identical interventions.

As Donald describes it, our hypothetical patient may well be treated using a step-by-step

plan of action for a 4-day hospital stay in which a patient who is admitted on day one for suicidal or otherwise harmful behaviour to himself, and who shows other signs of recurrent major depression and/psychosis, is turned by day four into a person who is able to cope with day-to-day life, is not suicidal, and may be released to his home (p. 433).

As Donald points out such plans consist of evidence-based practises that in turn, are the result of population-based research. Doctor V, the medical director of a Managed Care organization calls this approach an “algorithm of care” adding that “what people will get is treatment that has been proved effective in large numbers of people and which will hopefully lead to the (better) health of the population at large” (p. 430). In other words

the hope is to transform the individual by means of something akin to an industrial process designed for a general type or category of patient.

### **Rational Technology, Havoc and Discipline**

Given the well-known propensity of psychiatric patients for creating havoc, a special problem is created for caregivers implementing carefully timed, rationalistic plans aimed at shortening treatment times. As with regular hospital settings, getting patients out the door remains a priority, but more standardized and rationalistic procedures are being implemented in order to achieve this. As Alexander and Bowers speculate, this means that “ward rules may be implemented rigidly because patients are expected to comply rapidly with the treatment regimen so that they can be discharged” (2004, p. 623).

This speculation, moreover, is borne out by psychiatric patients’ descriptions of their hospital stays. According to one study of 38 admissions to two Montreal psychiatric wards, patients were struck by rules and restrictions unique to psychiatric units, such as locks on doors, and the confiscation of clothing and belongings. “Furthermore,” Letendre observes that patients “must submit to the regulation of everyday life imposed by the staff as regards times to get up and to go to bed, meals, hygiene, periods of activity and inactivity, permission to leave the ward or the hospital, etc...” (1997, p. 290). Moreover, 71 percent of patients who had been optimistic that psychiatric staff could help them saw their hopes disappointed. “When faced with staff’s authoritarian attitude, which focusses on applying rules and controlling symptoms through medication while excluding any

possibility of establishing a truly therapeutic relationships, disappointed respondents tend to become distrustful of staff members” (p. 292).

By and large then, Letendre’s subjects saw staff as rule-enforcers and themselves as “being treated like children” kept in the dark about treatment decisions (p. 293). As former psychiatric patient Judi Chamberlin describes her reaction to stays in hospital “I hated the regimentation, the requirement that I take drugs that slowed my body and my mind, the lack of fresh air and exercise, the way we were followed everywhere” (Chamberlin, 1998, p. 49). However, if people are in hospital in the first place because they have demonstrated a marked inability to adhere to social norms, then getting such individuals to acquiesce to hospital discipline may seem especially problematic. It should come as no surprise then, that drugs are typically the first-line of treatment for patients coming into mental wards (Fabris, 2011) as well as a primary treatment modality (Letendre, 1997).

### **Medication as Discipline**

At least some patients, moreover, see medication itself a punitive measure aimed at controlling disruptive behaviour. According to one patient in a British study “all of a sudden bang, and if you do something like [express anger] that you’ve got to be careful or you get an injection. You have to be careful how you behave” (Alexander, 2006, p. 549). However, in order to have a disciplinary function, drugs need not be a punitive measure, but may represent a means of rendering a patient compliant and amenable to treatment. Given the broader institutional context in which psychiatric drugs are

administered, it is open to debate whether they are medicines for diseased minds or more of a “chemical restraint,” as Fabris (2011) contends.

Fabris is a scholar who has been forcibly medicated in the past. He notes that “treatment is defined by clinicians, who tell patients that medicine will calm us and get us ready for the community as best as possible. Assumedly, medication would work in a shorter time than psychological treatment or social support alone” (p. 54). In observing a woman medicated with a first generation antipsychotic (FGA), Fabris notes “she is so passive, so amenable to the plans that others make for her, that she relents easily” (p. 49). The writer also cites research demonstrating that FGAs were found to render patients “less troublesome in a hospital context, but who were, it was conceded, not fit for release” (Glick and Margolis, cited in Fabris, 2011, p. 52). However, Fabris notes that research from the 1970’s also showed that such patients failed to thrive in the community and remained a burden on their families.

As for the presumably more efficacious and improved second-generation antipsychotics (SGAs), research has shown such medication to be better than FGAs “in the treatment of acute agitation” (Yildez et al, 2003, cited in Fabris, p. 51), which speaks of a tranquilizing effect. However, high rates of non-compliance with the reputedly new and improved atypical antipsychotics such as risperidone and olanzapine, speak against claims of greater efficacy for such drugs. A recent review of the literature showed compliance rates to be only marginally better for SGAs, while non-adherence rates for FGAs ranges from 24 – 90 percent depending on the study (Voruganti et al, 2008). In fact, one 18-month study comparing FGAs and SGAs saw 74 percent of all subjects

dropping out before the trial could even be completed (p. 135). If people do not like these drugs, they will not take them, and if they will not take them, then the scientific data supporting their efficacy is misleading at best.

Moreover, as Lentendre's research demonstrates, when patients are entering hospital, many are not looking for medication. Those patients who were forcibly medicated (23% of 47 admissions) "perceived medication as an aggressive intervention," while those entering for the first time (21% of 47) say "having medication prescribed to them comes as a shock." Even those patients who recognize that medication alleviates symptoms and prevents relapse complained that medication "numbs the brain" while producing a long list of unpleasant side effects such as "overall loss of ability to do things, general paralysis, hyperactivity, somnolence, dry mouth, tremors, nausea, blurred eyesight, spasms, major weight gain, etc ..." (Lentendre, 1997, 291).<sup>3</sup>

There is little reason to suppose that such attitudes are an important factor for those providing care, however. According to one forcibly medicated patient, "nobody has ever asked me why I have been crazy and mad when coming to the hospital, they have just injected Cisordinol [an FGA], telling me that 'this is no family therapy.'" The authors of the study in which this patient is quoted also note that when they compared patients' and nurses' perceptions of forced medication, "most patients expressed an awareness of having a mental health problem, whereas most nurse statements are concerned with patients demonstrating a changed behaviour" (Haglund et al, 2003, p. 70).

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<sup>3</sup> Various clinical trials have shown weight gain for 50 – 80 percent of subjects, while there are accounts of 10 patients developing diabetes, or seeing symptoms exacerbated with SGA therapy (Lieberman et al, 2000).

## Factoring in Staffing Cuts and Time Constraints

Given what appears to be a widespread aversion to psychiatric medication, any preference for such therapies derives from a source other than patients themselves. To understand why workers might be the ones most in support of medication, however, it is important to understand the context in which they work. The unpredictability of clients, coupled with seemingly ever increasing demands for efficiency heightens the stress of those, such as nurses, who work most closely with clients. According to Cleary,

This unpredictability of the unit was reflected in the commonly used metaphor '*touch wood*' and the gesture of touching wood. Nurses explained this as '*anticipating*', the need to '*be prepared*', and having in the back of your mind that all '*hell might break loose*'. Not knowing who the next person would be and when they would walk through the door, and dealing with unexpected and challenging patient behaviours as well as situations, all contributed to this unpredictability (Cleary, 2004, p.55).

Meanwhile, in Norway, a psychiatric nurse admits

On and off I worry about going to work, you never know what will happen ... and if something happens, if I can rely on getting some help to solve the problems. It is so stressful, we have too many things to do in a short time (Hummelvoll and Serverinsson, 2001, p. 20).

Given the numerous competing demands on a nurse's time, one ought not wonder why many want to see clients pacified with medication. As one RN in a study of New Zealand nurses explains

Some of the doctors are reluctant to treat the new admissions . . . and they say things like 'Lets just assess them for a few days.' Lets not. If you have someone come in who is psychotic, who's frightened and paranoid and are bashing the wall down or hitting their head against the wall, I don't want to assess them for three or four days. I want them treated (Fourie et al, 2005).

It is unclear how a nurse can hope to attend to frequent outbreaks of havoc while also fulfilling her numerous other equally time-consuming duties. As we have seen,

nursing time is increasingly controlled in order to maximize productive activities. Meanwhile nurses are also responsible for charting, discharge planning and transfers, accompanying patients to court, electroconvulsive therapy or other appointments, communications with external agencies and patients' families, team co-ordination, and numerous other tasks identified in ethnographic literature on psychiatric nurses (Cleary et al, 2011, Cleary, 2004, Deacon, 2003). As such, drugging patients is necessary if nurses are to satisfy the role allocated to them within efficiency-oriented healthcare regimes.

### **Impersonal Psychiatric Care**

Seeing the RTS paradigm structuring work then appears to entail the requirement to exercise control over patients' bodies, meanwhile, this approach to treatment and disease also renders care impersonal. As Phil Barker contends, the worldview associated with an evidence-based culture "urges us to swap our ideas of crafting care around the unique complexity of the individual, for a generalisation about what worked for most people in a study, which he adds "demolishes [nurses'] traditional practise" (2000, p. 332). Similarly, in regards to patients subjected to treatment plans designed for a mass population, psychiatric nurse Richard Lakeman argues that, "public mental health services tend to involve people with complex needs, multiple problems, and uncertain diagnosis" (2008, p. 321). Population-based research, meanwhile, will tend to wash out contextual factors that might skew results and limit generalizability.<sup>4</sup> "Whereas,"

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<sup>4</sup> It is striking how closely research for evidence-based medicine resemble the methods of mass production. Certain standardized (i.e. replicable double-blind studies) methods are employed in order to generate a product (in this case, findings) that are maximally generalizable to as many members of the population as possible.



Lakeman argues, “practice is concerned with specific individuals” (p. 322). In Lakeman’s view, the “background noise,” that tends to distort or bias generalizable findings, is crucial for psychiatric care. For example “a person who has a depressed mood may have reasonable concerns about losing a job, foreclosure on a mortgage, and an impending acrimonious divorce.”

Such factors, however, are not necessary for the purposes of psychiatric diagnosis, which will, in turn, determine treatment modalities. In the US, DSM diagnostic categories are used for this purpose and to satisfy the bureaucratic requirements of insurers. As nursing professor Beverly Hall notes, given the turn to biological accounts of mental illness, it is widely held that one needs only a narrow understanding of a patient since only the observation of the symptoms of the disease are required to classify a person. Hall argues

positive aspects or strengths of the person are ignored in the diagnostic scheme, which focuses narrowly on problems defined from biochemical or psychodynamic perspectives. The result is a contrived and sanctioned dehumanization of the person during the diagnostic process. Prognosis arises from diagnostic categories that do not take into account personal differences and contextual factors, forcing competing social, economic, and cultural factors that might be considered as foreground to recede into a very obscure background ... These descriptions are so standardized that they can be published in a manual for all practitioners and for use with all patients, regardless of culture, language, or personal characteristics. They can be used in this form because they flow from the assumption that diagnosis can be achieved almost entirely from outside the person.

According to Hall, this view of mental illness further objectifies patients because diagnosis

separates the knower from the known, because it invites the health professional to focus on the diagnosis rather than the person with the diagnosis. By categorizing aspects of the person (eg, the mind, the emotions)

as a disease, the whole person can easily be viewed and then treated as a disease, reflected in the phrase, "She is a schizophrenic." (1996, p. 16).

On such an approach to psychiatric care, the person has shifted from a complex, meaning-rich individual to an illness category with an identifiable proximal cause. Emotions have become things. Treatment has become an algorithm. "Under the guise of EBP," contends Lakeman, "practitioners of all kinds can be reduced to gatekeepers, data-collectors, and guideline followers, and the patient to a standardized case to be managed rather than a person to be engaged with" (p. 323).

Elenor Longden's surprise on meeting a psychiatrist who sought to relate to her as a person is evidence of the detached level of care psychiatric patients receive as a result of such attitudes

The very first time I met him he said to me, "Hi Eleanor, nice to meet you. Can you tell me a bit about yourself?" So I just looked at him and said "I'm Eleanor and I'm a schizophrenic." And in his quiet, Irish voice he said something very powerful, "I don't want to know what other people have told you about yourself, I want to know about you." It was the first time that I had been given the chance to see myself as a person with a life story, not as a genetically-determined schizophrenic with aberrant brain chemicals and biological flaws and deficiencies that were beyond my power to heal. Previously I'd been told by a psychiatrist that I would have been better off with cancer as it would have been easier to cure (Longden, 2010, p. 256).

As Letendre's research suggests, moreover, patients do not enter hospital looking for diagnosis and medication; they come in looking to talk. "I thought I could have regular, individual talks with the staff on the ward," says one disappointed patient in a different study. "I was hoping to find some help to find some new tracks in life" (Hummelvoll and Severinsson, 2011, p. 21). In a study of milieu experiences, researchers found that when they tried to discern how psychiatric patients experienced the

environment of an acute psychiatry ward, subjects mostly tried to talk about relationships. “It is person-to-person interaction on the inpatient unit that creates meaning for the patient. In other words, when asked to talk about the environment, patients wanted to talk about interaction” (Thibeault, et al, 2010, p. 216).

This theme also surfaces in studies of patients’ perceptions of quality care. In one survey of inpatients and outpatients all those interviewed agreed that a warm helping relationship, and being understood by one’s therapist were crucial components of quality care. Subjects also said that they needed time to open up, and many saw therapists as rushing the work. The authors of the study note that “according to the patients’ perception, the therapists were convinced that they should be efficient and ready to act, but the patients did not share this belief” (Johansson and Eklund, 2003, p. 242). Meanwhile, the most popular response from another set of psychiatric patients identified “accessibility” as an important aspect of good care. “It means so much, just knowing you can ring and talk to somebody.... You may not have to go there; perhaps they can give you advice over the phone” says one interviewee, explaining the importance of just having someone to talk to (Schröder et al, 2006, p. 97).

It is unlikely, however, that patients will form supportive relationships with psychiatrists. Many of Letendre’s subjects, for example, said they waited days to see a psychiatrist, and even then, the visit was brief and doctors mostly spent their time administering a questionnaire (Letendre 1997, p. 292), which speaks the limiting effect of objective diagnoses on client/patient relationships. There is reason to suppose that such brief and impersonal encounters may be a fairly typical experience. In fact, psychiatrist

Albert Kushlich describes himself and his colleagues as “hit and run” likening psychiatrists to “DC-10’s: flying in and out of the clinical settings; offering direct care for 10 minutes” (cited in Barker, 1999, p. 82).

### **Workers Responses to Patient’s Unmet Needs**

Regular workers then, who are more regularly exposed to patients, cannot help but bear witness to what seems to be a deeply felt need for connectedness over and above rationally prescribed treatments. As one nurse describes her response to her current work environment

It’s like working in a warehouse; people are just locked up. They’re not really treated psycho-socially from what I think they need. And they’re just given all these medications, try this, try that, you know just take a pill. I really feel like I don’t know any of these people; I know a name, a diagnosis, I know a med I’m giving them, but other than that I don’t really have a lot of time to learn these people. So I feel that a whole part is gone, and that was actually part of one of the biggest rewards in working here many years ago, was the relationships. I really got to know people, over a long period of time and got to make changes with them; people actually did change. (Donald, 2001, p 43).

Hence, some workers are saying they feel disconnected from their clients due to impersonal treatment regimens, and express regret at their inability to effect significant change in people’s lives. Meanwhile bearing witness to suffering they cannot alleviate causes outright anguish for others. Jean, a Canadian nurse helps to relay the sort of suffering that she, and others in her field, experience due to the constraints under which they aim to provide care. One night, says Jean, she “froze in her tracks” while walking out to her car after work. This is because she heard “one of the patients *scream, scream*

*his head off.*” According to Jean the patient was an elderly man who will likely die in hospital. Jean knew he was not screaming for medication, he had received that already.

He is screaming because of what she describes as *mental pain*. His pain, his suffering touches her. As Jean listens to the man who is crying out, she is aware that there will be no one going to him, comforting him: She knows the nursing staff will not have time tonight. Even acutely ill patients cannot be spared much time. *There is too much to do*, she says. If one patient takes an extra five or 10 minutes the staff will never catch up. Death is coming, if slowly, for this man and Jean suspects, expects, that his death will be a horrible one. For her a horrible death is a lonely one. Like many of the others here (*warehoused here*, she says), he is essentially alone (Italics in original, Austin et al, 2003, 180).

As with Nurse Trudy, the environment in which Jean works appears to be taking a heavy toll on her due to her empathetic responsiveness, which may be why, as we see in the next section, workers are explicitly encouraged to suppress or control such impulses in order to better accommodate the demands of a reified system.

Before turning to my last ethnography it is worth remarking that even if nurses are being run off their feet and work within a paradigm that fails to ascribe therapeutic value to relationships, this does not entirely preclude connections forming between them and clients. However, it appears that the more meaningful connections are apt to take root within those small spaces that permit for spontaneous interactions between workers and clients. For example, one patient describes a nurse who came into the patients’ lounge to watch a reality TV show along with patients. As he tells it, “it wasn’t just the patients watching the TV and the nurses behind the station, you know? Because there is this social line.” According to the patient, this action resulted in a conversation with a third person present at the time about what it was like to suffer from schizophrenia. “There’s a lot of

mystery there and I think that interaction at a special level made all the difference in the world” (Thibeault et al, 2010, p. 221).

The sense of specialness attached to such interactions, however, helps to illustrate their departure from the norm. Christine, another patient being treated for severe depression, relates the following story

B (nurse) was wonderful. She sat on the bed and she cuddled me. She rocked me like a child. I can see it as clearly... and she patted me and did all those sorts of things. And that moment in my time meant more to me than anything else. Meant more to me than any words, anything at all (Moyle, 2003, p. 105).

Subjects in the same ethnography, however, also described being yelled at by nurses and other staff, while others noted that an entire day could pass without them seeing their primary nurse. Not surprisingly then, patients designate certain workers as “one of the special ones” meaning these are nurses with whom the patient can relate. Given the harried atmosphere of the psychiatric ward, it would appear that only borrowed or stolen amounts of time and space allow for such interactions to occur. Such is the case, however, in permeable institutions where administrators seem to accept high turnovers in staff as the norm, while also relying heavily on casual labour (Quirk et al, 2006, p. 2110). It would seem that under such conditions workers are conceived as little more than interchangeable units in the rational delivery of care.

### ***III. Emptying Beds: The Work of an Emergency Psychiatric Unit***

If the previous ethnographies provided subtle evidence of the lack of value placed upon relatedness in modern healthcare environments, the next (Rhodes, 1995) lays the

claim bare. Here, we see how a reified conception of an organization's function coupled with the intense need to speed people through the system results in the explicit othering of mental patients and the overt denunciation of the importance of workers' empathetic responsiveness. Evidence of such consequences of the rationalization of human services is perhaps more subtle in previous sections, whereas the phenomena of othering and the suppression of empathetic responsiveness is plain to see in the grittier-sounding, more anarchic environment described by Rhodes.<sup>5</sup>

Part of the reason work in the acute psychiatric unit (APU) was conducted at a relative breakneck speed, was that the resources of the ward were sufficient only for the quick containment of havoc rather than representing workers with the means to providing treatment. The first thing to notice about the APU is that it lacks the sophisticated managerial techniques and rationalized technologies described in the previous sections. In fact, the APU was decidedly anarchic compared to the more controlled hospital environments previously discussed, which, as we shall see, opened up unexpected opportunities for relationships to take root, relationships moreover that appear to effect something of a paradigm shift described in Chapter One where one's perceptions switch from privileging reified work processes to seeing another as one with whom one might connect. What is interesting about Rhodes' account for my purposes, is how the role of the APU becomes reified such that it's overarching goal – the quick and expedient dispatching of patients – was not only accepted by workers, but even embraced. The

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<sup>5</sup> Rhodes's descriptions are more evocative of a frontline military unit during war time than they are of the seemingly controlled and tightly managed hospital environments described so far.

needs of the people moving through this system, moreover became secondary to the overarching imperative which was, as the book's title would suggest, to empty beds.

### **A Brief History of the Douglas Center and APU: From Oasis to Filtering Device**

The Frederick Douglass Community Mental Health Center, the site described by Rhodes which was built in the mid-1970's (Rhodes, 1995, p. 1) and appears to have been explicitly designed to provide a space for psychiatric clients to connect with their broader community but would stray from the original intentions of the center's designers due to funding cuts. Originally, for example, the APU had been conceived as an informal treatment facility or as Director of Emergency Services Ben Caldwell puts it, "a crash pad" (p. 85). The idea was to provide prompt and expedient care to people in crisis, but without removing them from their family or their own neighbourhood. As for the broader facility, planners had hoped to include a swimming pool and an auditorium in order to draw in members of the community at large, and thereby provide an "oasis of mental health" with an open door policy.

The finished product, however, disappointed many. One of the building's original planners walked through the building after it was constructed saying it lacked "the warmth [we had planned]; it was like a mental hospital" (p. 87). According to Rhodes, the move away from original intentions also involved a shift towards becoming a bureaucratic entity or a hospital with a more traditional workplace hierarchy. In the early days before the Douglass Center was built, workers, some of whom would later end up as staff in the APU, were already providing mental health services in the community.



According to some, their workplace was non-hierarchical and egalitarian, and they did not dispense a great deal of medication. Many even went out into the community to care for people. “She was right there in the middle of people’s lives,” Rhodes writes of one such nurse interviewed. “Free to come and go when needed and to solve problems in whatever way possible.” As Sally Morrow, who later would work as a screening nurse, states, “that was *my* idea of community mental health” (emphasis in original, p. 84).

When the center was finished, however, Ben explains how so-called “indigenous” workers, who’d been ensconced in the broader community became “colonized” and turned into “regular hospital employee[s].” A ‘regular employee’ Rhodes’ explains is one that is “bureaucratized, and set to the mindless processing of patients” (p. 88). Hence, where practice had once been shaped by clients’ needs, with the establishment of the Douglass Center, workers’ roles were now determined by the requirements of the organization. For staff this meant that forays into the community were halted, and the center’s focus shifted to being a medicalized inpatient facility. “The paperwork has increased,” commented Sally, a screening nurse who’d witnessed the changeover. She also adds that “in the old days we didn’t have medication to dispense. Most of the patients were in real crisis; we dealt with it by intervening, talking, brief therapy, and sending them to clinics. Now medicine is more accessible. But very often medication is not always indicated. Some of the residents rely on the prescription pads ... [before] we didn’t pump them full of crappy meds” (p. 89).

According to Rhodes, there was constant pressure on the nine beds that existed on the ward along with “the constant threat of a bottleneck within the unit that would make

beds unavailable to “emerging patients.” As Sally explained it, the Douglass Center had become more accessible to people who used to cope on their own, but who now threatened to clog the system. At the same time, people all over the city were being dropped off at the APU. “The police and other agencies are more aware of the Douglass Center. The whole city thinks we should be all things to all people.” The kind of patients who landed in the APU, moreover, were those found smearing feces, claiming to be God or undressing in the street. In other words, people flagrantly wreaking havoc.

Given this context, the sort of work that was possible with patients was limited. As staff saw it, patients “climbed the walls” and a primary task was “to get them off the walls” (p. 37). To such an end, psychoanalysis was not an option, as it would be overly time-consuming. In general, Rhodes notes “they [the staff] did not allow theoretical speculation to take them very far from the practical realities – the patient’s medication, potential for disrupting the ward, and options for discharge. Separation problems were interesting, but separation for the unit was paramount” (p. 64). Medication, perhaps then represented the most efficient way to alter patients’ disruptive behaviours in order to quickly eject them back into the community.

Thus, the APU evolved from a crash pad into a frontline buffer standing between patients wreaking havoc in the community and the scarce longer-term beds upstairs. By the time Rhodes began conducting her ethnography, she saw that the “the APU staff dealt immediately and directly with acutely disturbed patients, medicating them, secluding them if necessary and getting to work quickly on the task of getting them out” (p. 36). It was this particular understanding of the APU, moreover, that, based on Rhodes’ account,

seems was taken utterly for granted or reified such that clients' particular needs and workers' own responses to their charges became of secondary importance to this perceived function of the ward.

### **Reification: Filtering the Teeming Masses**

A view of the APU as a screening device to filter out inappropriate admissions is concretized in a statement made by Ben. "Only when the bacteria become virulent and invasive do we have to call on the APU to neutralize the "unwelcome invaders,"" he said to Rhodes (p. 47). Evidently, those patients who could be stabilized and released quickly were akin to an invasive infection. No doubt, the scarcity of resources informed his view here, a view that prioritized the needs of the organization to such an extent that those whose needs it cannot meet are characterized as pestilence.

As Rhodes notes, numerous researchers have documented the pressures on workers in healthcare facilities that are "swamped" with new admissions yet lack adequate bed space and staff to accommodate the teeming numbers of patients. At some point along the way the historically contingent factors that gave rise to this situation seem to have been forgotten. As such the APU's current configuration was normalized to the degree that it shaped workers' normative evaluations of the unit. In other words what the ward could provide patients became what it *should* provide while also serving to fix ideas as to what kind of patients ought to be served by the facility.

Even Sally, who said she missed the old days of the Douglass Center, now felt the ward ought be a quick "in and out place." She explains further that

the whole hospital is full; now what will I do over the weekend? The APU is misused when it is treated like a haven; we should give the patients meds and let them sit out in the lobby for an hour or so and send them home if they get better, not just let them in. That's what I'll have to do anyway over the weekend (p. 58).

As for patients deemed appropriate, they were those highly acute cases requiring emergency containment (p. 56). That is to say, only the sort of patients for whom the APU could provide were thought to belong on the ward. This was despite the fact that numerous distressed people were beating down the doors looking for some kind of help. Regardless of such demonstrated need, the notion that the APU ought to be adapted rarely seems to have been entertained, which speaks to the ideological impact of reification. The notion that the APU could ever be 'all things to all people' was simply a nonstarter. Instead, the APU and all its limitations represented the gritty reality to which people entering into the system were forced to adapt.

### **Ethos of Efficiency in the APU**

The most obvious way workers adapted themselves to the requirements of the apparatus was by thoroughly embracing the value of efficiency to swiftly discharge patients. As Ben notes, for him "everyone is an inappropriate admission. I don't admit patients, I discharge them" (p. 41). This view of the role of APU moreover trickled down to regular staff, leading Rhodes to observe that their main objectives were to "'place," "dispose of," "dispatch" or "turf" patients" (p. 31). "We discharge in 10 days," notes Ben, "so we won't be tempted to treat them and screw up" (p. 40). Sam, the head psychiatrist adds

On the APU, quick treatment is part of the job. We don't pretend to ourselves or the patient that we are providing complete treatment; I say to patients, "You're not getting treated here." One patient said to me "You're here to expedite, not to alleviate." I said, "You're 100 percent right" (p. 58).

The story of "God, who took Trailways," demonstrates how the imperative to empty beds played out on the ward. God, in this case, was a woman named Marilyn Nolan who Rhodes describes as "penniless, psychotic and friendless in a strange city" and who was admitted to the APU after becoming violent on a public intercity bus heading to Midway City, US. Instead of treating Nolan – she was a voluntary patient who could not be forcibly medicated – staff engaged in a bit of detective work all with an eye of getting her out the door as soon as possible. It was soon revealed she had a doctor and a social worker in New York.<sup>6</sup> In other words, Nolan was someone else's problem and could be expediently dispatched as a result.

In no time at all then the "quiet, neat middle-aged woman with an unassuming demeanor" was summarily dispatched to New York by bus. Rhodes notes that staff were racing against time, worried that her symptoms would flare up again and interfere with the travel plans made for her. At one point a social worker in New York even asked for the process to be slowed down, which made Sam exclaim "she thinks its short notice! Now my idea would be to call the doctor there after she is on the bus ... we can write in the aftercare note: "Appointment made with Doctor X"(p. 35). According to Rhodes, Nolan never made it to New York. It would seem she fell through the cracks, and "[n]o

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<sup>6</sup> Rhodes does not identify the city of the Douglass Community Mental Health Center, hence it is unclear how far away it was from New York City.

one ever found out what happened to her, though she lingered in the memory of staff as “God who took Trailways’ (Rhodes, 1995, p. 36).<sup>7</sup>

As the cavalier treatment of Nolan demonstrates, caring for, or nurturing patients was not an important job requirement. Instead, workers tended towards an instrumental stance and embraced the cognitive puzzle-like aspect of the work that involved sorting patients and engineering potential placements. “Sometimes I feel like a detective,” explains Robert who as a social worker played a key role in placing clients. Clients would be sent on to jails, hospitals, boarding houses or shelters, depending on the fit between the client and available amenities. For staff, the long-term institutions were an idyllic remnant of the past given the current shortage of space at such facilities.

Finding a placement then was a strategic endeavor that involved not only a working knowledge of available resources, but also a certain amount of deviousness and cunning. Improvised unorthodox ‘treatments’ might be employed, such as the “VIP treatment” to hurry patients out the door. A patient receiving the VIP treatment was secluded in his room, put on a 1200-calorie diet with no salt and denied cigarettes (p. 143). “Anything that might open up a place was considered, and subterfuge was sometimes a necessary part of the game,” notes Rhodes (p. 68). “It’s a shifty game,” says Sam, “and you have to seize opportunity as it arises” (p. 55).

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<sup>7</sup> This story is evocative of Foucault’s discussion of Bosch’s “Ship of Fools” which depicts a group of mad men sailing off to sea in a small boat. According to Foucault, this painting is one of “many signs that the expulsion of madmen had become one of a number of ritual exiles” (Foucault, 1965, 10). Madness was a sign of impurity and sin, and like the sea in its unreason and turbulence. Hence, Foucault suggests it would have seemed natural to those living in these times to cast out the insane by ship leaving it to the “breathe of God to bring it to port” and otherwise purify the tainted souls onboard (12). Similarly, APU staff was keen on making patients someone else’s problem.

Sam's comments suggests that he finds little reason to question the drive to expediently discharge patients. On the contrary, he seemed to embrace this mandate and concentrated on quantifiable results. For example, he would sometimes announce "scores" or the number of beds they're recently cleared. "We're down to five," Sam might cry out. "We're in good shape" (p. 60). Then, on one occasion after successfully placing several clients he exclaimed "this is how we will save the hospital!" (p. 61) demonstrating the sense of importance associated with keeping a certain number of beds free as well as the primacy of the institutional framework as that which needs saving, as opposed to the patients moving through the place.

Rhodes makes sense of this unmitigated appreciation of efficiency by noting that it represented one of the sole domains where workers have any hope of demonstrating competence so as to take pride in their work. The overwhelming needs of patients and the scarcity of hospital resources meant that effecting quick discharges was the only area in which workers could be efficacious. As I note in Chapter One, however, competence has long been equated with efficiency within workplaces that have evolved under capitalism. Efficiency then is also a socially sanctioned value, so there is reason to suppose that the broader cultural context in which they are embedded also helped to shape workers' value system. That is, supervisors and workers alike appear to be buying into a logic that asserts that being a good worker amounts to producing fast and quantifiable results and adapting themselves to a system that demands they achieve more with less.

### **Sources of Error: Empathy as Pathetic and Pathological**

Such adjustments to the apparatus, however, required not only competence in the “shifty game” of placing clients, but workers were also expected to modify their own affective responses to clients. Underscoring the sense that those entering into the workplace encounter a pre-existing reified mechanism, Ben noted that the APU was “a machine needing periodic adjusting. You do things but you don’t know if they’ll work out. Understanding (e.g. of patients) turned out not to be it” (p. 53). Moreover, as this statement makes clear, connecting with patients holds little value in a system engineered to get them out the door as quickly as possible. In fact, if one’s overriding objective is to discharge patients then attachments stand to largely hinder one’s efforts.<sup>8</sup>

Workers, moreover, who resisted the taken-for-granted state of affairs on the ward tended to be the ones represented as the problem, rather than the reverse. For instance, Sam notes of one new nurse that she “always wore white and wanted to be a nurse but it was pathetic to see her try to reconcile role and place, always outraged, everything was wrong, the patients were not treated right. She got into a big fight into something trivial” (p. 26). Noting the nurse’s alleged overreaction here seems to be an attempt to construe her as the irrational element in the system, or the source of error. This is in spite of the fact the APU saw a high turnover of nurses, according to Rhodes, which

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<sup>8</sup> The lack of value placed on building relationships with patients was also apparent from Paul’s experience. Paul was a mental health worker who spent most of his time at work in close proximity to patients. He remarked “I used to do things for the patients [during the early days of the unit’s existence], like playing guitar, getting cigarettes for them, singing. But since we got no recognition for it, we stopped. Nowadays the patients don’t get nothing but a bed and three lousy meals” (p. 90). Paul’s statement here helps to demonstrate the primacy of the productive ethos over and above a standpoint that might privilege relatedness. On the former scheme, relational work, or connecting with patients, receives no recognition and is effectively disappeared.



may well indicate that there is a problem with the work environment, as opposed to individual workers.

Meanwhile the devaluation of the caring work for which the nurse seemed to be advocating is evident in Sam's dismissal of her efforts as "pathetic." It is only when the workings of the APU are taken utterly for granted that responsiveness to patients becomes a source of error to be remedied in workers, rather than an expected response when face-to-face with a person in need. As we see, here, the gritty reality of the day-to-day workings of the ward was the immutable state of affairs, or a hard truth that had to be faced and which held little room for niceties such as compassion and care.

Not only was the understanding of patients and interpersonal connections viewed as superfluous, but workers were also actively discouraged from giving play to their own empathetic responses to those coming onto the ward. Senior staff, in fact, tended to dismissively parse newer workers' desire to help patients as "rescue fantasies," which suggests these were defects in the worker in need of a remedy. As Rhodes notes:

part of the task of teaching on the unit was to show students how not to take the viewpoint of the patient ... Efficient practice (in fact any practice at all) required that staff create distance from patients and from their own feelings (p. 103 – 104).

To this end, residents were told by staff to aim for emotional distance from clients. "The farther you get from patients (the more) you can show you're an empathetic person but the closer you are the less you can be good," explains Ben (p. 102), a statement that makes most sense when one recalls that "good" in the context of the APU means being able to get rid of patients quickly.

Sam taught this lesson to Renee, for instance, when the new resident became upset about the treatment of a patient who had been put into seclusion. Seclusion, notes Rhodes, was to prevent harm to self and others, while “as a “monastery” it disciplined them and attempted to turn their attention inward” (p. 22). The patient placed in isolation had kicked at the door causing Renee to remark, “what do you expect? They [the patients] are always frustrated. No one goes to them when they come to the window. I would be frustrated” (p. 104).

Sam, in his supervisory role, however, reinterpreted Renee’s taking up of the man’s perspective as part of the patient’s symptomology, a move that comes close to configuring Renee’s empathy as pathological. “He’s a borderline,” replied Sam. “He’s good at inducing identification. You are identifying with him and rightly so.” In Sam’s view, isolation was an ideal form of treatment since the frustration evoked in the patient served to make him show his true colours as borderline, while also creating sufficiently high levels of discomfort in the patient that he’d finally do whatever it takes to leave. As per Osborne’s observations in Chapter 1 regarding the co-optation of physicians by the neoliberal agenda, Sam appears to have so thoroughly blended therapeutic and administrative logic such that the objectives of treatment and the maintenance of the APU apparatus fall into perfect alignment.

In light of the normative expectations associated with the fully-formed apparatus into which they were introduced, entrants tended to modify themselves accordingly. This is evident from the manner in which new residents were quick to eschew their seemingly

naïve humanitarian concerns in order to embrace the ward's ethos. As one resident explains

Sam's task is not to be a magical, accessible therapist. He showed me that you can do more by not throwing patients into a vat of goodness and trying to straighten everything out for them, which was what I thought mental hospitals were all about ... Getting rid of them is the point: What are you going to do with them?" (Rhodes, p. 57).

### **Othered due to the Ethos of Efficiency**

Not only did workers modify themselves to fit into the machinery of the ward, but Rhodes' work also makes it plain that the nature of the work also influenced their perceptions of patients. Patients were often conceived of in terms of the extent to which they either facilitated or impeded to overarching project of creating available bed space. For instance, one resident described his reaction to an 18-year-old young woman whom he'd initially been excited to help. After she lapsed into a depression, however, the student said "I kept talking to her. And she kept withholding information and was very uncooperative. So my attitude about her changed and I didn't really care about her much" (p. 56). Withholding informative and a lack of co-operation are factors that stand to extend a patient's stay, which may well account for the negative attitudes the patient evoked.

In general, moreover, a patient's capacity to undermine fluid work processes came to be projected upon her and conceptualized as a fixed internal disposition rather than the external consequence of her particular situation. Patients for example were characterized as "difficult" not due to their behaviour per se but because they were

elderly and senile, which made them not only “inappropriate admissions” (p. 74) but also extremely hard to place. There were also the “despised repeaters” one of which was described by Sam as “horribly antagonistic” and “disgusting” because the patient would “whine and elicit dislike” during his frequent and intense attempts at getting readmitted (p. 100). The term ‘disgusting’ was regularly applied to such patients judging from Rhodes’ account. In one conversation in which the social worker had labeled a patient as such, one resident proceeded to remark to another “your job is to get that piece of shit out of here” (p. 134).

Something that will tend to intensify the othering that occurred on the APU would also be what Rhodes describes as a “residue of incoherence,” demonstrated by patients. This expression signifies patients psychotic, and therefore alien inner experience that others have difficulties fathoming. It is one thing to empathise with and acknowledge the humanity of a child crying over her broken finger. It is quite another to appreciate the personhood of, and identify with, someone who plays with his feces and “claims to be a doctor responsible for the fate of the world” (p. 36). In sum, as Sam noted, new workers had to learn that “we were not so nice and patients weren’t nice and weren’t appreciative” (p. 26). However, it is possible that a more leisurely approach with patients, one that has the time to patiently attend to unfamiliar mindset, could lend to the dissolution of the residue of incoherence that workers encountered some patients. Sam, however, appears to view patients’ less agreeable characteristics as an immutable state of affairs rather than considering whether such attitudes might stem partly from a set of contingent contextual

factors shaping mutual perceptions, and therefore, relationships between clients and workers.

### **Paradigm Shifts: Gaps in the System Open up Spaces to Connect**

This is not to say that every patient passing through the APU was dehumanized and objectified. Sometimes closer relationships between workers and clients did manage to take root. What is remarkable about these relationships is their transformative effect on caregivers' perceptions of the APU. That is, coming to care for an underserved patient worked to throw the reified system into sharp relief revealing its flaws and contradictions. Once the person and the legitimacy of his needs are taken for granted, contradictions can only be resolved by looking to the system designed to provide care.

Such a shifting perspective takes time, however, and in the course of Rhodes' study, such exceptions occurred only when, despite staff's best efforts, their contact with a particular patient persisted over the course of weeks or months. One striking example of this involved Charles Judge (nicknamed "The Judge") an alcoholic who suffered permanent brain damage from drinking. A nursing home worker dumped Judge at the ACU and absconded before the elderly man could even be processed and presumably rejected as an inappropriate admission by the ward. The origin of the behavioural problems that had provoked the nursing home worker's own act of subterfuge were organic and more a matter of cognitive impairment than a psychiatric problem. Sam summed up the difficulty they faced as follows: "the medical establishment says he's psychiatric, psychiatry says he's medical ... The Department of Mental Health says it

doesn't matter what you say because we are implementing deinstitutionalization as a policy" (p.79). The upshot here was that Judge was virtually impossible to place, and remained in the ward for months under an unofficial status.

According to Sam, at first "Judge was defined as offal – the piece of shit in the game of hot potato, or hot shit, among parts of the system. Whoever got stuck with him would be the person who takes care of the shit." Eventually however, Sam admits, "he became human to us" (p. 79). In virtue of Judge's continued presence on the ward, Rhodes observed that staff became more attached to him and characterized him as a "pet." They seemed to start to enjoy the Judge's personality, and according to Rhodes, took pride in accepting various quirks such as wandering, fits and babbling. Walter, the resident in charge of his care had initially been annoyed by Judge's presence on the ward, but over time became more empathetic and responsive and eventually commenting that "an old folks home is not good for him, no one would joke around with him."

Another example of staff's changing attitude came from Sam. "Judge would play in the bathtub which endeared him to us. At first it was seen as a behaviour problem because he didn't want to get out, but we redefined it that he enjoyed it and started putting him in there to play and sing" (p. 78). Such shifting perspectives of one person also served to spark a more global shift of consciousness. "Gradually," Sam notes, the fact that no other place can deal with him becomes the system's fault. We perceive the *awfulness of the system* instead of his awfulness" (emphasis added).

Certain so called "beloved repeaters" (p.100) also served to raise staff's awareness of a system in which needs outstripped resources. Patients who were more

lucid and affable could grow on staff, and form reciprocal attachments with workers over the course of their frequent readmissions. Rhodes notes

The return of patients brought into constant awareness the inability or refusal of families, other institutions, community care facilities, or homeless shelters to take care of people who were clearly in need. It often seemed that to staff that, as in the case of Judge, the game of “hot shit” ended at the doorway of the APU. Because repeating patients were well known to the staff as individuals, the extent to which their needs were not met by the available resources became very clear (p. 120).

The formation of such connections, however, was merely an accident of circumstances and due to gaps in the broader network of services in which the APU was meant to figure. For it is only in virtue of such gaps that patients would continually reappear on the doorstep of the APU looking for sanctuary, nurturing and comfort. “When I’m here I feel like I have friends” remarked Keith Holmes, a frequent admission, adding that while in the APU “the outside world seems far away” (p. 132). According to the APU counsellor, Holmes was “cuddly” and “Like Ponce de Leon, looking for true love” (p. 143).

Meanwhile, Sam’s contact with Holmes triggered the psychiatrist to entertain a preconception of the broader role of the APU. Instead of Ben’s notion of the APU as a screening device, Sam began to wonder if staff might not provide people like Holmes with “approval, love and reliable relatives” while also constituting a proxy for a state asylum with “the city as grounds.” In other words, Holmes was free to roam the city, maintain an apartment, visit his mother, but when things got bad again the ““warmth” of the APU enabled him to regain his equilibrium and, briefly, to try again” (p. 135).

## **The Space for “Strange Flowers” to Grow**

It is worth stressing then that it was due to flaws in the system, rather than a product of its design, that such relationships could take root at all. What was interesting about the APU was the fact that, broadly speaking, its operations appeared to lie beyond the scrutiny of upper management. Some felt that administrators maintained an “active ignorance” of the ward (p. 31) and Sam likened the ward to a sewer. “As long as we work OK she can pretend we’re not here,” he said of a particular administrator. “But when we get stopped up, the whole place stinks!” (p. 53). Most of the workers seemed to share the sense that upper management preferred not to know what actually went on in the APU. Staff also regularly sought to skirt or otherwise subvert the demands of paperwork designed to structure care, but which seemed laughably out of touch with the reality of the APU.<sup>9</sup>

It is probably the case that anarchic environment of the APU allowed staff to attempt many unorthodox interventions and to employ various dubious tactics in the course of their work. Workers were largely winging it and making it up as they went along. The overarching imperative to free beds did serve to structure the workplace, but only by providing a concrete goal. As Rhodes notes, insofar as workplace discipline went, “in their push to get patients out, the staff resembled school children rushing against the clock to finish an exam” (p. 172).

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<sup>9</sup> For instance, staff were required to fill out Patient Plan for Treatment (PPT) forms with areas in which to fill in different components of patients that bore little relation to work done on the unit. Rhodes records a conversation around such a form. “Sam is telling new students how to fill out the PPT. He says of the section “strengths”: “Sometimes we have to struggle to come up with any strengths!” Then he comes to “psychotherapy.” Roberts makes a noise. Sam: Don’t choke! Robert: Short term (p. 112).



Rhodes also likens the staff to workers hurrying due to an assembly-line speed up, but this is probably less accurate given that Douglass centre staff had the freedom to develop spontaneous, creative, and unorthodox solutions to seemingly impossible problems. For example, staff once sent a telegram to a patient with delusions of being a secret agent. The telegram ostensibly came from the “central agency,” and directed the patient to get a job, stop carrying weapons and maintain a low profile in the community. He was also informed that his pay would arrive in the form of disability benefits. The patient, delighted to be hearing from his superiors, obliged, and was not seen in hospital again. Staff agreed that “The Secret Telegram” had to be kept secret from administration, which made the social worker called to sign for it nervous to do so (p. 164). Interestingly, then, it was not any established methods or procedures that allowed staff to arrive at this unique intervention. Meanwhile, as Sam notes, “we have looked for strange flowers here, in such an austere and ugly place” (p. 165).

While some might find such a lack of supervision morally problematic, I hope to show in my following chapter that we have much more to lose if we deprive care workers of the space both to spontaneously interact with clients, and to exercise their faculties of moral judgment and discernment. So far in this chapter I have brought out how rationalized healthcare systems bent on efficiency impinge on the quality of personal connections between workers and clients. The moral significance of this observation, however, may not be readily apparent. ‘So what?’ a critic might ask, adding that so long as rationalized and efficient services result in a more equitable and economic distribution of scarce medical resources, this trade-off is worthwhile.

As I demonstrate in the following chapter, however, a reconfiguration of the field of moral discourse to accommodate the insights of care-based ethics shows what is at stake in barring workers from attending to their clients' particularities and delivering empathic care. In this chapter I also consider the harm such restrictions can inflict on workers themselves, which may go so far as to compromise their own moral development and even inure them to the suffering of others in general.

## **Chapter Three**

### **Workers at the Crossroads of Competing Moral Paradigms**

*“What about those ingredients of our humanity, what about compassion, love and personal understanding, which are mobilized only by the sight of a human face and which die when confronted with generalities?”*

~Paul Feyerabend, 2011, p. 11

#### **Introduction: A Return to Trudy’s Dilemma**

To begin this chapter on moral theory, I shall return briefly to Campbell and Rankin’s description of Trudy the nurse from the previous chapter.<sup>1</sup> Readers will recall that Trudy stood at the crux of a moral paradox when she came face-to-face with the suffering of an overwhelmed and overwrought Mrs. Jones. Trudy’s visceral, felt moral impulses seem to have come into conflict with the demands of an impersonal, universal moral system that emphasises justice as a primary moral value. While “it might feel like hell” to ignore Mrs. Jones’ call for support and comfort, Trudy eventually decides “I can’t hang on to him because his wife got teary” (p. 73). Trudy thus minimizes the significance of both Mrs. Jones’ distress and her own response to the woman’s suffering. The contradiction is then effectively dissolved by denying that it even exists. “It might not look like it’s very caring,” Trudy comments, effectively admitting to a sense of wrongdoing while immediately dismissing this as a mere matter of appearances. Readers acquainted with the many challenges facing healthcare institutions today might well see grounds for endorsing this second, dismissive assessment.

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<sup>1</sup> (See: pp. 91 -95)

By the end of this Chapter, however, it should be evident that Trudy is facing a genuine moral paradox. In weighing “all those people waiting for surgeries” against Mrs. Jones’ needs in the present, Trudy’s reasoning is consistent with rationalistic conceptions of morality that dominate ethical discourse today. As she notes, “it’s just not an efficient use of resources to hang onto this patient another night because his wife is having trouble coping.” Efficiency here is equated with the equitable distribution of resources, since it promises a means of providing medical services to a broader pool of people. Hence, personal feelings aside, Trudy seems to be saying that the right thing is to uphold standards that make work more efficient so that healthcare remains universally accessible. However, as I intend to show later in this chapter, the Trudy’s moral uneasiness cannot be so readily dismissed.

Conventional moral theorizing today is framed as a matter of sound reasoning, and providing individualistic nurturance to others does not rank high on its list of priorities. However, an alternative conception of morality that expands upon our obligations will help to articulate the morally problematic elements of modern healthcare regimes. These appear at exactly the points where rationalistic ethics of healthcare policy collide with norms that guide us in our interpersonal face-to-face relations. The present chapter is an attempt to understand this fundamental conflict and its implications in healthcare settings. Section I considers the traditional rationalistic approaches to morality that have influenced healthcare policy and which I argue are best suited to guiding social and institutional policies as opposed to our more intimate relationships.

Section II describes a contrasting care-based ethics, situating it within moral discourse, and then combining it with Robin Dillon's further conception of care-respect to problematize impersonal forms of professional caregiving. This section also considers various practices to adequately perceive another, or a skill-set that also help to flesh out what it means to adequately grasp another person's individuality. Section III examines Levinas' description of the sense of responsibility that is occasioned when we approach concrete others in the way that Dillon and others endorse. For my purposes, this sense of responsibility is important in two ways. First, it is immediate and non-rational, and secondly its call is so singular that ignoring it can only be experienced as a moral failing.

Section IV considers the painfully frustrating situation of workers placed at the crossroads of the pull of the concrete other and an implicit requirement to engage in rational moral deliberation. My aim here is to evoke potential frustrations workers might experience in order to bring out the harm done to those caught in such binds. Then, in Section V I shall seek to show how failing attend to workers' suffering may eventually blind them to the suffering of others while also potentially stunting the development of their moral wisdom. Workers, I shall conclude, need time and space to not only to cultivate caring relations with clients, but also to develop a sufficiently ethical practice.

It should be noted that a disparate group of thinkers are joined here to promote a particular view of ethics that links feminist ethicists of care with the ethical theory of Emmanuel Lévinas. The aim is not to promote a Levinasian ethics, however, but to provide a fuller, more comprehensive view of the ideal ethical relation I am seeking to promote. That is, not only do I argue for a care-based ethics, but I also seek to describe

the phenomenological impact of caring for concrete particular others. For it is only in understanding how one experiences care stemming from an appreciation of another person's uniqueness, that one can adequately grasp the dangers of suppressing people's felt sense of responsibility for concrete others.

## **I: Rational, systemic and universal approaches to morality**

For the sake of exegesis, I will begin then by examining Kantian ethics and utilitarianism, which are two prevailing systems within the Anglo-American philosophical tradition. The utilitarian's central concern to increase general welfare certainly influences many healthcare policies. The principle-based accounts of moral theorizing arising from a Kantian approach also influence the field of modern discourse, as is evidenced by the tendency, popularized by Beauchamp and Childress (2001), to resolve bioethical quandaries by recourse to the principles of beneficence, non-maleficence, justice and especially autonomy. After presenting a brief description of these two foundational approaches to moral theorizing, I shall further analyse them in relation to Margaret Urban Walker's "theoretical-juridical model" (TJM) of morality. In so doing, I hope to better reveal the suitability of such systems for guiding institutional conduct. For, modern moral systems are analogous to rationalized administrative technology in so far as such abstract moral systems represent an efficient means of deriving moral outcomes for large populations.

## God, Reason and Morality

As far back as Aeschylus's *Oresteia* Western culture has demonstrated a yearning to resolve moral disputes without resorting to violence and bloodshed. Arguably, learning to settle differences peacefully is a basic requirement for the formation of any civilization. For without arbitration, social stability is constantly threatened by eruptions of violence due to the sort of cycle of anger and vengeful violence that Aeschylus stressed in his trilogy of plays. In the *Oresteia* we see a father, Agamemnon, sacrificing his own daughter and thereby provoking his wife Clytemnestra to murder him. Agamemnon and Clytemnestra's son Orestes is then called upon to exact his own revenge upon his mother, who he murders in the second play of the trilogy. In *Eumenides*, the third play in the *Oresteia*, the furies are single-mindedly pursuing Orestes intent on exacting their bloody revenge for Orestes' act of matricide.

In these plays this endless cycle of bloodshed and revenge points to the need for humans to approach conflict in a reasonable and civilized way, which requires us to transcend our overly passionate and primitive natures, as represented by the bloodthirsty furies (Aeschylus, Collard Trans., 2002). As Kant will later put it, man has a duty to strive to "raise himself from the crude state of his nature, from his animality" (1797/1964, p. 45) by realizing his rational nature. The desire to use reason to avoid violent disagreement is also evident in Plato's writing as he notes that differing opinions on "the just and unjust, the fine and shameful, the good and bad" often give rise to anger and "our becoming enemies to one another" (cited in Nussbaum, 2001, p. 106 -107). Plato goes on to contrast this with disagreements that arise in mathematics, where we need only count

things up to “quickly be released of our differences.” The way to resolve such disputes then is by aiming for consensus among men in virtue of cool-headed and rational assessments of evidence and arguments.

### **Kantian Moral Theory: Universality and Reason**

Given the growing need for secular morality in his day, it is no surprise that Immanuel Kant developed a moral system firmly grounded in reason. In fact, according to biographer Manfred Kuehn (2001), Kant’s famous emphasis on autonomy in moral matters, or a man’s right to rationally assess matters for himself, was at least in part a response to Pietism, which favoured blind obedience over critical thought.<sup>2</sup> Undoubtedly Kant would concur that in being self-evident to all rational persons, reason, rather than divine commands revealed to a faithful few, is the superior arbitrator in moral disagreement. Broadly speaking, moreover, a Kantian moral system will refer to a collection of rationally discernible and unyielding moral principles that govern right action.

If, morality is not a code of conduct issued by a god, then Kant must say how it can have authority over all persons. Typically, we do not suppose, to use one of Kant’s examples, that the prohibition against lying applies to you but not to me. Rather, if lying is *morally* wrong, then it is wrong for all, and not just some. Moreover, if morality is

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<sup>2</sup> According the Kuehn, many Konigsberg Pietists, who educated Kant in his earliest years, agreed that “[w]hile the schoolmaster who seeks to make the child more learned is to be commended for cultivating the child’s understanding, he has not done enough. He has forgotten his most important task, namely, that of making the will obedient.” Kuehn notes that Kant described the reliance upon God for moral decision-making as “servile” and found the view that only a supernatural force could save a man to be repugnant (p. 52). Instead, a mature Kant embraced the view that a man should think matters through for himself rather than mindlessly obeying the dictates of dogma, and is evident from his essay “What is Enlightenment?”



something that applies to all persons equally, then there must be a discernible reason for this. Kant notes

Everyone must admit that if a law is to have moral force, i.e., to be the basis of an obligation, it must carry with it absolute necessity; that, for example, the precept, "Thou shalt not lie," is not valid for men alone, as if other rational beings had no need to observe it; and so with all the other moral laws properly so called; that, therefore, the basis of obligation must not be sought in the nature of man, or in the circumstances in the world in which he is placed, but a priori simply in the conception of pure reason (1785/1895, p. 4).

Hence, an underlying assumption driving Kant's enquiries is that if morality applies to all persons, and there is good reason for it to constrain our actions, then we must be capable of rationally apprehending moral truths.<sup>3</sup>

Kant emphasises rationalistic morality to such an extent, in fact, that he sees moral action generated by desire as less valuable than that which is motivated by duty alone.<sup>4</sup> Kant's views here accommodate the intuition that sometimes the most moral thing to do in a given situation is also the course of action we like the least, meanwhile one who is especially moral has the ability to override her personal desires and carry out her duty. For instance, it would certainly be easier to slip antipsychotics into the food of floridly

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<sup>3</sup> While such an assumption may itself be an article of faith, it is very difficult to engage in human affairs without giving it some credence. The level of uncertainty that would arise if we could not know that action x is objectively the right thing to do would likely cripple fluid social relations. Medicine, for example, is a statistical science hence neither its diagnoses nor its treatments are guaranteed. Yet even if one cannot be certain of the efficacy of an elected course of treatment, at least a medical professional should be able to know when she is behaving morally. The possibility of rationally discernible moral principles offer such reassurances. Being able to act on principle, moreover, is often the only approach that will allow one to negotiate morally ambiguous situations or to explain and justify disappointment or harm others might experience in virtue of our decisions. Broader fairness often looks like personal injustice from a self-interested point of view, and the absence of an existing principle to which an agent might refer can leave her at a loss to explain why another has been harmed by her decision.

<sup>4</sup> Hence, giving to charity because it makes me feel good about myself is less worthy than forcing myself to do so out of a sense of duty.

psychotic patients, but a caregiver's knowledge of a duty to inform ought to compel her to tell her patient what he is ingesting.

As such then, Kant seeks to capture the intuition that moral principles are absolute and necessary prescriptions of behaviour while his recommendation that we step outside our own interests and universalize particular courses of action coheres with the sense that moral principles apply equally to all moral agents. It is due to these rationalistic underpinnings for morality, moreover, that Kant places a high value on the value of autonomy evident in his second formulation of the categorical imperative (CI).<sup>5</sup> Kant's second formulation of the CI is "so act as to treat humanity, whether in thine own person or that of any other, in every case as an end withal, never as a means only" (p. 56). In other words Kant is saying, don't use other people to further your own ends, which many will agree, is fundamental for morally sound relations.

For Kant the rational being's capacity to set her own ends represents an end in itself, meaning it is intrinsically good (p. 35), meanwhile establishing good will is "the highest practical destination" of reason (p. 21). It follows, then, that manipulating another person, and thereby bypassing their rational choices is morally wrong not merely for subverting an intrinsically good capacity, but also because this stands to hinder that

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<sup>5</sup> In the Groundwork, Kant formulates the CI, or "the supreme principle of morality" in three different ways. "The three modes of presenting the principle of morality that have been adduced are at bottom only so many formulae of the very same law," writes Kant (p. 65). The connections between and priority of the formulations is a matter of some dispute, but have little bearing on my discussion here. Moreover, regardless of how the formula of humanity fits with Kant's other 2 conceptions of the CI, it is worth noting that this formulation provides the foundation for Kant's later and more substantive discussion of ethics in "The Doctrine of Virtue" which was the second part of "The Metaphysics of Morals."

person's moral development via the rational establishment of a good will.<sup>6</sup> The value of autonomy, or alternatively, respect for persons, therefore figures prominently in Kantian moral philosophy. However, as I shall show shortly, because rational capacities so thoroughly ground Kant's conception of autonomy, we are left with a somewhat barren conception of respect for persons on his account.

### **Utilitarianism: The Greatest Good for the Greatest Number**

The importance of respecting personal autonomy persists well into our present day. In fact respecting other people's choices can often counteract what might be understood as certain excesses of utilitarian impulses. In direct opposition with deontological theories such as Kantian ethics, utilitarianism is wholly preoccupied with consequences of actions, so that the moral value of an action can be assessed by looking at its effects. Hence, important individual rights we might want to assign on principle stand to be trampled in name of general welfare within a purely utilitarian moral scheme. In spite of such conflicts, the principle of utility, or what Bentham simply dubbed "the greatest happiness for the greatest number"<sup>7</sup> (Atkinson, 2006, p. 20) remains a predominant guiding force in the moral evaluation of laws and policies today. This is probably because

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<sup>6</sup> The capacity to set our own ends and to act on principle makes all persons intrinsically valuable, and, one might infer, this is because persons are capable of discovering morality. Interfering with any other person's ability to reason for herself and make her own choices stands to impede her ability to recognize and respect moral law and thus seriously undermines the moral project writ large. In line with this reasoning Kant's third formulation of the CI states "every rational being must act as if he were by his maxims in every case a legislating member in the universal kingdom of ends" (p. 68) which suggests that moral agents are not merely responsible for themselves, but also for the state of morality generally speaking.

<sup>7</sup> Bentham is reputed to have come up this famous phrase after reading Priestly's *Essay on Government*. "I cried out like Archimedes, as it were in an inward ecstasy, Eureka!" recalls Bentham of his epiphany (Atkinson, 2006, p. 20).

this theory aligns with the intuition that the best course of action is that which makes the world a better place for as many people as possible.

What is interesting about utilitarianism is the manner in which the theory renders so basic an intuition into an objective looking calculus. Bentham explicates the principle of utility in the following way: “[n]ature has placed mankind under the governance of two sovereign masters, pain and pleasure. It is for them alone to point out what we ought to do, as well as to determine what we shall do” (Bentham, 1843/1970, p.11). Bentham’s version of utilitarianism, also known as hedonism, is somewhat simplified in identifying pleasure with utility and pain with harm. Other utilitarians, however, might equate utility with welfare, meanwhile harm can conceivably include states that are not, strictly speaking, painful. Once such matters are settled, such a system could conceivably realise Plato’s aforementioned desire for a system of value that allows us to count things up “and quickly be relieved of our differences.” For, if all agreed that it was wrong to cause pain and right to cause pleasure, then morality could be a matter of comparing the amount of pain an action produces to its associated amount of pleasure and select for the course of action that maximises pleasure overall.<sup>8</sup>

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<sup>8</sup> Bentham, moreover, was interested in devising a precise and scientific-looking calculus to facilitate such derivations. In *An Introduction to the Principles of Morals and Legislation*, Bentham’s utilitarian treatise, he catalogues types of pain and pleasure while also tallying up 42 different kinds of circumstances that stand to impact a man’s capacity to experience either sensation.<sup>8</sup> A man’s strength, for example, can impact how much pain he can stand, and this argues Bentham “can be measured with tolerable accuracy” by which he means seeing “the weight or number of pounds and ounces he can lift with his arms in a given attitude” (1879/1970, p. 54). Arguably in identifying these circumstances Bentham is looking to control for extraneous variables affecting a person’s state of happiness (i.e. the independent variable), and thereby generate more accurate predictions about the consequences of one’s actions on the mental states of others (i.e. the dependent variable). As such, with notions of value fixed this way, moral deliberation is reduced to instrumental reason in virtue of being quantifiable (and therefore objective) while moral outcomes are made predictable.

As we saw above in the case of Trudy, she turns to utilitarian reasoning in the course of her deliberations when she starts weighing the welfare of all those waiting for surgeries against the welfare of the weeping spouse in front of her. Generally speaking, the drive towards efficient and economical healthcare systems is consistent with utilitarianism. In his ethical analysis of efficiency in health, for example, A. J. Culyer compellingly argues that if we grant universal entitlement to healthcare and assume that “the objective of health services is to maximise the impact on the nation’s health of the resources available,” then we must conclude that making services more efficient is morally good because in doing so we insure that the benefits of such services outweigh the costs (1992, p.7). Given that standardization is so thoroughly associated with efficiency in modern time, then according to Donald, the implications of this line of reasoning for American psychiatric practise are that

managed care has furthered its influence by *insisting* that actual clinical practice be rationalized in a standardized manner in an attempt to streamline practice and psychiatric action according to specific diagnoses in order to make practice efficient. Efficiency as a notion has therefore and for the first time entered into psychiatric action as a moral good (2000, p. 429).

As for the neoliberal turn that has seen reduced healthcare budgets worldwide, such a move also coheres well with the tremendous value placed upon respect for persons and autonomy as evidenced in Kantian ethics. For, as advocates of consumer choice to drive and direct the development of medicine seem to hold, the best directions in health will be arrived at when rational agents are given the ability to select among their available options, rather than having particular forms of care foisted upon them by centralized agencies.

### **A Morality of Administration: the Theoretical-Juridical Model of Morality**

Having briefly considered the origins of rationo-centric moral theories and their potential relevance to healthcare, I now turn to some important critiques of these ethical systems. To arrive at this point, it is worth highlighting first how it is that such systems are better suited for the purposes of policy and governance than they are for providing us with guidance in our personal relationships. To show the role that rationalistic moral theory plays in administrative systems, I draw on Margaret Urban Walker's (2007) analysis of what she calls the theoretical-juridical model (TJM) of morality. According to Walker, Kantianism and utilitarianism both fall under this model of morality, which Walker contends has "prevailed as the template for "serious" or "important" moral theorizing in ethics, especially in America, in the twentieth century" (p. 22). Within such theories, continues Walker, "the moral agent in action resembles a judge, manager, bureaucrat, or gamesman, exercising patterns of judgment appropriate to legal, institutional or administrative contexts," and many moral theories including utilitarianism, deontology and contract theories fall under this model.

According to Walker, proponents of the TJM are apt to hold that "a moral theory is a consistent (and usually very compact) set of law-like moral principles or procedures for decision that that is intended to yield by deduction or instantiation (with the support of adequate collateral information) some determinate judgment for an agent in a given situation about what is right, or at least morally justifiable, to do" (p. 43). That is, moral theories on this model are intended to confer certainty about right action not only for

ourselves, but for others as well. Brad Hooker explains this function of a principled morality .

One of the things a shared commitment to morality needs to do is provide people with some assurance that others won't attack them, rob from them, break promises to them or lie to them ... knowing that people have certain moral dispositions can give us added assurance about how they will behave. (2000, p. 16).

Few people need to know that our mother endorses the principle 'do not kill' in order to predict that she will not murder us in our sleep. Nor, for that matter, do we look to a close friend's sense of duty to keep promises to know that he will be there at 6 pm as planned. If Hooker and Walker are correct that much of the utility of moral theory lies in allowing us to make predictions, then these are predictions about self-interested strangers, and not our closest friends.

A careful analysis of certain qualities that Walker ascribes to TJM theories helps to further demonstrate that what we are looking at a morality appropriate for governing larger populations. As Walker points out, modern moral philosophy fashions itself as "a moral science seeking the covering laws that explain the outputs of an idealized internalized system" (p. 71). As such, morality is an instrument meant to generate right action, and moral deliberation is largely a procedural affair. The real challenge for moral philosophers is to tinker with the theory's fundamental axioms so that right action is consistently generated via rational processes such as derivation, calculation or instrumental rationality.

It is not difficult to see the appeal of such rationalistic approaches for a public morality. If deliberations are grounded in reason, then the outcomes should be as

predictable as  $2 + 2 = 4$ , or as unassailable as the assertion that something cannot be both red and not red simultaneously. If morality is universal it must be transparent. As Nussbaum observes in relation to a utilitarian approach,

if we set ourselves to gauge, in each situation, the quantity of a single value and to maximize that, we eliminate uncertainty about what is to count as a good activity. Choosing what to do becomes a straightforward matter of selecting the most efficient instrumental means to maximization, not the far messier matter of asking what actions are good for their own sake. And measurement, being precise, will also deliver a definite verdict about the instrumental alternative, by a clear public procedure anyone can grasp (2001, p. 109).

While contemporary moral systems enable agents to be publically accountable to other rational agents, in order to effectively govern, theorizing must also be expedient if it is being carried out on behalf of the multitudes. As Walker notes, the TJM approach favours theories that are compact, that is, since moral theories are modeled on scientific theories, philosophers will aim for a minimal set of foundational axioms to explain the broadest possible range of moral phenomena.<sup>9</sup> Once again, this calls to mind the reigning values of economism and efficiency in science, bureaucracy and production, values that, as I discuss in Chapter One, are as close to rationally generated values as one could hope.

Within morality we see a drive towards a system that not only produces certain and predictable outcomes, but is efficient as well in aiming to broaden the scope of its coverage while employing a minimal set of resources. A potentially dizzying array of moral quandaries in mass society becomes much more tractable if we can distil these down to a restricted set of competing principles, or better yet, a singular moral

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<sup>9</sup> Given the conception of ethics as a science, the widespread use of thought experiments to falsify moral theories comes as no surprise.



imperative. Cognitively speaking, moral reasoning of this sort stands to be not only less costly, but also less time-consuming, for instance in employing moral principles. As Bentham argues “a principle is but a word ... Cut down to a principle, a rule has a name by which it may be spoken of and called to mind without loss of time. You have thus and without quackery, the Iliad in a nutshell” (Bentham, cited in Bahmueller, 1981, p. 187).<sup>10</sup>

Moral knowledge is also represented as universal, or as consisting of “a timeless, contextless pure form of moral knowledge” in which “differences among the positions one may occupy within them can only provide occasions for different applications of core or essential moral knowledge which itself remains the same” (Walker, 2007, p. 9). As such, “the right equipment tells one what is right to do” as opposed to one’s station in life or one’s form of life. This impersonal conception of morality then aligns with egalitarian underpinnings of democratic mass societies, in which all persons are owed equal consideration under law. Because, as Walker notes

[The] picture of general formulas applied to particular cases projects a stylized and reductive logic of moral judgment, pressing moral consideration toward abstraction. Superfluous detail must be cleared away so that cases can be sorted into broad types that figure in the formulas that unify the moral field. This guarantees uniformity in judgment and action across cases” (p. 59).

As with mass administration, glossing over contextual details is yet another factor that helps make moral theorizing more efficient, as the consideration of contextual details will tend to call for longer periods of deliberation. Hence, just as we see with the reified productive systems described in the first chapter, much contextual detail or idiosyncratic

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<sup>10</sup> Although Bentham was writing about principles for the management for poor houses here, we can still extrapolate from this to moral theorizing, where, for instance in bioethics, we see a tendency to reduce the field of discourse to principles of beneficence, non-maleficence, justice and autonomy.

autobiographical detail becomes, to use Lukács phrase “sources of error,” in one-decision-fits-all approaches. Pragmatically speaking, if one is making decisions that stand to impact a multitude of lives, say legalizing abortion or euthanasia, contextual information or biographical details of the populace will not be readily accessible. Considering the claims of abstract persons based on the relative weight of equally abstract principles is what makes these sweeping decisions tractable.

### **Critiques of the ‘one-size fits all’ approach to morality**

According to Walker most modern moral philosophers would be apt to respond to her depiction of contemporary morality by saying “well yes. Of course. What else could (or should) moral philosophy do?”<sup>11</sup> The seeming naturalness of this approach, I argue, stems at least in part from its suitability for the requirements of mass governance, requirements that by now strike many as both natural and necessary. However, as the work of moral particularists such as Jonathan Dancy (2004), Margaret Little (2000) and David Bakhurst (2000) brings to light, a systemic approach to morality that aims to generate decisions for all, fits no one particularly well.

According to such philosophers, it is always possible to find exceptions to universal moral principles, while the resultant *ceteris paribus* clauses that get tacked on to principles and rules start to look like so many Ptolemaic epicycles<sup>12</sup> along with an implicit admission that what matters most to good moral deliberation is the context in

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<sup>11</sup> It may not be evident from my description of her work, but Walker is aiming to critique such systems. In her view morality is regularly negotiated and changing, while from the standpoint of lived reality, moral obligations are also determined by one’s standing in the social hierarchy.

<sup>12</sup> In order to square the Ptolemaeus’ geocentric model of the solar system with actual observations, astronomers added epicycles, or small orbital detours to the orbits of the various planets rather than challenge the model.

which such decisions occur.<sup>13</sup> As others argue in fact, adhering too closely to moral principles can lead to great harm. In an age when “a man of principle” is taken to be synonymous with being moral, C.H. Waddington notes, “the wars, tortures, forced migration and other calculated brutalities which make up so much of recent history, have for the most part been carried out by men who earnestly believed that their actions were justified, and indeed, demanded, by the application of certain basic principles in which they believed” (cited in Bauman, 1993, p. 68).

Aside from questions regarding the overly strict application of moral principles, another problem seems to be that when principles take precedence, flesh and blood people tend to drop out of the picture. As Michael Stocker argues in relation to dominant moral theories,

What is lacking in these theories is simply—or not so simply—the person. For love, friendship, affection, fellow feeling, and community all require that the other person be an essential part of what is valued. The person—not merely the person’s general values nor even the person-qua-producer-or-possessor-of-general-values—must be valued. The defect of these theories in regard to love, to take one case, is not that they do not value love (which, often, they do not) but that they do not value the beloved (1976. p. 459).

Love, Stocker argues, might be valued say from a utilitarian perspective because it increases pleasure. Engaging in a relationship for this purpose, however, is not love since the other is merely valued for being a container for pleasure, rather than for being

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<sup>13</sup> To show this, David Bakhurst, has suggested that at first blush, a man giving a gift to a young women that might be seen as generous and kind. In such a case, notes Bakhurst, the fact that the man is sexually interested in a young woman would not be morally relevant in and of itself. Nor would it matter if the man were a Catholic priest. Taken together, however, these two features will carry moral weight. According to Bakhurst, this helps to show that there is a potentially infinite number of features, or combinations thereof, that might be morally relevant in any given situation. Constructing moral principles that will help us anticipate such factors is therefore impossible since there is no way to predetermine how various features will interact (Bakhurst, 2000, p. 163, n. 12).

himself. Similarly, he argues, most would feel somewhat deflated on learning that the friend visiting us in hospital does so strictly out of a sense of duty. “Surely something is lacking there,” argues Stocker, “lacking in moral merit or value” (p. 462). This, however, runs in distinct opposition to the sort of view espoused by Kant, who, as we have seen, held that one ought to be motivated by duty or the rational recognition of moral laws rather than mere sentiment.

## **II: Personalistic Obligations to Concrete and Particular Others**

If we are only to employ the resources of rationalistic, abstract moral systems described so far, it will not be immediately clear why the impersonal healthcare systems described in Chapter 2, or the necessity for workers to quell their empathetic responses is morally problematic. Certainly othering can be construed as a problem on a rationalistic moral view, but only if this results in an unjust allocation of resources or a sufficiently sweeping reduction in general welfare. Meanwhile, both principle-based theories and utilitarian ones are preoccupied with duties that we owe all persons, and are hence under-equipped for telling us what we owe to the highly individual concrete others we meet face-to-face in the world. Such theories are especially deficient for describing appropriate relations with vulnerable others requiring our nurturance and support. As I hope to show, an ethics of care is better suited to provide workers with guidance when it comes to the delivery of human services to vulnerable others. In fact I shall argue later that insisting strictly upon rationalistic moral theories for deliberation can be harmful to workers as well as patients. To begin to make these arguments it shall first be necessary, for the

purposes of exegesis, to describe care-based ethics and situate it within the broader field of feminist moral discourse in the following section.

### **Gilligan's Care-Based Ethics**

Carol Gilligan's work "In a Different Voice" is notable for proposing both the existence and legitimacy of an alternative moral outlook to the detached and impersonal moral systems previously examined. This is a form of moral reasoning that she originally attributed to women and which holds that connecting with others and sustaining relationships is at least as morally valuable as respecting their autonomy or otherwise employing principle-based reasoning for deliberation. Her work has thus helped to showcase the importance of care and relational concerns for morality and thereby broaden morality's discursive landscape.

In Gilligan's day, moral philosophers were, as Walker observes, largely white males who proposed moral systems that embodied "a highly selective view appropriate to certain kinds of relationships and interactions in certain public, competitive or institutional venues. These are traditionally contexts of male participation and authority, symbolically associated with the masculinity of men privileged by class and race as well as gender" (1982, p. 60). In light of this, it is reasonable to doubt that even the best relationships borne within characteristically adversarial contexts will tend to be paradigmatic of morally ideal interpersonal relations. Gilligan's work suggested the context of close caring personal relationships provided a worthier model from which to derive our moral ideals.

Gilligan arrived at this conclusion after conducting research that demonstrated that women's moral deliberation differed from men's. At the time she was a student of developmental psychology working with Lawrence Kohlberg on moral development in children. In his research, Kohlberg outlined six stages of moral development with the apex being "the universal-ethical-principle orientation"<sup>14</sup> or the ability to make rational and impersonal judgments based on abstract principles, universalized conceptions of justice and respect for persons. According to Gilligan, however, fewer women than men seemed to arrive at this stage of moral development, stuck, as they were, at stage 3 (p. 18), because they emphasized interpersonal concordance. At this stage, "one earns approval for being nice" (Kohlberg and Hersh, 1977, p. 55). Gilligan notes

At this stage [three] morality is conceived in interpersonal terms and goodness is equated helping and pleasing others. This conception of goodness is considered by Kohlberg and Kramer (1969) to be functional in the lives of mature women insofar as their lives take place in the home. Kohlberg and Kramer imply that only if women enter the traditional arena of male activity will they recognize the inadequacy of this moral perspective and progress like men toward higher stages where relationships are subordinated to rules (stage four) and rules to universal principles of justice (stages five and six) (p. 18).

The deficiencies that many women saw on entering the male-dominated arenas however, ended up being in the cool and detached moral stance expected of participants in the public sphere rather than with their own brand of moral theorizing.

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<sup>14</sup> Kohlberg describes this stage as "right is defined by the decision of conscience in accord with self-chosen ethical principles appealing to logical comprehensiveness, universality, and consistency. These principles are abstract and ethical (the golden rule, the categorical imperative); they are not concrete moral rules like the Ten Commandments. At heart, these are universal principles of justice, of the reciprocity and equality of human rights and of respect for the dignity of human beings as individual persons" (Kohlberg, 1977, 55).

As Gilligan sees it, the alternative morality she associated with women is one that values strong relationships and where “care becomes the self-chosen principle of a judgment that remains psychological in its concern with relationships and response but becomes universal in its condemnation of exploitation and hurt ... This ethic, which reflects a cumulative knowledge of human relationships, revolves around a central insight, that self and other are interdependent” (p. 74). Meanwhile, Gilligan reversed the then reigning logic of moral maturity in noting that “[t]he discovery now being celebrated by men in mid-life of the importance of intimacy, relationships, and care is something that women have known from the beginning” (p. 17).

While some feminist scholars have rightly challenged Gilligan on anti-essentialist grounds (Code, 1991, Tronto 1987, 1993) others note that associating care primarily with women runs the risk of perpetuating the patriarchal domination of women by relegating women to secondary care-taking roles in society (Bartky, 1990). As Code notes, however, on the whole “feminist endeavors to revalue connectedness and caring nonetheless retain a strong appeal in disconnected and generally uncaring mass societies, governed by principles of instrumental reasoning” (1991, p. 93). Moreover, work in this vein has inspired a flurry of feminist critiques of conventional rationalistic moral thought while opening a space to explore the moral significance of caring human relationships.

As the dust of such debates has settled somewhat many care-based ethicists will agree with Nel Noddings, who holds that, of all relations between persons, caring relations are ideal and those behaviours stemming from a caring attitude are those which one should strive to emulate. In Noddings view, spontaneous natural forms of care and

our desire to remain related give rise to a moral evaluation of the goodness of care, and which in turn occasions a moral imperative, or “a commitment to behave in a fashion compatible with caring” (1984/2013, p. 705). As to the nature of this obligation, she notes “I am obliged ... to accept the initial “I must” when it occurs and even to fetch it out of recalcitrant slumber when it fails to awake spontaneously” (p. 702), meaning that one must try to care even when one may not be so disposed and, at the very least, behave in the manner of one who does care.<sup>15</sup>

### **Respect for “me-ness”: Care Meets Respect**

Having a solid understanding of care-ethics and how it departs from conventional rationalistic moral theorizing, one may then draw Kant’s notion of respect into a care-based ethos. As I shall show, doing so stands to problematize standardized systems for the delivery of professional care. Before making this argument, however, I must introduce Robyn Dillon’s notion of care-respect (1992).

As noted, the concept of respect derived from the Kantian formulation of the categorical imperative is to treat persons as ends-in-themselves. This idea Robin Dillon contends is “widely regarded as the pre-eminent statement of the principle of respect for persons” (1992, p. 113). Arguably, there is something compelling about Kant’s notion here, as it implies that all persons are intrinsically valuable, and hence ought not be manipulated, used or otherwise harmed in the pursuit of our own ends. If we go with

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<sup>15</sup> That is to say that even if one cannot muster up the affective dimensions of care, one can aim to manifest the four elements that Tronto argues constitute ideal caring practice. The first of these elements is attentiveness, or remaining alert to the need of another. Secondly, one must take responsibility to meet these needs. Thirdly, one must possess the necessary competence to provide the care another requires and finally, one must be responsive to the perspective of the one being cared for (Tronto, 1993, p. 165).



Dillon, however, and scratch below the surface of this formulation of personhood, we find a rather bare conception of what it is about persons that is due this universal call for respect. The problem is that, on Kant's account, what makes a person worthy of respect is her status as a rational autonomous agent.<sup>16</sup>

To explain the significance of this last point further, if the value of persons hangs on their ability to make rational choices, then it follows that respect largely amounts to relying on reason to change other people's point of view, and failing that, our most binding duty is to stand back and leave it to others to make up their own minds. As Kant puts it, respect involves "constraining myself within certain limits in order to detract nothing from the worth that the other, as a man, is entitled to posit in himself" (Kant, 1797/1964, p. 117). As Code notes regarding this conception of respect "[i]n its emphasis on impartiality and neutrality, it treats persons as indistinguishable and interchangeable; indeed, in the moral domain, it requires agents to overrule specific claims of loyalty and affection in the interest of treating all 'individuals' alike" (1991, p. 97) or to put it more colourfully, it "flenses the individual down to the bare bones of abstract personhood" (Johnson, 1982, cited in Dillon 1992, p. 117). It is this concept of a person, and the associated importance of autonomy some argue, that "shrivel[s] our sense of obligation" so that for instance, "physicians who, far from treating us paternalistically, treat us impersonally and distantly, respecting our autonomy but nothing else" (Callahan, 1984, p. 41).

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<sup>16</sup> Violations of mental patients' preferences are not uncommon, in fact, if it is determined that they lack autonomy insofar as the concept is contingent upon the ability to make rational decisions. However, if we are relying upon autonomy to determine appropriate treatment of such persons, something of a lacuna exists when it comes to determining an appropriate attitude.

As it stands, for instance, one espousing a Kantian notion of respect would have difficulty countenancing patient Jean Dann's complaints about an eye surgery she underwent.

I was shocked that the doctor did not speak to me, either before or after the procedure. He was very rough in adjusting the head rest and I actually had a sore neck after the operation. I also had a very painful eye abrasion. During the procedure (I unfortunately was awake) he talked about his daughter's university challenges with no apparent concern or interest for me ... I felt like simply a number with no concern, on behalf of the physician, for my well being ... I ... hope that eventually doctors (I am generalizing) will be educated to realize that they are dealing with people with feelings. We need to be treated with respect.<sup>17</sup>

A Kantian could very well argue that there are no clear signs in this account that the physician failed to respect his patient. Respect for a Kantian would amount to abiding by the patient's decision to have the surgery once she has been provided full information, and by not trying to coerce her decision-making in any way. Attending to her emotional needs during the surgery, on the other hand, falls beyond the scope of prescriptions derived from Kant's conception of respect.

As with Dann, others will intuitively understand that treating someone like a number, or even as a container for abstract personhood, lacks respect. There is something more to persons than their rational faculties and respect for them means we care about their unique life history, particular sensitivities and emotional dispositions. Respect also means that one works to understand that from such factors follows a standpoint that is necessarily different from one's own. In my encounter with another there is a certain onus upon me that calls me to attend to and discern that person's uniqueness, and true

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<sup>17</sup> <http://patientsassociation.ca/story/patients-educating-doctors-jean-dann>

respect lies in my awareness that she is not like all the rest. If Dann's letter is any indication, many would agree that reducing anyone to a category represents a failure to see her respectfully.

It may be that this conception of respect is missing from Kant's work because as Robert Paul Wolff contends "despite his overriding concern for moral matters, Kant seems never to have asked himself the fundamental question, what is it for one man to stand in a real relation to another man" (Wolff, cited in Code, 1991, p. 75). Kant's attitude regarding the expression of sympathy for someone who has suffered misfortune, for instance, is telling in this regard, given that he characterizes such sympathy as an "insulting kind of beneficence" that further "is called softheartedness and should not occur at all among human beings" (1897/1964, 34 – 35).<sup>18</sup> It is unclear, however, why such cool, unsympathetic relations should be taken as morally superior.

What is missing here is a notion of respect that includes recognition of, and concern for, what Dillon describes as "our individual and human 'me-ness'" (1992, p. 105). Dillon's formulation of care respect then, captures the further requirements for a truly respectful, and hence more morally valuable, relationship between moral agents. In her work she attempts a "conjugal bonding; a union of two apparently dissimilar modes of what Nel Noddings calls 'meeting the other morally,' a wedding of respect and care" (p. 106). While Dillon agrees that respect is an attitude that should be universally accorded to persons, she aims to incorporate insights from care ethics in order to add flesh to the otherwise "flensed individual" of abstract personhood. Dillon's conception captures the

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<sup>18</sup> The underlying notion here is that the man's rational faculties are left intact, hence an unfortunate person retains his moral worth and is owed an attitude of unequivocal respect, not sympathy.

sense that what we should respect in others is not merely their rational capacities but also their concrete individuality, or their ‘me-ness.’ “We are, on the care respect approach, to pay attention not only to the fact that someone is a ‘me’ but also to which particular ‘me’ she is,” argues Dillon (p. 118). On this view we owe others a certain level of attentiveness so that we may discern who they really are.

The upshot of work by thinkers such as Dillon, Code and other feminist philosophers is that considerations revealed by care ought to figure into our moral deliberations and our conception of respect. Code, for example, proposes friendship as the best model for morally superior relationships. According to Code, partial relationships have been viewed as anathema to good moral theorizing, however, she argues that

there is no reason to believe that the claims of friendship will blind a responsible agent to considerations of fairness and justice; whereas, on the contrary, an impersonal obsession with fairness and justice, as matters for impartial adjudication, often blinds people to the specific concerns of particular persons or groups. In short, there is no *prima facie* reason against granting priority in moral deliberation to the quality of relationships (1991, p. 97).<sup>19</sup>

Rather than operating merely as factors that cloud our objectivity, the emotional underpinnings of some relationships may actually enable others to better see what

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<sup>19</sup> In using friendship as her model, moreover, Code aims to emphasize an attitude of detached compassion. This stance is detached in that it is not overly controlling, and is similar, she argues, to the attitude of a good caring therapist to her client.

constitutes justice for a particular person.<sup>20</sup> As Seyla Benhabib and Drucilla Cornell describe the type of relational model such thinkers promote: “the standpoint of the concrete other requires us to view each and every rational being as an individual with a concrete history, identity and affective emotional constitution ... In treating you in accordance with the norms of friendship, love and care, I confirm not only your *humanity*, but your *individual humanity*” (1991, p. 87, emphasis in original).

### **I-Thou: Ideal Encounters Between Subjects**

Another way of understanding this highest form of human relatedness that such feminist philosophers advocate is in terms of the I-Thou relationship featured in Martin Buber’s work (1923/2000). I-Thou refers to the participatory attitude assumed by the I when she relates to another subject *qua* subject. This relation stands in distinction to an I-It relationship, which is a relationship in which the I experiences, imagines, observes or otherwise represents an object. In the I-Thou relationship we are not confronted with a butterfly bounded by the glass of consciousness, pinned down by attention and parsed into genera, species and kingdom, then stripped of its qualities altogether to be reduced to mathematical formulas. Rather the I-Thou is understood as pure unmediated responsiveness, and, in a comment that is evocative of Kant, is a relationship in which

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<sup>20</sup> Take the mother who can only send one child to college, her decision can only be informed by her intimate knowledge of the two children. If she cares deeply about their flourishing, her decision will be based on which child will thrive in college as opposed to some universal conception of justice. Code also extends this notion of a more friendly attitude as superior to the neutral, unbiased objective stance favoured in the sciences. She discusses female scientists Anna Brito, Rachel Carson and Barbara McClintock noting that they resist seeing knowledge merely as a means of control, let objects speak for themselves and are open to particularities while seeing the irreducible complexity in nature. As scientists, they also experience a sense of responsibility towards their subject. “The nearest an ordinary person gets to the essence of the scientific process,” declares Brito, “is falling in love” (cited in Code, 1991, p. 152).

“[e]very means is an obstacle,” for “only when every means has collapsed does the meeting come about” (p. 26).

Unlike Kant, Buber does ask after the ideal relationship between two subjects. For the latter, the pinnacle of relatedness is achieved when the only reason we interact with the other is because she is a subject, and for this alone she is owed our care and attention. This sort of relation comes alive when say, two old friends talk late into the night, enjoying an indeterminate open-ended conversation with no purpose in mind, and which meanders over the course of the evening so that both parties lose sense of place and time. When they relate to one another as subjects, neither is assessing the other or weighing her attributes, so all-engaging all-consuming is the spontaneous and reciprocal flow of conversation. Indeed as Lévinas writes of such moments of relatedness “[t]he best way of encountering the Other is not even to notice the colour of his eyes! When one observes the color of the eyes, one is not in social relationship with the Other” (Lévinas, 1985, p. 85).<sup>21</sup>

If we look to psychiatry, it is evident that a “good” professional approach to practice is one that suppresses I-thou relations in the interest of quick and efficient diagnosis. Take for example, the following description of an effective intake interview:

Except for open-ended questions at the beginning and specific questions at the end, history taking should flow easily and casually, as in a conversation. Patients should be permitted to talk about what they want to talk about, but they should be gently guided back into channels that provide information the examiner requires for a diagnosis. From the minute the patient walks into the examination room, however, the examiner’s mental “computer” starts making decisions. How is the patient dressed and groomed? Does the patient have a normal gait and range of

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<sup>21</sup> Conversely, observes Lévinas “You turn yourself to the Other as toward an object when you see a nose, eyes, a forehead, a chin, and you can describe them”

motion? Is the patient hostile or friendly? How old does the patient appear to be? Based on these first impressions, the interviewer starts narrowing the diagnostic range. The examiner's choices about probable diagnoses will determine which areas to emphasize and which to omit or skip over entirely. The examiner's mind, indeed, functions as a computer. By the end of the interview—if it is successful—the choices will have narrowed to one or a few” (Goodwin and Guze, 1996, p. 316).

The form of interaction recommended here is virtually the antithesis of the I-Thou relationship. There is no mutual intersubjective exploration in this interaction. Rather, the diagnostician is told to emulate a machine that takes in objective data and spits out a classification. The patient here is merely subjected to an efficacious algorithmic sorting procedure that has no room for the open-ended spontaneity that the I-Thou relationship demands. Nor is there evidence of any willingness to meet and acknowledge aspects of another that outstrip our prior knowledge, and thereby seek to expand our understanding.

### **The Problem for Impersonal Care**

On traditional accounts of morality objectifying others is only significant if the stereotypes we form result in unjust treatment of a particular group. For instance, Rankin and Campbell are careful to show how the ALC designation not only results in mildly disparaging and dehumanizing labels such as “bed blocker,” but that this also results in a unjust reduction in such patients’ welfare because workers perceive them as less deserving of hospital resources. Hence, even on traditional accounts of morality, institutional frameworks that encourage such forms of othering are morally problematic since this is likely to result in unfair treatment of a select group.

As I have been suggesting, however, it is possible to take this line of argumentation further than rationalistic ethics can take us. Which is to say that we owe it to others to see them as they truly are, and not merely as they have been construed within the rationalistic organizational structure of reified systems. We owe it to them to care about their personal wellbeing. Claiming an equal footing for rights both to personalistic consideration and autonomy within our conception of respect aligns with intuitions that there is something fundamentally wrong about treating people like numbers even if we are not violating their right to make their own decisions. In other words, care respect helps to capture intuitions such as Dann's cited above, that we owe something more to all persons, and especially to those who depend on us.

Importantly, moreover, such a view has more radical consequences for moral assessments of rational technologies that achieve efficiency in virtue of standardization. If one takes care respect seriously, then one will see any system as morally problematic if its first priority is to classify persons for the purposes of processing them. Rational technologies are not value-neutral insofar as persons are narrowly represented as objects defined in terms of their functional roles within such systems and managed accordingly. Rather, at their very core such technologies are morally flawed when implemented in systems serving or managing persons. This is not to say that such approaches to management and production are morally impermissible. Rather, I suggest that just as violations of a person's autonomy require some form of justification, so should systematized protocols that eschew the subjectivity of individual persons and reduce them as types to be acted upon algorithmically.



Currently, such considerations do not appear to factor into discussions entertained by those, such as Kujala et al from Chapter One who, with their ‘patient in process’ timesaving schema, actively endorse the use of mass-production techniques to manage patients receiving healthcare. Furthermore, the need to adhere to standards for efficiency pulls workers away from efforts to achieve a rich and nuanced understanding of clients. Advocates for efficiency may well dismiss such an effort as an unaffordable and needless luxury. However, if we accept the right of each person to be understood and appreciated as an individual, then we can see that workers are being barred from offering their clients the full respect they deserve. This is especially true in the case of many mental healthcare workers, if patients’ residue of incoherence is apt to lengthen the amount of time workers require to achieve an understanding of their clients. As I shall argue below, this restriction is demonstrably harmful to many healthcare workers.

### **The Vulnerability Principle**

An objection to the argument above is that the moral imperative to respect others in all their uniqueness applies only in the restricted sphere of friendship and intimate relations and not to everyone we encounter. It’s not clear that we are morally obliged to engage the humanity and individual personhood of retail clerks or our fellow passengers on the bus. Whatever its intrinsic merits, however, this objection does not apply to healthcare settings, where the relation between caregiver and patient is far more than a fleeting encounter between strangers. At a minimum, sustained bodily proximity brings

its own form of intimacy and, as Doka et al note, “crisis situations can intensify human bonding” and call for behaviour communicating care (1994, p. 346).

More importantly, however, as Robert Goodin, argues, we have more responsibilities to those who are more vulnerable to the consequences of our decisions and behaviour. Even if you have not chosen to be another person’s protector, argues Goodin “the simple fact that a person is very vulnerable to you imposes on you special responsibilities in respect to him” (1985, p. 38). As Goodin further notes, this principle is intuitive and helps to explain why, for instance, many find it especially abhorrent to exploit cancer patients “willing to grasp any snake oil offered to them” in order to make a profit. Such an understanding of the moral authority of vulnerability also helps to explain why when reflecting upon “infantile docility and juvenile dependence ... there is no viler crime than to abuse them, [and] there is no greater cruelty than to ignore them” (George Bernard Shaw, cited in Goodin, p. 37).

While certain behaviours are apt to be condemned in the context of an asymmetrical relationship, other positive duties will be called for, and I would contend that these include an obligation to act in a manner that is compatible with caring. Those who are frightened, anxious or disoriented by the technological environment of the hospital, for instance, may be especially sensitive to, or alarmed by, brusque or impersonal treatment from a healthcare worker. As we saw previously, for a psychiatric patient simply having a nurse leave the nursing station to come watch TV by his side seemed to make all the difference in the world.

Due to the significant impact that caregivers can and do have on the wellbeing of their charges, something more is owed to the patients than that which is due to anonymous strangers we encounter in the course of a day. As Tronto's work suggests, there is a certain onus upon a caregiver to be attentive to the ways in which a dependent other stands to be especially vulnerable to her actions and how he might best flourish under her ministrations. The only way to arrive at such knowledge, however, is in virtue of an understanding of the charge's individual dispositions, sensitivities and particular context; namely, her 'me-ness.'

### **Doing Justice to the Other: The Praxis of an Ethics of Care**

It will be useful for a moment to step back from moral theory in order to introduce some specific practices conducive to arriving at a more complete appreciation of another person's "me-ness." As we shall see, however, a description of these practices also serves to flesh out the nature of care-respect. After an examination of these recommendations for arriving at the special brand of knowledge required to care for and nurture others, the constraints under which healthcare workers currently operate become all the more obvious. As for the practices themselves, the ones I have selected to discuss here are Iris Murdoch's conception of "loving attention," as supplemented by Nussbain's recommendations regarding imaginative reconceptualization, and Maria Lugones' description of "world travelling." These practices will also prove to be useful tools for a positive assessment of ACT work observed in Chapter Five. As we shall see, ACT workers enact the techniques described, which I argue contributes to an attitude consistent with care-respect.

To start, I shall mention that Dillon herself looks to Iris Murdoch's work on "loving attention" to expand upon the notion of attentiveness required to reveal the uniqueness of the other so as to arrive at their "me-ness." Loving attention is the effort to counteract "states of illusion" regarding the nature of others that are "convincingly coherent, but false pictures of the world." (1970, p. 36). To counteract such misconstruals Murdoch stresses the need to patiently attend to others and characterises the act of will required for this as "obedience to reality" (p. 41). Murdoch argues that "as moral agents we have to try to see justly, to overcome prejudice, to avoid temptation, to control and curb imagination, to direct reflection." According to her, will influences belief by effecting a "sustained attention to reality." (p. 39).<sup>22</sup>

In other words, as Nussbaum puts it, there is an onus on moral agents to make themselves persons "on whom nothing is lost" (1985, p. 516). The idea here seems to be that we are morally obliged to remain alert to the finest of details if they lead to a fuller, richer and more nuanced understanding of another person. Nussbaum's work on what I have called "imaginative reconceptualization" moreover, supplements Murdoch's arguments regarding the need to give others loving attention. What Nussbaum adds here is the observation that it takes an act of imagination to find new ways of conceiving old faces, and to stretch our preconceptions of the other.

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<sup>22</sup> Murdoch's example of this involves M, a mother-in-law, and D, M's daughter-in-law. In this scenario we see that M privately harbours negative attitudes towards D, while her public treatment of D is nothing shy of commendable. Months pass, and D has either died or moved away for good. In the interval M, realising that she may be biased, reassesses her attitude towards D and comes to see her daughter-in-law in a new light. A young woman who previously seemed "vulgar," "undignified," "noisy" and "juvenile" re-emerges in M's mind as one who is "refreshingly simple," "spontaneous," "gay," and "delightfully youthful." (p. 22). M here has done something worthy of moral praise, and in Murdoch's view, that was to focus loving attention on D "the patient eye of love," argues Murdoch is what will reveal the reality of another. "M knows what she is doing when she tries to be just to D, and we know what she is doing too." (p. 39).

Nussbaum supports her arguments about the importance of imagination for this process with an example from Henry James' novel *The Golden Bowl*, in which a father compares his daughter to some wondrous sea creature. This creature is described as "consciously floating and shining in a warm summer sea ... buoyant among dangers, in which fear of folly, or sinking otherwise than in play, was impossible." The father here employs his imagination to conceive of his daughter's sexual maturity and her newly awakened passions in order to come to terms with her freedom and her choice to move away with her lover Amerigo (p. 519). The creative component of loving perception, then, calls for the development of untried analogies in order to reconceptualise the other.<sup>23</sup>

In light of Nussbaum and Murdoch's discussion here, it becomes evident why the paradigm shifts that took place in the APU with regards to the Judge and Holmes were worth remarking upon. Granted, characterizing the Judge as a "pet" bordered on dehumanizing, however, it was still the case that annoying characteristics such as a reluctance to leave the bathtub were reconceptualised as endearing and delightful. In other words, the Judge came to be conceived not as offal, but as someone workers could care about. In so doing, they were able to take in and appreciate facets of The Judge's personality that made him unique, while also providing them a means to increase the patient's level of enjoyment by leaving him in the bath to play and sing.

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<sup>23</sup> It does seem, moreover, that one of the great advantages of finding new analogies is that these bring out certain features, making them seem more salient than they might have seemed before. For instance, when Hannah Arendt (1976) conceives of Adolph Eichmann as a bureaucrat, aspects of his personality that were not as obvious spring to the fore, such as his mindless adherence to rules and obedience to authority. Such features, however, would not stand out, on the other hand, were we to simply dismiss Eichmann as an essentially incomprehensible psychopath or as some kind of demon.

Conceiving of Holmes, as “Ponce de Leon in search of true love” also represents an effort to, as per Nussbaum’s recommendations, imaginatively reconceptualise the patient in order to understand him better. Rather than representing nothing more than a despised repeater, he was actively likened to an idealistic explorer bent on an impossible quest. Such a move, moreover, on the part of the APU counsellor may well have helped to reveal Holme’s individuality, or what made him special. Such an observation helps bring us to Nussbaum’s point that doing justice to another when we represent her seems to require more than just a steady focused gaze; achieving this also requires an act of creativity.<sup>24</sup>

Responsible vision also requires “world travelling.” As Maria Lugones shows, understanding others adequately is also to know that they are multidimensional beings who inhabit different worlds. This observation brings us to the second practice of relatedness: Maria Lugones’ conception of “world travelling.” A healthcare professional must be finely attuned to this fact given that a clinical context or institutional setting is a world in which many will find themselves ill-at-ease if not bewildered. Outsiders, notes Lugones, “can only be known to the extent that they are known in several “worlds” and as “world travelers” (Lugones, 1987, p. 327) which is to suggest the way some present themselves while inhabiting an alien world says very little about them as persons.

Furthermore, on Lugones’ view we ought to avoid becoming overly comfortable in our own world and so occupied with personal concerns that we fail to venture into a potentially frightened and vulnerable reality inhabited by another. This is because world

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<sup>24</sup> For those who might lack for creativity, Nussbaum recommends literature as a device to stimulate our imaginations.

travelling stands to reveal to a medical practitioner, for instance, that she in is a position to offer reassurance and comfort. Hence one must extend oneself into the world of the other, rather than assuming he knows how to conform to ours. “The reason why I think travelling to someone’s world is identifying with them,” argues Lugones, “is because by travelling to their “world” we can understand *what it is to be them and what it is to be ourselves in their eyes*” (p. 326 emphasis in original) and, I would add, it is only in knowing how that other represents us that we know how to respond to them appropriately.

Travel to the world of another, argues Lugones (and this may seem alien to many professional contexts) requires a certain playfulness, by which Lugones means a sense of patient exploration and, most importantly, the openness to, and anticipation of, surprise. She aims to evoke this attitude by describing a certain game she enjoys, and which is significant due to its spontaneous and non-competitive nature. The game involves cracking open rocks down by the river. “I pick up a stone and break it and run toward the pieces to see the colors. They are beautiful. I laugh and bring the pieces back to you and you are doing the same with your pieces. We keep on crashing stones for hours, anxious to see the beautiful new colors. We are playing” (p. 326).

There are no rules for this game, nor are participants “wedded to a particular way of doing things,” while there is a simple state of openness to whatever comes next. And while Lugones aims to evoke the relaxed state of mind that best facilitates wonder, I might add that the attitude taken towards the rocks also provides us with a useful metaphor. That is, through the course of this game one approaches the rocks in a state of

wonder, and rather than viewing them merely as a means to an end, or one like all the rest, one is prepared to be surprised and even delighted by the beauty we find inside.<sup>25</sup> People, of course, cannot simply be cracked open by force, which is why small talk and forays into humour are not frivolous meaningless activities in a professional interaction. Rather such activities encourage a relaxed environment that may help another open up and reveal some of her world to us. As Bonnie Sturm notes, the psychiatric nurse's use of humour is "an understated skill ... which can develop the therapeutic relationship. This is clearly related to the development of rapport" (2009, p. 20).

Engaging in the practices described is a time-consuming affair that requires patience, a leisurely attitude, and the ability to act spontaneously. If we are to admit that care-respect is an attitude owed to persons, and especially to dependent and vulnerable others, then it follows that systems that encroach on the space and the time necessary to engage in such practices are morally problematic. For instance, something is wrong when, as one nursing aide describes it, at work she is "running a marathon" and adds "there's never any time to stop either and just talk to the people and treat them like people instead of messes or bothers." Meanwhile, a casual nurse, who sees "a stream of unknown faces day after day," likens herself to more of a machine than a person (Austin et al, 2003, p. 181). As was evident with Trudy in relation to Mrs. Jones, being harried for time, and preoccupied with the task of relaying aftercare instructions makes it virtually impossible for the nurse to simultaneously do justice to Mrs. Jones. It seems almost absurd under the circumstances to demand that Trudy attend to the woman

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<sup>25</sup> Having played this game myself as a youngster, I can attest that wondrous unexpected colours and sparkled textures sometimes exist inside the plainest-looking river rocks.



lovingly and travel to her world. Hence, while Trudy experiences an impulse to care about Mrs. Jones, she is deprived of the ability to act on this impulse or to provide the woman with individualistic care. In this respect she has no alternative but to act in a way that dehumanizes her patient.

### **III. The Majesty of the Face and Attendant Responsibility**

Thus far I have been promoting a care-based ethical position that sees care-respect as obliging caregivers to treat others in a way that is consistent with care, while also respecting their autonomy. An essential characteristic of care, moreover, is a recognition of another person's individuality. Arriving at this *me-ness*, it would appear, requires the patient attentiveness of loving perception as well as the application of our imaginative resources to stretch, as it were, our own pre-conceptions of the other. Lugones, moreover, reminds us that the subjectivity of the other is what matters for relatedness, and we only begin to grasp the full scope of another person's interiority when we engage in world travel, or aim to grasp how the unfolding of selfhood is context dependent. That is, it is important to understand that the other is not a static being, but someone who changes depending on the social context and her location in both time and space.

Striving, in this way to see others as they truly are by resisting easy classifications and concentrating on their subjectivity brings us close to a form of perception that Emmanuel Lévinas has described as seeing the Face of another. In Lévinas's philosophy the term "the Face" is laden with meaning and refers to more than phenomena or a visual representation of the face of the Other. "The face is signification" explains Lévinas.

Signification without context. I mean that the Other, in the rectitude of his face, is not a character within a context. Ordinarily one is a “character”; a professor at the Sorbonne, a Supreme Court justice, son of so-and-so, everything that is one’s passport, the manner of dressing, of presenting oneself. Here, to the contrary, the face is meaning all by itself. You are you. In this sense one can say that the face is not “seen”. It is what cannot become a content, which your thought would embrace; it is uncontainable, it leads you beyond (1985, p. 86).

“You are you,” writes Levinas, which is highly suggestive of Dillon’s notion of “me-ness.” While Dillon’s ethics of care-respect differs in some ways from that of Lévinas, this similarity has an important implication: to see another person as Dillon, Murdoch and Lugones seem to recommend is, as Lévinas shows, to experience a potentially overwhelming sense of responsibility for that person.

This sense of responsibility is overwhelming in the sense that most other abstract or rational considerations fade into the background relative to the felt responsibilities we experience for one whose Face we truly see. What lies beyond the face is limitless difference that we can never adequately contain with our categories and it is this otherness to which we are beholden, or as Lévinas puts it “held hostage.” Once the face is revealed, he adds, we shift from a mode of being-with, to the existential mode of being-for. As Lévinas writes, “to recognize the other is to recognize a hunger. To recognize the Other is to give,” (1969, p. 75). As we shall see, for my purposes, it is the non-rational nature of this experience of responsibility that is significant.

As Per Nordvedt contends regarding nursing for instance, “caring practices ... involve a concrete normativity, a sympathy between bodies, an experiential encounter with moral properties” (2001, p. 117). What Norvedt alludes to here are the special obligations we are apt to experience when we meet individuals in a caregiving setting. As

we reflect on the differences between a sense of general obligation to others, versus the experience of encountering concrete others who seek or depend on our care, the non-rational nature of this sense of responsibility should become more intuitive. For instance, it is easy to mercilessly apply rules to a person one has never met, but then, imagine she emerges out of abstraction and becomes a beseeching and concrete presence at one's office door. Where before she was a number on a spreadsheet, she erupts into the concrete world in all her particularity, upsetting one's neat and tidy preconceptions. At such a point, moreover, one's *felt* sense of responsibility, or conception of what she is owed, is apt to change.

When we reach out to the other it is "to give to the master, to the lord, to him whom one approaches as "Vous" in a dimension of light" (1969, p. 75). As the editor of *Totality and Infinity* notes here, "vous" in French is "the "you" of majesty, in contrast with the "thou" of intimacy." There exists a reversal of the logic of authority in Lévinas, however, since for him the face derives its authority not from strength or force, but from its nakedness and vulnerability.

The skin of the face is that which stays most naked, most destitute. It is the most naked, though with a decent nudity. It is the most destitute also; there is an essential poverty in the face; the proof of this is that one tries to mask this poverty by putting on poses, by taking on a countenance. The face is exposed, menaced, as if inviting us to violence. At the same time, the face is what forbids us to kill (1985, p. 86).

It is difficult to shoot a person in the face, and more so while looking him in the eyes, which helps to make Lévinas' claims about the authority of vulnerability more intuitive.

As Lévinas notes, the imperative not to kill “can also be explicated much further: it is the fact that I cannot let the other die alone, it is like a calling out to me” (1998, p. 104).<sup>26</sup>

### **A singular Sense of Responsibility as Occasioned by the Face of the Other**

The second aspect of Levinas’ discussions of the Face that is significant for my purposes is the singular nature of this felt sense of responsibility. To fully encounter the vast and fragile humanity of another person, is to assume the responsibility to heed her call. It follows then that a failure to respond to that call will evoke a sense of defeat at having failed the other. The reason is that for Lévinas this responsibility for the Other is “mine and mine alone”.<sup>27</sup> “My responsibility is un-transferable, no one could replace me” he argues. Someone else may give an elderly woman his seat on the bus, but this does not entail that I ought not have offered mine. From my own subjective point of view, I am now responsible for the one who is now standing as well; for as Lévinas contends in a formulation of the “the Jewish conscience” that he sees as universal, “all men are responsible for one another and “I more than anyone else””(1998, p.107), and this is because I am also responsible for others’ sense of responsibility. This

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<sup>26</sup> It is probably our understanding of the primal call, moreover, that lends to a sense of pathos to stories such as Alexandria’s who, in spite being surrounded by people, remained undiscovered for days after her death. The may also explain why, as we saw in *Chapter Two*, it is especially painful for workers to watch ACL patients slipping away from a lack of care, and why Jean’s anguish is so readily understandable once a reader learns about the screaming patient who stopped her dead in her tracks in the hospital parking lot. A patient, she adds, that will probably die a “horrible” and “lonely” death in hospital.

<sup>27</sup> Hence, a notable dissimilarity between Lévinas’s ethical relation and Buber’s I-Thou is that for Buber, the I-Thou is a dialogical relationship while the ethical relation does not rely reciprocity. As Bauman explains “I-Thou has an ‘address response’ structure, a structure of ongoing conversation ... if I treat you as Thou rather than It, it is precisely because I stipulate (expect, work towards) being also treated by you as your Thou” (1993, p. 49). In regard to Buber’s work, Lévinas writes that “according to my analysis, on the other hand, in relation to the Face, it is asymmetry that is affirmed: at the outset I hardly care what the other is with respect to me, that is his own business; for me, he is above all the one I am responsible for” (1998, p. 105).

“responsibility is what is incumbent on me exclusively, and what, *humanly*, I cannot refuse ... I can substitute myself for everyone, but no one can substitute himself for me” (1985, p.101). This last point is important because understanding this helps to emphasise the manner in which turning from the responsibility occasioned by the face-to-face will always be experienced as a moral failing, a failing that I shall argue, stands to harm workers.

The immediacy, intensity and singular sense of onus occasioned by the Face all speak to the need to enable workers to engage in those practices aimed at cultivating relatedness described earlier. This is because although proximity may evoke a felt sense of responsibility in another, the Face provides little by way of instructions as to how to act on behalf of that person.<sup>28</sup> This unspecific call of the other can only be met in virtue of the painstaking activity of slowly discerning another person’s me-ness, if a moral agent is to have any hope of meeting those needs for which, however unwillingly, she has assumed responsibility. Being able to act appropriately on behalf of another, however, is only part of the story as to why the responsiveness described by Levinas holds moral relevance. It is also important to consider the damage that might be done to workers who are forced to ignore the call of the suffering other.

### **The Moral Impulse**

At this point, I shall briefly argue for the great importance of this awakening of a visceral sense of responsibility before I move on to consider the potentially grave consequences that can arise when workers are commanded to suppress the urge to serve

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<sup>28</sup> Do not kill me, or do not let me die alone are not especially specific commands.

the other. The raw unmediated glimpse of the vulnerable other sparks what Zygmunt Bauman dubs the “moral impulse” or an unconditional need to serve the other. This reaching out to the other is effected before we were even aware of the urge. As Lévinas contends, this felt visceral sense of responsibility is akin to being held hostage, which suggests that this impulse is not ours to command. It is prior to rational deliberation, and is not a means to an end. It can inspire acts of intense bravery, as when rescuers are moved without a second thought to rush into churning rivers or burning houses. It is also behind the sense of shame occasioned when one dodges the outstretched hand beseeching us for money, glancing shamefully away from a pair of eyes bespeaking need. We may succeed in rationalizing away the sometimes gut-wrenching sense of moral failure that arises when we refuse the call of the other, but reason neither causes us to hear the call in the first place nor is it what makes the call so hard to resist.

The moral impulse is not necessarily good or moral, but it is of tremendous importance according to Bauman. In fact, he sees it as the ground of ethics. “Taking responsibility as if I was already responsible is an act of creation of the moral space, which cannot be plotted elsewhere or otherwise. The responsibility which is taken ‘as if it was already there’ is the only foundation morality can have. A frail foundation, one must admit. But here you are: take it or leave it ...” (1993, p. 75). For, if we are in an ethical relation with the other, and staring into the face of suffering, the question is not “why should I be moral” but rather, “how can I not be?” since we cannot ignore the other’s need written so plainly on her face, or deny our own responsibility to her. Noddings seems to agree with Bauman on this point when she argues that morality is predicated on

caring wherein “we accept the natural impulse to act on behalf of the present other. We are engrossed in the other”(1984/ 2013, p. 701). She adds later that the moral view “is the rational attitude built upon natural caring” (p. 707). The moral impulse is what commands our attention to the other signifying a need so that reason can step in to best determine how to best craft a response.<sup>29</sup>

However, it is just this impulse, this tenuous foundation for morality, that workers are either taught to manage and suppress, as in Rhodes’ APU, or whose importance becomes minimized as we saw with Trudy. Given both the devaluation of relational concerns described in Chapter One combined with the dominance of rationalistic moral systems, it may be very difficult for workers to articulate the significance of the visceral or *felt* sense of responsibility they are apt to experience in the course of face-to-face interactions. If, however, workers are being asked to ignore the very spark of morality, the reasons for doing so need to be especially good. Meanwhile, as I hope to show in what follows, if we wish to reduce the harm that may be incurred on workers, the notion that rationalistic principles can lead us astray must remain a live possibility, and especially when these are systematically conflicting with the duties occasioned by the face-to-face.

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<sup>29</sup> What is there, moreover, apart from the suffering in the face of the Other to tell us when our principles have gone wrong? Take the Kantian who refuses to lie, and therefore directs a murderer to his neighbour’s door. The true test of his act is likely not a test of logic. What will be more telling is whether he can stand look into his friend’s eyes, or perhaps those of the man’s grieving family, and say in good faith he did what he had to do, and is therefore absolved of responsibility. As Trudy puts it, doing so would be apt to “feel like hell” and, if like many, the man of principle balks at thought of this, we have as much reason as any to suppose our principles are leading us astray. For a morality that makes it difficult to face our fellow human and meet her gaze contributes little to social harmony.

## Responding to the Face of Suffering and Universal Ethics

Anesthesiologist Ian Nesbitt's immediate response, and subsequent misgivings, when confronted with a dying elderly burn victim helps to show that when a tension exists between the demands of the face of suffering and universalized ethics, sometimes the only decent response involves setting aside one's principles.<sup>30</sup> However, articulating why this is the case outstrips the forms of justification provided by any rationalistic principle-based morality. As Nesbitt describes it, a woman came in to hospital "a vivid patchwork of red and black from ankles to neck, surrounded by a miasma of singed hair and charred flesh" (2002, p. 1122). Seventy percent of her body was covered in agonizing burns and she had waited several hours to be discovered. Due to the extent of her injuries and her advanced years she had little hope of recovery, hence, doctors decided to give her opiates for the pain and to let her die. "My most meaningful contribution to her care," writes Nesbitt, "had been to talk softly to her as I prepared to anaesthetise her: "Think of something nice to dream about, we're just going to drift you off to sleep and get you sorted out. You're going to be all right."

Nesbitt entertains moral doubts, however. "I lied to her," he writes, "and would do so again in similar circumstances. Should I? Would you? Can lying to patients sometimes be the right thing to do? Or does this story illustrate a lingering paternalism and arrogance that doctors may have when dealing with patients? I have no easy answers to those questions, and suspect there aren't any." Such was Nesbitt's letter to the *British*

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<sup>30</sup> Nortvedt mentions a case where felt obligations will understandably have a greater pull on practitioners as when, despite a previously stated mandate not to provide "extraordinary ventilatory assistance" to a particular patient, once the man and his family present "at the hospital ... struggling for his life, what could the doctors and nurses do other than offer him respiratory assistance? (2001, p. 116).



*Journal of Medicine*. One respondent to the letter comments “It is inappropriate to lie in any given situation. Concealment of the whole truth may be an acceptable alternative” – a pithy two-line response that seems to minimize the drive Nesbitt must have experienced to offer solace to someone who had just lived through an extended period of intense agony. How can he truly be there for her, we might ask, if an abstract moral principle counts for more than her immediate suffering?

Although our rationalistic universal moral systems may be well-equipped to level the playing field for moral agents, their utility for discerning an appropriate response to suffering in the face of the other is, at best, underwhelming. As Arthur Kleinman notes, “one is surprised to find so many professional ethical volumes in which [“suffering”] does not even appear as an entry in the index.” He adds “ethical systems that leave the problem of suffering (and related concepts of tragedy, endurance, and courage) to particular theological or poetical traditions do not adequately engage the human core of illness and care” (1995, p. 50). This omission of suffering from ethics, however, may be due to the difficulty of articulating the visceral, immediate and non-rational experience of responsiveness and responsibility occasioned by the face-to-face. This is especially true if one is working within the confines of rationalistic moral systems. Such systems are woefully inadequate for capturing either the power and significance of the face-to-face relation or the force of its gravitational pull: the responsibility for the other that binds us to her.

#### **IV. Workers at the Crossroads of Hidden Paradoxes**

In case there might be doubt as to whether care workers find these sorts of paradoxes troubling, one need only look to the growing literature on moral distress in nursing to see that many are terribly conflicted about their work. According to Austin et al moral distress is described in the literature in the following way:

The state is experienced when moral choices and action are thwarted by constraints include frustration, anger, helplessness, despair and/or betrayal. Moral distress arises when one must act in a way that contradicts personal beliefs and values. It is uneasiness about not doing all that one could to fulfill one's moral obligations. There is a sense of being morally responsible, but unable to change what is happening. Nurses who are acting in a way that is contrary to personal and professional values or who are unable to translate moral choices into action feel like their integrity is in jeopardy. Nurses suffer anguish at such times and the consequences can be profound and lasting (2003, p. 178).

Granted, judging from the literature, the term “moral distress” is multifaceted and in some respects may serve as a catchall to describe all and any conflicts nurses experience. Distressing factors are said to include “physicians, nurse administrators, hospital policies, and laws or lawsuits” that undercut their ability to adequately care for patients. However, at least some nurses see moral distress as being occasioned by an inability to offer personalistic treatment to patients. According to one 1993 study, nurses said “they were concerned with the basic lack of human dignity shown to patients.” The authors of the study go on to note that nurses used terms such as “nightmare,” “grief”, “heartache”, “miserable”, “painful”, “sad, and “ineffective” to describe their responses to such situations (Holly, 1993, cited in Austin et al, 2003). Yet another study revealed that a particular group of nurses who saw morality as essentially grounded in care all left

nursing. Interestingly, those oriented towards rationalistic accounts emphasizing justice appeared to find the work tolerable enough to remain in the profession (Millette, 1994).<sup>31</sup>

Given the very existence of this burgeoning discourse, there is something to be said for turning the gaze of care respect towards those caught between the demands both of particular concrete others and universal principles, and for acquiring a rich and detailed understanding of their complex situation. As Dillon argues “[i]n acknowledging human limitedness, imperfection, and continual construction, care respect also comprises acceptance of frailty, patience, and lenience ... as well as responsiveness to each other’s needs” (1992, p. 121). Whether one is a patient or a administrator, the important thing is to see that real moral ambiguity exists when situations arise that involve a conflict between care for the concrete other and more abstract moral demands, and to have genuine empathy and understanding for those making decisions under such circumstances. In what follows, I shall attempt to evoke a deeper understanding of the experience such conflicts might occasion in workers situated in highly rationalistic healthcare settings.

The self-assured approach of the respondent to Nesbitt’s letter suggests that there may exist a subtle prohibition of even addressing the kinds contradictions I seek to bring to light, and this prohibition could cause workers harm. The conflict for care workers that I am aiming to unearth here cannot merely be reduced to a conflict of moral principles. Rather the conflict is between the felt pull of the concrete other and a general expectation that moral quandaries be settled by means of rationalistic principle-based deliberations.

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<sup>31</sup> The sample size of the study was small and involved 17 nurses in total. Seven showed a preference for a care-based morality while 9 favoured a justice-based perspective.

This is a conflict that may be especially frustrating for some workers, because it may be next to impossible to openly address or even to acknowledge its existence.

To show what I mean here, I shall turn to an article by Brit Mari Ákerlund and Astrid Norberg (1985), who examine the effect of what they describe as “double binds” faced by 40 care workers whose jobs include force-feeding clients suffering from severe dementia. As I shall argue, presupposing, as Ákerlund and Norberg seem to do here, the primacy of a principle-based system for good moral reasoning may cause workers harm. Before making this argument, I shall describe the broader context of the article.

Ákerlund and Norberg use of the concept of a “double bind” in their paper largely amounts to a misappropriation of the term. It is worth noting that Bateson et al introduced the concept to refer to a form of communication in which an individual is presented with two contradictory demands as well as an injunction against addressing the contradiction (Bateson et al, 1967). Commanding a child to “speak when he is spoken to,” while also teaching him not to talk back to adults can be construed as a double bind, especially if pointing out the contradiction will only be viewed as impertinence on the part of the child. At base then a double bind is one in which a person is “likely to find himself punished (or at least made to feel guilty) for correct perceptions, and defined as “bad” or “mad” for even insinuating that there should be a discrepancy between what he does see and what he “should” see” (Watzlawick, et al, 1967, p. 213). Arguably, the only thing

more frustrating than encountering an irresolvable paradox is encountering said paradox but being forbidden from admitting that it even exists.<sup>32</sup>

According to Ákerlund and Norberg, many workers are anxious and conflicted when cognitively impaired and non-communicative elderly patients press their lips together and refuse food. The paradoxes that writers reveal in the course of their interviews are explained as arising from conflicts between rules, such as ‘keep the patient alive’, ‘don’t cause him suffering’ and principles such as ‘autonomy’ and ‘beneficence.’ Meanwhile, Ákerlund and Norberg admit there is no real prohibition from meta-communication about such conflicts; rather, it is simply that such discussions do not tend to occur. (1985, p. 214). Hence, their work fails to capture the most painfully frustrating dimension of a genuine double bind: the injunction against addressing the paradox.

The way to alleviate anxiety, the writers contend, is by puzzling out the problem at the level of abstract moral theory as evidenced by their prescription of a more organized and systematic approach.

In order to solve the double bind conflict [and thereby reduce workers’ anxieties about feeding], the care workers must be able to metacommunicate about the conflicting demands. They must be able to decide which demand is to be given priority. An essential part of this process is to understand the different logical levels of these demands. An ethical model or theory would be needed to rank the priority of contradictory principles (p. 215).

Determining the priority of moral principles, the writers maintain, is a theoretical issue.

Hence, they seem to presume not only that rational deliberation should suffice to reassure

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<sup>32</sup> There is little reason to suppose that double binds induce schizophrenia as had been hypothesized in Bateson’s day, nevertheless this dysfunctional form of communication can be, to use the term colloquially, maddening.

workers of the rightness of their actions, but that this weighing out of principles can guarantee that they will get it right. Notably, Åkerlund and Norberg conduct their analysis in light of Kohlberg's conception of moral development and hold that in order to make a mature decision one would have to take the two ethical 'rules' into consideration such as 'Keep the patient alive' and 'don't cause him suffering.' ”<sup>33</sup> (p. 212) and assess their relative importance.

One subject, however, described her experience with force-feedings is as follows

When I started to work here we had quite a few patients who were difficult to feed. Some we didn't feed. I found it quite horrible to feed. You pry a little with the spoon ... It is terrible. It is the worst that can happen. I try to withdraw tactfully ... I feel a coward to withdraw and not do it. I still don't like to feed ... The only thing is a pair of scared eyes above the nose ... Sometimes they don't want [to eat]. You know they need it. I am not the type who tries to make them finish the dish. I have never done that ... Most of them have reached the stage when they are not hungry ... I feel as if the patient is worth something more than someone just sitting there feeding them ... It can't be pleasant for the patient (cited in Åkerlund and Norberg, 212).

On the one hand, the subject, who I'll dub "Subject L" for purposes of clarity, says she feels herself to be a coward, perhaps for her own inability to set aside her own seemingly irrational affective responses in order to uphold universal impartial rules such as 'keep the patient alive.' On the other hand, she also seems to be struggling to articulate something that could hearken towards the non-rational nature of Lévinas's ethical relation occasioned by her experience of the wordless authority of the face holding "a pair of scared eyes above the nose" and which is "worth so much more than someone just

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<sup>33</sup> The writers also make a bewilderingly circular claim when they approvingly describe Kohlberg as one who "regards morality as the individual's optimal conditions for morality, a quality reached at the end of adolescence" (214).

sitting there feeding them.” So much more, she seems to say than a person just doing her job. Is this not perhaps an awareness of the majesty of the Other and the state of “being-for” it induces in us?

It is possible that what this description most vividly captures, in fact, is what Lévinas and Bauman see as the highest form of morality, the raw awakening to the Other which Bauman suggests is sure to occasion anxiety.<sup>34</sup> He writes

To be frank, [the primacy of the face-to-face] is not the kind of foundation ethical philosophers dreamed of and go on dreaming about. It leaves quite a lot to be desired, and this is perhaps why the seekers for the building site of Law prefer to look the other way. No harmonious ethics can be erected on this site – only the straggly shoots of the never ending, never resolved moral anxiety will on this soil grow profusely. This foundation promises anything but architectural harmony and the residents’ peace of mind. And yet it is this moral anxiety that provides the only substance the moral self could ever have. What makes the moral self is the urge to do, not the knowledge of what is to be done; the unfulfilled task, not the duty correctly performed. ‘But it all adds up to the fact that a person can never be entirely sure that he has acted in the right manner,’ concludes Løgstrup (Bauman, 80).

Ákerlund and Norberg however do not seek to interpret the subject’s statements outside their efforts to distil what she says into sets of competing rules. Rather, the writers see Subject L as having an “ethical standpoint [that] may seem teleological but a closer analysis shows that it is not based on moral reasoning, but is more a question of a strong defense against intimacy with the patient.” Ákerlund and Norberg do not expand on this last point but add that such workers find their jobs quite difficult and “had a minimal ability to metacommunicate, probably due to their deficiency in their capacity for moral reasoning.” Importantly, on Kohlberg’s conception of morality, this is tantamount to

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<sup>34</sup> The fact that the patients in this case suffer from dementia, and hence have difficulty stating their own preferences, brings to the fore the anxiety occasioned by a responsiveness to the Other.

saying these subjects are morally immature. However, while Ákerlund and Norberg cannot make sense of the Subject L's statement within a rationalistic construal of morality, Lévinas may be better able to identify what the worker is struggling to articulate here. In fact it seems that the subject has communicated her standpoint, but because it is not couched in a language of principles, it seems to bypass the commentators' understanding.

### **A genuine double bind?**

The question remains, however, how is Ákerlund and Norberg's attitude here harmful to workers? The response is that in their apparent inability to fathom morality as stemming from anything other than rational universal principles, Ákerlund and Norberg may themselves be helping to perpetuate double binds for workers. As their response to Subject L reveals, they readily judge workers for giving too much sway to the face of the other in their deliberations. They seem to hold that a caregiver who responds to the call of someone's suffering acts unethically if, in doing so, he contravenes the universal requirements of an impartial and impersonal moral system. Yet, if he doesn't act, if he fails to use his power to meet the demands of the other, he will similarly experience a moral failing, a failing that is his and his alone.

Two factors stand to cinch the binding power of this paradox. Firstly, a prohibition against addressing this paradox would require questioning the taken-for-granted supremacy of universal, impartial and rational moral systems. Even questioning morality this way, however, can, as we just saw, be taken as a sign of amorality or moral immaturity. What one "should see" in such cases, thinkers such as Ákerlund and Norberg



seem to hold, is a moral dilemma to be puzzled out at the level of abstract theory. Someone who only sees the Face and experiences the powerful singular sense of responsibility the other evokes is at risk of being dismissed as morally deficient. Feeling compelled to suppress this moral call, on the other hand, puts the worker in a painful situation, one in which she finds herself forced into moral failure no matter what she does. For if it threatens their status as genuine moral agents in the eyes of onlookers, few workers would dare rise up to say that this very real pair of frightened eyes I see before me throws all of principled rule-based morality in doubt. Having no way then to communicate such conflicts can only make the situation all the more difficult and frustrating.

The second factor that makes meta-communication regarding the paradox difficult is the near impossibility of adequately explicating the non-rational and visceral experience of the ethical relation within the confines of a rationalistic moral system. Given this potentially frustrating paradox, Subject L's avoidance of feeding may be less "a strong defense against intimacy with the patient", and more a consequence of a double bind that Åkerlund and Norberg themselves perpetuate.<sup>35</sup> For, rather than risk either failing the other or failing to maintain one's status as a genuine moral agent, many

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<sup>35</sup> Watzlawick, et al discuss three typical responses to double binds, with one being a retreat from communication and contact with others altogether. Another involves an obsessive search for clues that might resolve the paradox. However, because there is an unspoken prohibition against addressing the paradox itself, "he will eventually be forced to extend this scanning for clues and meaning to the most unlikely and unrelated phenomena." A final reaction is to "choose what recruits quickly find to be the best possible reaction to the bewildering logic, or lack of it, to army life: to comply with any and all injunctions with complete literalness and to abstain overtly from any independent thinking" (218). Certainly when considering professional caregivers, we would prefer that they neither retreated from their clients, nor became blindly obedient automatons.

workers might, as Subject L seems to do, aim to retreat from the situation altogether in order to avoid such a painfully frustrating and seemingly irresolvable paradox.

## **V. Agamemnon's Sacrifices: Further Consequences of Suffering**

Admittedly, retreat from the situation is not the only way to respond to such difficult conflicts. Another option is to dissolve them by turning away from the face of suffering. Martha Nussbaum's discussion of Agamemnon's sacrifice in the *Oresteia* illustrates this point clearly. A seer tells the king that in order to get his ships moving to Troy he must sacrifice his own daughter Iphigenia.<sup>36</sup> Agamemnon weighs his piety and the lives of many against the life of one, and after agonizing over the monstrous choice he must make, submits to the sacrifice. His biggest mistake here, however, is in failing to realise that that which is necessary is not always right.

In relaying this story, Nussbaum highlights Agamemnon's attitude after the decision has been made, which is to wholeheartedly embrace the rightness of his action. "It is right and holy that I should desire with impassioned passion the sacrifice staying the winds, the maiden's blood" Agamemnon declares boldly (cited in Nussbaum, 2001, p. 35). Nussbaum further describes the scene after the decision is made.

Her prayers, her youth, her cries of 'Father' counted as nothing treating his daughter, from then on, as an animal victim to be slaughtered ... Agamemnon commands the attendants to lift Iphigenia 'like a goat' in the air above the altar. His only acknowledgment of her human status is his command to stop her mouth (Nussbaum, 36).

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<sup>36</sup> Agamemnon is going to war against Troy to reclaim Helen who was stolen by Paris. Artemis has becalmed the ships enroute and must be appeased.

Nussbaum holds that there is something repellent about Agamemnon's attitude here. It is bloodless and cold, and he acts as though by 'placing himself under the yoke of necessity' he is cleared of his responsibility to his daughter. It is worth adding that when he looks at her he is blind to the accusation and the suffering inscribed in her face, nor does he perceive the majesty of her Otherness; he sees a goat. It is not hard to understand, however, how someone who 'slips his neck through the yoke strap of necessity' might lessen his inner turmoil by affirming to himself the rightness of his choice. However, it is only by reducing his daughter to an animal that he can succeed in this.

"A proper response, by contrast," argues Nussbaum, "would begin with the acknowledgment that this is not simply a hard case of discovering truth; it is a case where the agent will do wrong" (p. 42). One can understand, however, how one might be tempted by the dichotomous nature of reason when approaching such a decision, as it promises us that something can be right or wrong, but not both, and hence presents such a case as soluble. Our minds rail against the painfulness of uncertainty and reason provides the balm for this suffering, but the price is the denial of reality. In fact a cost greater than a distortion of reality is incurred here, however, for Agamemnon also sacrifices his own humanity when he chooses to look upon his daughter as an animal for slaughter.

The relation between the face-to-face relation and the moral impulse helps to explain why Agamemnon might seek to reduce one he harms to what Lévinas calls "sameness," or some discrete category that eliminates all uncertainty as to how to respond to the face before us. The Nazis reduced the Jews to vermin, that is, to something less than human to justify their extermination. Meanwhile, no one wants to see the

suffering in the faces of say, Eichmann or his ilk. For, to see the Face of the Other is to experience a sense of responsibility for the Other; the need to ease that suffering. Better to look past their faces and conceive of them as a monsters or psychopaths than to risk experiencing any disconcerting sense of obligation that arises when we bear witness to the naked skin of destitute faces. For, as noted, the moral impulse is not rational, it would have us attend to the suffering of, and have care for those who stand to harm us and others. However, the power of its call is such that sometimes the only way to resist feeling responsible to the Other who we must harm is by blinding ourselves to both their humanity and their status as persons worthy of either moral consideration or care.<sup>37</sup>

In light of such reflections it is worth considering whether healthcare workers are in danger of becoming inured to their patients' suffering. For such a response could represent a means of avoiding painful feelings of uncertainty, guilt or shame that inevitably arise when one fails another. As for whether workers' distress eventually causes them to become inured to face of the suffering, we need only look to the othering that occurs in environments where workers appear to have little power to determine patients' course of care, for example Rhodes' "pieces of shit", the "dingbats" in Foner's nursing home or with ALC patients on acute care wards. As Nortvedt argues

If concrete moral responses and relationships are commonly violated, if nurses [and other care workers] frequently have to violate the integrity of

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<sup>37</sup> Intuitively speaking, when people are asking of us more than we want to give it's easier to villainize them or view them as flawed somehow than to deal with the guilt we might experience from denying their request. To wit: the man begging for change will get characterized as a "worthless bum," the telephone solicitor a "mindless automaton," demanding teachers might be called Nazis. Even in intimate relationships, when someone asks for more than one is prepared it's very easy to just dismiss them as too needy and avoid putting the very hard question to ourselves as to whether we're living up to our obligations to the other.

particular clients due to a lack of time and resources, insensitivity to concrete personal destinies will increasingly become a moral option (2001, p. 117)

Before this issue can be taken seriously, however, the tremendous importance of respecting and cultivating the bare human impulse to care for and nurture others must be, acknowledged. However, while care and compassion ought to be recognized as guiding forces, determining when responsibilities occasioned by the face of another should win out over general principles or policies is no easy matter. In view of this difficulty, I will argue that the best way to insure that systems are operating in an ethically sound fashion is by cultivating morally wise workers. Unfortunately, the rationalized systems employed for management and morality threaten to stunt the very moral wisdom that need to safeguard the integrity of our caregivers and their workplaces.

### **Blinded by Care**

In order to appreciate the importance of moral wisdom for caregivers, it is essential first to recognize that the cultivation of care does not represent a moral cure-all. As Bauman points out, “virtually every moral impulse, if acted upon in full, leads to immoral consequences (most characteristically, the impulse to care for the Other, when taken to its extreme, leads to the annihilation of the autonomy of the Other, to domination and oppression)” (1993, p. 11). A chilling example of the oppressive side of care devoid of broader concerns related to justice comes from Steppe’s (1992) account of nurses working under the Nazis in WWII. Nurse Pauline Kneißler, who perhaps possesses little

sense of irony, writes from her prison cell after the war that “I am being accused of murder, I beg the court for justice.” Kneißler explains herself in the following manner

No one can blame me because the laws of the Third Reich, which were not perfect, were not a matter for a nurse. At the bed of a patient there is a doctor who is superior to the nurse. It's his decision whether or not to prescribe a chest compress, an enema, heart medication, or a sleeping pill. In this case it was mercy killing. I never understood mercy killing as murder. I believe that only those who have sympathy and who can sympathize can understand this. There were people who could no longer be helped – mentally or physically ... An additional point is that only hopeless cases came to my ward. I beg you to consider all of this (Steppe, 1992, p. 750).

It would appear that Kneißler cares so much for her patients she feels compelled to end their lives entirely, which is as oppressive as one can get.

According to Hilde Steppe, nursing was seen as a womanly profession in Nazi Germany because officials held woman should only work at jobs that prepared them for “the future biological or spiritual role of motherhood” (p. 748). From this we can infer that nurses were encouraged to give free reign to their caring impulses in the course of their work. Anna G, another nurse described practises of euthanizing patients.

Patients who were strong enough sat themselves up in bed; we laid an extra pillow under the heads of the others in order to lift them up a little. In giving them the dissolved substance I proceeded with great compassion. I had told the patients earlier that they had to have a little treatment. Obviously I could only tell this little tale to patients who were conscious enough to understand. In giving them the drink I took them in my arms and caressed them. If they did not empty the glass, for example, because it tasted bitter, then I encouraged them by saying they had drunk so much of it, they should drink the rest of it because otherwise the treatment would not be complete. Some of them were so persuaded by my encouragement that they finished the glass completely. With others, we fed them by spoonfuls. As I said before, the way we proceeded was determined by the patients' behaviour and condition (Steppe, 1992, p. 751).

Such an example does much to highlight the importance of respect as an intrinsic part of the equation that yields the morally superior attitude that is care respect. As Steppe notes,

the nurse in this example adheres to a principle of “loving care.” She is both attentive and responsive to her patients’ needs, and she adapts herself to their individual requirements. However, while she may have been present to patients’ immediate suffering as she soothed them towards their deaths, both the importance of their autonomy and a broader grasp of justice seem to be absent from her moral outlook.

It is interesting to note, in fact, how a potentially touching description of gentle care becomes perverse when we draw back and situate it in its wider context. Just as most cannot escape the gravitational pull effected by our face-to-face encounters, neither can we deny that we co-exist in mass societies, the mere fact of which obliges us to be concerned with questions of social justice and general welfare. Admittedly, attentiveness to partial relationships can draw one’s focus away from the needs of people one has never met. This can occur when we suppose, as Anna G seems to, that caring for the other in the present moment compensates for being party to a larger monstrous injustice. A more mundane form of injustice can be seen whenever partial leanings result in placing disproportionate value on the wellbeing of a favoured patient at the expense of others equally deserving.

### **Blinded by Obedience**

It is important to note that many of the nurses in Steppe’s research fell back on the defense that they were just following orders. We see elements of this in Kneißler’s statement above, meanwhile Anna G explains

Through the long years of being a nurse, practically from my childhood on, I was brought up to be completely obedient and discipline and

obedience were the highest commandments in nursing circles. We all, myself included, viewed the orders of a doctor, head nurse or ward nurse as something that should be absolutely followed, and did not or could not decide for ourselves if these orders were legitimate or not (p. 751).

Such a conflation of obedience with goodness is anathema to good moral reasoning, since it undercuts the development of moral perception, or one's ability to recognise *for oneself* the morally salient aspects of a particular situation. As Bauman argues, "uncertainty rocks the cradle of morality, fragility haunts it through life" (1993, p. 77) adding that good moral practise "can never placate itself with self-assurances, or other people's assurances, that the standard has been reached. It is ultimately, the lack of self-righteousness, and the self-indignation it breeds, that are morality's most indomitable ramparts" (1993, p. 81).

While modern healthcare settings work for benign rather than evil ends and do not make a fetish of discipline or obedience, they still rely on rationalized systems that require a high degree of worker subservience. As I argued in Chapter One, concentration on rote procedures can undermine workers' ability to form relationships with clients, but it is also possible that a concomitant emphasis placed on compliance serves to deter workers from subjecting their own actions to serious moral scrutiny. That is, at least some may rest easy with the potentially false assurances that *someone* up top has thought through all the relevant details related to the moral status their work. Given their proximity to patients, however, I argue that workers themselves represent the best first line of defence against systems that have gone astray. The reason frontline care workers occupy such a role is that their particular situation gives them the clearest view of the



human consequences of decisions made higher up, while their proximity to individual clients raises the chances of a compassionate response to what they see.

### **Luke, the Morally Wise Janitor: a Further Argument for Space**

The ability to think for oneself and accurately judge when rules should be bent to accommodate individual needs can only arise if a worker is provided with the space to develop her moral faculties. Hence, the detailed control of workers' conduct not only limits their ability to recognize morally significant situations, it may also stunt their development of moral wisdom. Although there is not much room for error in modern risk-averse professional environments, as Barry Schwartz's (2011) work suggests, the space to make mistakes is essential for the kind of learning that leads to *phronēsis*, or practical wisdom. In Schwartz's view, *phronēsis* is the ability to adapt one's knowledge to particular situations in ways that yield the best possible outcomes.

Schwartz's description of a janitor shows how the appropriate treatment of others essentially relies on the freedom to act spontaneously. According to Schwartz, Luke worked in a hospital and was cleaning the room of a young comatose man. After finishing the task, the janitor encountered the patient's father in the hall. The father had not seen the janitor cleaning his son's room and so admonished the worker for this alleged oversight. The janitor nearly responded defensively, but in the end decided to just clean the room again. Luke remarked, "I cleaned it so that he could see me clean it ... I can understand how he could be. It was like six months that his son was there. He'd be a

little frustrated, and so I cleaned it again. But I wasn't angry at him. I guess I could understand" (2011, p. 7).

In Schwartz's view, the fact that hospital custodians' work was not closely monitored was what gave them the freedom to behave humanly with patients and their families.

They were not generic custodians; they were *hospital* custodians. They saw themselves as playing an important role in an institution whose aim was to see to the care and welfare of patients. Though the literature suggests that the way to promote such behaviour is by expanding the work role, their employers did no such thing. What they *did* do is avoid excessively close supervision and an increase in job demands, so that Luke and his colleagues had the time and the space to expand their jobs on their own (p. 7)

Given that their minds were not occupied with a series of set tasks, workers such as Luke were able to focus on other people in order to appreciate their idiosyncratic needs and thereby discern the most appropriate course of action.

### **Space for the Cultivation of Phronēsis**

While I have repeatedly suggested that workers require the necessary time and space to form connections with clients, it is also the case that openings to exercise their faculties of moral discernment are also required for the development of moral wisdom. As Schwartz argues, people need to make mistakes and learn from these if those people are ever to achieve the state of "phronēsis"<sup>38</sup> that enables them to discern the right action, at the right time, and in the right place. In Luke's case, this meant allowing his empathy

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<sup>38</sup> Phronēsis here is being used in the Aristotelian sense of the word and means "practical wisdom." This is a form of knowledge that includes moral knowledge and is more akin to a skill or an art requiring practice than it is a form of factual knowledge (Little, 2000). Epistemologically speaking, the term captures a state of "knowing-how," as it were, as opposed to a "knowing-what."

and compassion to guide him in his interactions while appreciating the grieving father's own particular context in order to know how to act. Tuning up wise networks to arrive at this state of wisdom, contends Schwartz, "requires varied experience – trial and error—with feedback, and not the same experience over and over again" (2011, p. 10). Seeing when a rule does not work is equally essential to wise action because it highlights the circumstances that can render standard practises ineffective. By contrast, anyone preoccupied with adhering to existing sets of rules is less likely to see their limitations.

To make a case for the detrimental effect of an emphasis on rule-following, Schwartz looks to a 2001 study of wildland firefighters. In the study it was noted that workers' survival rates decreased as the list of workplace ordinances went from 4 basic rules in the 1950's to 48 items over the years. The shorter list, argues Schwartz meant the workers were open to learning from experience, and were more apt to improvise in order to adapt to particular situations and extenuating circumstances.

But when general rules morph into detailed instructions, formulas, and unbending commands the important nuances of context are squeezed out. Weick concludes that it is better to minimize the number of rules, give up trying to cover every particular circumstance, and instead do more training to encourage skill at practical reasoning and intuition (p. 10).

Clearly, when it comes to developing moral wisdom, a different skill set is required, but the need for trial and error remains. In Luke's case, Schwartz suggests that the custodian's ability to discern which of his emotional responses would lead to optimal outcomes was critical in guiding him towards an appropriate action. Luke had experienced a flash of anger and defensiveness, but appears to have learned that allowing compassion to guide him through this particular interaction provided a better course of

action. “Luke’s emotions were not random – unstable and uneducated. He was compassionate about the right things and angry about the right things. And he had the self-control, the emotional-regulating skills – to choose rightly” argues Schwartz (p. 9).

Emotions on Schwartz’s view, are not experiences to be suppressed and ignored lest they blind one to one’s duty. Rather, moral action is a matter of cultivating emotions so that the most appropriate ones are given free rein to motivate action. As Chris Gastmans argues, emotions play two further roles in the provision of ethically informed nursing practice (and this will hold for any type of caregiving work). Firstly, emotional responses tend to draw attention to morally salient details of a situation, whether this is disgust at the abuse of a senior or outrage at the machinations of a system that consistently neglects and underserves patients suffering from SPMI. Secondly, being emotionally attuned to a client and showing the appropriate emotion under particular circumstances is key for communicating to a patient that one cares about her (2002, p. 502 – 503).

A complete moral education for care workers would include learning which responses to heed and under what circumstances, and perhaps even instilling a response to situations that had previously been overlooked at morally relevant. As various philosophers contend (Nussbaum, 2003, Ben-Zeev, 2000, Roberts, 1988, Goldie, 2000, Helm, 2007, Lacewing, 2005) emotions have an evaluative function and hence carry information about our environment in relation to our ends. As such, then, emotions are things that can be tutored and educated, given that they sometimes carry false information. However, any such education must be closely engaged with practice, since it

is only in dealing with concrete others that we encounter the feelings we must learn to assess, navigate and act upon to provide sound and compassionate care.

The hope here would be to make room for workers such as Trudy to be able to discern *all* morally salient aspects of a situation while also providing them with the freedom to consider the possibility that “feeling like hell” represents a morally salient bit of information, and may well constitute a worthwhile reason to slow things down in order to adequately provide care for Mrs. Jones. The end goal is to cultivate wise workers who can be trusted to spot inevitable exceptions to standardized protocol, or to know when rules underwriting the relentless drive for efficiency *must* be bent or broken in order to preserve both their own and their patients’ humanity.

As Bauman’s work suggests, making the space for workers to develop their own brand of ethically informed practise is an inherently risky proposition, as we can never be sure we’ve got it right. Moreover, as Schwartz suggests, to learn well, mistakes must be made. However, as the growing literature on moral distress indicates, mistakes are already being made at the level of policy if both patients and caregivers are suffering from a lack of the attentive personal care that should be everyone’s due. In light of such suffering, coupled with the importance of developing moral wisdom through practise and improvisation, there are strong moral grounds for administrative policies that ease constraints on workers’ time and open the discretionary space they need to acquire and apply moral wisdom.

Although there is no easy way to strike a hard and fast balance between the requirement for the fair and equitable distribution of health resources and the obligation

to provide personalistic treatment,<sup>39</sup> one thing is certain: the participation of compassionate and morally attuned frontline workers is essential to the process. As Nussbaum argues

the relation between compassion and social institutions should be a two-way street: compassionate individuals construct institutions that embody what they imagine; and institutions, in turn influence the development of compassion in individuals (Nussbaum 2003, p. 405).

It is those working at the ground floor who are best positioned to *see* suffering and understand patients' personal and emotional needs. Information derived from face-to-face encounters is crucial for knowing how to provide decent care, and for this reason care workers should be directly involved in shaping policy. While one cannot expect workers engrossed in the immediate needs of particular others to fully grasp the big picture or the claims of administrative justice, it is also clear that policymakers, themselves isolated from knowledge grounded in personal encounters, often fail to see what is needed for effective and compassionate care.

In this chapter I have drawn on a moral perspective enriched by an ethics of care to raise questions about the limitations of highly rationalized, efficiency-based systems for the delivery of care to vulnerable persons. I have argued that, to the extent that such systems suppress empathic moral responses to the needs of patients, they may do real harm to patients and healthcare workers as well. The point is that such concerns ought to figure into policy-level decision-making regarding the structuring of healthcare. The need for such information for the development of sound policy will reappear in the proposals I

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<sup>39</sup> Nortvert struggles with this very problem, and suggests either the articulation of positive duties to provide a "decent level of care" or negative ones specifying which values "ought not under any circumstances be overridden when caring for patients" (2001. P. 119).

make in Chapter Five regarding the current structuring of ACT work, and especially in Chapter Six where I examine current trends influencing the future directions for ACT.

Thus far, however, I have only examined the moral limitations afflicting inpatient caregiving work that is either grossly under resourced, as in the APU with its nine beds, or which is carried out within intensely supervised and rationalistically controlled settings, as in the first two ethnographies discussed in Chapter Two. However, there is another approach to psychiatric care that is explicitly designed to avoid the most obvious defects of these two settings while offering more discretion to caregivers. This the program for psychiatric outpatients known as Assertive Community Treatment, or ACT.

The rise of ACT teams can be understood as a direct response to the deinstitutionalization of mental healthcare and the need for an effective way of working with patients living in the community. The ACT program reflects an understanding of the limits of rationalized approaches to psychiatric care and was designed as a means of tailoring support for particular patients. Hence, ACT work is highly personal work, and, as I shall argue in Chapter Five, in many respects ACT workers' practice shows clear affinities with an ethic of care. In order to place our examination of ACT in its larger social context, however, we must first understand its origins and development. This will be my concern in the next chapter.

## **Chapter Four**

### **Assertive Community Treatment -- Its Origins and Moral Context**

*Riddled by psychotic illnesses, abandoned by the systems that once pledged to care for them as long as they needed care, they are ... the detritus of the latest fashion in mental-health policy ... It is extraordinary how immune we have become to their presence. Where we might have once felt compassion, revulsion, or fear, now we feel almost nothing at all"*

~ Paul Appelbaum, 1987, p. 34.

*In the 70's when you got discharged from a psychiatric hospital you were lucky if you got hooked up with a psychiatrist or a social worker. Then they would give you, and I know this from experience, an hour appointment in their office. But then, it often didn't include all the things that happened outside the office. You know I did some public speaking and usually I say," who are you going to call at 2:30 in the morning? It won't be your psychiatrist, it won't be your social worker. They're not going to be there."*

~Chris Buckley, ACT worker/former psychiatric patient.

### **Introduction: From wholesale to just-in-time productive methods**

Long gone are what Andrew Scull describes as "mammoth institutions, huge custodial warehouses" (1989. p. 305) housing anywhere from 1000 psychiatric patients and staff in England, to upwards of 4000 in some American asylums. Even then, interestingly, the ethos of mass production was influencing the provision of care so that those described by Foucault as "the residue of all residue," were raw material to be processed by a great machine. This is evident from W.A.F Brown's observation in 1859, that due to the size of such institutions, "all transactions, moral as well as economic, must be done wholesale," since their "number renders the inmates mere automatons, acted on



in this or that fashion according to the rules governing the great machine” (Brown, cited in Scull, p. 305).<sup>1</sup>

As we have just seen, a shift towards rational standardized treatments based on the objective classifications has moved us away from seeing masses of patients languishing in the asylums of a bygone era. This is the era of just-in-time manufacturing after all, and the use of warehouses is obsolete. Nevertheless, both these approaches are meant to work on a mass scale. Nowadays, it is simply the case that we see smaller numbers moving through the institutional machinery at any given time. Meanwhile, sorting is an efficient procedure requiring little understanding of a person while their subsequent care is sped up exponentially in order to accommodate the multitudes waiting for care. Hence, while there are differences between these two approaches, neither seems to have served psychiatric patients particularly well.

ACT work, however, is something different as it marks the venturing out of professionals from the confines of institutions and out into their clients’ homes. The fact that ACT work marks a significant departure from the type of psychiatric practice we’ve seen through history, or even in modern institutions today, makes it an important area of study. Furthermore, the program is interesting for my purposes insofar as it was developed as a response to the sort of impersonal treatment seen, for instance, in the

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<sup>1</sup> Nor are the mentally ill liable to be typified by experts as “more shameless and filthy in their conduct than so many monkeys “displaying a “revolting indecency and obscenity,” (Mercier, 1890, xiv). Mercier, a 19<sup>th</sup> century lecturer on insanity, did not hold an attitude that was particularly unique for his time. As Colin Samson notes, during this period other physicians and experts ascribed “an animal nature” to patients calling them “disgusting and dirty creatures of base biological motives, lacking the most fundamental powers of self-restraint.” Meanwhile, for the price of admission, members of the public were able to tour asylums where inmates would be put on display like animals in a zoo (Samson, 1995, p. 57).

APU, and which caused so many patients to fall through the cracks following deinstitutionalization.

As I shall show in this chapter, ACT was created specifically to provide more intense individualized support for patients, and relational work lies at the heart of the ACT ethos. In fact, as I shall demonstrate in Chapter Five, ACT work is consistent in many ways with the care-based ethos advanced in the last chapter. Before conducting a moral assessment of this kind of outreach work, it is first necessary to situate it historically and explain the nature of the program. Section I outlines the origins of ACT as a response to the less than optimal state of community mental healthcare following deinstitutionalization. In Section II I move on to explain the ACT model and the extent to which relational work lies at its core. Finally in Section III I examine the current state of debates around ACT work and show that there is room for further ethical analyses.

## **I. From Long-term Wards to ‘Crazy in the Streets’**

In the mid - 1950s Erving Goffman began researching mental hospitals for his highly influential work “Asylums,” and looked to institutions that had not changed much from the early 1900s (Grob, 1994). Goffman’s depiction of modern custodial psychiatric institutions was bleak. In *Asylums* Goffman compared mental institutions to other types of detention such as prisons or concentration camps in which inmates are separated from the rest of society and stripped of their outside identity so as to be reconstituted as a mental patient. Goffman also saw patients subjected to humiliation, non-negotiable rules and restrictions, hostility and oppressive power relations (Goffman, 1961). His work then

would be a highly influential force for justifying the shutdown of a great many such institutions.<sup>2</sup>

Various factors are regularly cited to have contributed to this enormous shift in the treatment of the mentally ill including the introduction of chlorpromazine (Thorazine) in the 1950s, which instilled a certain level of optimism regarding the treatment of even the most severe cases of mental illness. This, in turn fueled hopes that patients might one day be made well enough to return to the community (Grob, p. 230). Meanwhile, Thomas Szasz, who argued that mental illness was a myth and treatment nothing more than social control (Szasz, 1974) was also gaining recognition, as was the work of R. D. Laing who held that so-called insane behaviour was actually an appropriate response to a pathological society (Laing, 1967/1990).

The 1960s were also seeing the eruption of an anti-establishment ethos coupled with sustained critiques of cultural influences encouraging conformity. Given these intellectual trends many would have been inclined to turn on an institution such as psychiatry that both assumed a position of authority and included practitioners who sought to control and modify behaviour deemed abnormal. With the civil rights movement coming into full swing, moreover, freedom was in the air, as it were. As Paul

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<sup>2</sup> The book *Shrink Resistant*, a collection of Canadian consumer survivor stories from the 1960s through to the mid-eighties, does much to confirm Goffman's observations. In this book, psychiatric inmates reveal how wearing clothing was often conceived of as a "privilege" on a mental ward. As Ketu Kingston describes it, "[t]he nurses scolded 'Now you know you haven't earned any privileges yet—you are to wear the pajamas we give you!'" According to Kingston, she was issued

an ugly lime-green pair of pyjamas, at which point I turned them inside out and wore the bottoms on my top and the tops on my bottom. Whiffing down my bottoms, they gave me a needle. NOT APPROPRIATE (an all-powerful phrase which was a rationale to keep you in your place and earned you a lengthier stay if ignored, I soon discovered)" (Burstow and Weitz, 1988, p. 256).

Appelbaum notes, civil-libertarian attorneys armed with a set of values in which “individual autonomy was paramount,” launched numerous challenges upon statutes concerning involuntary commitment. Once the dust from these legal battles settled, psychiatric patients could only be committed involuntarily if they posed a demonstrable danger to self or others (Appelbaum, 1987, p. 34 - 35) a standard that appears to become increasingly difficult to reach.<sup>3</sup>

All of these factors contributed to the mass exodus from institutions in industrialized countries. In the US, Medicaid was launched in 1965, which provided federal funds for community psychiatric treatment, while long-term institutional care continued to be covered by the states (Stein and Santos, p. 10). As a result, individual state-funded asylums rushed to offload the costs of treatment to the federal government by moving patients into the community. The threat of being locked away in an asylum indefinitely is a thing of the past in Canada as well and between 1960 and 1976 the number of beds in Canadian mental hospitals dropped from 47,633 to 15,011 (Wasylenki, Goering, & MacNaughton, 1994, p. 346). Meanwhile, in the US 400,000 patients were released from mental hospitals between 1965 and 1975 (Stein and Santos, p. 10).

The generalized downsizing trend in the provision of inpatient care only gained momentum over time, but was not matched by significant increases in community supports. For instance, when Ronald Regan assumed office in 1980, only 650 community

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<sup>3</sup> In a recent story in the New York Times, Robert Davies, executive director for mental health services in New Jersey was interviewed and described cases in which clients could not be committed. The reporter writes “a man who was convinced that aliens were on the roof and that bugs were coming out of the walls and who would not sit on furniture but only lie on the floor was not committable. Neither was the man who refused medication and mutilated his own testicles. Nor the woman who wouldn’t eat because she believed the C.I.A. was trying to poison her. “It is unbelievable the condition of people who are found not to meet the standard,” Davison says.” (Interlandi, 2012).

health centers had been built, a number much lower than the 2,000 that John F. Kennedy's administration had, in 1963, mandated be in place by this time (Grob, p. 281). One result of this this lack of funding was the "revolving door syndrome" so vividly captured in Rhodes' ethnography of the APU. This syndrome refers to the behaviour of those "despised repeaters" who after being swiftly stabilized in hospital and released, turn up again days, weeks or months later looking for care, and this was largely due to a lack of supports in community.

In Canada, a similar situation obtained.

As in the United States, initial enthusiasm for deinstitutionalization dampened with the awareness that many discharged patients were leading impoverished lives in the community, swelling the ranks of the homeless and those in jails. In response, in the 1970s provincial governments began to flow funds to community mental health programs. Despite ongoing interest in enhancing community supports, this sector of the mental health treatment system remains underfunded, consuming only about 3% of provincial mental health budgets in 1990 (Wasylenki, Goering, & MacNaughton, 1994, p. 346).

Pat Capponi, a Canadian consumer survivor describes the situation of many at this time.

Imagine being told over and over for years that you have to be locked up. And then some clown is standing there talking about how it's time for you to go; being in hospital isn't good for you ... This hospital, this staff, the patients and the people you've been locked up with for years have become closer than the siblings you no longer remember, but no one seems to mind that for a second time you've been surgically removed from your family. No one talks about missing you. No one addresses the fears that are churning up in your guts. Seventeen years later, bloated by meds and starchy foods, in donated clothing, with a cough that can be heard four floors up, they send you out. No nurses, no shrinks, no clean sheets, no full meals, no daily ration of tobacco – you have to swallow this thing called freedom (1992, p. 29).

Capponi was both institutionalized and lived in the halfway homes that sprouted up to accommodate the tide of patients moving into the community. After being released from

a mental hospital in and around 1980, she recalls meeting Gary. Gary had been in an institution for 17 years before suddenly being released. “Yep,” he told her, “They sent me there from training school. Then the assholes give me a bus ticket and an address and I wind up in this house” (Capponi. 1992, p. 27). In the house there were as many as four to a room, and it lacked laundry facilities. The bathroom door did not lock and was always busy, so bathing was not possible. “Not to mention that there was no plug for the tub, or hand soap, or towels, or curtain, or mat” notes Capponi (p. 26).

As for the services that were supposed to be in place in the community for former mental patients, according to psychiatrists Roger Peele and Paul Chodoff, many patients would find themselves turned away from agencies meant to serve them (1999, p. 427). As Peele and Chodoff describe it, the nature of bureaucratic systems is such that a major concern is to avoid being embarrassed by the acts or omissions of a constituent department. In other words what leaders want most from their mental health departments is silence, as this equates to a lack of public scrutiny.

This objective, moreover, is most easily achieved with a narrower mandate and clients who are most easily helped. Peele and Chodoff note

When the disabled psychiatric patient moved from the public state mental hospital to the community, the responsibility for that patient, at best, is moved from one agency to many: departments of housing, welfare, vocational rehabilitation, recreation, etc., all striving to narrow their accountability, with predictable unfortunate results for discharged patients, many of whom fall between the cracks” (Peele and Chodoff, p. 427).

Appelbaum sums up the end result of such government downsizing alongside changes to civil commitment when he observed in 1987 that

chronically mentally ill people constituted “an inescapable presence in urban America,” where they could ever be found living in subway tunnels and parks or left to “die in cardboard boxes on windswept streets.” “Dying,” as psychiatrist Darryl Treffert puts it, “with their rights on” (Treffert, cited in Appelbaum, 1994, p. 30).

## **II. ACT: Committed Relationships in the Community**

As deinstitutionalization was in full swing in the late 1970’s three psychiatrists who were sympathetic to the anti-authoritarian ethos that had been gaining momentum in their day were also becoming familiar with the revolving door syndrome that plagued Rhodes’ APU. In light of these factors, Leonard Stein, Mary Ann Test and Arnold Marx strove to address the situation of patients diagnosed with Severe Prolonged Mental Illness (SPMI) in a way that did not require institutionalization. As they saw it, if it was neither ethical nor affordable to house patients with severe mental illness, then the time had come to take psychiatry into patients’ communities and into their very homes.

Today, the quintessential ACT client is a person with some form of debilitating psychosis who has spent 50 days or more in hospital per year, lacks stable housing and enjoys few “natural” social supports by way of family or friends. People, in other words, who in earlier times would have been committed to long-term asylums, and who were abandoned during the era of deinstitutionalization. Since the inception of ACT, Stein, Test and Marx focussed on patients diagnosed with some form of SPMI and who tend to vacillate between a stable phase and an “out of control” phase characterised by

“psychosis with delusions, hallucinations, and bizarre behavior” (Stein and Santos, 1998, p. 41).

ACT’s originators recognized that such individuals require a high level of support, not just because they are vulnerable to stress, but because they have difficulty relating to others, poor basic coping skills and difficulty transferring learning into different domains (p. 42). Such deficits often bring multiple failures leading to a downward spiral that ends in relapse and another admission to hospital. Given this vicious circle, Santos and Stein note regarding the shift from asylums to short term hospital stays, “what was accomplished was the replacement of one inadequate mode of care ... with another (p. 41).

A large part of the problem for such patients is that SPMI is marked by a persistent inability to cope with the demands of a complex modern society coupled with a high level of vulnerability to the stress occasioned by the effects of this inability. In this way, those with SPMI can become “sources of error” in the rationally organized systems they rely on for housing, healthcare, income support, work and the like. The vulnerability ascribed to patients, moreover, is perhaps more of a reflection of the interdependence of these numerous systems wherein failing to maintain one’s position within one, causes the rest to come crashing down like a set of dominoes. Relapse leading to a long hospital stay, for example, could lead to eviction, which in turn could mean that disability cheques must be rerouted, phone calls confirming medical appointments missed, work days lost and so on, so that the resulting levels of stress from the ensuing collapse would be overwhelming for most people, not merely the mentally ill. The highly bureaucratized



environment that governs most our lives is taken for granted and normalized, while those unable to meet its demands are pathologized.<sup>4</sup>

ACT's creators also recognized that the standardized treatment plans offered by bureaucratized community mental health centers at this time were no better in providing treatment for patients diagnosed with SPMI. A whole host of circumstantial factors could interfere with a patients' ability to conform to such plans, such as a patients' inability to navigate public transport, as well as anxieties around meeting and confiding in a new clinician. Rather than writing such patients off as "unmotivated" Stein, Test and Marx's strategy for working with people persistently falling through the cracks was to eschew standardized approaches altogether in favour of highly individualized care. To this end, they sought to "tailor programming to individual needs" and prescribe "regularly updated plans that incorporate clients' changing situations and their wishes." It is "critically important," Stein and Santos note in regards to history taking, to learn clients' attitudes towards earlier forms of care and their preferences (p. 75). Hence, gaining a client's trust and getting to know him well is crucial on the ACT model.

To better achieve such goals and to tailor treatment to clients' actual lives, in the 1970's the originators of ACT proposed to move hospital staff into the community and be made available to patients twenty-four hours a day, seven days a week. Patient programs were to be individually based on an assessment of particular patients' coping skill deficits

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<sup>4</sup> Given this, it is interesting to speculate whether the poorer outcomes for schizophrenia in industrial societies (Hopper, 2003, p. 62) have more to do with the fact that the deficits associated with the illness are far more evident, and represent far more of a liability within an environment imbued with highly structured rationally organized systems designed to govern virtually every aspect of functioning within industrialized mass societies.

and requirements for community living. Most treatment took place in vivo – in patients' homes, neighbourhoods, and places of work where workers taught and assisted patients with their activities of daily living such as laundry upkeep, shopping, cooking, restaurant use, grooming, budgeting, and use of public transportation.

Stein and Santos note, “rather than being consistent with the traditions, philosophy, and practice of the field, the ACT program was incompatible with them ... a hundred years of hospital treatment, as the primary locus of care for persons with serious and persistent mental illness, was challenged” (Stein and Santos, 1998, p. 36). As a resident at the time, Stein was keen to go “against the current” of contemporary psychiatric practise. Both he and Marx had completed their residency under the tutelage of professors who opposed the biological turn in psychiatry, favouring psychosocial perspectives instead. Thomas Szasz was also a regular visitor to the University of Wisconsin, where the two completed their early training, and his views were echoed by Dr. Seymour Halleck, a popular lecturer in the department. “This was during the 1960s,” write Santos and Stein, adding that it was

a heady time, when being anti-establishment was becoming very much in vogue. Given this strong antimedical bias, coupled with very strong beliefs that the mentally ill were unjustly incarcerated in mental hospitals, it is not surprising that, upon Dr. Ludwig's departure [a former director of the special treatment unit interested in inpatient care], Drs Stein and Marx were primed to do community instead of hospital psychiatry (Stein and Santos, 1998, p. 17).

As Stein and Santos tell it, hospital management saw plans of venturing out to work in the community as a radical departure from routine inpatient practises and therefore resisted early proposals. The authors explain

The idea was not congruent with the traditions and practice of the mental health sector. In fact, it was directly contrary to usual practices and inconsistent with the usual procedure of the health business environment. Its course was hazardous and its survival was tenuous; it was rarely nurtured or protected financially. Its growth was not encouraged by administrators, clinicians, or academicians (p. 34).

In spite of the initial barriers erected by administrators, however, Stein, Test and Marx prevailed. They rented a house in downtown Madison as their base of operations for the program “Training in Community Living,” the precursor to ACT. Marx died in 1975, and the other two carried on work that would culminate in a distinctive treatment model that is currently being adopted across the globe.

### **III. The ACT Model**

In their how-to-guide for ACT teams, *Assertive Community Treatment for Persons with Severe Mental Illness* (dubbed the “Act Bible” by one of my subjects), Stein and Santos describe their program model extensively. At the core of ACT work is the “continuous care strategy” that eschews quick fixes and looks instead at establishing “a lifelong supportive relationship” with clients. Santos and Stein note

Such a commitment provides an anchor in the community for people in a pattern of repeated hospitalizations and failed living arrangements. The long-term trusting relationship with the team becomes a vehicle for change in and of itself (Stein and Santos, p. 50).

The therapeutic relationship, then, is seen as central to ACT work, and maintaining this relationship is a clear priority.

The authors also hold that workers must be broadly involved in clients' lives and that no arbitrary time constraints<sup>5</sup> limit the duration of treatment. "ACT research clearly showed that services may have to be provided over long periods of time and, in some cases, a lifetime," note Stein and Santos (p. 48). ACT workers should broadly focus on all other aspects of patients' lives and strive to become the "fixed point of responsibility for all aspects of the person's life that affect his or her stability in the community" (p. 47).

One way to insure a patient doesn't fall through the cracks between service providers is to provide as comprehensive a set of services as possible, while taking responsibility for the rest. As such team members are not simply responsible for delivering meds, but also for helping clients with tasks related to maintaining a life in the community, such as managing housing, setting and attending medical appointments, and maintaining finances. Workers also provide substance abuse counselling and transportation when needed. Apart from providing support in a variety of domains, monitoring is also a key aspect of ACT work "to be aware of relapse as early as possible, so that rapid intervention may be employed to avoid a full-blown psychotic episode" (p. 47) and thereby avoid a hospital admission. To this end, workers must be familiar with each clients' distinctive signs of relapse.

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<sup>5</sup> For instance, one approach was to shift patients away from supportive facilities at predetermined intervals. Hence a patient would move from a hospital to a ¾ way house for a set period of time, such as 6 months, before he is again moved into a halfway house and so on, in an attempt, or so it would appear, to wean him off supported living. These fixed time periods may seem arbitrary to a caregiver looking at a particular client's situation. However, from the perspective of a policymaker or funding agency, it is clear that predetermined periods of time allow for better calculations and predictions of costs.

Typically, moreover, ACT teams will have a team leader who is someone other than the psychiatrist.<sup>6</sup> However, Santos and Stein's conception of an ACT team is that decision-making is shared, so the team leadership should be "egalitarian in nature" (p. 66). Each regular member, moreover, acts as the "primary" for up to 10 clients, meaning that she is the "primary point of contact"<sup>7</sup> for those clients (p. 49), and, according to my own observations, will tend to have a greater say in decision-making in and around them. The primary is also responsible for formulating a treatment plan and presenting extended updates to the rest of the team every six months or so. However, the authors stress that "the responsibility for the total client caseload is shared by all, even though persons on the team serve as the primary contacts for the team" (p. 71) so that over time clients know all staff members and vice versa.

Contrary to the suggestion that the "assertive" in ACT refers to an imperative to aggressively control clients, Stein and Santos explain that "it dictates that the team must be assertive about knowing what is going on with clients and acting quickly and decisively when action is called for." As for the notion that ACT workers aim to control clients, they add "the major goal of ACT is to help clients live successfully in the community, and the beauty of living in the community, as contrasted with living in an institution, is that clients are in control of their own lives" (p. 75).

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<sup>6</sup> The authors' anti-establishment roots show when they suggest that psychiatrists might have "difficulty in finding a comfortable place in the team hierarchy" because most "are uncomfortable having a nonphysician as their 'boss.'" They note further that this is "as much a cultural and political problem as a clinical one" (p.60).

<sup>7</sup> Santos and Stein shy away from the term 'case management' since this objectifies people as cases to be managed and suggests "passivity on their (the clients') part in the treatment process" (p. 49).

#### **IV. Ethical Responses to ACT**

In their work, Stein and Santos also emphasize the need for workers “to accept – and to believe to the core of one’s soul—that ACT clients are first and foremost citizens with all the rights and responsibilities of citizenship,” adding that due to their disabilities, these citizens see some of the greatest levels of discrimination in society. “The struggle to help them live successfully in the community is as much a civil rights issue as a clinical one” (p. 77), contend Stein and Santos, demonstrating the centrality of community integration not only as the guiding purpose of ACT work, but also for conceptions of the program as an essentially moral enterprise.

Although Stein and Santos’ may have a stated respect for clients’ civil rights, some patients do perceive the service as oppressive. That is, clients are not always pleased by attention from ACT workers. One client interviewed by Jay Watts and Stefan Priebe for example comments that he is ‘just trying to work out how I can stop them seeing me now. I don’t have a choice, they just come. They don’t listen sometimes. They’ll change some appointments but won’t change them all” (2002, p. 449). In general, ACT is not without its critics, and is seen by some as overly paternalistic and as an infringement upon clients’ rights and freedoms.

Such critiques, however, are not particularly broadly based. Despite the existence of a voluminous body of empirical studies in the literature, ethical examinations of ACT are reportedly been few and far between (Watts and Priebe, 2002, p. 442). As Appelbaum and Stephanie Le Melle note, moreover, criticisms of ACT mostly concern coercion (2008, p. 459). ACT workers face an acute paradox, argue Watts and Priebe, in that “the

model has the therapeutic aspiration of increasing personal autonomy, yet the program aims to engage people whose actions exemplify that they do not want to be involved with psychiatric services” (2002, p. 442). Jeffrey Stovall succinctly captures this paradox by asking, “is treatment that won’t go away ethical?” (2001, p. 140).

According to Brodwin, moreover, patients’ autonomy and the value placed upon fidelity to those in need constitutes an “ethical plateau,” a term Brodwin borrows from Michael Fisher (Fisher, 2003) to describe a particular configuration of technologies, institutions and ideologies that shape particular fields.

An ethical plateau operates as a legacy of the past in the present. It extends its influence forward in time by establishing an armature of notions about right and wrong that subsequently gets reproduced in other settings, in other registers, and in the voices of actors (clinicians, patients, advocates, policymakers, etc.) who enter the scene long after the original debates have faded away” (Brodwin, 2008, p. 137).

In the case of ACT, the legacy to which Brodwin refers are the debates discussed above between civil rights lawyers defending patients’ autonomy, and opposing concerns raised by legal scholars such as Appelbaum, aghast at the gross levels of neglect of the mentally ill in society during the period of deinstitutionalization. As a result, the field of discourse largely sees a tension between the value of autonomy versus “fidelity” to clients.

To see how this plateau plays out in the literature, one can examine firstly the work of Tori Gomory, who contends that ACT is paternalistic and harmful. Gomory argues that the program is overly focussed on a biomedical approach and is inherently coercive. He cites instances of workers ordering patients out of bed to go to work to

support his claims and also looks to the work of a “close associate” of Stein and Santos, who writes

Paternalism has been a part of assertive community treatment from its very beginning.... In the early stages of PACT,<sup>8</sup> consumer empowerment was not a serious consideration.. it was designed to "do" for the client what the client could not do for himself or herself. Staff were assumed to know what the client "needed." Even the goal of getting clients paid employment was a staff driven value that was at times at odds with the client's own preferences.... A significant number of clients in community support programs have been assigned a financial payee ... This kind of coercion can be extremely effective.... Obtaining spending money can be made dependent on participating in other parts of treatment. A client can then be pressured by staff to take prescribed medication ... the pressure to take medication can be enormous....While control of housing and control of money are the most common methods of coercion in the community other kinds of control are also possible. This pressure can be almost as coercive as the hospital but with fewer safeguards. (Diamond, cited in Gomory, 1999, p 7 - 8).

Gomory also examines instances of suicides that have occurred among patients of ACT teams and asks “can such coercive scrutiny be counter-therapeutic?” He then suggests that patients may be “managed to death, but no one is likely to sit down and spend ... time discussing your experiences, thoughts, feelings and reactions” (Mosher and Burti, 1989, cited in Gomory, 2001, p. 183).

Others argue, however, that there is little evidence to support claims regarding coercion, nor are there higher rates of suicide among ACT clients. Clients consistently report high satisfaction levels with ACT service across studies, while yet further research shows that few clients describe ACT teams as being overly coercive (Appelbaum and Le Melle, 2008, p. 459). As for ACT teams that are coercive, one response from advocates of ACT is to stress that such teams have departed from the ACT model (Krupa et al,

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<sup>8</sup> Program of Assertive Community Treatment.



2005, p. 23). ACT originators Test and Santos, meanwhile admit that in its early days, ACT was overly paternalistic, and that health practitioners did assume that the staff “knew best.” They add, however, that

Fortunately, the courageous voices of consumers, along with years of experience, have led us to see the enormous strengths of persons with mental illness. The assertive community treatment model has evolved into one of ongoing collaboration with consumers in making and reviewing decisions about goals and methods. The model will continue to improve only when we work in partnership with consumers (Test and Stein, 2001, p. 1396).

In fact one recommendation of Stein and Santos is that teams include a peer counsellor on staff, which is to say someone who has herself experienced SPMI and has been through the system. One might hope that the presence of such persons on teams helps to curtail abuses of clients.

Meanwhile, some clients’ reports of ACT make it difficult to accept depictions of ACT as more aggressively coercive than a consistent source of material and social support for people in need

I was living in the streets all over the country... all I had was the clothes on my back. And they got me into a little trailer, they got me food, they got me money assistance, and then I just kinda worked my way up. I have a nice home now, it took me a long time... During the whole time they were very, very, very supportive... It was very enjoyable and they helped a lot. If I had any problems, if it wasn’t going good – they were right there, and they got me through a lot. If it wasn’t for the ACT team, I’d be living under a bridge... ACT team was one of the best things that ever happened to me in my life... it was the first real help I ever got... practical, physical help. Being there for moral support... If I needed hospitalization they were there, and they would come and check on me. One of the best things in my whole life! (McCall and Wakefield, 2012, p. 32).

Relationally speaking, moreover, there appears to be much to be said for ACT since, as research has shown, “clients long to connect not only with their case managers, but also to the social world” with some ACT clients saying the program provides them with just such a conduit (Buck and Alexander, 2006, p. 472). To illustrate the value clients place on their relation with workers, researchers cite a subject describing a time when he was fearing an eviction.

She comforted me and explained that they would probably not throw me out but that they would need to give me notice. She was there for me, not for her job or the system, but because she wanted to be” (p. 476).

These relational aspects of ACT work has caused some to aim to reconfigure the field of moral discourse related to community treatment. Psychiatrist Richard Christensen, for example, argues that the reigning virtues that should guide community psychiatry ought to be compassion, as marked by an involved understanding of patients and a willingness take their pain seriously, humility, without which practitioners can become “inflated with self-importance and oblivious to the possibility that our decisions may be hurtful or even downright wrong,” and fidelity to clients, or a refusal to abandon people who refuse treatment (Christensen, 1995, p. 1217).

Given that ACT is coming to represent an increasingly dominant treatment modality for persons diagnosed with SPMI, a claim that is well-supported in Chapter Six, moral evaluations of the program are especially valuable. Furthermore, to date, and possibly due to the relative newness of the program, ACT has yet to be thoroughly morally evaluated in the literature. As we have seen, moreover, current moral evaluations

focus largely on those concepts such as autonomy and consent, which are largely associated with contemporary rationo-centric moral theories.

In keeping with the moral outlook advanced in Chapter Three then, I shall go against the grain, as it were, and attempt a moral ethnography of ACT through the lens of an ethics of care. In Chapter Three, I endorsed care-respect as the ideal ethical relation, while noting that an essential feature of this attitude is a recognition of another person's me-ness. Arriving at this me-ness, as was shown requires the patient attentiveness of loving perception as well as the application of our imaginative resources to stretch, as it were, our own pre-conceptions of the other. Lugones, moreover, shows us that attention to the subjectivity of the other is what matters for relatedness, and that it is important to understand that the other is not a static being, she changes depending on her location in both time and space, and her subjective experience will change accordingly.

The results of my ethnography suggest that, in contrast to the disengaged, rule-bound approach to treatment found in so many psychiatric settings, the daily practices of ACT teams begin to approach the alternative conception of morality advanced in Chapter Three. Certainly its workers enact many of the relational practices described there and generally seem to speak of their clients in both a caring and respectful way. Moreover, the othering described in hospital environments is only conspicuous in its absence from the discourse of team members. These differences, it would seem, represent good first steps on the road to the cultivation of an attitude that is consistent with care, which would be the bare minimum for assuming an attitude of care respect.

As I shall try to show, the daily practices of ACT teams also include some elements that go beyond those usually found in accounts of care-based ethics, though they help to build the imaginative sympathies that make care respect possible. Here I am thinking of a certain kind of storytelling often seen in team meetings, which appears to stretch participants' understanding of clients, while also reinforcing the subjectivity and agential nature of those being described. Many of these stories seem to be of a kind that contributes to the cultivation of genuine fondness or care for each of these individuals by situating him or her as 'one of ours.'

As I noted in my introduction, in conventional mental health settings acts of this nature are often "disappeared," in either being trivialised or not acknowledged at all. Hence, there is value in bringing them to light and seeing how certain phenomena emerge as morally salient and even praiseworthy when situated within a paradigm that privileges a caring attitude and concern for "me-ness." Nevertheless, ACT work is challenging work, and we also see that it can cause workers to suffer from a sense of futility. This response is likely a direct reflection of the situation facing the people they serve – a fact that calls for limits in what we expect of these workers, while pointing to the need for a workplace structured to accommodate the emotional challenges they invariably face.

## Chapter Five

### A Moral Ethnography of ACT

*“I often think a lot of the clients don’t have advocates or family members saying they deserve better. Some do, but there are very few. Family members are supportive but can realize how our hands are tied in a lot of ways. It is rare, and a lot of clients don’t have advocates and I think ‘ok, our job is to advocate for them.’ We are the people who see them and get the glimpse into that life. But then you are advocating against yourself in a way. You are saying ‘yes you need more things, you need a better life, but I can’t do that for you.’”*

~Rose Neilson, ACT worker

Having described the history, purpose, and structure of ACT, as well as the contemporary state of ethical debates around such services, it is now time to take a closer look at the actual practices of workers. As I showed at the end of the previous chapter, there is still room for further ethical analyses of ACT work. Hence, after describing the particular team I observed and its daily functions, as well as the nature of my research and its guiding questions in this chapter I will conduct a moral ethnography of ACT from the perspective of care ethics. Section I presents the ACT team I observed and describes the nature of the research conducted. In Section II I highlight central aspects of the work which tend to be undervalued both under the RTS paradigm described in Chapter One and under the rationalistic conceptions of morality described in Chapter Three.

The most important result of my research was the relative absence of the “othering” so prominent in most conventional mental health settings examined earlier. Rather, as I note in Section II, ACT workers appear attentive to clients’ uniqueness. Team members engage in “world-travelling” as a matter of course, and are responsive to

clients' individualized needs. As I shall also argue, the central role of storytelling as the dominant medium for communication about patients helps to keep othering tendencies at bay. In light of all these factors combined, we see workers demonstrating an attitude that is compatible with Dillon's conception of care-respect<sup>1</sup> and consistent with the kind of openness to a person's otherness advocated by feminist care-ethicists described in my chapter on moral theory.

While ACT workers do exhibit a caring and respectful attitude towards their clients, they are also constrained by certain rationalistic requirements built into their mandate. As anthropologist Paul Brodwin (2011), notes, pressures upon ACT workers to produce quantifiable signs of progress results in a narrow conception of particular clients and limits the fullness of ACT workers' accounts of such clients. Here, as I argue in Section III, elements of the RTS paradigm described in Chapter One re-enter the picture with predictably negative effects. Beyond hindering client/patient relationships, the pressure for a "narrative of progress" can easily lead to a sense of futility among workers and, beyond that, can cause empathetic suffering in workers due to constant reminders that clients' lives will never change.

Their own empathetic suffering does not appear to have inured workers to the suffering of their charges, and this is probably due to the development of certain tactics. After examining further aspects of the job in Section IV that can cause workers to suffer due to their inability to respond to the call of their patients, in Section V I describe

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<sup>1</sup> I am not licensed to conclude that workers do show their clients care-respect because I was not able to observe them in the field. Having only observed discourse in team meetings, I can only conclude that the way they speak about their clients together is suggestive of this attitude.

tactics workers employ to push back against pessimism and despair. As we shall see, some of these tactics crucially depend on having the time and the space to conduct their work as they see fit. Finally, in Section VI I suggest that a fuller appreciation of the intrinsic value of unearthing clients' stories and thereby achieving a rich and nuanced understanding they provide might ease the sense of futility such difficult work is apt to occasion. This recommendation yet again reinforces and reiterates earlier calls in Chapter Three to provide workers with the time and space necessary to cultivate caring and respectful relations with clients and to ethically enrich their practices.

## **I. Sunnydale Hospital ACT Team**

### **Data Collection, Research Questions and Ethics**

Over the course of my research I took detailed field notes on 42 morning meetings of the ACT team over a six-month period, attending two meetings per week. These meetings, which might be likened to hospital rounds, took place for at least one hour at the beginning of each regular workday, Monday – Friday at 8:00 am. One of the two meetings I attended each week was specially designated to focus on a “clinical situation” or on complicated issues ranging from technical problems to ethical quandaries. Sometimes such a situation would be selected in advance by a team member, while at others team members would reach a consensus about what to discuss during the allotted time. I endeavored to attend that meeting. At the end of my six-month observational

period, I also recorded and later transcribed semi-structured interviews with 11 of the 13 core workers.<sup>2</sup>

Before the research began, I made a presentation to the ACT team stressing that I was interested in their everyday ethical behaviour. Given that relational values are said to drive much of the work of ACT due to the need to preserve a long-term therapeutic relationship, I wanted to see whether connectedness with clients did indeed take center stage in their work. Where such values did appear, I hoped to learn how they were expressed and how these played out in practice. In other words, what could ACT team show us about maintaining supportive and enduring client/patients relationships? Finally, I also remained alert to ethical dilemmas that might arise due to workers' commitment to relationships with clients while working under the rationalistic requirements of their institution. Here my concern was to understand how workers navigate this difficult terrain.<sup>3</sup>

Having heard my presentation, team members then took an anonymous vote on whether the research should proceed with the stipulation that the group had to be unanimously in favour for this to occur. After the vote was taken, each team member signed a consent form vetted by both York University's research ethics board and the employees' own research ethics board. The form guaranteed workers' anonymity and

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<sup>2</sup> Of the core workers, I was unable to schedule an interview with Guy, the recreational therapist, or Henry, the head psychiatrist.

<sup>3</sup> Given that I was only privy to talk among team members over the course of my research, this last question, although perhaps most interesting, was the most difficult to answer. Navigation of competing obligations is something that is more apt to occur in the field as opposed to phenomena that is apt to be revealed in the course of a team meeting.



their right to withdraw from the study at any time. All names appearing below are pseudonyms that were also used during the process of data collection.

### **Core Team**

**Talia Powell:** Team leader/Social worker in her mid-30s. Had been with the team eight years having started as an intern out of school. Talia was generally conscious of keeping things moving along, especially if things got a bit boisterous, but would indulge in the odd dry remark or funny anecdote.

**Stephanie Silver:** Social worker (speciality in addictions) in her early 30s. She was completing her MSW and working full time and had been with the team for 3 years. She was a vocal participant in team meetings who laughed easily and would tease other members including the psychiatrists.

**Otto Ball:** Psychosocial psychiatric rehabilitation therapist (BA in psychology and post grad specialization in psychiatric rehabilitation) in his late 30's. Otto had been with the team for 9 years. In meetings Otto demonstrated a concern to preserve relationships with other agencies as well as the therapeutic relationship with clients.

**Trevor Moore:** Occupational therapist in his late 20's who has worked with the team a little over a year. He was in the same program as Rose. Guy, another team member, openly dubbed him Clark Kent due to his conservative looking presentation.

**Rose Neilson:** Occupational therapist around Trevor's age who has been with the team 1.5 years. Rose appeared a bit hesitant to voice her opinion in team meetings, although her interview revealed her to be very articulate and thoughtful. She also seemed to be emotionally impacted by her clients

**Greg Anderson:** Social worker. He was in his mid-20's and had worked with street-involved youth before starting with the team a month into my research. Greg was less outspoken during meetings, but was getting accustomed to the team and his new job at the time.

**Beth Carpenter:** Nurse. Beth was in her early 20's and was the youngest member of the team. She had been with the team just over 1 year. Beth was the only other non-Caucasian member of the team apart from Peter.

**Diane Palmer:** Nurse. Diane was in her late 30's and had been with team a little over 2 years. Diane, as Beth said, 'has a heart.' She genuinely seems to care for her clients and was most outspoken when it came to injustices suffered by them.

**Chris Buckley:** Peer support worker. Chris is a consumer survivor with a diagnosis of schizophrenia. Chris was in his 50's and has been with team 10 years occupying .6 of a position. He was rarely in team meetings due to the fact that he is part time. He also suffered from insomnia so he tended to take evening shifts.

**Peter Layton:** Peter is one of 2 part-time psychiatrists with the team. He is non-Caucasian and also works on an Ethnic-specific ACT team. Peter was thoughtful and articulate and during their interviews, most of the team members flagged his contributions as especially valuable. He is respectful of other team members and is highly diplomatic. He is not without an apparent sense of humour, but he jokes less than Henry.

**Henry Murphy:** Head psychiatrist who has been with the team for over 10 years. Henry will tend to take over from selected chairs during meetings and will move things along. Henry has been with the team since the beginning and is also the director of the Westview Hospital inpatient unit, such that there is an onus upon him to keep beds free. This causes conflicts with other team members who sometimes press to have certain patients hospitalized but who meet resistance from the psychiatrists.

**Guy Dawson:** Recreation therapist. 40's and longstanding member of the team. Guy was tremendously fit (he'd recently competed in an Iron Man competition) and appeared to have a lot of energy. Guy had recently had a client throw hot coffee in his face while another wanted to include Guy in her will but was disallowed from doing so.

**Gail Powers:** Nurse in her early 20's who was quiet and soft spoken. Although her mother was a nurse, her parents do not support her work because they feel it is too dangerous. As a result, she does not feel that she can talk about what she does to her family or spouse and doubted she would be on the team much longer.

**Tammy Hanson.** Nurse in her mid-20's. Tammy left the ACT team to work in geriatrics shortly after my research ended, hence I didn't interview her. I did go out to job-shadow Tammy one day. She seemed blasé when one client out on a front stoop ignored her, and noted that at least he wasn't flipping her the bird or yelling 'fuck off' as was generally the case.

#### **Transient members:**

**Peggy Smith:** Resident. Peggy started her rotation shortly before my research commenced and ended while I was there. She joked regularly with the team (and often shared humorous asides with Henry) during meetings and made occasional side comments to me.

**Audrey Jones:** Resident. Audrey was on the same rotation as Peggy. Audrey was more reserved than Peggy and I saw less of her in meetings.

**Virginia Alexander:** Twenty-something recreational therapy student doing a placement and working under Guy.

## **The Work**

The primary goal of the ACT teams is to facilitate community tenure for psychiatric patients. To aid in this all workers outside of the two team psychiatrists, regularly visited clients in their homes, shelters or at the office depending on a client's living situation. Occasionally, a psychiatrist would go to a client's home to assess whether they should be admitted to hospital. Residents, however, were expected to do regular home visits just as other staff members did. At the time the research was being conducted the team was serving 88 clients. Outside of the team leader, physicians and residents, each team member is the "primary" for up to ten clients. Although one worker served as a client's point-person, as it were, most members of the team also worked with that client.<sup>4</sup> A key aspect of the work is the delivery of medication. All workers delivered oral medications but only nurses and physicians administered depot injections (IMs). Nurses, OT's and social workers also tried to interact with and monitor clients during visits and reported on their presentation at team meetings.

Beyond medications, however, and as per the ACT model, client interventions did not appear to have a standardized pre-determined form. During my job shadowing, Tammy, a nurse, mentioned that she planned to visit a boarding home to help a client clean her room. Troubleshooting with clients around bedbug extermination was another

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<sup>4</sup> The standard practise for ACT teams is to have all workers who are not physicians work with all clients. However, this was flexible, when, as was the case with the team I observed, a particular client asked to limit his exposure to female staff because he found the contact too sexually arousing.

task that frequently came up in team meetings. Rose also mentioned mopping floors and giving clients showers. According to Stephanie, who called herself “a glorified life assistant, ... I’ve helped people clean houses, I’ve helped them bathe, helped get people to appointments, I’ve cancelled family visits, I’ve helped with medication. You name it, there’s a lot to be done. “

### **Clients and Their Living Conditions**

The vast majority of the team’s 88 clients suffered from some form of psychosis, and I was informed by Talia before my research began that whatever form the mental illness took, it was debilitating. According to Rose, their clients were “the sickest, the ones you typically see that are disheveled, stained, incontinent, hair is matted.” Work was carried out in the inner city of a large North American metropolitan area, and when she went into people’s homes Stephanie characterised herself “as wading through cockroaches or bedbugs ... not able to shake people’s hands because they have scabies.” In one team meeting, Talia reported seeing bedbugs on the stairs of one of the boarding homes that housed a number of the team’s clients. Many clients lived in the sort of boarding homes described in Chapter Three, with as many as four to a room, while others lived in low-income apartment complexes. A few were homeless and others stayed in shelters. During my brief stint job-shadowing, I noted that the many clients were housed in stark, dank, utilitarian structures where the halls smelled of urine.

### **The Team Meeting**

“If the ACT team is the heart of the ACT program, the daily team meeting is its nerve center” note the originators of ACT (Stein and Santos, 1998, p. 98). A single white board on the wall provides the focal point of meetings. It is divided into 8 or 9 sections. Front and centre is the ‘agenda.’ The agenda is a numbered list of items to be discussed in the morning meeting. All team members can enter items onto the agenda, and this is done in a seemingly haphazard manner with say, #4 entered on some days even though there is no #3 entry. There is also an FYI section. Up top are small boxes labelled: “Inpatients.” “Patients in hospital.” “Crisis.” “Incarcerated.” A box at the bottom right contains: “Waitlist.” Above this is a box for patients due to have blood work.<sup>5</sup> Below the agenda at the bottom is a box for “Reminders” (usually work-related items, picnics, etc...), “To be charted,” and “Discharges.”

Generally, workers saw the meeting as a venue for the straightforward exchange of information and strategic planning. As Stephanie describes it, the function of the meeting is

to communicate the administrative stuff we have to do ... we have to know an awful lot of what’s going on in [patients’] lives from family, to medication to you know, and if that communication isn’t always ongoing something is going to get missed and it happens because we are human. And you forget sometimes ... Ideally what is supposed to happen, if I go out, or another one of my teammates goes out to see somebody it’s supposed to be like the client is seeing the same person. That we all have the same information. That’s what it means to have a team-held caseload. So yeah the morning meeting is to make sure that everybody is on the same board, or the same page rather. It’s also to brainstorm and come up with suggestions about where to go with somebody. To get support with ‘I’m really frustrated and I’m not quite sure what to do.’ So it’s communication and planning.

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<sup>5</sup> Patients on Clozapine have to get blood tested regularly because the medication is associated with agranulocytosis, a blood condition that can make patients more vulnerable to infection. Patients must have their blood examined every 2 weeks.

Team members all take turns chairing, and before the agenda is tackled on-calls are announced. The team has a pager and one person is always on-call. That person then reports on any communications that occurred during the night or early morning. After on-calls are reported all voicemail messages are relayed to the team. After this the chair moves the meeting through the agenda items. Some items are just things that are being flagged and other items call for problem solving. Every so often in meetings primaries will present a service plan for a client, which is a report that includes a client's history, past interventions and client goals, which the team then discusses. I was able to observe three service plans being presented in the course of my study. Finally, if agenda items are covered in enough time, the team conducts a weekly review in which they move through a list of patients' names while various workers contribute whatever bits of news or information come to mind concerning that client.

At team meetings medication was the most common topic of discussion, appearing around five times per meeting. Sometimes the conversations were about how to win a patient's compliance with medication, but often they were about whether a patient was taking his medication, whether housing staff were prompting him to do so, or whether the medication needed to be adjusted. Workers spent little time discussing delusions except perhaps to mention that someone was still complaining that "Barack Obama was living inside her." Rather than discussing symptoms of mental illness, something that seemed more intriguing to the residents, workers by and large focussed on troubleshooting the concrete problems of daily living. In fact, after medication, the

second most frequently discussed area was housing. Issues related to housing arose an average of three times per meeting in relation to different clients, and of the 42 meetings I observed, only three saw no mention of housing. Bed bugs were frequently mentioned both because clients were regularly dealing with infestations, and because several bed bugs had also been spotted in the office. Diabetes, or discussion of blood sugar levels in patients, was also a reoccurring theme in meetings – hardly surprising given the association between certain atypical antipsychotics and type 2 diabetes.<sup>6</sup>

### **The Recovery Board**

Off to the side of the white board is a stand with a large pad of paper. On it team members note client victories large and small (mostly small). The recovery board is an innovation of the team studied, and is not part of the ACT model. Below is an example of a recovery board

#### *June/July recovery notes*

*A: voluntarily chose to do laundry*

*B: recognized need for assistance with budgeting sat down to create June budget.*

*C: completed bail program*

*D: wants to “mix up” exercise program*

*E: meeting long term goal of getting glasses.*

*F: new shirt, disposed of old shirt.*

*G: heart is healthy.*

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<sup>6</sup> Items that saw little discussion included diagnoses and symptoms, discharges, finding employment for clients or drug and alcohol abuse. In this vein, however, there was virtually no talk of finding work for clients, which is notable for the fact that this was a major preoccupation for ACT originators. As for patient discharges, discussions arose in relation to 3 different clients, two such discussions ended inconclusively, and the third client was traded for a client on a different ACT team because the client had moved quite far away. Moreover, although the team had a dedicated addictions counsellor, there was very little observable strategizing around clients' use of illicit drugs or alcohol. On various occasions someone might make a side comment about a patient's use of crack, and during interviews workers noted that one area of frustration for them was drug use among clients, but workers did not discuss ways to curb clients' addictions.

*H: "Today was the best day of my life." Heard no voices during July 7/09 (all day).*

Recovery notes are typed up at the end of each month and placed in a visible spot in the communal office.

### **Office Layout**

All the doors in the office had coded locks on them. The bulk of the staff (apart from the psychiatrists and Talia) shared an office separated into cubicles. Talia, the team leader, had her own office, and there were two spare offices. One of these was used by the psychiatrists when they held clinical meetings with patients. There was also a laundry room and washroom back in the office. The meeting room, which is where the meetings I observed took place, has a large glass window and a large boardroom table. It separates the communal office space and Talia's office. In the communal office space all staff members other than the psychiatrists, residents and Talia, have their own cubicle with a desk and a phone.

### **Atmosphere and Team Dynamic**

Friendly chitchat and banter tended to occur in the meeting room shortly before meetings got underway. Meetings were typically fairly formal and team members appeared cognizant of time constraints and the need to stay on track. No overt disputes were observed during meetings, and there was room for humour which seemed to cut back on formalities. Henry, the head psychiatrist and some other team members made a number of jokes during meetings.



From all reports, a somewhat different dynamic operated within the communal office space. While workers used a communal office space for regular work activities such as charting, and contacting clients and agencies on behalf of clients, most of the team members used the term “vent” to describe a regular activity that occurred there. The communal office space belonged to the regular workers and they used the space to share their frustrations and to strategize in the event that they disagreed with the decisions of the psychiatrists. In the event that workers sharing the communal office felt they weren’t heard, as Stephanie explained, “that’s when we would go back [to the communal office], and sitting about the desk and you know, have a good bitch about it or something like that and try to strategise about how we’re going to re-present our case.”

Team members also mentioned regular occurrences of practical jokes in the communal office. For instance, shortly after Greg started work, team members gave him a “squishy ear.” As Greg recalls I walked up to my desk, I see my phone ringing and I see it’s Guy’s name comes up. I’m like, ‘he’s 2 feet away, why is he calling me?’ So I pick up the phone and it’s covered with hand sanitizer. Alternatively, workers sometimes made funny flyers or put up humorous pictures on each other’s computers. As Stephanie notes,

It’s kind of the game around here ... I left my computer on and someone went in to change my computer wallpaper. So when you turn your computer on, it’s like oh my god, it’s a man who is standing in a pair of leopard print bikini with the watch! With the watch! Like seriously, why are you standing there looking at your watch? He’s got the best mullet as well too, and the moustache .. So harmless fun stuff like that. Oh and I came in not long ago my phone was locked in my cupboard and my keys were gone so I couldn’t get to my phone. I noticed it quickly. But, the plan was had I not noticed it, someone was going to call me so my phone was going to be ringing from my cupboard and I couldn’t get at it.

As Otto noted in his interview, the practical jokes functioned as a team-building device that helped to make new workers feel welcome and part of the group.

## **II. Morally Salient Aspects of Sunnydale ACT Work**

### **A Eulogy for Tom “Kodak”**

To contextualize the moral aspects of my ethnography it will be useful to highlight a somewhat exceptional moment in a team meeting given that it helps to bring out morally salient details of ACT work, as analysed from the perspective of a care-ethicist. Moreover, I shall return to this story at the end of the chapter in making the case for my own modest proposal for ethically enriching ACT practices.

One night Tom died in his sleep. When team members got the news of their elderly long-time patient’s death, Rose, who had taken the call, left the meeting room in tears, and was followed out by her concerned colleague Guy. An awkward silence followed and team members appeared unsure how to proceed given that the regular business-like flow of the meeting had been interrupted. It became evident that something outside their routine business was called for in this instance. Eventually, team members acted as most people would under such circumstances, and began telling stories about Tom. As we shall see, the sharing of small anecdotes was a common practice in ACT meetings, so ultimately, team members were on familiar ground. Over the next few meetings Tom’s story would unfold such that details of his life, his funeral, and even the people there, would enter into the team’s shared lore regarding the man.

In the first brief conversation that occurred, small details began to emerge: Tom had lived for many years in a warehouse converted into an open-concept supportive housing facility, a facility that represented a first stepping-off point for people getting off the streets. ‘It makes me strong,’ Tom was reported to have said of his housing, while expressing a desire to stay where he was in spite of deteriorating physical health requiring higher levels of support. Tom also loved St. Patrick’s Day, which had just passed, and it appeared that the client had managed to celebrate one last time. “He died with dignity,” noted Beth once the storytelling had wound down, marking a shift back to the team’s regular discussion. For the next fifteen minutes, the remaining team members returned to their regular discussions of various clients’ issues. As the meeting came to an end, Guy, who had returned without Rose, noted Diane had left. “She didn’t want to be here. She broke down.” Team members proceeded to return to the subject of Tom and his life. It was briefly mentioned that Tom had been friends with the city’s mayor. Team members had originally assumed this was one of the client’s many delusions, until, that is, they saw an article written by the mayor’s assistant describing the impact Tom had on their office.

### ***The next day***

After regular discussions of patients ended more was said about Tom. Team members speculated whether it would be appropriate to write an obituary for the client, or perhaps submit something to his blog. It became clear that the story of Tom being friends with the mayor was part of the team’s established lore.

Talia: I want to tell the story about calling the Mayor’s office.

Stephanie: We thought Tom had delusions about being friends with the mayor. Through time we found this is true. More the mayor’s assistant [who Tom was friends with]. Tom gave him our

contact details. That's how we found out he wasn't delusional. Turns out the assistant wrote an article about Tom so I called the mayor's office. He said 'I was the one who wrote the article on him. It's so fascinating that he came from the family he did, the Kodaks.'

Peggy: Oh! He didn't know it was a delusion?

Stephanie: I am 98 percent sure. He talked about Kodak and Tom's claim to the Kodak millions. He said 'it's so amazing that Tom, coming from the background he did, chose to live as he did.'

Peter: The article might be in his file. He had different levels of delusions. Owning Kodak was peanuts compared to being the Tsar of Russia and the new President of the American Republic. He didn't say the significance of St. Paddy's Day. Just that he was a diehard.

Talia: His worker was out on St. Paddy's day trying to win Tom a new hat.

Peter: If there was a lot of alcohol, my money is that there would be a lot of respiratory depression. The coroner will be able to tell.

Stephanie: Well, he wanted to die [where he was] and have one last St. Paddy's Day.

Peggy: It sounds like it was peaceful.

Talia: So more to come on Tom in the next few weeks.

### ***Two weeks later***

The team received an update about Tom's funeral, which Gail, a team nurse, had attended.

Gail: Ok, Tom's funeral. They got up and told the most interesting stories.

Henry: Did you get up and tell a few stories?

Gail: No, I was embarrassed by the stories.

Henry: It actually wouldn't be appropriate. I'm sure he didn't give his consent for us to tell stories at his funeral. What kind of stories, tell us.

Gail: There was a priest standing there. This woman said every time I saw Tom I would lift my shirt and he would say 'that is worth one cigarette.' One lady was giving the finger to another during the service. There were a lot of alcohol-related stories.

Trevor: I'm sure Tom would have loved that.

Henry: What about the family? No one knows? Did he write a will? I thought a guy like him would have written an elaborate will, given it all to the Kremlin or something.

These relatively exceptional moments within the meetings the ACT team observed help to fully reveal some of the more humanistic elements that arise out of this form of treatment. Rose and Diane's grief help to demonstrate the workers' attachment to their clients. The exchanges also help to bring out the team's longstanding knowledge of those they work with, a familiarity with clients' contexts, and a fine-tuned attention to their particularities. While the following account is of necessity based mainly on team meetings rather than field observation, it nonetheless shows that ACT work is of a highly personal nature. In any case, it should be clear that the kind of talk about patients that takes place in these meetings stands in sharp contrast to the standardized, efficient and impersonal treatment of patients previously described in institutional settings.

### **Practices of Relatedness in Vivo**

ACT clients stand at the intersection of a variety of bureaucratically administered systems. They receive money from government agencies while public trustees, who meet with clients once a year, are often appointed to manage clients' finances. Meanwhile, public housing facilities dictate the terms of many people's living conditions. A significant part of ACT work then, is helping clients negotiate this labyrinth of impersonal bureaucratic systems by helping clients fill out forms, escorting them to appointments and contacting public trustees on their behalf. As will emerge, ACT work

stands out against these other agencies because of the quality of the interpersonal relationship that forms between the team and clients.

### ***We Are in this For the Long Haul: The Longitudinal Approach***

One of the most significant factors in the establishment of a trusting relationship between team members and clients is the duration of treatment. Team members had a great deal of history with many clients. Henry, who, as noted, had been with the team from the beginning, had the longest memory of various patients and the following exchange reveals the kind of knowledge acquired by observing patterns in patients over time. Below, the team was discussing a particular patient who was showing signs of stress because she'd recently been assigned a roommate. The patient was not coming to the door and Rose reported the "she didn't look particularly great all bundled up in her winter coat."

Henry: Having known patient for 12 years, over time she has become more vulnerable. Clearly she needs to be in a place where they supply food.

Diane: But if another person hadn't moved in!

Henry: This has been happening for the last 2 years. She is clearly less responsive to treatment than she used to be.

Peggy: Does she have delusions as well?

Henry: Yes.<sup>7</sup> My plan is to re-evaluate her financial capacity. We should contact the sister who would be very much in favour of her living elsewhere. Problem is there is no power of attorney for finances.

Diane: My thinking is she doesn't need a nursing home.

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<sup>7</sup> Henry's one-word reply here helps to demonstrate my point regarding the limited discussion of psychiatric diagnosis and symptomology. Peggy, a resident, is interested in the nature of the patient's illness. However, in the context of the morning meeting, Henry remains focussed on more concrete problems such as finances and living arrangements.

Otto: She rejected other options.

Henry: There is a number of legal domains. Financial capacity which we assess on admission. There is a separate domain for discussions of housing. This requires power of attorney. She has to agree to stay there. She doesn't realize she is incapable. It would be better if housing would evict her<sup>8</sup> and we could go from there.

Otto: What happens if no family member wants to take responsibility?

Henry: Then we can't do anything, personal care is only for a family member or friend. We have to call the sister. Sonya is fiercely independent and has been in hospital more than she has been out. She gets reasonably well in hospital.

Peggy: have her meds changed?

Henry: No it's the structure. The other issue is she smokes less. She is on a depot [injectable medication] and while she is not great with oral meds, we have that much. When we first took her she was taking courses at the university taking German philosophy. She was reading Hegel – her marks weren't great. She has had quite a decline.

Peter: Last time we tried she was 2 weeks in hospital. She did very well. If you want to do it you should do it fast. When she is well and not well she is two different people.

Certainly, this extended relationship represents a significant departure from the brief treatment periods described in Chapter Three. As we saw with Douglass Center workers, for instance, personal longstanding knowledge of clients was only gained by accident, whereas for ACT workers this has been the norm. Another case helps to illustrate the importance of this knowledge and how it can be put to use. In one meeting, Diane noted that a client's apartment was beginning to smell. Talia turned to Trevor to explain why this was especially worrisome.

Do you know her history? In previous years a sign she wasn't doing well was that she would start to jar and contain feces and urine. Once there was so much build-up of methane gas there was an explosion risk. The alarm bells Diane is talking about is a risk.

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<sup>8</sup> It was interesting to note that the team often exploited other more impersonal agencies to preserve their relationships with clients. It was better for the relationship if bad news was not coming from team members.

The team's memory can also serve to reconfigure misconceptions of a patient that could be formed on the basis of textual documentation alone. For example, in one discussion of Jim, it was noted that the client first came into contact with the team after being convicted of "assault and possession of a bag of guns." Rose, who had not had much contact with the client laughed when she heard this.

**Talia:** Just to flush out the story. Dave is a dumpster diver. He was diving and found antique guns. They weren't functional and couldn't be fired. He found the bag and he is a hoarder and brought them back and when he was confronted by the police they found the bag. He was charged with stolen weapons. He didn't do any jail time but does have this scary sounding ...

**Rose:** Maybe we can change the word to "antiquities."

The longstanding relationship also contributes to a sense of patience with clients. That is, if things are not going well with a particular client, or workers are not sure which way to turn, then, they might remind one another, as Talia did in one meeting, that "we are in this for the long haul." In this case, Talia was referring to difficulties in placing a new client, Sophie. Talia was suggesting here that the team would be there to provide ongoing support even if their current efforts were to fail. Trevor, who was the patient's primary worker, was having a difficult time determining the best housing for the client in question.

Henry [to Trevor]: Are you feeling burdened?

Trevor: I'm feeling lost, I just don't know what to do with this woman.

Henry: This is where the team approach helps. We have a long-term memory of past successes.

Peggy: This is on a weeks-to-months timeline. You have to look at the bigger picture.



Henry: ACT changes over time.

Talia: Each time we try, she might move further along.

As such, the pressure to effect fast and efficient therapy evidenced in forms of hospital care in Chapter Two is largely absent from ACT work. Freedom from this particular brand of workplace stress, moreover, could help to explain why the sort of othering seen in the APU and in Rankin and Campbell's work was not observed among members of the Sunnydale ACT team. That is, workers were not being regularly frustrated in their ability to implement efficiency schemes as mandated by their employer and hence might have been less inclined to project deficiencies of the system onto clients. Instead, workers were able to adopt the more leisurely attitude Lugones sees as essential for "world travelling."

### ***Sexy Time: Travelling to the World of the Other***

As I note in Chapter Three, Lugones' conception of world travelling represents an important way of connecting with others whereby one must be attuned to the fact that people change in relation to their environment and are multidimensional beings.

Travelling to the world of the other requires a patient attitude, as revealed by Lugones' description of cracking open rocks by the river. A mindset bent on efficiently sorting and managing persons is not conducive to effective world-travelling. In the case of ACT we see that while workers had a long history with many clients, many were familiar with client's broader context in having contact with family members, spouses and landlords. The following exchange nicely encapsulates the extent of the social network to which workers were exposed. Jason, a client, had broken up with his girlfriend and was

reportedly harassing her, which was especially problematic since the two lived in the same public housing complex. Workers had talked to the housing manager and the partner, and were even aware that their client's girlfriend's parents disapproved of the relationship.

Peter: In the long term can these two people live in the same building?

Guy: No. his big thing is he is showing no insight. 'It's not my problem.' She is crying, saying 'I'm going to kill myself.'

Otto: It's like we're treating two people.

Because they are entering into patients' most intimate space, or travelling into clients' worlds, as it were, over time, workers were bound to be exposed to multiple dimensions of clients' personalities. Jason had a history of violence, having torn his refrigerator from the wall socket, punched holes in his walls because he thought he heard Gail talking in them, and exhibited other forms of aggressive behaviour. In spite of the problems between Jason and his girlfriend Sonya, they would eventually reconcile and move in together. Then, the following incident occurred when Peter, who did not usually visit clients at home, went to Jason's in order to assess whether the team should enact the client's community treatment order (CTO).<sup>9</sup>

Peter: We saw him. He was naked behind the door. I did an assessment about the CTO. I think he was having an intimate time. Candles were lit and there was a fragrance in the air.

Trevor: Sexy time!

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<sup>9</sup>A CTO is a legal mandate signed by clients specifying that they will remain compliant with treatment, which typically includes psychiatric medication. Decompensating patients who are not taking their meds can then legally be brought into hospital, but only after a psychiatrist has assessed them.

Talia: Oh no! And a psychiatrist is at the door.

A gentler side to Jason was thereby revealed in this encounter, which may be likened to the world travelling recommended by Lugones. In visiting their clients at home workers need not imagine the world of their clients, but are directly exposed to the unfamiliar environment inhabited by the another. Due to this, caregivers could not help but be made immediately aware that they were working with multidimensional persons. Moreover, given the team's longstanding history and familiarity with clients' particular contexts it is possible that they achieve a deeper understanding of patients and are thus more responsive to individuals' particular personalized needs.

***Pretty in Pink: Attentiveness to Clients' 'Me-ness'***

ACT workers are also better acquainted with various aspects of a patient's life than those dealing with admissions to inpatient wards. One further aspect of ACT work worth remarking upon is team members' attentiveness to the smallest details of their clients' particularities and how these observations stand to reconfigure certain conceptions of clients. There is something to be said for likening this attentiveness to loving attention described by Murdoch in Chapter Three, which is a form of attentiveness that is open to a reconceptualization of a person. We can also see how this paves the way for workers' to appreciate clients' particular "me-ness," which as Dillon argues, is a crucial step in conferring care-respect onto another.

It would appear, moreover, that attention to detail was expected of workers. For instance, during the weekly review, something, anything, had to be said about each client whose name came up, as the following exchange reveals. Henry, who is chairing, has been going through the list, and called out Greg Wallis' name. Trevor, who was still fairly new to the team and perhaps unfamiliar with the norms around the weekly review merely responded "he is ok."

Henry [laughing]: That is all you have to say Trevor?

Talia: He is far away and the team doesn't see him much.

Trevor: He was really collected when he came in with the chicken pox.

Henry: There is a study here. The virus changes the brain.

After this, the team went on to discuss another patient. Admittedly, on some occasions workers would simply report that "John is John" in relation to some long-time client who was much the same. However, it was more common to see something more informative offered up. For example:

Tammy: Lisa Walters.

Talia: She came to the BBQ and her dog looked like a llama. She shaved her dog to look like a llama.

Trevor: See a little alpaca looking around

Diane: I was sitting at Pride<sup>10</sup> and someone said 'cute dog.' She was in her pajamas at Pride with a shaved poodle. Totally strange.

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<sup>10</sup> Gay Pride parade

Demanding high levels of attentiveness from ACT workers makes sense when one recalls that part of an ACT worker's role is to monitor clients for signs of decompensation. Personal hygiene, behaviour and other telltale signs particular to individual patients can therefore represent important data as demonstrated by Henry's observation of Stephan that "he went out had a fight with Julia [his girlfriend] and came back in his red pants and his cravat. It's a sure sign he is more manic when he is wearing his red pants." Such observations were not intended to efficiently classify patients in the computational manner recommended by Goodman and Guze. In fact, it is worth emphasising that diagnoses were rarely mentioned in the context of team meetings. With new clients, the psychiatrists would provide a diagnoses while describing a patient, and occasionally, there might be speculation about "mood components" or personality disorders in existing patients but this was brief and infrequent. Hence, clients were not reduced to little more than a diagnosis, rather, attention to clients' particularities was to raise awareness of their individual dispositions, preferences and situations in order to be alert to sign of relapse in clients and to find ways of tailoring their care.

Nevertheless, observations of particular details pertaining to clients could take on a far more commonplace flavour, such that they could have been made by anyone concerning a mutual acquaintance for whom the speakers might share a certain amount of fondness, i.e.

Stephanie: FYI, Linda is back from Florida. She looked great. She was wearing a nice pink suit and pink lipstick.

Otto: Was she pretty in pink?

Stephanie: Yes, I told her that yesterday.

Otto: Was she tanned?

Stephanie: No

As both the observation above and team members' predilection for practical jokes demonstrates, many appeared to delight in the unexpected. Hence, they tended to be aware of, and eager to share, seemingly incongruous traits they noted in patients. That is, they have not necessarily neatly categorised their patients, but have, perhaps by happenstance, become alert to details that tend to alter preconceptions they may have formed about the other. Describing such perceptions in meetings, moreover can serve to reinforce clients' me-ness, or the sense that each one is not like all the rest. For example, Maria was a client whose "ADLs were never great," about whom there had been reports of her in the streets with food stains running down her clothes. Rose also tells a story of having to help Maria clean herself when the patient left her menstrual flow unchecked. Not surprisingly then, certain female staff members seemed to take pleasure in the fact that Maria enjoyed having her nails and hair done. Meanwhile, on a couple of different occasions, Talia remarked of Tim, another patient, that "he is the cleanest hoarder I have ever met" adding that she was struck by his level of organization he showed in maintaining his vast collection of items.

Henry's observations of Frank help to further illustrate how this attention to and appreciation of the unexpected can lead to a reconceptualization of a client that aligns well with Murdoch's notion of loving attention. Frank was a gruff man, which I knew because Guy would often mimic his manner of speaking, Otto remarked in one meeting

that Frank was “rough around the edges” and many commented upon his frequent cursing. As Talia reported in one meeting “he told me he likes it in hospital. He actually said “yeah, it’s really fucking good in here.” I never heard the f-word used so many times it’s just punctuation, it’s not an adjective.” The reason Frank was in hospital in the first place was to have several frostbitten toes removed. For, as much as the man loved hospital, he appeared to despise the housing available to him and had thus chosen to live outside for 6 years. “I’m not going to a fucking boarding home,” Frank had stressed to Guy, and only hoped that no one had taken over his “cubbyhole in the park,” to which the client longed to return.

A special relationship, moreover, seemed to exist between Henry and Frank. When Frank was receiving foot care, Henry went on vacation and Peter started to see him in hospital and was poorly received by the patient. “He’s become more cranky,” noted Peter adding that Frank had said to him “I don’t want to talk to fuckin’ anybody except for Murphy! You are terrorizing me.” Shortly after Henry returned from vacation he went to see Frank and was enthusiastic to learn that in spite of the client’s reluctance to be housed, Frank had agreed to move to a rehabilitation facility that would provide him with a few more months of foot care.

Henry: He was sitting there all packed up ready to go. When I spoke to him the day before he was like ‘ok.’ It was amazing.

Peter: when you were away he was saying ‘I am not talking to anyone, just Murphy.’<sup>11</sup>

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<sup>11</sup> The theme of Peter’s comparatively poor relationship with the client re-emerged a few weeks later during a discussion of Frank’s post-operative experiences.

Guy: He told me “everything is beautiful. The surgeons did a beautiful job”  
Peter: with me he was saying “I don’t want to talk about it. You’re a terrorist.”

Henry's fondness for the client was made evident when he would sympathetically click his tongue during earlier discussions of the state of Frank's feet and would later make similar noises in later discussions of Frank's reluctance to accept housing. Something that seemed to stand out for Henry when visiting Frank, was the patient's use of an elliptical trainer while in hospital. In light of Henry's fondness for the patient, it is easy to see how the following observation might have delighted him. On February 6<sup>th</sup> Henry noted

I came in yesterday and it was the sweetest sight. Frank was on the elliptical. He was going up and down and it was really cute. We should get him to the Y. Monday we should get him to infirmary and I hope he goes. He might go. It's a similar environment but nicer than the hospital.

Henry, it would appear, was sufficiently surprised at seeing the gruff and temperamental homeless man enthusiastically using an elliptical, that this particular detail stuck with him. Two weeks later, during a discussion of rehabilitation programs for Frank, Henry remarked, "if we sell this as another hospital, especially if they have an elliptical trainer, he will be happy." Then again on March 6<sup>th</sup>, Henry briefly reported on Frank saying that "his left foot is healing nicely. It's just the right foot. He is happily using the elliptical and enjoying himself."

Guy, the recreational therapist, also picked up on this enthusiasm for the cross trainer. When Henry asked Guy to see Frank in the rehabilitation facility to which he'd been moved, Guy agreed adding "actually Henry, I want to make sure they have an exercise machine there for him. His sister said he would never go, but he has defied those



expectations.” What this illustrates is how workers might key into one small, surprising detail so that it persists through time and becomes interconnected with shifting perceptions of a particular person, helping get past preconceived categories and closer to perceiving another person’s uniqueness.<sup>12</sup> This is especially true given the infrequent use of diagnostic categories for description, so that workers were instead absorbed in clients’ present contexts and situations as these pertained to that person’s wellbeing.

### ***The Polite Thing to do: Enacting an Ethos of Care-Respect***

An awareness of individualized dispositions, needs and context also increases the responsiveness team members can show clients. This aspect of the work came out during a discussion of whether to visit a client in jail. There was some uncertainty at the time as to whether the team would continue working with the man in the future, hence the indecision. The client had also recently assaulted Guy, so not all team members were enthusiastic about visiting the imprisoned man. However, his concerned, but faraway parents, described by Talia as “elderly and frail,” had requested that someone visit the patient. Otto pressed for one last visit.

Otto: it is a polite kind of gesture. In the day when people are breaking up over email.

Henry: text him. It’s not you it’s me.

Otto: I’ll go.

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<sup>12</sup> Not all team members took the same delight as Henry at the sight of Frank on the elliptical, however. While he was caring for Frank in Henry’s absence Peter, who as noted, was at the time making little headway relating to Frank, remarked during one meeting that the patient “has no intention of going anywhere but here or the cubbyhole. He spends hours at the treadmill. He has a very autistic existence”.

Peter: I think it's great if Otto goes. I really respect that. It's a good thing to do.

Henry: you know you get a total body cavity search.

Otto: I want to tell him 'what you did wasn't right' ... I think he has had a lot of traumatic loss. His son passed away of cancer. This adds to that. There has been a lot of loss. This is just a polite way of doing things.

It is worth remarking here that Otto's work role also provided him with the space to respond to his client's particular needs as is evidenced by his ability to volunteer for a visit mainly because, as he and Peter saw it, it was the right thing to do, especially given the client's situation.

Team discussions saw no lack of examples of a certain responsiveness to patients crafted in accordance with their particular traits and dispositions and thereby enacting an ethos of care-respect. "We have to be human about this" Peter recommended to staff in communicating with a client who was on the verge of eviction. "We can tell him. Normally people appreciate some honesty. He's not a child either; he's worse than the average person because he has paranoia he can sense insincerity." A similarly nuanced approach was recommended with a client who was reportedly coming into the office "dripping with bedbugs." Workers were aiming to give him medication in his home or on a day other than weekly open clinics because as Talia noted "if we can't protect our space, we can at least protect our [other] clients." Many were concerned, however, with how to relay this message to the client without upsetting him. "He still has the capacity to feel 'hey, I'm being helpful' noted Peter who went to suggest that workers present their request in such a vein. Hence, not only was there much evidence of a general sensitivity

to patients' particular responses to the team members' approach, but workers also showed a willingness to adapt themselves in accordance with a client's preferences.<sup>13</sup>

## **Storytelling**

As I have shown in Chapter Three, Nussbaum contends we all should strive to become persons "on whom nothing is lost," and it seems that workers approached this ideal in their practice. It would appear, moreover, that in virtue of efforts at patient attentiveness and inescapability of world travelling, workers tended to enact an attitude of care-respect for patients. That is, ACT workers did more than merely strive to respect their patients' autonomy, but actively sought to recognise patients' particularities in order to provide personalistic and individualised care. However, one further element of workers' practise I would like to emphasise here, because it was such a prevalent theme in my observations, was the potentially positive impact of the very storytelling medium itself on workers' attitudes towards their clients.

Although workers saw the morning meeting primarily in professional terms, that is, as a venue to exchange information and to strategize around patient care, as many of the exchanges above reveal, more went on in these meetings than this. As we've seen with the small anecdotes that were shared, professional discourse could morph into a more common human activity, which was storytelling. Although I would never meet most of the clients discussed, I came to care what happened to many purely by virtue of

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<sup>13</sup> Of course sometimes some needed a reminder of this, as with a patient who wanted to take a particular medication after regular work hours, but which workers were mandated by a CTO to observe. In response to those suggesting the patient was being rigid Peter replied "part of the rigid people are us. We are saying we don't do 9 o'clock. There is rigidity on both sides. This is one of the only powers they have left. She is saying my body is saying 9 o'clock. That is why we have to talk to her and say we can come at 7."

hearing their stories play out in team meetings. After expressing this sentiment to Talia, she replied “as a person who has gone away for a few weeks and come back, you see that the stories just go on and on. I’d say it’s like the morning soap opera, but it’s obviously a lot more serious than that.”

The storytelling engaged in by team members has three potentially beneficial outcomes. Firstly, in relying upon a narrative form of communication, storytellers effectively emphasise the agential nature of story’s subject. This is because a story is not a story unless it involves an agent, or an individual with motivations, beliefs and desires, as opposed to representing a causal description involving neurotransmitters, firing synapses and subsequent observable behaviour. It should perhaps not be surprising that a team of workers bent on maintaining relationships, and who are therefore sensitive to clients’ attitudes and preferences, should tend towards a narrative modality in discussions of clients. However, it is worth asking if the very medium they are employing to communicate also helps to reinforce clients’ statuses as persons with whom one interacts and negotiates rather than objects one manages and processes.

Secondly, the public sharing of a story also invites participants to add their own observations to the narrative being shared. Doing so effectively stands to cause alternative interpretations, or a variety of perspectives to be aired. As a variety of viewpoints find expression, moreover, there is a good chance that one will find her own perspectives and presuppositions challenged. Hence, similar to Nussbaum’s recommendations regarding the importance of the imaginative reconceptualization of

others, such an activity can cause certain participants to expand their understanding of a particular client, or stretch their preconceptions about that person.

Thirdly, there is an affective component to storytelling. As noted, mere exposure to another person's story can make a listener concerned about the wellbeing of the subject. I was also left with little doubt that workers were empathetic and cared for their clients. This is not to suggest that all workers were especially fond of all clients, but most workers appeared to have affection for at least some of their clients. This was evident from say, an off-handed remark about being up half the night ruminating over a decompensating client, comments such as, "I'm feeling for Steven right now," or the mention of bringing by a mini cake for one client's birthday which also evoked workers' affection and care. Such affect also came through by way of nonverbal cues elicited during discussions of clients such as smiles, affectionate tones, sympathetic clicks of the tongue, or leaving the room when feeling overly distressed. Such expressions, moreover, not only communicate a speaker's attitude, but also relay the more subtle message that the subject of the story is a person is worthy of care.

Meanwhile, as anyone who has sat around a table at a large family dinner knows, storytelling serves as a way of building community. Take for example, the following exchange about a particular client's pride over his new job

Guy: He said to me 'working is the best drug.' He also talked about how proud he is walking down the street in the morning on his way to work. He brought himself a 40" LCD TV and a laptop. He's saved \$150 a week.

Stephanie: He also bought his nieces and nephews a Wii.

Otto: He likes to eat lunch in his uniform so people can see that he is working.

The telling of this story garnered a collective “aw” from team members, which suggests that it helps to build camaraderie among those present for the telling. However, it is also possible that sharing lore, so long as it is not done maliciously, also helps to reinforce the sense that the subject of the story belongs to the community sharing the story: he is one of theirs. In this way, storytelling as a medium could serve to cultivate a genuine experience of care, and thereby move one beyond the mere demonstration of an attitude that is merely consistent with care.

### **III. From the Narrative of Progress to a Sense of Futility**

#### **The Institutional Context of ACT Stories**

As Talia’s comment about the seriousness of clients’ stories reveals, however, ACT discourse has certain distinctive features that sets it apart from the kinds of stories people tend to tell in domestic, or community settings. Probably the most important element that distinguishes ACT stories from other types of narratives is that there appears to be an implicit injunction against telling a story merely in order to entertain those with whom one is sharing. Rather, ACT stories are purposeful in that their telling tends to have a therapeutic focus. As Polletta et al argue, in relation to the sociology of storytelling, within organizations research suggests that “power comes less from knowing the right stories than from knowing how and when to tell them: what to leave out, what to fill in, when to revise and when to challenge, and whom to tell or not tell” (2011, p, 115). For instance, as one might recall, Henry reinforced a certain prohibition against sharing

stories at Tom's funeral due to the team's professional status. If we understand the term "power" above as professional prestige, we can see how the status of team members as professionals within an institution shapes their stories.

### **Just The facts: The Instrumentalization of Relatedness**

If knowing when to share an anecdote is what distinguishes team members from regular members of Tom's community, or worse, mere gossips, knowing what to share has a similar function within the context of the team meeting. That is, in order to remain professional, workers by and large stuck to details that were therapeutically relevant and there appeared to be an implicit requirement to maintain this focus. The following exchange helps to reveal this.

Talia: she didn't run screaming and permitted me to get her a cola. On returning James – who seems well – was sitting beside Maria and she was like 'get away from me.' James was 'Talia is great I have known her for years.' This escalated Maria and she ran down the ward and I could hear her screaming for 4 minutes. I noticed she was walking and holding onto the rails.

Henry: I didn't notice. She could be dizzy with the increase in dose.

Diane: Is she on the ward?

Henry: she has been for a while. She is not participating in ward activities.

Tammy: [smiling] she got her nails done.

Henry: but she is not participating in group therapy.

Tammy was one of the team members who seemed to find Maria's love of beauty salon services endearing. However, Henry's dismissal of her remark demonstrates that this observation carries little weight and is perhaps not worth mentioning.

Workers overall appeared aware of the implicit requirement to reconfigure all the delightful idiosyncrasies they may have been prone to notice into therapeutically relevant information. For instance during a service report for Maria, Rose noted affectionately that “when she goes to get her hair or nails done, she just glows. She has this look like a Princess being taken care of.” Rose also strove, however, to cash out such observed dimensions of Maria’s personality as therapeutically relevant information. As charming as Maria’s love of pampering might have been, Rose was careful to add that perhaps Maria’s enjoyment of being cared for explained her hospital admissions, while noting that that “salon visits and manicures are inroads for us,” or means of establishing contact and coaxing the client’s cooperation. “Treats and a good hamburger” were other means that Rose suggested could be used to win Maria over. The manner in which Henry immediately parlayed Frank’s enjoyment of exercise equipment into a therapeutic goal such as getting him to the Y, also helps show the appropriate response to such observations.

Hence, we can see that the knowledge of clients accrued tended to have a specific purpose, and this was to get them on board with treatment plans. Understanding a person merely for the sake of coming to appreciate another and how they see the world is not a worthwhile goal in this context. Peter, in fact, was the only speaker in meetings who made regular attempts to actively explore and share the manner in which clients perceived their world and constructed meaning for themselves. As we’ve seen, the psychiatrist wondered aloud at the meaning of St. Patrick’s Day for Tom and in another meeting I saw him pondering the significance of Frank’s refusal to accept housing. “It is



fascinating” said Peter. “It is like he has been testing the goodness of housing. He said ‘I tried this housing thing, and it’s not for me.’” In the case of the aforementioned client with extraordinarily dangerous levels of methane building up in her apartment, it was Peter who explained that “she grew up in the Caribbean where people believe these [the urine and feces collected] are fertilizers. She believes she is returning things to a natural cycle. That’s why she does things in twos. It’s all about balance and symmetry and balance with nature.”

The following exchange reveals when and how such observations of Peter’s tended to be taken up by the rest of the team

Peter: [Frank] spends hours at the treadmill. He has a very autistic existence.

Talia: is he autistic?

Peter: many schizophrenics present as autistic.

Guy: should we apply for housing? We can get him into a place.

Talia: sure if he would take a place.

Other meetings had revealed that special housing existed for clients with a dual diagnosis of autism and mental illness, and the facility seemed to be underused. Hence, Talia appeared alert to remarks concerning autism. If then, there were practical and concrete implications that stemmed from Peter’s observations, other team members would be more apt to pursue this line of thought.

This is not to suggest that Peter was unaware of the practical implications that could stem from understanding a patient’s inner world. For example, during one meeting Peter had what seemed to be an epiphany regarding Sophie

Peter: One last fascinating observation of Sophie. I would see her as a combination of delusions changing in front of you adapting to the moment as well as a 7 to ten-year-old style of interaction with shifting delusions and psychotic background. Some interesting things: 'I am moving to 10<sup>th</sup> Street. You are going to be happy that I am moving there.' [which the client was reported to have said after having refused housing at this particular location the day before]. Suggests she understands the options she has even though at the time we delivered the news she was saying 'I am your doctor, I own St. Mike's,' but the next day she incorporates what you have told her.

Other times, there has been a shifting playful but I would say antagonistic youngster who takes no responsibility or future planning. I think how that will affect our interaction. You have to be firm and sometimes challenge her stuff but the effect might not be immediate. Yesterday she said to Di 'you don't work for me.' But she was interested in hearing what you said 'because my lawyer is going to court to sue you all.' We used that to say to Di that 'housing is really important to continuing treatment and her only options were shelter or long-term care.'

Peggy: Were you talking to her?

Peter: No. Diane and I were talking in a compassionate and supportive way in front of her. This allows her to incorporate this information in a face-saving way.

Guy: They don't want her to take any furniture.

Relationally speaking, configuring Sophie's behaviour according to the very human need to save face represents a valuable meaningful insight about another. Guy did not follow up on Peter's observation, but returned to more concrete matters at hand, helping to illustrate the very pragmatic orientation of the ACT team. Peter's musings, however, were not merely idle, and, as with the rest of the team, he found a way to parlay this insight into a therapeutic tool. Six weeks after he made the comment above, Peter reported how his understanding of Sophie's need to save face helped him to convince her to accept an IM. Before the meeting began, Peggy had been excitedly questioning Peter about the incident. Later, when the item came up on the agenda Peter reported.

She didn't want the IM. I made it clear we could do it here or the hospital. The fact that I could point to the hospital [which was visible from the Sophie's window] probably helped. Before I left I said we are going to wait for 4 minutes. Knocked on the door and she was 'oh hi, come on in' like a totally changed person. Classic Sophie. So typical, she can change

on the spot and is able to absorb things but is oppositional right at the moment. Every two weeks [the patient's IM schedule] is a struggle ...

### **The Quantification of Progress**

It is becoming clear then that ACT team members had longstanding and detailed knowledge of their clients in all their particularities, as well as a focus that was undeniably relational. However, the value of building relationships and learning clients' stories was largely instrumental and represented the means to achieving therapeutic goals. Such goals at times meant little more than adherence to a pharmaceutical regimen. Anecdotal or narrative accounts that emerged in team meetings then were framed more broadly by what Paul Brodwin describes as a "narrative of progress," or a master narrative that imbues workers' professional training as well as the intuitional demands placed upon them in the workplace. This narrative, Brodwin notes further, is etched into the very fabric of ACT work by virtue of bureaucratic documents such as the aforementioned service plan delivered by Rose.

Drawing on his observation of an American ACT team over two years, Brodwin notes that "simply to get their job done, clinicians must produce a mandatory story of progress and continually measure, update, and reinscribe it every six months" (Brodwin, 2011, p. 205). The treatment plan includes various sections to be filled out by a primary including background information on the client, client's strengths, present problems and goals. According to Brodwin, each goal requires a specific intervention that is then entered into the weekly schedule. As he points out,

The model treatment plan sets the state for everyday clinical routines and supplies them with an orderly, almost transparent rationale. The client's diagnosis, problems, goals, and services line up in a single logical chain, each link justifying the next. The plan unfolds according to an intuitive – and intuitively appealing—clinical logic. The suffering in [the client's] life gets transformed into a list of discrete problems, each problem linked to a concrete, attainable goal; and each goal calls for a bundle of visits, relationships, “support,” assessments, medications, and monitoring (p. 195).

Hence, while standardized methods do not dominate practice, workers are still expected to produce quantifiable results. Moreover, the view of a client's life as a series of problems to be solved was echoed in the ACT team I observed, primarily through the use of the term “piece.” “Piece” was commonly used to refer to critical aspects of a client's wellbeing. Talia, for example, would talk of the “medication piece” or the “housing piece” which gave the impression that these were discrete aspects of a puzzle that if appropriately modified and reassembled in the correct manner, would result in a picture of progress and recovery. Piece is “a word I used to hate,” Greg told me in his interview

But I think it's just ingrained into my vocabulary now. A lot of social workers use the word ‘piece.’ I think it's how we describe and compartmentalize the things that we do ... there's the housing piece, there's the socialization piece and there's the finances piece and the community engagement piece.

Greg was less sure why he once disliked the term

I think it was just one of those words that I think was used so often and by everybody, I found myself asking ... why that word? And I think over time it becomes incorporated in your vocabulary and it kind of makes sense.

It is worth asking, however, whether experience within a bureaucratic context is what is required for this term to become meaningful. For as Brodwin notes, given that the ACT team he observed was publically funded, an auditor came in every two years to insure that goals were being quantified and that these lined up with progress reports.<sup>14</sup> Incomplete reports threatened the agency's funding. Hence, "the pervasive "audit culture" of public sector health services powerfully affects how people fill out these forms," notes Brodwin (p. 195). It is no small wonder then that individuals might, over time, come to perceive their work as an aggregate of rationally manageable parts, if their continued status as professionals relies upon their ability to cash out their interventions in terms of quantifiable units that are amenable to categorization and which can be pieced together to construct a logical story of progress.

### **The Mandate for Progress Obscuring the Face of the Other**

In her paper, *The City is My Mother* anthropologist Anne Lovell (1997) tells a story that vividly demonstrates how the drive to produce objective and quantifiable results can clash with the values and worldview of someone who experiences psychosis thereby hindering worker/client relationships. In her research, Lovell came across a young homeless man named Rod who was diagnosed with schizophrenia. Little was known of Rod's actual history, beyond a few sparse biographical details. However, he did

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<sup>14</sup> Over the course of my research, the ACT team I observed was also undergoing an institutional evaluation that occurred every 3 years. This, however, was part of an institution-wide accreditation process that the hospital underwent in order to retain its status as a teaching hospital and research institute. Canadian hospitals, as I explain in Chapter Six do not see funding relying on the kinds of audits described by Brodwin. Nevertheless, team members did tend to emphasise the importance of therapeutic progress.

like to tell how his mother provided for him by leaving food and other necessities in various parts of the city for him to find.

In Lovell's view, Rod's delusions provided a means of setting himself apart from the other "indiscriminate scavengers" and "bums" who shared the city streets with him, while she further describes Rod's existence, somewhat romantically, as "a quest that never ends" bent as it was on the discovery of self. A well-intentioned social worker,<sup>15</sup> however, appeared to take Rod to be expressing a desire to reconnect with his family, and went to great lengths to track down his biological mother. When she informed him of her accomplishment, Rod became angry, accused her of attempting "a false reconciliation" and was never heard from again. "Were the plot to reach a climax," explains Lovell. "Were he to find his mother, his travels would terminate. His homelessness would become banalized, stigmatized, his voyage meaningless" (p. 360).

Unlike the anthropologist, however, the social worker probably did not have the luxury to engage in the painstaking hermeneutic analysis of meaning Lovell recommends. For, to put it simply, the social worker would have nothing to show for her work. This is because doing so would not cohere well with the mandates of healthcare systems bent on quantifiable results, especially since, if Lovell is right about Rod's worldview, the social worker had very little to offer him. As noted, a worker's job is to map a narrative of progress over a story such as Rod's, so that certain concrete steps towards recovery are made visible. Reconnecting a client with estranged family members is just the sort of

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<sup>15</sup> Based on Lovell's description, this social worker may well have been an ACT worker, but it is not explicitly stated.

tangible and concrete step that can be noted in a chart to demonstrate that real progress is being made with a client.

As Lovell describes it, the social worker was genuinely attached to Rod. It would seem, however, that she was unaware of the extent to which her ability to adequately respond to his Otherness ran counter to the demands of her work. Contacting Rod's mother was not merely an example of good intentions gone wrong. Rather, it would appear that the requirement that his story follow a logical progression towards recovery precluded her very ability to appreciate his unique self-narrative on his own terms. Rod's angry response and withdrawal then, represents the moment at which two intertwined but competing narratives clash and come grinding noisily to a halt.

As Rod's story demonstrates, one problem with the overarching drive towards therapeutic progress is that clients themselves are not swept up in the narrative to the same degree as caregivers. For instance, as Gail remarks during a service plan for Louis, who smokes heavily, is obese and whose highlight of the year appears to be his annual running shoe purchase, "Louis presents a lot of negative symptoms. He lacks the motivation to do the things he says he would like to work on ... I should say that Louis' only goal is not to change." Most clinicians, however, want to help move patients along the trajectory of wellness, have received years of training to achieve competence in this effort, and, as Brodwin notes, see the goal as a moral enterprise. According to him, "futility is produced by the mismatch between one's professional training and the current opportunities to apply it" (2011, p. 192). Given the necessary cooperation of clients for

the achievement of therapeutic progress, workers seem destined to fail when, as one case manager, puts it, “they don’t want anything we have to give” (p. 201).

#### **IV. Further Sources of Suffering among ACT Workers**

Clients’ lack of cooperation will not be the sole source of a sense of defeat among workers. Practitioners exposed to clients’ contexts and often working towards a rich and nuanced understanding of them witness other conditions apt to give rise to a sense of moral failure due to their inability to answer the felt call of the Other. As Trevor said in relation to clients resistant to help,

There is only so much that we can do ... we can’t just pick somebody up and throw them in a hostel or in a house and that sort of stuff just really wears on you after a time. There are just those times when you pretend to be calloused and just do your thing and whatever. You can’t help but bear some weight or at least feel like you are bearing it. Be it either responsibility or just feeling sorry for the person

Although ACT workers do not seem to be persistently constrained by workplace regulations that preclude them from responding to the call of the Other, as with nurses described in Chapter Three, they still may tend to suffer from sense of responsibility for circumstances they cannot change. As Trevor notes, “it’s a very emotional job and you often see people [fellow workers] get overwhelmed by their emotions.”

#### ***Like Taking a Garden Hose to a Forest Fire: Material limitations***

Given the sheer lack of resources available to clients, and other factors they are powerless to address, the odds are stacked against efforts to improve the client’s life. For, it would appear that the actual course of clients’ lives rarely match any carefully plotted



trajectories towards improvement and recovery. This will be especially true in large urban centers, where, as noted earlier, living conditions leave much to be desired and many clients are reportedly living at subsistence levels.

It is doubtful, in fact, that much has changed since Sue Estroff conducted her two-year-long ethnography of ACT clients in the late 1970's (1981). In her time with ACT service-users Estroff noted dismal living conditions, and a lack of any real integration into the broader community. At least half of Estroff's subjects lived in the downtown YMCA and for the most part the only work available to them involved mindless repetitive tasks carried out in sheltered workshops alongside developmentally delayed people. "It makes you feel like you're retarded too, or at least somebody thinks you are" notes Doc, one of Estroff's subjects. "How do they expect me to feel when they tell me I should work there? Man, it's just too depressing, looking around at who's there and knowing you are too" (p. 137). Estroff notes

As time passed I began to realize that maybe a house in the suburbs, a family, a car, credit cards, and a full-time job might not be part of the present or foreseeable future for the people from whom I was learning. The lofty goals of reintegration into the community, satisfactory quality of life (or one like the general population's), and lessening of personal distress and isolation put forth in the community psychiatry literature seemed far removed from what I was observing. At this point, I became very disheartened—all seemed gloomy and destined to fail. These people were not changing significantly in predictable and reliable ways. And then I began the recurring cycle of pessimism and hope that is probably perpetual if one does work in this area (or so I am told by the staff). Little alterations seem like major successes—a spontaneous smile, a good day, a new apartment. Yet, the creeping hopelessness always comes back. (p. 18).

Not all are cut out for the enduring patience necessary to stave off the suffering a worker is apt to experience when placed in close proximity to hopelessness and despair

that he is helpless to alleviate. As one disillusioned worker remarked to Brodwin shortly before leaving the ACT team

If I woke up tomorrow as Vicky Inger [his client with active delusions, a lifelong cocaine habit, and no family or friends], I would simply say, “Go ahead. Shoot me.” This is not a life worth living. Is just living, sheer biological survival worth it? ... it’s an exercise in futility. You’re going keep them psychiatrically stable until they die. But where do you go with it then? Just line’em up in a ditch? (Brodwin, p. 203).

As we can see, intimate knowledge of clients’ contexts is a double edged blade. Although the familiarity with their broader context can bring about a more intimate understanding of a client, workers are still mandated to stand by and watch some die impoverished, addicted and alone.

While no one I spoke with expressed a sense of futility to quite the same degree as Brodwin’s subjects, Otto did liken working in community mental health to “taking a garden hose to a forest fire.” He named minimal housing options, discrimination against clients and a lack of the basics required for daily living as contributing to the tide of factors that overwhelmed workers’ efforts to improve the lot of the people they strove to help. Meanwhile Rose admitted that after four years doing assertive outreach, her days with ACT were numbered due to the frustrations and obstacles she encountered in her efforts to help clients. Gail expected to leave the team soon, Tammy had already left, and Beth and Trevor also expected to move on one day. Moreover, the summer before my research began, Rose noted that six positions had turned over. Two of the eleven workers interviewed, moreover, mentioned that they had turned to counselling in order to deal with work-related stress. Many others had family members or partners who were either in

healthcare or a helping profession and reported that this supportive understanding from their inner circle was essential for their ability to deal with the most trying aspects of the work.

### ***Cuts and Chemicals: the Dominant Therapeutic Approach***

Apart from bearing witness to dismal living conditions, moreover, sometimes workers must also bear witness to harms effected by psychiatric drugs. In her interview Rose emphasised the need for not only better housing, but also better drugs, possibly due to the numerous clients struggling with diabetes and other side effects. Otto also showed concern about cases in which medication appeared to worsen, rather than improve, a client's wellbeing. He relayed a story of a client who had very florid psychotic symptoms and limited insight, but who was paying his bills, cooking and functioning in the community. Otto explains

We convinced him to take the medications and within 18 months he developed type 2 diabetes because of the medication. So what's better? Was it better if he was just left the way he was or when he went from a size 36 pants to a size 48 in 18 months? He gained excessive amounts of weight and type 2 diabetes and now he is struggling ... Now ... he doesn't take any antipsychotic medication. He still lives in the community. He eats, lives, gets on with his life. Yeah, he's got some beliefs, but everyone does have some sort of odd beliefs. Be he's able to function, so I'm wondering. That's an ethical thing.

Otto further maintains that “cuts and chemicals are what is important” in the current healthcare environment, hence there is continuous emphasis on medication. However, this is not a factor in patient care over which regular workers have much control even if their job is to deliver drugs and convince patients to stay on board with treatment.

This is not to suggest, however, that all workers questioned the value of medication. Non-medical staff such as Rose and Trevor seemed to defer to psychiatrists' expertise around medication, while Peter acknowledged that side-effects problematized treatment, but that the benefits mostly outweighed the costs. Interestingly, Diane's reaction when she heard about her colleague's doubts helps to reveal the well-entrenched nature of the medical model described by Otto. "Wow" said Diane incredulously during her interview. "What are they even doing here if they are going to start questioning that kind of stuff? Wow, I'm really blown away by that." For those left questioning the cost/benefit value of antipsychotics, however, the sense of futility attached to this kind of work can only deepen when hearing clients complaints or witnessing adverse reactions to drugs that non-medical staff have little power to address beyond informing the doctors.

### ***They Are Not Your Friends: Limits to Emotional Support***

While many would agree that they cannot provide their clients with material support, at least, some might suppose, workers are providing social support. The reality is, however, that an implicit demand for professional detachment limits what an ACT worker can offer a client in terms of community and connectedness. For one thing, the relationship between a worker and a client is part of the job, and ends when a worker leaves that role. Rose, for example, pointed out that in spite of wanting to know about clients from the first ACT team she worked on, she did not see it as appropriate to look in on them. "I only entered their lives through professional care, so I'm not a friend." She also said she found it difficult "teasing out mental health care from just wanting to know

[about clients personally],” then added “I’m terrible about that,” minimizing the importance of concerns for clients stemming from her care for them. Rose is left with the sense that she must foreclose upon whatever attachments she has formed when her job comes to an end.

Such an expectation, however, creates a conflict for workers. As Trevor notes, worker turnover is something clients find difficult. “They often struggle with people coming and going a lot and I think that is just a testament to just how important that consistency is for a lot of our people.” He admitted that he expects to feel guilty when and if he decides to move on from ACT. Rose, similarly seemed conflicted about the prospect of quitting the job. She wondered aloud, for example, about workers who have known their clients for 20 years

What happens when they retire? What happens to all that information? ...  
How do you just forget about them or not wonder how they are doing? ...  
and I wonder, what’s that called? That worry, or care, or something, where  
it goes.

Even within the scope of their jobs, ACT workers cannot function as regular members of their clients’ communities, as Henry’s comment about the impropriety of sharing stories at Tom’s funeral helps to show. Rose, moreover, relayed a story of a co-worker on another team who invited several long-term clients to her wedding.

She thought this will be such a nice day for them, and it was. They got dressed up and they were just beaming and they couldn’t believe that they got invited to a wedding ... She got in so much shit for that. She was told ‘you have crossed a line here, they are not your friends.’

Hence, while there is an impetus to help clients become integrated into ‘the community,’ this term becomes something of an abstraction given the implicit injunction against this being a community of which a worker herself is a part.

There are also limitations upon the kind of emotional support workers should provide clients. This became evident in a discussion involving Steven, a client who was calling the pager 6 or seven times every night. The issue being brought forward at two different meetings was how to set boundaries with Steven so that he would stop paging the on-call staff members just so he could have someone to talk to. The psychiatrists’ suggestions were as follows

Henry: That was totally inappropriate to tell you he got a can of sardines ... He does say ‘I’m lonely.’ We should encourage the use of other relationships.

*Later in the meeting*

Peter: what is he doing at night? We should look at his sleep schedule. It’s also an opportunity to do therapy.

Although many in this meeting seemed to agree that the client was calling out of loneliness, during the long discussion that followed, the possibility that anyone should chat with the client to alleviate this feeling never emerged. Arguably, doing so is simply not an ACT workers job. It is not anyone’s job in fact.

Rather, engaging with someone who is lonely is the act of a friend, but a key problem for the clients of ACT seems to be that many lack a supportive community. As Trevor notes “in a lot of ways we might be [clients’] only social contact.” Estroff’s work, moreover, revealed a subculture of “Crazies,” or people who identified as mentally ill. Most of these people were cut off from, and even actively avoided, so called “Outside

Normals” such as policemen, business owners, landlords and other members of the community. Of the 43 individuals with whom Estroff interacted, only five had friends that were not receiving psychiatric treatment. She notes “many clients had difficulty understanding why I would spend time with them, or would even like them, demonstrating how unaccustomed they were to interaction with Inside Normals who were not somehow treating or advising them” (1981, p. 183).

Workers, however, are barred from crossing over the professional divide to provide clients with genuine friendships and community, and are thus no better situated to provide social support than the material resources their clients so desperately need. Mandated to achieve observable progress, yet often powerless to do so, workers are often left merely bearing witness to a multiplicity of devastatingly lonely lives. In other words, workers are brought face-to-face with many who have been abandoned and forsaken, and due to this proximity, will be acutely aware of their needs. In spite of being mandated to form relationships with those people, they are still restricted in how this is achieved.

As a result of this contradiction, some will second-guess and calculate every act of generosity or kindness called forth by such encounters, given that in many instances they are being required to reach out to, and ignore the call of the Other simultaneously.

As Beth describes it

you build your relationship with them, you build rapport. It's just like you know, it would be so nice if, they have no friends, they have no anything and sometimes you think it would be nice to go out and have a coffee or something. But you have to kind of weigh, what is it for? Is it so they will like me more? Is this going to build rapport? If I already have rapport what is this doing? It's sort of reinforcing that we're friends and it shouldn't be like that. When buying the client stuff you have to be careful. At the same time they have absolutely nothing, what is it for you to give them a dollar?

For them it would make their day. So it does get, yeah some of those professional boundaries are difficult.

The point I am making here is not that ACT workers ought to be friends with their clients, but rather that they are regularly faced with a call from the Other which they are either obliged to ignore, or must ignore for the sake of their own wellbeing. Moreover, this is not to suggest that all clients will issue such a call for forms of engagement that exceed a worker's professional role. One ACT patient interviewed for a different study, seemed to prefer a relationship circumscribed by professional boundaries

It's one relationship that isn't entangled like all my other relationships are, whether it's family or friends, there's that professional boundary. I can trust that it's more ... like normal. I can check things out with them. It's a cleaner, safer, healthier relationship for me (Stull, et al, 2005, p. 20).

Meanwhile, few would argue against a worker's right not to bring her work home with her, or to avoid having it permeate other aspects of her life. However, this will often create contradictions for and perhaps feed into the sense of futility experienced by workers. For, knowing that one possesses certain rights or is obliged to maintain certain boundaries, might do little to stave off the experience of failure or guilt occasioned by resisting the felt call for more involved engagement and connectedness.

## **V. Tactics for Resisting Futility**

There is reason to suppose that workers' own distress has not made them inured to their charges, and this may well be due to certain tactics they've developed. As we shall



see, however, the fact that workers have the time and the space to conduct their work as they see fit provides them with the means to push back against pessimism and despair.

### ***He Made an Omelet: The Importance of the Recovery Board***

In spite of certain previously mentioned difficulties, the team I observed consciously strove to stave off a lingering sense of futility. The aforementioned “Recovery Board” was one method this team in particular had found to remind themselves of the small successes Estroff mentions in the passage cited above. For example, on February 2 a note appeared on the recovery board that “Gerald has a new bed! Cooked an omelet! (independently).” Three months later, Beth reported that Gerald was not eating, and was becoming increasingly emaciated. He was also covered in bedbugs but was resisting a move into a more supportive group home. Hence, team members decided to give Gerald a trial period of three weeks during which he would get more frequent home visits before a more concerted effort was made to move the client. As Beth noted, “we know he is capable. He made an omelet. Let’s not take that from him until we see it in play. We are saying ‘this is your opportunity to show us.’” The fact that such a seemingly trivial detail would stick with a worker for three months speaks both to the lack of improvement caregivers were apt to witness as well as the meaningfulness of items appearing on the recovery board. It is worth noting, that such an attitude and patient attentiveness to change can only be accomplished when arbitrary time limits have not been placed on the duration of work with a client. Clients here are allowed to change in

their own time and workers are not rushed to hasten their recovery before some pre-determined deadline.

### ***Boiling Blood and ACT advocacy***

In spite of such efforts, however, it would be very difficult not to experience a sense of defeat in the face of an overwhelming number of systemic barriers limiting what a worker could hope to achieve with a client. Workers, it would appear, are relatively powerless to confront or solve such broader issues, hence it does not seem to be the case that those who are closest to ACT clients are participating in broader policy decisions regarding their care. As Rose said in her interview, “there is a bigger system at play and it is hard to navigate against the system when you are in the system ... Unless you take it as your life and do it in your evening and off-times.”

As noted, workers’ time during their shifts is largely occupied with medication drops, paperwork, phone tag, helping clients maintain their personal hygiene and living conditions, among other things. Little time will be left over to address systemic barriers to their work with clients, and even if one has the drive, it is difficult to assess when one has achieved a tangible win. Perhaps it is not surprising then, that workers so genuinely involved in their patients’ lives were quick to dive in and champion those who’d been clearly wronged by less personally involved agencies and institutions. However, it is only because they have the space to devise spontaneous solutions to problems, that workers were able to engage in such forms of advocacy.

The care for clients evidenced in meetings did, on occasion, translate into indignation on their behalf. For example, Talia's remarked "he paid all that money. Wow, my blood is boiling! They said they would chop it up and remove it and we bought him a new bed." Talia mentioned this on at least two meetings in relation to a mishap that occurred after a company treated a client's apartment for bedbugs. It was probably the case that team members' richer and more nuanced and detailed understanding of clients' particularities served to exacerbate the frustrations they experienced on seeing clients mistreated by impersonal agencies implementing standardized procedures with no regard for clients' particularities or context.

However, given the number of obstacles team members were powerless to overcome, any chance to effect clear and concrete change should represent a golden opportunity for those bent on progress. Not surprisingly then, I witnessed no small number of cases in which workers not only expressed clear indignation, but also avidly leapt to the defence of wronged clients. "That is a very unethical way of doing things," remarked Stephanie in one meeting while discussing a case in which a housing program was holding back \$1,600 from a client, allegedly to cover expenses after she moved. Money, the discussion revealed, had only accrued because the client had accidentally paid double her required rent for several months. "We should champion this," Peter replied.

A case that vividly illustrated workers' indignation on behalf of a client, and their rapid mobilization to right a wrong against him, involved James. Although many team

members had conflicts with James,<sup>16</sup> an enduring fondness for him appeared to abide. “He’s a strange guy,” Henry once remarked. “Strangely likeable.” When James was awarded \$100,000 in a back-dated lawsuit, the Public Guardian and Trustee (PGT) representative managing his money deemed it unnecessary to inform the mental patient of his windfall. Rose, who was James’ primary, had been engaged in an ongoing struggle with James’s trustee, when the administrator had offhandedly mentioned the money.

Rose was in contact with the trustee because she’d been working on getting \$500 released to buy a new bed. The next morning during their daily meeting Rose stressed that it was a complete “fluke” that she learned about the award at all, and reported on the conversation with the PGT worker to other team members. According to Rose, the trustee was on the verge of locking away James’ money in order to preserve his disability support payments. When Rose said that James should be involved in this decision, the trustee had replied “we don’t usually do that.”

Rose: The issue is, can’t we spend some of this money? He [the trustee] said ‘better do it quickly because we will lock the money away in a registered disability account. It is locked in for 10 years.’

Peggy: He is 55, he might not be alive in 10 years.<sup>17</sup> That is very cruel!

Rose: That is so wrong. So I have started a paper trail. Does James even know [it was later determined that he had not been informed]? I expressed the concerns [to the PGT] is this the right thing to do? Is this in James’ best interests?”

Stephanie: And he might not be alive in 10 years!

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<sup>16</sup> Especially over medication, which he believed gave him schizophrenia. James was also inconsistent in his reception of workers. Some said he opened the door to them and pointed to the threshold stating “there’s a line, and you do not cross it.” Meanwhile, the same week, he told Peggy that “angels like you are always welcome.”

<sup>17</sup> During her interview, Rose explained that James was “extremely unhealthy, extremely frail. He doesn’t eat properly, he’s got emphysema.”

Peggy: They are about to lock away the money. Is there a patient advocacy office we can call?

Henry: We need a face-to-face meeting

Peter: They also have what they think are James' best interests in mind. We can say he is not well, his quality of life is low. We need to bide our time.

Henry: I propose an emergency meeting on the ward. He needs to know about this. He has to be notified. The other option is to encourage him to get himself a lawyer.

Peggy: Right now he is so sick, calling the patient advocacy office will be hard. He'll just yell.

Otto: We have to get the PGT to wait on this.

Rose: The trustee said he has to get this done.

Stephanie: You were so lucky to have called.

Rose: It was just a fluke.

Peter: Part of the reason he is so unwell is the struggle with the PGT for 3 years. This could be very therapeutic for him.

Guy: That insight is not far off. He would get rid of that box and mattress. For 2 or three weeks he's been saying 'this is not what I want.'

Peggy: It's good we connected this to our team.

Otto: I'm sure he will blame us.

Rose: For today I can place a preliminary call. It might be more effective if a physician speaks to them.

Peter: Good clinical situation.

Henry: Interesting. Too bad more of our clients don't have \$100,000.

A clear action plan emerged from this discussion such that in the end, Peggy would phone the trustee and explain James' broader health concerns and put a temporary hold on the trustee's plans.<sup>18</sup>

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<sup>18</sup> This case also provides an example of the manner in which the narrative of progress shapes team members' perceptions, as was evident when Peter noted in relation to James' settlement that "another

The othering of patients that occurred with other less personally involved healthcare providers sparked further acts of advocacy from ACT workers. These were cases in which hospital workers were too quick to dismiss ACT patients' very legitimate medical concerns. Diane, for example, told the team about a trying time she had in the ER trying to convince a "cocky and condescending" doctor, that her client Danny was not suffering from a cocaine overdose, but was exhibiting the symptoms of a more serious health problem. Peter's best guess, as revealed in the meeting, was that Danny had had a heart attack.

Diane: I have been struggling with emerge's attitude towards our clients with either discharging them too quickly or wanting to discharge them too quickly. With Danny they thought he took drugs and it wasn't about him doing that at all. I dealt with some real attitude problems with one physician and became paralyzed by my anger and was glad Talia was there to debrief ... I wanted to tell you that the paramedics that picked Danny up said, 'ah, it's drugs.' Val told the paramedic off in her abrupt way. She said 'no way it is not drugs, no way it is. Take him, he is really sick' ...

Peter: what worked in the end?

Diane: Talia being there because I was so angry.

#### *Later in the meeting*

Talia: You could really see how someone could really fall through the cracks. A lot of it is ruling things out. I can imagine if I was a family member. Danny's brother Sam was told it was a cocaine overdose. A kind of narrative is created when you are at the point of ruling out things, when you are disclosing to family members but there are no tests saying that is what happened. Sam was saying "I don't know my brother to do this."

Diane: so I saw the nurse.

Peter: in the end, how did he get the CT and admission?

Diane: the nurse told me that the next shift did it.

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possibility is that we have the duty to assess his competence regularly. If we propose a more stable treatment plan, see how well his financial competence becomes. If he gets organized enough to manage money, he could regain control of his \$100,000. Set up a lawyer until he runs out and he can go back on [disability]. It would be a win-win to get him onboard with good treatment."

Peter: so you guys left in frustration?

Diane: no, no, we asked 'please do it.' And the nurse said 'I will tell the doctor.' I went to crisis and gave them the heads up. The emerge nurse saw me and said 'I have never seen anyone come to emerge to advocate, that is fantastic.' The other doctor did all the CT scan and the tox. The next shift was more proactive. In general our involvement and presence is very important. We do need to advocate. Our clients can't advocate for themselves.<sup>19</sup>

In all such cases<sup>20</sup> team members had a chance to make a real difference, which was to correct a tangible and clear cut wrong committed against one of their own.

However, had her day been highly structured, replete with predetermined tasks, Diane would not have had the ability to camp out at the ER. Moreover, the spontaneous, collaborative space of the team meeting was what enabled workers to come together, share their indignity and then creatively brainstorm together to arrive at a unique solution tailored to James' situation.

### **If You Don't Laugh, You'll Cry**

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<sup>19</sup> Such a drive to advocate on behalf of patients was not unmitigated, however. As Beth noted later in this meeting

*I feel that emerge in general is a chaotic place and everyone is going there for a crisis. If you are not able to articulate why you are there, then there is no one else to do it for you. We should definitely make it a priority if it's between the hours of 8:00 am and 8:00 pm [time when the team had active members on shift*

<sup>20</sup> Otto told me about another case involving a patient who had just been discharged from hospital and Otto and Guy went to see the man and found him a little disoriented. Otto showered the man, got him some food, and returned the next day to see the food still on the table and Mike slouched on the sofa in his boxer shorts exactly as they'd left him the day before. Emergency response workers, however, refused to take Mike to the hospital assuming that he had just been drinking. *I said 'this is not his presentation, this is not what he looks like. This is not him'.* Otto even pointed out that there were no evidence of alcohol in the apartment, but to no avail. According to Otto, the EMT worker had replied that *'he doesn't want to go, he knows what day it is,'* and left. Otto and Guy's only recourse then, was to have the client arrested under the mental health act, and brought to hospital by a team consisting of a nurse and a police officer. *They brought him in and the guy went onto a respirator and went up to the ICU, that's how bad it was.* Mike, was suffering from liver failure. It was true that patient had a history of drinking, as Otto notes, however, *mental health is a stigma, even for people coming into the emerge, then with addictions attached to that mental health, it make it even worse. People will dismiss what they see as addiction. They'll boot them out.*

The more relaxed atmosphere of the team meeting also enabled workers to engage in spontaneous forms of humour that many found essential for coping. The concept of ‘gallows humour’ was explained to me early on in my research process by Stephanie, who appeared concerned that I might take things the wrong way. Many team members seemed to share a dry sense of humour and otherwise agreed that laughter represents a coping device. When asked if a sense of humour was crucial to do the job Rose replied,

I think so, just on Sunday I was cleaning Maria’s female area and she farted right in my face. I just burst out laughing and she started giggling and [later] I was telling Otto, ‘ew, guess what happened to me?’ I was laughing. If you are like, ‘ew, that is so revolting,’ I don’t know. I think we laugh a lot and in that office [communal office space] there are pranks on a daily basis. There are a few of us that are like that and I am one of them. I think that is our way of coping. We say you’ve got to laugh ...

It was then noted that Henry jokes regularly in team meetings

And that’s why he does it too. I consider myself pretty sensitive but if you are sensitive in that way, or getting offended easily then I think you would find it hard because that is how a lot of us cope.

Stephanie put it a little more succinctly when explaining the importance of humour in the workplace. If you don’t laugh, you’re going to cry [Stephanie laughs]. And sometimes we cry too, but probably [laugh] more so.” Because workers were not severely monitored they could indulge in the occasional practical joke in the backroom, as I noted previously. Such behaviours, and regular quips were for many an important source of team cohesion and helped to make their jobs more bearable.



## **VI. Relationships and Stories as Ends in Themselves: A Tonic for Futility?**

The most obvious way to alleviate the suffering in the lives of SPMI patients, and by proxy, their care workers of course is to provide more in the way of material resources for the patients, many of whom, as has been made evident, are effectively disabled and thereby shut out from a decent standard of living. When and if such changes occur, they will not happen overnight. In the meantime, there is something of a moral imperative to ease the demand for quantifiable forms of progress from workers in light of suffering this causes them. Moreover, there is much to be said for taking care-ethics seriously and endorsing the work of forming relationships as valuable, meaningful and praiseworthy in and of itself so that workers in close proximity to such patients might fully appreciate one of the most worthwhile aspects of their work.

As Ivan Illich writes

We are creatures that find our perfection only by establishing a relationship, and that relationship may appear arbitrary from everybody else's point of view, because we do it in response to a call and not a category (Illich, cited in Baldwin, 2005, p. 1024).

In other words, the mere existence of a singular relationship founded upon a sensitivity and responsiveness to another is valuable in and of itself. Although I have argued that there are serious limitations to what an ACT team can provide in terms of community and connectedness, there is little doubt that the care and attention that ACT teams show their clients certainly counts for much among people abandoned by so many. Christensen, a psychiatrist who has been doing street-based outreach to mentally ill people for ten years, sees the formation of strong social connections as central to his work. Christensen

stresses the importance of building relationships with people living at the margins of society over and above issuing diagnoses, creating treatment plans or dispensing medication. “At the risk of sounding blasphemous in this era of evidence-based medicine, [meaningful outreach work] is not solely about measurable clinical outcomes” (2009, p. 1034), argues Christensen.

According to Christensen, his team does not aim to discuss treatment plans when they meet people on the streets. “We provide food, water, and clothing, offer a shelter bed and, above all else, listen deeply.” According to the psychiatrist the sole outcome he has in mind is that individuals are receptive to a conversation next time he meets them. Christensen relies on an anecdote from his early days doing outreach work to explain how this turnaround in his thinking was effected.

On one of our team’s initial forays years ago we made contact with a woman living on the street who was floridly psychotic, filthy from head-to-toe, malodorous, and fairly agitated. After telling her who I was, and what I did, she totally and completely ignored me. Staring off into the distance, she pressed on with a monologue that made sense only to her. I remember being flustered because I was unable to interrupt or otherwise get her attention. Looking for any hook to engage her, I said something along the lines of, “You know, Ms. Virginia, I could give you medications that would make you feel better.” At that moment, she stopped her psychotic soliloquy in mid-sentence, looked me full in the eyes, and replied, “Hmmm . . . Ya’ think? Well, I think giving me medication would make you feel better, but it sure as hell won’t make me feel better!”

Those who have become estranged from society, noted Christensen, often become suspicious and distrustful. One might suppose that a skepticism about the motivations of others would be something of a natural response in people who have been marginalized and discarded by their society, but that this response also results in a vicious circle, such that their wariness keeps people with SPMI at a distance from available caring

communities. Although relatively few ACT clients were homeless, comments such as “she keeps telling us to get lost, like most of our clients” as uttered by Stephanie in one team meeting, suggest that at least some of those served by the team were unreceptive to visits.<sup>21</sup> Likely it is true that merely connecting with such individuals, gaining their trust and as Christensen puts it, “the promotion of a reconnection to a community of welcoming compassion and overt caring,” stands to be the most important service a caregiver could provide.

As Christensen’s notes, ‘listening deeply’ is essential for building such relationships, and I would suggest that what needs to be listened for is the story of the person one encounters. For, mandated as they are to come to know their clients well over an extended period of time, ACT team members are well-positioned to spare the marginalized and forgotten people with whom they work “the terror of being deprived an any story whatsoever” (Crapanzano, cited in Lovell, 1997, p. 364). It is mainly within the framework of a narrative conception of the self that such a deprivation can be understood as a terror. Various thinkers (Baldwin, 2005, MacIntyre, 2007, Taylor, 1989), hold that we are essentially narrative beings in that our sense of self is contingent upon the stories we tell of ourselves. Given such a view, Baldwin (2005) argues that mental health care practitioners are implicitly entrusted with the co-authorship of patients’ narratives, given that SPMI often leads to fractured and incoherent stories of the self. Excavating a client’s story then, and sharing it with him on his own terms is to help him find himself. This

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<sup>21</sup> During a ride along with Guy, I witnessed a client who wordlessly came to the door, extended her hand for medication but otherwise refused any further form of interaction. As we returned to the car, Guy informed me that this behavior was fairly typical for this particular woman.

position of trust, argues Baldwin, entails a certain onus to help patients re-establish both narrative integrity and narrative agency, while also resisting the imposition of master narratives upon clients' stories (p. 1024). In other words, it is important to help clients to make sense of their lives in a way that coheres with their own conception of meaning.

There are at least two ways in which the narrative of progress works against the kind of project of reconstruction recommended by Baldwin, however. Firstly, there appears to be an implicit injunction against exploring the content of patients' delusions and the meaning such fictions hold for clients. That is, the narrative of progress interferes with a careful mapping of the world of someone who experiences psychosis due to the concomitant biomedical discourse that construes delusions as the mere signifiers of a diseased brain. On this view, progress demands the elimination of such aberrant neural processes rather than representing beliefs and utterances that one might seek to understand, or even engage with.

As I noted earlier, the content of delusions and their meaning from the perspective of patients was rarely a focal point of discussion in team meetings. A brief joking exchange among team members helps to bring to light the taboo against participating in a patients' delusions. Sophie, who was particularly difficult-to-place at the time, had recently gotten two offers for housing. In a quick aside during the meeting, Trevor joked that perhaps the team ought to connect the offers with the fact that the client accepted medication the day before.

Trevor: You know, look you took your IM yesterday. It's magical.

Peggy: [laughing] That is evil! Delete that! [to me].

Peggy's animated outburst in response to Trevor's suggestion along with her comments and laughter helped to fully reveal the impropriety of his comment. Although the coerciveness of such an act would account for the taboo against it, a reluctance to engage in a client's delusionary schemes may also be at play here. According to one study in fact, patients with psychosis will often try to discuss their symptoms. Psychiatrists however, mostly hesitated in their responses, laughed, or answered patients questions with a question rather than engaging with patients' concerns (McCabe et al, 2002, p. 1148). As Bracken and Thomas point out, health practitioners who might be tempted to participate in their clients' delusions stand to be "accused of colluding with madness" and that the reluctance they show "may be institutional ... the professional view is that it is unhelpful to dwell on psychotic material" (2005, p. 58).<sup>22</sup>

Yet resisting these aspects of a client's story can create isolation and loneliness for a client. As Louise Penbrooke, who suffers from delusions, says about friends who pick invisible hissing snakes off her body for her

It helped that someone believed me. Someone was taking me seriously enough and doing something. It did not necessarily help the snakes disappear, but I did not feel totally alone (Penbrooke, cited Bracken and Thomas, 2005, p. 58).

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<sup>22</sup> This was not always the case. In *Madness and Civilization*, Foucault describes a treatment for a man with the delusion that he was dead and who would therefore not eat. Various individuals painted their faces to make themselves appear pale and dead, and ate dinner at his bedside in order to convince the man that the dead do, in fact, eat. From Foucault's account, they successfully persuaded the patient to share in their dinner (1961/1988, p. 188).

For someone who experiences psychosis, moreover, the content of her delusions cannot help but factor into her story and thereby become an essential part of her identity. Hence ignoring such experiences and what they mean to an individual limits one's ability to arrive at a rich understanding of another person.

Moreover, the work of anthropologists such as Lovell and Alex Cohen (2001) suggests that exploring the content of delusions is important to understanding the personhood of a someone who experiences psychosis. Cohen, for example, suggests that one can see delusions "as fictions representing behaviour by which individuals sought to infuse their lives with meaning and to present positive images of themselves and others" (p. 292). Delusions of grandeur, then for instance, are best understood against a backdrop of boredom, brutality, disenfranchisement and marginalization and are tactics for achieving that same sense of self-worth that so many people crave. Cohen's work helps to demonstrate how being aware of an individual's particular delusions can help us to recognize his basic humanity, and thereby identify him. Meanwhile, as we saw earlier, Lovell similarly sees delusions suffusing an otherwise banal existence with meaning, but her work brings out the importance of understanding and responding appropriately to differences we encounter in the Other while cautioning us not to reduce him to "sameness."

If one truly hopes to achieve an understanding of a person who experiences psychosis, the perspective that Lovell calls for is a "hermeneutic" approach that appreciates the intricately connecting symbolic parts of Rod's experience, and which neither imposes a temporal framework onto his story nor deprives him of his narrative

agency. According to Baldwin, moreover, “chronologically fragmented stories or repetitions of stories by a person with mental illness may be understood as unaddressed, misunderstood, reoccurring meaning rather than simply the result of the impact of impairment” (2005, p. 1026). One might then supplement Lovell’s recommendations with Baldwin’s notion of “narrative quilting” whereby stories are joined together to “build up a narrative map both with and for the person with severe mental illness, a map that may have little immediate meaning or use for that individual, but which is essential for us in understanding the landscape of that person’s experience.”

The second way in which the emphasis on objective and quantifiable markers of progress in clients bars this rich comprehensive understanding of the Other’s story is in virtue of the narrow focus evident in meetings. For, in such discussions workers persistently zeroed in on clients while bracketing their own responses out of the discursive field. As Baldwin argues, providers of psychiatric care “have a tendency to approach people with severe mental illness, because of their vulnerability and dependence, as recipients of our care, service and narrative constructions rather than contributors to our own narrative constructions” (p. 1027). The discussions of Tom relayed at the beginning of this chapter were unique in that workers were permitted, perhaps even encouraged, to reflect on the manner in which Tom impacted their own lives and what meaning his life may have had more broadly speaking. It is just such an attitude, that, according to Baldwin, is necessary to preserve a client’s narrative agency. This is because in his view, “narrative ethics involves reciprocal claims that bind together listener and teller in a relationship in which both find fulfillment.”

Achieving this state of reciprocity requires listeners of a narrative to open themselves up to, and become aware of, the manner in which a client's story impacts their own self-narrative, or shows them, as listeners, something about their own lives. For instance, Christensen's story above effectively demonstrates this openness. The client he describes, and his interaction with her, has become an intrinsic component of his own story. The client not only appeared to teach Christensen a certain amount of humility, as perhaps Tom did to ACT workers when they learned he really was friends with the mayor, but Christensen's encounter was also a formative experience that would shape his view of the world, and his practise for years to come.

### **Living Eulogies**

As I indicated early on in this chapter, assuming the attitude of a eulogizer is what stands to bring about this sense of openness to which Baldwin hearkens, and perhaps from there, onto greater appreciation of the relationships formed with clients. A good eulogy does more than provide a flattering picture of a person's life; it describes what was meaningful to a particular person, what was meaningful about his life, while also remarking upon both his struggles and accomplishments. Most importantly, however, eulogies function as a mutual exploration and public testament to the manner in which a person's existence impacted the lives of those gathered to share these stories. A good eulogy tells us why we should care that a particular individual once lived. Hence, assuming such an attitude towards the living will tend to cultivate care for the person so described.



A break from the relentless therapeutic focus in meetings, however, would be necessary for this sort of perspective to gain traction. That is, there would need to be room simply to reflect on a client's personhood above and beyond any instrumental focus, so that workers might share in the pleasure of an ever deepening collective understanding of the people with whom they engage. They would also need to take time to reflect together upon the manner in which their clients and they themselves have, in concert, changed over time. Encouraging workers to acknowledge the meaning that particular clients' lives hold for them in the semi-public setting of the team meeting could perhaps help to further combat the sense that some workers harbour, which is that the lives they work so hard to preserve are meaningless existences. For there is no better evidence for the conclusion that clients lead valuable lives than a first-hand recognition of the impact they have had on one's own life, while also hearing about the meaningfulness of clients' stories for other members of one's team.

As this chapter comes to a close, I would like to call to mind how in Chapter One I demonstrated how reified productive, administrative or scientific systems, and their associated values – which include objectivity, quantification, efficiency and economism, and replication, prediction and control – structures the provision of professional care in ways that is detrimental to human relatedness. So far, in this last section of the present chapter, I have shown how the value placed upon objective and quantifiable data serves to structure ACT work in ways that are detrimental to workers, and possibly clients. I have argued that giving ACT workers even more latitude and discretionary time than they are currently allowed would make for a more ethical working environment.

In my next chapter I shall return to the themes of reification, economism and efficiency and standardization in healthcare. This is because I will be looking at a growing trend now underway that could entrench these values more deeply into the ACT work, while the ACT model may well be in the process of becoming reified. This trend raises the disturbing possibility that the relational values that make ACT work morally distinctive will succumb to rationalistic priorities over time. Once again the spectre of Agamemnon will be raised to remind readers of the potentiality of workers inured to the Face of the suffering Other.

## **Chapter Six**

### **From Fidelity to Persons to Program Fidelity: Future Directions for ACT**

*“Having them in my life has kept me out of hospital ... if you did not have all those appointments and rules and regulations you’d probably be hanging yourself with a rope and getting in hospital.”*

~ACT client, cited in McCall and Wakefield, 2012, p.33

As I noted in Chapter Four, Christensen, a street-based psychiatrist, has argued that fidelity ought to figure as a prominent value in community psychiatry. Certainly, members of the Sunnydale ACT team demonstrated this value through their willingness to stand by persons abandoned by society so as to advocate for them, offer ongoing support and to patiently attend to minute changes seen in clients over time. However, while Christensen and others stress the importance of fidelity to persons, fidelity to an abstract model of ACT is seeing far greater play in the clinical literature of late. The fact that this model was designed primarily to guarantee cost-savings achieved by early ACT teams, only underscores the inappropriate colonization of a concept that many might otherwise presume signifies a particularly caring type of outreach work.

According to researchers the second kind of fidelity can be measured using scales. The most established fidelity scale is the Dartmouth ACT scale (DACTS), and a second up-and-coming construct is the Tool for Measuring ACT (TMACT). Although fidelity scales have been developed to quantify elements of ACT most closely correlated with cost savings from decreased hospital use, they fail to capture the importance of relational values that originators saw as central to their project. TMACT also encourages

standardization, while its designers also promote the scale as means of streamlining the ACT model. Hence, we may be witnessing the reification of ACT with the values of objectivity, quantifiability, economics and efficiency and standardization all coming to bear upon the emerging model. In this chapter I shall argue if ACT becomes thoroughly reified along such lines, some of the moral qualities described in the previous chapter are at risk of being eroded. Currently, ACT work in Ontario, the site of the Sunnydale hospital, is not closely monitored by funding agencies, at least not using the kinds of fidelity scales which I shall be describing shortly (Randall et al, 2012).<sup>1</sup> Given the potential to lose morally important aspects of ACT work, the introduction of fidelity scales is a trend that should make practitioners, clients and proponents of care-based ethics wary.

In my first section I will show that ACT has largely been understood as a tool to effect predictable decreases in hospital use. In Section II I describe fidelity scales and show how criteria has been selected for based on ACT's functional role in achieving these cost-savings. In Section III I note that current sets of criteria do not necessarily correlate with the kinds of improvements in patients' lives that might alleviate workers' empathetic suffering, and may even undercut some of morally valuable aspects of the work I remarked upon in Chapter Five. Finally, in Section IV I argue that if fidelity scales are used to produce a leaner, more streamlined program, we risk seeing work structured in ways that inure caregivers to clients' suffering. Overall then, in this chapter we shall

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<sup>1</sup> I shall describe Ontario assessment practices in more detail on p. 310-311, along with the current push to employ more stringent quantitative assessment tools to insure that programs comply with program standards, and thereby achieve predictable outcomes.

see the theory presented in Chapter One, the moral arguments from Chapter Three and my moral ethnography of ACT converge to warn against a potentially bleak future for the program.

## **I. The Trajectory from Non-Conformism to Status Quo**

In Chapter Four we saw that the creators of ACT – a program now described as “the Cadillac” of community mental health programs by Stephanie – once saw themselves as going against the grain and upsetting conventional approaches to psychiatric treatment. Meanwhile they report they were striving primarily to help patients “to achieve a stable life of decent quality and to become involved in activities that promote meaningful community living” (Stein and Santos, 1996, p. 1). The value placed upon fidelity to clients, in so far as this amounts to efforts to connect with disenfranchised people, the commitment to folding them into a supportive community certainly strengthens conceptions of ACT work as an morally worthwhile enterprise.

It is not clear, however, that the ethical dimensions of ACT work account for the increasingly widespread adoption of the program. For, while Stein and Santos may have been motivated by humanistic concerns in the development of their treatment model, they were by no means naïve idealists. Rather, given that ACT had been presented to administrators as a way to save money since day one, they showed themselves to be savvy enough to understand that their program needed not only moral justification, but that it also had to be efficacious and economical.

To demonstrate the former, ACT originators conducted randomly controlled studies comparing outcomes for ACT clients versus a control group of patients with equally severe symptoms. As Brodwin notes, ACT was taking root around the same time the DSM III was published, and in which illnesses were clearly defined and discretely catalogued for the purposes of research and treatment.

The academic clinicians who scaled up ACT applied the same logic [evident in the DSM] of standardization and verification to mental health services. They measured outcomes in a way that invited further refinement, with validated instruments that quantified community adjustment, self-esteem, family burden, etc. With these outcome measures in hand, researchers across the country could replicate the program and test it against other treatments (Brodwin, 2010, p. 135).

Meanwhile, a cost-benefit study was undertaken to demonstrate that ACT was not any more costly than whatever care was being provided to psychiatric patients at the time. The financial study was undertaken since, as the researchers note, even in the event of positive outcomes, they expected to hear “it all sounds so well and good, but aren’t the costs prohibitive?” (p. 22). In spite of any such concerns, ACT was determined to be a cost effective treatment, with savings achieved by virtue of reduced hospital stays. As the originators of ACT note

The hospital is the most expensive cost center in mental health budgets. The cost-effectiveness of the ACT model is directly linked to its ability to reduce hospital use; therefore, using the hospital as efficiently as possible is a major objective of the ACT program. These outcomes are consistent with the goals of modern health-care administrators because the cost of inpatient treatments has become prohibitive (Stein and Santos, 1996, p. 53).

Stein and Santos' stated aims for ACT were to reduce patients' symptoms and subjective distress, increase community tenure, increase levels of satisfaction with life and improve their psychosocial functioning. As the authors note, however, "some of these outcomes are easier to measure than others. For example, community tenure is reflected both by a reduced number of hospitalizations and shortened lengths of hospital stay ... it is not surprising that community tenure is the one outcome domain most consistently reported by ACT programs as a measure of their success" (p. 135).<sup>2</sup>

Decreased hospital admissions, in fact, typically tops the list of notable outcomes for ACT cited in the literature. Since its inception, ACT has become the most researched community mental health program such that even in 1998, there were more than 40 empirical studies in the literature (Drake, 1998, p. 173). Apart from a voluminous number of randomized controlled studies, there are also numerous literature reviews or meta-analyses, which further help to demonstrate a keen interest in the program. There is also reason to suppose that economic outcomes have a higher priority than clinical ones. For instance, one well-cited review is a cost-benefit analysis of ACT achieved in virtue of reductions in hospital use (Latimer, 1999).<sup>3</sup>

Moreover, Bond et al identified 14 reviews that had been conducted before 2001 all of which agreed that the most robust outcome for ACT studies was reduced hospital admissions. After conducting their own analysis of 25 randomly controlled studies, Bond et al note "in agreement with most other reviews, we conclude that ACT substantially

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<sup>2</sup> In other words, long or frequent hospitalizations may well jeopardize clients' living situations, so that decreasing hospital admissions could mean fewer evictions for instance.

<sup>3</sup> Google Scholar shows 138 citations of the article, and Web of Knowledge shows 67.

reduces psychiatric hospital use, increases housing stability and moderately improves symptoms and subjective quality of life, but has little impact on social functioning” (2001, p. 149). However, the authors of an earlier review note “we are unable to draw conclusions about effects such as quality of life, family well-being, and involvement with the criminal justice system in part because these outcomes have been less studied and also because the few studies that have examined these domains have produced conflicting results” (Scott and Dixon, 1995, p, 663 – 664).

The fact that there have been fewer studies looking at these domains suggests that these factors hold less significance for researchers than economic outcomes. However sparseness of evidence has done little to deter recommendations to implement the program more broadly. For example, reviewers of the oft cited Cochrane report<sup>4</sup> recommended wide-scale implementation of ACT in the US, noting

ACT is an effective way of caring for severely mentally ill people in the community. It maintains contact with severely mentally ill people, dramatically reduces the use of in-patient care, and improves some aspects of outcome ... Policy makers, clinicians and consumers should therefore encourage the setting up of ACT teams.

Nevertheless, the authors also note that “there was no significant difference between ACT and traditional case management on imprisonment, mental state, social functioning and self-esteem” (Marshall and Lockwood, 2011) an observation that does not seem to have undercut interest in the program worldwide.

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<sup>4</sup> Google Scholar shows 512 citations in the literature.



Due in part to ringing endorsements such as the Cochran Review,<sup>5</sup> within 20 years of its inception, ACT had been adopted in over 30 US states (Drake, 1998). It has also been adopted or trialed in various countries including Denmark (Aagaard and Müller-Nielsen, 2011) the Netherlands (Systema et al, 2007), and Japan (Nishio et al, 2012), Germany (Karow et al, 2012) and New Zealand (Abas et al, 2003). Meanwhile, Canada (Lafave et al, 1996), Australia and Sweden (Philips et al, 2001), and the UK (Hussain et al, 2011) have more established programs. Part of the appeal of ACT is that it is now broadly recognized as “evidence-based practise” (Munroe-DeVita et al, 2012, p. 743). However, the evidence in ‘evidence-based’ is not a replicable decrease in disease or disability due to a given treatment, but is rather a reduction in the consumption of hospital resources due to a particular program structure. In other words, the program’s primary site of action, as demonstrated in the literature, appears to be healthcare budgets rather than mental illness. The fact that patients are not necessarily getting much better, living better lives or staying out of jail is seemingly insignificant so long as their care is costing less.

## **II. From fidelity to clients to program fidelity**

In some ways, moreover, it may be that ACT falls victim to its own success. This is because as it enters into mainstream practice, researchers become increasingly bent on devising ways to guarantee the program’s original outcomes. The way to do this, it would

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<sup>5</sup> The first Cochrane review was published in 1998 by the Cochrane Collaboration, an independent, non-profit organization that conducts systematic reviews of the literature as part of its activities. The initial 1998 review was often cited in earlier literature in support of the efficacy of ACT. The updated 2011 version is cited here.

appear, is by insisting on program fidelity, which amounts to a standardized model of ACT work that places reduced hospital use at the pinnacle of the program.

Program fidelity refers to methods employed to structure teams in a way that guarantees the earliest successes of the Madison ACT teams. As I have shown, however, such successes largely amount to cost savings. Meanwhile program fidelity is explicitly correlated with reduced hospitalizations. Hence, it is not surprising that the concept of fidelity and the scales used to achieve it have seen much discussion in the literature these days (Monroe-DeVita et al, 2012, Monroe-DeVita et al, 2011, Harvey et al, 2012, Kidd et al, 2010).

### **The Development of Fidelity Scales: Standardizing the Program Structure**

Initially, calls for ways to measure program fidelity were driven by the requirements of comparison-based research. It is very difficult to assess ACT in relation to other kinds of programs if a researcher cannot say whether all ACT teams studied are relevantly similar. As reviewers Marshall and Lockland note

From the point of view of this review, an obvious direction for future research is to find a more systematic way of classifying ACT and case management trials. The way forward is likely to be through the application of a validated ACT fidelity scale ... it remains a long-term aim of the reviewers to base our classification of ACT and case management trials on some form of fidelity scale (Marshall and Lockwood, 1998).

Fidelity scales, however, were already in the works in the mid 1990's but were not merely generated to meet the need to replicate findings and permit comparisons across programs. Researchers' needs for a scientifically valid, i.e. replicable, construct coalesces

with funders' needs for predictable economic outcomes. As some researchers note, the scales developed are also useful in assisting "funding organizations in determining if they are receiving value" (Randall, et al., 2012, p. 138).

Given the emphasis placed on economic outcomes as evidenced by the preoccupation with reduced hospital use, it is possible to see fidelity scales as also representing something of a value for money (VFM) form of audit as opposed to merely representing a tool to assess the quality of particular programs. As Michael Power notes,

VFM demands that effectiveness be quantifiable. It does this by standardising measures of effectiveness (on the one hand) and/or by reducing effectiveness to standardisable measures of economy and efficiency. Either way, there is a necessary drift towards 'managing by numbers' which enables a drift towards centralised forms of control and the displacement of concerns about good policy by concerns about good management. Where the measurement and attribution of outputs from a service are ambiguous, or the preserve of the service expert, there is a tendency to concentrate upon inputs. For example, in the case of child care it may be that social workers themselves are unable to agree about whether fostering or residential care is most effective in nurturing the balanced development of children. In this case, it is natural to focus on unambiguous measures of input, primarily cost. It follows that efficiency in this context may come to be seen in terms of cost saving for existing levels of service provision rather than an improved relationship between inputs and outputs, which in industrial contexts represents productivity (Power, 26 - 27).

This type of assessment tool aids funders because the criteria selected for in assessing the structure of a high fidelity ACT team are those features most closely correlated with reduced hospital use. In fact, in one of the earliest studies aiming at isolating the critical ingredients of ACT teams, reduced hospital use was the only outcome examined in relation to characteristics deemed essential for a paradigmatic ACT team. What is interesting is how easily the authors slide from notion of community

integration, the stated purpose of ACT, to reduced hospital use when they explain that “the effect size of reduction in number of days hospitalized was used as a measure of program impact. This criterion is appropriate in that it is central to the mission of ACT programs” (McGrew et al, 1994 p. 674).

While McGrew et al’s study showed a correlation between certain characteristics and reduced admissions, Latimer et al note that more generally “higher-fidelity programs appear to reduce hospital days by about 23 percentage points more than lower-fidelity programs” (Latimer, 1999, p. 443). Informed by the work of McGrew et al, another group of researchers started work on DACTS. Teague et al consulted with experts and also looked to the early Madison teams to contribute to their development of exemplary model of the program (Teague et al, 1998, p. 219). Shortly thereafter, DACTS in particular was found to correlate positively with reduced hospital use (McHugo et al, 1999). Soon, DACTS became a standard measurement of ACT, at least for the purposes of research (Philips et al, 2001). Effectively, then the paradigm that prioritizes economic outcomes is in the process of crystallizing into a reified model of ACT by virtue of fidelity scales that both inform those establishing new teams and are used to evaluate existing ones.

### **DACTS Items: Quantifying Program Elements**

The 26 point scale features the three areas with which to test a program’s fidelity. These areas are team structure and composition, organizational boundaries, and nature of services (Teague et al, 1998, p. 218). The first area specifies the staff-to-client ratio, and

includes criteria such as a daily meeting, a nurse on staff, etc... The second area includes the requirement that ACT workers be involved with hospital admissions and discharge planning, while also specifying careful client screening, as well low intake rates, 24-hour coverage and time-unlimited services among others. Criteria in the third area includes offering services in-vivo, assertive engagement systems, high numbers of contacts, and having peer support workers (consumer survivors) on the team.

Table 1  
PROGRAM CRITERIA FOR FIDELITY TO ACT

<b>HUMAN RESOURCES: STRUCTURE/ COMPOSITION</b>	
H1. Small Caseload: client/provider ratio of 10:1.	O5. Responsibility for Hospital Admissions: program is involved in hospital admissions.
H2. Team Approach: provider group functions as team rather than individual practitioners; clinicians know & work with all clients.	O6. Responsibility for Hospital Discharge Planning: program is involved in planning hospital discharges.
H3. Program Meeting: program meets frequently to plan, review services for each client.	O7. Time-Unlimited Services: program closes no cases, remains point-of-contact for all clients as needed.
H4. Practicing Team Leader: supervisor of front-line clinicians provides direct services.	<b>NATURE OF SERVICES</b>
H5. Continuity of Staffing: program maintains same staffing over time.	S1. In-Vivo Services: program monitors status, develops community living skills in community rather than office.
H6. Staff Capacity: program operates at full staffing.	S2. No Dropout Policy: program engages/ retains clients at mutually satisfactory level.
H7. Psychiatrist on Staff: at least one full-time psychiatrist per 100 clients assigned to program.	S3. Assertive Engagement Mechanisms: uses street outreach, plus legal mechanisms (e.g., representative payees, probation/parole, OP commitment) as indicated.
H8. Nurse on Staff: $\geq 2$ full-time nurses per 100 clients.	S4. Intensity of Service: high total amount of service time, as needed.
H9. Substance Abuse Specialist on Staff: $\geq 2$ staff with 1 yr training/clinical exp. in substance abuse treatment.	S5. Frequency of Contact: high number of service contacts, as needed.
H10. Vocational Specialist on Staff: $\geq 1$ staff member with $\geq 1$ yr training/exp. in vocational rehab/support.	S6. Work With Support System: with or without client present, program provides support/skills for client's support network: family, landlords, employers.
H11. Program Size: sufficient absolute size to provide consistently the necessary staff diversity & coverage. (Data on this variable not collected in current study.)	S7. Individualized Substance Abuse Treatment: $\geq 1$ program member provides direct treatment & substance abuse treatment for clients w/substance use disorders.
<b>ORGANIZATIONAL BOUNDARIES</b>	S8. Dual Disorder Treatment Groups: group modalities used as tx strategy for people w/substance disorders.
O1. Explicit Admission Criteria: clearly identified mission to serve particular population; measurable, operationally defined criteria to screen out inappropriate referrals.	S9. Dual Disorders Model: uses a stage-wise treatment model that is nonconfrontational, follows behavioral principles, considers interactions of mental illness & substance abuse, & has gradual expectations of abstinence.
O2. Intake Rate: takes clients in at a low rate to maintain a stable service environment.	S10. Role of Consumers on Treatment Team: clients involved as team members providing direct services. (Data on this variable not collected in current study.)
O3. Full Responsibility for Treatment Services: as well as case management/psychiatric services, program directly provides counseling/psychotherapy, housing support, substance abuse, employment, & rehab services.	
O4. Responsibility for Crisis Services: 24-hour coverage of psychiatric crises.	

(Teague et al, 1998, p. 218).

Teams can achieve a maximum score of 5 with the Dartmouth scale, so that high fidelity ACT teams score 3.8 and above, while traditional case management will receive a score of around 2.3 (Teague et al, 1998, p. 226).

### **Towards a Reified Model of ACT**

It is fairly obvious how items such as frequent client contacts (S5) and 24 hour crisis support (O4) will tend to reduce hospital use. Not only are clients under regular surveillance for relapse, but trips to the ER are likely to plummet if members of the team are on hand to respond to outbreaks of havoc that might occur day or night. Being involved in discharge planning (O6), moreover, stands to reduce time patients spend in hospital since inpatient staff would likely be more inclined to release patients earlier if they are in the hands of a team of 10 or more professional caregivers. It is perhaps less obvious how explicit intake criteria (O1) might have economic consequences. However, as Eric Latimer notes for ACT programs to break even, clients must typically be those who are hospitalized for 50 days per year or more. Reducing admissions for clients with fewer inpatient days becomes less cost-effective relative to the costs of implementing ACT programs (Latimer, 1999). This finding most likely informs Lockwood and Marshall's observation that "ACT, if correctly targeted on high users of in-patient care, can substantially reduce the costs of hospital care whilst improving outcome and patient satisfaction" (2011).

Therefore, the model itself is coming to be shaped and delineated in accordance with administrative concerns so that those aspects of ACT most closely correlated to

lower rates of hospital use are codified so as to emerge as central defining features of the model. Generally speaking, however, DACTS only captures elements that can be observed objectively and tallied up in a straightforward manner. Hence, it is evident that both the bureaucrat's and the scientist's need for objective and quantifiable data are influencing the structure of the program being communicated in the literature.

As quantifiable elements of the program move into the foreground, however, what recedes from on this model are the relational values associated with ACT. For example, DACTS provides no way of assessing the quality of the "trusting relationship" that Stein and Santos see as so crucial for ACT work and "a vehicle for change in and of itself" (1998, p.50). Personal traits that Stein and Santos note are key for good team members such as "patience, empathy, optimism, persuasiveness, pragmatism, flexibility, good judgement and "street smarts" (p. 55) cannot be measured and fall to the wayside. The authors also note that ACT teams should aim to recruit workers who show "a high level of commitment to clients and their families to ameliorating their problems" (p. 132). Otherwise, the team should have a "close team spirit." Given DACTS emphasis on operational and quantifiable outcomes, however, none of these elements are captured by the scale.

### **TMACT: Standardized Interactions**

The creators of TMACTS, an up-and-coming assessment tool, see their product as superior to DACTS because further aspects of the ACT work are made measurable. DACTS items, as we have seen, mainly refer to the structure and composition of the ACT

team rather than assessing “processes (e.g., interactions, procedures)” (Monroe DeVita et al, 2011, p. 19). Hence, while DACTS might be useful in assessing the set-up of a team, it has less utility for evaluating *how* the team interacts with clients. TMACT seeks to rectify this oversight by including subscales for evidence based practices. Monroe et al proceed to cite the 2009 Schizophrenia Patient Outcomes Research Team (PORT) review to provide examples of suitable evidence based practices for ACT teams (Dixon, et al, 2010). The PORT recommendations provide a list of evidence based practices found efficacious for people diagnosed with SMPI, such as cognitive behavioural therapy (CBT), skills training, supported employment, family-based therapy, use of a token economy (in long-term inpatient care) and psychosocial interventions for alcohol and drug abuse as well as weight loss.

The drive to create a standardized program, it would appear, begets yet further standardization so as to encroach upon work extending all the way down to the ground floor level of interactions taking place between workers and clients. Including subscales for evidence based practices, moreover should appear quite natural to the developers of TMACT given administrators’ preferences for standard processes with guaranteed outcomes. As noted in Chapter One, what evidence based practices have in common is they have demonstrated statistical efficacy on given measures as shown through the use of RCT’s. Apart from promising predictable outcomes, such procedures are also ideal for producing the objective assessments favored by the RTS paradigm. As Power notes regarding assessment tools

What is audited is whether there is a system which embodies standards and the standards of performance themselves are shaped by the need to be



auditable. In this way, the existence of a system is more significant for audit purposes than what the system is; audit becomes a formal 'loop' by which the system observes itself (Power, 1997, p. 28).

Given that evidence based practices are routinized standard interventions, observing whether or not such processes are being carried out by an ACT team is a fairly straightforward affair requiring either the observation of work in the field, or as seems more likely the case, an analysis of documentation produced by workers demonstrating that prescribed interventions were enacted.

Another reason TMACT is seen as a superior assessment tool by Monroe-DeVita et al, moreover, is because it expands upon certain items and operationalizes them further so as to “create more explicit instructions to minimize rater subjectivity” (2011, p. 20). The creators of TMACT, moreover, are not only interested in assessing the quality of interaction between workers and clients this way, they also zero in on interactions between team members by operationalizing the team meeting for assessment purposes. Unlike DACTS, then, which only assesses whether a daily meeting occurs, with TMACT, the team meeting is assessed for ‘quality’ in virtue of being broken down into distinct quantifiable elements which are

the review of all consumers each day, documentation of relevant clinical information, and development of a daily schedule that is driven by the consumer’s treatment plan, emerging needs (e.g., crises, or medical appointments) and proactive contacts to divert future crises. Also assessed is a mechanism to determine whether scheduled contacts were completed (2011, p. 20).

While the requirement to produce objective and quantifiable data determines the selection of elements worthy of assessing here, the drive for efficiency appears to be shaping this

manner of assessing the team meeting. That is, the most rationalistic and business-like aspects of the team meeting, namely those tasks lending to the most effective management of clients, are those which are emphasized in this item of TMACTS. Just as the evidence based practices subscale on TMACT potentially moves ACT teams towards more standardized interventions, managerial concerns are also likely to encroach further upon the space of the daily meeting due to the expansion of this item.

In light of the relationship between fidelity scales and economic outcomes, there is reason to suppose that these will become a tool that funding bodies use to assess teams. However, such a change has yet to happen. Currently, for instance, ACT teams like the Ontario-based Sunnydale Hospital team are not assessed using such instruments.<sup>6</sup> According to Randall et al, in fact, the most current set of standards that apply to the Sunnydale team are

written in narrative fashion and lacked details regarding: (1) the identification of individual standards by number; (2) whether or not all standards are of equal importance or weight; (3) standardized measurement scales to use to assess fidelity to standards; and, (4) expected (or acceptable) levels of compliance for each standards (2012, p. 139).

Meanwhile, the researchers note that ACT teams are not required to report annually to the provincial government, while the data that teams do submit “only superficially collects information related to the fidelity to some individual program standards” (p. 147). Hence, funding of the Sunnydale team is currently not contingent on complying with such standards.

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<sup>6</sup> The only external evaluation Sunnydale Hospital currently sees is a hospital accreditation process requires to retain a special level of ranking among hospitals by maintaining a set of standards across the institution. Funding for operations however, relies on the reporting of statistics to the Provincial Ministry of Health.

However, in response to this perceived failure to monitor teams “more aggressively” the researchers themselves developed *The Ontario ACT Program Fidelity Tool*<sup>®</sup>, which is a 33 point fidelity scale similar to DACTS, and derived from the “narrative document” (p. 140).<sup>7</sup> Recently, moreover, DACTS itself was employed by another set of researchers to assess all 79 of the ACT teams currently operating in Ontario (George et al, 2010). Given that DACTS scores are now routinely reported in ACT research literature and in light of calls from researchers for more rigorous attention to fidelity, there is reason to suppose that more quantitative forms of assessment are in the pipeline for Ontario ACT teams. However, as I will show, there are reasons to be wary of any such trends.

### **III. Assessing the Assessment Tools: Beyond the RTS Paradigm**

It is evident that the fidelity scales described align well with the RTS paradigm’s suppositions about what matters and what constitutes evidence. As Power notes, moreover, many forms of audit involve a “displacement from first order experts, such as teachers, social workers, police and so on to second order experts, such as accountants and managers” (1994, p. 26). Given the emphasis on reduced hospital use as the predominant outcome measure, the creators of fidelity scales have had little need to consult those at the ground floor, or rely upon their special brand of knowledge as to what clients either need or what they are owed. Unsurprisingly, during their interviews

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<sup>7</sup> Randall and Wakefield’s instrument lacks the requirement that ACT workers play a role in hospital admissions and discharges, while adding items requiring internally produced program evaluations and fidelity assessments.

none of my informants pointed to the reduction of hospital admissions as the reason they entered the work.<sup>8</sup> Rather, many said they came to ACT work out of a desire to help better the lives of people who have been unjustly stigmatized and disenfranchised by society. Hence, the goals of practitioners in the field (not to mention those of clients) are likely to be at odds with the priorities set by funders.

### **A Dubious Measure of Success**

It is open to question whether fidelity scales can significantly improve the quality of patients' lives and in this way reduce the sense of futility practitioners experience in the course of their work. Although reduced hospitalizations and less homelessness are clear and unambiguous measures, these do not automatically translate into a markedly better life. As Estroff's work demonstrated, and my own observations confirm, the quality of housing offered to ACT clients does not seem to be a primary concern for policy-makers. That is, if what is assessed are percentages of patients housed over a particular period, then a measure for community tenure will be satisfied whether a client inhabits a bedbug-infested dwelling in an area rife with crack dealers or if she is housed in a clean, well-kept facility run by caring and dedicated workers.

Moreover, even those clients in supportive housing are not necessarily seeing any real integration into the community and may instead be largely experiencing the segregation, or separateness Estroff describes (Estroff, 1981). As one client recently put it

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<sup>8</sup> As my own research indicated, in fact, a major point of contention between other team members and the psychiatrists, and which from all reports frequently arose, stemmed from psychiatrists' reluctance to admit certain patients to hospital. Rose at one point even left a meeting in tears because doctors refused to hospitalize a homeless client whose condition she found particularly distressing.

“we all know we’re sick, so we’re sick and tired of sickness. I guess some of us get sick and tired of talking about it. If we could find somebody to socialize with who isn’t a patient, I believe that’s a breath of fresh air” (Krupa et al, 2005, p. 22). Hence, those difficult conditions that clients endure, and to which workers are helpless to do other than bear witness, do not stand to be significantly impacted by administrators’ unrelenting focus on reduced hospital use.

What is interesting, moreover, is Gomory’s suggestion that since hospital admissions were discouraged or even disallowed as a caregiving strategy in early ACT work, a decrease in admissions was largely accomplished by fiat rather than representing an independent clinical outcome. Gomory writes

reduced hospitalization is not the result of assertive community treatment but simply the tautological result of administrative decisions to treat all assertive community treatment patients in the community regardless of symptoms and their severity while patients in the control group are not subject to such a rule and are thus hospitalized frequently. If such an administrative rule were adopted for any other treatment approach, similar results would be obtained (Gomory, 2001, p. 1394).

If Gomory is right, the take-home message from ACT research is that hospital stays are not necessary for the maintenance of the population targeted by the program. Even if patients are not necessarily getting much better, they do not seem to be getting worse, and this can be achieved with less funding. The real problem, however, is that reduced time in hospital then becomes the *raison d’être* for ACT programs, so that programs that fail to show such outcomes become jeopardized.

In fact, currently in the UK there is a certain amount of debate concerning the value of ACT. This is due to the large, multisite REACT study demonstrating that ACT

was no better than traditional case management at reducing hospital use (Killaspy et al, 2006). Debates about the viability of the program help to demonstrate the importance of reduced hospital usage as a key indicator of ACT's success. In the aftermath of the REACT study, lead researcher Helen Killaspy noted

The problem for assertive community treatment in England is that reducing the use of inpatient services is seen as the main measure of success. This correlates with the cost of the service, but its great success in enabling staff to work with clients that community mental health care teams had failed to engage for years seems to be being ignored. The model is popular with staff working in assertive community treatment and with clients (Killaspy, 2007a, p. 312).

As it turns out, other research shows that “engagement” alone does not correlate with reduced hospital use (Meaden, et al, 2004), making its value difficult to articulate in terms the RTS paradigm can understand.

### **Standardized Responses to Clients' Call for Connectedness**

Although fidelity scales fail to capture the importance of interpersonal relatedness, clients understand its value. Currently, having someone “be there for me” is an outcome of ACT that research across multiple sites shows to be most meaningful for clients (Buck and Alexander, 2006, Hughes et al, 2006, Krupa et al, 2005). As one client puts it, one of the best qualities of his case manager is “his dedication to my wellness ... he's there for me when I need him” (Buck and Alexander, 2006, p. 477). Many clients, in fact, seem to yearn for more social interaction with their workers reporting to researchers for instance that “I wish she could spend a whole day with me. I'd like us to go out to lunch and go shopping.” Alternatively, another explained “I'd like him to take me out to eat to get a milkshake or something,” while a third finds it meaningful that his case

manager “takes me for breakfast. That’s something I’ve never had before” (Buck and Alexander, 2006, p. 476). The authors of this last study cash out such expressions as a longing for social inclusion and connectedness (p. 478) outcomes that it would appear, are valued highly by many clients.

Workers themselves, it would appear, also have a desire to respond to such calls for connectedness. As Beth said to me during her interview

I wish there was more client interaction, could have longer visits. Usually on a day I have roughly about 5 – 6 visits depending on if there is an appointment or not. It would be nice to spend a bit more time with the clients. To do other things, even to do impromptu visits. I wish there was more, I thought there would be more going out into the community and kind of, accompanying clients to different community centres and other services.

Gail also noted that the importance of such visits for building rapport

You really need to take the time [to go for coffee with a client] but it’s very rewarding. You learn so much from your client, you really engage well, you are able to build a better relationship, a better therapeutic relationship. The clients sees you as someone they can trust and talk to. So those kind of, those times are difficult to get. You need to get them when you can but they are invaluable to the relationship.

Both workers and clients here express a desire for the time and space for unstructured spontaneous forms of social interaction with their clients. If TMACT was adopted more broadly, workers would likely feel pressured to respond to such calls with standardized interventions. This is because teams that employ such methods garner higher scores on the TMACT. As the creators of TMACT themselves note, “feedback from fidelity measures can affect programs by focusing greater attention on features that are assessed” (Monroe-DeVita et al, 2011, p. 10). In addition, Powers argues, “systems-based audits can easily become a kind of ritual, concerned with process rather than

substance, and governed by a ‘compliance mentality’ which draws organisations away from their primary purpose” (Power, 1994, p. 16).

As Brodwin’s work demonstrates, often treatment initiatives take the form of questionnaires and checklists for use by clinicians. For example, when faced with a worker frustrated by a client’s lack of engagement, one supervisor Brodwin observed was handed over a document containing 29 “recovery questions” published by the Bureau of Community Mental Health (Brodwin, 2011, p. 199). The client interacting with a practitioner working off a predetermined set of questions may find the interaction impersonal and even alienating. As one community psychiatric nurse explains, “just going down a checklist of psychiatric and mental status assessment questions is de-humanizing and interferes with developing a therapeutic rapport. While the assessment is the task of the visit, the relationship is what matters to the patient” (Sturm, 2009, p. 20). As I have shown, a worker focussed on carrying out standardized tasks cannot always be present and responsive to the person with whom he is working.

It is perhaps such a mode of engagement that one client complained of when he said “why don’t they just hang loose and unbutton their tight collars, just treat you like you are having a sociable time, rather than I’m the staff and you’re the patient” (Krupa et al, 2005, p. 23). Yet, if the more formalized exchanges governed by the evidence based practices protocol produce documents that can be filed away as evidence to earn higher fidelity score on the TMACTS, then these are likely to dominate whatever brief intervals of time are allotted to individual clients. Workers in such cases may well experience a



distressing tension between their institutional obligations and what they feel they owe to clients.

As I noted in earlier chapters, standardized forms of treatment call for patient compliance, which in turn forces workers to assume an authoritative, and hence disciplinary role, which can also hinder the development of a trusting relationship. As Gail remarked during her interview, this role already interferes with the development of rapport.

If you are constantly with your client signing these forms, take these medications, it's not the kind of relationship I thought I would be building within a community setting. It's a very medical model relationship where you can see the power dynamics between yourself and your client. You're the one delivering the medication, you're the one asking to sign these forms. You need to do that but you don't want to become so authoritative.

Workers already require patients to comply both with standardized requirements of other agencies (forms) and ACT's own pharmaceutical regimens and hence must exert some level of control over clients' behaviour. Requiring patients to also participate in various types of rote procedures can only intensify the disciplinary nature of the relationship between worker and client

A final way that fidelity scales could serve to frustrate clients' and workers' desire for connectedness is in virtue of increased demands for paperwork, which means time away from clients. During her interview Beth brought to light the administrative duties that compete for time with clients

I know for any job you have to chart. But as a nurse you have to chart all the time. But their method, even the system is different. It's computerized, there's a lot of things to keep updated. There's the service plans ... there is a lot of documentation and charting and everything. Sometimes you forget. Like we have to change their cardex which is their blueprint. It's kind of

their snapshot: where they live, how old they are, what they look like, what meds they're on, how many times they've been hospitalized. So every time they're hospitalized you have to keep that updated. So yeah there's a lot of charting and faxing.

It would appear that the sort of biographical details that are prioritized by the institution are those required by disciplinary apparatuses to locate, identify, monitor and control individuals as opposed to those details that are more meaningful to both clients and workers. As Rose notes, this is simply part and parcel of working in a bureaucratic environment: "that's just the nature of being a regulated mental health professional and having to document your ass all the time." As Talia and Diane informed me ACT work requires far less paperwork than other organizations. However, a side effect of more intensive monitoring of team members' every move and the associated requirement for objective evidence in evaluations, could be an increase in work aimed at meeting administrative needs rather than those of clients themselves.

### **Encroachments on the Space to Meet, Laugh and Learn**

The creators of TMACT, as has been shown, are not merely satisfied with efforts to exert more control over work done in the field, but they also aim to operationalize the team meeting. As was evident in Chapter Four, discussion during the morning meeting is often influenced by the need for narratives of progress, and this tendency becomes all the more mandatory within the framework provided by TMACT. In the previous chapter I also suggested that the daily team meeting is about much more than a mere exchange of information and the straightforward management of clients. Regular quips help to ease

tension and build team cohesion, as do celebrations of small successes. Meanwhile collective expressions of indignation at injustices suffered by clients helped to mobilize advocacy measures. Frustrations and disappointments are also shared, creating opportunities for mutual support in the face of inevitable setbacks.

Finally, as my observations in the previous chapter demonstrate, sharing the most minute details of their clients' lives as workers do shows affinities to loving attention as endorsed by Murdoch. That is, we see workers demonstrating a willingness to reconceptualise a person to do her justice, as it were. Workers also cannot help but recognise a client's "me-ness" or her own unique affective dispositions, and particular tendencies in light of such attentiveness. Conversations in meetings where "world travelling" is evident moreover, can further reveal clients as multifaceted individuals, while all such factors may help to keep othering tendencies at bay.

If the team meeting becomes increasingly structured and determined by pressures to adhere to assessment protocol, invariably, what stands to get squeezed out are these relationally meaningful aspects of the meeting along with the non-therapeutic dimensions of the talk that lead to deeper, more nuanced and richer understanding of clients. Instead there is an explicit requirement to stick to "clinically relevant" data, scheduling and the containment of havoc or future "crises." Not only do TMACTS' detailed and explicit criteria fail to capture the elements mentioned above, but the model of ACT that is being constructed reinforces the conception of these other unsanctioned facets of meetings as being secondary to the *real* work of ACT, perhaps even to the extent that they come to represent an inappropriate use of time.

At the more general level, as workers' particular practices are increasingly monitored and scrutinized, it is possible to see some of the ill effects that Foner's alienated nursing home workers suffered. A reader might recall how the strict regulation of their activities caused many to adopt a compliance mentality while coming to work "routinely and without feeling " due to the strict disciplinary apparatus that constituted their workplace. Likely, the special relationships workers form with clients, combined with the ability to arrive at unique and creative interventions based on their localized understanding of the Other, is a source of job satisfaction for at least some workers. In order for work to be meaningful, a worker needs to be able to invest part of herself into it, and see her own special investment reflected in the outcome, rather than simply carry out rote, predetermined tasks at behest of some external authority.

#### **IV. Streamlining ACT: Possible Future Directions**

While elements of the RTS paradigm such as economism, objectivity, quantification, and standardization are evident as factors shaping the emerging model, the drive for more efficient processes is not as obvious. The use of fidelity scales, however, may well extend beyond evaluating current teams to help shape future directions for the model as well. As the creators of TMACT note of their construct

The more comprehensive TMACT may provide a useful tool to evaluate not only overall effectiveness over the broad range of outcomes now expected of services for this population but also the extent to which specific ingredients are critical for specific outcomes (Monroe-DeVita et al, 2011, p. 27).

In other words, a further function of fidelity scales may be to streamline ACT by eliminating those aspects of the program that fail to impact on cost-savings. As the creators of TMACT note, ACT is among the most costly community health programs but “questions remain regarding exactly which features and what dose are most critical to desired outcomes” (2011, p. 26). According to the authors TMACT can potentially provide, “more specific feedback to guide ongoing performance improvement efforts” (p. 27). In other words, one function Monroe DeVita et al see for TMACT is as a means of streamlining and refining the ACT model in order to achieve maximum yield at the minimum expense.

However, if economic priorities already serve to determine the outputs for ACT, then it seems unlikely that workers will have any more say in determining future directions than they did in devising current assessment protocol. Based on Power’s claims that funders will tend to focus on unambiguous inputs such as cost in value for money audits, one could expect more refined measurements and more precise correlations between the cost of services and reduced hospital use resulting in a stripped down model of ACT. This would be one that only preserves those quantifiable elements of the model that correlate with keeping patients in the community.

Medication and community surveillance would likely top the list here given that, as I noted in Chapter One, there is currently no limit to the medications that Canadian physicians can prescribe. No doubt the distribution of medications is the most cost-effective use of human resources so long as it effectively suppresses the outbreaks of havoc that so often bring a psychiatric patient to hospital. It is not uncommon, moreover,

to see housing agencies or landlords requiring that a person be medicated before housing will be offered (Robbins et al, 2006). Hence correlations between medication and community tenure can be accomplished by decree rather than necessarily representing the existence of any causal relationship between these two factors.

Any drive for greater efficiency moreover means that one aspect of the program likely to fall under scrutiny is the lack of limits placed on the duration of treatment with ACT. For, if clients can be parcelled off to cheaper forms of service such as case management, then ACT teams can admit a greater number of clients. As Peter noted in his interview “there is a big debate in the field of ACT how to graduate people.” Such research includes calls to examine outcomes of the continuous care strategy (Burns and Santos, 1995), and research demonstrating that certain patients can be transferred to other providers after a period of time without an increase in hospital use or reduction in mental health status (Rosenheck and Dennis, 2001). The moral and practical importance of the kind of nuanced and contextually rich understanding that members of an ACT team can acquire of person over time, a person moreover who generally lacks any other enduring forms of social support, does not usually enter into such discussions.

Pressures to shorten terms for treatment could also undermine the relaxed attitude the Sunnydale team displayed regarding patient progress, as well as their openness to experimentation to achieve optimal results over extended periods of time. Meanwhile team members’ tactic to stave off futility by attending to minute signs of improvement over the “long-haul,” as it were, crucially relies on maintaining long-term relations with clients. Instead we may find workers’ focus shifting to the implementation of methods

aimed at quickly achieving a sufficient level of stability so as to quickly process one batch of clients and, in this way make way for “all those other” patients waiting for services. The sort of trial and error approach that the Sunnydale team employed could also come to be seen as less acceptable under such circumstances, if the ambition is to hasten treatment instead of patiently waiting to see what works for particular individuals.

If fidelity scales effectively entrench a conception of the real work of ACT as keeping clients out of hospital, many kinds of activities are reduced to Kujala et al’s category of “superfluous time,” or those non-value adding activities that, we as saw in Chapter One, tend to be abolished in the name of greater efficiency. One such activity might be taking some extra time to actively engage with and listen to a clients’ story in order to achieve a better understanding of how she sees herself and understands the trajectory of her personal narrative. If, as research suggests, “engagement” does not reduce hospital use, then under the RTS paradigm, there is sufficient justification for eliminating time for non-productive activities such as sharing a laugh, providing a shoulder to cry on or simply catching up on a clients’ life. Meanwhile workers who suffer because they have neither the time, nor the space to offer such forms of support to their clients end up reduced to nothing more than mere sources of error.

A final aspect of the work that is both difficult to codify on a fidelity scale, or to correlate closely with reduced hospital use is the time and space workers require to advocate effectively for clients. “It makes you feel good sometimes advocating for someone who does not have anyone advocating for them,” notes Gail, demonstrating the importance of this aspect of the work for both practitioners and clients. Part of what

seemed to make a difficult job bearable was the possibility of insisting on a farewell visit to a jailed client, and insuring that others, such as trustees and ER doctors alike treat ACT clients fairly. As we have seen workers require a certain amount of unstructured time to act on behalf of clients this way. The importance of this time, however, is difficult to justify to those whose overarching concern is the development of a leaner, more efficient system that produces guaranteed outcomes. This is because workers probably do not advocate for clients to keep the latter out of hospital, workers act as they do in such instances because it is the morally right thing to do

### **Raising the spectre of Agamemnon**

Yet if such aspects of the work are dismissed or overshadowed by quantifiable items determining the shape of ACT, we risk altering the very face of teams. Already, patients' seemingly inescapable and dismal living conditions are difficult for workers to bear. There is a question, then, as to who would remain in the profession were the model to drift towards a stripped-down version with only enough resources to keep clients medicated in the community and out of hospital. It is worth recalling that although its sample size was small, one study cited in Chapter Three noted that individuals who saw ethics as care-based tend to leave nursing due to moral distress. If genuine care for clients is only apt only to create hardship, then as with Agamemnon in Chapter Three, we may find that only workers capable of insuring themselves to their clients' suffering staying in the profession. As has been shown, the end result of this can be complete dehumanizing



of the suffering Other, which is especially problematic given that the others in question are already stigmatized and living at the margins of society.

Probably our best first step in averting such any such future scenarios is carefully attending to workers' complaints in the present, especially those which stem from care or empathetic suffering. As I noted in Chapter Three, according to Nussbaum, a reciprocal relationship ought to exist between compassionate individuals and social institutions with each contributing to the formation of the other. While frontline ACT workers appear to have a great deal of compassion for those they work with, it is not clear that either their vision of clients' needs, their understanding of what it required to do their job well, or even clients' own desires are shaping ACT as it crystallizes into a standardized form of practice. Rather, fidelity scales appear tailored to meet the needs of second-order experts such as accountants and managers.

There is a real danger then that workers' voices will remain outside the field of discourse, especially if their concerns are largely grounded in affective care. Due to the well-entrenched RTS paradigm among the administrators and funding agencies most apt to rely on fidelity scales, there may be a tendency to dismiss certain individuals as overly sensitive, insufficiently rational, or even harbouring "rescue fantasies" as in the APU. One ought to take pause in the face of such assumptions however, and ask if those who succumb most easily to the face of suffering are not akin to canaries in a coalmine. Far from being mere "sources of error," they may call our attention to forces hostile not only to another person's wellbeing, but to our very humanity.

## Conclusion

*“People nowadays think that scientists exist to instruct them, poets, musicians, etc. to give them pleasure. The idea that these have something to teach them-that does not occur to them.”*

~Ludwig Wittgenstein, 1984, p. 127.

*“Good bye” said the fox. “Here is my secret. It’s quite simple: One sees clearly only with the heart. Anything essential is invisible to the eyes”*

~Antoine De Saint-Exupery, 2000, p. 63

*“Nature loves to conceal herself”*

~Heraclitus, Fragments.

## Avenues for Further Inquiry

For much of this work I have been stressing that workers in caring professions need the time and the space to get to know clients, to cultivate a caring attitude and to respond adequately to patients’ particularities. To this end, I have taken care to highlight occasions where small cracks in a highly rationalized system have allowed such connections to form in order to look at their effects. I have also suggested that it is important to take the suffering of workers seriously, especially that which stems from care for their clients. Not doing so risks perpetuating workplace conditions that cause workers to become blind to the Face of vulnerable Others, and thereby inured to their suffering. Unfortunately, the workers who command the public’s attention tend to be those who have already arrived at this place, and who neglect or abuse patients as a matter of course.

However, we really ought to be attending to the calls of those who have not yet given up and who continue to suffer on behalf of their charges. It is worth noting that there are workers who do care a great deal about their clients. Rose, for example, found Alexandria's story meaningful enough to tack it up on the wall at work where it hung for six months. As Rose recalled it, Alexandria's ACT team was dutiful but perhaps remote. "They had meticulously delivered her labeled medication, but beyond that, they couldn't do that much with her," she said to me. The fact that these particular details stuck with her hearkens, perhaps, to her own sense of futility about the value of her work. However, the act of calling attention to the story also operates as a suggestion that perhaps she and her team mates could be doing more.

Certainly it is true that indifferent, conflicted and emotionally exhausted care workers are a concern for us all. However, the need for caring and sensitive workers is all the more crucial for people diagnosed with severe mental illness. Those individuals who show especially severe symptoms are effectively invisible when out in the world. Passersby are careful to avert their gaze, and few people will ever reach out to such a person in the street. They are people such as Alexandria, who die in a housing facility full of people but are not missed for days. There are few rationalistic disciplinary apparatuses or productive structures to which such people can adapt. As I have shown, this inability is apt to cause workers adhering to such schemes to distance or "other" those who don't fit the plan.

For this reason, connecting with people diagnosed with SPMI is all the more important, but it can also be the most difficult work. This is because relations with such

individuals are rarely easy, due in part to clients' idiosyncratic forms of communication, cognitive deficits or just the residue of distrust they've built up after a lifetime of discrimination. While Allemang's use of personal details about Alexandria and her predilection for Madonna and showy jewellery might be enough to kindle the sympathies of a distant reader, it wouldn't be enough for a person working with her day in and day out. As Allemang tells it, Alexandria had once rubbed her naked breasts on a car window while a mother and her three children sat inside afraid. She'd uttered death threats, started fires and "had a tendency to strip off her clothes and defecate when landlords complained about her loud music or her defiance of smoking bans" (Allemang, 2009, F1). Only a sensitive, patient and responsive worker, namely, one who is morally wise, will be capable of drawing a person such as Alexandria into a community of care.

Once we strip away the façade of professionalized discourse that distinguishes therapists and patients and thereby drives a wedge into their social relations, the central importance of a strong relationship between the two becomes all the more evident. There may be those who position workers as interchangeable tools functioning in rational and predictable ways to help clients along the road to recovery and reintegration into some abstract conception of 'the community.' Given, however, that workers interact regularly with clients, enter their homes and become involved in multiple aspects of their lives, ACT workers are as much a part of a client's own immediate and concrete community as any local storekeeper, pastor or family doctor. In other words, far from being separate from 'the community,' ACT workers are the vanguard of that which reaches out to draw clients in.

Workers' less formalized role as frontline members and representatives of the broader community carries with it obligations that rank as highly any set of professional responsibilities that might dictate their practice. This is because workers provide an example of the persons a client might expect to encounter as she becomes reintegrated more deeply into society. As Stein and Santos note, the relationship between the team and clients is a vehicle of change in and of itself and this may be because connections with workers give the client hope of potential relations with others with whom she might build relationships. A relationship with a worker also helps to show a client that she is worth caring about. As Sturm argues regarding the importance of relationship-building with vulnerable psychiatric patients,

A consistent, interpersonal, therapeutic relationship with a [worker] has the potential to foster trust and to make guidance acceptable, while demonstrating respect for the rights of the patient. This relationship allows patients to experience themselves as persons whose particular needs are worthy of both acceptance and individualized approaches (2009, p. 24).

Only the patient cultivation of trust, something most people only extend to those who acknowledge and care about their personal 'me-ness,' might bring an excluded person to believe that a community worth connecting to actually exists for them and in which they might achieve a sense of belonging. "Meaningful community living" in other words, requires meaningful relationships with workers who are the frontrunners of a client's community.

Viewing the client/worker relationship from this perspective then is to admit that psychiatric patients deserve to be accepted by someone who cares about them, and that

mental health practitioners are well-positioned to provide this. Although I have suggested that at minimum an attitude “consistent with care” must be shown to such clients, it is possible that patients receiving this are still left wanting for love. However, a question remains which is how to genuinely come to love people who are very difficult to love. As I have stressed on a number of occasions, psychiatric patients are difficult to connect with in any meaningful way. It is one thing to rail against the notion that we owe such persons nothing more than dutiful respect in Kant’s sense. However, if we admit that such individuals deserve to be loved, how is one to achieve this state?

Even if this last question had an easy answer, however, it would merely give rise to another which is, who should be the ones to provide those loving supportive relationships that so many psychiatric patients seem to lack? If we are to admit that paid workers are not the ones to offer such persons love, then what level of closeness is both reasonable and appropriate to ask from practitioners? Whether or not the situation is an ideal one, workers are in a position of rationing in the face of scarcity. They are the ones to recommend particular services, advocate on behalf of a client, or decide in the moment how much precious time to dedicate to an individual patient. Hence, beyond the problems associated with endeavoring to care about another person “on demand,” as it were, there are also difficulties that arise when special attachments are formed with particular clients, attachments that might encourage preferential treatment. A finely tuned balance is perhaps required to determine what level of care is sufficient to adequately nurture one person, without allowing for the development of special bonds that result in the deprivation of others.

As my arguments in Chapter Three suggest, cultivating the moral wisdom of workers themselves should go some way in determining where such relational boundaries lie. However, because it entails a responsiveness to changing circumstances and knowing when the rules are more harmful than helpful, moral wisdom is itself a necessarily ambiguous concept. If moral wisdom is always changing, how do we know when we've arrived? By what standard do we judge a worker's level of moral understanding and how are workers to train their moral sense, if not in virtue of simply learning a set of rules? If one agrees that workers can only achieve moral wisdom through practice, and this in turn requires mistakes, then what level of error ought we allow for among workers who hold the lives of others in their hands, and who decides what level of risk is acceptable?

Within work environments that beget a seemingly ever-increasing number of specializations, drawing workers into such talks so that discourse is not dominated by bioethicists will require a concerted effort. It is not easy to communicate the concerns raised here to practitioners, administrators and academics. The results of a recent project, "Leadership in Ethical Policy and Practice" (Shick Makaroff et al, 2010), suggest that barriers already exist when it comes to discussing ethics with practitioners. The project saw academic researchers collaborating with "nursing practice leaders" interested in conducting ethical talks in their particular workplaces while also contributing to the broader three-year project. According to authors, academics were surprised to see that nursing practice leaders showed reluctance to explicitly discuss ethics, or even to clarify what the term meant. The authors reporting on the process reproduced the exchange to show differing perspectives about the topic.

Practice leader: I actually sometimes find [the language of ethics is] almost a barrier. People don't understand it; they just think it's very soft. It's language they're not comfortable or familiar with. It's too 'mom and apple pie'.

Interviewer: All right. [Are] there other ways then to convey the same ideas that you find you use?

Practice leader: Yeah. There's all kinds of ways. It's all around influencing agendas and decisions made by a variety of decision makers within the health authority using whatever language they understand most effectively (p. 572).

If ethics alone is viewed as “soft” any such dismissive tendencies could only be compounded if the ethics in question takes seriously questions of appropriate forms of love between practitioners and clients. Recalling Michael Hardt's observations quoted in the Introduction, such discourse even makes academics squirm in their seats during talks. However, does a researcher or philosopher not weaken her own position, or dilute discourse on the importance of relatedness, if she buys into the dominant paradigm and couches her reflections in terms of, say, quantifiable markers of health, or perhaps even economics in order to be taken seriously? Taking such an approach to such subject matter appears merely to reproduce, and hence reinforce the very logic that this work has sought to challenge. And yet if this is the only way to be heard by policy makers or even front-line practitioners, perhaps such a compromise is necessary.

### **Closing Words: The Hidden promise of “Strange Flowers”**

As the RTS paradigm touting efficiency and economy has gained increasing influence over the life of institutions, and as forms of technological rationality dominate virtually all aspects of our lives, a deceptively simple truth retreats from view. This is that



relatedness is so fundamental for human flourishing that all our ingenious technological advances, efficient productive systems and accumulation of wealth are rendered meaningless if individuals are consigned to a social vacuum devoid of relational ties. It is possible, however, that the very same dehumanizing paradigm associated with rational technologies may also hold its cure.

It is only when kindness and compassion retreat from view that we begin to fully appreciate the conditions necessary for their cultivation. It is only when we are barred from spontaneous interaction that we come to see its critical importance in laying the groundwork for trust and care. Depriving workers of the time to care, moreover, helps bring to light just how precious are those moments spent comforting or nurturing a vulnerable Other. A workplace environment that restricts personal relations has the paradoxical effect of making such relations all the more precious.

Although the ethos of efficiency and central control erodes relatedness, “strange flowers” always seem to manage to take root, just as they did in the austere setting of the APU. Their very rarity helps to reveal their rarified and transcendent nature and the very darkness of their circumstances is what allows the value of relatedness to shine forth in all its resplendent light. Relationships that take root under stifling conditions are the daisies sprouting up in cracks in the sidewalk, helping to remind us of the beauty and importance of those parts of the natural world that a rationally managed and highly technological society serves to keep, however unwittingly, at bay.

While science will never show us why these relationships are so precious, and how it is that they can spark entire paradigm shifts, legal philosopher Joseph Raz

illustrates the fundamental value of human connectedness with a simple children's story. Raz readily admits that a milestone in any moral agent's development is achieving the maturity to recognize that one's own claims and the claims of those she loves hold no special merit above and beyond anyone else's. By the same token, however, our partial relationships confer meaning to our lives and make them worth living. To show this, Raz cites a section from *The Little Prince* where a fox offers the Prince an explanation of why he would like the boy to "tame" him

"My life is monotonous", he said, 'I hunt chickens; men hunt me. All the chickens are just alike, and all men are just alike ... I am a little bored. But if you tame me it will be as if the sun came to shine on my life. I shall know the sounds of a step that will be different from all the others ... Yours will call me, like music ... and then look: the grain fields ... You have hair ... the colour of gold. Think now how wonderful that will be when you have tamed me. The grain, which is also golden, will bring me back the thought of you and I shall love to listen to the wind in the wheat" (de Saint-Exupéry cited in Raz, 2001, p 15).

Emotional attachments enrich our worldview by infusing it with meaning, and drive us forward with a purpose otherwise lacking in a world of objects where none matters more than any other. For Raz personal meaning, or people's reason for living, derives at least in part from our relationships, and this sense of meaning gives us the will to live. He notes,

If you doubt that, try and revive the spirits of a depressed or suicidal person by pointing out how much of value there is in the world: mention the beauty of nature, treasure of supreme art filling the museums, the wealth of sublime music, the great number of lovers, etc. One is more likely to drive a person further into gloom. Their problem is not the absence of value in the world but meaning in their lives (p. 15).

Raz's insight finds an echo in Viktor Frankl's epiphany about the importance of relatedness, which came to him under extremely adverse conditions in a Nazi concentration camp. As he tells it, every day before sunrise prisoners stumbled for miles in the cold, in shoddy clothing, their worn out shoes slipping on icy spots along the way to arrive at their work site. During one of these marches someone beside Frankl remarked "if our wives could see us now!", adding that he hoped the women were faring better wherever they were. Visions of Frankl's wife came to him then as the sun came up. "My mind clung to my wife's image, imagining it with an uncanny acuteness. I heard her answering me, saw her smile, her frank and encouraging look. Real or not, her look was then more luminous than the sun which was beginning to rise." Frankl continues,

A thought transfixed me: for the first time in my life I understood the truth as it is set into song by so many poets, proclaimed as the final wisdom by so many thinkers. The truth—that love is the ultimate and highest goal to which man can aspire. Then I grasped the meaning of the greatest secret that human poetry and human thought and belief had to impart: The salvation of man is through love and in love. (Frankl, 1997, p. 49).

No surprise, then, to hear Saks tell us that "what those of us with suffering from mental illness want is what everyone wants: in the words of Sigmund Freud, 'to work and to love'" (Saks, 2012).

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