Information, Self-Management and Common Sense: An ethnography of NHS mental healthcare as an accountable bureaucracy

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ABSTRACT

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This thesis presents mental healthcare as an 'accountable bureaucracy.' I find a resemblance between clinical expertise and the ethos of the office. Accountable clinicians must produce documentation of disinterested, standardised, justifiable decisions. What staff members consider to be good clinical practice emerges as being good, accountable bureaucratic practice.

My fieldwork investigates an attempt to promote patient 'empowerment.' I use the term empowerment to refer to a set of interlocking clinical goals that pertain to increased patient input to decision-making, more equal clinical relationships, and a wider reconfiguring of services. Patient empowerment is thought of as correcting inappropriate and outdated paternalism in healthcare, leading to better quality care, improved outcomes and reduced costs.

I argue that patient empowerment and accountability are contradictory, in such a way that thin conceptions of empowerment may be compatible with accountability, but thicker conceptions are not. Contradictions between empowerment and accountability exist at the level of basic concepts, clinical style, documentary practices, and clinical relationships. In typical care, accountability is primary, and much of what clinicians consider to be empowering is ignored or excluded. To deliver routinized care, clinicians simplify, and think in terms of reified mental disorders. As they require standardised knowledge about patients, clinicians become adept at 'routinized intimacy.' Attempts to promote empowerment face serious obstacles. Thinner conceptions of empowerment are bureaucratically less problematic, but unsatisfying to many clinicians. Thicker versions of empowerment make care harder to document, control, justify and standardise, and risk escalates.

My findings shed light on an under-acknowledged but important contradiction. I contribute to anthropological literature on accountability, ignorance and uncertainty, professional knowledge and ethics, responsibility and patient self-care, and mental healthcare as a source of disempowerment.

CONTENTS

ACKNOWLEDGEMENTS……4

GLOSSARY……5

INTRODUCTION: AN ANTHROPOLOGIST AMONGST THE MEDICAL SCIENTISTS……...6

CHAPTER TWO:
THE MECHANISMS AND VIRTUES OF ACCOUNTABILITY……..…….....53

CHAPTER THREE: PATIENT EMPOWERMENT AND THE BUREAUCRATIC IMAGINATION……...98

CHAPTER FOUR: MEDICAL DOCUMENTATON AND VARIETIES OF EMPOWERMENT……139

CHAPTER FIVE: PATIENT EMPOWERMENT, BUREAUCRATIZED WORKING PRACTICES AND IATROGENIC HARM……...173

CHAPTER SIX: AN ACCOUNTABLE BUREAUCRACY IN ACTION……205

CHAPTER SEVEN:
CLINICIANS AND PATIENTS ON THE BUREAUCRATIC STAGE…….....238

CHAPTER EIGHT: CONCLUSION…….....278

BIBLIOGRAPHY……...297

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I do not here name my many informants, both clinical staff and patients, but I thank them for their time and honesty. I hope they feel I have been fair, and that my thesis contributes something useful.

As a returning student, to the university, the department and college, I found myself to be, from a bureaucratic point of view, rather unusual. It is due to the kindness and discretion of many people that this was not a problem and that I was able to restart my studies. In particular, I am grateful to Bob Parkin and Marcus Banks.

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I was married a month or so before submission. My wife and I are united by (amongst other things) a shared interest in bureaucratic accountability, and, with a meticulous eye, Nadia read the whole thesis. I am grateful to her for this, for her heroic forbearance over the last few weeks, and for much more besides.

I dedicate this thesis to the memory of Neil Vint.

GLOSSARY

Care-Co-ordinator. Clinician responsible for a patient's care plan. Usually as CPN, or social worker

CPA, or Care Plan Approach. A standardised document which defines the responsibilities of the team to an individual patient.

CPN. Community Psychiatric Nurse

DSM. Diagnostic and Statistical Manual, a text in which mental disorders are defined

EBM. Evidence-based medicine

MHA or Mental Health Act assessment. Informally known as a 'section,' an assessment in which three mental health professionals decide if a person can be detained or treated compulsorily

PD. Personality Disorder

INTRODUCTION: AN ANTHROPOLOGIST AMONGST THE MEDICAL SCIENTISTS

1.1 Ethnographic Vignette: Bureaucratic blind-spots

One morning I was with a consultant psychiatrist during his clinic. The consultant was being shadowed by two junior doctors. Also present in a rather cramped room was a community psychiatric nurse whom I knew quite well. It was a comparatively warm day, and the stuffy conditions in the room were made worse by our collective inability to figure out how to open the window.

The junior doctors were curious about why I was there. I said that I was a medical anthropology doctoral student, investigating patient empowerment, self-management, and bureaucracy. Self-management was a familiar term to them, but overall I struggled to explain myself. It all sounded so abstract, remote from the 'real-world' problems they dealt with. So I tried to find a different way to describe my work. I said that over the course of my research I had asked many mental health professionals whether they believed they could predict which patients would recover and which would go on to a lifetime of mental ill-health and mental healthcare. I said I was often told that they could, and that qualities in the patient like 'patience' and 'courage' seemed to help, or 'determination,' or 'hope,' or 'self-confidence'. This made much more sense to the junior doctors. I had their attention now. So I went on:

'If mental health professionals tell me this, I always ask a second question: what do they do to promote these qualities? The professionals reply that they do nothing, that these qualities are neither recorded in notes nor addressed during the delivery of care. In a sense, they are invisible to the world of mental healthcare. Yet they seem to be of real and substantial clinical significance.'

I looked at the junior doctors. I thought I had managed to make sense to them. But I was worried I had sounded too radical. I was in the room as a guest of the consultant and I wanted to tread carefully. However, I also knew that the psychiatrist was himself seen as a maverick. So I asked him:

'Does that sound too controversial? I just find it odd that qualities in the person that have to do with patient empowerment, and that seem to lead to better mental health, are effectively ignored by mental health professionals as they go about their work. There may be very good reasons for this, but I do find it odd.'

The consultant shook his head:

'I agree, and it isn't too radical at all: I find it odd too' he replied.

In this introductory chapter I set out my research questions, describe my field sites and discuss my methodology. I reflect on fieldwork experiences, in particular regarding clinician and patient intuitions about the nature of expert knowledge. I suggest that clinical knowledge is organised around pragmatic needs located in the office as much as the consulting room or hospital ward. This is why the bureaucratic blind-spots discussed in the vignette above come to influence clinical care. The following section introduces the idea of bureaucracy. In particular, I review Weber's insight that the office is a moral domain, with a distinct ethos and set of epistemic practices. I outline some reasons why I chose Weber's work as the theoretical basis for my thesis and discuss some of the literature on bureaucracy. Next, I review some literature to set up an opposition between executive control and individual professional autonomy. In a bureaucratized work environment, top-down control stands in opposition to ground-level autonomy. This distinction sets the scene for the upcoming discussion of accountability. Finally, I move onto the relationship between bureaucracy and clinical expertise. I suggest that these two should not be treated as being necessarily opposed. Rather, the clinical expertise of Oxford Health staff members emerges as itself being bureaucratized.

1.2 The Fieldwork Question: Information and Health

This anthropological project formed part of the 'qualitative evaluation' of a new 'self-monitoring' and 'self-management' technology, known as True Colours. Starting in June 2013, True Colours was introduced into standard care to the 10,000 people receiving secondary mental healthcare from the NHS in Oxfordshire and Buckinghamshire. The programme of research associated with this introduction is known as OXTEXT-7. It forms part of a larger body of research activity, funded by the NHS, in the form of a programme grant RP-PG-0108-10087. The work was carried out by a research team based in Oxford University Department of Psychiatry. Most of the research activity focussed on attempts to measure the effects of the introduction of True Colours. For example, does using True Colours decrease symptoms in patients? Are they discharged more quickly? Are costs reduced? My doctoral research formed part of the attempt to investigate the implementation of True Colours from a qualitative perspective. Qualitative research was seen as being a means to document the experience of implementation and to increase understanding of any facilitators or barriers to its uptake.

In its simplest form, True Colours works by sending each user a weekly text or e-mail message from a central mobile phone. The message prompts participants to complete one or more questionnaire. Each questionnaire seeks to express numerically the severity of a symptom, such as 'depression,' or 'mania,' or 'anxiety'. It does this by asking simple questions about particular phenomena thought of as making up the symptom. These are sometimes broader than might be expected. The questionnaire for depression mentions 'feeling sad' but is also concerned with weight, appetite, sleep and other qualities such as 'feeling slowed down.' Each question offers alternatives that indicate intensity (I feel slightly unhappy, I feel very unhappy) or frequency (I feel unhappy some of the time, I feel unhappy all of the time). Each alternative is 'scored' numerically.

The scores to individual questions produce an overall figure that is understood to express the 'level,' 'degree,' 'severity,' or 'burden' of symptoms. The overall figure can be simply the sum of all the answers, but more often scores are combined in more complex ways, using an algorithm. The accumulated answers form a 'mood graph' that is stored online and can be accessed by the patient at any time.

The first two questionnaires used by True Colours was the Altman Self-Rating Mania (ASRM) scale, which measures high mood or mania, and the Quick Inventory of Depressive Symptoms–Self Report (QIDS-SR) scale, that measures depression (Altman et al. 1997; Rush et al. 2003). The ASRM consists of five questions, each scored from 0 to 4. Questions address issues such as feeling happy, being active, talkative or self-confident, and sleep. For example, question two offers the following options: 'I do not feel more self-confident than usual', which scores the minimum of 0; 'I occasionally feel more self-confident than usual', which scores 1; 'I often feel more self-confident than usual'; which scores 2; 'I feel more self-confident than usual most of the time'; which scores 3; and 'I feel extremely self-confident all of the time', which scores the maximum of 4.

The QIDS consists of 16 questions each of which is scored from 0-3. Questions concern sleep, appetite and weight, plus 'feeling sad,' 'view of self,' 'feelings of 'restlessness,' 'sense of self-worth,' 'energy level,' 'feeling slowed down' and 'thoughts of death or suicide'. For example, question 11 ('view of myself') offers the following options: 'I see myself as equally worthwhile and deserving as other people,' which scores 0; 'I am more self-blaming than usual', which scores 1; 'I largely believe I cause problems for others', which scores 2; and 'I think almost constantly about major and minor defects in myself,' which scores 3. Participants text or email their answers to these questionnaires. One participant showed me her answer to the QIDS-SR, which were: 1110100001110121. When combined according to the algorithm, produces an overall score of 8,

indicating a low level of depression. Another participant answered: 3220310103332323, which produces a total of 24.

As a part of the implementation, some booklets were developed for use alongside True Colours. Five such booklets were produced: 'Managing Depression'; 'Managing Bipolar Disorder'; 'Managing Schizophrenia and Psychosis'; 'Managing Alcohol and Drugs'; and 'Managing Medicines'. These were described by the research team as examples of 'psychoeducation'. It was thought that they might enhance the benefits of using True Colours. They provide 'information' about how mental disorders can affect people and how True Colours can be used to help each person 'learn' more about their personal health.

The research team believed that for True Colours to create health benefits, it was crucial that patients were not only better informed, but that they changed their behaviour. So the booklets suggest that patients use their 'symptom graphs' produced by True Colours as a guide in making changes to their lifestyle and day-to-day behaviour. This can help people to respond quickly to sudden downturns in health (known as 'relapse prevention'). In the longer term, the booklets promote the idea that people can change their habits and lifestyle such that their health is improved. Suggested changes are to eat well and exercise more, to drink less and to have clear plans for each day. The Managing Bipolar Disorder Booklet puts it like this:

> In this booklet you will find out how to take an active approach to managing your bipolar disorder…This booklet will help you to use True Colours to learn more about how bipolar disorder affects you, consider making changes to your daily routines to manage your bipolar disorder…[and]…Gain more control over you symptoms and have a better chance of feeling well. (True Colours Team 2013: 1)

In the language of biomedicine, self-monitoring with True Colours was intended to become an additional or adjunctive intervention to be used alongside existing treatments.

The rationale of True Colours is that better outcomes or reduced costs are produced through measurable information. Patients generate information, have access to it, may use it to make

behavioural changes, and are guided by further information provided by the research team. When members of the research team discussed True Colours, the understanding was that technology might assist in making patients better informed, and that better informed people make better health related decisions. For example, patients might be able to take steps to modify their habits such that they limit the impact of symptoms, or they may spot the early signs of relapse and seek help. The team also thought True Colours might favourably impact on clinical relationships. Simply by owning one's own health data and having personal access to it might reconfigure the relationships between doctor and patient making it more equitable. In addition, the team hoped to give patients a degree of 'autonomy'.

As an observer, I was puzzled by this faith in information. Why did the team believe that poor mental health arose out of information deficits? Would texting 3220310103332323 really help a person paralysed by ennui? What sort of information is it that can be expressed in this rather remarkable form? It is a striking thought that the answers to questionnaires expressed as a sequence of numbers and letters and texted to a central computer might unlock the mysteries of the human condition. And why might technologies enabling patients to access information of the same form and in the same manner as clinicians improve clinical relationships? Later on in this thesis I will explore how this might also be understood as a deepening of clinical power and authority, a further unbalancing of relational asymmetries, even as an extension of biomedical hegemony. I was unsure, too, of the link between information and patient empowerment. Why might expert medical researchers think that computerised information can turn passive patients into active, health-seeking agents? And why assume that increased empowerment would improve health or reduce healthcare costs? Is this really patient empowerment? And if so, do we really want it?

1.3 Methodology

My fieldwork for this thesis took place from May 2013 to the end of July 2014. However, my preparations for fieldwork extend further back. From November 2011, I became embedded in the OXTEXT group based in the Oxford University Department of Psychiatry. The team was led by two senior academic psychiatrists from the department, with additional input from two academic clinical psychologists and an academic psychiatrist with an interest in qualitative research. As well as a full-time project manager, between three and five research assistants were employed to work full-time on the project. Between February 2012 and January 2013 I was a member of a group to develop the functionality of True Colours, a team aiming to enhance its look and ease of use, and a booklet editorial group. The system was piloted and revised from January to March 2013.

What was called 'the roll-out' of True Colours began on 10th June 2013. The project manager and research assistants from the research group were responsible for introducing True Colours to the eleven adult mental health teams that, at the time, made up the Oxford Health General Adult Services. Each team covered a different geographically defined area, extending from Banbury in the north, Witney in the west, Aylesbury in the East and Amersham in the south. The True Colours group trained teams in a randomised sequence. Training consisted of one to three formal training sessions that introduced True Colours. Support was then provided by a research assistant for the following two weeks. As a part of the training package, I gave a ten-minute presentation. This was a brief account of why qualitative work, and especially anthropological work, might be a worthwhile undertaking. My talk was intended to be humorous and memorable, as I needed to forge good relationships with staff members.

True Colours training sessions and subsequent team meetings were a good setting to observe mental health professionals at work. Team meetings are held by all the community adult mental health

teams. They are used to discuss clinical business such as new referrals, difficult cases, discharges from care, and admissions and discharges from wards. By observing more than thirty such meetings I gained a sense of the dynamics of teams, how a patient's problems might be described and assessed, and how constraints or needs that might be invisible to the patient can determine clinical decisions. These meetings allowed me to develop relationships with staff members, some of whom became key informants. This enabled me to arrange to accompany staff members as they went about their work. Over the course of fieldwork I accompanied three psychiatrists. With two of them I spent respectively two full working days. With the third I sat in on seven of her morning clinics. I spent a working day with, respectively, an approved mental health professional, a social worker and a community psychiatric nurse. I got to know an occupational therapist and a member of the chaplaincy service. Through them, I attended seven two-hour 'recovery groups' and two two-hour 'spirituality groups' on a men's acute ward. These facilitated longer times chatting informally on both the ward and a day hospital service.

The organisational base of Oxford Health is sited next to two universities, Oxford Brookes and Oxford University. Connections between these institutions are substantial. Many members of staff have professional roles that are partly academic and partly clinical. An academic or researcher who holds a contract of employment in the department of psychiatry is likely to hold an honorary contract with Oxford Health; some clinicians in Oxford Health hold honorary positions in the university. Many clinical staff members are students or former students of the local universities, or attend training courses held by them. I attended lectures, seminars and classes held by the University Department of Psychiatry, and occasionally in other university departments, including Experimental Psychology, Social Policy and Intervention, and Primary Care. I also attended two annual general meetings held by Oxford Health.

During fieldwork I spent time documenting the main hospital site as a built environment. The Warneford is an old asylum that, in the nineteenth century, offered moral therapy, and in the early decades of the NHS was known, through its association with the nearby Littlemore hospital, for its innovative therapeutic communities (Turner et al. 2015). It is now thought of as a centre of evidence-based medicine. The modern Warneford site is scattered with signposts. These give instructions, such as not to smoke; where to park and how much to pay; the locations of entrances to wards; and rules for entering wards, such as warnings that bags will be searched. Inside the hospital are numerous pictures and posters, mass-produced artworks that seem to form a kind of genre. Typically, they are naturalistic and rather anodyne: soothing, soft-focus photographs and gentle watercolours of subjects such as such as waterfalls and sunsets, or cute animals. Similar works are to be found across Trust premises in cafes, waiting rooms, corridors and consulting rooms. I photographed these signs to produce a record of the visual environment. I felt the signs and pictures contained a clue as to the goals and methods of Oxford Health: mental healthcare aimed at tranquillity through information and instruction.

Central to my fieldwork were close relationships with people who could be described as participants of mental healthcare. Many of these were clinicians, or patients, but the circle extended to include former patients, the partners, carers, friends or relatives of patients. Most people I know belong to at least one of these populations. It can seem as if mental healthcare is something everybody in contemporary Britain has experienced in one way or another. Friends became informants and informants became friends. Some of my best informants were already known to me prior to fieldwork. Other relationships were established and built up during fieldwork. Friends and acquaintances knew of my interest in mental healthcare, and would sometimes seek me out to express an opinion, give or seek advice, or share an experience. I spent a great deal of informal time chatting with these assorted participants. Interaction like this was often unplanned and unstructured, shaped as much by chance as design. Unanticipated and slightly haphazard remarks and encounters

gave me some of my most useful fieldnotes. These rather 'unbureaucratic' research methods did not produce standardised data, but I felt they might be ideally suited to an investigation of the deficits and blind spots of bureaucracy.

In the pursuit of ethnographic data I attended birthday parties, Easter Celebrations, and services in a hospital chapel. I went on cinema trips, and barbeques. My fieldnotes take in weddings and funerals, comments overheard on a bus and bitter tales of anger and remorse during the breakup of relationships. I drank innumerable coffees and teas in cafes, and, in moments later into the evening, over beers in the pub, found myself drawn into sometimes very lengthy discussions of the meaning of life, via distress, disability and madness. My fieldwork took me to an Alcoholics Anonymous meeting and I spent two weeks observing the process of a murder trial.

My research was approved through the NHS ethics process, with the registration 13/SW/0155. This allowed me to observe care delivery. It also permitted me to conduct interview with adult patients of Oxford Health. I was not permitted to contact patients directly. Instead, I asked clinicians to ask patients of theirs who they regarded as suitable to complete a 'consent to contact form.' Once I received this form, I was able to get in touch and arrange the interview. I was able to ask staff members for interview directly.

In total I conducted fifty recorded interviews. I interviewed eighteen community psychiatric nurses (often abbreviated to CPNs), social workers and care support workers; three psychiatrists and a hospital chaplain, all of whom work for Oxford Health. In addition, I interviewed a psychologist and two psychotherapists who work for the NHS, but not for Oxford Health. I interviewed twenty-three patients, eighteen of whom were at the time of the interview patients of Oxford Health, and five people who are mental healthcare service users, but not patients of Oxford Health. I also interviewed two 'carers,' in each case the partners of patients. Most interviews took between an

hour and an hour and half. Some informants were interviewed twice. All Oxford Health Staff we interviewed on NHS premises, but patients were interviewed in a variety of settings, most often their own homes, but sometimes also their back garden, and in the quiet corners of cafes and restaurants.

The consent form for patient interviews enables me to directly quote from the recording, provided I conceal the identity of the speaker. In the subsequent ethnography, sections from recorded interviews are precise, verbatim quotes. Other quotations recorded as direct speech of informants come from fieldnotes. These notes were written either at the same time as the speech being reported, or very shortly afterwards. I have tried to capture the exact wording, but, inevitably, these quotes will contain small errors and omissions. Often the key words and phrases are exact, but some of the linking sentences maintain the sense of what was said, and capture the tone, but do not have word-for-word accuracy and may be slightly cleaned up. I put commonly used technical words and phrases such as 'psychosis,' or 'mood instability' in single inverted commas in the first instance of use, and on other occasion where it seems helpful. For both verbatim and paraphrased quotations, material is both added and subtracted to conceal identity. All names of informants are pseudonyms and many personal details are disguised.

For interviews of Oxford Health patients, I also obtained consent to examine medical records. These include all the notes made about them by Oxford Health staff, questionnaires or scales staff members asked them to complete, letters to and from GPs, family members and so on. The interviews were quite informal and flexible. I aimed for as natural a conversation as possible. I would prepare notes of the sorts of questions I wanted to ask, but often found the conversation veered off towards other topics my informant was interested in. The NHS research ethics process prefers that the content of interviews is explicit and fixed. There is a concern at the potential emotional impact of interviews on patients. This putative impact is regarded as an ethical risk. My

experience was that patients enjoyed the interviews, often remarking that they appreciated the fact I had taken the time to listen to them.

I spend little time discussing the internal structure of Oxford Health. Neither do I provide statistics outlining performance. For example, I do not describe the composition of teams, or give numerical data about diagnoses, appointments and admissions. Part of the reason for this is that organisational data is not required for my larger argument. My focus is on the expertise and ethos of staff members. The institutional structure neither verifies nor falsifies my argument. The working practices I analyse are a result of bureaucratization, but not of any particular bureaucratic arrangement. Indeed, this thesis is a critique of the forms of knowledge deployed of Oxford Health clinicians. I try to suggest that a reliance on quantitative data is part of a set of practices that creates highly consequential clinical blind-spots. For that reason, I do not wish to reproduce these forms of knowledge.

However, there are practical reasons for this as well. During fieldwork, Oxford Health was undergoing radical reorganisation. The structure of teams was being changed, as were a number of basic working practices. This included changes to documentation. Additional to this, a new electronic notes platform was introduced shortly after fieldwork ended. These changes made the provision of structural and internal quantitative information unfeasible. Where in times of organisational calm, it might have been possible to discuss quantified patient flows, or the proportion of patients in a particular locality diagnosed with Schizophrenia, during my fieldwork this simply wasn't possible.

Race and ethnicity have formed a key part of some notable anthropological studies of mental healthcare (Littlewood and Lipsedge 2001). However, they are peripheral to my argument and do not form part of my thesis. Similarly, gender is not included in my analytic approach. Many of the

issues I discuss below are the subject of controversy. This has led to key terms gaining a partisan ring. There are few really neutral words available. I have decided to use the term 'patients,' rather than one of the alternatives, such as 'service-users,' or 'clients.' This reflected the most common usage in the field, and seems to have the least implications. It does not indicate any particular commitment or viewpoint. I treat the names of diagnoses as proper nouns, such as: Bipolar Disorder, Schizophrenia, or Personality Disorder, to indicate they are not natural kinds, but I do seek to further relativize them by placing them in inverted commas. I mostly use the term 'distress' or other non-technical, common sense words to refer to the problems in patients that the clinicians attempt to treat. In general, I try to distance myself from clinical terms and clinical knowledge. I am not actively hostile, but recognise them as part of my subject matter, and so not part of my analytic scheme.

Ethnographic fieldwork meant for me immersion in the world of mental ill health and mental healthcare. I read literature, particularly novels and life-writing by patients and mental health professionals. These can be revealing, for example in conveying something of the life-worlds of people having psychotic experiences (Saks 2007; Delegan et al. 2011; Burke 1996). Others capture something of the excitement of madness (Behrman 2002; Wurtzel 1995). Two notable memoirs chart the impact of mental health problems on family members (Cockburn 2012; Greenberg 2009). Some publications talk about personal experiences in much the same way as psychiatrists, perhaps inadvertently framing lived experience within biomedical categories. (Adams 2002; Jamison 1996). The Warneford Hospital is associated with a number of notable literary figures, including the poet Elizabeth Jennings and novelist Jennifer Dawson (Jennings 1979; Dawson 1961). Much of my reading was directed by my patient informants, who would sometimes mail me to suggest to me novels that I might not know.

I also watched film, TV and theatre related to themes of my project. Two plays I saw during my fieldwork stand out. Both deal with the impact of things unsaid: Enda Walsh's Walworth Farce and Brian Friel's Dancing at Lughnasa. Although different in many ways, the plays deal with a social surface that is dazzling but misleading. The key to understanding the present lies in events in the past that are not directly referred to. In the thesis below I try to describe mental healthcare in such a way as to show the impact of absences and things unnoticed. The absences operated in both directions: clinicians fail to attend to their patient's experiences and preferences; and patients are unaware of hidden factors that determine the way their clinicians behave.

I was also influenced by a Norwegian film about a suicidal heroin user, called Oslo August 31st. In the film the protagonist who has a history of drug-taking and suicide attempts, is discharged from a therapeutic community and proceeds to makes a series of self-destructive decisions. It would be easy to read it as a story about addiction, in which imprudent or irrational acts are explained in terms of a disorder, an inherited vulnerability manifest in abnormalities in the brain. As we see below, this is the kind of approach adopted by many of the mental health professionals I observed. However, the film tells a different story. It shows the protagonist at length and in context. Because we get to know him, we find we are able to understand him in common sense, non-specialist terms. His self-destruction emerges out of a very familiar mix of qualities, such as fearfulness and idealism, combined with some vanity, stubbornness, and impatience. Addiction looked as much a lifestyle as a condition. A specialist knowledge based on the neuroscience of addiction might help us make quick decisions about treatments, whilst failing to tell us much about the person.

1.4 True Colours as a Failure and as a Success

My fieldwork extended until the close of the roll-out of True Colours. Before it began, the team had been very positive about True Colours and had hoped for an enthusiastic reception and widespread

uptake amongst clinicians. There was a feeling that the goals of True Colours, in particular the idea of promoting patient empowerment, would appeal to clinical staff, who might be grateful for an extra piece of kit. The reality was very different. Staff members were unimpressed by True Colours and were reluctant to even consider using it in routine care. A psychologist commented that it 'was a good idea in theory, but won't work in practice.' A nurse told me that True Colours: 'doesn't fit in with our way of working.' Some seemed to doubt the value of active patients. One psychiatrist told me: 'I can tell if the drugs are working or not, I don't need patients to fill in questionnaires to help me.'

In some cases, team members were openly hostile. An experienced CPN summed up more critical responses: 'True Colours is healthcare on the cheap…It fits with the policy goals and ticks all the boxes, it is automated…a blunt tool…what most people want is good quality relationships with staff they can trust. There is a difference between data and personal relationships.' For this CPN, the problem was not that the goals of True Colours were undesirable. He sees himself as promoting patient empowerment already. Instead, he doubted the capacity of such a crude technology to be very helpful. He sees empowerment as something derived from intangible therapeutic relationships, and not to be aided much by data or measurement. For staff members sympathetic to this viewpoint, True Colours presented a barrier to the promotion of empowerment.

The quantitative investigation of the roll-out was expected to require a minimum uptake of 2,100 patients for the statistics to be sufficiently powered to generate evidence of an effect. When I examined the online responses three months after the end of the roll-out, fewer than 100 patients had answered a questionnaire in the last month. True Colours is now seldom used in routine clinical care in Oxford Health. One of my informants, a CPN who I met whilst writing up, remarked to me that she couldn't remember the last time she heard of True Colours mentioned in the team. As a science, medicine presents itself as the disinterested gathering of data and testing of hypotheses.

Behind this, in the scientists themselves, lie hopes and dreams. One of the clinical researchers on the team described the failure of the uptake of True Colours as a cause of ‘deep personal grief.’

True Colours has, however, proved a great success as a research tool. Part of the appeal of True Colours to researchers is the ‘quality’ of the data is records. Attempts have been made to investigate the mood data mathematically, with the aim, as yet unrealised, of being able to make useful prediction about future mood (Moore et al. 2012, Moore et al. 2014; Bonsall 2015). It is used to measure the burden of symptoms in a study investigating potential biomarkers of mental distress (Rosa et al. 2014), and to measure mood instability in a study of the impact of mental imagery on the symptoms of Bipolar Disorder (Holmes et al. 2011). There are a number of publications about the development of the system itself (Bopp et al. 2010; Miklowitz et al. 2012). As a member of the team, I published a paper about the recruitment process to trials using True Colours (Armstrong, Price, and Geddes 2015).

True Colours is used by other research teams at Oxford University Department of Psychiatry. For example, researchers analyse mood graphs seeking signs of mood instability in a study of the children of people diagnosed with Bipolar Disorder and, potentially, collects evidence of improved mental health in a randomised controlled trial of digital cognitive behavioural therapy for insomnia. It is also used in a study of forensic inpatients. True Colours has also been adopted by other research teams. A group based in Cardiff University use it to record long-term data about mood in a large group of people diagnosed with Bipolar Disorder. But it is also seen as applicable outside mental healthcare, for example in an initiative by the department of neurology promoting participants to self-manage their headaches and migraines, through completion of questionnaires and a 'headache diary'. There are efforts to use True Colours as a clinical tool to promote self-management for in ulcerative colitis, hepatology, orthopaedics and cancer care.

One of the questions I try to address in this thesis is why the implementation of True Colours failed. My answer does not consider the particular features of the technology, or speculate whether details of True Colours design or functionality or some facet of implementation led to the failure. In no way do I allocate blame or seek to account for the failure in terms of the contingencies of True Colours and its implementation. Instead I attempt a more general account that seeks to explain why any attempt to promote patient empowerment in Oxford Health was likely to fail. I try to show that mental healthcare, as currently delivered by the NHS, is unsuited to efforts to promote empowerment.

It might seem outlandish to claim that mental healthcare is unsuited to efforts to promote patient empowerment. Like other providers of secondary mental healthcare within the NHS, Oxford Health appears to make the promotion of patient empowerment a priority. Oxford Health presents itself as delivering patient-centred care, and promoting psychoeducation, self-management and recovery-based care. This is not empty rhetoric. During fieldwork I observed many examples where clinicians seek to 'empower' the patient, or were at pains to engage in 'open communication,' 'shared decision making' and more 'balanced' or 'equal' clinical relationships. In the ethnographic chapters below I describe several situations where clinicians talk patients through clinical decisions, explain what 'the options' are, the advantages and disadvantages of each choice, and try to elicit their preferences. When I checked, I found that the rationale subsequently recorded in medical notes matches the reasoning process discussed between clinician and patient.

The case I am making here is not that efforts to promote patient empowerment are not real, or never take place. Rather, to borrow a phrase from the theorist Spivak, the promotion of empowerment falls against the grain of clinical language, practice and expertise (Spivak 1988: 271–313). Oxford Health is an accountable bureaucracy. Collectively and individually, staff members can be held to account. They practice in such a way as to produce documentation justifying their work. My

argument is that there is a conflict between the pull of these bureaucratic forces and the promotion of patient empowerment.

The impact of bureaucracy on the promotion of patient empowerment has two aspects. On the one hand, as a bureaucratic institution, Oxford Health delivers care that is organised around a particular set of bureaucratic goods, such as 'quality', 'efficiency' and 'transparency.' These goods stand in competition with the goal of increasing patient empowerment. If patients become more agential, taking a greater control of their care, for example, this undermines efforts to achieve bureaucratic goods. The less clinicians know about a patient's health, and the less control they have over it, the harder it is for them to deliver accountable care. True Colours is thus unwelcome in clinical care because it threatens bureaucratic goods. On the other hand, True Colours arises out of a particular, highly bureaucratized, environment. The way that it implicitly represents empowerment is thus shaped by bureaucratic pressures. In particular, the conception of empowerment is very limited. As a result, True Colours is unwelcome to those clinicians who see themselves as wanting to promote patient empowerment because they think empowerment means much more.

This suggests a twofold barrier to the adoption of technologies like True Colours. The explicit goals of True Colours are dissonant with the bureaucratized ethos of mental healthcare. Patient empowerment is risky, hard to document, difficult to standardise, is less based on 'decision-making' and demands a different set of relations with services. Whether or not they are healthier, active agential patients are a bureaucratic headache. But, equally, given the limited model of empowerment that True Colours rests upon, it is unappealing to those who take empowerment seriously. Staff who understand their role to be about empowering patients talk of inspiring hope, handing over power, taking risks. Patients who want to find ways to exercise or increase their empowerment find True Colours inadequate. There is more to human empowerment than stressors, risk and protective factors and the ups and downs of symptoms graphs.

I try to develop my argument by examining the analytic concepts 'bureaucracy' 'accountability' and 'audit culture.' I use these ideas to help frame my understanding of clinical expertise. Next, I then try to think a little about the Biomedical concept of 'empowerment' and suggest different ways that it might be understood. The final four chapters present ethnographic evidence to support and illustrate my case. I prefer not to define or directly examine the notion of common sense. Rather, I hope that aspects of its meaning gradually emerge over the course of the thesis. At times common sense is opposed to professional knowledge. In this case, my question is whether expert knowledge is necessarily preferable to common sense when promoting patient empowerment. At other times it refers to forms of reasoning that seem obvious and defensible and which enter the thinking and practice of mental health professionals themselves, giving their practice a distinctly local colour. Here the opposition between expert knowledge and common sense breaks down. At the end of the thesis I speculate about whether any bureaucratic institution can be well equipped to deal with the challenge of accountability. It may be that the dissonance between patient empowerment and bureaucratized mental healthcare contains important clues as to the limits of what we can reasonably expect institutions to deliver. To develop this argument further, I need first to define bureaucracy. Before I do this, I will discuss some remarks made by patient informants regarding the notions of expertise and formal knowledge.

1.5 Reflections on Fieldwork: Wanting to be mentally ill

Some patients suggested that my lay-person's understanding of their lives seemed more insightful than that of the professionals. It was as if, by knowing less about mental health, I was able to know more about them. To some this was odd, counter-intuitive and even slightly unsettling. It appeared that they saw 'being understood' as arising out of some formal expertise or technical training in the knower. How could their distress be so accessible to the untrained observer? How could it be

comprehensible just with what one might call simple common sense? Lay-understandings and common sense was frequently conceptualised as an absence of knowledge, of untutored guesswork filling in for 'science,' 'medicine,' 'evidence,' 'facts,' or 'statistics.'

Despite the multidisciplinary constitution of mental health teams and the contested nature of psychiatric practice, many staff and patients had a rather unitary conception of knowledge. Very often, in conversation, it seemed that knowledge was conceptualised as forming a kind of continuum. A person might have more or less knowledge about mental health, such that a person's degree of knowledge might be plotted on a single line. The expertise of a psychiatrist or psychologist might be at one end, representing a high degree of knowledge. Popular or common sense understandings of distress would be at the other, in that they were not counted as understandings at all. Expert medical knowledge was really the only kind of knowledge, of which a person might have more or less. Some patients used the medical phrase 'lay understanding' to express the limitations of the non-medical gaze. This prompted questions about me: was I medically trained? Perhaps I had degrees in clinical psychology or psychotherapy?

Atran finds common sense or 'ordinary thinking' categories describing vegetation to be largely continuous with those of the biological sciences (Atran 1990). Expert knowledge is a refined version of what I'm calling 'common sense'. Barrett takes a similar stance regarding mental healthcare, describing the psychiatric hospital as a site where 'common-sense ideas about mental illness are concentrated and refined' (Barrett 1996: 6). My data suggest that the relationship between common sense and expert knowledge may not be so harmonious.

Part of the argument of this thesis is that there may be reasons to prefer the categories common sense over those of the mental health professional. For this reason, I have tried to adopt a simple, pared-down style to write this thesis. I've adopted an uncomplicated prose style and use footnotes

sparingly. My hope is that the medium is part of the message. I do not claim that common sense is more likely to be true. Hsu makes this point clearly: 'anthropology has long held that common sense does not coincide with empirical fact and that any anthropological study that distinguishes between a manifestly perceivable empirical fact and symbolic elaboration is ultimately untenable' (Hsu 2010: 20). My suggestion is that common sense notions of the person as agent may emerge as richer, and more complex than the slender categories of the bureaucratic imagination.

When I explained to patients that I was simply listening and using what I thought of as common sense, some were disappointed. They didn't want their distress to be so familiar. There was comfort in the Otherness of mental healthcare expertise. Throughout my fieldwork I found that some patients emphasised that their distress was 'clinical' or 'medical.' What they often meant by this was that their distress was beyond the reach of common sense. I discovered several reasons for this. Some are pragmatic. Accepting clinical descriptions is part of a process that enables the patient to meet sometimes pressing bureaucratic demands. Time off work or access to benefits, for example, is dependent on medical support.

Practical pressures to use medical descriptions can affect staff members too. Less Biomedically-minded clinicians complain that in certain circumstances they have to use biomedical terms even when they'd prefer not to. During fieldwork, whilst parking my car in one the hospital car parks, I encountered one of my clinical informants looking rather vexed. As we walked together towards the hospital, he explained that he wanted one of his patients to get admitted. This was because: 'he's going through a tough time, a really difficult time.' The problem, he explained, was that to get him admitted he had to describe the patient as 'psychotic' and 'suffering from schizophrenia.' My informant was not sure that either description was correct, but said he was about to use them anyway, as this was the only way to get the bed.

Frequently during fieldwork, medical terms were used by patients as a means of conveying the reality and scale of personal suffering. The use of medical terms can give a sense of authority to what are otherwise hidden, interior and hard to verify experiences. If a person's sadness is a psychiatric problem, rather than just a case of feeling sad, or having the blues, or being melancholic, then we know it is serious. But if suffering is comprehensible to an untrained non-medic, this association is threatened.

In Biomedical publications it is sometimes taken to be counterintuitive that patients might want to be thought of as mentally unwell. For example, in an article called "I want to be bipolar"…a new phenomenon, Chan and Sireling find it counterintuitive that patents express a desire to be diagnosed (Chan and Sireling 2010). They speculate that reduced stigma and 'the lay person's aspirations for higher social status' in combination with 'the implicit association of bipolar disorder with celebrity status and creativity' lead to people seeking out the diagnosis as a supposed desirable description (ibid.: 109). To the clinical gaze, illness is intrinsically undesirable, and, therefore, wanting to be seen to be ill seems to require explanation.

However, classic early works focussing on mental healthcare from the humanities and social sciences should suggest a degree of caution here. Goffman, following Parsons, noted 'secondary gains' to stigmatised identity (Goffman 1963; Parsons 1951). For example, he thought that some people who belong to stigmatised groups use their spoiled identity as 'an excuse for ill success that has come his way for other reasons' (Goffman 1963: 21). Once diagnosed, a person might gain other incentives to want to be ill. In a similar vein, Scheff argued that medical descriptions that label mental patients as deviant can reward mad behaviour and punish attempts to return to a non-deviant role (Scheff 1966: 84).

In her ethnography of life as a mentally ill person, Estroff notes that: 'Problems arise when the benefits of sickness outweigh the obligation to get well. Further difficulties are generated when the constraints and symptoms of the illness outnumber and include not only a lack of capacity but a lack of desire to get well (Estroff 1981: 240–1). For Estroff it is highly problematic that a lack of desire to recover is interpreted as a symptom of mental disorder. She draws a parallel between chronic psychiatric patients and drug-addicts, in that something about the social role of 'crazy' and 'addict' seems to promote weakness of the will and redirect a person's preferences and ambitions for themselves away from those of recovery and good health. In the same discussion she argues that both the 'symptoms of psychosis' and a patient's 'adaptations to them' lead to people becoming 'not only unable but unwilling to return to health' (ibid.: 241). The patients she describes so vividly sometimes get a taste for the life of a crazy person, however personally costly. This, she argues, is why mental disorders tend to be self-perpetuating.

Despite their status as impartial and scholarly works, these publications sometimes contain traces of censoriousness. In some sense, they struggle with the thought that it is wrong to want to be sick. As we see below, Biomedical writers tend to read a desire to be ill as pathological. In a fascinating essay about being sick, Virginia Woolf, writing from her first-hand experience of mental illness, is less fastidious (Woolf 2012). She describes the many benefits of being sick, such as the 'divine relief of sympathy,' the opportunity illness presents for 'outspokenness,' and being ill as a 'confessional.' She describes sickness as a kind of preference, suggesting that when ill we: 'Cease to be soldiers in the army of the upright; we become deserters. They march to battle. We float with the sticks on the stream; irresponsible and disinterested and able, perhaps for the first time in years, to look around, to look up – to look, for example, at the sky' (ibid.: 12). One of my patient informants described how although he didn't like the symptoms of his mood disorder, or the sense of being marginalised that he felt was part of being long-term mentally ill, he did enjoy the 'insight' it gave him into the lives of those around him. He believed that being mentally ill made him both a

participant and an observer, with an estranged, slightly uninvolved and agnostic viewpoint. It is a perspective, he suggested, 'like that of an anthropologist.' He also valued the freedom it gave him. He said his diagnosis of bipolar disorder as 'carte blanche' to excuse his 'wayward moments.'

1.6 Reflections on Fieldwork: Not wanting to be a mental patient

Throughout my fieldwork, I was struck that many patients did not feel that healthcare experts understood them very well. However, not everybody saw this as a reason to complain. Some people seemed to quite like it. A dislike of the practicalities of mental healthcare, coupled with scepticism about its intellectual foundations are very common among patients. Doubting and dissident patients can prefer a little hermeneutic distance between themselves and their care team. Some of my patient informants would begin by talking about the side-effects of medications, or doctors not listening to them, and then present sophisticated critiques of Biomedical psychiatry and, albeit less often, of standardised talking therapies and CBT as well. Some referred to classic anti-psychiatry texts such as Laing's The Divided Self, Szasz's The Myth of Mental Illness, and the work of Foucault (Laing 1990; Szasz 1961; Foucault 2001). More recent authors such as Whitaker, Bentall and Healy were also widely cited (Whitaker 2003; Bentall 2004; Healy 2004). Others referred me to websites or organisations deemed to be hostile to current mental healthcare.

Researchers working within Biomedicine regard this as familiar, frustrating and puzzling. For example, Thornicroft describes it thus:

> It is a paradox that many mentally ill people do not speak highly of mental health staff, who are specifically trained to treat people with such conditions. The experience of people with mental illness is that they often feel patronized, punished or humiliated by such contact. Indeed service users often rate mental health staff as one of the groups which most stigmatises mentally ill people.
> (Thornicroft 2006: 88)

Whether or not we agree with Thornicroft that it should be considered to be a paradox that people who use mental health services have these views might depend on prior assumptions about the

nature of psychiatric expertise. Thornicroft takes a fairly orthodox stance. He regards professionals as possessing expert knowledge. Expert knowledge, according to this view, trumps lay knowledge. Problems to do with stigma and prejudice are mistakes, based on faulty reasoning. The properly defined and scientifically supported concepts of Biomedicine are part of the solution to these errors. Looked at from this point of view, expert knowledge can be expected to reduce stigma, and promote understanding, and, thus, be desirable to patients.

The humanities literature on health contains plenty of clues as to why mental healthcare patients might be antagonistic to those trying to help them. Commentators on the notion of medicalization, and, more recently, Biomedicalisation have not been wholly approving of the capacity of expert knowledge to displace existing common sense (Zola 1972; Clarke, 2012). In his influential polemic, Limits to Medicine, Illich regarded medicalization as a kind of colonial occupation that interrupts the most fundamental human experiences:

> Medicalization constitutes a prolific bureaucratic programme based on the denial of each man's need to deal with pain, sickness, and death…Suffering, healing and dying, which are essentially intransitive activities that culture taught each man, are now claimed by technocracy as new areas of policy-making and treated as malfunctions from which populations ought to be institutionally relieved. The goals of metropolitan medical civilisation are thus in opposition to every single cultural health programme they encounter in the process of progressive colonization. (Illich 1990:137–8)

Echoes of Illich's position were frequently found in remarks made by my patient informants. For example people told me that periods of even quite disabling sadness has meaning and value, and is something that might be learnt from.

The potential of distress to be of value forms the basis of Davies' monograph The Importance of Suffering (Davies 2012). People who told me they saw value in their distress tended to go on to say that the value is invisible to clinicians. An important challenge or stage in life is interpreted as a lifelong vulnerability in the brain. Meaning is erased by clinical preoccupations. Sadness is not ennui, or a spiritual crisis, or melancholy, but a disorder, a harmful dysfunction to be reduced and if

possible, eliminated. To some patients this feels reductive, even aggressive, and motivates a resistance to medical interventions and the knowledge that lies behind them.

Both staff members and patients sympathetic to anti-psychiatry regarded expert clinical knowledge and 'the medical model' was an obstacle to comprehension. In the terms suggested by Mishler, the voice of medicine can marginalise the voice of their lifeworld (Mishler 1984). Quite understandably, this makes patients resentful, even angry. There is nothing very paradoxical about this. Mental patients want their lifeworld back. Talking to me was an opportunity to both express their experiences in their own terms and to vent their frustrations at the way that mental health professionals devalue or reject their account of their own experiences and inner life, in a seemingly unreflective, even dogmatic way.

In an unsettling way, sometimes the scepticism expressed by more or less disgruntled patients seemed more sophisticated than the knowledge of the experts. For example, some patients were critical of key ideas used in mental healthcare, such as 'mood,' 'psychosis,' and 'mental disorder' and speculated about the historical contingencies that lie behind what are presented as impersonal scientific categories, even natural kinds. This echoes work in the humanities. For example, in From Soul to Mind, Reed argues that psychology has adopted a 'liberal protestant' conception of human nature (Reed 1997: 7). In a similar vein, Dixon suggests that the current category of emotion is shaped by the theological concerns of the medieval church (Dixon 2003: 60).

Sometimes patients discussed with me their doubts about the way that clinicians talk of subjective experiences as fixed and universal. Historians find important differences between emotions across time. Langhamer's work on the English in love suggests quite recent shifts in the emotional lives of English people (Langhamer 2013). Anthropologists find complex differences in emotions across culture (Abu-Lughod 1999; Lutz 1988; Trawick 1990). Some of my patient informants would freely

speak of medical science as being in some sense social and cultural and full of embedded and unacknowledged assumptions in a way that resembled, and was occasionally informed by, some classic work on science such as Haraway and Latour (Haraway 1991; Latour 1979, Latour 1987).

To some patients, it was natural that common sense was superior to expert knowledge as medium of communication when talking about distress. This was quite a surprise. Why would highly trained mental healthcare professionals with years of experience find it more difficult to communicate with and understand patients than a person simply relying on common sense? As I thought about this I began to wonder if it revealed something about the nature of mental healthcare expertise. Their skills are not oriented towards understanding patients, but towards making decisions about patients. In making decisions, they need to fulfil obligations of various kinds. As I try to show below the office is in many respects the true audience for the clinical activities of staff members. The question I seek to address here is whether expertise with this orientation can also be turned to the promotion of patient empowerment.

1.7 Bureaucracy, Information, and Secrecy

A set of related ideas about confidentiality, data security and secrecy loomed large in my preparations for fieldwork. I knew it was important not to disclose personal information, and had received training from the Department of Psychiatry on this as part of a series of 'good clinical practice' online training sessions. This seemed particularly important as many of my informants live in close proximity to me. Our paths were bound to cross, both during the fieldwork and afterwards. In addition, I was familiar with the idea that anthropologists in the field hear confidential matters, even that anthropological fieldwork might be characterised as a 'trade in secrets' (Dresch 2000: 109).

I had assumed that it would be the intimate details of patient lives that I would have to be careful about. I was wrong. Most of my concerns with confidentiality arose with members of staff. Many staff members used the interviews as an opportunity to tell me secrets. They wanted to express their frustrations at how services are organised or delivered, how unsure they are about the benefits of mental healthcare, and how harmful they felt it can be. It quickly emerged that there are high levels of professional disagreement in mental healthcare, and that the disagreements arouse strong feelings. That these were confidential seemed to reveal something of the nature of bureaucracy and the standardised practices it rests upon.

I do not want to suggest that the discovery of secrets and hidden tensions indicates institutional dysfunction. Rather, it points to the critical role of information as the lifeblood of a bureaucracy. Producing, supplying and withholding information is the centre of clinical life. However, I did feel that the practices of confidentiality and secrecy revealed something about Oxford Health as an ethical domain. Being a good clinician does not relate to truth-telling in a very straightforward way. Graeber sees ethical ideals that make up the prescriptive ethos in the office to be highly significant: 'institutions always create a culture of complicity. It's not just that some people get to break the rules – it's that loyalty to the organisation is to some degree measured by one's willingness to pretend this isn't happening' (Graeber 2015: 26). A part of the argument of this thesis is that the office is a moral domain.

In a discussion of the contradiction of what he calls 'public culture,' Shryock suggests that secrecy has a critical role in the way that public institutions conduct themselves: 'The production of identities meant to be public, that have publicity as part of their function, will create, of necessity, a special terrain of things, relations and activities that cannot themselves be public but are essential aspects of whatever reality and value public things might possess' (Shryock 2004: 3). If Shryock is

right, the functioning of bureaucracy, even when directed towards transparency, might be assisted by, even require, secrets.

When clinicians talk about dealing with risk, or weighing clinical responsibility against the autonomy of the patient, it was sometimes unclear whether they were doing what they thought was right or what they thought the norms of the job required. The result was often shifts in tone, moments of strategic irony, lapses into insincerity, and continual efforts at concealment. In his ethnography of an assertive outreach community team in the US, Brodwin notes how compromised staff members can feel: 'People measure the gulf between their own values and what the job forces them to do…and criticize some of the core practices of their workplace as brutal and inhumane' (Brodwin 2013: 4) He notes that this leads to various kinds of encounters with clinical informants: 'comments in many registers: sometimes a systematic argument, but often sarcastic jokes, emotional outbursts ad private confessions' (ibid.: 4).

Secrecy, humour and irony were unexpected entry points into thinking about bureaucracy. Weber famously stated that 'the concept of the 'official secret' is the specific invention of bureaucracy, and nothing is so fanatically defended by the bureaucracy as this attitude, which cannot be substantially justified beyond these specifically qualified areas' (Weber 2009: 233). At times, during fieldwork, staff members' concern with confidentiality and data security did seem to verge on the fanatical. The ethical weight of lapses in this area is regarded as highly significant. Staff members feel directly accountable for a wide range of information failures. I observed considerable concern amongst staff when two members of the same Oxford College met, and recognised each other, in a waiting room. The risk of such failures is part of the texture of day-to-day life as a mental health professional. Handling the risk requires considerable effort and expertise. In informal and formal interaction, confidentiality seemed to draw greater attention, for example, than concerns about unwanted effects of medication, or the directionlessness and emptiness of many patients' lives.

At least part of the reason why this might be so could be so is suggested by some recent work by Seligman et al. who suggest it as necessary for people to adopt shared viewpoints and practices if they are to be able to co-operate (Seligman et al. 2008). These viewpoints and practices are pragmatic and may not be entirely sincere. It is through insincerity and the creation of imagined worlds that we are able to co-operate: 'subjunctive universes… permit the very existence of a shared social world…hold us in a universe that, without such performatives, would simply not exist' (Seligman et al. 2008: 8). At times it seemed as if the work of a mental health professional had a subjunctive quality. Very few members of staff seemed convinced by the work they did or the work they were supposed to do. Most indicated that they had to set their true beliefs to one side and act as if they believed in the official vision of Oxford Health.

1.8 Mental Healthcare and the Spirit of Bureaucracy

Bureaucracy is frequently seen as an unwanted necessity. It can be presented as something irrational, unpredictable, inefficient, backward: the target of jokes. For example, the nineteenth century economist Bagehot remarked that 'It is an inevitable defect, that bureaucrats will care more for routine than for results' (Bagehot 1910: 155). Working at the end of the nineteenth and beginning of the twentieth centuries, Weber writes against this conception of bureaucracy, in that he believes that bureaucracy can be a source of efficiency. He regards bureaucracy as a characteristic feature of the modern world (Weber 2009: 196). With efficiency, Weber sees bureaucracy as bringing what he calls 'disenchantment.' Bureaucracy shapes and even defines who we are as people. Weber's work on bureaucracy is placed within a series of fundamental oppositions, between reason and emotion, pleasure and duty, public and private. Central to the notion of bureaucracy is routinisation, governance by rules. It is associated with cold, instrumental rationality: heartless, amoral, even inhuman. It traps us, and leaves us bereft.

Weber lists six key attributes of bureaucracy:

> [1] the principle of fixed and official jurisdictional areas, which are generally ordered by rules…[2] the principles of office hierarchy and of levels of graded authority…[and 3] written documents ('the files'), which are preserved in their original…[4] thorough and expert training…[5] official activity demands the full working capacity of the official…[6] The management of the office follows general rules, which are more or less stable, more or less exhaustive, and which can be learned. Knowledge of these rules represents a special technical learning which the officials possess. It involves jurisprudence, or administrative or business management. (ibid.: 196-8)

This thesis will demonstrate that Weber's insights still apply today. As Oxford Health staff members go about their work, each of these six key bureaucratic attributes is visible. On some occasions they are locally understood to be examples of bureaucracy impinging on clinical work, perhaps as a necessary evil, sometimes as an excessive and wasteful diversion from the 'real work' of the mental health professional. But on other occasions, features of service delivery that are understood as 'clinical' resemble the bureaucratic. Aspects of mental healthcare practice, expertise and knowledge seem to overlap with typical features of a bureaucracy as elaborated in Weber's ideal type. As my argument develops, it becomes difficult to differentiate the clinician from the bureaucrat.

Weber presents bureaucratic authority as superseding charismatic authority. The office outcompetes feudal and patrimonial arrangements. This is in virtue of bureaucracy's superior efficiency. The office is a place of 'precision', 'speed' and the 'reduction of friction' (ibid.: 214). However, according to Weber, the bureaucratic machine has limitations. Bureaucracies work according to 'calculable rules' and therefore 'without regard for persons.' There is something inhuman in this machine-like system: 'the more bureaucracy is 'dehumanised,' the more completely it succeeds in eliminating from official business love, hatred, and all purely personal, rational and emotional elements which escape calculation. This is the specific nature of bureaucracy, and it is appraised as its special virtue' (Weber 2009: 216). This suggests that, at least for Weber, bureaucracy is suited to some tasks rather more than others, and that this limitation arises in part out of the form of knowledge it produces. Weber's office is suited to tasks in which the elimination of the personal is

unproblematic, where the exclusion of that which is not calculable poses no functional problems. This conception of the office sits awkwardly with the very personal encounters and intimate experiences that are the focus of mental healthcare.

Criticism of Weber's work has been a prominent theme in post-war sociological literature. Early critics challenged Weber's claim that bureaucracy out-competes other forms of authority. For example, in a series of influential publications Merton pointed out that bureaucratic structures in the workplace can create secure employment and a clear set of rules, but this tends to come at the cost of inefficiency, rather than increased efficiency (Merton 1968). In some cases, this can result in what Merton called 'bureaucratic ritualism' in which the rules become an end in themselves. In highly bureaucratized work settings, employees can find themselves following the rules cynically to avoid making decisions. This seems to be the antithesis of rules generating efficiency. In other cases, officials know that rules are not the means to efficiency, and working habits suggest that the pursuit of the organisation's interest is achieved through the circumvention of the rules (Blau 1964; Gouldner 1955).

Other critiques cast doubt on the way Weber characterized institutions as unities. Selznick argued that groups of office-holders can have interests that diverge from the interests of the organization (Selznick 1949). Over time, organisations sometimes find that new rules have developed that serve senior office holders at the expense of the organization as a whole. Crozier found that Weber understated the importance of internal differentiation in organisations (Crozier 1964). He argued that bureaucracies are frequently unable to learn from their mistakes. This is because each layer in a hierarchy is dependent for information on the layer below, and, when transferring information upwards, each layer has vested interests in interpreting information in a particular way. Like Chinese whispers, the information that gets to the top of the organization bears little relation to how it started out at the bottom. A series of publications, known as the Aston Studies, found bureaucracy

to be more diverse than Weber's ideal type might suggest (Pugh 1976; Pugh and Hinings 1976; Pugh 1977). Local variations were clearly observable, and are linked to environment in a way that is quite predictable.

It is not clear to what degree the above publications should be read as successful critiques of Weber. Du Gay suggests that some critiques, although producing valuable findings, rather understate the subtlety of Weber. This can be to the extent of seriously misreading him (Du Gay 2000: 4). A number of commentators more sympathetic to Weber stress that his model of bureaucracy is an ideal type. As such we should not expect it to be perfectly instantiated, but, rather, use it as a heuristic (Morgan 1990: 64). Seen from this point of view, Weber's work should not be understood to suggest that all bureaucracies are the same, that they are unchanging, or unified, or that all aspects of a bureaucracy contribute to increased efficiency.

In the chapters below, Oxford Health does not conform precisely to Weber's work. The ideal type is revealing, both in what conforms to Weber's model and where I observe divergences. In particular, I do not address questions of efficiency, or make recommendations to improve performance. However, I try to examine the consequences of thinking in terms of efficiency. Investigating quantification and an understanding of clinical reasoning based on scales, measures and evidence lie at the heart of my work. Neither should my Weberian analytic perspective obscure the individual actor. Officials may resist or seek to subvert unwanted bureaucratic intrusion. This is what I found among the staff members of Oxford Health. Indeed, below I point to instances where staff members perceive that the aim of imposed working practices lies in the interests of the organization itself, not the promotion of the interests of patients.

1.9 The Ethical Style of the Office

Perhaps Weber's key insight, at least with regard to this thesis, is that the office constitutes a distinctive ethical domain. It has its own ethos. Gellner and Hirsch suggest that: 'Weber's ideal type captures an important insight, namely the organisational aspiration to be separate from the values and practices of non-bureaucratic, everyday life' (Gellner and Hirsch 2001: 3). Bureaucracy represents a distinctive set of values and practices. Weber calls being an official a 'vocation'. The particular character of the office is the norms that shape the behaviour and sensibilities of bureaucratic actors, at least during office hours. One aspect of this ethos is the imposition of discipline on the official. Parsons took it to be the key feature of the office: 'Above all, bureaucracy involves discipline…It is the fitting of individual actions into a complicated pattern, in such a way that the character of each and the relation to the rest can accurately be controlled' (Parsons 1937: 507). The office is characterized by regularity and routine. This is achieved by subordination and the curtailment of personal liberty. Officials are not sovereign. Their agency is restricted. The exercise of personal judgment is constrained by rules and norms. It is through routinisation that the work of individual officials can conform to institutional goals.

The ethnographic chapters below demonstrate how control over staff is exercised. Documentation, treatment protocols and systematic data-gathering all exist, in part, to ensure that the actions of officials conform to the rules. The rationale is explicit: through this monitoring and control, Oxford Health seeks to deliver care that can be shown to be efficient, effective, of high quality, and uniform. It is in the pursuit of these bureaucratic goods that personal clinical judgment is constrained by impersonal, rational norms. Clinicians may express distaste for the shift from the informal to the formal, the tacit to the explicit, the inchoate to the propositional, but find it difficult to oppose. It is hard to weigh personal discomfort against the pursuit of efficiency and quality.

Weber's notion of the office as an ethical domain suggests more than just this idea of discipline. The Nazi government in Germany used the machinery of state to pursue goals such as the holocaust. This can colour subsequent readings of Weber. Bureaucratic process can become associated with inhuman calculation rather than values. According to some commentators, such as Bauman, the amoral instrumentalism of bureaucratic culture naturally, even inevitably, leading to such horrors (Bauman 1989). This is not what Weber had in mind. For Weber, the official is not an automaton, but, rather, finds his or her role by means of a particular defined set of skills. Official expertise takes the form not only of knowledge of the rules, but of something more subtle: a particular set of epistemic habits. Weber suggests that: 'The more complicated and specialized modern culture becomes, the more its external supporting apparatus demands the personally detached and strictly 'objective' expert, in lieu of the master of older social structures who was moved by personal sympathy and favour, by grace and gratitude' (Weber 2009: 216). This expertise is how Weber describes the spirit of the office entering into and transforming the official. Du Gay presents this as a major strength of bureaucracy:

> The ethical attributes of the good bureaucrat…are the product of definite ethical techniques and routines – 'declaring' one's personal interest, developing professional relations with one's colleagues, subordinating one's ego to procedural decision making – through which individuals develop the disposition and ability to conduct themselves according to the ethos of the office. (Du Gay 2000: 120)

So being an official is understood as an ethical project. Rather than simply being imposed from the outside, as an iron cage that contains the official in contravention of what he or she would really prefer, the office comes to shape the spirit of the official.

Brodwin also finds the notion of ethos helpful to describe the working practices of mental healthcare professionals. He suggests it might mean:

> a shared basis of knowledge as well as the moral standards that people use to orchestrate their daily conduct...The ethos of a workplace actually helps people find a way through ordinary difficulties and frustrations; it encourages them to imagine that their individual actions advance a common purpose. The ethos involves a shared set of emotional attitudes that exert a compulsive force. An ethos thus functions as an implicit demand to pledge loyalty to the institution, its standard recipes for action, and the ideals woven into ordinary gestures of work. (Brodwin 2013: 56)

Part of the usefulness of the term is how it unites such diverse constituents as knowledge, emotions, skills and habits into an ethically charged whole. The mental healthcare professionals that I observed have an ethos, rather than just expertise.

Throughout my fieldwork, I was struck by how deeply the spirit of the office penetrated clinical staff members, and how well suited the ethos of bureaucracy is to the style of mental healthcare delivered by Oxford Health. The mental healthcare professionals I observed conduct themselves according to what Weber thinks of as the spirit of the office. Clinicians often told me how their expertise consists of, amongst other things, detachment and objectivity. In contrast, being moved by personal sympathy is seen as unprofessional. This is what Weber meant by officials working 'without regard for persons.' A great deal of time and effort in Oxford Health is devoted to maintaining good relations with colleagues. Staff members explicitly subordinate themselves to norms and guidelines. Indeed, in appointments with patients, several of the staff members I describe below present their clinical decisions as externally determined by 'the evidence'. This emerges as serving important rhetorical functions, for example in promoting a certain kind of dynamic between clinician and patient.

As a result, clinical virtues resemble bureaucratic virtues. Being a good clinician means being a good bureaucrat. As we shall see, clinicians don't think of it this way. They regard their detachment, objectivity and concerns with confidentiality and data security as arising out of an autonomous body of professional expertise, oriented towards promoting patient health. If successful, the argument of this thesis should give good reasons for being sceptical about such claims.

In this thesis I make comparatively little use of the work of Foucault. This creates a contrast with some anthropological work on mental healthcare, including work I discuss below, such as monographs by Barrett and Rhodes (Barrett 1996; Rhodes 1995). The influence of Foucault on humanities and social science work on mental healthcare has been immense. In addition, he was a key influence on antipsychiatry and continues to be referred to in publications that position themselves as current forms of internal critique to Psychiatry (Laing 1990; Bracken 2005). Even where he is not directly discussed, his work may lie not far below the surface, in concepts such as the 'medical gaze', 'discourse,' 'biopower,' 'the dossier,' or the 'dispositif'(Foucault 2001; Foucault 1975; Foucault 1970; Foucault 1976; Foucault 1977; Foucault 1979; Foucault 2007). More recently, anthropologists have given attention to Foucault's concept of 'care of the self'.' Had the implementation of True Colours been a success, such that thousands of people in Oxfordshire and Buckinghamshire were using it to manage their health, this concept might have been the theoretical backbone of my thesis.

I prefer not to use Foucualt's work here. This is in recognition of my own intellectual limitations. It is also out of a desire for theoretical parsimony. I try to make my argument with sufficient theoretical resources, but without engaging in larger theoretical debates. One of the themes of the thesis is the relationship between expert knowledge and common sense knowledge. It is part of Weber's genius that he was able to construct his analysis of bureaucracy using relatively simple, clearly defined and perhaps commonsensical concepts. I hope to write this thesis in a similar style, without reproducing some of the difficulty and obscurity of some the forms of knowledge I seek to critique. In doing so, I attempt to make lesser demands on my ethnographic evidence, and to remain agnostic about higher-level analytic claims.

1.10 Limits to Bureaucratization

In Seeing like a State, Scott describes how actors working on behalf of the State have applied their official knowledge in a range of arenas, from forestry and town planning to the extraction of revenues (Scott 1998). In Scott's account, their efforts have been facilitated by simplified and standardised forms of knowledge, built out of replicable, impersonal schematic categories, that make aspects of the world 'legible' and manipulable. But this comes at a price. According to Scott, the generation of knowledge like this 'necessarily entails collapsing or ignoring distinctions that might otherwise be relevant' (ibid.: 81). This can lead to sometimes catastrophic failures of state planning. The epistemic limitations of bureaucracy need to be countered by a different form of knowledge. Scott calls this knowledge 'metis': 'Broadly understood, *metis* represents a wide array of practical skills and acquired intelligence in responding to a constantly changing natural and human environment' (ibid.: 313; emphasis in original). Metis is everything that the standardised knowledge of states is not: local, flexible and practical. It is situation-specific, often tacit, often dealing with unmeasured and unmeasurable qualities.

Scott's work has not gone unchallenged. Several scholars have questioned the capacity of the state to impose itself through bureaucratic control. Breckenridge shows the limited control even of the Apartheid state (Breckenridge 2005). As the South African government created a vast, centralized and inflexible bureaucracy to administer Apartheid, it become less powerful and less well informed about events on the ground (ibid.: 105). In his analysis of attempts by the Mexican state to control forests, Mathews argues that the ideological power of the state to shape people's understanding has been overstated: 'In the case of Mexican forestry, the calculations and techniques which are supposed to produce official power/knowledge have been subverted both by the internal culture of the forest service, and by the existence of long-standing traditions of fire use which low level officials and rural people have simply concealed from official notice'(Mathews 2005: 815).

Similarly, Hull's account of state bureaucracy in Islamabad, Pakistan, finds a large space between official documentation (which he calls 'The Master Plan') and the actual, real-world enactment of these documents (Hull 2012).

Dresch and Scheele have queried Scott's distinction between abstract, fixed, and rule-based bureaucratic categories and the flexible, localized metis (Dresch and Scheele 2015). They argue that local knowledge can have some of the attributes Scott reserves for the machinery of the state: 'everyday life, no matter how local, itself often involves quite formal categories. In many contexts, they are central to what it means to be human' (ibid.: 6). Rules determining relatedness, for example, that determine who one can and can't marry can be fixed and rule-based yet highly localised. If Dresch and Scheele are right, knowledge constructed out of fixed categories may be characteristic of the state making the world legible and manipulable, but it can also be a found elsewhere. In the context of my research, fixed, formal categories might form part of everyday intuition and common sense as much as the formal knowledge of medical practitioners.

Graeber expresses concerns with the epistemic limitations of bureaucracies in a way that resembles Scott:

> Bureaucratic knowledge is all about schematization. In practice, bureaucratic procedure invariably means ignoring all the subtleties of real social existence and reducing everything to preconceived mechanical or statistical formulae. Whether it is a matter of forms, rules, statistics or questionnaires, it is always a matter of simplification (Graeber 2015: 75)

For Graeber, bureaucratic simplification is a kind of 'structural stupidity' that creates 'dead zones' in our imagination. He suggests that we can trace its spread by following changes in language, in the arrival of a distinctive idiom full of 'bright, empty terms like vision, quality, stakeholder, leadership, excellence, innovation, strategic goals, or best practice.' According to Graeber, the terms are vacuous rather than expressive of alienation or disenchantment. Unsuited to epistemic work, they are not the building blocks of serious thought. This seems a long way from Weber's vision of the ruthless precision of bureaucratic reason outdoing all competing runners. If we want to

deal with what Graeber calls the subtleties of real social existence, and to avoid what he dubs structural stupidity, we might prefer the common sense of lay people over the knowledge of expert bureaucrats. This raises distinct concerns in a study of mental healthcare. If the knowledge of bureaucrats is so flawed, how can they deal with suffering as complex as that displayed by their patients? Is it structural stupidity that makes the appeal of mental disorders so baffling to clinicians yet so obvious to many patients?

However, we might find reason to be cautious here, and wonder if Graeber himself is guilty of a little oversimplification. In a paper examining the way that traditional Chinese medical practitioners construct knowledge, Hsu draws on Weber to make distinctions between 'styles of knowing' according to how a medical practitioner establishes his or her authority (Hsu 2000). Hsu finds that vagueness is used to establish charismatic authority (ibid.: 203). Polysemy is linked to traditional authority. Clear, fixed knowledge with defined denotation she identifies as linked to bureaucratization. Vague concepts create uncertainty in a charismatic healer's clients. Clients look to the charismatic healer for his or her interpretations and this creates a close bond between healer and client. In contrast, following bureaucratization, a clinician's authority is derived from his or her fellows and superiors. Categories of knowledge need to be suited to professional communication and discussion. To achieve this, professionals are orientated away from communication with clients. The consequences of this, for Hsu, are significant: 'Clients are thereby turned into disempowered patients' (ibid.: 211).

This, warns Hsu, can have undesirable consequences that have a direct bearing on the themes of this thesis. A gap opens up between clinician and client:

> The experts' knowing in the bureaucratic setting becomes more self-confident, with a greater claim to "intersubjective truth"…given the institutionally inbuilt tendency for experts in bureaucratic institutions to get out of touch with the needs and wants of their social environment, this process not only disempowers their clientele: it may, as a final consequence, result in the production of knowledge that is irrelevant for their clients and the healing process. (ibid.: 221)

This observation is very resonant in my own fieldwork. In the chapters below I describe many occasions when the expert knowledge of staff members appears to be more suited to professional communication than engaging with patients or building of therapeutic relationships. Tensions between the 'outcomes' towards which Oxford Health staff members direct their efforts, and the preferences and wishes of their patients, run throughout. In official documentation, or discussions in team meetings, staff members focus most of their attention on co-ordinating with other professionals, recording risk, dealing with issues regarding compliance, and patient discharge. Events that are of great importance to patients, such as moments of insight, the acquisition of skills that help them live with their symptoms, even occasions of major improvement in health, are difficult to express in official documentation or using clinical vocabulary. Key events in the lives of patients can have a very low profile in the official life of the mental health team.

However, in the ethnography below, clinical categories do not appear to be particularly clear or well defined. Terms like 'mood' or 'mania' emerge as being very fluid and inclusive. They communicate very little about the patient. As I go on to discuss, clinical discourse seems to deploy a strategic vagueness regarding the meaning of key clinical words, whilst trying to achieve professional agreement about the people and phenomena they refer to. I will argue that this vagueness is a way of dealing with knowledge deficits that would otherwise threaten the capacity of clinicians to make rapid, well-reasoned and recordable clinical decisions.

1.11 Discretion Versus Bureaucratization: the dynamic of the office

In a short but resonant monograph, the philosopher O'Neill describes how we currently live in a 'culture of suspicion' that may even amount to a 'crisis of trust.' This seems to be very pertinent to mental healthcare:

> amid widespread and energetic efforts to respect persons and their autonomy and to improve regulatory structures, public trust in medicine, science and biotechnology has seemingly faltered…In many

> developed countries, and particularly in the UK, there is evidence that mistrust of various professions, experts and public authorities is quite widespread (ibid.: 3)

O'Neill finds that in the contemporary West trust is felt to be risky, based on inevitably incomplete knowledge and a lack of absolute guarantees. Relying on trust seems increasingly counterintuitive and imprudent, even irresponsible. As a consequence, we take for granted initiatives to replace trust with institutional mechanisms. In addition, various auditing technologies seek, at tremendous cost, to prevent abuse of trust. These include performance monitoring, examinations, and the location of cameras and recording equipment in the workplace. Measures that might have seemed extraordinary a few decades ago are now ubiquitous.

O'Neill does not discuss the notion of 'discretion' as it is found in the sociological literature on street level bureaucracy. However, the concept is closely related to her notion of trust. The phrase 'street-level bureaucracy' was coined by Lipsky, first in an article published in 1971 and then in a seminal monograph published in 1980 subsequently republished in revised form in 2010 (Lipsky 1971, Lipsky 2010). The subtitle of the monograph: 'Dilemmas of the Individual in Public Services', provides the key to Lipsky's approach. His intention is to capture the role of the individual in the interface between state bureaucracy and the public.

Lipsky says that it is through street-level bureaucrats that citizens encounter the government. Street level bureaucrats are teachers, police officers, social workers, judges, public lawyers and other court officers, health workers and many other public employees who grant access to government programs and provide services within them (Lipsky 2010: 3). Lipsky's central claim is that we can't understand this encounter simply in terms of policy. Rather, we have to take into account the complexities of person-to-person interaction. For Lipsky, it is the street level bureaucrats, as much as their seniors, who make policy. This is because, above and beyond the formal requirements of their job, street-level bureaucrats enjoy 'relative autonomy.' They are guided by 'rules, regulations and directives from above' as well as 'the norms and practices of their occupational group' but

‘exercise wide discretion in decisions about citizens with whom they interact’ (ibid.: 13). For example, police officers ‘decide who to arrest and whose behaviour to overlook …[and]…teachers decide who will be suspended and who will remain in school’ (ibid.: 13). This may be seen in a positive light. Through discretion, in the form of improvisation and responsiveness, street-level bureaucrats are able to adapt their work to meet the needs of individual cases. Flexibility like this appears to be critical to the delivery of mental healthcare. However, discretion is also the means by which service bureaucracies might consistently favour some populations (such as articulate and assertive middle-class people) and disadvantage others (such as marginalised black people). In practice, discretion allows street-level bureaucrats to deal with an excessive burden of work, inadequate resources and limited time.

This gives Lipsky’s work a very non-Weberian feel. Lipsky’s street-level bureaucrats are officials, but they are insulated from bureaucratization. Instead of being constrained by an iron cage, they are relatively free to exert their non-routinized and non-rational influence on the office. Much of their expertise rests in using their discretion to match their relatively scarce time and resources to the urgent and almost limitless demands placed on them. They learn how to choose which rules to apply and which to ignore, on a case by case basis. Lipsky argues that discretion can never be eliminated from the work of street-level bureaucrats. This is because he regards the work as simply too complex to reduce to rules; because the ‘human dimension’ is felt to demand ‘compassion for special circumstances and flexibility;’ and discretion if favoured by the street-level bureaucrats themselves (ibid.: 15).

Much of the subsequent sociological literature investigates the impact of changes in managerial practice on street level bureaucrats and considers whether discretion still has much of a role. Some are doubtful. For example, in an influential book chapter on social work in the UK, Howe argues

that staff training, monitoring and skilful management have greatly limited discretion (Howe 1991). This is something he sees as highly desirable:

> If practitioners were completely autonomous, running welfare organisations would be difficult and hazardous. Generally, the solution lies in training practitioners to think and act as the organisation would like them to…as a result, the practitioner is made ideologically compatible with the department's values and purposes, so that she can safely be handed direction allowing her to act flexibly but acceptably in volatile situations (ibid.: 159-160)

Others make the same empirical claim, but evaluate it differently. Several scholars find that new management has reduced discretion, but are sceptical as to its benefits (Hadley 1996; Harris 1998). Echoing some of the themes of this thesis, Jones regrets the 'routinized relationships' between social workers and their clients imposed by new management styles (Jones 2001). In contrast, some commentators make an opposing case, finding empirical evidence for a continued and highly valuable role for discretion in social work (Ellis, Davis, and Rummery 1999). Others identify the continued exercise of discretion, but regard it as an unfortunate way of undermining official policy (Baldwin 2000).

As a way of taking the debate forwards, Evans and Harris seek to add nuance to the notion of discretion (Evans and Harris 2004). They argue that we should not think of discretion as simply being either present or absent. Rather, that is a matter of degree. Evans and Harris suggest that the concept of discretion should reflect greater or lesser degrees of individual freedom, and even varieties of discretion. In a later paper, Evans develops this argument, suggesting that Lipsky's work understates the role of professional expertise, disposition, and ethics as guiding an individual social worker's discretionary decision-making, and, indeed, the perspectives and judgements of managers (Evans 2010).

The themes of professional autonomy and managerial control are explored by Mintzberg in an influential early monograph on organizations (Mintzberg 1979). Mintzberg makes a useful distinction between two kinds of bureaucracy. In a 'machine bureaucracy', the work is highly

standardised and management is relatively straightforward. But in a 'professional bureaucracy', the work is more complex, and workers have a greater degree of autonomy. In this case standardisation is achieved more by training and professionalism, in which professionals reproduce the required habits, disposition, ethics and epistemic preferences (a process that Mintzberg calls 'indoctrination'). This can create management challenges. There are 'problems of coordination' as professionals who work independently nonetheless need to collaborate. If insufficiently indoctrinated, individual discretion can lead professionals to ignore both the needs of the organization and the needs of their clients (ibid.: 374). Here Mintzberg's sense that training and professionalism do the work of external monitoring recalls Weber's remarks, discussed above, about the spirit of the office. The norms and values of the office, as felt by the official, are a key element in the achievement of bureaucratic goals.

A recent book chapter by Harrison examines the relevance of Lipsky to NHS healthcare (Harrison 2015). He finds that: 'the ostensible indeterminacy and uncertainty of medicine, along with the excess of demand over supply in the context of a non-marketed system, have historically prevented the bureaucratization of medicine, and have established physicians as street-level bureaucrats' (ibid.: 65). However, over the last two decades, Harrison sees two important sources of change. The adoption of Evidence-Based Medicine and the introduction of market mechanisms to NHS healthcare have, together, eroded the barriers to bureaucratization.

The way Harrison describes this is reflects the argument of this thesis and will be highlighted in some of the ethnography below. He states that Evidence-Based Medicine and marketisation: 'share an underlying logic that treats medicine and healthcare generally as capable of explicit specification, rather than esoteric, indeterminate or dependent on tacit knowledge' (ibid.: 73-74). Harrison suggests that it is this transition, away from instinct or personal judgement, and towards propositional knowledge and instrumental rationality, that has greatly increased the potential for

bureaucratization of medicine. In the language of Scott, it is a turn from metis and towards legibility. Harrison goes on to argue that the autonomy of medicine may always have been illusory, and that the degree of resemblance between the assumptions of medicine and management may be underappreciated by scholars. Mental health professionals, for example, may always have been more bureaucratized and less autonomous than they or others might have assumed.

1.12 Discussion

In this chapter I have introduced my research questions and the way I set about addressing them. I reflected on my fieldwork experiences, in particular to draw out local intuitions about knowledge and expertise. Many staff and patients assumed that expert knowledge of mental health professionals was a good way of understanding patient's experiences of distress and madness. It is not clear that this is the case. This is because expert knowledge seems to be focussed on other tasks associated with bureaucratization. According to O'Neill, a general decline in trust in professionals has led to increased bureaucratization. Bureaucratization helps professionals to achieve certain goals, such as working in a uniform way and to uniform standards, and producing detailed documentation. However, it is less well suited to other kinds of goals. Weber was concerned about the capacity of officials to deal with work that is hard to record or quantify, particularly in the context of highly complex human subjects. This raises doubts about the suitability of bureaucratized working practices in mental healthcare. Can rules and routines really adequately respond to the immense variety and complexity of madness and distress? Critics of bureaucratization such as Scott and Graeber stress the shortcomings of routinized knowledge. In their work, instrumental reason appears oversimplified, even crude, and has sometimes disastrous effects.

Some bureaucracies appear to have dealt with the complex nature of their work by giving staff members considerable scope for personal autonomy. This enabled them to deal with complex

human situations, albeit whilst creating a significant gap between official policy and practice, and being open to abuse. Bureaucratization is in a zero-sum relationship with discretion. If officials are trusted, they can exercise personal autonomy. Increasing routinisation or the scrutiny of officials is likely to diminish the scope for individual discretion. Indeed, this is what some commentators believe is underway in healthcare, an impression that my ethnography bears out. A key insight of Weber was that the office is an ethical domain. Ethics influence all aspects of professional life. The expertise of officials can never be isolated from the ethos of the office. This contributes to how bureaucracies control officials. Alongside rules and regulations, the ethos of the office may be interiorised by staff members. Part of the claim of this thesis is that this is what has happened in Oxford Health. The values of bureaucracy have entered professional formation such that good clinical practice is also good bureaucratic practice. This routinized setting is the place where the self-management technology True Colours was designed, and introduced. Its goals have to do with patient empowerment. In this thesis I try to explore the relationship between empowered, agential patients and routininised clinical expertise and working practices. Understanding this relationship helps explain why True Colours, and other technologies like it, are liable to fail.

CHAPTER TWO: THE MECHANISMS AND VIRTUES OF ACCOUNTABILITY

2.1 Ethnographic Vignette: Accountancy and patient perspectives at the AGM

As piece of preparatory fieldwork, I attended the Annual General Meeting of Oxford Health. This took place on September 6th 2012 at 6 pm in a conference and events centre that forms part of the Oxford United Football Club ground. As well as something like two hundred Oxford Health staff members, and two representatives of an accountancy firm, fifty or so members of the public were present. The conference room was packed, to the extent that not everyone could find a seat. Senior executives in the Trust each gave a short presentation. They discussed the financial state of the Trust, the care it provides and the future. This was expressed in the language of 'performance,' 'targets' 'challenges' and 'issues.' There was talk of 'care pathways,' 'payment by results' and 'clinical clustering.' Some discussion followed and questions were taken from the floor. This was a very early ethnographic experience and I was surprised at how corporate the event felt. My impression was that the AGM could be a meeting of any mid-sized commercial organisation.

Much of the time was occupied with budgetary concerns. The board was worried about reductions in Trust income and whether adequate provision had been made by the chief accountant. Pressures from competing healthcare providers were a topic of concern. Problems with staff discontent and the difficulties of recruiting and retaining staff members were also discussed. However, it was also described as an 'opportunity to listen.' This meant that time was set aside in the AGM for comments and complaints to be raised by patients and the wider community. During this period, and also later on, patients stood to express strong reservations about the care Oxford Health provides. Some were angry, even slightly belligerent, whilst others were tearful. They made demands for patient 'rights' to be respected. In response, board members spoke about how services

'need to reflect patient perspectives' including 'patient centred care,' 'the recovery model' and 'patient self-management.'

The AGM had what seemed to be a very heterogeneous agenda. To those at the meeting, institutional responsibilities, facing competition, being financially prudent, reflecting patient preferences and having less hierarchically structured relationships with patients seemed to form part of a single interconnected process. At the time I found this puzzling. Why were patients expressing discontent at the same meeting that accountants were going over the books? Why did including patient perspectives mean adopting the recovery model? What possible connection could there be between market mechanisms in the NHS and the concept of patient self-management? The answer to these questions lies in the notion of accountability.

The AGM was an exercise in accountability. The chief executive and others explicitly described Oxford Health as an 'accountable institution.' The Trust is formally accountable to the Board and, more loosely, other local stakeholders. Accountability involves satisfying the board that the finances are in order. It also means being responsive the patient preferences and experiences. Many of the key terms that form the argument of this chapter were also central to the AGM. Notions such as 'transparency', 'openness', 'responsivity', and 'feedback' shape the theory and practice of accountability. All are discussed below.

2.2 Introduction

In the previous chapter I introduced the notion of bureaucracy. Using the work of Weber, I suggested there is an affinity between the behaviour and ethic of officials and the behaviour and expertise of mental healthcare professionals. I went on to argue that bureaucratic machinery tends to stand in a zero sum relation with professional sovereignty and personal discretion. An increase in

bureaucratic machinery or oversight tends to exclude personal discretion or other professionalized ways of thinking and working. In this chapter, I introduce the notion of accountability. This concept captures aspects of Oxford Heath's institutional culture not described by Weber's ideal type. Oxford Health is not just an office that follows rules and regulations, organized around documentation and staffed by dispassionate, hierarchically ordered experts. Instead, these features are orientated towards the telos of accountability. The notion of accountability is the key to understanding Oxford Health as an institution.

Oxford Health is formally accountable to a range of bodies and populations. It needs to be able to show that it fulfils obligations that pertain to value for money, care quality, transparency and prudence. These obligations are bureaucratic in nature. They require a distinctive kind of documentation. This is often primarily quantitative, based on standardized metrics and scales. By producing information of this nature, Oxford Health demonstrates its accountability. The production of this documentation shapes the day-to-day work of its staff members. It influences the way that healthcare is conceived of and the nature of professional expertise. Good clinical care is, by definition, accountable care.

In this chapter I try to sketch out the relationship between accountability and mental healthcare. I begin by briefly outlining the way that political scientists understand accountability. My purpose is to bring conceptual clarity to the subsequent discussion. I then sketch out the history of the NHS, showing how the idea of accountability has increasingly come to shape NHS institutions. Next, I look at how Oxford Health fits in to the NHS as a relatively autonomous institution that is held to account in various ways. I then consider interpretations of NHS reforms, looking at the literature on neoliberalism to suggest that accountability is tied to class and the interests of capital. The following section looks at the anthropological literature on audit culture and how the technologies of audit relate to the workplaces they attempt to describe. The thought is that mechanisms of

accountability cannot be neatly separated from working practices. Instead, the values of auditing become internalized by staff members. They can fundamentally change the way that professionals go about their work, and how they conceive of their expertise. The following sections discuss evidence-based medicine (EBM). I suggest that EBM is ideally suited to the needs of an accountable institution. It is a means by which accountability is internalized by mental healthcare professionals. This is likely to be reflected in their patients, who tend to pick up on the way that their clinicians describe them.

The political science literature and the official documentation produced by Oxford Health and discussed below use a shared vocabulary. Both appear willing to take accountability at face value. They make links with other policy goals such as efficiency, transparency and public participation. These ideas do not form part of my analytic vocabulary. Instead, I understand them to be part of local knowledge. Looked at from this point of view, the notion of accountability (and the theories that lie behind it) is a way of presenting and authorizing a particular style of care delivery by Oxford Health. In other words, Oxford Health clinicians conduct themselves in such a way that they are able to produce a record of care that enables their employer to show it is accountable. My claim here is not to assess how effective Oxford Health's attempts to be accountable have been. I don't know if Oxford health is 'really' accountable. Neither do I take a view on whether this is, or would be, a good idea. Rather, I try to show the contribution of the notion of accountability to local bureaucratic practice.

2.3 How Does an Institution Become Accountable?

Weber was not particularly concerned with the notion of accountability. He was sensitive to the risk that bureaucracies might become too powerful or serve particular interests, which he calls *Beamtenherrschaft*, or civil-service rule (Weber 2009: 95). But, otherwise, the idea of

accountability receives modest attention in his work. This is in stark contrast with both popular and academic discourse over the last few decades. Many commentators stress the extraordinary scale of the increase in the prevalence of technologies of accountability and auditing. Power, even if he suggests certain qualifications and caveats, describes it as an audit 'explosion' (Power 2003). In the introduction to the seminal collection Audit Cultures, Strathern writes that 'The concept of audit…has broken loose from its moorings in finance and accounting; its own expended presence gives it the power of a descriptor seemingly applicable to all kinds of reckonings, evaluations and measurements' (Strathern 2000a: 2). Accountability seems to have become both ubiquitous and necessary. Merry describes how it has become 'naturalized' (Merry 2011: 92). It seems to have entered our common sense, such that alternatives are unthinkable (O'Neill 2002: 45–8). Strathern and Shore both suggest that however much accountability mechanisms are disliked, they seem impossible to contest (Shore 2008: 291; Strathern 2000a: 3). Weber's reticence now looks rather dated.

How to define accountability has been the focus of academic attention from a number of disciplines, including political science, constitutional law and public administration (Mulgan 2000). I will seek here just to make a few points, using The Oxford Handbook of Public Accountability (Bovens, Goodin, and Schillemans 2014). My purpose is not to take a particular stance, normative or descriptive, on how accountability should be understood. Instead I hope that the concepts and distinctions drawn by political scientists and associated disciplines help clarify my discussion below and cast light on the ways that accountability may be manifest in the field described in the ethnographic data in subsequent chapters.

According to Bovens et al., one way of understanding accountability is as a virtue of officials. In this case, accountability consists of a sense of responsibility and a willingness to act in a fair and transparent way. It is something that arises out of professionalism, or training. Accountability as a

virtue is something that, in O'Neill's terms, rests on trust rather than formal or explicit means. However, as O'Neill discussed, trust has begun to appear imprudent and irresponsible. It would be hard to imagine the chief executive of Oxford Health addressing the AGM and talking about the quality of care only with reference to the quality of staff. Such a thing would be understood as incompetence. Board members and other AGM attendees want statistical evidence of care quality. In place of trust, institutions are required to be able to document features of accountability, such as 'care quality'. Explicit bureaucratic mechanisms are necessary for the demonstration of accountability.

Perhaps for this reason, institutional mechanisms of accountability attract most academic attention. Bovens et al. state that: 'accountability is conceptualized as an institutional relation or arrangement in which an agent can be held to account by another agent or institution' (ibid.: 9). They identify three kinds of accountability mechanism which result in this 'holding to account'. The first is an obligation on the part of the accountable actor to provide information about their work, including information about outcomes and procedures. This can mean, for example, high levels of routine documentation that can assist in the provision explanations and justifications where failures occur. Next, there needs to be some institutional arrangements to enable the accountable actor to be questioned about their conduct. Thirdly, there is a process by which external bodies pass judgment on the actor. This judgment may be approving, but there may also be scope for condemnation. Arrangements may be in place such that negative judgments lead to the imposition of sanctions or positive judgments leading to commendation or rewards.

The AGM is an example of such an institutional arrangement. It was an opportunity for questions to be raised and concerns discussed. Both the Board and the public were understood to be holding the Trust to account. In a formal, written sense, the Trust needs its plans to be approved by the Board. Throughout fieldwork, I observed clinicians discussing how exposed they felt to both the second

and third type of accountability mechanism: internal and external bodies that might pass judgment on their conduct. The emotional tone of clinics and team bases seemed to be more a fear of negative judgments than an anticipation of what Bovens et al. call commendation or rewards.

However, my data caution against too strong an opposition between accountability as virtue and accountability as bureaucratic mechanism. This distinction may exist as an analytic device, but the empirical reality is muddier. This becomes clear in my discussion of the audit culture literature, where staff members are said to internalize the culture of auditing, such that external rules and internal dispositions merge. Part of the argument of this chapter is that the rules and ethos of bureaucracy cannot be clearly separated. The impact of accountability is felt as much in the subjective experience of the clinician as it is in the rules they follow. If that is right, then the notion that auditing can be carried out with minor impact on institutions is part of the ideology, even the disguise, of accountability.

Within the political science literature, there are concerns that mechanisms of accountability might interfere with the smooth running of a bureaucracy. Policy goals are not assumed to form a consistent set. Dunn puts it this way: 'practices of democratic accountability form the key site of putative reconciliation between the norm of bureaucracy and the apparently antithetical implications of state authority' (Dunn 1999: 330-331). Regulation and monitoring can create 'red-tape' that can become a formidable barrier to efficiency. Accountability might nonetheless be deemed desirable because it appeals to democratic principles. It might be understood as a means of participation, and for public institutions to reflect the wishes of the people, even at the expense of reduced efficiency. Looked at from this perspective, accountability is a kind of compromise between competing goods. However, in the history of the NHS, conflicts between policy goals have not always been acknowledged in policy or popular discourse. Although accountability is conceived of as a means of public participation, it is also seen as improving efficiency, care quality and safety. This is why, in

the AGM, questions about accounting and questions about patient participation were both on the agenda.

2.4 From Trusted Machine to Accountable Service Provider: Six decades of the NHS

Bosanquet and Pollard remark that it is part of the mythology of the NHS to suggest there was no proper healthcare in Britain before 1948 (Bosanquet 1997). Instead, they suggest, from the 19th century, Britain had a 'viable, individually orientated and community-based forms of healthcare provision' that were 'formidable' (ibid.: 11). However, even if the capacity of pre-NHS provision was greater than sometimes stated, it was not rationally organised. The best healthcare was available in wealthy areas where it was least needed, whilst voluntary and municipal hospitals needlessly competed against each other when they might have co-operated (Klein 2013: 2–3).

Plans for a centralised and state-owned NHS were developed in the 1920s and 1930s (Rivett 1998: 27). Most historians of the NHS stress how the unique social conditions found in the aftermath of the Second World War gave new impetus to the plans, and shaped the emerging legislation. For example, Rivett emphasises how social solidarity, in part arising out of shared experience of war and serving in the forces, formed a key ingredient at the NHS's birth:

> Behind it all was an attitude epitomised by an elderly Civil Defence worker who told Richard Titmuss, the social scientist, that 'The war made us realise that we are all neighbours' (ibid.:29). Commentators both scholarly and popular refer to a 'consensus' emerging. It appears there was little resistance, and what there was came from the doctors themselves. Minister of Health Bevan described his method of overcoming the objections of medical doctors to be 'stuffing their mouths with gold' whilst the BMA described the nationalisation of the hospitals as 'the largest seizure of property since Henry VIII confiscated the monasteries' (ibid.: 35).

When the NHS was founded on 5th July 1948, it was conceived of as a centralised, nationalised institution that was designed to harness a rather Weberian vision of the power of rational bureaucracy address certain recognised problems. Klein remarks: 'the NHS represented the victory of the values of rationality, efficiency and equity' (Klein 2013 :20). Central to the original

conception of the NHS was that care would be free at the point of delivery, would be comprehensive, and that resources within the NHS would be pooled.

Unlike Weber's ideal type, in which bureaucracies are unified institutions, several historians of the NHS find contradictions to be the core of NHS historiography. Klein states that 'fundamental contradictions' lie at the heart of the conception of the NHS. Policy was to be guided by advances in medical expertise and knowledge, but also reflect political and bureaucratic processes. Control was to be located at the centre and also to be decentralised. Klein remarks that 'The history of the NHS since 1948 can largely be seen as the working out of these contradictions: a continuing and never-ending attempt to reconcile what may well turn out to be irreconcilable aims of policy' (ibid.: 21). Bosanquet and Pollard take a similar view, describing the NHS as 'a study in conflicting values…the story of the NHS is the story of the working out of those contradictions' (Bosanquet 1997: 7).

For historians who stress internal contradictions in the NHS, the first few decades are a time during which external pressures bring these structural issues to light. In the 1960s the demand for healthcare, and thus the costs, sharply escalated. The recession that began in 1973 increased the stress as government spending became more circumscribed. Policy debate about the NHS at the time was framed in a language that now feels alien. Basic facts and figures were produced expressing capacity and resources, such as the number of nurses and number of beds. But data was not gathered regarding efficiency. Outcomes were not defined by bureaucrats and measured by metrics. Instead, it was assumed that medical professionals could be trusted to treat their patients, if they were given adequate means to do so.

But as financial pressures grew, value for money became a more important political concern in Westminster. The relationship between inputs and outputs drew more attention, leading to the

devising of performance indicators (Klein 2013: 115). Klein describes the early performance indicators as 'extremely crude' in that they tended to measure activity (number of procedures, for example) rather than clinical outcomes or quality. However, they did highlight differences in performance between health authorities. This concern is still felt today, where commentators complain about an unjust 'postcode lottery' determining care delivery (ibid.: 116).

Klein sees what he calls 'the managerial revolution in the NHS' to date from October 1983. This is the date of publication of the Report on NHS Management Enquiry by Roy Griffiths. Griffiths had been the managing director of the supermarket chain, Sainsbury's. His report set the tone for subsequent managerial change. He said that as an institution, the NHS was 'stagnant' and 'swamped.' The problem was that it lacked effective leadership. Griffiths concluded his report in stark fashion: 'If Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge' (ibid.: 147).

Most commentators identify two distinct phases of competition in the NHS. The first, between 1991 and 1997, is sometimes called the 'internal market.' The second in the 2000s, sometimes called the 'quasi-market'. Under Thatcher and then Major, successive Conservative governments sought to develop the internal market. They did so without making significant increases to the overall budget. Rather, by introducing market mechanisms it was hoped that improvements would be made to efficiency and quality. Individual patients were not given choice. Instead, markets were introduced by separating the purchase of care from the provision of care. For the internal market, this meant making hospitals independent of health authorities, and creating competition between them and private providers. Care was purchased from hospitals by healthcare authorities and various types of GP fundholding groups, which were allocated budgets for the purchase of elective care. GPs who were part of a fundholding group could thus choose where to refer their patients.

The degree to which this arrangement successfully introduced competition is the subject of some debate. Hospitals were considered to be financially autonomous only in that they were required to avoid deficits. This 'negative autonomy' was very limited: in particular, they could not retain surpluses gained through successful competition with alternative providers. This meant they lacked a strong incentive increase their market share. In addition, there was very little information on, of regulatory insight over, the quality of care. Waiting lists were published, but not data about outcomes or costs.

Unlike the founding of the NHS, the introduction of market reforms is not seen as arising out of popular demand, and the internal market was not politically successful. Klein remarks that making the NHS more exposed to public scrutiny makes the government, as a consequence, more vulnerable to criticism for perceived failures (ibid.: 178). Public confidence in the NHS fell, and the NHS became a major focus for New Labour. This is, Klein argues, despite the fact that policy differences between the two parties are often more rhetorical than real. Nonetheless, following the election victory of 1997, Blair's New Labour government increased the level of funding to the NHS in a historically unprecedented way. Spending in the financial year 1997/8 was £35bn. This went up to £44bn in 2001/2 (ibid.: 211). In 2002 New Labour introduced and developed the quasi-market in the NHS in England.

In the quasi-market, care was to be purchased by groups of GP surgeries organized into primary care trusts or PCTs, which could choose between providers. To facilitate this choice, more information was generated. The performance of hospitals, measured according to particular targets, was published and centrally managed. The prices of care were also set centrally, so that competition was based around perceptions of quality, not cost. Patients were given direct choice between hospitals for elective care in 2006, through the 'choose and book' electronic booking system.

Following the 2012 Health and Social Care Act, PCTs have been superseded by clinical commissioning groups or CCGs. These bodies are organized by geographical area. Each CCG has a high degree of autonomy, and is intended to be 'downwardly accountable', reflecting local preferences and needs. For example, the Oxfordshire CCG is one of the CCGs that buys mental health services from Oxford Health. Oxford Health must compete for the contract against other providers. To do this it produces detailed performance data. Oxfordshire CCG in turn is accountable to NHS England. Each CCG submits standardized data. These data include indicators drawn from the NHS Outcomes Framework.

Foundation Trusts were first introduced in 2002, as independent, public interest organisations. Foundations Trust have a high degree of financial autonomy and can now generate revenue through the delivery of services. Each Foundation Trust has a board, made up of staff members, patients and local people. The board examines the progress of the Trust through monthly meetings in which performance data is assessed. The presence of patients and local people on the board is seen to provide 'downward accountability', linking the trust with the people who used the services, and people in the locality. 'Upward accountability' is achieved by making Foundation Trusts accountable to independent regulators. Since 2006, Foundation Trusts have been placed in competition with an increased number of players: other Trusts and Foundation Trusts, private providers and independent sector treatment centres.

A body, now known as Monitor, was set up to assess the financial viability of Foundation Trusts. Part of the purpose of Monitor is to ensure fair competition between providers. Monitor rates Foundation Trusts in a transparent process. It provides simple data for each Foundation Trust expressing 'financial stability risk' and 'governance'. Since 2009, the Care Quality Commission has been responsible for assessing the safety and quality of healthcare. Its current methodology, in place

since 2013, is described as 'intensive' and consists of expert-led inspections of Foundations Trusts leading to publically accessible ratings.

2.5 Oxford Health as an Accountable Institution

Oxford Health was granted Foundation status in April 2008. It currently provides community health, mental health and specialised health service across Oxfordshire, Buckinghamshire, Milton Keynes, Berkshire, Swindon, Wiltshire, Bath and North East Somerset (BaNES). It had a total income for the 2014/15 of £288.3 million (CQC 2016: 14). At present Monitor gives Oxford Health a financial stability risk rating of 3 out of a possible four, where 1 indicates the highest risk and 4 the lowest risk. The governance rating is green, indicating no evident concerns. [1]

The current CQC report on Oxford Health gives it an amber rating: 'requires improvement.'[2] (This is because, of the five core domains ('safe,' 'effective,' 'caring,' 'responsive' and 'well-led') Oxford Health was rated 'good' for the final three, but 'requires improvement' for the first two. The report praises the Trust for qualities such as good at 'recognising safeguarding concerns,' 'reporting incidents' and 'multi-agency and multi disciplinary working.' The CQC were pleased with the way clinical performance was monitored and reviewed by the board and the processes for monitoring risk were described as 'robust.' In contrast care plans were 'variable' 'inconsistent' and 'not always personalised.' In addition 'unidentified ligature points in acute mental health services' were highlighted as needing to be addressed.

The way that accountability, transparency and participation are seen as aspects of a single whole can be seen in public documents, where the buzz words I heard in the AGM resurface. In central

[1] https://www.gov.uk/government/publications/nhs-foundation-trust-directory/nhs-foundation-trust-directory accessed 16.04.16
[2] http://www.cqc.org.uk/provider/RNU accessed 16.04.16

government, transparency and the free flow of information is held to be a good in itself. On the cabinet office website, it states that:

> Openness and transparency has the potential to transform government. It can strengthen people's trust in government and encourage greater public participation in decision-making. Transparency is also a key part of this Government's efficiency and reform agenda. Freeing up public data and putting it in people's hands can help them have more of a say in the reform of public services.[3]

As a consequence, the aim of a white paper called Unleashing the Potential is 'putting data and transparency at the heart of government and public services.' [4]

The perceived advantages are manifold. In the words of the cabinet office website, that this will:

- enable the public to hold politicians and public bodies to account
- deliver better value for money in public spending
- realise significant economic benefits by enabling businesses and non-profit organisations to build innovative applications and websites using public data [5]

By uniting safety, efficiency, quality and value for money, accountability appears an unopposable rationale across many areas of public spending.

In healthcare these free flows of information are thought of as enabling accountability and fostering democratic mechanisms. On the Department of Health webpage dealing with the 'A to Z of modernisation' it is put thus: 'Local democratic legitimacy in health is the Government's intention to give more of a voice to local people, by involving local councillors and patient representatives in shaping and influencing the strategic direction of the health and social care system in their area.'[6] As I tried to show in my sketch of the history of the NHS, in the early decades, there was no perceived need for local democratic legitimacy. The medical profession knew how to do its job. The Department of Health website quoted above suggest that medical expertise is not enough, or cannot

[3] http://www.cabinetoffice.gov.uk/transparency accessed 06/09/2012
[4] http://www.cabinetoffice.gov.uk/resource-library/open-data-white-paper-unleashing-potential accessed 06/09/2012
[5] http://www.cabinetoffice.gov.uk/content/transparency-overview accessed 06/09/2012
[6] http://healthandcare.dh.gov.uk/a-z/#Local%20democratic%20legitimacy accessed 06/09/2012

be trusted, to deliver healthcare. Instead, 'strategic direction' requires other kinds of input and, thus, other kinds of institutional arrangement.

On a Department of Health website it is argued that accountability brings with it a range of benefits particular to healthcare:

> Evidence suggests that transparency can have a positive effect in improving our care services…research shows strong proven benefits for us as patients from shared decision-making, including:
>
> - Better treatment adherence – we stick to our treatment plans;
> - We have improved confidence and coping skills;
> - Fewer of us choose major surgery, creating cost savings;
> - Our health behaviours improve, such as increasing exercise and reducing smoking; and
> - We use services more appropriately, particularly fewer emergency admission.[7]

This suggests a deep significance to free flows of information that suggests the benefits extend into many aspects of healthcare. More information is seen to lead to better decision-making on the part of the patients, and potential patients, regarding their treatments and their wider 'health behaviours'. In addition, the Department of Health anticipates changes in patients themselves, in their morale and basic approach to their illness. 'Improved confidence and coping skills' seem to be of intrinsic value, and to be highly desirable in mental healthcare, where low confidence and poor coping skills are commonly reported and understood to be symptomatic of mental disorders.

These policy goals and priorities are manifest at the local level. On their website, Oxford Health list ten 'commitments' to 'people who use their services and their carers'. Of these, five have to do with accountability:

- To be fully involved in and informed about any decisions about their care
- To be supported to manage their own care
- To have information about treatment options available to them
- To have a service that promotes recovery and independence
- To be consulted on all service developments [8]

[7] http://healthandcare.dh.gov.uk/a-z/#Local%20democratic%20legitimacy accessed 06/09/2012
[8] http://www.oxfordhealth.nhs.uk/about-us/overview/what-we-do/ accessed 06/09/2012

Oxford Health appear to share central government's confidence that accountability is the key to better services and to improved efficiency. There are perceived benefits to the relationship between staff and patients and a direct positive change in patients themselves.

The creation of Oxford Health as an autonomous accountable institution demonstrates a considerable development from the early days of the NHS. Despite this lack of apparent grassroots demand, the notion of accountability lies at the heart of this new dispensation. Klein describes the changes in sardonic terms, as making healthcare seem less like a 'church' and more like a 'garage' (Klein 2013: 304). However, the optimism of the public discourse discussed above seems to suggest something more than this. Accountability is understood to unite efficiency, quality and safety and to have direct benefits for clinical relationships and morale. In other words, accountability is not just seen as consistent with patient empowerment, but is a preferred means by which empowerment is achieved. The bureaucratic mechanisms that make Oxford Health accountable to its board, to Monitor and the CQC, to the CCGs that buy services from it, and, more diffusely, to local community stakeholders, are thought of as promoting both economic benefits and patient empowerment.

2.6 The Discreet Charm of Accountability

Klein argues that although reforms have given patients choice and have sought to make services more accurately reflect patient preferences and needs, there was no public demand for this. Commentators agree it does not simply reflect a new 'emerging consensus' that might mirror the post-war founding consensus. Support for the reforms is patchy whilst opposition has been vociferous. Patients have had choice thrust upon them. This observation is consistent with my field observations. Patients and their families and friends were often not aware of the institutional mechanisms described above. Those who were aware of them were frequently cynical. Sometimes,

in appointments, distressed patients seemed unsettled by being offered choices, such as between antipsychotic medication. Using Klein's analogy from the above section, for some people in distress, the church is preferable to the garage. Being cared for by an expert can be more important than transparency or clinical relationships based on equality and openness. Although the design and implementation of reforms has been extremely costly, both in terms of time and resources the reforms have been supported by politicians from all parties. So why has this happened? How can we account for the rise of accountability in the NHS?

For Klein, the notion of accountability is central to the story of the NHS, but not just in the sense that it is perceived as a desirable feature of NHS institutions. One of the drivers of change, for him is the location of blame. Centralized control could lead to what Klein calls 'the centralisation of blame' (Klein 2013: 217). For government, accountability is risk. The more the government was able to control the NHS, the more responsible they are for its shortcomings. One of the advantages to the government of giving NHS providers more autonomy is that it transfers responsibility and, potentially, blame. Rather than themselves being the focus of public disapprobation when things go wrong, the government is in the politically more appealing position of being able to be censorious of NHS Foundation Trusts.

Webster accounts for the reforms in part by reference to long term underfunding. He argues that the NHS 'has been mismanaged, neglected and starved of resources' (Webster 2002: 2). Mechanisms of accountability are appealing to politicians because funding has been insufficient. He is cautious, however, about interpreting the changes in the NHS as being unique. This is because many of the changes in the NHS outlined above resemble changes in the health systems of other countries: 'In some important respects, the national health systems have developed in unison…For every Western state, healthcare metamorphosed from a virtuous prize into an incubus with the potential to wreck the economy' (ibid.: 253-4). One of the drivers of these global changes is the arrival of new

medical technologies. The scale of the change is enormous. Rivett stresses that this has transformed healthcare in a way that 'is hard to comprehend' and, perhaps, difficult for any institutional arrangements to accommodate (Rivett 1998: 470).

Pollock argues that market and accountability reforms are a result of pressure on government by commercial bodies: 'The NHS, with its enormous range of activities and £74 billion annual turnover, offers marvellous opportunities for companies seeking security of income and healthy profits' (Pollock 2004: 1–2). She sees this process as changing the very nature of the NHS. It is a 'revolution' a change of 'doctrine' and 'culture.' She argues that 'commercial values are increasingly displacing the service ethos' (Pollock 2004: ix). According to Pollock, concepts such as 'choice' are little more than a rhetorical screen, behind which genuine accountability and transparency are in decline (ibid.: 217). Overall she argues that the introduction of markets has harmed the quality of care whilst generating inefficiencies and other problems.

The empirical effect of the reforms is the subject of controversy. Bevan and Skellern note difficulties in studies attempting to measure the empirical effects of markets in the NHS, resulting in methodological doubt, and contradictory findings that are 'intensely controversial' (Bevan and Skellern 2011). Studies by Propper et al. looking at the first phase of marketization support Pollock's case, finding that the internal market had the effect of increasing mortality rates within hospitals to a degree that outweighed any benefits, such as reduction to waiting times (Propper, Burgess, and Green 2004; Propper, Burgess, and Gossage 2008).

There are opposing views, however. Part of this is theoretical: some argue that introducing patient choice is empowering and, therefore, a good in itself (Le Grand 2007). Similarly, in a paper with Hamblin, Bevan describes the assumption that medical personnel are solely motivated by the interest of patients and can thus be trusted as 'Panglossian' (Bevan and Hamblin 2009: 162). This

suggests an orientation against simply trusting medical professionals that arises from wider theoretical commitments. However, supporters of the reforms are able to gather evidence in their favour. In their investigation of the performance of ambulances responding to emergencies, Bevan and Hamblin find evidence that performance measurement can improve healthcare delivery where it is attached to 'systems designed to inflict reputational damage on those that have performed poorly' (ibid.: 161). Studies of the impact of the quasi-market of the 2000s find reductions in mortality rates and other benefits (Cooper et al. 2011). Niemietz states that 'there is good evidence that the market reforms of the 2000s have increased quality and efficiency in the NHS' (Niemietz 2015: 103).

On this point, and at stages throughout this thesis, the relationship between evidence and policy emerges as being somewhat complex. Underlying the themes of this thesis are a number of empirical questions. These include the impact of particular institutional arrangements or the effectiveness of particular interventions. Many of these questions are disputed. As a result, sophisticated research has been undertaken. In principle, gathering data in this way can settle questions. It may determine that the quasi-market has increased efficiency, for example, or that lithium beats placebo in the reduction of suicide among people diagnosed with Bipolar. This prospect is tempting because it suggests that data may determine policy, rather than human opinion, judgment or custom. Decision makers would thus be insulated from responsibility and risk of blame. In practice, it does nothing of the sort.

Research is more pliable than it may seem. Conversely, the world may be less knowable than we might expect, or hope. Oreskes and Conway describe how the tobacco industry were able to use research findings to increase uncertainty and sense of complexity (Oreskes 2011). The results of scientific research are not certain, and doubt and ignorance can be deployed tactically (Proctor and Schiebinger 2008). In a paper on tobacco and science, Ulucanlar et al. call this 'evidential landscaping' (Ulucanlar et al. 2014). Many of the topics I address in this thesis rest on empirical

questions, but they are seldom answered definitely by quantitative data. Data usually generates fresh disputes. Empirical research findings are contradictory. The data may be interpreted in various ways according to the prior theoretical commitments of the researcher. In practice, evidence cannot replace human decision making and the need for judgment. However, evidence or data might have a bureaucratic value. Research data provide an explicit and standardised means by which decisions may be justified and documented. In this way, secure knowledge might appear to drive policy.

2.7 Accountability, Modernity and the Disguise of Power

Bosanquet and Pollard suggest the impulse for markets and accountability came not from commercial values or pressures but a broader sense of upward movement. They describe changes in the NHS as 'mirroring' society (ibid.: 27). The sense of community that marked the founding the NHS now appears to be receding. We no longer feel like neighbours:

> The NHS was by the 1980s an institutional anachronism. It was born in 1948 into one type of society – a working class, cloth cap society where open rationing was the norm – and reached maturity in quite another. Its fortieth anniversary in 1988 was celebrated in an affluent consumer society where deference had almost entirely disappeared, not just towards royalty but towards experts as well. Insider knowledge was now public information, and the trend was for more shafts of knowledge to be paraded. Consumers wanted choice, but the NHS had barely changed. (ibid.: 18)

Societal change demands a corresponding change in how the NHS works. We are now less impressed by professional expertise, and expect our individual preferences to shape our encounters with the NHS (ibid.: 27). In the terms proposed by Klein, we no longer want churches we want garages.

Some commentators link accountability to global cultural processes associated with neoliberalism. These arguments link changes in the NHS to cultural change, but in a rather different way from Bosanquet and Pollard. The argument here is not that public institutions simply 'mirror' society. Institutions have become accountable not merely to reflect popular preferences. Instead, the discreet charm of accountability reflects the exercise and disguise of power. From this perspective, to

interpret healthcare institutions as changing to resemble a changing society is to mistake a disguise of neoliberal power for an analytic frame.

Stedman Jones understands neoliberalism as a 'coherent, if loose, body of ideas' that has several distinctive elements (Jones 2012: 19). These include lowering taxes, trade liberalisation, privatisation, deregulation and strong property rights. At the economic level, this can be seen as making up two quite separable elements: an emphasis on the free market as opposed to central planning, and at a macroeconomic level, control of the money supply to address inflation and balance the budget. Indeed, Stedman Jones argues that it is a particular and highly consequential feature of neoliberalism to fuse these ideas together into a single, seemingly inevitable, whole (ibid.: 270). The neoliberal agenda is often expressed in a positive language of 'free markets', 'free trade' or 'globalisation', which Graeber dismisses as 'obvious propaganda terms' (Graeber 2010: 79–80). It has become the dominant way of designing and talking about policy, a hegemonic discourse that guides not just political and economic policy but, according to Harvey, 'the commonsense way we interpret, live and understand the world' (Harvey 2007: 23).

Anthropologists and other scholars have found various ways to approach neoliberalism, looking in particular at how neoliberalism shapes understandings of the person and personal agency (Kingfisher and Maskovsky 2008). Post-structuralists focus their analysis on changes in the relationship between the state and its citizens made by neoliberalism. In the past the state was an active agent that intervened in the life of citizens, for example through welfare services. The early decades of the NHS might be an example. In contrast, the neoliberal state has a more entrepreneurial ethos. There is a greater emphasis on personal responsibility and an increased role for community organisations to take over the functions previously carried out by the state. Attempts to encourage patients to 'self-manage' their condition might be examples of this. Equally pertinent

are institutional relationships between Oxford Health services and other health providers such as Mind and Restore.

Giddens is the scholar perhaps most associated with this approach (Giddens 1990, Giddens 1991). Drawing on the work of Beck, Giddens argues that accountability is linked to risk and anxiety (Beck 1992). It forms part of the 'contours of high modernity' in which personhood is being reshaped (Giddens 1991) see also (Rose 1996; Clarke 2004). Giddens picks up the themes of personal choice and responsibility and places them within his broader theoretical account of modernity (Giddens 1990, Giddens 1991). He notes how individuals increasingly see life as containing risks, and that dealing with risk and controlling the future is one of the 'core aspects of modernity.' (Giddens 1991: 114). According to Giddens, dealing with risk is now an individual challenge. The modern individual seeks to personally equip himself or herself by means of gaining knowledge to enable autonomous decision-making. This leads to a widespread dissatisfaction with opaque or inaccessible professional expertise and a desire on the part of the public to claim back knowledge from experts.

For Giddens, something amounting almost to an epistemological reformation is taking place. In a similar vein, Rose has written of 'an increasing emphasis on the responsibility of individuals to manage their own affairs, to secure their own security with a prudential eye on the future. Nowhere have these been more telling than in the field of health, where patients are increasingly urged to become active and responsible consumers of medical services and products (Rose 2007: 4). Rose stresses that the promotion of patient empowerment creates new forms of responsibility, such as 'genetic responsibility', and new ways of conceiving of prudence (ibid.: 134). These responsibilities do not appear to be very clearly articulated on the True Colours web site or supporting materials, which talk more of positive aspects, such as 'being in control, 'taking charge' and 'personal choice.'

Harvey argues that following the Second World War, social democratic politics led to a redistribution of wealth and the reduction in the power and wealth of superordinate social groups. Neoliberalism works to restore their power. This means the ultimate driver of neoliberalism is the interests of the elite classes. By removing barriers to free trade and introducing low tax regimes, neoliberalism transfers vast amounts of money upwards, from the masses to the upper classes. Over the last few decades neoliberalism has led to the restoration of capitalism and the reassertion of class power. This has led to greatly increased levels of inequality, and a reduction in the capacity of subordinated groups to successfully resist their exploitation.

Just as Weber saw bureaucracy as being inhuman and machine-like, for Harvey and others, neoliberalism seems to overpower human populations, whilst serving the covert interests of a privileged minority. The impression created is of a self-serving system running out of control. Harvey describes the impact of neoliberalism as 'creative destruction,' because in the creation of markets, so much has been cleared away. 'The creation of the neoliberal system has entailed much destruction, not only of prior institutional frameworks and powers (such as the supposed prior state sovereignty over politico-economic affairs) but also divisions of labor, social relations, welfare provisions, technological mixes, ways of life, attachments to the land, habits of the heart, ways of thought, and the like' (Harvey 2007: 23). Markets and competition are not conceived of as drivers of efficiency and mechanisms by which services reflect popular preferences. Instead, these terms, which figured large in the AGM, are part of how neoliberalism conceals its workings. For Harvey, if neoliberalism is to maintain economic growth, new products must constantly be to be created. This pressure originates in supply, not in demand: 'Technological developments can run amok as sectors dedicated solely to technological innovation create new products and new ways of doing things that as yet have no market (new pharmaceutical products are produced for which new illnesses are then invented)' (ibid.: 69). The profession of psychiatry has been subject to criticism

that its ever-increasing roster of diagnoses reflect the marketing ambitions of pharmaceutical companies more than the clinical needs of the public.

Commentators such as Graeber, Harvey and Glyn all argue that neoliberalism fails on its own terms as a way of stimulating economic growth. They point to the low levels of economic growth achieved under neoliberal economic regimes, which, they suggest, may be unfavourably compared with the levels of growth of less neoliberal economies. The argument here is not just that equality is preferable to inequality, but that economic growth need not conflict with at least some effective efforts to promote equality (Glyn 2007). Neoliberalism is also associated with instability. The financial crash of 2009-9 can be interpreted as caused by both the institutional policies of neoliberalism, and the culture of the those working in high finance (Ho 2009).

Part of the problem for writers like Harvey and Graeber is how such an irrational and harmful discourse gained the upper hand. Neoliberalism refers to more than a belief in how to keep the economy ticking over. Expectations, intuitions, assumptions, norms, and beliefs, glossed by the political scientists discussed above as the 'virtues of accountability,' may be shaped by neoliberalism. Neoliberalism is based on fundamental beliefs about the person and human flourishing that lie beyond the reach of data to confirm or disconfirm. In this sense it is about values and a moral programme as much as technical details about monetarism.

Harvey writes of neoliberalism becoming 'deeply embedded in common sense' and 'naturalised' (Harvey 2007: 25). Kapferer makes a similar claim (Kapferer 2010). He argues for the emergence of a 'corporate state' in which 'economic principles' become 'ontologically foundational, permeating all social and political relations' (ibid.: 127). Graeber describes a neoliberal ethic which he states is 'simultaneous emphasis on personal self-realisation for the affluent and "personal

responsibility" for the poor' (Graeber 2009: 83). Neoliberalism proposes a vision of the human as a utility-maximising individual who should be left to pursue his or her goals free from interference.

Critical interpretations of neoliberalism cast light on aspects of my field. The justification made by all governments of all parties for market reforms in the NHS is that competition drives efficiency. In the current arrangements, making providers compete to secure contracts form the CCG is held to drive cash savings and improvements in quality. Similarly, regulation and auditing from the CQC and Monitor are believed to hold Oxford heath to account. At the same time, market mechanisms make mental healthcare services more responsive to patient perspectives and preferences. Marxian readings of neoliberalism invite caution about claims regarding the supposed benefits of the reforms. The supposed benefits and rationales are simply power's disguise. If Harvey is right, then the reason for these arrangements, ultimately, is the material interests of the elite classes.

Perhaps of most importance to my argument is the way that accountability enters into the subjectivity of healthcare professionals and their patents. The neoliberal model of the person surfaces at points throughout the ethnography. The way health and illness are conceptualised seems to reflect neoliberal priorities. Mental disorders are detected when a person becomes economically inactive. Distress is understood to arise from individual failings or weaknesses, not societal inequality and unfairness, or the lack of community bonds. In the ethnography I describe how clinicians feel obliged to be impartial, to reason in a particular kind of way, to produce particular kinds of justifications for their care. The model of self-management implicit in True Colours is articulated in terms of managing risk and maximizing wellbeing. How might it be that economic forces operating at an international scale might be felt as moral imperatives in the clinic? The following section discusses how this process might take place, and what the consequences might be.

2.8 Anthropology and Audit Culture

One of the most prolific writers on auditing is Power, mentioned earlier. With a background in accounting, Power's series of publications take a generally quite favourable view of audit culture and often seem to form the foil for more sceptical anthropological critiques (Power 1994, Power 1997, Power 2003, Power 2004, Power 2007). However, Power's approach to audit begins with the notion of uncertainty. Uncertainty provokes anxiety. Audit is a response to that anxiety. Here Power and anthropological critics such as Strathern find common ground. In a resonant early paper on anthropology and audit, Strathern examines the procedures for evaluating performance in higher education (Strathern 1997). She argues that auditing is not just a neutral process of monitoring, however much it may be presented in that way. In her view audits have 'a life of their own,' a 'runaway character' that impacts upon, and even jeopardizes, the life it audits (ibid.: 305). In her introduction to the edited volume Audit Cultures, she describes audit as 'a kind of actant' (Strathern 2000b:5). Strathern traces the origins of audit culture in the present form to changes in higher education across Europe in the eighteenth century. Written exams were being added to existing arrangements for oral exams as an improved means of scrutiny. In addition, there was a move towards marking exam answers numerically, a measure adopted by Cambridge in 1792 (Strathern 1997: 307). These changes enabled students and colleges to be compared. It also created a pathway for the inclusion of female students.

The power of auditing is a moral power. Auditing procedures introduce what Strathern calls 'a new morality of attainment' which is commercial in character. This is because, in Strathern's view, by presenting data that is numerical and comparable, auditing implicitly but inevitably introduces the notion of improvement. Auditing conflates what 'is' with what 'ought' to be. It combines measures with targets. Once an institution is audited, targets and ranking follow. 'In audit, self-examination is linked to self-improvement' (Strathern 1997: 314). Auditing places a moral pressure on institutions.

Like a moral agent, they become accountable. It becomes possible to have expectations of institutions that may be tested through performance evaluations. For Strathern the moral qualities of audit are highly complex. Ethics may be invoked to justify auditing itself. In most cases, it seems irresponsible not to audit institutions. Auditing brings with it a moral force that impacts on the institution being audited, demanding competition and improvement. But, equally, for members of the institutions being audited, both compliance and resistance can be understood as unethical (Strathern 2000b: 5).

Strathern is concerned about particular problems with auditing. Audit requires that an institution makes itself legible. It must represent itself in a particular way stipulated externally. Problems arise from the adequacy of these representations. Strathern writes about the limited capacity of teaching quality metrics to capture the value of teaching. She suggests that research time is particularly hard to scrutinize, not least because of all the 'wasteful and dead-end activities that precede the genuine findings' (Strathern 1997: 318). Auditing removes complexity whilst creating an immense burden of extra work. In a subsequent paper, called 'The Tyranny of Transparency' Strathern looks at how the notion of transparency is embedded in audit. Transparency appears to make things visible, but she asks the question: 'what does visibility conceal?' (Strathern 2000c: 310). The technology of transparency is not a good procedure for finding our how organisations 'really' work. It gobbles up one kind of information…but cannot get at the 'real' productivity' (ibid.: 315). It erodes trust (Strathern 2000c: 313).

O'Neill makes a similar case about transparency causing mistrust (O'Neill 2002). Technologies that enable information flow, and so make transparency and openness cheap and easy to attain, have had major, and, to O'Neill's mind, harmful effects. This is because, for O'Neill, transparency destroys secrecy. But it is deception that undermines trust, not secrecy. And 'transparency has marginalised the more basic obligation not to deceive' (O'Neill 2002: 18). Transparency can actually increase

deception and suspiciousness because it produces a ‘flood of unsorted information’ (ibid.: 72). Problems arising out of excesses of information have been noted by a diverse range of other commentators. Writers in the popular media have coined neologisms, such as 'information overload', 'data asphyxiation', 'data smog', 'information fatigue syndrome' and 'cognitive overload'. In a discussion of the way the internet functions, philosopher and computer scientist Lanier describes how technology makes a vast amount of information available by a process of decontextualisation (Lanier 2010). This gives information a distinctive, and, to Lanier, troubling form. It is, in his words, ‘flattened.’ Units of information become interchangeable, untraceable ‘content.’ In a memorable phrase evoking the epistemic cost of this, Lanier calls it ‘the unbearable thinness of flatness’ (ibid.: 123). These remarks recall some of the objectors to True Colours. Those who thought that True Colours was too crude and simplistic were, I think, doubting whether such unbearably thin data could ever have much of a role in patient empowerment.

Scholars have been at pains to stress that officials do not always behave in ways described by auditing. Power writes of audit technologies being decoupled from actual work (Power 1997: 95–7). This can be because of deliberate strategies to ‘buffer’ practice from the pressures of audit (Sauder and Espeland 2009: 64). Harper’s ethnography of an IMF mission to a unnamed African country, included in Audit Cultures, shows ways in which standardized auditing guidelines and working practices can conceal a great deal of what happens on the ground (Harper 2000). The use of standardised assessment tools and quantified data do not exclude unique personal encounters. The language used by political scientists, such as Bovens et al., of mechanisms of accountability can suggest that the processes are impersonal, predictable and automatic. Harper’s argument is that they are always social and moral, involving relationships and susceptible to change according to local culture. As such, they are less rational than they might appear (ibid.: 51).

Compliance with auditing becomes a required part of professional life. The practices and values of audit culture become internalised through a combination of what Sauder and Espelund call 'seductive and coercive incentives' (Sauder and Espeland 2009: 64). In this way the dichotomy between auditor and auditee is broken down (Power 1997: 143). Individuals being audited here emerge as permeable. Perhaps the most distinguished approach to this permeability within anthropology is the work of Bourdieu. In Outline of a Theory of Practice, Bourdieu considers how people's interior life, their view of the world and their experiences are tied to wider social and historical processes. What Bourdieu calls a person's 'disposition' which he glosses as a 'way of being', 'inclination' and 'predisposition;' is shaped by his or her 'habitus', the 'structuring structure' or 'system of dispositions' which organizes action such that practice is patterned (Bourdieu 1977). In Distinction, he showed how social stratification is manifest in mattes of taste, such that class can be thought of in terms of habitus and disposition as much as income, job type or relationship to the means of production (Bourdieu 1984). Habitus shapes intuitions that make up common sense. What is seen as unwise, irresponsible or unprofessional can be understood as habitus. Bourdieu provides a model of how the professional habitus of my clinical informants, which shapes how they see the world and how they conceive of their work and its ethics and goals, may itself be shaped by audit culture.

In chapter one I defended my use of the notion of ethos because it captures the moral force of ideas of professionalism, expertise and clinical experience. Here I suggest that audit culture is part of the ethos of my clinical informants. So where does the moral force of audit culture come from? Power answers this in terms of trust. He argues that audit techniques are trusted because, whatever the shortcomings and practical issues, they more or less 'work' (Power 1997: 88). Indeed, for him, making audits work is essential to their continued role. Auditing is needed because we increasingly live in what Beck called the risk society (Beck 1992). Auditing is a way of responding to risk and uncertainty (Power 1997: 123).

This contrasts with most of the anthropological and sociological work on audit, which conceptualise audit in terms of power. In a series of publications, Shore and Shore and Wright link audit culture to neoliberalism and stress how the reshaping of moral sensibilities is part of the process (Shore and Wright 1999; Shore 2008; Shore and Wright 2015a, Shore and Wright 2015b). They describe how audit culture brings with it a cloud of buzz words. I came across many of the same terms during fieldwork. They include: 'efficiency', 'effectiveness', 'best practice,' 'value for money,' 'empowerment,' 'enabling' and 'emancipation.' Taken at face value, these terms indicate the benefits of auditing, and might form the basis of an impression that audit, broadly speaking, works. It is difficult to declare oneself opposed to effectiveness, or take a contrary stance towards emancipation. Shore and Wright understand the discourse around audit culture as forms of mystification, disguises for power that conceal and legitimate (Shore and Wright 1999: 557). Believing in them, from their point of view, is to be taken in, misled by forms of knowledge that should be the object of study, not part of the scholar's analytic vocabulary.

In his account of audit in British schools, Ball makes a related case: 'concepts like efficiency are treated as though they were neutral and technical matters, rather than being tied to particular interests. The question 'efficiency for whom?' is rarely asked. Efficiency is taken as a self-evidently good thing (Ball 1990: 154). External interests redefine the purposes of work environments and enforce it in part through ethics. In an unpublished anthropology doctoral thesis investigating a mental hospital in Norway, Teig interprets the language of efficiency in a similar way, as a kind of mystification, enforcing and disguising new and sometimes contested ways of running the hospital (Teig 2012: 23). These arguments echo remarks made by some of my clinician informants.

So how might the values of audit culture enter into the professional habitus of the clinicians I observed? Perhaps the most visible means I saw was the philosophy of EBM. As a practice and philosophy, EBM seemed central to a lot of what I saw in the field.

2.9 EBM as an Accountable Form of Reason

In the following sections I describe the theory of EBM. I do not here adopt the concepts of EBM into my own analytic vocabulary. Instead, my approach is ethnographic. EBM is an example of local knowledge and my account of it, even when derived from prestigious academic publications, is part of the ethnography I use to support and illustrate my argument. My purpose is to present it as a highly accountable form of reason. It creates knowledge that is, in Adams' terms, 'actionable' (Adams 2013). EBM helps clinicians to deliver care such that they can be held to account. It is a means by which audit culture becomes interiorized in the clinician. EBM understands healthcare in a particular and distinctive way. It has a striking simplicity and economy. Only a small number of qualities in the patient are relevant to clinical care. EBM understands healthcare as a sequence of decisions. It provides explicit, authoritative rationales for clinical decisions, derived from impersonal RCT evidence. Decisions are based on simple, repeatable relations between a small set of mostly measurable phenomena in the patient and a body of evidence.

In EBM, a clinician has to make a lot of assessments about scale. A clinician must assess, in a standardized way, the level of symptoms in a patient and match this to the scale of the interventions that target the symptoms, whilst taking into account the scale of side effects and future risks. This is a very distinctive clinical role. As one psychiatrist told me, with a wry smile: 'I can do four things. I can start medicine, stop medicine, increase the dose and decrease the dose.' These are the core decisions that EBM authorises in mental healthcare. EBM makes the patient legible in such a way that these decisions can be reached in a predictable and repeatable way. If care is a sequence of

simple, evidenced decisions, everything can be quickly and easily recorded and defended. Care can be documented and shown to be effective, good value and transparent.

EBM emerged as a powerful new force in biomedicine in the early 1990s (Eddy DM 1990; Guyatt 1991; Guyatt G et al. 1992). Sackett et al. defined EBM as: 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients' (Sackett 1996: 71). From the US, its message spread with remarkable speed, and it is now an almost unchallengable 'gold standard' in global biomedicine.

I will try to pick my way through the main features that I observed in the field, using as my guide Howick's monograph The Philosophy of Evidence-Based Medicine (Howick 2011). What is innovative about EBM, according to Howick, is that it takes a particular view on what counts as good evidence and how this may be differentiated from less good evidence. This is often expressed in terms of 'hierarchies' of evidence. In many publications, and, indeed, many academic seminars I attended as a part of my fieldwork, these hierarchies are depicted as pyramids. High quality evidence is located at the apex of the pyramid and low quality evidence at the base. There are debates about how best to depict the pyramid, but Howick, like most of my informants, finds a common central core:

> The EBM 'philosophy' of evidence is best expressed in the EBM 'hierarchies'. The idea behind the many 'hierarchies' can be summed up quite simply with three central claims
> 1. Randomised trials (RCTs), or systematic reviews of many randomised trials, generally offer stronger evidential support than observational studies.
> 2. Comparative clinical studies in general (including both RCTs and observational studies) offer stronger evidential support than 'mechanistic' reasoning ('pathophysiologic rationale') from more basic sciences.
> 3. Comparative clinical studies in general (including both RCTs and observational studies) offer stronger evidential support than expert clinical judgement. (ibid.: 4)

This places randomised trials at the top of the evidential pyramid, observational studies in the middle and mechanistic reasoning and expert clinical judgement at the bottom. The reason why EBM rejects mechanistic reasoning and clinical intuition is important for my argument.

Mechanistic reasoning means using models of how an illness is believed to function to justify a treatment. It is rejected because of the low level of current medical knowledge. It is not that such reasoning is of necessity flawed. Rather, we currently do not have a sufficiently high level of understanding of illnesses and their mechanisms for such reasoning to form the basis of clinical decisions. Howick comments that:

> There are two common and related problems with mechanistic reasoning. Both are epistemological. First, biochemical mechanisms upon which they are based are rarely sufficiently well understood…Second, the inferential chain…linking the intervention with the patient-relevant outcome…is generally more complex than appreciated. (ibid.: 136)

It appears as a hallmark of the evidence-based paradigm that knowledge is currently very limited, and that our clinical reasoning needs to take this fully into account. The evidence-based philosophy attempts to make it possible to record reasoned clinical decisions whilst acknowledging a very limited level of understanding. This significance of this becomes more apparent in chapter four where I describe how clinicians work to contain or 'black box' uncertainty and ignorance. EBM provides clinicians with a justification for a lack of knowledge or curiosity about distress, and shifts the focus to the effects of interventions.

Having dismissed mechanistic reasoning and clinical judgement, the evidence-based philosophy leaves us with observational studies and randomised trials. Both observational studies and randomised trials investigate the effects of an intervention by comparing 'health outcomes' in a group of people who received an intervention (the 'experimental group') with a group who did not receive the intervention (the 'control' group). However, randomised trials are seen as producing evidence of a generally superior quality. This is because, to understand the effects of the intervention, we need to know that the only relevant difference between the two groups is the intervention. If that is the case, then any difference in outcomes between the two groups may be regarded as being caused by the intervention.

If outcomes are better in the experimental group, this constitutes evidence that the intervention has health benefits. But if there are other differences between the two groups, it might be the case that these differences are responsible for a disparity in outcomes. Factors that potentially affect the outcome which are unequally distributed across the experimental and control groups and which are unrelated to the experimental intervention are known as 'confounders,' or 'confounding factors'. Much of the debate in EBM concerns how best to design RCTs to rule out confounders as much as possible. Randomisation, the blinding of clinicians and participants and the use of placebos are all designed to eliminate confounders. Clinical trials attempt to produce a numerical figure that expresses the 'effect size' of the benefits of a given intervention for a given patient population measured in standard deviations.

Trials measure the effects of intervention on specified populations though quantified 'outcomes', produced using 'validated' metrics, often in the form of clinician or patient completed questionnaires or some other quantified events such as 'time to relapse' or 'suicide'. As we see in the ethnographic chapters below, during clinical appointments, in waiting rooms and even at home, patients are frequently asked to fill in questionnaires. As they do so, the clinic and the RCT begin to draw closer. Medical notes are full of scales expressing symptom severity, general wellbeing, suicidal intent, and so on. Often prose notes express generic wellbeing and symptom severity in terms of quantities that may change through time.

Although central to EBM, metrics are the topic of controversy among clinicians. When I asked clinicians how reliable or trustworthy formal metrics are, my clinical informants often expressed caution. I was frequently told that one can't understand the scale until one knows the patient. Apparently, people who are very depressed sometimes have scores indicating normal mood, whilst others who are barely depressed at all, score high. So what counts as a high score for one person might be perfectly fine for another. Sometimes staff members are critical of particular scales,

usually for either tending to exaggerate the level of symptoms, or failing to register symptoms. Others are resistant to scales per se. There seemed to be a generational shift among staff. Older and more experienced staff members seemed both more sceptical about the use of metrics and more cautious about thinking of health and ill health in terms of quantities of depression, anxiety, psychosis and so on. In casual conversation it emerged that clinicians who are sceptical about quantification find it difficult to document care. Metrics and quantification help clinicians to be accountable by providing a simple and economical justifications for decisions.

During fieldwork I would sometimes pause to attend to my field notes. Sometimes I would duck into empty rooms used for teaching where I could sit unnoticed and undisturbed. Often these rooms had blackboards or whiteboards on which traces of previous teaching were preserved. This might take the form of impromptu graphs with things like ‘time’ on the x-axis and ‘mood’ on the y-axis. I was often struck at how familiar even approachable the graphs looked. There seemed nothing terribly specific to mental healthcare about them. They looked like so many other graphs that describe share prices, or climate change, or voting patterns. If you didn’t know, you might have to look quite hard to tell what the field of expertise was. My impression was that this hinted at something very important about EBM. The kind of knowledge approved by EBM is very fluid, even generic, ideally suited to communication with other healthcare professions and statutory bodies and to interdisciplinary research.

EBM specifies good practice as consisting of good clinical decisions. It determines the right way for a clinician to make a decision, and provides a simple genre to document these decisions as accountable. It also critiques alternative visions of mental healthcare. Individual clinical judgment is the target of specific attack. This is presented as a response to individual fallibility and the state of current knowledge. I quote it in full to try to convey some of the concerns that motivate EBM:

> Placebo effects can sometimes exacerbate the confusion between real treatment effects and natural history. A clinician might observe dramatic remission from depression after Prozac therapy, but without

> further investigation it is impossible to conclude that recovery was based on the characteristic effects of the treatment… spontaneous resolution, or placebo effects…The limits to the detection of large and small effects are exacerbated by the common reasoning fallacies of naive and well educated clinicians…These fallacies are well documented and they include ignoring base-rates and sample sizes, misperceiving chance, engaging in the gambler's fallacy, using the law of small numbers, disregarding predictability, and disregarding regression to the mean. (ibid.: 166)

When Howick discusses individual human judgment, he is mostly concerned with the capacity of humans to think in a 'logical' and 'unbiased' way. He takes judgment to be a process in which a person weighs up evidence, and he is convinced that unaided humans fail to do this accurately, even if they are trained and experienced clinicians looking for large effects. According to Howick, expert judgment should not be muddled up with evidence from trials. Instead, the role of clinical judgment is to apply the appropriate evidence to a particular patient. In some cases, algorithms, in the form of 'decision-trees' and flow charts can standardise clinical behaviour. Nationally, NICE produce a number of such protocols. A smaller number are produced by Oxford Health.

This rather narrow, rationalist vision of the clinical role seems not to address many of the clinical skills that previous generations of psychiatrists regarded as part of their expertise, such as building therapeutic relationships, having insights into a patient's unconscious motivations, identifying patterns in a person's behaviour, or inspiring hope. Instead, EBM directs a clinician's attention towards decisions about treatments. The evidence-based philosophy authorises economical, easily comprehensible and uniform justifications for treatment decisions, by linking clinic rationales to data from trials. In doing so, it orients a clinician's attention towards simple, standardised and quantifiable categories. The question I seek to pose here is whether this form of reasoning, and the categories it rests upon are suited to the goals of patient empowerment.

2.10 Concerns about EBM

The proponents of talk therapies have tended to believe that features of their role, or the 'therapeutic relationship' itself, is important. These ideas are fundamental to how psychological

therapies have been conceptualised and are a key part of many therapists' theoretical understanding of their work. For example, I found that Rogers' phrase 'unconditional positive regard' to be frequently used by mental health professionals of all kinds (Rogers 1990). However, relationships or interpretations do not lend themselves to quantification and clinical trials in the same way that medications do. The goals and methods of talk therapies are difficult to standardise and measure.

In recent decades, researchers of psychological therapies have attempted to gather evidence to investigate treatment benefits that are not characteristic effects of standardised therapies. For example, data have been used to suggest that qualities in the therapist, such as warmth or empathy, can be measured in a standardised and replicable way and these measurements can be used to predict better outcomes independently of the therapeutic modality eg. (Norcross 2002:441). Others have tried to develop scales to measure the quality of the therapeutic alliance and use it as the basis for making predictions about treatment outcomes (McCabe 2003) (McGuire-Sniekus et al. 2007) (Priebe et al. 2011). Research of this nature is problematic because it relies on phenomena that are not amenable to easy quantification. Measurements of the quality of the therapeutic alliance, for example, require highly trained external observers.

However, some commentators have argued that, in the light of this evidence, all talk therapies have equal effectiveness because the variables that matter - the variables that determine therapeutic success or failure - have to do with the clinician, the patient and their relationship. For example some research indicates that the therapeutic alliance between clinician and patient is the best predictor of success (Horvath et al. 2011; Falkenstrom, Granstrom, and Holmqvist 2013; Arnow and Steidtmann 2014). Other research finds that some therapists are much better than others and it is this that predicts good outcomes (Wampold and Brown 2005). However, it has not proved easy to investigate. Detailed investigation has not uncovered what it is about some people that makes them much more effective therapists than others (Miller, Hubble, and Duncan 2008; Vollmer et al. 2013).

The idea that therapeutic outcomes are connected to features independent of the specifics of treatment itself, the treatment style, or the philosophy that lies behind it has a long history. Some argue that all therapeutic modalities are equally successful. In the literature, this is known as the 'dodo bird hypothesis' or 'dodo bird conjecture' because, like in Alice in Wonderland, 'all shall have prizes' (Rosenzweig 1936). If treatment modality has little or no impact on health benefits, this would prompt enquiry into the more inaccessible, hard to routinize and difficult to quantify world of personal and interpersonal characteristics. There have been many publications arguing against the dodo bird, suggesting instead that treatment modalities can be more and less effective for particular presenting problems (Castonguay and Beutler 2006).

EBM lends itself to the ethos of Weber's office. A practitioner of EBM seeks to be disinterested and impartial, to follow rules in an unemotional way, based on independently existing impersonal evidence. Trials are understood to have the potential to produce overwhelming evidence on a question, such that it is 'definitive' or 'conclusive'. But in practice it is rare to find clinical questions where researchers regard the evidence as sufficient as to be even approaching 'definitive' or 'conclusive'. EBM makes a virtue of stressing this, both in published research papers and when talking to patients. As Howick puts it: 'an initial aim of EBM was to emphasise that medical 'knowledge' is uncertain' (ibid.: 38). Aside from the findings of RCTs, the evidence-based clinician is in the dark. Gupta argues that the evidence-based philosophy has the potential to improve clinical encounters because basing decisions on standardised, impersonal data, improves transparency and the opportunities for 'shared decision making' and 'informed consent' (Gupta 2011).

Some commentators, however, are sceptical about the epistemic modesty of EBM. Although EBM starts out from a frank admission of the limits of knowledge, it moves from this to authoritative

claims about how to proceed (Tanenbaum 2014). A single, fixed, non-negotiable form of deliberation is proposed. As I try to show in the ethnographic chapters below, patients are encouraged to think in terms of explicit rationales for decisions, based on a very simple model of distress, and a single method of evaluating competing options. Alternative understandings of distress are ignored or dismissed. Nonetheless, some commentators argue that EBM creates clinical freedom (Parker 2005). Others suggest that too much of the clinical exchange is omitted. For example, Fulford suggests that we can replace what is missed out by the evidence-based conception of the clinical encounter using the notion of 'values' alongside the 'facts' established by trials (Fulford 2008).

Various other concerns about EBM have surfaced. For example, many drugs used in mental healthcare have major side effects that may be detected by both patient and clinician. This threatens the blinding process deemed an essential part of the production of high-quality evidence (Moncrieff 2008: 20). Most mainstream commentators dismiss this view (Barth et al. 2016). Do the kinds of quantified outcomes measured in RCTs really correspond to the goals of care in 'real world' mental healthcare? It is not clear that the kinds of harm that clinicians told me could arise from treatments, such as 'dependency' and 'institutionalisation' are measured in RCTs in the same way as positive health outcomes. Others argue EBM is philosophically naive, particularly regarding the sometimes unselfconscious use of terms like 'objective', or 'rational', and shows a limited sense of the intellectual problems associated with key elements of the philosophy, such as incommensurability and quantification eg (Loughlin 2006, Loughlin 2008; Miles and Loughlin 2006; Miles 2008; Kerridge 2010). Circularity is a concern as well. Perhaps ironically, EBM is not itself 'evidenced' very well (Saad 2008).

There is much discussion of the fact that EBM appeals at least as much to bureaucrats as clinicians. Rivett describes EBM as a 'new gospel for government ministers' (Rivett 1998: 382). Concerns within the medical profession remain. One reason for this is that EBM threatens clinical autonomy. During fieldwork I was told by clinical informants that EBM was 'nonsense' or 'rubbish' or 'doesn't work.' One psychiatrist said it has 'wrecked' the profession. A CPN explained 'for us, EBM is a dirty word.' Concerns of this nature are articulated by Grimley Evans:

> The political stars smiled on the birth of EBM, because it offered the prospect of total standardisation of medical practice. EBM would define the one sequence of investigations that should be followed and the one treatment that should be provided for each disease. To each a price tag could be applied to control health service costs…At last, total managerial control of the healthy system lay in the grasp of politicians and civil servants. Managers, with their loyalties to their political masters, have now supplanted caring professions, dedicated to the well-being of patients, as the dominant caste in the NHS. (Grimley Evans 2010: 254–5)

Similar worries are expressed by Tudor Hart and Tallis (Tudor Hart 2006; Tallis 2005).

2.11 The Relationship Between the Culture of an Accountable Bureaucracy and Clinical Expertise

During fieldwork I often asked mental health professionals about the role of bureaucracy in their working lives. It was a familiar topic, but could nonetheless be emotionally impactful. One informant dramatically shook her fists. Joking was a common response. One social worker said, with deadpan tone but a knowing glance: 'Oh yes Neil, it is through good organisation that we are able to achieve our targets.' For the majority of my clinician informants, bureaucracy was by no means related to efficiency, or associated with speed and precision. However, neither had audit culture entirely colonized their sense of professional expertise. Instead, staff sensed a conflict between the two.

Bureaucracy is often spoken of as something separate from healthcare. Staff members talk of 'red-tape' and 'paperwork' as an extra burden and something that gets in the way of clinical care. A frequently heard remark is that they 'spend too long filling in forms and not enough time with patients'. One of my interviewees, a community psychiatric nurse, said: 'I seem to spend two-thirds of my time on paperwork.' Another interviewee, also a CPN, made the opposition between the two explicit: 'Most of what I do now is writing notes, not seeing patients.' Looked at from this point of view, bureaucracy and clinical care are more or less mutually exclusive. Time spent on paperwork is not time spent delivering care.

For many staff members bureaucracy is an excessive and obstructive burden. Most support the view that the burden of bureaucracy has increased, and that as a result there is a reduction in the scope for personal discretion. Some informants expressed this in terms of quantity: bureaucracy might be a necessary evil, perhaps, but there is simply too much of it and the scale is ever increasing. This issue blends into concerns about the nature of the paperwork and red tape, and the way it impacts on the manner in which clinicians go about their work. Here staff members express concerns that resemble O'Neill's remarks about the redefinition of expertise under audit. One social worker told me in an interview: 'Do you know what I did this morning, Neil? I wrote two risk assessments. Imagine it. Who benefits from that?'

In these cases, staff members see bureaucracy as serving interests or needs that do not quite coincide with their vision of the interests and priorities of their patients. Jackie, a social worker, was particularly eloquent in interview:

> Doing my job, now, it feels like a factory, a production line… I'm not sure whether what I do now is of any value to the patients at all. We spend our time on things that are of no meaning to the patient…60% of our time is inputting data…The system doesn't care about the therapeutic relationship, the system is interested in outcomes, people coming in, getting treated, getting discharged, getting paid.

Jackie was by no means alone in being so forthright. Rather, many staff members, particularly those with more experience, suggested that bureaucracy made it more difficult to do their job, and diverted their efforts from things that might help patients to tasks associated with documentation. Staff members who made remarks like this present themselves much as Lipsky's street-level bureaucrats, in that they see themselves as needing time and freedom at work to give the right care based on the needs of individual patients. There can a sense of solidarity amongst staff who try to help their patents by pitting their wits against the inflexible and uncaring bureaucratic machine.

In discussion, this issue often becomes blurred with concerns about limited or reduced resources. Having excessive amounts of work to do is often raised at the same time as having excessive and unwanted bureaucratic tasks such as documentation. Staff members frequently told me that the impact of restrictions on resources, such as increased caseloads and more rapid discharge from wards, makes it impossible to do their job properly. These criticisms merge with remarks about red tape and bureaucracy. It can be hard to tease the two issues apart. This is perhaps because staff members typically see bureaucratic tasks as both external to their 'real work' of delivering care, and as a mechanism for imposing greater workloads. One community psychiatric nurse complained at some length about 'all the forms she had to deal with' and then said: 'How can I deliver meaningful care with a caseload of thirty-five?' For her, these were two sides of the same coin. The result is that clinicians doubt the value of what they are doing, and feel that bureaucracy has diverted them away from helping their patients. A social worker told me: 'I end up just sorting out care packages, doing the minimal statutory stuff, then the rest of the time is taken up with those who shout loudest, really, fire-fighting, not delivering care.'

Although I suggest that professional expertise has not been immune to the ethos of the office and the values of audit, there are plenty of signs of resistance. Many staff members were privately

furious at more and more documentation precisely because it prevented them from doing their job. But this should not conceal the degree to which professional expertise is itself bureaucratized. The institutional context in which care is delivered exerts a crucial influence. Much of the extended ethnographic description in the chapters below is intended to show that much of the expertise of mental healthcare clinicians is oriented towards the needs of the office and their obligations as officials. Much of Weber's account of the ethos and spiritual qualities of the office emerged as being common sense to staff members. Audit culture and good clinical practice at times seemed inseparable. 'Being professional' or 'doing the job well' often meant accepting distinct and defined areas of responsibility, fitting into a hierarchical office structure, following rules and protocols, receiving training and producing written documents of a particular, routinized form. In the ethnographic chapters I try to show how staff perceive knowledge to be recordable, standardised and replicable and clinical judgment (at least ideally) to be 'objective' and independent of personal feelings. When recording clinical decisions, staff members mention simple observable rationales, even when informally talking of 'gut instinct' and 'intuition.' It is hard to imagine how clinicians would behave if they were freed from a sense of being scrutinized and held to account.

In the chapters below I show how the ethos and epistemic norms of the office coincide, at least in part, with the expertise of mental health professionals employed by Oxford Health. Clinicians try to be impartial and detached, and are much concerned with confidentiality. Clinical relationships are intimate, yet asymmetrical, compulsory and standardised. Clinicians offer support, but must also gather information in a routinized manner. Clinical decisions are often rule-based. Much of what is taken to be good clinical practice is, at very least, also good bureaucratic practice. Each of these qualities are explained by clinicians in terms of effectiveness, safety, professionalism or best practice. My suggestion is that it is more parsimonious to explain them as typical features of an accountable bureaucracy.

2.12 Discussion

This chapter opened with a description of the Oxford Health AGM. As an observer, I was puzzled that this was an opportunity both for the board to go over the books and for patients to raise grievances. The reason why both activities seemed to belong together lay in the notion of accountability. Oxford Health is accountable, both financially and in terms of service quality. It must satisfy obligations to the Board, to external bodies and to members of the general public. I understand this to be a development of Weber's ideal type. Oxford Health has goals not envisaged by Weber. But the means by which it approaches these goals falls within his model. The rules and regulations, documentary practices and professional ethos enable Oxford Health as an institution to be held to account. Each of its staff members practices such that they too may be subject to mechanisms of accountability.

Accountability seems to be close to the heart of the history of the NHS. Over time, it has formed part of a set of interlocking policy goals that have guided the transition from church to garage. In the process, politicians have become less responsible and less exposed to risk of blame, whilst independent and accountable Foundation Trusts now find themselves with freedom and autonomy but also external scrutiny and numerous mechanisms of accountability.

The literature on audit culture is particularly focused on higher education. It reveals how techniques derived from bookkeeping are taken up by institutions and interiorized by their employees to quell anxiety and uncertainty. Technologies of measurement and comparison introduce an ethic of improvement. In the process, work becomes redirected, even redefined. That which is difficult to audit becomes neglected, whilst attention is directed to league tables, metrics and targets. It is

argued that these processes are linked to neoliberalism. If that is right, it may be that the language of audit is essentially a smoke-screen, concealing material interests. Whatever we make of these higher-level arguments, it seems clear that audit culture transforms as much as it records.

EBM is a means by which the moral project of audit culture enters the professional habitus of the clinician. EBM provides a means by which clinical care may be bureaucratically justified. It helps Oxford Health to be accountable by suggesting the goals of healthcare are simple quantifiable outcomes. Through its distinctive epistemic humility, it justifies care that is uniform and repeatable. Attention towards interventions and explicit propositional knowledge and away from relationships and inchoate ways of knowing. It endorses a style of justification that can be easily documented by individual clinicians. Using the EBM framework means clinicians can produce simple comprehensible and economical documentation that can be easily compared. The question I seek to address is how such a model of care can be directed to individual patient health. How can a clinical culture organized around routinization and documentation serve the needs of patient? Does the pressure to make mental healthcare demonstrably safe and effective distort clinical work such that some clinical goals become impossible to achieve? This is the topic of the following chapter.

CHAPTER THREE: PATIENT EMPOWERMENT AND THE BUREAUCRATIC IMAGINATION

3.1 Introductory Vignette: Claire's multiple jobs

Around the midpoint of fieldwork, I went to interview an occupational therapist called Claire. Claire works in a clinic outside Oxford. By this stage some of the themes of my research were beginning to develop and I was interested to ask Claire about the role of bureaucracy in her day-to-day work. Below are two excerpts from our conversation. I quote at some length because Claire's remarks introduce the main topics of this chapter.

Claire: 'Services, as you know, have changed so much in the Trust in the last ten to twelve years...part of what I don't like, personally, is...Payment by result, very target driven, very data quality-esque shaping of services, it wasn't, to my feeling, really based on individual need, it all looked very good on paper, and it all looked like it would meet the needs of any given individual, but actually people are so unique, in what they want and what they need and the kind of support they find helpful, and I think that when you introduce these very target driven services, I worry that that gets lost a little bit.'

Neil: 'Yeah.'

Claire: 'Part of what happens when services get that way, and I see it happening within all aspects of the NHS, is that services change.'

...

Claire: 'There is the job I would love to be doing, the job I'm expected to do.'

Neil: 'Yeah.'

Claire: ‘and the job that I actually do, and,’

Neil: ‘Could you tell me about each one of those?’

Claire: ‘The job I would love to be doing, is, I would love to, and this is very idealistic, but this is my ideal, blues skies, ideal, I would have a much lower caseload.’

Neil: ‘OK.’

Claire: ‘I would have a caseload that predominantly consisted of people with significant mental illnesses, and that’s not excluding people with depression and anxiety because they are incredibly debilitating illnesses, but people who I feel are actually going to benefit from my interventions, again, in an ideal world my caseload would be a lot lower risk.’

[Laughs]

‘But I would actually have a caseload of people who are actually unwell, you know, there’s always going to be a bit of a mix, from the people we in an un-PC way call the lifers.’

Neil: ‘Yes.’

Claire: ‘But also people so I can do very very short term focussed intervention work, with a real recovery focus to try to get them well, to a point where they feel more stable and able to continue to implement what we’ve done. I, again, this is personal feeling, but I feel the job I’m expected to do is that, that’s what I’m expected to do, a bit, when we’re, from a promotional perspective that would be the job that the Trust would say I should be doing. In reality I think the job I’m expected to do is to, yes, do those things, but with a high caseload and making sure my paperwork is up. For me, particularly recently I think, there has been a huge emphasis on data quality.’

Neil: ‘Yeah.’

Claire: ‘And I’m not negating, I’m not negating that there needs, er,’

Neil: ‘It’s got to have a role.’

Claire: ‘It’s got to have a role and always will do, but [pause] with the introduction of payment by results and target driven outcomes, I feel that they don’t really match what someone may be asking for or what I think they need.’

Neil: ‘Yeah.’

Claire: ‘So, I feel that part of the job that I’m expected to do is a little unrealistic.’

Neil: ‘OK, yeah.’

Claire: ‘Umm, and the job that I want to do is a little unrealistic in the current climate and the job that I actually do is that I attempt to do both and feel that I’m not doing either well enough.’ [laughs] ‘Does that make sense? If I’m being honest.’

Neil: ‘OK, yeah, be honest.’

Claire: ‘If I’m honest I feel I’m trying to combine the two...We all work late, we all come in at weekends, occasionally, to catch up on things because it’s not just that, there are casenotes to do, supporting letters to write, medication to get sorted, if people are high risk you need to see them a lot, there are safety plans to negotiate, there are referrals, you know, with a caseload of more than thirty people, that’s a lot of work in the week, and the unfortunate result is, yes, I feel split in the middle and I feel I’m like I’m doing a half-baked job of both...its a compromise, the two don’t marry up as they should.’

3.2 Introduction

In the previous two chapters, I introduced the notions of bureaucratization and accountability as analytic terms that help to explain why clinicians in Oxford Health deliver care in the way I observed. I suggested that rules and norms that make it easier for Oxford Health to be held to account shape in particular ways the working practices of staff members. Efforts to make Oxford

Health an accountable bureaucracy influence the ethos and expertise of clinicians. For example, I identified EBM as a means by which audit culture can reshape clinical reasoning.

In the interview quoted above, Claire talks first about how the Trust organises care around data collection, and how this makes the services it offers 'look good on paper.' In her view, this is misleading. Patients are just too varied and complex for bureaucratized care. Despite this, she believes that services are becoming increasingly bureaucratic. Claire's remarks recall some of Strathern's concerns with audit culture. But Claire does not just talk of accountability versus clinical autonomy. She goes on to talk of three, not two putative jobs. She has a 'blue skies thinking' philosophy of care in which is based on 'recovery.' The purpose of this chapter is to introduce the idea of recovery, and its associated terms, and see how it relates to bureaucracy and accountability. What is recovery? And why does the Trust approve of recovery, but only, perhaps, from what Claire calls 'a promotional perspective'? Why does Claire think that both the bureaucratized job and the recovery-based job are idealised and impractical? And why is it that the different jobs clash such that she feels compromised and unhappy about the actual care she gives?

In this thesis I use the notion of patient empowerment as an umbrella term for a set of closely related, locally expressed clinical goals. These include 'recovery', mentioned by Claire above, and 'self-management', the term preferred by the True Colours team discussed in chapter one. This chapter begins with a discussion of how these terms are defined and used within Biomedicine. I then consider different ways of understanding empowerment, and try to tease out some perhaps hidden implications. I do this first by comparing empowerment with consumer choice. Then I move on to discuss some anthropological and philosophical work that investigates divergent understandings of empowerment. I then look at literature that understands distress and mental disorders to be problems of personal agency. Next I discuss literature that considers mental

healthcare itself to be a source of disempowerment. The following section considers reasons why empowerment might and might not be desirable in mental healthcare. The final sections are devoted to a review of the anthropological literature on mental healthcare, read in the light of the above discussion.

My basic claim is that patient empowerment lies against the grain of bureaucratic accountability. This tension is not unknown to clinicians, but it is under acknowledged and remains poorly examined. The conflict between accountability and empowerment is not just a matter of time pressures and overfilled clinical caseloads, although that is part of the story. Neither can it be understood simply as alternative clinical styles. The conflict is more fundamental than that. Basic clinical categories, observations, interpretations, relationships, attitudes to risk, interventions and decision making that are organised around the need for clinicians to provide bureaucratized forms of justification are very different from those oriented towards a telos of patient empowerment. Making care more accountable, or more efficient, or more uniform is likely to make it less good at promoting active, agential or empowered patients. And, conversely, if staff make the promotion of patient empowerment a priority, this is likely to come at the expense of poorer documentation, care quality that is harder to demonstrate, and a style of care delivery that is more difficult to conform to policy goals.

3.3 Patient Empowerment as a Clinical Good: A review of Biomedical knowledge

The origins of this research lie in attempts by academic psychiatrists in Oxford to use technology to involve patients in their own healthcare. The intended effect of the sequences of letters and numbers texted in by patients each week was to promote patient empowerment. As the True

Colours promotional materials put it, the technology is designed to 'turn better self-knowledge into better self-management' (True Colours Team 2013: 1).

Within biomedicine, patient empowerment is referred to by a range of terms, such as: 'personalised care,' 'self-management,' 'recovery,' 'shared decision-making,' 'the co-production of meaning,' 'patient autonomy' 'service user involvement' and 'patient-centred care.' During fieldwork it emerged that these are not notions with clear, defined and fixed meanings. They overlap semantically but are not synonyms. When staff or patients talk of self-management, or patient autonomy, or service user involvement, they are seen as interconnected topics. They are not, however, neutral terms. Each is tied to a theoretical hinterland that represents a particular position in the contested terrain of mental healthcare. For example, 'recovery' is associated with the 'service-user movement' that is sometimes deeply critical of existing mental healthcare arrangements, whilst 'personalisation' is a term widely used amongst mainstream biologically-minded mental healthcare professionals. However, when I observed healthcare professionals going about their work, the terms tended to merge, or be seen as part of a common cause. My sense is that is how Claire thinks of recovery in the vignette above. In this thesis I use the umbrella term 'patient empowerment' as a relatively non-partisan term that refers to interrelated goals that are directed towards the patient's role and his or her freedom as a decision-maker, clinical relationships, and the way that mental healthcare is conceptualised.

From a Biomedical point of view, the origins of the promotion of patient empowerment as a clinical goal are often traced to Tournier's 1940 publication, Médecine de la Personne, translated into English as The Healing of Persons, and Balint's The Doctor, His Patient and the illness (Tournier 1966; Balint 1968). Tournier was a physician who was concerned that a focus on illnesses as solely biological prevents a doctor from seeing the patient as whole. To remedy this, he called for a

greater attention towards the psychological and spiritual aspects of the person. Balint was a psychoanalyst who was concerned with the therapeutic potential of clinical relationships. He called for a more 'patient-centred' model of medical care, and criticised the paternalism of much current practice.

Patient empowerment is connected to the capacity of patients to help themselves. A Canadian psychologist, Bandura, introduced the notion of self-efficacy, which he defined as: 'the capacity to exercise control over one's own thought processes, motivation and action' (Bandura 1989: 1175). Within Biomedicine, the concept of self-management was developed by Creer, based on his work in the 1970s with chronically ill children (Lorig and Holman 2003). Most recent academic commentators from within Biomedicine are approving of increasing patient empowerment. Indeed, in many publications, the question is not whether or not patient empowerment is a good idea, but, rather, how to implement measures to increase it. The authors of a key text about the introduction of 'user experience' into healthcare design describe it as a 'quiet revolution' (Bate 2007: 14).

Within Biomedicine there have been some efforts to reach a clearer definition of what might be involved. In a recent review article seeking the 'core elements' of person-centred care, Kitson et al. usefully isolate three themes: patient participation and involvement; the relationship between the patient and the health professional; and the context where care is delivered (Kitson et al. 2013). The first of these involves notions such as respect for patient autonomy, care plans reflecting patient preferences, and delivering care in such a way as to address a patient's physical and emotional needs. The second refers to such matters as 'genuine' or 'therapeutic' clinical relationships, social skills, warmth or empathy on the part of the clinician, the open communication of knowledge and reasoning, health professionals being in possession of appropriate expertise, and effective co-operation between health professionals. The third theme, the context of care, refers to issues such as

care being delivered in an accessible and therapeutic environment; a consistency between policy and practice; satisfactory technology and sufficient staff time.

A recent document published by the King's Fund entitled People in Control of Their Own Health and Care identifies eight 'key forms of individual involvement' (Foot et al. 2014). The first is 'engaging people in keeping healthy' for example through diet and exercise, which might be promoted by information and behavioural nudges (ibid.: 16-18). Next, 'shared decision-making' suggests that the patient's experience of illness, social circumstances, attitude to risk, values and preferences should be construed as 'expertise' and brought alongside the clinician's expertise. Clinicians should be open in their deliberations, explaining to the patient how they understand the situation and what the options are. Included by the authors is a recommendation that decision and rationales should be explicitly recorded (ibid.: 21). Supported self-management, including personalised care planning, patient access to care records and educational programmes, is required for patients 'to increase the control they have over their lives and minimise the constraints placed upon them by their state of health or disability' (ibid.: 25). The authors also suggest the inclusion of family and carers (ibid.: 35). Two of the recommendations involve increasing patient choice, by having personal or social care budgets (ibid.: 31-35) and choosing care provider (ibid.: 40-43). Two final forms of involvement seek a closer relationship between provider and patient: participating in research (ibid.: 44-48) and evaluating services through feedback (ibid.: 49-53). This can alert staff to unmet needs, poor quality or unacceptable care, and reshape care provision to better suit patient priorities and experiences.

In a recent BMJ roundtable debate on improving care, the participants spoke optimistically of patient 'ownership' of healthcare, creating a 'partnership of trust' between health professionals and patients (Parish 2015: 2). Increasing patient empowerment is naturally associated with openness

and transparency, and concerns about over medicalisation (Richards and Godlee 2014). Empowerment is sometime presented as a necessary complement to evidence-based medicine (Fulford 2008).

Most of these publications share a common vocabulary and represent a consensus over the basic ideas. Increasing patient empowerment means delivering care via transparent and responsive institutions providing more symmetrical and equal clinical relationships, leading to informed and active patients who, in their private lives, take effective steps to promote their health. Lying behind this appears to be a transfer of power and responsibility. The individuals and institutions that deliver empowering care have less autonomy. Patients or other stakeholders have increased leverage over healthcare providers, resulting in greater input to service design, increased access to clinical information, greater influence over healthcare institutions and individuals, and a greater capacity to improve their own health.

The promotion of patient empowerment can be understood simply as a clinical goal or set of goals. Nonetheless, in policy discourse it is connected to the bureaucratic goals of accountability, care quality, value for money and transparency. As I argued in chapter two, within Biomedicine, these goals are spoken of as forming a consistent, even synergistic, set. Patient empowerment is presented as joining this set. Within the NHS, the promotion of patent empowerment becomes visible in policy discourse in the 1989 White Paper Working for Patients (Department of Health 1989). From the start, a link is made between patients as active agents and the accountability of healthcare providers. The Patient's Charter (Department of Health 1991) articulated certain 'rights' held by users of the NHS, involving issues such as limits to waiting times and complaints procedures. The General Medical Council's 1995 guide Good Medical Practice presents empowerment as a potential counterbalance to paternalism and included a duty on the part of clinicians to 'respect the right of

patients to be fully involved in decisions about their care' (General Medical Council 1995: 4). The second wave of NHS reforms, the quasi-market, accelerated these trends. More autonomous patients who are more involved in their own care are linked both to aspirations towards improved public health and to cost savings and greater efficiencies in healthcare delivery (Department of Health 1999). The NHS Plan of 2000 was unequivocal: 'the NHS must be redesigned to be patient centred – to offer a personalised service…by 2010 it will be commonplace' (Department of Health 2000: 17).

The Wanless Report saw patient empowerment to be part of the solution to projected major increases in healthcare costs over the coming decades (Wanless 2002). More equal relationships and flows of information make for efficiencies. A 'more effective partnership between health professionals and the public' is likely to be necessary, including: 'improved health information to help people engage with their care in an informed way' and 'patient involvement in NHS accountability arrangements' (ibid.: 136). An association between patient empowerment and safety is sometimes made. An example of this is the Francis Inquiry, ordered after a major public scandal following a series of unexpected deaths and substandard care delivered by the Mid Staffordshire General Hospital between 2005 and 2008. As a part of safeguards against a repetition of the tragedy, the Francis Inquiry Report called for the 'real involvement of patients and the public in all that is done' including 'openness, honesty, transparency and candour' (Francis 2013: 78).

3.4 Patient Empowerment in the Field

As an institution, Oxford Health publically endorses the promotion of patient empowerment. On their website Oxford Health describe themselves in the following way: 'We are committed to continuously improving our services and provide quality, patient-centred care, focusing on the

entire patient journey, from access to and eventual discharge from care.'[9] During fieldwork, many clinicians routinely used the vocabulary of patient empowerment when I asked them in general terms about their work. However, as our conversations became more specific, talking about particular encounters with individuals, for example, it seemed that patient empowerment played a smaller role. Many staff members acknowledged this. The conversation with Claire that opens this chapter is typical of this pattern. The promotion of empowerment is seen as an aspiration or goal. It can be presented as something supererogatory, the icing on the clinical cake. Excessive workloads, time pressures, and documentation were often given as barriers that prevented them from promoting empowerment.

Sometimes staff members would use vocabulary associated with empowerment in a way that seemed superficial, cosmetic, even sardonic. Tone and sincerity were frequently hard to gauge and the intentions of speakers could be ambiguous. Whilst looking through the medical notes of my patient informants I came across a letter written by a CPN to a small local charity, recommending that a particular patient be considered for a discretionary grant to pay for a holiday. In the letter the CPN described the patient as 'hardworking' and 'deserving'. Rhetorically at least, being hardworking was a way of praising the patient. It sounds like a quality that might be allied to empowerment. But I wasn't sure. I thought this might just be a matter of the CPN choosing a quality that has positive associations. I knew the CPN liked this patient. They had got to know each other well over the years. Although he had become a more reliable attender of appointments and taker of medicine, I wasn't sure if the CPN really saw him as hardworking.

In team meetings and informal conversation, I sometimes heard staff members express concern that a particular individual is 'inactive,' 'inert,' or 'passive.' This appeared to be the opposite of

[9] http://www.oxfordhealth.nhs.uk/service_description/adult-services/ accessed 25.09.2015

empowerment. Sometimes it is understood to be a symptom of mental disorder. On other occasions it is seen as iatrogenic: being 'institutionalised.' During fieldwork in a clinic south of Oxford I observed a team discussion about a patient who many of the team agreed was institutionalised. The patient's care co-ordinator, a social worker, said the patient no longer has any symptoms but didn't want to be discharged. The social worker was frustrated. He described this as 'the worst thing that can happen, the worst thing we can do to somebody.' But truly equal relationships between professionals and patients are quite difficult to envisage. I never observed health professionals taking seriously ontologies or epistemologies other than their own. As I try to show in the ethnography below, such asymmetries seem essential to getting the job done.

One of my patient informants is a man who, after many years of quite intensive mental healthcare, including periods of very intense distress and admissions to wards, became disenchanted with mental healthcare. He began to read antipsychiatry literature. Over time he came to doubt the safety and effectiveness of the many pharmaceuticals he was taking, and had fundamental objections with the way the healthcare professionals conceived of his problems. So, after some careful planning, but without the knowledge of his healthcare team, he first reduced and then stopped all treatments. He said that the months coming off medication were difficult, but he gradually felt better. After six months he seemed completely restored. He had regained his full health, completed his degree and was discharged. He commented, with some bitterness, that although the team seemed convinced he was completely well, no-one showed the slightest interest in how he had recovered. He felt they could learn from him. He thought that some of his problems were caused by medication, but others he had overcome, or learned to live with. Why didn't they take his expertise seriously? Instead, he said that they didn't seem curious in any way. He wondered if accountability might be part of the problem, in that if staff seriously engaged with him, it might expose the Trust to legal action.

3.5 Patient Empowerment and Consumer Choice

Illich regarded a loss of autonomy on the part of patients to be an element of medicalization (Illich 1990). For him, empowering mental healthcare is something approaching an oxymoron. In contrast, in their paper on the shift from medicalization to biomedicalisation, Clarke et al. present the promotion of patient empowerment as a key feature of a global transformation of medicine (Clarke et al. 2003). According to Clarke et al, biomedicalization involves the 'customisation' of care, in which healthcare is increasingly tailored to the individual patient. This, in turn, makes the patient increasingly responsible for his or her own health.

Cant and Sharma find the rise of complementary and alternative medicine (CAM) to be associated with patient demand and empowerment (Cant and Sharma 1996). They suggest that the increasing popularity of CAM is linked to a popular dissatisfaction with typical Biomedical clinical relationships and a desire for a less hurried and more personal approach: 'Certainly, it is widely agreed that users of alternative medicine require more from their relationships with their practitioners, in particular that they be more involved in the healing process…dissatisfaction with the medical encounter and the hierarchical and disempowering modes of consultation within biomedicine that explains the popularity of alternative medicine' (ibid.: 26). From this point of view, making the care delivered by Oxford Health better suited to patient empowerment is likely to mean making it more closely resemble CAM.

Mol is cautious about the way in which Biomedical healthcare is increasingly understood as if it is a commercial transaction, such that increasing choice is desirable and medical practitioners are seen as providing services to customers (Mol 2008). In her view, clinical relationships are importantly different from market transactions. To develop her argument, Mol differentiates between what she

calls the logic of care and the logic of choice. Markets are built around the logic of choice. The question is whether this serves as an adequate model for healthcare: 'in one way or another a market requires that the product that changes hands in a transaction be clearly defined. It must have a beginning and an end. In the logic of care, by contrast, care is an interactive, open-ended process that may be shaped and reshaped depending on its results' (ibid.: 23). She suggests that the logic of choice sits uneasily in the practicalities of healthcare. One reason is that better health does not necessarily result from more healthcare products. Another problem is that in healthcare, the quality of care cannot be deduced unproblematically from the results. If this is the case, simply promoting choice is not a good way of promoting patient interests. It is not truly empowering because choice and empowerment have a more complex relationship.

For Mol, the problem arises out the way freedom is conceptualised. We are familiar with an association between paternalistic medical authority and disempowered, passive patients. Perhaps this is how the social worker mentioned above thought of 'institutionalisation.' But, according to Mol, making patients into consumers may not be the only way to counter disempowerment. Choice and freedom do not map onto each other as simply as the logic of choice suggests:

> If you have a potentially lethal disease and there is a drug like insulin that is likely to allow you to live for quite a while longer, what do you do? When they talk about this, most patients say: 'I have no choice.' But this lack of choice does not call for emancipation. That they feel no freedom is not because they have been submitted to the force of authority. Something else is going on…In that context, their first concern is not with who is in charge, but with what to do. (ibid.: 46)

In other words, in many clinical contexts, the freedom of choice that seems constitutive of being a consumer is irrelevant to both clinician and patient. Providing choice such that a patient can be construed as active and agential seems wrong-headed in such settings. Thinking of patients as consumers and promoting them as such is not, it appears, a good way of promoting genuine patient empowerment.

This line of thought has been taken up by advocates of increased service user involvement. Barnes has criticised consumerist approaches to healthcare for positioning patients as customers, rather than citizens with rights (Barnes 2002: 330). Some commentators see a consumer ideology as a way of embedding a medical model into care (Morrison 2005). In the introduction to an edited volume on coproduction and personalisation, the authors make a distinction between earlier models of care in the NHS, consumer choice and patient empowerment, suggesting that empowerment represents:

> A different way to think about the relationship between the state, service providers and service users. It differs both from the traditional public provision model, where the state is the administrator of a unitary system, the professionals are powerful experts and the service users are grateful recipients, and from the consumerist model where the state is the funder and market-maker, the provider agencies are competing suppliers and the service user is a free and informed shopper (Hunter 2007: 15).

The same distinction is found in a discussion of barriers to service user involvement by sociologist Lewis (Lewis 2014). For all these writers, there are important differences between thinking of patients as consumers and patient empowerment.

The appeal of empowerment is not necessarily tied to understanding patients in terms of consumer choice. Consumer autonomy is not a necessary aspect of empowerment. If it has a role to play, it isn't a very substantial one. In the ethnography below I describe lots of instances where patients seem to be offered consumer choice: which drug to try first; whether they feel they can tolerate a higher dose of a drug; or whether a drug should be discontinued because a couple are planning a pregnancy; even psychiatrists asking 'how can I help you?' This can be a topic of some irritation and a degree of gentle mockery amongst patients. Each might count as representing empowerment as consumer choice. They emerged as largely irrelevant to patients even if, as Claire suggested at the beginning of the chapter, they can help the Trust look good on paper. In the next chapter I describe how a patient, called Viv, conducts herself very much like a consumer. This has consequences that do not appear to enhance the quality of her care.

3.6 Thinking about Empowerment: Some philosophical contributions

Much of the above debate revolves around different ways of conceiving of patient empowerment. I don't here intend to devote too much time to investigating key concepts. However, to develop my argument, in the following two sections I will delve a little further into the Biomedical notion of empowerment. First, I very briefly examine some philosophical work on one of the key ingredients in the notion of patient empowerment: autonomy. Then I move on to some medical anthropology publications dealing with narrative and personal transformation. My purpose in these sections is not to engage in normative debates about how empowerment should be understood. Instead I am trying to get a better understanding of the meaning of empowerment as it is used in natural language and in clinical contexts. Part of my aim is to highlight what is absent in clinical encounters. A clearer understanding of what empowerment might mean gives a sharper focus on facets of empowerment that go unaddressed and unremarked upon during consultations, in medical notes or in more formal expressions of Biomedical knowledge.

I take as my starting point Dworkin's The Theory and Practice of Autonomy (Dworkin 1988). Dworkin finds that philosophers understand autonomy in an exceedingly broad fashion. It may mean liberty, self-rule, sovereignty, or freedom of the will. It is associated with dignity, integrity, individual independence, responsibility, and self-knowledge. It is identified with qualities of self-assertion, with critical reflection, with freedom from obligation, with absence of external duress, with knowledge of one's own interest. To try to make sense of this multiplicity of meanings, Dworkin identifies ten features of the notion of autonomy. These are (1) freedom to and freedom from; (2) sovereignty, meaning being able to weigh up reasons for actions; (3) not being subject to the will of another; (4) self-rule – 'I rule me and nobody else does'; (5) actions can be criticised on the basis of reciprocity and fairness, or some other externalised viewpoint for evaluation; (6) ability to choose how to think and act; (7) freedom from obligation; (8) ability to explain choices and

actions in terms of one's own activity of mind; (9) acting on principles that one has consented to; (10) having personal responsibility for actions.

For Dworkin, it isn't clear quite how these qualities interrelate and to what degree they overlap or contradict each other. He suggests that about the only features held constant are that autonomy is a 'feature of persons' and that it is a desirable quality to have (Dworkin 1988: 6). In Principles of Biomedical Ethics, Beauchamp and Childress stress that as well as a free and independent decision maker, autonomy requires enough knowledge, understanding and capacity to reason to make self-determining decisions (Beauchamp 2013). If a patient is understood to lack capacity, then involuntary treatment may be justified, if it is viewed as being in the best interests of the patient.

From this summary we can see there are areas of overlap between some of the basic ideas behind the notion of autonomy and, for example, the purported empowering effects of True Colours. The promotion of patient empowerment in general, and by True Colours in particular, is intended to give more freedom and choice to the patient, to make decision-making more symmetrical and for the patent to be less subject to the will or power of the clinician. True Colours is also said to promote personal responsibility. Agential, True Colours-using patients are expected be able to reflect on themselves from an external viewpoint, and to evaluate their actions and patterns of behaviour from that viewpoint according to how they influence health.

Debates about autonomy reveal some additional ideas that add to my argument. Dworkin argues that autonomy involves reflecting on oneself such that one might develop preferences about one's preferences. This is 'a second-order capacity of persons to reflect critically upon their first order preferences, desires, wishes and so forth, and the capacity to accept or attempt to change these in the light of higher order preferences and values' (Dworkin 1988: 20). Rather than autonomy simply

relating to the freedom to make unconstrained choices, Dworkin presents making choices about the self, including, potentially, reshaping one's self according to certain goals or ideals, as a critical aspect. For Dworkin, much that is of value in autonomy is located here. 'By exercising such a capacity, persons define their nature, give meaning and coherence to their lives, and take responsibility for the kind of person they are' (Dworkin 1988: 20). This aspect of autonomy seems less connected to the kinds of freedom offered by True Colours.

True Colours promotes health-related self-monitoring and decision-making. But it does so in a rather inflexible, externally determined way. It gives a small range of qualities in the self to be vigilant about and an equally small set of reasons for action. Users of True Colours are invited to look for pre-defined symptoms such as low mood or anxiety. They are offered reasons for decisions such as 'decreasing risks and stressors' or 'increasing protective factors.' So although self-monitoring and self-managing with True Colours promotes some aspect of autonomy and empowerment, it does not include independent reflection on one's preferences, desire or wishes that Dworkin sees as so important. Indeed, it might be argued that it expressly restricts these aspects of autonomy.

The philosopher O'Neill takes a different tack (O'Neill 2003). She argues that the concept of autonomy should include the reasons that lies behind a person's choices. This means that autonomy might be a quality not just of persons, as Dworkin suggested, but of reasoning itself. She describes how Kant argued that only certain kinds of decisions, those made in conformity with moral laws, should count as autonomous. In this case, increasing the number of options a patient has is not at all the same as increasing their autonomy. Bioethicist Kukla makes a related point (Kukla 2005). She argues that we need to consider more than just decision-making opportunities when assessing patient autonomy. She suggests that in many areas of healthcare, especially where self-management

or self-care is important, part of the goal of the treatment is to make patients more conscientious (ibid.: 38). In as much as this is a didactic task, it might be seen as disempowering to patients. This, for Kukla, would be a mistake. She argues that efforts to promote conscientiousness can be understood as increasing autonomy provided the content of decisions is considered to be part of autonomy. If conscientious patients have better rationales for their decisions, they may be considered to be more autonomous.

The designers of True Colours might seek to defend the variety of autonomy promoted by True Colours this way. They might see True Colours as empowering patients not despite the way it is focussed on pre-determined categories but because of it. They might argue that True Colours teaches patients what count as good reasons to make health-related decisions. Looked at from this point of view, increasing freedom in the sense of offering a wider range of choices, as might result from a consumer model of patient empowerment, would simply mean increasing the scope for poor decisions. Enabling more ways for patients to make bad decisions seems a strange variety of empowerment.

This line of thought is related to arguments that the goals of medical practitioners need not be taken up by individuals as their personal ethical projects. Bioethicist Verweij has argued that medicalization and self-management can erode personal confidence whilst unjustly imposing health as a dominant value over other individual priorities and moral intuitions (Verweij 1999: 113). Accountable clinicians might have good reasons for trying to impose their priorities on patients. It enables them to justify their care. But there may not be good reasons for a patient to adopt the priorities of the clinician. Even leaving aside clinical epistemic problems, we cannot assume that clinical and personal priorities necessarily coincide.

Philosophical approaches to the notion of autonomy suggest that although it is widely seen as desirable, it is a complex and ambiguous idea, with multiple potential ingredients. There is considerable disagreement about how best to define it. For Dworkin, much of what is valuable about autonomy has to do with the freedom to develop one's own second-order preferences. The practice of doing so, in his view, brings meaning to life. O'Neill's more Kantian approach is concerned with the kinds for reasons for decisions. According to this line of argument, genuine autonomy is not served by bad decisions. These distinctions and arguments help illuminate my ethnographic material below. When noting cases of patient empowerment or purported empowerment, I try to assess the data using this philosophical material.

Part of my argument rests on differentiating thinner and thicker conceptions of empowerment. I take these terms from Geertz, who was himself indebted to Ryle (Geertz 1973; Ryle 1971). Geertz differentiates between thin and thick description with reference to the difference between a twitch and wink. He suggests that 'the difference, however unphotographable, between a twitch and a wink, is vast (Geertz 1973: 6). A wink may indicate complicity or mockery, for example, whilst a twitch communicates nothing. A thin description, however, of eyelids simply closing and opening, misses out on this. So, instead, what is required is a thick description that goes beyond the directly observable to include meaning, context and intentionality. Without thick description, argues Geertz, we fail to understand people and culture. My purpose here is not to reproduce Geertz's argument, but to begin to make a distinction between different ways of conceptualising empowerment and to suggest that the apparent epistemic safety of thin description can be misleading.

3.7 Thinking about Empowerment: Some contributions from medical anthropology

A concern with narrative has been a particular focus in medical anthropology, in particular in finding an association between narrative and healing (Mattingly and Garro 2000). Narrative is a way of bringing meaning to events. In narrative, time is 'configured' (Mattingly 1994: 813). This means it has direction and form, moving from beginning to middle, and from middle to end. Events acquire significance in virtue of their placement within a sequence. For Mattingly, a feature of narrative time is that it makes events open to human intervention. In a narrative, events may be caused by human actions, which brings human motive and intention into play, potentially to be the subject of conflict and drama, and the cause of uncertainty, suspense or surprise. Positioning people within a narrative structure means that personhood is also configured in a particular way. Ochs and Capps declare that 'narrative and self are inseparable' (Ochs and Capps 1996: 20).

Based on fieldwork with occupational therapists in the US, Mattingly shows how clinicians and patients negotiate together a plot structure that places their therapeutic encounter within a wider therapeutic story. This she calls therapeutic emplotment (Mattingly 1994). Therapeutic emplotment is designed to 'motivate' the patient and 'solicit interest and co-operation' (ibid.: 815). In Csordas' work on Catholic Pentecostal healers in the US, something like therapeutic emplotment can be seen (Csordas 1983). When distressed people approach the healers, their experiences are reframed within a new narrative drawn from Catholic and psychotherapeutic sources. For Csordas, Catholic Pentecostal healing comprise of three rhetorical tasks: persuading the supplicant that healing is possible; that the healing is efficacious; and that he or she accepts the personal cognitive, affective or behavioural changes proposed by the healers. This can lead to changes in 'attitude, affect or self-image' in supplicants (ibid.: 348). In her ethnography Ritual Healing in Suburban America, McGuire suggests that new ways of narrating illness, conveyed in healing rituals, can redirect a person's attention, change their interpretation of distress and increase their sense of personal empowerment (McGuire 1988: 183).

The strategic use of narrative, therapeutic emplotment and symbolic healing is neither restricted to experts nor absent in Biomedicine. In his work with an early intervention psychiatric service in Denmark, Larsen concludes 'The point here is that symbolic healing is active also in contemporary evidence-based practice, and that even a reductionist biomedical scientific perspective has a significant symbolic function in the healing process' (Larsen 2007: 301). Working with survivors of cervical and testicular cancer in Mexico, Hunt shows how narratives are shaped and deployed to creatively renegotiate social roles (Hunt 2000). Steffen conducted fieldwork at Alcoholics Anonymous meetings in Denmark, a setting in which therapeutic emplotment is expressly pursued away from the Biomedical gaze (Steffen 1997). Group members tell personal narratives that become rather 'stereotypical' as they are shaped by the moral commitments of the group. The stories stress personal responsibility and the need for personal commitment and effort, whilst drawing on the 'bonding' and 'strong feeling of relatedness' produced by the group. In an ethnography of the cult of St Jude in Chicago, Orsi describes how devotees share stories of their troubles with out of work or alcoholic husbands or mortally sick children (Orsi 1996). He argues that the appeal of the group lies in the opportunities it gives for women to control their own narratives (ibid.: 139-140).

The anthropology of narrative suggests aspects of empowerment not discussed by the philosophers above. In therapeutic emplotment, selfhood is not static. Rather, the person is remade, transformed. This healing can take the form of a new sense of self, new attitudes or beliefs about the self. Sources of distress or ill-health can be redefined and contained. Narrative orients and motivates individuals. It unites groups. Empowerment is not just a quality of narrative itself. Ownership of one's story, opportunities to share and the collective, sometimes repetitive experience of doing so

can be empowering. As I review my ethnographic data below each of the elements come to the fore as aspects of empowerment.

3.8 Distress as a form of disempowerment

At the turn of the twentieth century Durkheim argued that differences in suicide rates between, and also within, European countries were socially caused (Durkheim 2002). In societies where shared values are weakly reinforced, he claimed that individuals lack the resources required by self-governance. Anomie and egotism make individuals vulnerable to despair, leading to suicide. Distress, for Durkheim, can be caused by problems with personal agency. Individual freedom creates vulnerable populations.

An ethnographically rich but controversial development of this style of argument is found in Scheper-Hughes' monograph Saints, Scholars and Schizophrenics, which seeks to account for the high reported rates of schizophrenia in rural Ireland in the 1960s and 1970s in terms of a 'broken culture' (Scheper-Hughes 2001). Scheper-Hughes notes how rural men lack the social skills to deal with the demands of a changed social world. They can't talk about feelings, for example, and lapse instead into joking and periods of heaving drinking. This, according to Scheper-Hughes, leaves them isolated and lonely. In the monograph, men are described spending evenings in their fields, standing with the cows. In some sense at least, the men described by Scheper-Hughes appear disempowered. From this perspective, creating the conditions to reverse these failures in empowerment might reduce the social causes of mental illness.

Ehrenberg makes a recognisably Durkheimian argument (Ehrenberg 2010). He seeks to investigate depression in the contemporary West in terms of problems with personal agency. For him it is the

contemporary Western culture of personal freedom, tied to the ethical project of self-actualisation, that causes the current increase in depression. According to Ehrenberg, modern individuals experience a high degree of personal freedom. This leaves them without direction or constraint. In a context of aimless personal freedom, the 'weight of the possible' bears down on individuals who have failed to develop the skills of self-governance and end up depressed. 'The depressed person has trouble forming projects; he or she lacks energy and the minimum motivation to carry them out. Inhibited, impulsive or compulsive, she has trouble communicating with herself and others (ibid.: 233). Autonomy seems to be both the problem and the solution. Too much freedom has left Ehrenberg's depressives disempowered. Successful agency is linked to better mental health, but it requires the individual to attain a kind of maturity beyond inhibition, impulsivity and compulsivity. Empowerment appears not to be linked to freedom, but, rather, to self-control.

Many mental health conditions seem to contain failures of personal agency as part of their defining features. Withdrawal, apathy, inactivity, a lack of motivation or indifference may be understood as symptomatic of mental disorder. It is said that depressed or psychotic people can become almost wholly inert. People described as manic may be too optimistic or accelerated to make prudent decisions. They are said to be prone to impulsivity and anger. People diagnosed with personality disorders are believed to find relationships difficult. They may find symmetry and reciprocity in relationships problematic, fail to be able to see things from another person's point of view in a consistent way, or be liable to intense and unstable relationships. For all these people, becoming a responsible, self-governing agent may, in itself, be counted as a positive health outcome. In a statement about increasing empowerment in mental healthcare, the World Health Organisation Regional Office for Europe stated: 'enhancing the empowerment of mental health service users leads to tangible biological, psychological and societal benefits. These include enhanced self-esteem, a greater sense of connectedness to local social groups and meaningful engagement in

society (World Health Organisation 2010:8). If mental disorders are disorders of agency, an effective increase in patient empowerment is likely to be of direct benefit to mental health.

3.9 Mental Healthcare as a Source of Disempowerment

Researchers and activists from positions external to, and critical of, current Biomedical mental healthcare, such as the 'Recovery Movement' or 'Survivor Research' argue a rather different case. They see mental healthcare not as part of the solution, but as part of the problem. A loss of empowerment is a part of the experience of being a patient, some or all of which arises directly out of contact with services. In a policy document produced by Sitra called Co-production: Its About Time, a former patient writes that he or she 'found the experience of being a passive recipient of care dehumanising, disempowering and disenfranchising' (Sitra n.d.). He goes on to describe how improvements to his mental health involved resisting or withdrawing from healthcare: 'I started to claw my way back to life with the help of my peers. I started to take the power back that I had all but lost. I started to become a participant in my own recovery. I started to fight against passivity.' For this person and for many others, online and in printed publications, healthcare has been disempowering, and obstacle to be overcome on the path to better health.

Several contributors to an edited volume, Mental Health, Service User Involvement and Recovery, make this case (Weinstein 2009). In a chapter called 'The Ethos of Involvement as the Route to Recovery' Gosling writes that:

> User involvement can also contribute towards recovery in situations where users become part of a team or group…with a sense of purpose. People start to feel depended upon and needed and gain a sense of responsibility. Their expertise, experience and knowledge are recognised and they become aware of their potential to grow and gain new skills…Involvement can help people feel powerful again. (Gosling 2009: 33)

Gosling sees in the experience of being a mental patient consequences such as a loss of a sense of purpose, and feeling unvalued or weak. Reversing this, through the promotion of patient

empowerment, brings direct health benefits. He thinks of empowerment in quite broad terms, including features such as making and following through plans, self-confidence, hope and a robust sense of self-worth.

These remarks are echoed in Estroff's classic ethnography of patient experience, Making It Crazy (Estroff 1981). Estroff found the role of mental health patient self-perpetuating. Spending time as a patient – making it crazy – means becoming accustomed to a distinct and recognisable way of life, defined in opposition to the life of non-patients or 'normals.' As the years go by, being crazy may not stop being painful, insecure, limited and excluded. But it seems it becomes familiar and comfortable, and thus a source of disability in its own right. Motivation and willpower are gradually reduced over time, whilst 'crazies' feel ever greater anxiety about whether they can ever make it again as a normal:

> The paradox here is that the accessible group with which one shares similarity is a group of long-term psychiatric patients. The group that one does not perceive to be accessible and with whom one has little in common is the presumed normal, unmedicated group. This identity system, constructed by the self and others, perpetuates the viability of the crazy identity. Those who stay within the network are not only exposed to the continual failures, problems, inertia and frustrations of their comrades, but they experience their own. It is not difficult to ascertain possible factors reinforcing the crazy life. The dismal becomes the routine; failure and distress become the norm. (ibid.: 112)

For Estroff, mental healthcare is part of the problem, providing what Hopper calls the 'institutional circuit' (Hopper et al. 1997).

In a series of articles developing the concept of 'social defeat', Luhrmann makes a similar case (Luhrmann 2006, Luhrmann 2007, Luhrmann 2008). Social defeat is the subjective consequence of repeated social encounters in which an individual finds themselves demeaned, humiliated, shamed or subordinated (Luhrmann 2007: 151). In a moving ethnographical account of a women's homeless centre in Chicago, Luhrmann describes the 'countless small humiliations' experienced each day by users, accumulating as a burdensome, corrosive, even toxic load (ibid.: 159). A

continual sense of being socially defeated leads to anomie, demoralization, humiliation, self-stigma and helplessness.

Luhrmann's contention is not just that social defeat makes schizophrenia worse. She argues that social defeat arises in contact with services designed to help. This is an alarming idea. For people diagnosed with schizophrenia in the US, 'our standard model of care not only does not help but may even make the illness worse' (Luhrmann 2007: 136). The problems are deeply rooted. The way subjective experiences are conceptualized as psychological obscures the social and political background (Luhrmann 2006: 359). Indeed, the category of Schizophrenia is so devalued that some homeless women prefer to sleep rough rather than stay in a hostel that requires them to accept the label (Luhrmann 2008: 19).

Social defeat grossly impairs empowerment. Luhrmann's informants have lost fundamental preconditions of empowerment: the ability to make decisions and act on them. We might imagine that offering one of them consumer autonomy, for example a choice of antipsychotic medication would do little alleviate this. Whitley found rather less social defeat and rather more vibrant social resistance, albeit in a group of severely mentally people housed in a recovery community (Whitley 2011). More recently Wright has drawn a picture of highly variable levels and varieties of social defeat in a recovery community in Texas, interspersed with occasional personal resistance (Wright 2012).

For Luhrmann and Wright at least, mental healthcare services seem to contribute to social defeat and, thus, erode empowerment. Overall, there are widespread concerns that mental healthcare is disempowering, and can make distress or mental disorders worse. Over the course of fieldwork I

met a remarkable number of people who attributed their improved mental health to their having withdrawn from services. More than one informant described it as having 'escaped.'

3.10 Is empowerment always desirable in mental healthcare?

Pulling in the opposite direction are concerns about whether empowerment is a desirable constituent of mental healthcare. Philosophers have sometimes found reason to doubt the benefits of the experience of being a free and sovereign agent. Part of the reason for this is the way that empowerment entails responsibility. Kierkegaard saw a direct causal link between freedom and anxiety. In her monograph on Kierkegaard's thought, Ferreira presents as a central insight of Kierkegaard that 'our recognition of possibilities in life reveals our freedom to us, and with this comes the fundamental mood or disposition of anxiety' (Ferreira 2009: 78). Do mental health patients want more of the mood or disposition of anxiety? A sense of personal empowerment can make anything seem possible, but can also cause shame where ambitions are not realised. Perhaps some of the social defeat observed by Luhrmann and others arises out of this shame. As Salecl points out, personal blame can conceal the structural factors that might work against disadvantaged individuals (Salecl 2010: 148).

Cederstrom and Spicer make a similar case, arguing that what they describe as the 'current ideology of personal wellbeing' is unrealistic, causes excessive introspection, leads to an obsession with health and authenticity, and leaves a person burdened with guilt, whilst inequalities associated with neoliberalism are unobserved (Cederström and Spicer 2015). During her investigation of mental healthcare in post-Soviet Latvia, the anthropologist Skultans found amongst patients an increasing sense of personal responsibility for distress and misfortune. Where sadness might once have been associated with dissent towards the Soviet authorities, it is now a personal failing and generates a

burdensome sense of guilt, that, ironically, seems to make the distress worse (Skultans 2007: 244–262).

Increasing empowerment may be particularly problematic to people who are liable to become recipients of secondary mental healthcare. Several commentators have discussed how medical discourse bleeds into moral discourse, turning 'smoking is bad' into 'smokers are bad', for example (Brewis and Grey 2008; Metzl and Kirkland, 2010). Many depressive patients struggle with disproportionate and sometimes wholly delusional guilt. Radical psychiatrist R D Laing, saw psychosis quite specifically as a retreat from responsibility: 'A good deal of schizophrenia is simply nonsense, red-herring speech, prolonged filibustering to throw dangerous people off the scent, to create boredom and futility in others. The schizophrenic is often making a fool of himself and the doctor. He is playing at being mad to avoid at all costs the possibility of being held *responsible* for a single coherent idea, or intention' (Laing 1990: 164, emphasis in original). If Laing is right, the role and symptoms of Schizophrenia represent a kind of decision against personal empowerment.

Laing's insight is developed in Desjarlais' ethnography of a homeless shelter in Boston Shelter Blues (Desjarlais 1997). Desjarlais describes how mentally ill homeless people adopt a highly rhetorical form of speech that is shifting, allusive, ludic, and ambiguous. Although sometimes bizarre, even baffling, Desjarlais shows how it helps service users resist authority and reject repeated nudges from staff members towards mainstream models of autonomy, responsibility and reason. What clinicians might describe as 'disordered speech' emerges as part of a tactical game in which aspects of empowerment are resisted by service users. This highlights tensions in the notion of patient empowerment. Efforts to promote empowerment tend to assume that empowerment is desirable to patients.

I described in chapter one how the True Colours team thought that better information would empower patients to make better decisions, something I called a 'faith in information.' Desjarlais' homeless informants have other ideas. They are uncooperative out of choice. Their 'poor compliance' does not arise out of passivity or weakness of the will. Measures typically understood to be constitutive of increased patient involvement, such as more input to clinical decisions or the promoting of healthy lifestyles, appears to be actively rejected by some patient populations. Making healthcare institutions responsive to these patients' preferences or values might indicate something quite different from the transparent and flexible bodies envisaged in the literature. An unresponsive, top-down inflexibility might be more desirable to people who seek to escape the clutches of healthcare provision.

In addition, there is a concern that the desirability of empowerment arises out of conceiving of it as a form of resistance. Laidlaw has argued against popular anthropological conceptions of empowerment that are based on individual resistance to dominant values. Part of what is wrong with this way of thinking, according to Laidlaw, is that it tends to introduce to the analysis certain assumptions about valid ethical goals. This can arise from a tendency to be attentive to the individual, in such a way that individual needs and preferences are valued above group norms and rules:

> Because an opposition to structure, and therefore to existing systems of values and power, is built into its definition, this conception of empowerment recognizes as efficacious only actions conducive towards certain ends and outcomes: empowerment, liberation, equality and so on…For this reason, this conception of empowerment muddles rather than clarifies matters when applied to any form of life or project whose ends differ markedly from these imputed values. (Laidlaw 2013: 182)

In other words, we need not automatically approve of empowerment among the patients of Oxford Health. Moral or ethical projects should not be endorsed simply because we class them as forms of dissent.

In this work I do not take a view on whether empowerment is clinically beneficial. However, in the ethnography below I try to be attentive to the complexity of forms of empowerment. For example, Simon, a patient deemed psychotic and described at length in chapter seven, seems to be trying to negotiate a surrender of some aspects of personal sovereignty whilst retaining others. His lapses into disordered speech resemble the tactical ploys described by Desjarlais. He is an active agent, but his empowerment does not take the form of the rational pursuit of health, as his care team would like. But he neither furthers the goals of social scientists critical of Biomedical power, such as by critiquing the discursive hegemony of Biomedicine nor maximizes his personal freedom. The literature discussed in this section helps to produce a more realistic model of complex and conflicted personal motives and goals found in everyday healthcare.

3.11 Bureaucracy and Mental Healthcare in the work of Luhrmann

The notions of bureaucracy and empowerment are central to the analysis of two of the most important recent ethnographic monographs on mental healthcare, Luhrmann's Of Two Minds and Lakoff's Pharmaceutical Reason (Luhrmann 2000; Lakoff 2005). In these studies, the interface between mental healthcare and external bureaucratic bodies shapes a great deal of apparently autonomous clinical practice. I will examine these books in detail because they are directly relevant to my argument.

In Of Two Minds, Luhrmann finds 'contradictions' in the heart of mental healthcare in the US (Luhrmann 2000). The most important, the 'two minds' of the title, lies between biological and psychodynamic psychiatry. Luhrmann shows that biological psychiatry approaches human distress in terms of mental disorders caused by 'dysfunctions' in the brain that tend to occur in people who have a 'biological vulnerability.' The role of a clinician is to provide treatments for these disorders,

usually in the form of pharmaceuticals. Psychodynamic approaches, in contrast, understand distress as being a result of someone learning to interpret and respond to other people in maladaptive ways. This may be a result of childhood experiences, such as trauma or neglect. Distress understood in this way is primarily addressed by therapeutic relationships between clinician and patient. Luhrmann calls this a 'split' that gives mental healthcare 'a divided consciousness' (ibid.: 203).

Although contradictory, Luhrmann argues that the two minds were, for a while, in a state of relative harmony. She approvingly quotes a clinician who describes the relationship between them as a 'happy pluralism.' This relationship came to end towards the close of the 1980s when Luhrmann saw 'the balance tilt irrevocably' (ibid.: 238). By the time Luhrmann conducted her fieldwork in the early 1990s, the care she observed was mostly not of patients benefitting from therapeutic relationships but medical teams treating discrete mental disorders with drugs that are thought to target underlying pathologies that cause 'symptoms'.

Many of the clinicians she spoke to presented this as the result of new pharmaceuticals supported by high quality evidence of effectiveness, coupled with research evidence undermining old methodologies. In other words, changes in the variety of care delivered by American psychiatrists came about through scientific progress. But Luhrmann is not so sure. She believes there has been a 'sharp improvement in psychiatric medication in the last fifteen years,' which includes both increased effectiveness and decreased side effects (ibid.: 236). But she does not believe this is the sole cause of the shift towards biological psychiatry. Not all the clinicians she observed were happy with the biological turn. Some were sceptical about the role of research evidence. Luhrmann herself interprets the change as revealing the influence of external bureaucratic pressures on healthcare provision exercised by health insurance companies.

Luhrmann's argument is that insurance companies prefer biological approaches. This is because biological psychiatry is much better than psychodynamic psychiatry at producing documentation. Insurance companies require clinicians to produce detailed records outlining and justifying clinical decisions. Biological psychiatry provides a much more suitable set of concepts and practices for this purpose. A small set of defined biological disorders with quantifiable symptoms and matching, quantifiable interventions makes record keeping relatively easy. The complex and ambiguous world of psychodynamic psychiatry, based on unstandardized categories and tacit, intuitive judgement, presents the clinician with serious problems.

Although she doesn't develop the point, Luhrmann suggests that bureaucratic expediency can flow into ideological commitment, such that psychiatrists who might otherwise be more sympathetic to psychodynamic thinking end up more biologically minded:

> the more time they spend on the phone with insurance agents negotiating for a six-day admission to be extended to nine days because a patient is still suicidal, the more administrative interviews they need to do, the more discharge summaries they need to type, the less the ways of thought and experience of psychodynamic psychotherapy fit in, the less they seem relevant or even real, and the more psychiatrists are willing to fall back on the ideological position that the cause and treatment of mental illness is biological and psychopharmacological. (ibid.: 238)

It is striking that Luhrmann suggests not just that psychodynamic practice gets regretfully side-lined, or even squeezed out, as overburdened clinicians try to get through their working day. What Luhrmann is claiming is that documentary practices have the unintended consequence of making the psychodynamic world seem less *real*. This suggests that it is because of documentary practices that a notion like 'countertransference' might seem more nebulous or conceptually suspect than 'depressive illness.'

I would like to make two points about the monograph that pertain to my argument. First, Luhrmann accepts the possibility of harmony or 'happy pluralism' between the two schools of psychiatry. She takes the view that even if the fundamental concepts are contradictory and incommensurable, the

interests of mental healthcare, and its patients, are best served by finding a balance between the two.

A similar argument emerges in a short and memorable ethnography of a psychiatric emergency ward in the United States by Lorna Rhodes, Emptying Beds: The Work of an Emergency Psychiatric Unit (Rhodes 1995). Rhodes vividly describes mental healthcare professionals as hard-pressed and over-worked, continually placed in difficult, almost impossible positions. They are forced to somehow balance patient interests with the needs of the ward, ensuring enough patients are discharged quickly enough to free up the beds for the continual flood of new arrivals. Rhodes suggests that staff respond to these pressures by talking about care and making records of care using terms from a range of sources to create what she calls a 'patchwork quilt': 'The staff…were bricoleurs of psychiatric and social theory, using what was available according to whether it would fit a particular context…at any moment, and sometimes all in the same moment, a staff member might be a biological empiricist, a Freudian or a Laingian antipsychiatrist' (ibid.: 4). This pragmatic mixing and switching sounds rather different from the two schools Luhrmann describes, but both Rhodes and Luhrmann regard it as possible and potentially desirable to combine various philosophies of treatment.

Barrett's ethnography of a Schizophrenia hospital in Australia creates a different impression (Barrett 1996). Barrett finds internal rivalry and competition, even 'schism,' between the different professional roles that make up a care team. Each professional role: psychiatrist, psychologists, psychiatric nurse, social worker seeks autonomy and power relative to the others: 'A struggle for professional autonomy influenced the way clinical staff at Ridgehaven Hospital defined people as cases of psychotic illness. Each profession emphasised its unique perspective. Each profession exercised power by defining cases in its own distinctive way, thereby controlling the movement of

the cases' (ibid.: 69). Barrett finds that combinations of divergent disciplinary knowledge are not always successful.

In this thesis I suggest that competing forms of Biomedical knowledge do not combine, either into Luhrmann's happy pluralism or Rhodes' patchwork quilt. Instead, I find that the forms of knowledge and expertise shaped around audit culture and accountability displace other readings of mental distress, including readings of distress that might be associated with thicker understandings of patient empowerment. This is why professional knowledge can be a barrier to understanding individual distress, as discussed in chapter one. Once a person sees distress as mental disorders, lodged in the brain and manifest in symptoms, vulnerabilities and risks, he or she finds it more difficult to think, see or act according to alternative approaches. Knowledge is in this sense exclusive.

This leads on to my second concern with Of Two Minds. Luhrmann appears to take for granted the way that biological and psychodynamic psychiatrists characterise their work. This includes accepting the autonomy, internal logic and self-understanding of each discipline. The risk here is that categories from psychodynamic and biological psychiatry have influenced or even become part of her own analytic repertoire. This can be seen in the way that Lurhmann constructs her argument. She suggests that insurance companies have determined the outcome of a contest between competing methodologies, but she does not consider whether they have influenced the content of the methodologies themselves. She does not query, for example, whether bureaucratic pressures have promoted the evidence-based paradigm within biological psychiatry. The implication is that evidence-based medicine is the natural outcome of biological thinking, and that it is by chance that biological thinking is conducive to the documentary practices of insurance companies. This suggests a limitation to Luhrmann's work, which is explored in a subsequent monograph by Lakoff.

3.12 Bureaucracy and Mental Healthcare in the work of Lakoff

Lakoff's monograph Pharmaceutical Reason gives ethnographic depth to the distinction between biological and psychodynamic psychiatry (Lakoff 2005). Lakoff describes how, in Argentina, there has been a rapid increase in the sales of antidepressants without a corresponding increase in the diagnosis of depression. This seems counterintuitive. Where we see antidepressants being prescribed we feel we can assume that depression is being diagnosed. It seems a fundamental part of biological psychiatry. An aspect of the logic of what Lakoff calls 'pharmaceutical reason' is that drug treatments are 'targeted', meaning that specific drugs (such as antidepressants) treat specific mental disorders (such as major depression). But in Argentina, Lakoff finds psychiatrists prescribing antidepressants not for depression, but for vague, undefined problems such as 'socially induced stress.' Drugs are not seen as dealing with dysfunctions in the brain, or illness mechanisms at all. In fact, the notion of 'depression' as a clinical entity with its own causal power receives little attention (ibid.: 158). Features that appear intrinsic to biological psychiatry are widely disregarded in Buenos Aires.

Lakoff explains this primarily with reference to reduced external regulatory and bureaucratic pressures on clinicians: 'The missing ingredient for the growth of the category of biomedical depression in Argentina was not pharmaceutical marketing but the regulatory bodies – government and third-party payers – that demand specificity of effect in order authorize pharmaceutical prescription, and the use of DSM-based protocols in the clinic that embed the model of specificity' (Lakoff 2005: 158). Clinicians in Argentina who prescribe drugs for distressed patients do not need to justify their decisions in terms of specificity, and so do not need to think in terms of mental disorders at all. And, in Argentina, although the marketing pressures from pharmaceutical

companies are present, regulatory authorities do not insist that adverts present products as medical treatments for biological disorders.

Furthermore, Lakoff describes how the local 'epistemic milieu' places a high value on psychodynamic thinking and the notion that social pressures create personal distress, whilst biological psychiatry is associated with the machinery of state repression. This is a potent association in Argentina, which between 1974 and 1983 was ruled by a repressive military junta that conducted a brutal 'dirty war' torturing and killing its own citizens. Lurhmann does not investigate the local appeal of biological thinking to patients and potential patients in the US. It might be that ideas like specificity appeal to patients as much as they do to insurance companies. In chapter six I describe the clinic of a psychiatrist called Olivia. I suggest that the local epistemic milieu of contemporary Britain is largely empiricist and atheoretical. This makes the simple categories of Biomedicine appear robust and real, whilst more complex and theoretically elaborated concepts seem intellectually ambitious and, thus, precarious.

What is striking is that the pharmaceutical reasoning that appears to explain care is a kind of red herring. Ideas that appear to be the product of autonomous clinical reasoning and research, such as 'targeting' and 'specificity', and mental illnesses as discrete clinical entities located in the brain, are explained with reference not to research papers or clinical experience but regulatory authorities, norms governing advertising, and the presence or absence of informational demands from insurance companies. Looked at from this point of view, the DSM is a link in a chain, itself determined by external sociological factors, but then having its own causal effects, describing and authorizing a form of pharmaceutical reason so that features such as specificity become embedded in clinical practice.

3.13 Lakoff and Luhrmann on Personhood

Lakoff directly addresses Luhrmann's monograph in ways that are pertinent to this thesis. In Of Two Minds, Luhrmann argues that there are moral consequences to the dominance of biological psychiatry. It changes our sense of personhood, as if we are 'fixable, perfectible brains' rather than complex moral agents who can and should take a degree of responsibility for themselves. 'It may be neither helpful nor accurate to say that a person or his family is responsible for the fact that he hears voices or feels suicidal. But to leap from that insight to the sense that he is not capable of responsible choice is to deny him status as a fully moral person'(Luhrmann 2000: 291). For Luhrmann, psychiatric patients are treated as helpless victims of their neurocircuitry. It also implies they are less than human, because the part of their personhood associated with madness is externalised. Luhrmann takes this to mean that although biological psychiatry attempts to reduce stigma, it actually increases it.

Lakoff takes issue with this claim. He is unconvinced that biological psychiatry undermines personal empowerment and responsibility in the way she suggests. For Lakoff, Luhrmann largely infers these effects from a rather psychodynamically-orientated reading of the logic of biological thinking. For Lakoff, such inferences are unsafe. This is because, as his ethnography demonstrates, medical reasoning is fluid. It is determined as much as determining, accommodating external pressures and demands.

Lakoff references the work of Rose to argue that biological understandings of the person can bring with them new conceptions of moral personhood, organised around notions like self-care (Lakoff 2005: 107). Patients enjoined to self-care enter into a relationship with mental healthcare not as passive recipients but as active and autonomous consumers, exercising personal choice to maximise

wellbeing. Lakoff describes it thus, for an informant called Perreira, who has been diagnosed with Bipolar Disorder: 'the fact that the site of illness is not in the self but in the body does not make Perreira less responsible, but rather indicates a different type of responsibility and a different range of possible interventions. Part of his self-care will involve monitoring his moods, protecting against the excesses of the body' (ibid.: 111). In other words, different philosophies of treatment, although they appear to be autonomous bodies of knowledge, are predicated on differing concepts of the person and differing ethical projects.

In the ethnography below I describe a number of patients who, like Perreira, are encouraged by clinicians to think of themselves as self-managing their mental health, for example by avoiding stressors. My argument is not that these do not count as versions of empowerment. Rather I suggest that they represent thinner conceptions of personhood and moral responsibility. Models of empowerment based on such thin conceptions are simple, routinisable, and recordable. They are oriented towards bureaucratic accountability. My claim is that imagined in such slender ways, much of what clinicians regard as valuable in empowerment is absent. These are themes I return to in the next chapter.

3.14 Discussion

This chapter opened with an extended exchange between a clinical informant, Claire, and me. As she talked about her work, it emerged that she feels compromised by competing demands. She queries whether it is ever really possible to do the job properly. Part of the problem is that she wants to organise her work around recovery. I have tried to present recovery as one of a set of clinical and policy aims united under the umbrella term patient empowerment. These goals receive a good deal of attention in policy papers, government reports, public pronouncements, and in the

intimate space of the clinical appointment. Patient empowerment is regarded as an almost unquestionable good. It is expected to improve health, decrease costs and make mental healthcare better reflect patent needs. However, behind the public discourse, there are concerns that mental healthcare is disempowering, and forms a barrier to both the goals of patient empowerment and to better mental health.

Empowerment begins to emerge as a very complex idea. I have tried to investigate the concept using anthropological, philosophical and wider social science literature. Sometimes empowerment connotes something like consumer choice. Anthropologists and philosophers have been quick to question this. Mol argued that the logic of choice has limited relevance to healthcare. Others stress that autonomy has a much wider set of meanings. These include access to externalised perspectives on oneself, making choices according to one's own reasons and having second-order preferences. For some, autonomy is linked to having particular kinds of reasons. Medical anthropologists have pointed to features of narrative that might be construed as empowering. Personal change, a renegotiation of social roles, the public rehearsal of one's narrative and ownership of one's narrative all feature as potentially empowering. In a review of broadly Durkheimian literature, it emerged that mental health problems themselves can be read as problems of agency, derived from freedom. Yet ethnographic evidence suggests that a flight from agency and responsibility are features of the trajectory of some mental health patients.

As I argued in chapters one and two, NHS mental healthcare institutions are required to be accountable. This shapes the ethos of clinicians. As employees of accountable bureaucracies, members of staff know that they must deliver care in a particular way. In this context, a good clinician is an accountable clinician. In this chapter I have used both theory and ethnography to begin to show how accountability conflicts with empowerment. For a clinician, it is hard to promote

empowerment and be accountable. The goods of accountable care tend to exclude the intangible ingredients of empowerment. Consumer autonomy seems consistent with bureaucratized care, but holds limited appeal. Self-monitoring and self-managing according to a pre-set pattern seems amenable to bureaucratization, but is rather slender. Much of the appeal of empowerment lies in the thicker or more substantial conceptions, where sovereignty or second-order goods are included. It is these conceptions of empowerment that fall most heavily against the grain of bureaucratic accountability.

CHAPTER FOUR: MEDICAL DOCUMENTATION AND VARIETIES OF EMPOWERMENT

4.1 Introduction

In the first chapter I looked at the notion of bureaucracy and suggested that there are affinities between Weber's ideal type of the office and the mental health professionals I observed during my fieldwork. I noted that in the literature bureaucratization is associated with a decrease in the scope for staff members to exercise discretion. Bureaucracies have a distinct ethos that makes the work of officials controllable and recordable. In chapter two I introduced the idea of accountability. I suggested that, like any constituent part of the NHS, Oxford Health is bureaucratically orientated towards the goods of accountability. This means that mental healthcare practice to some degree coincides with the ethical project of audit culture. Goals such as transparency and standardization, certain documentary practices regarding care quality and the justification of care, particular styles of communication and relationship building are simultaneously clinical goods and audit goods. Even if the goal is improved health, good quality care is, in practice, care that leaves a satisfactory audit trail.

In chapter three, I examined the clinical goal of patient empowerment. This is described in various ways, such as patient-centred care, recovery, self-management and service-user involvement. I found that the goal of promoting patient empowerment is in conflict with the goal of accountability. Promoting patient empowerment makes care harder to document and standardize, more difficult to justify and more risky. In other words, care oriented towards empowerment is difficult to audit. Empowerment is understood in various ways. There are understandings of

empowerment that seem more consistent with the workings of an accountable bureaucracy. An example of this is the model of self-monitoring suggested by the True Colours technology. However, these understandings seem not to include some of the features of empowerment that staff regard as making it clinically desirable in the first place.

In the following four ethnographic chapters I provide detailed empirical data to illustrate and develop this argument. This chapter begins with some examples of medical documentation. I offer a short commentary on these, suggesting that medical notes can be seen as a genre in which clinicians justify their decisions according to particular narrative conventions. The way clinicians record their decisions in medical notes favours the use of rather thin categories that reveal little about the patient. I try to point to features that might be left out, side-lined or neglected in these narratives. My focus is on aspects of patient empowerment that escape attention. Finally, I consider whether categories like this may be suited to the goals of patient empowerment.

At the end of the chapter I provide an ethnographic case study in which the wife of a patient suggests reasons for her husband's distress. Her account is very different from that of her husband's psychiatrist. Where the psychiatrist sees Bipolar Disorder causing low mood, she sees bad habits, mistaken goals and character flaws driving justified guilt and suspiciousness and leading to feelings of emptiness and a lack of fulfilment. Indeed, in her view, Biomedical readings of her husband's distress have become part of the problem, in that they constitute a barrier to personal empowerment and better health. A central part of my argument in this chapter is that these competing forms of knowledge are not just contrasting, or divergent. They are incommensurable. Looking at a distressed person in one way excludes an alternate reading. Seeing Bipolar Disorder and low mood means not seeing mistaken goals or justified guilt.

4.2 Medical Documentation: 'Objectivity' and other genre conventions

When I asked clinical informants how to write good notes, or what differentiated good notes from bad notes, I was often told that good notes are 'scientific.' Clinicians often said they tried to write in a 'scientific' and 'professional' way. Another commonly used word was 'objective.' These emerged as overlapping terms. As people talked to me about writing notes, or showed me notes they had written, I began to see what this meant. Notes are remarkably uniform. Clinicians who present very differently in person can be hard to distinguish on paper.

Being professional or objective is a part of the ethos of my clinical informants. It means conforming oneself to shared and uniform disciplinary norms and excludes personal elements. In this setting, being scientific and professional entails standardization. If a clinician describes a colleague as having a unique clinical style, or being quirky or eccentric, it is not usually meant as a compliment. Informants told me that unusual writing styles seem self-indulgent. There was sometimes a note of censoriousness to these remarks. A failure to contain one's personal views or personal style is read as a moral failing. Being a good clinician includes self-discipline and self-denial. There is also a rationale, however, related to the functioning of healthcare. Unstandardized notes are said to be harder to understand. Writing in a uniform way makes notes very quick to read and reduces the likelihood of misunderstandings. Objectivity and professionalism are thus held to enable communication.

Montgomery has written two monographs that deal extensively with medical writing (Montgomery 1991, Montgomery 2013). They key to understanding medicine, for Montgomery, is to see that it fundamentally misunderstands and misrepresents itself by claiming to be a science. She thinks this shouldn't be controversial, but, in fact, is. 'Medicine is not a science. Instead it is a rational,

science-using, inter-level interpretative activity undertaken for the care of a sick person' (Montgomery 1991: 25). For Montgomery, medical notes cannot be objective, impersonal science, even if that is how medical practitioners describe them. Medicine is an interpretative activity that reads patients as texts and produces narratives. The clinicians discussed above talk of medical notes being scientific and objective. These terms suggest that clinicians discover independently existing facts about patients in a dispassionate and unbiased way. For Montgomery, this is not the case. Terms like 'objective' conceal the way that clinicians necessarily interpret patients.

According to Montgomery, this misdescription of medicine is highly consequential. It has led to 'exorbitant expectations' of medicine. It has also led to an unbalanced, misdirected system of medical training. Here Montgomery's remarks resemble the vignette at the beginning of chapter one. In the vignette, I noted that qualities in patients that staff believe are related to improved mental health are marginal, even irrelevant, to mental healthcare. Montgomery's argument is that the same point can be made of medical staff themselves. Qualities in a physician such as being 'caring,' 'psychologically perceptive' and 'skilled in human interaction,' each important in the practice of medicine, are given 'haphazard attention' in medical education and fail to be 'properly integrated' (ibid.: 25). For Montgomery, this occurs because medicine misunderstands its own nature. Montgomery is not particularly concerned with accountability, and does not consider how audit culture might have shaped the ethos and expertise of medical professionals.

Montgomery's work gives insights into the nature of medical notes. She understands medical notes to be a way of dealing with uncertainty such that decisions can be reached. The result is a distinctive genre: 'Written medical narrative…is narrowly conceived and standardised by strict conventions of tone, plot and allowable detail, and it reflects medicine's simple, action-oriented positivism' (ibid.: 102). This leads to what she describes as a 'remarkable' level of standardisation

in medical writing. It is built up out of simple, thin concepts and descriptions. Medical categories are poorly suited to conveying personal experiences with any subtlety, but enable uniformity in diagnosis and treatment (ibid.: 139). Critically, for Montgomery, doctors' stories are necessarily distinct from patients' stories. For her, patients' narratives and medical narratives are incommensurable. They are not equivalents or variants. They can't be reduced to one another. Instead, the doctor's story supersedes the patient's story.

The question here is whether the medical narrative, if it displaces the patient's narrative, and is composed of simple, thin categories and stories, contributes to the disempowerment of patients. Do medical categories capture enough of the detail, subtlety and complexity of personal distress to generate hope, provide insight, or direct plans for the future? Notions like low mood may be helpful if clinicians are to make justifiable decisions about treatment. But do they supersede and exclude richer common sense ideas that might be more useful in empowering a patient to promote their own health?

4.3 Standardisation and Communication

Standardisation and communication lie at the heart of Timmermans and Berg's study of the effects of EBM on healthcare The Gold Standard (Timmermans and Berg 2003). In their analysis, EBM is a means of standardization. They propose four 'intertwined' kinds of standardization (ibid.: 24). These are: standardization of design (pertaining to such matters as the size of hospital beds or the features of x-ray machines); of terminology; of performance standards (that regulate health outcomes, such as survival rates or waiting times); and procedural standards (that determine how staff members should do their work). In the medical documents below, there are high levels of standardization of terminology and procedure. As Timmermans and Berg argue, these features

cannot be separated. Using standardized terminology directs clinical attention a certain way, and shapes deliberations. As a result, actions and decisions become routinized.

For Timmermans and Berg, part of the impulse behind this is accountability. Standardisation thrives in audit culture. It protects individual clinicians and institutions from blame. If clinicians are able to represent their care as entirely standardised, the absence of the unexpected and exceptional puts the clinician beyond the reach of mechanisms of accountability. This has become of increasing importance in global Biomedicine: 'More and more, record-keeping procedures gradually became shot through with the awareness that every inscription in the record might end up on the desk of a lawyer or judge' (ibid.: 46). This has not, the authors argue, entirely removed discretion from medical practice. However, neither is collective professional autonomy immune from standardization. Rather, standardization has become part of professional expertise. The capacity to observe patients, make clinical decisions and produce documentation in standardised ways is part of the skill set of clinicians. Timmermans and Berg put it like this: 'The process of standardizing generates and confirms an explicit sense of professional identity' (ibid.: 116). For the mental healthcare professionals I observed, subordinating oneself to routinized practices is a valued part of one's expertise.

Although the medical notes discussed below are couched in terms that are simple and able to achieve consensus, the meaning of many of them remains elusive. Central concepts like 'mood' or 'psychosis' remain unclear. Fassin and Rechtman discuss this question in their work on PTSD (Fassin and Rechtman 2009). They suggest that the notion of trauma as a 'floating signifier' (ibid.: 276). Never quite pinned down, the fluid notion of trauma decontextualize and de-ethicises distress produces a description 'in a language that appears natural and universal' (ibid.: 281). The power of these concepts to create communities and interest groups, generate funds and change policy is

achieved through simplicity and semantic flexibility. Reifying distress creates slippery, polysemic terms that might be seen to be unsatisfactory to observers who favour conceptual clarity and precision, but have major communicative potential.

A key source of standardisation is EBM, which unites the documents produced by Oxford Health with work of many other professions. The spread of the evidence-based philosophy is sometimes understood by its biomedical proponents as unsatisfactory, even alarming. During my fieldwork I found this a popular topic of joking in academic seminars in psychiatry. Howick describes the evidence-based paradigm as having 'colonised' other disciplines (Howick 2011: 4). However, this might be based on a slight misapprehension of the qualities of EBM. My argument is that the triumph of the evidence-based model lies precisely in its capacity to cross boundaries. As a pure expression of bureaucratic rationality, it is a form of reason that is understood to be valid and authoritative by external bodies as much as it is by clinical committees. A capacity to meet diverse informational requirements does not occur by chance. Mental health teams are structurally tied to other institutions. Much of their day-to-day work involves liaising with the employees of institutions dealing with social care, housing and child protection, for example, plus the police and judicial system. Each has its own forms of knowledge and professional expertise. The capacity of the evidence-based philosophy to function in these diverse settings is the source of its success.

The forces towards standardisation seem immense. They appear essential for communication and co-operation between clinicians, and between clinicians, researchers, managers, scrutinising bodies and funders. The use of simple and uniform, yet semantically flexible categories is particularly important when clinicians have to communicate, and, potentially, justify themselves, to non-clinical audiences. Yet discussions of patient empowerment suggest that care should be personalised and patient-centred. Ideally, big data should inform individual decisions. Conflicts

and accommodations between standardisation and personalisation are visible throughout the documentation discussed below. Clinicians seek to address the needs of each individual patient. But to justify their decisions they behave in routinized, impersonal and uniform ways. In this way, efforts to promote patient empowerment fall against the grain of standardisation.

4.4 Methodology and medical documentation

In June 2014, I interviewed Stephen, a senior Trust manager with responsibility for data. He suggested a distinction between clinical information, designed to help efforts to promote health and management information required to enable audits and performance reviews. 'In principle' he said: 'Management information should be a byproduct of clinical activity… A lot of the data, it isn't clinically necessary, or, if it is useful, it is tenuous.' In some cases, according to Stephen, care delivered by Oxford Health is organized around bureaucratic needs. 'We have to be able to get the data out' he said. A tension between audit value and clinical value surfaced at points throughout fieldwork.

All medical documentation was recorded and stored on an electronic system called RiO. As part of my fieldwork I attended training to use RiO. The training is regarded as mandatory for staff whose role requires them to create or read medical notes, and is required prior to being given an account enabling access to the system. The other attendees were new members of the trust, mostly CPNs, social workers and administrative staff. The training took place in a special facility in Oxford designed for the purpose, in which rows of PCs were connected to a dummy version of RiO that contained false data. The training was scheduled to take a complete day, although in practice everyone completed the course and received the certificate by mid-afternoon. The trainer was a computer scientist who was not clinically trained. He explained that one of the advantages of the

system is that it promotes ‘uniform data gathering.’ At times he apologised for ‘how clunky’ the system was, and how ‘it works for data collection, but it is not so good for clinical needs.’ He was sensitive to the tensions between the two.

During fieldwork with clinicians, RiO was never far away. When a clinician has official ‘contact’ with a patient, this is recorded in what are known as ‘progress notes.’ These progress notes form a spine of chronologically ordered records by members of staff about the patient. Each entry includes the name of the author and their role, such as nurse, psychologist, psychiatrist. When a psychiatrist sees a patient in a clinical appointment, as well as progress notes, a letter is often written to the patient’s GP. These letters supplement the notes held in the GP surgery. It is usual that the patient also receives a copy of this letter. These letters are stored electronically by Oxford Health staff members on RiO under the heading: ‘clinical documentation.’

Most often, progress notes are typed up by a staff member after the appointment. Sometimes a backlog can build up as staff members struggle to find time to enter handwritten notes. Backlogs of this nature are a common topic of grumbling amongst staff. Some psychiatrists have a functioning computer in their clinics are able to enter progress notes whilst the patient was present. I never observed a case where a patient was invited to read the notes being made about them. On one occasion a patient asked to see their notes. They were told they had a right to see them, but that they had to make a Freedom of Information request, though ‘the proper channels.’ Some psychiatrists dictate GP letters into a portable recorder, for their PA to type up later. Notes are typed up rapidly and once entered can’t be erased. They contain numerous typing errors that I have left uncorrected in the examples below.

Clinical documentation includes other documents, such as contact with the Benefits Agency, the council, or the DVLA. Sometimes patients or carers contact the team. Incoming emails are copied and letters scanned and stored under clinical documentation, with a remark made in progress notes about what response was made. If a patient is admitted to a ward, any Mental Health Act Assessment documents, and other documentation, for example from the ambulance service or the police will be scanned and entered. Standardised questionnaires are sometimes found. These may be regarded as measures of symptom severity, such as the Beck Inventory that measures depression. Examples of other standardized instruments include questionnaires completed by a staff member following a suicide attempt that are designed to measure level of intent.

It is widely remarked by staff members that notes are read much more than they used to be. All the team bases have a large number of computers, and notes are typically read by a clinician before each appointment. When a clinician goes to visit patients in the community, he or she will often see three of four patients over the course of the day. In this case, the notes of all the patient to be visited are read at the start of the day, and sometimes details jotted down by hand in a diary or notebook.

In the final months of fieldwork I shadowed several members of staff, including a social worker as he went through his working day. He emphasized to me how important it was to read notes before leaving the hospital. Part of the reason was straightforward. He would check he knew how to drive to the day's locations and programme his satnav if required. However, he also said he used notes to 'keep focused.' They can save time in clinical appointments. Notes are reminders of what to look out for. This prompted me to think that technologies that enable notes to be viewed more frequently are likely to lead to a closer relationship between clinical observations across appointments. The time-saving focus they provide is likely to make the questions and observations of clinicians more

restricted and more predictable over time. In this sense IT may contribute to the routinization of clinical work.

During fieldwork I had access to the medical notes of patients who consented to a recorded interview. I spent many hours reading through these notes, following a patient's first contact with services, assessments, admissions, discharges, remarks made by CPNs, support workers and social workers in progress notes and letters from the psychiatrist to the GP. I tried to match the various metrics, such as numerical assessments of depression and mania, general functioning, wellbeing, or suicidal intention, with prose notes and the actual recollection of patient and staff. I looked at incoming letters, for example from the patient himself or herself, friends or family members or concerned others. Some patients have many pages of notes particularly when they have spent long periods on acute wards.

Several staff members warned me that notes are inaccurate and inconsistent. I was often surprised at how frequently diagnoses changed. For example, one of my informants started out with Depression, was rediagnosed as having Schizoaffective Disorder and end up as having Borderline Personality Disorder. Another informant was described as being psychotic on arrival on account of hearing voices. But in pages of notes covering years of subsequent treatment, no references to voices or other psychotic experiences occurs again and no treatments for psychosis were given. When I asked her about this, she said she had never experienced psychosis.

The examples of documentation given below were selected by me to illustrate my argument. My intention is to provide typical documentation, suggesting the variety and tone of medical writing, and enabling me to consider the ways in which clinicians justify their work, and the degree to which empowerment is represented. I have tried to contextualise as much as possible by suggesting

alternate phrasing commonly found in medical documentation, for example, or pointing to usual and unusual features. Of course, due to the constraints of space, these examples can only be a tiny in number. However, I believe they convey an impression of medical documentation as made and used in Oxford Health during my fieldwork.

4.5 Examples of Oxford Health Documentation

Progress notes and GP letters stored as clinical documentation sometimes constitute parallel narratives. Typically, the letter is rather longer than the progress notes. For example:

> XX[rd] XX 2013
>
> Dear XX
>
> Re: First name LAST NAME, D.O.B. 00/00/1900, NHS No. 12345678
> Number, STREET NAME, CITY, POSTCODE
> Diagnosis: F31.7 Bipolar disorder, currently euthymic
> Medication: sodium valproate reducing to 500mg per day and then 250mg per day, thyroxine 100mcg per day
>
> Patient was very well when I reviewed her in clinic today. She has finally resolved the financial issues and family difficulties following her father's death in Jamaica and she is now happy to be back in her own house. She has no current mood symptoms and is not using any alcohol.
>
> We agreed the time is right to gradually withdraw her sodium valproate, which she is keen to do. She will reduce the dose to 500mg per day for the next couple of months, and if she remains well will further reduce it to 250mg per day. I will see her again in three months' time and see how she is getting on with this. If she develops evidence of a relapse in the meantime, she will no doubt be in touch.
>
> With kind regards
>
> Yours sincerely

The letter begins with the patient's diagnosis and medication. Then the psychiatrist gives his impressions of the patent's state of health, indicating it is good, and discusses the perceived risks to this arising from 'financial and family difficulties' and alcohol. It appears the patient has expressed a wish to reduce medication. The clinician's detachment wavers a little at the end, as he remarks

that ‘no doubt she will be in touch.’ It could be that this patient has a reputation for being ‘overinvolved’ with staff members. Both in medical documentation and verbally, clinicians sometimes signal their disapproval of patients they perceive to be burdensome by hinting that the trouble arises out of deficits or pathologies in the patient. Overall, the focus and clarity of the letter are striking. However, in progress notes, this is distilled down to thirty words spread over five lines:

> OPD. [Out-Patients Department]
> Very well. Back in own house, father’s flat sold, financial dealings with sister finished.
> Keen to now come off valproate - agreed, over next 4-6/12.
> L to GP. [Letter to GP written]
> See 3/12.

The electronic notes recorded on RiO present clinical decisions as directed towards the reduction of symptoms and a return to a patient’s default health. The stated target is either to eliminate all symptoms, or to minimise the symptoms and their impact on the patient and those around them. This goal is expressed in a number of ways. A patient may be described as ‘doing well’ or being ‘in good mental health’ or ‘having stable mood.’ He or she may be ‘currently stable’ or being ‘subjectively and objectively euthymic’ or simply, as in the notes listed above, ‘euthymic’. A patient may be described as ‘free of psychotic symptoms’ or ‘stable’ or ‘balanced.’ Remarks pointing in a similar direction include: ‘There is no evidence of psychosis;’ ‘rational, good eye contact;’ ‘well-presented;’ ‘appropriate conversation.’ Sometimes a patient’s wellbeing is expressed positively in terms of reduced demands on staff: ‘No immediate issues;’ ‘no immediate concerns.’ Good health is understood to mean the absence of symptoms of mental disorders and of risk. Sometimes the notes will hint at the clinician’s pleasure at recording good news: ‘I’m glad to say that patient is now quite euthymic’ and ‘fortunately, patient’s severe depersonalisation has now faded.’

The excerpt from a GP letter below shows how a narrative is developed organized between the recognized tropes of EBM Psychiatry.

> Dear Dr XXX,
> [Patient's name, address and date of birth]
> [Patent's NHS number and diagnosis]
>
> I reveiewed Patient on XXth February. His mood has been more stable over the last month. He continues to suffer from fairly frequent fluctuations but these are of short duration (one to three days) and not too severe. He is managing to attend his voluntary work again. His relationship is going well. I will therefore continue the same medication as before which is valproate 1500mg, aripiprazole 15mg, moclobemide 1200mg and lamotrigine 150mg dily. i will see him again inn two months.
> With best wishes,

In EBM research papers all symptoms are written about as existing in quantities that may be measured by validated questionnaires and may increase or decrease. Here, in the clinic, clinicians do not use questionnaires all that often. However, the estimation of symptom severity is key to the clinical encounter. Assessing symptom severity in a standardised way forms a central aspect of clinical expertise. In notes, symptoms may be 'serious,' 'severe,' or 'acute.' Most symptoms that are recorded are forms either of psychosis, mania, depression or anxiety. Each has its own vocabulary to express scale. Terms that relate to mania include 'elevated mood;' 'accelerated;' 'disinhibited;' 'rapid thoughts;' intrusive thoughts.'

Perhaps the most commonly expressed clinical goal is that of 'stability.' Stability can pertain to mood, psychosis, anxiety, relationships with family, friends and work colleagues, and more generally, the shape and pattern of daily life. The letter above suggests that the patient's clinical needs, expressed as stability, can be understood to consist of symptom reduction, such that the concept of symptom is capacious enough to accommodate all the patient's clinical needs. Being 'more stable' indicates a degree of clinical success. Stability does not mean the symptoms are gone, but it suggests that they are under control. Stability is a clinical goal that is good enough, but not maximal.

Brodwin discusses how complex the notion of stability is: at once a clinical goal and sign that a professional is doing a good job, and an 'encounter with futility,' in which a clinician is confronted with painfully limited goals (Brodwin 2013: 76). A recurrent problem, which I discuss in chapter five, is how clinicians and patients differentiate symptoms from 'normal' or 'healthy' distress. Amongst my informants, clinical and patient, this is a topic of some disagreement, controversy and humour. However, everyone seemed content to assume that stability was healthy. It seemed obvious and unremarkable common sense that instability, by its very nature, is necessarily or at least possibly pathological.

The 'fluctuations' mentioned above indicate a decrease in the level of stability, and are assessed according to their severity and duration. These clinical observations are tied to remarks that seem less obviously Biomedical: voluntary work and relationship quality. These indicate levels of 'functioning.' Maintaining a relationship and attending voluntary work is indicative that the impact of the illness isn't too severe and that life goes on. Judgments of scale regarding symptom severity and general functioning are the means by which the clinician justifies his or her decision. In the above case, no changes need to be made to medication. Instead, the patent will continue and be seen again in two months' time.

Something that might be seen as absent from the letter is a sense of the potential for personal change. Proponents of empowerment sometimes point to personal transformation achieved via therapeutic relationships, or example. The medical anthropology literature on narrative reviewed above suggested several ways in which empowerment might be manifest. There is no sense of that here. The relationship between clinician and patient seems not to be oriented towards personal change. Indeed, the patient emerges a fixed point, acted upon more than acting. If the patient is

making efforts to address their distress, that is not mentioned. However, that doesn't mean that all sense of patient empowerment is expunged from the letter. Activities such as voluntary work are thought of as promoting better mental health. Similarly, relationships with others promote better health and are said to protect against relapse. In as much as the patient chooses to work, and commits to his relationship, he is to a degree empowered in a way that is recognized by his psychiatrist as improving mental health.

If a patient is psychotic examples are often given that convey severity. The progress notes of my patient informants include the following: 'he said he was president Obama;' 'she claimed to have swum to Britain from America;' 'he tried to eat flowers and grass from the hospital garden;' 'she has apparently been storing excrement in her socks.' If a patient hears voices, notes will often state if they are male or female, single or multiple, familiar or unknown and how distressing the patient finds them. Severity can be assessed in terms of whether they are 'constant' or 'occasional;' or whether they 'criticise,' 'attack,' or 'command' the patient. If they command the patient, care is taken to note whether the patient obeys. Anxiety may be 'overwhelming,' or it may 'prevent the patient from leaving the house.' Depression may leave a patient 'deeply depressed,' they may be lethargic,' 'unable to experience pleasure,' have 'limited speech,' or be 'unable to get out of bed.'

These descriptions of symptom and scale are all flexible enough to enable clinicians to guide their observations towards phenomena for which there are treatments underwritten by evidence from RCTs. Clinical observation is thus directly linked to decision-making. Increased symptoms can be matched with increased treatments. Very little is noted down that could not form part of an explicit justification of a clinical decision. By making familiar and defensible decisions, such as increasing or decreasing medication, a clinician is able to justify his or her care.

4.6 Making decisions without deciding: reasoning in medical documentation

The following letter describes a number of decisions and rationales.

> Dear Dr XXX
> [Patient's name, address and date of birth]
> [Patient's NHS number]
>
> This letter is the patient's care plan or forms part of the patient's care plan
> Diagnosis: Bipolar Affective Disorder
> Care co-ordinator /Lead Professional: Dr XXX
>
> I saw Patient for a review at the XXX Surgery , Name of Town, on XXth XX Month, 2013 .
> As you may know Patient recently attempted to further reduce her dose of lithium but after two weeks she became aware of signs suggesting the beginning of elevation of mood. This included increased speed of thought and agitation. She contacted the team who recommended that she resumed her previous dose of Lithium and that she start Olanzapine, currently at a level of 7.5mgs nocte. Since making these medication changes Patient's mood has stabilised and she is sleeping well. Today, I have recommended that she continues with Lithium Carbonate 600mgs daily, an Olanzapine 7.5mgs nocte. She is due to have a Lithium level next week. If all remains stable she can reduce her dose of Olanzapine to 5mgs providing she continues to sleep well.
> She has been receiving regular support from XXX, CPN, from the CMHT and I plan to see her for a further review in the New Year, and will write to you then with details of her porgress.
> Yours sincerely

A feature that emerges in many of the notes discussed in this chapter is the partial erasure of the clinician as agent. This arises out of the notion of objectivity. Porter makes a distinction between what he calls 'disciplinary objectivity' and 'mechanical objectivity'(Porter 1995). The former arises out of a consensus of experts. In contrast, mechanical objectivity is a derived from the use of quantified data and the following of rules. In place of the overt use of judgment, Porter describes how basing decisions on numerical data and rule-following appears impartial, rigorous and unbiased.

Porter suggests that much of the appeal of quantitative, mechanical objectivity is 'mythical' and confused. Part of what makes it attractive is that it appears impersonal, in that data and algorithms replace personal judgement. According to Porter, underlying mechanical objectivity is an ethic that

'rules should rule', rather than people ruling. In the pursuit of objectivity, 'professional as well as personal judgment be held in check' (Porter 1995: 5). According to Porter, the effects of this are ubiquitous, but, particularly found in medicine:

> In public even more than in private affairs, expertise has more and more become inseparable from objectivity. Indeed, to recur to the previous example, it is in part because the relation of physician to patient is no longer a private one— due to the threat that it might be opened up in a courtroom— that instruments have become central to almost every aspect of medical practice. (ibid.: 7)

The notion of objectivity emerges as a means by which professional expertise protects individuals from mechanisms of accountability, such as legal process.

In medical notes, impartial and fair care delivery is signalled by a degree of erasure of the clinician as an individual agent. Once fairly simple clinical observations have been made, the rules determine the decisions. Porter puts it like this: 'Scientific objectivity thus provides an answer to a moral demand for impartiality and fairness. Quantification is a way of making decisions without seeming to decide' (ibid.: 8). In the notes, it is striking how the components of Biomedical reasoning, such as diagnoses, symptoms and outcomes, all of which are the subject of expert disagreement and intense controversy, lock together seamlessly to make narratives that seem natural, calm and unobjectionable. Rhetorically at least, deliberations and reasoning feels inevitable and necessary.

In the letter reproduced above, the key players seem to be 'the illness' which causes the symptoms of poor sleep, elevation of mood, speed of thought and agitation, and the drugs which are intended to counter them, but have undesirable side effects. A consequence of the tight focus is a reduced sense of uncertainty and ambiguity. When I observed clinical encounters I was often struck by how little certain knowledge the clinician had to work with. It seemed to threaten his or her capacity to make justifiable decisions. But when I read the notes, much of the uncertainty was gone and all that remained was fine-tuning. Decisions seem determined by facts, even to be predestined.

One aspect of this seems particularly important. If symptoms reduce, the only explanation seems to be medicines because no other candidate causal factors are mentioned. Thus the efficacy of the medications is suggested through genre conventions. In some cases a causal link between medicine and symptom is explicitly made: 'Patient picked up on sertraline;' 'Patient doing much better now on Olanzapine 7.5mg;' 'Patient began lithium two weeks ago and her mood is improved;' 'Suicidal thoughts now less intense because of an increased dose of risperidone.' In the clinic it can seem impossible to understand what is driving an improvement or deterioration in health. The range of potential causes is immense. But in medical notes the efficacy of medication for at least some patients seems certain.

4.7 Documenting Empowerment: Support, self-management and skills

Empowerment appears or nearly appears at other times in medical documentation through the notions of support, self-management and skills. Support is a key feature of care. It isn't officially classed as 'an intervention' but is increased and decreased according to symptom severity much as if it were. Often support refers to appointments with a CPN, social worker or care support worker. This is deemed to be helpful in a non-specific way to the patient. Support might make the pain of depression more bearable, for example. It brings social contact to people who might be lonely and isolated. Support can be seen as helping a patient who is demoralized, despondent or inert. It is also a way of monitoring the patient and enables the creation of documentation demonstrating the management of health, and of risk of self-harm, or suicide, or violence.

When a patient's symptoms seem to be getting worse, the frequency of appointments increases. After each appointment notes are left, creating a stream of multiply authored observations. Below are the progress notes for a patient diagnosed with Schizophrenia with a long history of admissions.

The notes are written by four mental healthcare professionals: two CPNs, a psychiatrist and a student nurse.

Progress notes by Name CPN.
Seen at may Name of Clinic with student nurse Name.
Patient continues to feel "not quite himself" although he is unable to articulate specific stressors at present. It is possible that the proposed trip to Greece is playing on his mind.
He has not been attending his maths class regularly because his sleep is poor and he has struggled to get up in the mornings, but will try going back next week.
Discussed increasing the dose of Olanzapine from 2.5mg to either 5or 7.5mg daily for a short time to see if it helps calm him down and improve sleep. I will ask Dr Consultant to advise and I will liaise with Patient and his GP.
Agreed to meet up on a weekly basis and keep his situation under review.

Three days later the following notes were added:

Progress notes by Dr XXX, psychiatrist:
HV [home visit]
feeling mre stressed
developing some overvalued ideas re people being able to tell what he thinks etc
coping
mood
ok
not at all tense or hostile

plan
increase olanzapine to 10mg od
CPN seeing regulalry review by me as needed

The following week these notes were added:

Patient's mood was improved. Patient seemed more relaxed and rested. Patient has increased his Olanzapine to 10mg. Patient feels this has helped take the edge off and feels better for it. Patient said his sleep is much better. Patient thinks that finance worries could have been the reason for him to feel more stressed. Patient will remain on the increased dose of Olanzipine and CPN will meet with him on XX/XX/XX.
Written by XXX, Student Nurse.

The next entry is by the psychiatrist, made the following week:

[s]een

well
mum has been down for two weeks
mood ok
no irritablility or tension
sleep ok
no psychotic symptoms
generally taking olanzapine 10mg daily but does increase to 15mg if feels he needs it

plan
review 8 weeks
aware CPN Name is off and that i am around if he needs anything
given 2 week script for olanzapine 15mg to allow dose flexibility as part of his increasing self mgmt

Progress notes by a second CPN, made the following week:

Reviewed Patient's recent presentation. He has been struggling more with low mood recently and is feeling more stressed in general. Will increase his Olanzapine dose from 10-15 mg daily for greater mood stability and to help disturbed sleep.
Phoned DLA and his re application is with the adjudicator, should hear from them in 3-weeks.
Has interview at Restore next Tuesday as he is intersted in volunteering there.
Mother has retruned to XXX from Devon unexpectedly, and Patient is aware that spending too much time in her company can increase his stress levels.
He uses Cannabis on an occasional basis and last had some a week ago. However, his usage is not currently problematic.
Patient will meet up with Named CPN every two weeks for now and has been encouraged to contact her in the interim should he find that he is not coping.

There are many traces of the promotion of patient empowerment to be found here. The psychiatrist proposes a flexible dose of olanzapine be prescribed allowing the patent to scrutinize themselves and choose the appropriate dose. Making one's own clinical decisions and having the responsibility to both judge oneself and to decide on the correct dose are constitutive of empowerment. The reference to Cannabis use links lifestyle decisions with health. In the same way, identifying the company of the mother as a stressor that might destabilize mood or precipitate a relapse is part of patient empowerment. Overall, it appears that the patient is being asked to internalize and reproduce the observations and reasoning of the doctor.

When not in an acute phase of illness, formal 'care plans' are developed. In the letter below, the clinician considers the patient as an agent in a number of ways. He assesses her 'capacity' meaning

her ability to make rational decisions, and her 'insight' which in this case means whether or not delusions and hallucinations have undermined her reasoning. Shared decisions about drugs are being made, in which the patient's dislike of weight gain on olanzapine and her desire to have a child in the immediate future are weighed against clinical benefits such as reducing psychosis, improving mood and reducing anxiety.

> Dear Dr XXX
>
> [Patient's name, address and date of birth]
> [Patient's NHS number]
>
> This letter is the patient's care plan or forms part of the patient's care plan
> Diagnosis: F316 - Bipolar affective disorder, current episode mixed
> Care co-ordinator/Lead Professional: First Name Last Name
>
> I reviewed Patient's Name for a psychiatric review on XX, XXXX 2014.
>
> She has been continuing to work as a XXX, yet remains sad, tearful and anxious. She continues to feel low and is experiencing visual pseudo hallucinations lasting thirty seconds, consisting of images of violent animals. Although her sleep remains good, she recognises these early warning signs. She says she wants to have a baby still and has asked for advice about Lithium. The couple are having fertility tests. We have decided to reduce lithium weekly in 100mg increments once she is stable. We made a cost-benefit analysis for each of her medications and on balance, she can substitute Lithium with Olanzapine, monitoring for side effects at high doses. Her mental state examination confirms a dysthymic lady, without retardation or agitation, with significant anxiety. She is not suicidal, self harming or psychotic. She retains capacity into treatment options and insight is good. Care Plan I recommend increasing her Olanzapine to 5mg (or alternative night 2.5/ 5mg approaches, for subtler symptom control). She remains concerned about side effects of Olanzapine as weight gain. Her CPN, First Name Last Name remains involved in case of evidence of a future relapse signature.
>
> Yours sincerely

In this letter we see a distinctive point of entry of the patient as agent: in the calculation of risks and benefits of medication. The patient 'recognises' the warning signs just like the doctor does. Her concerns about weight gain are entered as a relevant factor to be weighed up. She might also detect benefits or side effects the psychiatrist is unaware of. In the letter the psychiatrist writes that 'we' have made decisions, suggesting an open or shared decision-making process. When changes to medication levels are made, the patient is expected to 'monitor' herself to assess the level of benefit and to see if the change is worth it. This is particularly important as the psychiatrist appears to be

looking to a time when they can fine-tune the medication. What the letter suggests is that the patient is able and willing to adopt the same cognitive strategy as the psychiatrist, conscientiously assessing positives and negatives, weighing them up and making rational decisions about medication.

4.8 Contested Models of Empowerment

Some care plans give the patient a bigger role than this. For example:

> Dear GP's Name
> [Patient's name and address]
> [Patient's NHS number]
>
> This letter is the patient's care plan or forms part of the patient's care plan
> Diagnosis: F 20 Paranoid Schizophrenia
> Care co-ordinator/Lead Professional: XXX
>
> I saw Patient for his CPA today along with Name, his new care co-ordinator. Patient appears to be engaging well with CPN and seems to feel well supported. He also sees XXX from Connection once per week regularly and is looking into doing some voluntary work in a charity shop in XXX, which would obviously be a hugely positive thing both for Patient and for others. He has recently been on a music festival with his mum in Witney and enjoyed this although it was fairly 'full on'. He has a good relationship with his mum and is seeing her regularly and is keeping up with his friends. Patient gets some break through symptoms, principally female voices talking down to him and being derogatory about him. He finds these stressful and distressing and can punch out at the walls as a result. However, he is not putting himself at significant risk, does not find them unbearable, and does not feel he can increase his Olanzapine at present.
>
> We reflected on Patient's progress over the years and it is absolutely clear that he has made really fundamental changes in his life and has moved from a position where he was in great distress and was surrounded by much uncertainty to one where he is in many respects functioning well. We are now working with him to try and focus on positives and increasing his activity and engagement and he continues to very significantly input into this and try to maximise his achievements. We will keep you informed as to Patient's progress, but are seeing him regularly. He continues on Olanzapine 15 mg od.
>
> Yours sincerely

This letter was the best example of a piece of medical documentation in which the patient is given a large role for empowerment I could find for a patient diagnosed with a severe mental illness. There are lots of remarks that indicate a recognition of aspects of empowerment. The psychiatrist talks of

the patient feeling ‘well-supported’, and that voluntary work in the charity shop would be ‘hugely positive for Patient and for others.’ In the discussion of risk, the patient capacity to make good decisions is noted: ‘he is not putting himself at risk.’ His preference not to increase Olanzapine is part of planned care.

In the letter, improvements in symptoms are described in a wider context: as ‘fundamental changes in his life’ such that having been in great distress, he is now functioning well. It isn’t stated what the changes are, but the phrasing suggests major personal progress. These changes are not being presented as to imply just the success of interventions. The letter mentions the patient’s own ‘input.’ He has increased his activity and engagement. It is expressed here as ‘maximizing his achievements.’

It might sound as if the psychiatrist has succeeded in completing both the idealized jobs mentioned by Claire, the occupational therapist quoted at the start of chapter three. Ostensibly, the letter seems to be a happy marriage of justifiable care leading to accountable clinical outcomes, but also personalized care promoting the patient’s independent empowerment. However, a key clinical informant, Aisha, who knows this patient very well, takes a different view. She and I met many times over the course of fieldwork. I also met with the patient himself, both in formal interview and informally. Over a number of conversations Aisha suggested a very different interpretation to that found in the documentation above. She explicitly disputed several aspects of the psychiatrist’s interpretation.

I don’t here take a view about whether Aisha’s account is accurate or not. Uncertainty over this seems inescapable. Both Aisha and the psychiatrist are trained and highly experienced mental healthcare professionals. Whatever the truth of the matter, what Aisha told me pointed to a lacuna

created by the thinness of the descriptions produced in medical documentation. She felt that much that was unexpressed, elided and, perhaps, erased, was clinically significant.

In the notes, the patient struggles against a frightening and disabling disorder. When we chatted about him, I noticed that Aisha was reluctant to separate symptom and person. According to her, this patient is a 'very fearful person,' frightened by many aspects of social contact and the 'challenges of adult life.' She thinks of him as 'over cautious' and 'ruminative.' Aisha said that his relapses occur when he is stressed. They take the form of intrusive and distressing voices. They are very unpleasant, thinks Aisha, but also serve to 'protect him' by preventing him from facing the things he fears. When his voices get worse, he gets access to attention and care. She says he values very highly 'being important to people who are kind to him.'

Aisha believes that the great personal strides outlined in the letter are rather misleading. When he started to do some work in a charity shop 'it became impossible' and he soon abandoned it. Over the time he has been a patient, Aisha thinks he has become more fearful and anxious. 'Now he can't even take the train to Oxford' she said. This doesn't sound much like the fundamental changes mentioned in the letter. Aisha also claimed that he now seeks out the support and praise of staff members where once he was resistant to their suggestions. Staff members offer him attention and care and in return he has become 'obedient' and 'docile.' 'He's handed over responsibility for major decisions to members of staff' she said. As a more tentative character who seeks reassurance and support for even small decisions, Aisha is worried that services have taken away the 'fight' he might need 'to really get well.'

The upbeat tone of the letter might reflect that he is now more open and compliant, less inclined to aggression and more likely to turn up to appointments. The result is a patient who is easy to take

care of, but who is dependent on services and whose compliance is such that it indicates a reduction in personal empowerment. In Aisha's view, the patient's capacity to be an empowered agent has been eroded to meet the pragmatic needs of staff, and then this docility has been represented in medical documentation as a clinical success. Perhaps ironically, this successful clinical stability is characterised in such a way as to include aspects of thinner models of empowerment, even though, in Aisha's eyes, these apparent benefits come at the expense of what is really important about patient autonomy.

4.9 What Gets Missed Out of Medical Documentation? Cathie talks about Don

During fieldwork I confronted many disagreements about mental healthcare and patient empowerment. Does mental healthcare empower or disempower patients? Do clinicians really take empowerment seriously? This prompted me to consider how an anthropologist might approach incommensurable local conceptions of empowerment. How might different models of empowerment be differentiated by ethnographic means? Can care ever be both empowering and accountable?

A source of evidence that seemed to help me address these issues came from an unexpected source: the partners, family and friends of patients. The intimate knowledge they provided constituted a parallel narrative to that of medical staff. Some essentially agreed with staff, but many did not. Often the divergences and disagreements were instructive as I sought to understand what empowerment might mean. I will try to capture the gist several such cases by means of a single example.

Before my fieldwork began I knew Cathie and Don, a couple in their mid-forties who live in Oxford. Don works in the IT industry and Cathie works part-time as a tutor. They have two children in their early teens. For about ten years Don has been a patient of Oxford Health. He is diagnosed with Bipolar Disorder. As a part of fieldwork I got to know Cathie and Don much better. We met many times for coffee and drinks in the pub, culminating with a formal, recorded interview with each of them, conducted separately in the final few days of fieldwork. I also got to know some of Don's colleagues and friends and I know his psychiatrist well. Cathie and Don serve as a useful ethnographic case in part because of the richness of my field data regarding them. More than this, Cathie is a thoughtful and highly articulate sceptic about the model of empowerment proposed by Don's psychiatrist. She is able to sketch out in some detail what might be missed out and, indeed, some possibly harmful consequences of this for Don and those around him.

Don is ambitious, charming and highly motivated and has been very successful. However, he described to me how he is troubled by periodic feelings of intense guilt. He said that these were periods of 'isolation' and 'fear.' During them he says he is 'terrified that people don't like him' and feels cut off from those around him, including family members. Don talked quite a lot about how his psychiatrist described these experiences. Although I haven't seen interaction between the two of them, many of the details Don mentions, such as the particular clinical terms used or explanatory models suggested, resemble my own fieldnotes made whilst observing this psychiatrist with other patients with the same diagnosis and similar profiles. Don says his psychiatrist calls these experiences 'depressive episodes'. As such he thinks of them as constitutive of a 'mental disorder' called Bipolar Disorder. Don thinks his psychiatrist is primarily interested in the pattern the episodes make across time, and in predicting future changes. He is less concerned with the qualitative nature of the episodes.

Don said that the psychiatrist has explained that Bipolar Disorder is an illness that takes the form of an innate vulnerability to mood episodes and mood instability. A lot of the vulnerability is mysterious. Don says his psychiatrists speaks vaguely of Bipolar as 'highly heritable' and having its origins 'in the brain' and 'at a neurological level.' According to Don, this vagueness does not indicate a lack of confidence. In appointments, Don says he is taught the facts about Bipolar.

Don's psychiatrist presents an aspect of this vulnerability that is 'better understood' as 'cognitive biases.' Don takes this to be the way in which sad people notice and remember sad things to a disproportionate degree or find themselves inclined to interpret events in a pessimistic or 'negative' way.' Don says that the psychiatrist thinks that Don's fears about being disliked are 'distorted cognitions' which are false and painful, and 'drive low mood.' As symptoms of depression their ultimate origin is in the brain. Don explained to me how the psychiatrist says that these episodes can be 'triggered' by 'stressors' such as overwork. So he prescribed medication to try to alleviate the symptoms, but also asked Don to use True Colours to 'self-manage' his condition. Don takes this to mean monitoring how he feels, understood in terms of symptom severity, limiting stressors and building in to his lifestyle plenty of relaxation and downtime. So far, Don resembles Perreira, described by Lakoff in the chapter above. His psychiatrist seems to think of an active, angential patient as being someone who 'self-monitors' and makes simple lifestyle changes to limit symptoms. This is a rather limited conception of empowerment. It includes some of the elements Dworkin lists as pertaining to autonomy. But it gives Don a restricted set of reasons for action based on a fixed set of descriptive terms. It doesn't include second-order preferences.

Don's wife Cathie is a woman who speaks her mind. Towards the end of fieldwork I spent many afternoons drinking coffee with her as she spoke about her life and her marriage to Don. The way she described her husband was unsparing and direct. She told me that the problem with Don is Don

himself. In Cathie's view, Don's fears about those around him were largely true. He really is unpopular. She said he was widely regarded as narcissistic, a charismatic man who can be highly entertaining company, with a magnetic quality, but, also, manipulative and ruthless, known for his cruel wit. This is a rather extreme description, but, knowing Don and his social world quite well, I feel I could see why he might be described in this way. I know a colleague of Don's who describes him in similar terms. Cathie thinks that his suffering is very real, but she believes that, at least in part, it is caused by aspects of character and the way he interacts with people. She sees his pleasures as transient and intrinsically unfulfilling, having to do with success and domination. Because he is focussed on these rather limited goals, Cathie thinks he misses out on some of the goods that might come from deeper relationships with people.

For Cathie, the solution is for Don to change. She felt that people would like him more if he were less arrogant, for example. He would get more out of life if he were less focussed on winning. Cathie thought that if Don could cultivate 'humility,' or 'self-control,' or even 'compassion' then his distress might reduce. These are second-order preferences, indicating a broader conception of empowerment. The clinical language used by the psychiatrist describes Don not as unpopular or unfulfilled, but rather experiencing low mood. This non-evaluative language tends to erase links between Don and his distress. Low mood arises in the mysteries of brain chemistry. Mood episodes have no intentional content. They are not about anything. Instead they are just triggered by stressors. Guilt is presented to Don by his psychiatrist as a symptom of a mood disorder, one that boosts his QIDS score that measures 'depressive symptomatology.' As such it is to be controlled and ideally eliminated. Cathie thinks that his sense of guilt could be very helpful in providing him with information about how he appears to other people and as a motivator for change. In her view, the self-management proposed by the psychiatrist was a way of maintaining the problem.

My point is not to determine whether Cathie's interpretation is right or wrong. In any case, it is sure to contain biases and omissions. There is more to Don's mental health problems than feeling unpopular, or trying to extract too much value from feelings of victory. I did not, for obvious reasons, ever tell Don that his wife told me these things, so I never really heard his side of the story. However, it is not implausible that Don's character, values, world view and habits are causally implicated in his downward spirals. Indeed, Cathie's remarks resemble many conversations I had during fieldwork with the partners of patients.

The kind of self-management envisaged by Don's psychiatrist seems to constitute one model of empowerment, whilst Cathie has a different model of how Don might seek empowerment. The difference between the two is, in part, ethical. I hope that the above example will help me make some remarks and distinctions that will be useful as I advance my argument in the ethnographic chapters. First, my ethnographic evidence gives empirical reasons to make conceptual distinctions between different models of patient empowerment found in mental healthcare. Some models, such as those that do not restrict or determine a person's reasons for actions, or which allow for second-order preferences, are broader or more comprehensive when compared to thinner or more limited models. Conceptions of empowerment are not free-floating, but linked to models of healthcare, distress and self-management. This means that changes to the conception of empowerment are likely to lead to changes in the way healthcare is delivered.

The model of patient empowerment I found in the medical documentation is quite thin. What gets missed out is shown by the dissenting remarks of Aisha and Cathie. Thin empowerment is amenable to the needs of bureaucratic accountability, in the sense that it helps clinicians and clinical institutions to produce records that justify their care according to particular documentary practices. Thinking and talking of thicker models of empowerment is easier using common sense

terms. The thin, non-evaluative, flexible terms found in the medical notes above serve as a barrier to other readings of selfhood.

Each of these points can be seen in the case of Don. The model of empowerment proposed by his psychiatrist is very different from that suggested by Cathie. If Don uses the clinical terms suggested by his psychiatrist, he will think of himself as suffering from 'depressive symptoms' that arise in his brain, and associated false beliefs about himself arising out of cognitive biases. He will take his medication, and seek to self-manage by avoiding the stressors that trigger the symptoms. This contains some elements of empowerment. For example, it gives Don a degree of freedom and responsibility. Each are of limited scope, however. Significantly, it only offers Don a small range of reasons for actions, such as to reduce stressors or to limit symptoms. The overall moral project is determined by clinicians. This makes it possible for care to be justified bureaucratically. Making care justifiable means using simple, repeatable defensible categories and procedures. In contrast, Cathie thinks that Don's character traits, values and styles of interaction combine to create a variety of painful experiences. He needs to change himself if he is to reduce his distress. This is a much more complex and ambitious undertaking. Care based on this model would be much harder to standardize, record, and justify.

4.10 Discussion

In this first ethnographic chapter I used medical documentation and an ethnographic vignette to illustrate how accountability and empowerment play out in the field. Medical notes emerged as a record of sensible, even inevitable decisions. They record simple facts in a clear and unobjectionable way. Yet they are made in a context of extreme uncertainty. Uncertainty threatens to undermine clinical justifications and forms much of the focus of the next chapters. It is mostly

concealed in the medical documents. Medical documents reflect a distinct focus away from the patient as agent and towards decisions made about mental disorders. Notes and letters describe clinicians seeking to make a record of standardized, defensible decisions using a small vocabulary of simple, flexible, interlocking terms.

Inevitable care delivered almost automatically, with a machine-like precision is, of course, a rather Weberian vision. My point is not that it is efficient, but that it is a manifestation of audit culture. Routinization deflects scrutiny and protects both the office as a whole and the officials who staff it. It also has an effect on clinical relationships. What Montgomery calls the 'performance of certainty' can reassure patients as well as create fitting audit trails. The creation of a sense of reassuring certainty is not only generated by the clinician. As Montgomery reminds us, patients are participants in these performances, and both clinician and patient benefits from the comfort provided (Montgomery 2013: 197).

In practice, although accountability generally trumps empowerment, traces still remain. It is unclear to what degree the traces of empowerment are rhetorical, and whether they are sufficiently broad to have therapeutic benefits. Important to my argument is that increasing empowerment in patients makes it more difficult for clinicians to deliver accountable care. Documentation will be poorer, care less uniform, decisions harder to justify and recorded risks will escalate. Holding clinicians to account might promote certain virtues, but it seems to inhibit other clinical and policy goods.

The case of Cathie and Don shows incommensurable narratives in action. Seen as a person with Bipolar Disorder, Don's problems have to do with mood. These have their origins in vulnerabilities that start out in the brain, and are manifest in features such as cognitive biases. Feeling guilty, empty or isolated is read as part of low mood or mood instability. The solution is primarily

medicinal. However, Don is enjoined to self-monitor and self-manage. This means being vigilant for symptoms or the advance of symptoms, and trying to limit stressors and risks. This is not what Cathie sees. Her version of Don is built of thicker descriptions. She does not de-ethicize or decontextualize. Neither does she rely on technical terms or professional expertise. Instead, she understands Don's distress in common sense terms, as arising out of misplaced values, bad habits or personal weakness. She holds Don to a greater degree of responsibility. He is not simply the innocent victim of a brain abnormality. But he is in a position to personally address his suffering, using the thicker, more subtle terms favoured by non-experts. This seems to be what some professionals have in mind when they talk of empowerment. From this perspective, Don is disempowered by the narrative offered by his psychiatrist.

The relationship between empowerment and the creation of an impression of impersonal, objective certainty is unclear. An aspect of thicker understandings of patient empowerment is that patients are expected to make their own decisions based their own interpretations, values and preferences. This is a kind of autonomy. It seems to separate the patient from sources of certainty and reassurance that come from mechanical objectivity. Autonomous, empowered patients might not be able to generate such a sense of certainty themselves, yet need to act nonetheless. How could personal plans for the future match the certainty of medical notes? If a patient grows accustomed to objective decisions made by clinicians, their own decisions might seem unsatisfactory: flimsy and insubstantial. Mental healthcare which, because of the need to be accountable, includes the performance of certainty and decisions made without deciding, might reduce the capacity of patients to make realistically uncertain, non-reassuring, non-rule derived decisions which empowerment might be seen to consist in. It appears that mental healthcare services have a low tolerance for acknowledgements of uncertainty, which they potentially pass on to their patients.

Empowerment might include fostering in staff and patients alike a tolerance for high levels of acknowledged uncertainty and a capacity to plan and act in spite of it.

CHAPTER FIVE: PATIENT EMPOWERMENT, BUREAUCRATIZED WORKING PRACTICES AND IATROGENIC HARM

5.1 Introduction

This chapter investigates complexity in bureaucratized mental healthcare. In chapter one I reviewed literature that suggested that bureaucracies function by a process of simplification. Scott, for example, regards the production of simplified and manipulable information as critical to state institutions required to act in the world. In chapter two I outlined why Strathern regards simplification to be a key aspect of audit culture. Documenting work such that it may be audited necessitates simplification. In the medical notes reviewed in chapter four I looked at how clinicians create an impression of calm, confident decisions, based, in part, on eliding or erasing uncertainty and ignorance. When I spoke to Cathie about her husband Don, it appeared that she attributed his problems to his character, values and ethics. These are hard to simplify. They are precisely the kind of things that are problematic to clinicians if they are to produce documentation appropriate to an accountable bureaucracy. I found they play a limited role in medical notes.

During fieldwork it struck me that staff describe some patients as ‘complex.’ Because I was thinking through the theoretical fame of bureaucracy, to me the notion of complexity had a special significance as a potential barrier to routinization. But I noticed that to staff members as well, the term ‘complex’ had a charged quality to it. Complex patients appeared to be problematic patients. They were the subject of intense controversy and elicited strong emotions. This seemed to confirm my theoretical approach and to prompt a new focus for fieldwork. If

Oxford Health is thought of as an accountable bureaucracy, instances of perceived complexity deserve particular ethnographic attention. Occasions of complexity might indicate institutional machinery under pressure. It could be a sign that phenomena that are hard to routinize are becoming difficult to contain. Locating and understanding complexity might be a means of understanding Oxford Health as an institution.

Throughout fieldwork I would hear staff members describing a person as 'complex', or 'possibly complex,' or, even, 'he's not as complex as he appears.' 'Complex' may be used in two distinct but overlapping ways. One sense of 'complex' refers to a person's 'multiple problems' or 'multiple needs.' For example, a patient who is complex in this sense may be dependent on alcohol and be diagnosed with Bipolar Disorder. It is not that Bipolar drinkers are intrinsically more complex than others. Their complexity is created in relation to the structure of mental healthcare services. Alcohol services are separate from the general adult teams that deliver care to most people with Bipolar. Liaising between teams to ensure a complex patient receives coordinated care can be time-consuming. So, in a very straightforward way, delivering care is more cumbersome when patients are complex. A different clinical taxonomy or a different organizational structure would create different populations of complex patients.

However, the term 'complex' can indicate something else. It can mean that a patient has what staff call 'personality traits,' 'personality issues,' 'personality problems,' 'personality disorder traits,' or even a full-blown 'personality disorder,' often abbreviated to 'PD.' 'Complex' in this second sense is used by mental health staff members quite loosely. Personality traits or personality problems are perceived by staff not just on occasions where a patient has been formally diagnosed with a personality disorder. In many cases they will use these terms of patients who they do not expect to ever be formally diagnosed. PD traits are said to be

independent of mental illness. They are a source of distress and disability in themselves, and are understood to harmfully interact with mental illness.

This chapter deals with complexity as it pertains to what staff think of as personality. The concept of PD has received very little anthropological attention. In this chapter I first provide two ethnographic case studies that describe occasions in which complexity causes problems. In the first, Moira, a CPN, describes what it is like to deal with patients regarded as having complex personalities by describing a patient called Chloe. In the second, I describe an encounter between a complex patient, a CPN and a psychiatrist. In each case, bureaucratized healthcare struggles to deal with complexity. To further investigate why this might be so, I first outline some of the Biomedical literature on PD. Then I look at ethnographic material describing how staff members talk about personality disorders, drawing on informal conversations and formal interviews with a number of members of staff. In particular, I examine critiques of mental healthcare made by clinicians themselves. Finally, I look at some philosophical literature on responsibility without blame.

My argument is that complex patients are highly problematic to mental healthcare teams in an accountable bureaucracy. It is revealing that what makes complex patients problematic is understood to be their personality. The concept of personality emerges as what Douglas calls a 'residual category' in that it deals with things rejected from the normal classification (Douglas 2002:45). In this case, what is rejected from normal classification is character, ethics and values.

Complex patients are people whose character and ethics cannot be ignored. They are empowered, but not in the right way. Complex patients are less adherent, less predictable, more

demanding, yet they are active, agential, and very far from passive. Complex patients demonstrate how multifaceted the notion of empowerment can be. Indeed, some complex patients appear to behave like consumers of mental healthcare services, but not in ways that support a consumer model of patient empowerment. Complex patients thus undermine what Mol calls the logic of care. In chapter three I discussed literature that investigated ways in which mental healthcare can be disempowering. The ethnography in this chapter contributes to this debate, suggesting reasons why accountable bureaucracies delivering mental healthcare might disempower their patients.

5.2 Problematic Empowerment in Practice: Moira and Chloe

During fieldwork, I often found myself asking clinicians about diagnoses. What is Schizophrenia? What experiences do Bipolar people have? How do clinicians recognize PD? Frequently, an informant would reply with reference to a particular person. This person would be a typical or classic case of the disorder in question. These cases have a heuristic or exemplary quality that informants use to help illuminate less obvious cases. I occasionally wondered about the effects of this cognitive habit. Having a bold prototype in mind might serve to focus attention in an inflexible way, or encourage interpretations of innocuous but ambiguous experiences or personal characteristics as clinically significant not because of the distress or impairment they cause, but because they resemble these prototypical bad cases.

When I asked a key informant Moira, a CPN with many years of experience, about complex personality, she immediately thought of Chloe. She said Chloe would frequently telephone Moira at difficult times, such as around five p.m. on weekdays, and especially on Friday afternoons, saying she was suicidal. Moira said that at first she *'*took these calls seriously.*'* She

felt there was no doubt that Chloe was in considerable distress. Moira said that if Chloe called, she would either go and visit her or speak to her on the telephone. But she said she began *'*to see a pattern.*'* She began to suspect that offering support like this might not be helping very much. Even, perhaps, that by responding to the calls she was making things worse. She said it might be a case of *'*rewarding bad behaviour.*'* She wondered if the short-term relief for Chloe of contact with a concerned and caring staff member could ultimately reinforce the problem, thereby putting therapeutic goals at an ever-greater distance. She explained to me that she suspected that Chloe had become *'*over-involved*'* in her relationships with members of her care team, perhaps even *'*dependent.*'*

Moira told me she raised the topic of Chloe in a team meeting. This might be an opportunity to hear different perspectives and perhaps new ideas on how to proceed. It is also an opportunity to deal with risk. Group discussions, especially if they reach a consensus, are recognized by staff members as a way of reducing the responsibility of individuals. On this occasion Moira said the team supported her interpretation, with a general sense that responding to the calls was contributing Chloe's problems. Moira said she also raised the issue privately with a psychiatrist and other CPNs.

I asked what Moira considered her options to have been. She said that people agreed that Chloe's best interests did not lie in responding to these phone calls and that in the long term it could make the her worse. She might become 'institutionalised,' 'dependent,' or exhibit 'learned helplessness.' The alternative, Moira told me, was to get Chloe to learn to 'self-soothe' rather than relying on members of staff. Moira understood her to be lacking in skills having to do with 'emotional self-regulation,' or 'self-management.'

So Moira began to change her approach to Chloe. An explicit plan was recorded in Chloe's notes. She would meet with Chloe only at arranged times. She would not allow Chloe to engage her in long phone conversations at other times. In appointments, Moira would discuss self-management and self-soothing skills. She would tell Chloe that it would be best for her to learn to deal with these states on her own. To Moira and the team, it seemed like a good approach. But things didn't go according to plan. The problem was that if Moira didn't respond when Chloe called with suicidal thoughts or feelings, she would simply call back later having taken an overdose. *'*What would you do*'* Moira asked me, *'*now that she has taken thirty paracetamol and washed it down with the best part of a bottle of vodka?*'*

As Moira and I discussed Chloe, I could see what a difficult situation this was. Both Chloe herself and the clinical context seemed complex. It was difficult to separate patient and disorder. Chloe's intentions, meanings and goals formed part of the clinical picture. The care team couldn't just focus on symptoms and treatments. The distress leading up to the overdose is regarded as painful and real, but not quite the same thing as the depression or anxiety caused by illness. The overdoses resembled a suicide attempts, but Moira and the team saw them as 'suicidal gestures' and they were interpreted by the team as 'manipulative.' Chloe was imitating the actions of a desperate and deeply depressed person, to secure some sort of response from Moira.

Chloe said to Moira that when Moira was unavailable, she felt vulnerable and couldn't cope. Moira thought differently. She said that complex patients can try to elicit a heightened emotional response in mental health team members. Moira explained that complex patients act in ways that are liable to elicit anger, or frustration. In this case, she wondered if her frustration

was somehow desirable to Chloe. She wondered if Chloe wanted to secure attention, or to elicit concern, perhaps gain power, or to have a sense of being looked after.

Moira said she found communicating with Chloe was very difficult. The team's own understanding of Chloe was uncertain, yet a key element of her agreed clinical approach was to disregard Chloe's alternative interpretations. For example, Moira said that Chloe interpreted advice about self-soothing as personal rejection or abandonment. Part of Moira's strategy was to resist this interpretation. She said this is a particular issue with complex patients because a patient's firm commitment to a particular version of events, and a sometimes fierce rejection of other understandings, is regarded as being a part of the disorder. But for staff members, when under pressure, it can be hard to confidently maintain the team's interpretation. Moira said that even where a behavioural pattern seems obvious to the team, the patient may deny or reject it.

One of my patient informants is diagnosed with PD and has a history of repeated suicidal actions that, on paper at least, resembled Moira's patient. She told me that each of her suicide attempts was a genuine effort to kill herself. She explicitly rejected the claims of the team that she had become dependent. She said she didn't have a PD and was offended by the claim she did. The staff who said she did were incompetent, and the concept of PD was anyway fundamentally flawed. Instead, she said that she wanted to die because of clinical depression, for which she needed the support of a member of staff.

One of the problems Moira faced was that the level of risk of suicide is not only tied to 'level of intent,' but also suicidal activity itself. Overdoses can be dangerous even if they do not arise out of a desire to kill oneself. A patient starts to become a genuine source of risk even if they are understood to be manipulating staff with 'hysterical' or 'dramatic' behaviour and suicidal

gestures. They might end up killing themselves anyway. With Chloe, in one scheduled appointment, Moira told the patient that she was due for annual leave. A family holiday was planned. Moira was nervous, but felt she had to be firm. As she expected, Chloe said that she couldn't cope without Moira being there, at least to speak to on the telephone. Nonetheless, Moira went away on holiday. When she returned, she found that Chloe had indeed died, having taken an overdose.

I felt very sorry for all concerned in this story. Chloe is dead. Moira lives with her grief and regrets. This is not her only contact with suicide. She said she felt guilt, at not having done more, at being causally implicated in Chloe's death, and, as part of services, unintentionally contributing to Chloe's problems. She didn't know what else she could have done, but felt that what she did, and what her team as a whole did, only made things worse.

This case study is suggestive of features of Oxford Health as an institution. Bureaucracies tend towards rigid ways of working. Moira's team has a distinct and not very flexible model of care. Its ethos and expertise are organised around delivering standardized, recordable care for rather abstract but measurable mental illnesses. This approach seemed hardly suitable for Chloe. The problem of how to deliver care to Chloe arises out of her complexity. In one sense she seems very empowered, able to express preferences and exert an influence over Moira. But this doesn't seem to be a very satisfactory understanding of empowerment. Part of why this is so recalls my discussion of O'Neill's Kantian approach to autonomy in chapter three. For O'Neill, autonomy, properly understood, is a property of reasoning. Only decisions made with certain kinds of reasons count as autonomous. In this case, at least in Moira's telling, Chloe's calls to Moira and her reasons for her suicide threats emerge as being part of the problem. Responding to Chloe's wishes or incorporating her rationales into their treatment plan would, on this

understanding, just further disempower Chloe. Indeed, the team's therapeutic approach was to ignore her preferences and resist her interpretations in the hope that it would promote empowerment.

Understood more generally, the designation 'complex' indicated that the team were unable to make a separation between disorder and person. Uncertainty about Chloe's motives, intentions and goals clouded the clinical picture. Unable to create a simpler picture, decision-making became difficult too. Moira seemed caught in the middle. Her clinical expertise didn't seem to help her understand Chloe very well. When she spoke about Chloe, clinical concepts only took her so far, and gave very limited help when it came to making decisions. Indeed, the gaps and omissions that, in medical notes, eliminate uncertainty and enable the recording of justifications of treatment seemed to be part of the problem with Chloe. Chloe's distress arose out of just those features that tend to be overlooked in clinical writing.

5.3 Problematic Empowerment in Practice: Jill, Giles and Viv

Viv and her family were widely described as being *'*well known to services.*'* This includes input from social services, mental healthcare and the police, as well as a local charity. Viv recently came to the attention of the team following the arrest of one of her sons for a string of serious sexual offences. The case was locally notorious, and received extensive media coverage. Viv was briefly admitted to a psychiatric ward as an 'informal' or voluntary patient. She was discharged a few days later and was due to come and see a CPN, Jill.

I asked Jill about Viv. What kind of person is she and what kind of care do the team provide? Jill said that Viv was depressed and anxious. She's feeling guilty about her son and his crimes

and hated by other members of the local community. She talks about wanting to kill herself (known as 'suicidal ideation') and, in the view of the team, she presents a substantial suicide risk. But, Jill stressed, they want to provide *'*the minimum care possible*'* for Viv. I asked why. The first part of Jill's reply was that *'*we don't believe Viv has a mental illness.*'* She explained that they think that Viv is depressed, but she doesn't suffer from a depressive disorder; she is anxious, but she doesn't suffer from an anxiety disorder. The reason for this is that her distress seems broadly proportionate to the environment. Jill describes it as *'*normal depression.*'* She added that Viv has plenty to feel depressed and anxious about. *'*How would we feel' Jill asked 'if we were in her position?*'* Jill articulated this in terms of stressors. The level of stress is very high, and so the level of distress is also high.

However, Jill also explained that Viv's personality is *'*being taken into account.*'* Jill said that the team feels that Viv has *'*personality issues*'* and *'*definite personality traits.*'* She says that the team takes the view that these personality issues are important when thinking about appropriate treatment. Jill put it to me this way: *'*Mental illness is something that could happen to anyone, to me and to you. Who you are doesn't make any difference. It can come and take your life away. But with personality, it is who you is the problem.*'* She went on to say that personality problems have their origins in childhood, either in abuse or neglect. As I understand it, she regards Viv's childhood as causing dysfunctions or pathologies that are distinct from mental illnesses but of the same order of magnitude. She says that these problems go on to shape character such that the patient finds it hard to lead a functional or fulfilling life.

Jill talked more about how Viv's depression and anxiety are caused in part by her personality. She has poor coping skills, for example, at a time when she has a lot to cope with. Jill says that like many people with personality traits, Viv is poor at self-soothing. I notice that Jill is reticent

when talking about these issues. She goes on, but she talks in a rather cautious way, almost like a politician in a tricky interview, choosing her words carefully. I wondered if it was because she felt uneasy apparently criticizing or blaming Viv. It felt slightly rude to be indicating that Viv herself is the problem, even if, as a clinical category, the concept of PD mitigates responsibility.

However, I also felt unsure how sincere Jill was about Viv's personality issues. I couldn't tell what her real views were on the subject of complex personalities. She was able to talk convincingly, in the way that would be required for team meetings or medical documentation, but I thought her heart wasn't really in it. This gave some of the words a slight ironic edge. At times during fieldwork I sensed the rhetorical power of a particular variety of understatement. For example, during a team meeting in which a female CPN described to the team how a male patient had been sexually aggressive towards her, I noted how she used phrases like *'*he really had a poor sense of personal boundaries*'* and *'*I did detect some impulse control issues.*'* These anodyne, non-judgmental, bureaucratized terms acquired rhetorical force through understatement. They were immensely effective. With Jill, I felt we were in a grey area. Jill didn't entirely accept the PD model, but neither did she reject it. With regard to Viv, her stance was undefined.

Jill went on to say that instead of looking to her own resources, Viv might already have *'*become dependent on services.*'* She wanted to be in contact with Jill each day, either by phone or in person. Jill seemed wary. She thought that this might lead to Viv losing skills, where she might benefit from improving them. *'*I know it is hard' said Jill, *'*but life is hard. You have to learn how to cope.*'* She said she didn't want Viv exaggerating her distress to secure attention. *'*Manipulative behaviour*'* like that is expensive and it *'*diverts us from our real job.*'* Viv could

easily *'become a burden on services,'* whilst, in the same process, losing her autonomy and self-reliance. In their dealings with Viv, Jill said the team had made sure not to prescribe Viv any medication. Their aim was to restrict the scope of any dependency they might create by basing her treatment on generic 'support' offered by Jill.

Before we go to meet Viv, Jill steps into the waiting room to introduce me and ask if it is ok for me to be present in the appointment. I stand behind her as she introduces me as a researcher in medical anthropology. Viv is sitting with her sister, who, we understand, will stay in the waiting room. She seems expectant, slightly excited. Jill stresses that I don't have to be there; that the appointment can go ahead without me, but her tone suggests that there is no reason why not. But Viv seems pleased I am there. She asks what medical anthropology is. As I explain I am a research student, I sense she is a little disappointed that I am not more senior, but that she is nonetheless pleased.

Having established that I will join them, Viv rises quickly. She seems expectant. We walk together down a long corridor and enter a tiny room. It seems too small for an appointment, and is made worse by my presence. Airless and cramped, there is barely enough space for a table and three chairs. We are forced into physical proximity. Jill sits on the other side of the table and I sit with Viv. Jill begins by talking quite neutrally about *'how have things been going?'* Viv starts to talk about how depressed she has been. She says that she can't sleep and that she finds it *'painful to be alive.'* Jill nods, listens, and asks simple questions. Is Viv in contact with her son? She says no. Is she in touch with her other children? Viv says yes she is. Jill is supportive, but without offering opinions or advice. She tends to repeat back what Viv says or make remarks such as: *'that must be very painful,'* and *'I can see how difficult that is.'* Viv starts to discuss how she feels that her husband is *'supportive, but doesn't understand'* and that

she is becoming forgetful at work. She presents herself as overwhelmed by her feelings, and baffled by them too.

As she talks, she scans Jill quite carefully. She says it is too much to cope with. She describes how she comes downstairs in the night, unable to sleep and tormented by intense, overwhelming feelings. Hours go by sitting alone on the sofa not knowing what to do. Viv continued, saying that she was thinking of killing herself, that she wanted very much to do it, but was held back by concern for her younger children. There is a pause, as Jill offers reassurance and comfort. Viv goes on: *'*I know drinking doesn't help, I know that, you've told me that and I don't do it when I feel terrible.*'*

As she talks she begins to cry. She says: *'*I can't manage,*'* and *'*it is all too much.*'* Hunched over the table, her body tenses and shakes. She hugs herself and gasps for breath. Jill hands her the box of tissues. She waits for Viv to compose herself, sitting perfectly still. *'*Take your time, Viv, its ok, there's no hurry. Just take your time.*'* Viv returns to the topic of medication. She says she doesn't want tablets because they don't help, but she knows she needs something because nobody could bear what she is bearing, nobody could go through what she is going through. Might there be some tablets that could help? Something to help her cope, to take the pain away? Otherwise, suicide is always there.

Jill asked if Viv might want to speak to the doctor about antidepressants. She said yes. We got up and went to find Giles. As we were leaving Jill said: *'*You'll be alright, won't you, for a few minutes, while I speak to the doctor?*'* Viv agreed that she would be fine. Giles' office is further down the corridor. Jill explains to Giles what is happening. She says that Viv seems very depressed and is talking of suicide. The risk seems to be real, so might it be worth giving

her antidepressants? Giles says he can see that *'*there might be a justification for prescribing antidepressants.*'* He asks me what I think. I'm out of my depth and don't know what to say. He then talks through a possible rationale: that she is very distressed, that antidepressants *'*might help a bit,*'* that she is at risk of both suicide and of *'*developing a depressive illness*'* and, anyway *'*antidepressants won't do any harm.*'* Giles finds several ways to justify prescribing antidepressants. But his tone suggests he is slightly flippant. I don't think he has any expectation that the medicine will be effective, perhaps, even that she will ever take the pills. He went on to say that the notoriety of Viv's son's crimes make her *'*a very high profile case*'* and the team *'*needs not to take unnecessary risks.*'* They will be looking after Viv for the next six months at least, during the wait for the trial. It might be safer to put her on medication.

So the three of us return to the room. Viv seems much calmer, and visibly brightens when she sees Giles. There is no room for another chair, and he crouches down in front of her. She is almost flirtatious: *'*You're a very tall doctor aren't you?*'* When, later, he writes down her date of birth on the prescription she jokes coquettishly about her age *'*I shouldn't be telling you that should I?*'* Giles is undeflected and impassive. He talks her through *'*the options.*'* His role is to impart information: it is clear from the outset that she is getting the tablets she wants. He says that there shouldn't be any side-effects, but that you can never be sure. He gives her a leaflet, writes out the prescription, and the meeting is over.

Viv was genuinely very distressed, but I sensed a certain directionality to her emotions. The distress was, in a sense, being offered to Jill. I began to see that Viv wanted something in return. The relationship between Viv and Jill includes an element of exchange. A kind of deal is being done. The exchange is predicated on the moral commitment that Jill has towards Viv. As an accountable clinician, Jill has a responsibility for her patients. Viv seemed to be handing

over distressing feelings. The feelings are intense and painful and they give Viv leverage. It is as if Jill is obliged to reciprocate. Viv's distress, once articulated in the clinic, had become a bargaining chip, which might be exchanged for a certain kind of support, and for medication.

In this case study, bureaucracy again appears rather inflexible. Expertise and working habits anticipate a different kind of patient. The clinical terms that Jill and Giles use seem poorly adapted to Viv's needs. They talk of self-soothing, dependency, self-regulation and skills. Viv talks of grief, guilt and remorse, and of feeling isolated. By reading her distress as low mood, resulting in risk for which appropriate steps can be taken, Jill and Giles find a way to respond clinically. Jill listens sympathetically and Giles writes a prescription. The expertise that Jill and Giles have is really directed towards other goals.

Giles and Jill both see Viv as having PD traits and being potentially harmed by healthcare. Before the appointment, Jill explained to me how Viv didn't have clinical depression and so didn't need medication. She also suggested that contact with the team might be disempowering to Viv, for example by creating dependency. However, they seem powerless to resist her. Part of the reason for this is that it is harder to justify inactivity than it is active clinical steps. A record of no treatment might expose Giles to censure if something went wrong. It is noteworthy that Giles is able to produce a plausible sounding justification for a prescription of antidepressants even if it seems doubtful that he believes they could be helpful. There is a quite a distance here between medical documentation and the true opinions and motives of clinicians.

Giles' first priority is to maintain relations with Viv. Contact with patents is the foundation of accountability. In this case it means responding to Viv's demands, even if it may be against the team's better judgment. In a sense, Viv's approach is very agential. Rather in the style of a

healthcare consumer, she seems to be maximizing her receipt of healthcare services. What this means in practice seem very far from the discourse of patient empowerment discussed in chapter three. The logic of choice appears to be distorting the content of care. Accountability seems to make it possible for Viv to make Giles and Jill responsive to her preferences, even if, in their clinical judgment, these preferences are not in her clinical interests.

5.4 Why Having a Personality can be a Problem: Personality disorders in theory

Historically, the notion of personality has been used within Biomedicine to describe people who displayed patterns of abnormal behaviour, and had perhaps come to the attention of the law, but had normal intellect and seemed not have be suffering from acute psychiatric symptoms (Crocq 2013: 149). Within academic and clinical psychology it is now regarded as well-established that the concept of personality can account not just for unfavourable health outcomes, but for a range of phenomena: *'*Personality traits are clearly central in predicting a wide array of important life outcomes, such as subjective well-being, social acceptance, relationship conflict, marital status, academic success, criminality, unemployment, physical health, and job satisfaction…even mortality years into the future*'* (Widiger 2012: 13). The way that knowledge about personality has been constructed is to find associations between measureable traits and outcomes across time, using epidemiological data.

In the DSM 5, a rather simple concept of personality is proposed: 'Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personality contexts' (American Psychiatric Association 2013: 647). When I chatted with psychiatrists about the official definition of personality and how it might work in practice, I was told that the key features are that it is 'enduring' and 'pervasive.' A

trait didn't qualify as an aspect of personality unless it was longstanding (and ideally, lifelong) and affected many areas of life.

The notion of disordered personality is not derived from a concept of ordered personality. Instead, clinicians told me that personality is disordered if it causes distress or impairs function. Disordered personality is personality gone wrong: healthy and unhealthy personality is differentiated by its impact on feelings of distress and capacity to work or fulfil other social roles and obligations. It is said that people who are successful at work and in relationships and who pass through life relatively untroubled are not personality disordered. However, I was also told that most PD goes unnoticed and undiagnosed. Despite this, in the language of the DSM 5, PD 'deviates markedly from the individual's culture.' There is an expectation that personality disorders make people visible, at least to those with the right training.

In the DSM 5, personality disorders are grouped into three 'clusters.' Cluster A includes paranoid, schizoid and schizotypal disorders. Individuals with these disorders are said to often appear 'odd' or 'eccentric.' Cluster B includes antisocial, borderline, histrionic and narcissistic personality disorders. These people are described as 'dramatic,' 'emotional' or 'erratic.' Chloe and Viv would probably be seen by staff members to have some of these traits. Cluster C includes avoidant, dependent, and obsessive-compulsive personality disorders. Individuals with these disorders are said to appear 'anxious' or 'fearful.' In the DSM, people may have features of several PDs, both within and across clusters. In much talk about PD, the cluster or type of PD is not mentioned.

Personality disorders are understood to be wholly distinct from mental disorders. In the DSM 5 they are described as existing on different 'axes.' They may interact with each other, but have their own independent supposed origins, mechanisms and symptoms. Sometimes complex personality traits can be used as an explanation for why pharmaceutical remedies have failed. This can be a topic of

joking amongst staff and patients. One patient told me he was on his fifth combination of medications for Bipolar Disorder. He said, with a smile, that *'*I can try one more combination before they say I'm PD.*'*

The DSM 5 states that personality traits must be inflexible or maladaptive to count as PD. The notion of fixity is interesting here. PD traits appear alienated from the person, involuntary and unwanted. Tied to childhood, they are fixed aspects of character. This accounts for why a person is held not to be responsible for their PD traits. How can a person be blamed for something they can't change? But, equally, fixity gives a reason as to why clinical input might be justified. If a person can't change themselves, then they need external interventions.

Amongst my clinical informants there seemed general agreement that there is very little that is stable and secure in the understanding of personality disorder. Some were reluctant to use the word personality disorder at all. One psychiatrist said to me *'*how can a personality be disordered? We don't know what an ordered personality is.*'* I observed quite heated debates in academic seminars and lectures regarding the relationship between personality disorders and normal personality, the relationship between the various personality disorders themselves and between personality disorders and mental illness. These disputes are played out in Biomedical publications. For example Claridge is resistant to some of the basic distinctions of Psychiatric nosology that relate to personality (Claridge 1995: 235–6). Despite these disagreements, I found it more or less universal amongst clinical informants that some patients were problematic, and that this was to do with difficulties separating their distress from their character, values, habits or ethics.

5.5 Treating Complex Personalities

I discussed PD with Giles, the psychiatrist treating Viv. He said he personally prefers to minimise contact with patients he regards as complex, but will offer short-term support and treatment, with an eye to referral. Oxford Health has a specialist unit, known as Complex Needs, where people with personality problems are treated in a group therapy environment.

He said that not all psychiatrists see things the same way on this issue. Giles presented his approach as being positioned midway between the extremes of current practice. Some teams, he said, were more willing than him to treat PD. He said this might be on the grounds that the distinction between mental illness and PD is not clear-cut. In contrast, some teams are unwilling to engage with PD patients at all. According to Giles they refuse to treat even in moments of crisis if they believe a person's problems are, in origin, PD. They take the view that delivering mental healthcare to people who don't suffer from mental illness only makes things worse.

Giles presented his approach this being quite risky, at least in the short term. *'*If things go wrong, it looks bad if we haven't offered any treatment*'* he said. However, he described it to me as both clinically advisable and pragmatically better for the team if they limit their contact in a judicious way and *'*carry the risk.*'* The clinical case for him was clear: patients like this don't have mental illness. In Giles's view mental illnesses are real, underlying, pathologies that are independent of the person and intrude, harmfully, into otherwise healthy lives. So the rationale for treatment is negated. In addition, treating people with PD as if they suffer from mental illness is liable to have unintended adverse effects, making them less autonomous and more needy. He went on to say that some PD patients become very difficult. They *'*create a lot of stress for the team,*'* and take up a lot of time that could be much better used.

One of the teams I observed during my fieldwork seemed to conform to Giles's description of teams that are prepared to treat people they think of as having PD. The team as a whole appeared to be less Biomedical or biological than others I observed. In team meetings, even where the patient was diagnosed with Schizophrenia, there was discussion of life events and external circumstances as drivers of distress. Team members were more vocal regarding their scepticism towards diagnostic categories and the 'medical model.' A psychiatrist who is part of that team told me he liked to use certain antipsychotic medications as what he called *'*psychic glue*'* for PD patients who find it difficult to manage their inner lives. He said psychic glue was helpful to people who were trying to get their lives together.

Whether they envisage care being delivered by a specialist therapeutic community or general adult teams, there is an aspect of the way clinicians conceive of their goals with complex patients that pertains to my argument. I was often told by clinicians that complex patients have to commit to treatment. It is believed that personal change can't be involuntary. This claim was found in case discussions, informal chats, academic seminars and textbooks alike. For example, in a chapter on the general management of personality disorder from a recent textbook, Newton Howes states that:

> giving the patient as much control over the process of recovery as possible is important. This ranges from how and when they engage in treatment, to what (if any) medication they take and how they are reviewed. This makes clear that the patent's task is to move towards improved psychological health and ensures that they are taking responsibility for their actions, finding ways to manage both behaviourally and cognitively (Newton-Howes 2015: 42)

It is also of note that qualities like determination or patience that were raised in the vignette that opened this thesis, and were found to be side-lined or even excluded from mental healthcare now re-emerge as active ingredients promoting better outcomes. It appears to be difficult for clinicians to treat complex patients without taking a wider view of what might be relevant to care.

It is striking that Newton-Howes regards this as a departure from care as usual. Following the above-quoted remarks, he states: 'This is somewhat at odds with the current biomedical model used in psychiatry which can disempower the patient and lead to a myriad of problems' (ibid.: 42). It was noticeable during fieldwork that a lot of disagreement about personality was expressed, both openly and covertly. How flexible is it possible for bureaucratized care to be? How can a team aimed at producing routinized care of mental disorders also deliver care for complex patients? Might not the ethos and expertise of professionals who are primarily oriented towards delivering accountable care for mental illnesses be unsuited to complex patients? To further investigate these issues, I examine first how staff talk about complex patients, before turning to some internal critiques of the care delivered by Oxford Health.

5.6 'He's definitely got personality traits, that guy.' Staff Talk about Personality

Staff members use a particular set of terms and descriptions to refer to complex patients. They form a largely distinct vocabulary from the language used to describe mental illness. Patients with PD traits are described as 'emotionally unstable,' 'volatile' and 'manipulative.' They are said to be 'extremely responsive' to various triggers such as 'perceived slights,' 'threats of abandonment' and 'signs they're not being taken seriously enough.' When staff use these terms in team meetings to describe a patient, it hints at PD traits. Attempts to win over staff members are also viewed with suspicion. Gifts and cards might be seen as overly ingratiating, hinting at manipulation. Similarly, patients who are thought of as overly charming or flirtatious may be deemed 'superficially charming.' Complex patients are said to primarily experience problems with mood and anxiety. But rather than experiencing the long periods of low mood or high

mood that are said to typify mood disorders, PD patents are seen as 'rapidly changeable,' 'reactive,' or 'labile.'

As well as lacking in self-management skills, complex patients are often said to be 'inflexible' or 'resistant to change.' This can be perceived to be a consequence of a failure to see patterns in their own behaviour in the way that staff do. Staff talk about people being 'in denial', or 'so worked up they can't see what's going on.' Their 'high states of emotional arousal' prevent them seeing themselves from the outside, also called 'mentalization'. Equally, habits may have become 'habitual' or 'entrenched', such that it is very difficult to change. This can be a particular issue for staff were the patient is dependent on alcohol or drugs. A CPN told me how frustrating it can be: *'*you talk to them, you discuss how a certain way of behaving is unhelpful, is making them depressed, they agree, they say they'll change, then they walk right out the door and continue exactly the same...it can feel like an endless cycle.*'*

Tracey, an experienced social worker, spoke eloquently about complex patients. She said that she: *'*can now spot a PD a mile off. You can tell within ten or fifteen minutes from their attitude…everything is not right, they're complaining about everything, can't sustain employment or relationships…and they want things from you, they want stuff, you feel that in your gut.*'* Although these are widely held views, there is something striking about Tracey's remarks. A part of the goal of patient empowerment is to encourage people to express their needs. Yet here, it understood to be a problem. Similarly, being attentive to one's life and environment, and caring about it, is part of many visions of empowered patients. Here, Tracey disapproves of apparently identical qualities. Would a passive acceptance of a miserable life be preferable to being both attentive to life's struggles and engaged in efforts at improvement?

Isn't Tracey here denigrating an active stance towards services? As with Moira and Chloe, the discourse of empowerment is difficult to apply to complex patients.

Tracey describes how she detects PD traits by means of bodily signs. Several of my clinical informants said they could do the same thing. At first, I found this puzzling and rather alien. But during fieldwork my view began to change. I felt that I began to have similar sounding embodied responses. Sometimes, during a conversation I would feel tension, muscles tightening, my neck suddenly stiff and uncomfortable. After more conversation I might begin to consciously notice that my interlocutor was trying to pressure me, that, in Tracey's words, they wanted stuff. For example, one informant tried to elicit information about members of her care team, and another seemed to want to create a stronger bond between us than I was prepared for.

This also gave me an insight into an additional reason why staff members claim complex people are troublesome. The scale of patient suffering was a shock to me as a fieldworker. Confronting distress each day is challenging for the most robust person. Being placed in a position of responsibility, and making decisions that might have terrible unintended consequences only adds to the burden. Staff members encounter frequent reminders of how little they can help. Some patients are grateful, but many are critical, uncooperative, and even hostile. Staff members get little respite. They told me that they have to learn to compartmentalise if they are to survive. Complex patients are said to be a barrier to successful compartmentalisation. Encounters with patients deemed to be complex linger in mind. My personal experience was that PD patients were harder to put out of my mind, and, sometimes days and weeks later, involuntary and uncomfortable memories of odd and challenging encounters would return. Staff members indicated this is common. Moira, for example, still thinks often about Chloe. The emotional burden of patients with PD traits can be very high.

I discussed complexity in patients at length with Katie, an experienced psychiatric social worker and AMHP. She said that personality disorder is a *'*touchy subject.*'* Neither staff nor patients are really comfortable with it. For patients it is because *'*it isn't nice to be told you've got PD traits.*'* For staff the reason is rather different:

> We all have PD traits, we all manipulate to get our way, or need to feel needed, so it can be hard to refer a person you like to complex needs [the clinic for personality disorder]…I don't mind being woken by the police at 2am when it's a Bipolar person because you know they're really unwell, there is really a chemical imbalance. Mania is preferable, is best of all, because treatment is obviously necessary, there are clear steps and rapid effects, more effective for mania than for depression.

For Katie, PD patients are not really unwell. Their distress is caused by extreme or exaggerated versions of normal personality. It is harder to know what to do for them. Katie went on to say that says she finds PD patients *'*fascinating, but difficult.*'*

When Katie spoke about PD patients, she seemed to regard their distress as qualitatively distinct and in some way less 'real' than the distress that arises out of mental illness. I asked Katie if this meant that PD patients faked their symptoms. She replied this wasn't the case, at least most of the time. She said that there are 'factitious' psychoses, where a person pretends to be hearing voices, or having paranoid beliefs. There is also a mid-position between the factitious and the real, known as 'pseudo psychoses,' where a person has odd experiences that are like psychosis but they *'*aren't the real thing.*'* The difference between the two lies in their causes or 'aetiology.' Real psychoses, like real mania and depression arise in the brain, in chemical processes. She said it could be difficult to tell pseudo psychoses apart from real psychosis, and that sometimes the line is blurred.

Many staff members told me that their caseloads had changed over the years such that more and more patients suffer either mainly or wholly from PD. This was generally greeted with displeasure. Many clinicians commented that it feels like a diversion from real work, and that their efforts are of uncertain consequence. One CPN reaching retirement age told me that *'*I didn't join the service for these people, I joined it to help people who are really mentally ill, who have mental illnesses and who need our help. Not these people with personality traits.*'*

Part of the problem here seemed to relate to accountability. Staff find themselves accountable for patients who they don't regard as being the appropriate recipients of mainstream care. They have responsibilities towards these patients, but their expertise and ethos are directed elsewhere. The kinds of problems complex patients are said to have directly concern empowerment. Rigid personality traits, an incapacity to adopt an externalised perspective, or poor self-soothing all seem to diminish personal empowerment. Yet contact with mainstream services is held to make matters worse. Staff struggle to find ways to empower complex patients.

5.7 Mental Healthcare as a Source of Disempowerment

I got to know Polly well over fieldwork. She is an experienced social worker, whose clinical work I was able to observe both in one-to-one appointments and in group settings. She also consented to two very long recorded interviews. Polly is outspoken. However, I tested her beliefs in conversation with other clinicians. I found that others had similar views. Many of her views resemble the literature that identified mental healthcare as a source of disempowerment, social defeat and ill-health, reviewed in chapter three. Other clinicians, of course, have different

beliefs. Polly's views are those of a dissident, perhaps, when compared to the dominant views in the Trust.

In our first interview, Polly said she often tried to warn off potential patients. The first contact is a key moment for her: *'*I meet people and I tell them, quite frankly, you don't want to get enrolled in our service, you need to look at your life and yourself and find a way to live with yourself.*'* This seems a remarkable statement. Polly described several cases to me where she had met a person who had been picked up by the police and taken for an emergency assessment. The person would be deeply distressed and might be suicidal. But, for Polly, this did not mean that becoming a mental patient was the best thing for them. It was better, in her view, for people to learn how to cope. Being a recipient of care could obstruct that process and introduce new problems.

Polly made a link between personality traits and the potential for contact with services to do harm. She thinks that services are more likely to harm people with complex personalities. Part of the she appeal, she thinks, of being a patient lies in the opportunity it offers for a reduced sense of responsibility: *'*A lot of people with strong personality traits buy into that, buy into the medical model, so they're not to blame.*'* Polly explained that she thought a desire not to be personally responsible for oneself and one's life is perfectly understandable. Many patients find their lives have gone badly wrong. They might have lost their job, or been suspended from studies. Their relationships might have broken down or contact with friends and family damaged. But if the desire is understandable, for her, it is misdirected. Polly thinks these are bad reasons to become a patient.

As we talked, Polly also queried the value of the kind of clinical relationships formed by Oxford Health staff members. She said that many staff *'*walk on eggshells*'* with patients. They tread carefully so that they can get the job done. Challenging patients is risky. This is because, above all, a clinician needs to maintain contact with his or patients and, ideally, promote their adherence to treatment. In Polly's view, these relationships can be far from helpful. She thinks they are very different from the empowering or inspiring human connections that encourage personal change. Equally, she was sceptical about the benefits of medication. They can help, she thinks. But pharmaceuticals themselves can make a person less resilient or independent: *'*meds reduce self-efficacy, reduce the capacity to cope.*'* In the longer run, the patient role is disempowering in other ways. Patients *'*get narrow and selfish*'* they are *'*too scared to recover*'* and become *'*a slave to their diagnosis.*'* She summarised her position like this: *'*Everyone has to make an effort to be normal. But they [long term patients] learn they don't have to, they learn not to make that effort.*'*

These problems, in her view, are maintained in part by the psychological needs of staff members. She suggested to me that the way care is delivered reflects *'*staff neediness,*'* even if it is only patient personality flaws that are discussed in team meetings and medical documentation. For Polly, the personal interests of the clinician may flatly contradict the genuine interests of patients: *'*Tea and sympathy can keep a person like that, much easier to manage, makes you [clinician] feel good about yourself…but I'd prefer to have a moving target.*'* The suggestion here is that a 'moving target,' meaning an agential patient, is not just harder work, but it is less rewarding to staff members. Polly suggested that the psychological issues of staff are excised from the official account, but play a leading role in care delivery. If staff were less needy, things might look different.

Other clinical informants made similar remarks. When I asked Iqbal, a CPN, about his work, he said that of the patients on the team caseload:

> Many aren't really mentally ill, they don't really have mental illness [he makes an 'inverted commas' gesture with his hands as he says this]. If people want to invest, if they want to sort themselves out, they can use the complex needs service. But there are risks to support, of making people dependent, of opening a can of worms, that can be more than I can manage to deal with. People want to adopt a sick role, and they get institutionalized.

Devon, a social worker, makes a similar point: 'People want to be looked after, it can be for various reasons…a lot of people with strong personality traits buy into that, into the medical model, so they're not to blame.' Delivering care to this kind of person is, according to Devon, a waste of their time and expertise.

According to these informants, something about the way care is delivered makes it unsuitable for some, perhaps many, patients. The adverse effects of care are described in such a way as to be a form of patient disempowerment. There seems to be a connection bureaucratization here. Routinized practices are stretched by complex patients because clinicians are accountable for the care they give patients. The skills and knowledge of staff members do not seem suited to tasks of either dealing with complex patients or of promoting empowerment. At least according to Polly, the patient role is disempowering, and even corrupting.

5.8 Responsibility without Blame?

What is it about mental healthcare that makes it potential harmful? One way to approach this issue is through a series of publications by Pickard and Pickard and Pierce that find a link between mental disorders and moral shortcomings (Pickard 2013; Pearce and Pickard 2009, Pearce and Pickard 2010, Pearce and Pickard 2013). They argue that this link is seen most

clearly in the case of personality disorders because many of the attributes and behaviours that make up the diagnostic category of personality disorder are clearly moral qualities.

Part of what it means to have such a disorder, they suggest, is that a person behaves badly. For example, patients with personality disorders are frequently aggressive and manipulative. These behaviours are part of the disorder. An improvement in the disorder is likely to mean an improvement more generally in the moral content of a person's behaviour. For Pierce and Pickard, treatment for personality disorders is, in a sense, a moral education. Like other moral journeys, it requires effort. They argue that agency, and 'willpower' are therapeutic assets for mental illnesses and for personality disorders.

Recognizing a moral dimension to clinical care has complex therapeutic consequences. As a part of treatment, patients need to attend to the consequences of their actions. They need to see themselves from an externalised perspective. Improved self-governance may be required. Yet how can a person be confronted with a picture of themselves as being harmful to others, as lacking basic self-regulations skills or, even, largely being a destructive force without being paralysed by guilt? The solution lies in a key distinction:

> Clinicians must hold service users [patients] responsible and accountable for behaviour if they are to improve and recover. But blame, on the other hand, is highly detrimental. Blaming service users may trigger feelings of rejection, anger and self-blame, which bring a heightened risk of disengagement from treatment, distrust and breach of the therapeutic alliance, relapse, and, with service users with personality disorder, even self-harm or attempts at suicide. (Pickard 2013: 3)

Pickard and Pierce find it therapeutically important to differentiate responsibility and blame, such that in a therapeutic setting, a clinician avoids actually blaming a person, whilst conveying a sense of responsibility. In this thesis I do not take a view as to what is and is not therapeutically helpful. Neither do I want to dip into the deep conceptual waters around

responsibility and blame. However, their argument that mental healthcare can be understood to have moral content clarifies some issues that relates quite directly to my thesis.

In the previous chapter I described how medical writing uses simple, de-contextualizing and de-ethicizing categories. Staff members told me that it is unprofessional to use judgmental language. Cathie is critical of Don's psychiatrist for precisely this reason. Her alternative take on Don's distress is expressed in a much more ethically-charged language. She believes that Don's character and conduct contribute to his distress. The argument of this thesis is that de-ethicizing categories are favoured by bureaucracies. Don's psychiatrist prefers a different vocabulary because he works in an accountable bureaucracy. Routinized decision making is possible for simple, reified disorders, with measurable symptoms but rather less so where the patient as a moral subject is being considered. Making 'value-judgments' feels contrary to the ethos of mental healthcare professionals. Limiting the moral content of care makes it easier to fulfil bureaucratic goals of accountability.

Pickard and Pierce's work suggests reasons why de-ethicized or morally neutral 'non-judgemental' terms and phrases can be a barrier to empowerment. A part of Pierce and Pickard's therapeutic strategy is to create a sense of responsibility without the unhelpful creation of blame. Clinical language that de-ethicizes distress makes it more difficult to promote both blame and responsibility. In the ethnography below are many examples of cases where clinical concepts suggest the disorder alone is responsible for distress. When distress is described in a non-evaluative way, it becomes more difficult to frame goals that pertain to personal responsibility. If creating a sense of responsibility is a part of patient empowerment, then my ethnographic data suggest reasons why clinicians might find it hard to promote empowerment whilst also being professional.

5.9 Discussion

Where does this leave the promotion of patient empowerment in an accountable bureaucracy? In routinized care, simplification is critical. The expertise and ethos of mental healthcare professionals seeks to exclude that which can't be simplified. This is why patients deemed to be complex or have PD are a problem to Oxford Health as an institution. Complex patients are patients with 'personality.' The concept of 'personality' brings a patient's values, habits, ethics and goals into the clinical arena. Irreducibly complex qualities become relevant to care. The concept of PD seem to be a response to situations where a patient's character and ethics cannot be easily ignored.

Services are rigid, and targeted towards mental illness. The professional expertise of staff members enables decision making about people with mental illnesses. Staff are left unsure of what to do with complex patients. Recognising clinically relevant associations between a patient's character and ethics, and their mental health, threatens care delivery. Patients with PD are empowered, but this is, at least from staff perspectives, the wrong sort of empowerment. Nonetheless, staff become accountable for complex patients. This gives them a kind of leverage. Viv, and perhaps others too, appeared to follow what Mol calls the logic and choice and seek the best possible care from Oxford Health. This led to clinical decisions that, although defensible, were probably a diversion from the real opinion of the clinicians involved.

Staff are very conscious of the potential for services to harm complex patients. The kinds of harm they envisage are revealing. Staff members fear that services can reduce a patient's independence, that their existing self-management skills are undermined. Patient can be

institutionalised, even when living outside of institutions. They become tentative and overcautious where they might need confidence and willpower to get better. The work of Pickard and Pierce suggests reasons why standard clinical care might tend to be disempowering. Empowerment is linked to the notion of responsibility. Severing that connection protects patient from blame, but also potentially transformative responsibility. A consequence of thinking of patient dependency as arising in complex patients but not normal patients is that services themselves are not responsible. This recalls Polly's claim that staff needs are an important contributor to services. One possible role of the concept of complexity is to shield clinicians from responsibility and blame.

It is important to note that the concept of personality used by the clinicians I observed is entirely negative. In the section on the history of the clinical concept I noted that it was developed to account for abnormal distress and disability, and was not tied to a conception of human flourishing. These antecedents are relevant in the clinic today. When staff members see personality as clinically important, it is either a disorder in its own right, or as a factor making treatment of mental illness more difficult. Personality is always a force for harm. There is no corresponding positive personality. The sorts of values, beliefs, commitments, habits and preferences that can be constitutive of personality disorder and so be harmful are not matched by a corresponding set of positive, helpful, protective qualities. Staff do not systematically note traits that contribute to robustness, or promote good mental health, and there are no clinically recognized clusters of protective traits.

CHAPTER SIX: AN ACCOUNTABLE BUREAUCRACY IN ACTION

6.1 Introduction

In this chapter I describe the professional disposition and habits of a consultant psychiatrist called Olivia. My aim is to portray how Olivia reconciles the competing demands of accountability and empowerment. The ethnography includes conversations between Olivia and her patients. I describe the decisions she takes and the methods she uses to justify those decisions. I include comments that Olivia made to me before and after appointments and some details of her own intellectual trajectory. The ethnographic material ends with a more extended encounter between Olivia and a patient called Julie, who is diagnosed with Bipolar Disorder. In the chapter I review the ethnographic material in the light of literature to consider how, despite international linkages, this bureaucracy is nonetheless very local. I consider the nature of Olivia's conceptual repertoire and how semantic flexibility assists in the task of treatment justification. Finally, I discuss the effects of bureaucratization on clinical relationships.

In describing her work, I will try to show that Olivia's practice is consistent with the promotion of thinner understandings of patient empowerment. In fact, Olivia actively promotes a model of patient empowerment based on self-monitoring, self-quantification, and decision-making based on the comparison of risks and benefits oriented towards the control of symptoms. Some of the potential constituents of thicker conceptions of empowerment do not form part of the clinical exchanges I observed, and I will try to highlight these absences. I try to think about how these practices might and might not contribute to the promotion of patient empowerment.

My argument is that the pressure to be accountable puts clinical relationships under stress. There is very little reciprocity in the relationships I observed. The flow of information is more or less one way. Olivia needs to extract standardised data, and give standardised advice. She asks very personal questions, but must do so in a uniform, generic way. I will suggest that Olivia's clinical relationships represents a 'routinized intimacy.' To fulfil her role, she has to create relationships that have features that, in other circumstances, might appear to be the antithesis of open, trusting, intimate relationships. Qualities associated with richer conceptions of patient empowerment do not survive this degree of routinization. However, my data suggest that routinized intimacy has a certain appeal to both clinician and patient. Furthermore, Olivia, and that she has a number of strategies to deal with the particular problems they throw up.

6.2 The Clinic

Olivia's clinic takes place in small room located at the top of a steep but rather grand staircase. On a desk is a computer, and, usually, a British National Formulary. This is a reference work on pharmaceuticals produced annually by the Royal Pharmaceutical Society. It is a widely used text, found in all the clinics I have observed. Its main role is as a comprehensive and up to date guide on drug doses and interactions. The copy here is well-thumbed and rather worn. Olivia uses it frequently, both during appointments and outside of them, when she is thinking about changing a patient's medications. Although it is central to debates in the literature about mental healthcare, there is no DSM in the room.

Appointments with Olivia are quite frequently interrupted. Olivia's colleagues knock, and then, with apologies, enter the room to pass on written messages or printed documentation, or ask questions in hushed voices. The room can get stuffy, and when the windows are open I can clearly hear other patients discussing their problems in appointments going on in the adjoining rooms.

Olivia is a short woman, with a brisk, good-humoured manner. She sits at the desk in front of a computer and turns to her right to speak to her patients. The computer is used to access RiO and, sometimes, websites. It is possible to angle the computer screen so that patients can see the display, or turn it away to shield it from them. The equipment is quite delicate, however, and too much turning of the screen can lead to a loss of signal. When contact to the electronic notes is broken in this way, the appointment effectively stops. Regaining contact can take several frustrating minutes. For this reason, it is often easier for patients to move than it is to risk turning the screen around. Appointments are frequently punctuated by Olivia suggesting a patient move his or her chair around so that the screen is visible, and then move it back, so that the screen is invisible, ready for note-taking. This awkward choreography is suggestive of a reversal of the expected relationship between care and the recording or care. It is as if the task of representing clinical work has priority over the work itself, the cart of bureaucracy somehow pulling the horse of clinical care. Other objects on the desk might include a voice recorder that Olivia uses after appointments to record patient letters (to be later typed up by her PA) and the personal alarm that protocols insist she carries with her when patients are present.

One morning a patient failed to arrive for her appointment, and I used the opportunity to ask Olivia about the origins of her interest in psychiatry. She said an uncle had been a notable psychoanalyst with a personal connection to Jung. This inspired early interest. As a medical student she had been ‘captivated by psychosis and psychotic people.’ She was ‘fascinated by the meaning of people’s delusions and hallucinations,’ and ‘the question of what it is that makes people who experience psychosis different from other people.’ It was this curiosity that drove her interest in psychiatry. She started working under a senior research clinician who she described as ‘highly charismatic.’ He was very much a scientist, interested in bringing the results of laboratory work into the clinic. His influence was critical. She said ‘all at once I had a light-switch moment. I realised it is all the

brain.' To me it sounded like a conversion experience. Although initiated by a charismatic individual, the conversion was to Science.

Once converted to a more biological take on psychiatry, Olivia sought an explanation for psychosis in the brain, not in interpersonal dynamics, personality structure, trauma or an individual's search for meaning. People who experience psychosis do so because their brains aren't working properly. Mental illnesses, she thinks, are brain diseases. It followed from this that she doesn't need to understand the patient very well to make decisions on how to treat the illness. Instead, the goal is to proceed according to scientific norms, to investigate the causes and treatment of brain disorder. Olivia presents it as being a bit of a relief to be free of the burden of the more theoretically elaborated psychodynamic or psychoanalytic perspectives. The biological approach seems, to Olivia, to require less intellectual defence, to arise out of a kind of default empiricism that is self-evident. It is part of her common sense.

Olivia explained that she seeks to base her research and care on down-to-earth, no-nonsense information. She said she looks for clear empirical evidence that any competent trained colleague might be expected to perceive. She rejects the intangible or the impressionistic that forms the basis of the disciplinary approaches she has left behind. 'I want to think only in terms of what I can observe' she said. 'A good psychiatrist sticks to what they can observe.' To do this, she says that she tries to structure her interaction with patents, for example by using the structured checklists produced by the DSM and NICE.

Olivia went on to describe working according to the evidence-based paradigm. It 'really helps' when it comes to writing notes and GP letters. This is because 'notes based on feelings are not useful, because we couldn't really know what the clinician meant.' She stressed that 'decent

notes' economically outline decisions with a rationale that is based on observations that others are likely to understand and agree with. As she talked, she seemed to shift to and fro between talking about clinical virtues and talking about bureaucratic benefits.

6.3 Persons and Symptoms

Routine appointments begin with Olivia bringing the patient to her consulting room, asking them to sit and closing the door. She starts off with a general enquiry. 'How are you?' or 'How have you been?' or sometimes 'How has your mood been over the last couple of weeks?' Olivia's patients tend to answer using biological language and making the sort of associations Olivia herself makes. For example: 'I'm fine, you know, a bit up and down, a bit of instability, but nothing major. No cause for alarm.' Or: 'my mood has been a bit low, I've not been eating well, my sleep has been bad. I can't concentrate.' Sometimes they even use biomedical terms attached to simple, matter-of-fact descriptions: 'I've been a bit hypomanic, sleeping less, feeling full of life and energy.' Or even: 'I'm euthymic now, back up after several weeks of low mood.' On occasion a patient might provide details that could be more or less written straight into their progress notes: 'I've been sleeping just three or four hours a night, and I have become snappy and short-tempered with my kids,' or 'I have felt so heavy and low, I'm sleeping and eating all of the time, I've gained five kg already.'

Olivia frequently jokes with patients about things she 'simply doesn't know,' or 'might have forgotten from her training,' or might need to 'think hard about' to understand. It is a way of softening the impact of asking distressed patients repeated, standardised, direct questions about intimate and painful experiences. She will often apologise for this directly: 'I know I keep on asking you the same questions' and: 'I know I asked you before, but you know I have to ask this.'

Sometimes, she will draw attention to her own loss of sovereignty. She explains that it is because of 'rules and regulations' or 'the powers that be' that she has to ask these indelicate questions.

In a paper on the notion of the 'patient perspective' in mental healthcare in France, Velpry notes that 'patients do not spontaneously create a 'view.' Rather the patient's view is something that has to be produced jointly with the participation of the staff ' (Velpry 2008: 243). She notes that the production of a view can be seen by mental healthcare professionals as a clinical goal. This seems to be the case here. Olivia and her patients coproduce meaning. She nods and smiles encouragingly when patients use clinical terms. There is a pedagogical element to her clinical style. She seeks to teach patients how to self-manage their health. Teaching patients to use clinical language can be part of this process. She introduces words like 'depression,' 'mood episode' and 'mood instability' when she talks to patients about their distress. My impression is that she regards it as desirable for patients to think of themselves in these terms, as a means to improved self-understanding and, therefore, as a better foundation for self-management.

Olivia uses the term 'mood' in complex ways. Martin warns that 'manic depression does not sit easily with our everyday understandings of emotion' (Martin 2007:49). In Olivia's clinic, it is the notion of 'mood' that departs from everyday usage. Mood tends to have valence. It is up or down, high or low, positive or negative. It also has quantity and is measurable. Sometimes low mood and high mood are thought of as independent variables, each of which may be scored high or low. An excess of high mood is mania, an excess of low mood is depression. In this sense, it is possible to simultaneously experience low mood and high mood, in a 'mixed state.' At other times they are combined into an overall mood which may be expressed as a single quantity. A desirable level of overall mood is moderate and steady, neither very positive nor very negative. This can be expressed as an absence of high mood and low mood, or just moderate levels of overall mood.

At times mood is abstracted from direct experience, a kind of umbrella term for a range of features of a person's subjective experience combined and expressed as a quantity. Optimism, hope, joy, vigour, pleasure, a sense of meaning or connectedness, contentedness, a sense of making progress, happiness, a sense of the world as beautiful, rewarding relationships, the satisfactions of achievements, engagement in fascinating activities or a sense of peace or fulfilment might all be aspects of positive mood in this abstract sense. Added to these are more 'objective' and unambiguously measurable phenomena like sleep and weight. This more general or umbrella sense of mood is sometimes glossed by staff members as 'wellbeing.' At other times mood is more experience-near, a felt experience, that may still be expressed in terms of quantity. In this case, mood is more like physical sensations of pleasure. 'Mood instability' is seen as a related problem, raised by patients at least as often as troublesome high or low mood. Mood instability is also spoken of in terms of quantities. In all these senses, mood is separable from the person.

For Olivia, the meanings a person might attach to their experiences are a kind of distraction, even a smokescreen: 'It is important not to get too caught up in a patient's story,' she says. Ultimately, a patient's beliefs, however compelling, are only relevant as markers of symptom and severity. Personal idiosyncrasy threatens to conceal from the clinician what is occurring in the brain. Patterns might be concealed underneath the surface narrative. For example, for patients diagnosed with Bipolar Disorder, Olivia looks for fluctuations in mood that, in their upward and downward cycles, resemble a sine wave. She explained that patterns like this indicate biological origins. A disjunction between the person and the disorder is indicated by a mathematically elegant pattern, suggestive of a lack of connection to environmental stressors that might be expected to be less patterned.

In conversation between appointments, Olivia talks about the distinction between 'normal sadness' and 'depression.' One way of making the distinction was to consider the degree and duration of the sadness. Normal sadness should be 'proportionate' to the cause and should recede after an 'appropriate' length of time. A depressive illness either has no external cause, or vastly outweighs the ostensible reason, and it may linger for months, or even years. In addition, with clinical depression, the 'breadth of symptoms' is expected to be much wider. For example, a clinically depressed person might be expected to have problems not just with feeling sad, but with reduced appetite, poor sleep or impaired concentration.

There are also what Olivia calls 'very biological features' of clinical depression. She said that these include being most depressed on waking, finding one's mood lifting during the day, and moving and thinking more slowly than usual, which she calls 'psychomotor retardation.' If Olivia observes psychomotor retardation in a patient, for example, plus other biological features of depression, she might begin to suspect a depressive illness rather than 'normal sadness.' In a similar way, she believes that 'there are some things that normal people don't experience…and these things are due to the brain.' She explained that these experiences include psychotic experiences and mixed states of mania and depression.

This may seem to suggest that there is a clear distinction between ordinary and pathological states, between everyday sadness and clinical depression, for example. However, Olivia sees a more cautious and nuanced picture. She feels that 'there is a big overlap' between these two, as well as some important differences. For her, one of the difficult parts of doing her job, (and one of the reasons why it is important to be systematic and to restrict oneself as a clinician to structured observations of visible phenomena) is to tell them apart. A surprising amount of time in appointments is occupied by Olivia reassuring patients diagnosed with a mood disorder that their mood was 'normal,' or 'healthy,' or 'completely natural.' For example, a new mother tearfully

described to Olivia that she felt ‘tired and emotionally overwrought.’ What made this worse was that she feared she might be entering a phase of illness. As she put it: ‘I can’t become ill again, not now, not now I have a baby to look after.’ Olivia reassures the patient: ‘Don’t worry. These feelings are totally normal. I can tell you this as a mother. I know these are really difficult times. It is fine, its normal. You’ll get through it.’ By explicitly discussing with her patients the distinction between normal feelings and pathological feelings, Olivia lays down some of the foundations for self-management.

6.4 Treatment Justification, Self-Management and Empowerment

Fears about ‘getting ill again’ are a common subject of concern amongst Olivia’s patients. Because they understand themselves to have a biological vulnerability, patients can become very alarmed by quite small scale instances of distress. As a patient informant diagnosed with Depression wryly told me ‘the most depressing thing in my life is knowing that I have clinical Depression. However good I feel, I know the next episode is just round the corner.’

As she talks to her patients, Olivia looks for concrete recordable details that express quantities of mood, and how these relate to external factors. If the external ‘stressors’ are on the same scale as the experiences, then the mood state is not pathological. However, ‘stressors’ might also be relatively small in scale and still ‘trigger’ the symptoms of the illness. Many of Olivia’s questions are about scale and magnitude. They also prompt the patient to consider themselves from an external perspective. ‘You say that you were happy, but were you too happy?’ ‘For how long did you feel speeded up, or energised?’ ‘Did you sleep less?’ ‘Did you find you were talking or thinking more quickly?’ ‘Did other people remark on this?’ ‘Were they worried about you?’ These final questions are significant. Olivia doesn’t just ask about how the patient felt. She asks her patient what it looked like externally and how other people reacted.

Olivia also seeks to get a sense of scale for environmental stressors: ‘Have you been under pressure at work?’ ‘Are things ok at home?’ A sense of scale comes from measuring moods and actions according to what Olivia takes to be societal norms, but adjusted (‘personalised’ or ‘tailored’) to the individual patient. This is where it is important, says Olivia, to ‘really get to know the patient.’ Personalization is associated with the goals of promoting patient empowerment. In this case, it just refers to a clinician learning to interpret a patient’s behaviour and remarks to correctly. For example, some people are more likely to make impulse purchases than others. For one person a pair of new shoes might be a clear sign of mania, for another, a new car may indicate nothing of concern. Oliva explained how she tries to be sensitive to the individual patient by knowing whether the purchase of a new pair of shoes is clinically important or not. This constitutes an important aspect of clinical skills.

On other occasions, I watched Olivia as she encouraged her patients to be attentive to their mood in the same way that she is. She wanted them to assess whether a slight increase in low mood, high mood, or mood instability indicates that a more serious mood episode is coming. There may be various ‘prodromes’ for mood episodes, which are individual to the patient. One person may notice they smoke before breakfast only in advance of mania. Smoking may, for that patient, be described as part of their ‘warning signs’ or ‘relapse signature’ for mania. A patient informant told me that he begin to listen to Leonard Cohen songs only when his ‘mood drops.’ Listening to Leonard Cohen then gains significance as one of this patient’s ‘warning signs’ for depression. Olivia’s role is to try to prevent the symptoms developing and to ‘educate’ her patients to be attentive to the signs.

A lot of time in Olivia’s appointments is spent talking about ‘lifestyle.’ Patients want advice about plans and opportunities. When Olivia talks about this, it has the same form of deliberation

as weighing evidence from trials. Patients have innate vulnerabilities, which are independent of them, and might cause excesses of mood, anxiety or psychosis to intrude into their lives. To guard against this, Olivia asks patients to increase 'protective factors' and decrease 'risk factors.' Protective factors include exercise, having a structured day and eating well. Risky or negative factors include excessive drinking, late nights, drug-taking and exposing oneself to large pressures at work. These factors are spoken of as commensurable variables, to be weighed against each other. One psychiatrist said to me: 'we confidently tell our patients not to drink too much. There's no science behind the advice we give, none at all. It seems to be common sense and it seems to work. That's what our patients tell us, and we have to honour our patients' experiences.' The style of deliberation resembles that of EBM. It feels reasonable to clinicians and may be recorded economically. But the content of the reasoning is not itself justified by trials.

Lifestyle advice conforming to this model of deliberation has a distinctive ring of confidence about it. One patient with a history of heavy drinking reports that she is under a lot of stress at work. Olivia tells her this means it is 'particularly important to keep drinking under control.' Olivia asks her how much is she drinking at the moment. She replies: 'I'm being really careful. It might be a bit obsessive, but I mark the bottle to limit how much wine I have. I am drinking a bottle of wine every three days.' She glances up at Olivia who offers an approving smile: 'That is very sensible, it is tough, but it is a really good idea, as you know, to keep all that under control.' Another patent, a student, is anxious about forthcoming exams. Olivia recommends regular hours, for waking and sleeping, for work, setting aside some time for fun or relaxation, and allowing time for 'winding-down' before sleep. Similarly, she asks if that the student is 'eating properly' and she suggests that exercise is a good way to relieve stress. This patient says she enjoys swimming, so Olivia says: 'why not schedule your week so that you go swimming twice. Would that be too much? You could

do more or less, or course, it is up to you. But a swim after the lab might be just the thing.' She goes on 'You need to be extra careful. You have bipolar, so you're extra vulnerable.'

Olivia's lifestyle advice includes aspects of patient empowerment. She wants her patients to be on the lookout for the onset of symptoms, and to act when they emerge. Scrutinizing oneself from an external perspective, being responsible for responding to warning signs, making plans and following them through are all mentioned in discussions of patient empowerment. There are limitations, however. The patient as self-manager just takes on the same role as the psychiatrist. He or she adopts the same set of categories and goals. This is a fixed, pre-ordained universe of self-regulation.

Olivia's clinical style enables her to produce a robust audit trail. But much of what empowerment might mean, such as personal change, second-order preferences, or health-related character traits are not included in the process. The personal qualities of hope, persistence and fortitude that, in the vignette that opened chapter one, were said to predict better health, are not dealt with in appointments. No character traits, values or ethical commitments are included. Patients are not encouraged to see distress as arising from their values. Olivia does not suggest that her patients work on their character, only that they make judgments of risk. There are also limits to the open communication and equal relationships that are held to be constitutive of efforts to the promote patient empowerment. Olivia only talks of mental disorders and symptoms. Sometimes people diagnosed with mental disorders understand their distress as being part of personal transformation, indicating a spiritual crisis or arising out of commonplace social and economic pressures. None of these alternative interpretations are taken seriously by Olivia. She does encourage her patients to be agential, but it is according to a thinner conception of empowerment.

6.5 Symptoms and Treatments

If Olivia finds the scale of the symptoms to be high enough, she will think about changing the treatment. In her deliberation about medication, Olivia is open in her reasoning. She explains to the patient what the 'science' and 'evidence' indicates. There is never any doubt that the role of mental healthcare is to use medication to reduce symptoms, or that medication is effective in this task. Olivia is able to offer the reassurance that comes with clarity and certainty: 'we know that lithium is effective against bipolar depression,' 'there is clear evidence that Quetiapine is helpful where people have mood instability.' Olivia's task is to match symptom and treatment, such that the treatment is proportionate to the symptom.

Whether a particular medicine will work for a particular person, and what the scale of the side-effects will be, however, is discovered more or less by trial and error. Olivia gives precise and unambiguous expressions of likelihoods, through numerical estimates such as 'we know that 2/3rds of patients with depression, like you, get better because of this medicine' or 'side-effects can be a problem. You may experience weight gain. But most people do not. Only 1 in 3 people who take this drug experience weight gain.' Olivia tries to elicit information about the scale of side effects so that they can be weighed against the benefits of treatment. 'How much weight have you gained?' 'What was your weight before? And now?' or 'Is the nausea bad?' In some cases, the side effects are judged to be clearly greater than the benefits. At other times the balance is less clear, and Olivia and her patient will spend time weighing up the costs and benefits. I never observed cases where incommensurability was felt to make this process impossible. Even if digestive problems were being weighed against a sense that life is meaningless, or moments of harmony and connection calibrated against poor concentration, the facts that need to be considered all seem to exist in comparable quantities.

Knowing the evidence demonstrates her expertise and authority, but reporting on it as independently existing facts makes Olivia a conduit for information, not the source of that information. If there is bad news, she is not responsible. Sometimes the evidence is like a third person in the room; the bad cop to Olivia's sympathetic and conciliatory good cop. At times she is breaking bad news, sharing in the patient's distress as they hear that they have a mental illness: 'I'm sorry John, but this is a well-researched topic, and we know that x.' She's just letting her patients know, helping them interpret and understand. Talking in this way suggests that Olivia is still on her patient's side. So when Olivia advises a patient to take medication, it is not her that is seeming so pedantic or annoying, but Science.

I observed a similar dynamic when observing the clinic of another psychiatrist. He was speaking with a slightly irritable patient who appeared psychotic. The patient became agitated when medication was suggested. The psychiatrist said: 'You've told me that you've started to hear voices in your head. I'm sorry, but that is a form of psychosis. It is an illness.' The patient looked testy. The psychiatrist went on: 'we know that the best thing to do with psychosis is to treat it quickly. Evidence shows that treating symptoms like voices with Olanzapine is helpful for the majority of patients.' The patient appeared unconvinced, but the tension reduced. It no longer seemed like a stand-off between doctor and patient. The psychiatrist went on: 'Sometimes it doesn't work. If that is the case, we can try another. But there is clear evidence that untreated psychosis tends to get worse. If we treat it now, we can stop it.' It was the 'clear evidence' that might persuade the patient. Rhetorically, the psychiatrist was able present the facts, rather than impose his will.

Like many psychiatrists, Olivia stressed to me that her patients want to get rid of their symptoms. 'They just want to get back to their lives' she said. This presumption of a certain variety of rationality can be fiercely defended. Staff members sometimes understand questions

about whether a particular patient might like aspects of being ill as a kind of attack on the patient. In a discussion with a psychiatrist about this, he told me: 'I will always defend my patients against the claim that they are just morally weak. That is stigma.'

There is an exception, however, widely recognized by healthcare professionals. Olivia explained to me that many patients enjoy being slightly manic. 'It can be a lot of fun,' she says, 'and some patients get a taste for it.' This is a widely remarked upon idea I heard throughout my fieldwork. It is discussed by staff and patients alike. Sometimes members of staff talk about this as if it is slightly counterintuitive; something that in some sense shouldn't happen, yet we know it does. On the other hand, some patients stress that they don't enjoy their mania at all, as if this is indicative of virtue. According to this view, it is bad patients who turn into 'mood junkies.'

6.6 Evidence-Based Psychiatry in Action

To tie together the threads of this chapter, I give a more extended description of a single clinical encounter. Many of the themes discussed above are present. Olivia gauges the scale of symptoms and risk of future symptoms. She gives advice and promotes a style of deliberation in her patient that she herself uses to produce accountable decisions. Her clinical style enables rapid and highly standardized documentation. She deploys a range of ploys and gambits to soften the repetitive, intimate and one-sided questions she asks her patient. She promotes a narrow version of empowerment.

During the encounter I made brief field notes. These covered the gist of what was said, and recorded particular words and phrases. The notes were then written up a few minutes after the end of the appointment. As a result, the text below is not a verbatim account of the exchange, but it is close to one. I have tried to capture the content and tone faithfully. There are, however,

likely to be errors and omissions and I am aware that the text looks rather smoother than the vignette of Claire the occupational therapist at the beginning of chapter three.

Olivia had an appointment with Julie. Julie works as a flute teacher for a number of local schools. She is in her early thirties. She was diagnosed with Bipolar Disorder about five years ago. She is a socially confident, attractive woman, from a similar social background to Olivia. They seem genuinely pleased to see each other. They talk almost as friends. Or, perhaps, Olivia is more of a well-liked and respected but slightly stern aunt, with whom Julie likes to run through her ideas and plans.

'How are you Julie' asks Olivia 'How are things?'

Julie sits back in her chair with a smile replies:

'Things are fine, really, not too bad at all. I'm doing quite a lot of work, I wonder sometimes if I have taken on too much, working at three new schools, but I'm enjoying it.'

Olivia glances up from the computer keyboard: 'You know what I'm going to ask. Is is affecting your mood?'

'Not really' Julie replies, 'I've noticed I've been slightly jittery some mornings, just a bit accelerated, a bit jumpy. But I know the drill. I'm sticking to regular habits, not letting things get out of control. You know, I'm making sure I do things to relax, all of that. Well, I'm trying to. You see, well, the thing is I've met someone, a new man.'

'A new man?'

'Yes. Well, I say new, but it really is someone I've known for years, really, we knew each other from when we were kids. Our parents know each other.'

'Are your parents happy? Are you happy?'

Julie beams: 'I am. It is early days, but it's really exciting. I like him.'

'That sounds good. To me you look happy.'

‘It is hard maybe to tell between actual happiness and mania, I know I find it difficult to tell them apart, but, you know, I think this is just real happiness.’

Olivia laughs. ‘I think so too. It is something I puzzle over as well. How to tell them apart. But you seem fine to me. I think you’re ok.’ Olivia pauses to type into Julie’s electronic notes. Julie glances round, smiles at me, then pokes around in her bag for a few seconds.

Olivia looks up and smiles at Julie. She asks: ‘You’re having psychological therapy, aren’t you, with Christine. How is that going? Is it any help?’

‘It is helpful. We’re coming to the end of it now. It has helped me to learn about my stuff, that, I, how I tend to think quite visually, and how that might be quite, you know, might be a, well, Christine said that some people tend to think in visual images and others don’t so much, and that I do tend to do that’.

Olivia frowns, but with a smile: ‘I’m just thinking, I wonder if I do, or not.’

Julie goes on: ‘So, for example, I love going out, and I, for example, when I was getting ready, I would visualise myself as the life and soul. I’m looking fabulous, I’m at the centre of everything, everyone’s eyes are on me, I’m making it all happen. It’s exciting. But I need to be careful. Things like that, they can make you less stable.’

After some discussion, the conversation moved on to a new topic.

Julie said: ‘But I’ve got plans for the summer. I’m thinking of going travelling in Eastern Europe. It’s partially a work thing. There’s a chamber orchestra workshop I want to attend. That lasts a week, in mid-July. It’s Belgrade. But then I thought I would spend the rest of the summer, all of August, basically, touring round the Balkans. Serbia and Croatia. I’ve got a friend whose family owns a place in Montenegro, really beautiful, completely off the beaten track. He, Jack, my man, he, could come and join me there.’

‘That sounds fun. You know what I have to say now, though, don’t you?’

‘I do. I do. Risks and benefits. It is true that I’m a bit more choppy than usual at the moment. While away there will be lots of excitement and lots of opportunities.’

‘It’s true, Julie, and if, heaven forbid, things did go wrong, it would be much harder to get help.’

Julie is serious now: ‘But I have learned how to reduce the risks - I really have. I am careful with bed-times and drinking and taking my meds.’

Olivia prescribes some prn Olanzapine, which can be taken: ‘if your mood becomes unstable, or starts to go up.’ Julie agrees she will ‘make a real effort’ to avoid drinking and going out too much ‘whilst also having some fun.’ Olivia stresses that she is available on email for the duration of the trip. After some reassurance, followed by high-spirited reflections on the beauty of the Balkans, and the pleasures of eating local food whilst lazing on sunny beaches, the appointment drew to a close.

As Olivia and Julie start to discuss the balancing of risks and benefits I am struck how fluent Julie is in what we might call evidence-based decision-making. In thinking about whether or not Julie’s holiday plans are a good idea or not, both Olivia and Julie weigh up, in a rough and ready sort of way, quantifiable commensurable factors. We have seen how, in appointments, excesses of mood, or mood instability, are treated by medication, and treatments may be adjusted if the side effects ‘outweigh’ the benefits. Now the benefits of an exciting holiday enter in to the same calculations.

They conclude that Julie is well enough and stable enough to go, but that certain safeguards need to be in place. Julie needs to be extra vigilant. Her responsibilities are increased by her diagnosis. It is because Olivia is satisfied that Julie monitors herself and can and will take appropriate steps if necessary that she takes the view that the trip is a good idea. Julie can be seen as empowered in the calculations of risk and benefit, of mood episodes versus the pleasures and rewards of travel.

In a paper on a Bipolar support group in the US, Weiner detects tensions in the notion of agency found in self-management (Weiner 2011). According to Weiner, in self-help and self-management

textbooks, a sharp distinction is made between the rational agential patient self and the external interposing illness. This seems to be required by the notion of self-management, which consists of a person observing and responding to the incursions of an illness. However, in a seeming paradox, the illness that the self-managing patient monitors is held to undermine both accurate self-monitoring and rational decision making. For example, a patient may decide they need to be hospitalized because they fear they are becoming suicidal. They are making a judgment about a forthcoming loss of judgment, making an autonomous decision about when to surrender their autonomy. So, for Weiner, self-management 'includes intuitions about when and to what extent to defer management' (ibid.: 476). Olivia seems to be prompting Julie to cultivate such sensibilities, especially when away on her trip. She wants Julie to be rational about losses of reason, to be a fair and accurate judge of losses of judgment.

After she had left, Olivia said that Julie had 'benefitted a lot' from diagnosis. The benefits seemed to have to do with how the notion of 'the disorder' externalises and renders visible some of Julie's actions. Olivia put it like this: 'For years she had been quite wild, really, quite out of control. She had periods of quite deep depression when she withdrew socially, stopped working, stopped eating. Then her mood would lift and she'd get really quite manic. She started partying, being really social, being impulsive. And she never really understood what was going on. She'd just go off on these massive adventures. So she was really relieved when I diagnosed her. I'll always remember it. I said I'm sorry, but you've got Bipolar Disorder, that it will mean years, probably a lifetime of medication, and she sad to me "thank goodness. That was what has been going on. I thought for all these years I was just a cunt. But I'm not. I've got Bipolar".'

I found it difficult to know what to make of this lifestyle advice. Stressing a person's vulnerability might be read as empowering and as disempowering. During fieldwork I met patients who seemed trapped by a sense of being at risk, and who interpreted much of their lives in terms of exposure to

danger. But for others a sense of vulnerability seemed to promote self-reflection and prudence. I was also unsure about the utility of the advice Olivia gave. Although I was never able to follow this up in a comprehensive way, on occasions when I did investigate, I found that patients frequently fail to act on the advice Olivia gave. I noticed that Olivia did not ask patients whether they had followed her previous advice and often made no reference to the advice in notes.

Overall, this model of deliberation seemed rather optimistic, both about the scale of the benefits derived from lifestyle changes and from the epistemic barriers to self-monitoring. My suspicion is that it is very difficult to track the impact of lifestyle advice because the effects are likely to be small, and they combine with a great number of other factors that might be deemed causally relevant. When I spoke to patients they made the same point. If a person is feeling more irritable and less energetic, for example, is this due to something in his or her diet, or work pressures, or relationship problems, or social commitments, or grief following the loss of the loved one? Perhaps, instead, it is the novel the patient happens to be reading. The list of causal candidates seems endless and the scope for deliberation is unlimited. The model of reasoning proposed by Olivia resembles how EBM data is weighed up in appointments. It is simple and easy to record. But it appears slightly artificial, suggesting rather less complexity and ambiguity in the lives of patients, and rather large effects of the proposed lifestyle changes.

6.7 Hard Focus and Soft Focus in Clinical Classification

In chapter four I discussed how semantic flexibility helps clinicians deal with uncertainty, communicate between professions and deliver standardised care. In the ethnographic material above, semantic flexibility helps Olivia justify her care. Much of the terminology she uses seems to connote exactitude. Accuracy seems to set the tone. Care involves precise measurement, the calibration of symptoms, treatments, side effects, and even such nebulous notions as ‘wellbeing’

and ‘quality of life’ being expressed in numerical terms. Clinical terms are elastic enough to be used in a soft focus when talking with patients and then hard focus in describing decisions and documenting the delivery of care.

In chapter three, I reviewed some anthropological literature that dealt with the notions of targeting and specificity. Luhrmann argued that targeting and specificity are helpful in interaction between psychiatrists and insurance companies. Here, something similar can be observed. Prescribing antidepressants for a person with depression or medicines with antimanic properties for people who are manic is a decision that may be recorded quickly and seems entirely justifiable. Thinking of symptoms as quantities contributes to this process. To assess how depressed a patient is, Olivia adds up a range of features. This may be calibrated against level of treatment. If overall symptoms are thought of as increasing and decreasing, then treatments may be increased or decreased. Changing the level of treatment includes adjustments to doses of medicine, but can extend to admissions and discharges from hospital, or the inclusion of a care co-ordinator in a patient’s care. Quantification is central to justifications Olivia produces for her decisions.

Critiques of Biomedical psychiatry made from research clinicians that self-identify as representatives of ‘antipsychiatry', ‘postpsychiatry' or ‘critical psychiatry’ often attack the scientific validity or ontological status of the key terms of psychiatry. For example, in The Myth of the Chemical Cure, Moncrieff, an academic psychiatrist, argues against specificity and the idea that medicines target the symptoms of illnesses (Moncrieff 2008). She is sceptical about the existence of mental disorders as clinical entities, and feels that the notion of targeting misrepresents the action of pharmaceuticals on the brain. Instead, she argues that we should think of drugs having a range of effects, some of which may be useful in helping people deal with their distress. She calls this the ‘drug-centred model’ of care. Like many internal critics of biomedical psychiatry, Moncrieff attributes the current insistence on specificity to the material interests of pharmaceutical companies:

'the idea that drugs act directly on the biological basis of a disorder lends credibility and respectability' (ibid.: 156). For similar critiques, see (Bentall 2004; Bracken 2005; Double 2006; Healy 2004).

The argument I make here is rather different. I do not discount the influence of material interests. In chapter two I discussed links between audit culture and neoliberalism. For example I reviewed the work of Graeber, who sees a link between neoliberalism as a set of economic practices driven by material interests and the spread of bureaucratic processes. However, in this thesis I propose a different way of understanding the appeal of existing Biomedical psychiatry. Biomedical psychiatry may be routinized in a way that helps it to out-compete alternative philosophies of mental healthcare. Thinking in terms of mental disorders, symptoms, treatments and stressors, as Olivia does, enables the production of forms of justification that are reproducible, easily comprehensible, about which the clinician and institution can be transparent, and which appear unbiased, equable, rational and fair. In a bureaucratized world, Biomedical psychiatry is fitter than its competitors. In contrast, Moncrieff's proposed 'drug-centred model of care' would be bureaucratically disadvantageous. Care would be harder to justify according to current bureaucratic standards of accountability. It would be likely to reduce the focus of the clinician, and multiply possible observations and decisions.

During fieldwork I would sometimes ask clinicians about antipsychiatry, or rehearse arguments derived from it, such as problems regarding the ontological status of mental disorders. Many of my informants were quite dismissive. They regarded the work as irrelevant and impractical. At times I was surprised by the vehemence of their responses. My sense was that my informants were angry because antipsychiatry challenges not just current practice, or cherished habits, but the ethos of the mental healthcare professional. As I discussed in chapter one, Weber regarded the office to be an ethical domain. Clinicians are bound by norms and obligations that both

represent obligations to their patients and bind the community of clinicians together. Criticism of psychiatry that queries the ontological status of mental disorders threaten this. It is a moral as well as a conceptual or practical challenge.

Biomedicine also bureaucratically out-competes psychodynamic psychotherapy. This was brought home to me one day when I sat with a psychiatrist as he opened and read a letter from a psychotherapist. They had a patient in common, who, it appeared, was dangerously depressed. The psychiatrist looked up at me and said that he was just as concerned about the patient as the therapist was. But, with raised eyebrows, he pointed to the sheer length of the letter from the therapist, which extended over two pages and was comprised of prose, without tick-boxes and the like. It was much longer than the Biomedical documentation reviewed in the previous chapter. The psychiatrist read aloud sections from the letter, suggesting to me that the wording was 'woolly' and 'takes a lot of time to say something, but who knows what he's saying really.'

I did not read the letter, or discuss the case at length. However, during fieldwork I sought out interviews with psychotherapists who, amongst their clients, have patients who also receive mental healthcare from Oxford Health. My therapist informants often claimed that their understandings of distressed clients were more subtle and nuanced than that of their client's psychiatrist. I found it hard to disagree. The therapists tended to use a wider and more sophisticated set of key concepts and seemed to capture more of the uniqueness and complexity of each patient. This was presented to me as part of the appeal of psychotherapy, which, some said, made it preferable to psychiatry. However, I could also see the psychiatrist's point of view. The theoretical economy of Biomedicine enables far crisper and more efficient documentation. Therapists working in private practice are less burdened by accountability. They have a lesser degree of responsibility for their clients, and are under far less pressure to produce an account of

their care. For clinicians working in an accountable bureaucracy, the capacity of a philosophy of treatment to enable the production of documentation is vital.

Olivia's makes a virtue of attending to her patients in a focussed way. For her, professionalism consists of being calm and methodical, and excluding observations, impressions, facts or phenomena that do not contribute to treatment rationales. This focus might also be seen as a limitation. In chapter four I described how Cathie thinks of her husband Don. She believes that his psychiatrist misconstrues his problems because he fails to consider or even notice Don's character, values or ethics. Olivia uses the same vocabulary as Don's psychiatrist and has broadly the same clinical focus. She deliberately seeks to exclude the qualities that Cathie regards as being so important. Olivia does not consider Julie's character at all. Her ethics, values, sense of hope, confidence or courage are not considered to be clinically relevant. It is clear that, say, Cathie's belief that Don's tendency to arrogance and ruthless self-promotion that might result in his being unpopular is impressionistic, unmeasurable, hard to routinize and unlinked to treatment decisions about medications. It is clear how difficult it would be for Olivia to raise such issues with her patients. She might see herself as having good reasons to stick to her rather restricted conceptual repertoire.

Olivia's clinical expertise emerges as a barrier to the kind of thick descriptions favoured by Cathie. Incommensurability forms a barrier between thicker and thinner readings of the person. A question I return to at the end of the thesis is this: how useful are the thin, reproducible categories of Biomedical psychiatry to a person who wants to self-manage? Notions like 'mood' seem vague, heterogeneous and distant from felt experience. If self-knowledge is envisaged to be a part of the process of patient empowerment, how helpful are vague umbrella terms that are organized around clinician needs? Might this be a case where non-technical and non-specialist common sense is preferable to expert knowledge?

6.8 Locating Accountability

Olivia's clinical approach is both linked to global networks and exchanges and also highly local. Decisions in the clinic are justified by evidence that may be gathered in New Delhi, Beijing or Barcelona. Rosenberg makes a related point: 'Perhaps most fundamentally, the act of diagnosis links the individual to the social system; it is necessarily a spectacle as well as a bureaucratic event' (Rosenberg 2002: 255). Although ostensibly sealed off, the clinic is always tied to the outside world, and the doctor and patient are never the only interested parties. Likewise, in a paper about multiple personality disorder called Reality, Truth, Power: The Dialogue between Reason and Necessity, Littlewood remarks that the disorder 'Is simultaneously a psychophysiological state, an identity, a medical technology, a disease, a theory of the mind, an allegory of late capitalism and an expressive aesthetic. It is also a political drama' (Littlewood 2002: 188). Olivia's clinic is tied to other clinics, offices and labs. But the solutions Olivia finds to the challenges of making clinical relationships that are personal and yet routinized reflect local culture. This scientific and technological enterprise has, of necessity, a regional colour. In many respects, this is a local bureaucracy.

In 1990s Buenos Aires, Lakoff found an association between biological psychiatry and the recently deposed violent military dictatorship that coloured the 'local epistemic milieu' leading to a resistance to biological psychiatry (Lakoff 2005: 150). Ecks' recent monograph, Eating Drugs, describes the strategies employed by psychiatrists in Calcutta to forge relationships with patients (Ecks 2014). These psychiatrists face very little bureaucratic scrutiny or constraint. Of greater relevance to them is the need to secure sufficient work. There are a range of potential barriers to business. In Calcutta, psychiatrists face competition from other treatment modalities, primarily

homeopathy and Ayurveda. In addition, their patients tend to go 'doctor shopping' and see other psychiatrists.

In Ecks' ethnography, patients and potential patients are generally unsympathetic towards some of the ideas behind biological psychiatry. There is a local character to these concerns. Ecks explains how medications are seen in humoral terms, as substances that cause heating when ingested. The idea of humours has, globally, posed an obstacle to ideas like targeting and the notion that interventions treat the causes of a health problem. In the face of these obstacles to business, Calcuttan psychiatrists need a good 'headside manner' to find ways to make pharmaceuticals appetising. Ecks finds that they are ingenious in finding ways of speaking of medications in a way that is locally 'resonant.'

The local conditions described by Ecks take Calcuttan psychiatrists much further from the logic of specificity and targeting than those described by Lakoff. Ecks observes psychiatrists speaking of psychiatric medication as 'mind food'(ibid.: 188). Describing pharmaceuticals as mind food makes potentially scary and off-putting pills seem familiar and safe. Part of the power of the phrase is that it incorporates humoral thinking:

> 'Mind food' is intuitively convincing because it works with, rather than against, older ideas. One could even argue that current biopsychiatry, with its profound materialism of neurotransmitters and its reference to neurochemical 'balance' and 'imbalance,' is far closer to humoral pathology than any approach dominant in psychiatry since the ear of psychoanalysis (ibid.: 191)

Thinking of drugs as mind food is both elegant and ironic. It enables psychiatrists to speak of distress and mental disorders as imbalances in the brain that resemble the kinds of imbalance popularly associated with diet. Such a strategy would not work for Olivia. However, her talk of 'well-designed drug trials,' and 'emerging evidence' is locally resonant. Sometimes patients appear rather impressed by the reputation of their psychiatrist. Some of the psychiatrists I observed are active researchers, academics based at Oxford University. Patients can develop an interest in the publications of their psychiatrist. This can become the topic of some rather

specialised one-upmanship. I once heard two patient informants competitively compare the research profiles of their respective psychiatrists.

In Oxfordshire and Buckinghamshire, local epistemic conditions figure in the instantiation of bureaucratic accountability. Olivia's instinct is that simple 'atheoretical' empirical observation is more authoritative than abstruse theory. A local interpreter of local knowledge, Fox, suggests that a distaste for theory is a part of a typically English empiricism that is:

> anti-theory, anti-abstraction, anti-dogma elements of our philosophical tradition (particularly our mistrust of obscurantist, airy-fairy 'Continental' theorising and rhetoric) and our stolid, stubborn, preference for factual, concrete and common- sense. 'Empiricism' is short for our down-to-earthness; our matter-of-factness; our pragmatism; our cynical, no-nonsense groundedness; our gritty realism. (Fox 2005: 405)

If Fox is right, then Olivia's interpretation reflects local intuitions about knowledge and authority. Common sense shapes clinical practice.

Similarly, we see Olivia consider the risks and benefits of a holiday in terms that seem reflect class. In his discussion of the values of the English upper class, whom he calls 'Uppers,' Mount outlines features of class-based ethical imagination (Mount 2004). According to Mount there are no real obligations in the Uppers' world 'because strong commandments are uncool' (ibid.: 78). This recalls how open and undirected Olivia's advice can be. She is reluctant to pressure patients and frequently stresses that ultimately, choices are up to them. However,'the commitment to be true to your own feelings trumps any commitment to a particular person' and not trying things is looked down on as life denying. So people, ought, in a very understated sort of way:

> Hope to explore his or her full potential in every way, not only materially, but culturally, sexually and spiritually. His or her notion of the full life encompasses, indeed insists on, what I would call 'maximum travel.' Travel, first of all, in the most literal sense to see as much of the world as possible, including and especially its most remote and exotic cultures…But 'maximum travel' also has a more profound implication for Uppers. They are under an obligation, too, to explore as many experiences as possible. (ibid.: 76-7)

When Olivia offers advice to her patients, she affirms the value of maximum travel. New love and foreign travel have a worth that cannot be ignored. Indeed, part of the tragedy of mental disorders is that they inhibit such aspirations.

Olivia and Julie both think that it is desirable and valuable to have a wide range of experience, including Julie's proposed trip to the Balkans. In their discussion, the advantages of the holiday were taken as experiences of value, which may be approximated in terms of quantity. However, travel is risky and the consequences of an 'episode' are more serious in the Balkans than it would be in Oxford. As Olivia and Julie discuss the trip, they weigh up these factors. However much these calculations reflect personal, class, and national qualities, they are discussed in the same calm tones as comparisons of the effect sizes of medications. The relationship between scientific expertise and common sense can seem one-way. Common sense can be understood as, lay-knowledge, uninformed intuition that stands to be corrected by scientific expertise. My evidence here suggests a more two-way process. Locally constituted common sense enters the hospital to shape evidence-based clinical practice.

6.9 Relationships in an Accountable Clinical Bureaucracy

Working in an accountable bureaucracy puts pressure on clinical relationships. The relationship is routinized and yet profoundly intimate. Rules and regulations are held to erode trust, yet trust is said to be a key ingredient in therapeutic relationships. Clinicians told me that self-confidence is critical for recovery. But, in clinical relationships, power and expertise lies with the clinician. Mental healthcare professionals have to extract routinized information about very personal matters. Psychiatrists have to ask repetitive, formalized,

standardized questions about the most delicate of subjects: childhood abuse or neglect, sexual behaviour, suicidal intentions, personal hopes and fears, secret fantasies, terrors and moments of transcendence. As I tried to show, Olivia has a number of strategies to cope with these challenges.

Accountability promotes clinical relationships that are configured such that they defuse some of the emotional burden on clinicians and patients. This begins with the foundations of psychiatric classification. Mental illnesses have very little to do with the patient. The illness is independent of the person, and is impersonal, almost a kind of abstraction. The sense of distance between the illness and the person is added to by the language of genetics and heritability. The illness is a defect passed on between generations, located but latent in the genes, then active and destructive in the brain. In a biological universe, Olivia's patients are perfectly normal and nice people, leading productive and blameless lives.

As discussed in a review of publications by Pickard and Pierce in chapter five, relationships can be damaged where the patient feels blamed or judged. Olivia is able offer care without judgment. Some of her patients find that they are criticized in their day-to-day lives for things that Olivia takes to be symptoms of Bipolar Disorder, such as impulsivity, irresponsibility, and lack of concern for others. In the clinic, the power of diagnosis offers a kind of relief that Olivia can bestow on her patients. Apparent moral failings are reinterpreted as a consequence of a biological disease, as was the case with Julie. Olivia is able to sympathise where, with a different philosophy of mental healthcare, she might have to criticise.

Olivia often stresses that she feels sorry for patients, that they are 'unlucky to discover they have inherited these problems,' or that they are the victims of 'terrible bad luck.' Olivia can rhetorically unite with patients against their critics who might be described as prejudiced or ignorant or perhaps, even, as stigmatising the symptoms of Bipolar Disorder. One of my patient informants explained it to me in these terms: 'When I was diagnosed with Bipolar, it gave me freedom. I could do whatever I wanted, however extreme. I had a diagnosis. I had carte blanche.' Matching this, a psychiatrist once put it to me in religious terms: 'What we offer, when we diagnose, is absolution.'

By externalising pathological moods, the patient's character, views or lifestyle remain personal and private. Unless they have a direct bearing on the illness, they are none of Olivia's business. She presents this as a kind of courtesy to the patient, almost a form of respect. I have observed several psychiatrists adopting this stance. The narrow bounds of professional expertise described by the evidence-based philosophy are a kind of disciplinary humility and a way of acknowledging the autonomy of the patient. I heard a psychiatrist tell one patient: 'I'm just trying to treat your symptoms, the symptoms of Bipolar Disorder. That is all I am qualified to do. We have evidence about treatments and symptoms, but that is all.' This psychiatrist was keen to suggest that the limits of his expertise, were, more or less, the limits of evidence from clinical trials. This seemed to strengthen his claim to actual knowledge; rhetorically, his humility became a source of reassurance for his patients. If the only kind of information or expertise available is that derived from RCTs, then a psychiatrist's authority is reaffirmed.

6.10 Discussion

The purpose of this chapter is to use detailed observation to try to show how Olivia's clinical work is shaped by accountability and how this might relate to the clinical goals of patient empowerment. In an accountable bureaucracy, staff members need to go about their work in a standardized fashion. They must use a small set of familiar terms and procedures, such that care is uniform and clinicians can justify their care and communicate with other mental healthcare professionals and staff from other concerned institutions.

Olivia tries to structure her observations around a small set of clinical categories like 'mood,' 'disorder' and 'side effect.' These are drawn from the global networks of Biomedicine. Their instantiation her is also, however, local. Each of these is structured around the decisions that she can make. As a result, Olivia's attention is drawn to features in a patient for which there are treatments available. Disorders are conceived of as external to the person, unlinked to character but located in the brain. As Olivia explains it, they are essentially visitations, malfunctions in the brain that the patient is unlucky to have a probably inherited vulnerability towards.

A lot of Olivia's efforts are directed towards assessments of scale. She tries to understand how much mania a person experiences, how severe their depression is or how intense their mood instability. Measurable symptoms may be calibrated against treatments. Part of the appeal of medication, rather than other treatment modalities, is that it is possible to make changes in dosage that might correspond to symptom severity. This, as well as targeting and specificity, forms part of the bureaucratic advantages of pharmaceutical-based mental healthcare. But when Olivia described to me her clinical role, she did not suggest that these habits were organised around the need to document accountability. Instead she describes

what she regarded as good clinical practice. Psychiatry and the bureaucracy in which it is located are mutually constituted.

The needs and impulses of an accountable bureaucracy create a distinctive kind of relationship between psychiatrist and patient. Routinized intimacy seems to be very different from the way that proponents of thicker versions of empowerment envisage the therapeutic relationship. However, in some ways accountability helps, as, in the clinic, standardisation feels external and imposed on doctor and patient alike. This creates a bond between Olivia and her patients. It is as if 'the rules' make Olivia ask difficult questions and 'the evidence' makes the uncomfortable decisions. In this way, the burden on Olivia is reduced.

Olivia's biological stance is relationally helpful as well. She thinks of her patients as healthy, balanced people with inherited vulnerabilities. Olivia does not have to make awkward connections between a patient's character, values, or worldview and their distress. She may, in fact, privately make such associations. But in the clinic, the elastic notion of illness explains and absolves her patients. Julie's pre-diagnosis 'massive adventures' for example, are forgiven as manifestations of mania. If her patients appear imprudent, self-destructive, or fearful, Olivia does not comment on it. Such a thing would be unscientific and bad practice. Instead, Olivia's is able to sympathise with her patients.

Olivia explicitly models a pattern of deliberation that forms part of a thin understanding of empowerment. Olivia wants her patients to become dispassionate, unbiased decision-makers, weighing up risks and benefits and ever vigilant for warning signs of oncoming illness. In times of relative calm, they will be prepared to make behavioural changes, such as drinking less, having regular meals and engaging in the relaxing pastimes, to protect against

symptoms. These lifestyle changes seem to Olivia to be common sense. She speaks of them almost as if they are evidenced interventions. They actually owe much to Olivia's own social background.

The kind of self-management promoted by Olivia might not satisfy some of those mental healthcare professionals who favour thicker or richer models of empowerment. In Olivia's clinic, the patient's observations and decisions are essentially the same as the clinician. The pattern of reasoning is fixed, and not very nuanced: heavy drinking is a risk factor and enjoyable hobbies are protective factors. There may be variation regarding whether or not a particular patient drinks enough for it to be a potential problem, or whether it should be country walks or bell-ringing that might be a favoured protective pastime. These elements of personalisation feel rather thin. Being attentive to risk factors, but not character traits, is a very limited ethical project. If Olivia's patients talked about what it is about them that contributes to their problems, they might develop second-order preferences such that they learn to control their symptoms, or live with their distress, for example. I continue to address these issues in chapter seven.

CHAPTER SEVEN: CLINICIANS AND PATIENTS ON THE BUREAUCRATIC STAGE

7.1 Introduction

In this chapter I describe a meeting between three people. A patient called Simon has come to the attention of services. He appears to be psychotic. He describes himself as having spiritual experiences communing with nature. But he also appears to be committing acts of indecent exposure, and possibly presenting a risk of sexual assault. For these reasons an emergency appointment has been made for Simon to meet his psychiatrist, Dr Woolf. To facilitate this, Simon's CPN, Diane has arranged to meet Simon in his home town and drive him to the clinic. On the twenty-minute drive Diane and Simon talk. In the appointment, Dr Woolf talks with Simon and reaches a decision about his care. Diane then drives Simon home.

By describing these events in some detail I try to further develop my account of mental healthcare as an accountable bureaucracy. Bureaucratisation and accountability might be expected to make Dr Woolf and Diane's jobs more difficult. As I showed in the discussion of the street-level bureaucrats literature in chapter one, discretion is seen as the way that an inflexible bureaucratic process is made to deal with the complexity of human life. My argument here is that, on the contrary, bureaucratisation and accountability are part of the solution. It is through standardisation and rule-following that Diane and Dr Woolf's problems with uncertainty are resolved. It is bureaucratisation and not discretion that makes it possible to deliver care quickly and efficiently. Diane and

Dr Woolf have only a small number of possible treatment options and a narrow range of evidence that they can use as the basis for their decisions. Giving them more freedom would be likely to make it harder to complete their work.

The opening sections of this chapter describe in some detail interaction between Simon, Diane and Dr Woolf. I go on to interpret the ethnographic material in the light of anthropological literature about knowing, not knowing and ignorance. I then consider the role of canonical texts in the delivery of mental healthcare. Rule-following is a key part of Weber's model of the office. Textbooks, regulations and guidelines seem to be important as the source of such rules. However, canonical texts such as the DSM emerge as having a rather limited role in clinical practice. Next I discuss the way staff members understand psychosis, and suggest that it can serve as a kind of disguise, a barrier, behind which Simon's motives, intentions, preferences and plans are concealed. Finally, I look at Sinclair's work on healthcare. I suggest that his theatrical model of staging and audience contributes to our understanding of mental healthcare as an accountable bureaucracy, and might usefully be developed.

However it is characterised, Simon is a very disturbed man. It might seem irrelevant to think in terms of empowerment in such circumstances. At least during the interaction described above, promoting empowerment might seem beside the point. The claim I wish to make is that the ethnography below is suggestive of how accountable clinicians might inadvertently disempower their patients. The ethos and expertise of Dr Woolf and Diane encourage them to be relatively incurious about Simon himself and to focus their attention on information they need to make decisions. This is how recordable and justifiable care is delivered to patients, and how risks to the community are responsibly managed. It rather

obscures Simon's own stake in what is going on. Diane and Dr Woolf work in an efficient and professional manner but, as a result, may disempower Simon such that, at a later date, he might lack qualities he needs to recover his health more fully.

7.2 Diane and Dr Woolf talk about Simon

On a bright but uncomfortably cold spring morning, I met with Diane in the team office of a small mental health clinic in a town not far from Oxford. As we sat together, she showed me her diary in the electronic record, RiO. Five appointments with patients were scheduled for that day, which she described as particularly busy. One was to meet a patient called Simon. Diane explained that although Simon had been known to services for almost a year, it was still early days. The team was unsure what to make of him. Quite what was wrong with him, how serious it was, and how serious it might become, was regarded as being unclear.

Like many experienced care co-ordinators I met, Diane comes across as warm, kind but watchful. She's a robust physical presence, tough, indomitable, unflappable. It is easy to see that she can be reassuring or comforting. Diane's stability and calm make her an anchor for people who find themselves blown off course, a fixed point for those who feel lost. She's worked as a CPN for many years and has a reputation for being able to deal with some of the most disturbed people.

Diane described Simon to me in a clear and systematic way. Members of staff are often called upon to summarise patients. It is a clinical skill. In case presentations, in team

meetings, in more unofficial interaction, patients are outlined and discussed in a concise fashion. On this occasion, she begins by saying that she regards Simon as being 'interesting' and 'a puzzling case.' She explains that Simon is in his mid-twenties and, until recently, seemed to be moving along through his life trouble-free. He had a job in retail, a girlfriend, a network of friends and family living locally, and had what she called 'realistic plans' for the future. She said Simon had been 'completely fine and doing well' until, something like a year ago, his personality and behaviour seemed to change unaccountably. He seemed to be both distressed and to be behaving in a bizarre way. As a result, he lost his job and his girlfriend. As an unemployed single man he 'began to drift,' becoming 'isolated' and 'preoccupied.'

Diane said that Simon had had come to the attention of the mental health team via a number of sources. He had seen his GP complaining of depression and anxiety and his GP. In addition, complaints had been made by members of the public, both directly to the team and to the police, that he had exposed his genitals in residential areas of his home town. Diane said the team were unsure how to interpret these events. They weren't clear whether Simon intended to expose his genitals to people, or if he simply wanted to be naked for other reasons and people happened to be in the vicinity. In any event, no formal police action had been taken, but the police had passed on their complaints and expressed their concern such that it was now part of Simon's mental health record.

Simon had been assessed by the team's consultant psychiatrist, Dr Woolf. The outcome of this was that Simon was taken on to the caseload and a 'care plan' had been established. He had been prescribed the antipsychotic medication Olanzapine and an antidepressant Citalopram and appointments were made for him to see Diane once a fortnight and Dr Woolf

once a month. However, the team has not yet ventured what it regards as definite diagnosis. In his notes he was diagnosed with 'Delusional Disorder' but, Diane explained, this is understood by the team to be provisional. It is designed to fill the space where a diagnosis is required, such as in patient notes and letters to a patent's GP. It does not refer to what the team really thinks is wrong with Simon. Diane said that Delusional Disorder is a rather generic and relatively less severe category indicating psychotic illness. Using it might be seen as a kind of diagnostic courtesy. It allows the team to care for Simon whilst waiting to see how his health progresses. The team suspects that Simon's symptoms might get worse. This could mean that he develops Schizophrenia. If this is what happens, Simon's records will show that the quality of his care was not adversely affected by the earlier provisional diagnosis. The team could be expected to treat Simon in exactly the same way had it decided to diagnose him from the start as suffering from Schizophrenia.

Diane went on to say that there is doubt that Simon is taking his medication regularly enough for it to have any beneficial effects. One reason for this doubt is that even irregular doses of Olanzapine can have a number of side effects. These include weight gain, or a sense of lethargy and lack of focus. Diane believes there are no signs of these in Simon. She thinks it is unlikely that his 'medication adherence' is sufficient for the medication to be effective as a treatment for psychosis. But this doesn't mean that the team regard their involvement to be useless. As well as medications, the team provides support.

Support means regular contacts with staff members. This includes listening to problems in a caring way and offering advice. In this case, Diane seems to have offered quite a bit of advice aimed at trying to steer Simon away from trouble, not least with regard to his predilection for

nakedness. Diane said she was worried that his behaviour resembles 'normal' flashing, where we hold the flasher responsible for their actions, but it might instead be a consequence of his illness. However, Simon has more recently revealed that he 'gets the word rape into his mind.' Diane explains that Simon reports that he doesn't want to have the thought, and doesn't like it, but it arrives in an involuntary fashion. The question for the team is whether this indicates a likelihood to commit rape. Does Simon represent a risk to the community, or is he the victim of a distressing psychiatric abnormality? He has also visited his ex-girlfriend's parents to talk about his sex life with their daughter. For Diane this indicates an absence of 'insight'.

In the process of offering a therapeutic ear to Simon, Diane has tried to get some clarity on these ambiguous issues. By getting Simon to talk openly she tries to gauge how his health is, and whether the illness is getting worse. This also enables her to get to know Simon and gain a sense of how he used to be prior to the illness. Diane says it is essential to help them understand how his illness is 'impacting' on him now. In addition, it creates a relationship with Simon that is deemed likely to increase co-operation and adherence. Although 'support' sounds like a therapeutic exercise, and is presented to Simon this way, it is also understood and recorded as a way of 'monitoring' Simon. It is thus a way of responding to the risk Simon poses in a way that might be documented.

Diane showed me the most recent entries on Simon's health record. We looked at the letter from Simon's GP. The GP was worried about Simon's 'bizarre presentation' and 'depressed mood' and had written to the team asking them to see Simon as a matter of some urgency. The letter had been scanned by Diane and now formed part of the 'documentation' in his

notes. The day after the GP's letter arrived, the team received a telephone call from a local priest who said that Simon had visited him and spoken about his religious interests and experiences in a peculiar way that the priest found alarming. Diane had made a brief entry in Simon's progress notes recording this, and then had a chat with Dr Woolf. The decision was to see Simon in the clinic for what is known as, and recorded as, an 'urgent appointment'. Diane had telephoned Simon to arrange the appointment. She had agreed to drive him to and from the clinic. This was the journey Diane was to make today. She felt that Simon's continued co-operation in making and, mostly, sticking to such arrangements demonstrates the good relationship she had established with Simon.

7.3 Mental Illness, Risk and Responsibility

I was to accompany Diane for this trip. As we were getting up to leave, Dr Woolf entered the team room. He started to make tea in an adjoining kitchen. As the kettle heated up he started to chat with Diane. Diane and Dr Woolf know each other well having worked together for many years. They also sometimes meet socially. Their conversation is relaxed and informal. Dr Woolf asks Diane about the date of a charity sporting event being organised by her husband. Apparently Dr Woolf plans to attend, along with his wife and children. They exchanged a few light-hearted words on the subject, including speculating about whether it be well attended, the imponderables of the English weather, and will Dr Woolf really have to participate in the tug-of-war. Then, with a small joke and a shift in tone, Dr Woolf changed the topic. He mentioned the priest's phone call. He asked Diane if everything was ready for Simon's appointment. Diane said it was.

I asked Dr Woolf more about the priest's contact with the team. He said it wasn't uncommon to receive messages like this. In his view, the priest was not required to contact the team, but went out of his way to make his concerns known, in part out of sincere concern and in part as a way of covering himself. Earlier fieldwork experience had demonstrated to me that some of the paper trails that lead to a mental health team are prepared very scrupulously indeed. People devote time and effort because the stakes can be very high. The cushioned, almost euphemistic, language of 'concerns', or 'unmet needs,' or 'keeping an eye' on a 'vulnerable adult' that sound so innocuous can refer to intense human suffering, to violence, despair and even suicide.

Dr Woolf ended his remarks about the priest by saying: 'And the upshot of it all is, we now have an extra problem to deal with today.' He had had a slightly rueful tone. Paper trails like this often lead to his desk. Dealing with extra problems deposited by concerned others is the norm for a mental health team. When a patient has an appointment with a mental health team member, it is often the culmination of a long story of distress to both patients and those around them, that has been propelled by bureaucratic vectors, by letters, phone calls and meetings. Whether they are formal referrals or not, these written expressions of concern are additions to the overall audience. They create new demands on clinicians, new obligations and potential evaluations. For a clinician, working within complex interlocking bureaucracies, this makes the potential audience very large indeed. I sensed a certain connoisseurship of this in both Diane and Dr Woolf. As mental health professionals 'on the front line,' as it is sometimes put, they are the actors who maintain their composure when

others have lost theirs. They see themselves as the ones who accept responsibilities that others cannot deal with.

There were many occasions during fieldwork when I heard mental health professionals talk about the psychotic features in a new patient as, at least potentially, the tip of an iceberg. As they gain the trust of a psychotic patient, they might find that what looked like an occasional, unwanted intrusive voice is really a constant stream of abuse from two voices. Whilst observing on a hospital ward, some slightly odd remarks made by a patient in a corridor and overheard by both a ward nurse and me turned out to be part of a wider set of complex and elaborate paranoid beliefs in which the patient believed humans are being replaced by aliens. There are very many reasons why patients may want to conceal their experiences. Some may be 'part of the illness.' For example, voices may command a patient not to reveal their existence to a doctor. Another reason is that the patient doesn't accept their team's interpretation of their experiences, doesn't want to take antipsychotic medication or to be admitted to a ward.

Lack of trust or suspiciousness arising out of these preferences may mingle with other sources of disquiet that are understood to be pathological. Paranoid people, who may believe they are being monitored by the government or followed by criminal gangs, really are, in virtue of their status as mental health patients, observed, monitored and evaluated to a highly unusual degree. It is not unusual to hear anxious, fearful and paranoid patients talking about this. One of my patient informants expressed this very crisply: 'I knew someone was secretly monitoring me' he said, 'I just didn't think it was my CPN.'

Dr Woolf told me the team suspect that Simon has been unwell for some time but that the illness was not spotted at first. He said this might be because Simon did not share odd experiences and ideas with the team or his friends and family. But the emergence of a disorder also means the emergence of a new way of reading of Simon's conversation and behaviour. It might suggest that some of his behaviour that could be read as perfectly healthy, if idiosyncratic, personal enthusiasms, now begins to be understood as a manifestation of illness. Some of Simon's strong religious preoccupations, for example, might be re-interpreted this way. In this sense, the effects of the illness are not clear cut. The illness may displace Simon, but it has fuzzy edges. Even if the team were convinced that Simon is hearing voices, for example, they may be unsure of, and disagree about, whether his religious ideas are pathological or not.

As Diane and Dr Woolf chat, it appears that they fear the worst. Although they consider the illness to be, by its very nature, undetermined and unpredictable, they suspect that it is gradually growing stronger. This is something they have seen many times before and was a story I heard several times during fieldwork. A functional, healthy person who seems in no way untypical or abnormal begins to change. He or she slips down the normal distribution curves that describe human populations to become more and more of an outlier, more odd, and more individual. It may well wreck his or her life. The damage, if it occurs, will not be restricted to the individual. We have already heard that Simon's relationship is over and we can imagine strain on friends and family. The illness getting worse also means that Simon's 'risk' escalates. The risk mainly concerns exposure of his genitals, and Simon's reported experience of frequent, upsetting, involuntary thoughts about the word 'rape.' He also has

times when he feels despairing and talks of suicide. On one occasion at least, to the knowledge of the team, he acted on his 'suicidal ideation' by putting an overdose of paracetamol into his mouth. Although they are not sure, Diane and Dr Woolf think he didn't ultimately swallow all the pills so this was understood not to be an attempt at suicide and in his notes it is described as having a 'low level of intent.'

7.4 Diane and Simon Offstage

Diane's task is to meet up with Simon and take him to see Dr Woolf, so that they can 'assess' how he is. Diane explained that the rationale is straightforward: they need to decide how bad things are. Their options are to continue as before with Olanzapine, to try to convince him to agree to monthly injections of antipsychotic, or have him sectioned. If he is on a ward, his adherence can be ensured and the effects of medication observed. He will also be out of harm's way, unable to expose himself to the public. If they want him to agree to injections, the threat of a section can be used to pressure Simon into compliance.

The arrangement Diane made was to pick him up at eleven a.m. outside a café in the market square of the small town where Simon lives. There's a twenty-minute drive from the clinic to the meeting place, and as we drive over, we chat. 'You'll like Simon' she says, 'He's a really nice boy. This illness is so terrible for him. I feel really sorry for him.' I asked her about Simon's diagnosis. She says that it is important not to rush into a diagnosis of Schizophrenia. Schizophrenia is not a good thing to have on your records. Quite apart from the effects of the illness, Diane feels that Simon's life will be adversely affected both by a diagnosis of

Schizophrenia and by an involuntary admission to a mental hospital. She says 'Schizophrenia isn't a nice word is it?' Both the diagnosis and being sectioned are in themselves consequential as bureaucratic entities. As Diane puts it as she reverses into a parking bay: 'A section or diagnosis like Schizophrenia will stay in your records forever. Once they're there, once the word Schizophrenia has been entered, it can never be erased.'

We get out of the car and look around. We are on time, but Simon is nowhere to be seen. 'You'll probably know him when you see him,' she says, 'because he looks a bit odd at the moment.' We walk around, glancing at passers-by, in between cars, in the windows of cafes and down streets. Diane says that a lot of her work is like this, trying to track people down, waiting to see if someone is late, or will be entered in their records as a DNA, or 'did not attend'. The Trust gathers DNA data as a part of 'routine monitoring.' So in weekly team meetings, members of staff will record the number of DNAs they had over the week, and the team will use this data to produce a collective figure. Typically, team members declare their number of DNAs in sequence. In some teams it can be almost like listening to sports results, with high numbers greeted with collective sighs and groans and low numbers with half-ironic cheers. Sometimes patients are late, or go to the wrong place, or disappear completely. Some patients are known to be 'difficult', and DNA frequently; but if a member of staff has a lot of DNAs, his or her own skills in forming relationships with patients might be brought into question. As we look around, Diane points out someone leaving the bank. It is an ex-patient of hers, and she is able to summarise in two or three sentences the nature of her problems (depression, anxiety, OCD, agoraphobia) and their trajectory (reasonably successfully treated with CBT and medication, leading to discharge).

Then we spot Simon, a tall, thin, smiling figure ambling good naturedly towards us. He's dressed in a slightly unusual way, perhaps, but nothing that would attract attention. His slightly worn and rather dirty jumper seems insufficiently warm on a cold morning, and he's wearing tracksuit bottoms and ageing trainers. If this is an odd outfit at all, it is because it is the clothing of a young teenager, not a man in his mid-twenties. Simon wouldn't have looked out of place dressed like this ten or fifteen years ago. Primed by suspicions of an emerging psychotic illness, his attire is enough to be entered in his notes as 'slightly unkempt.'

Simon greets Diane warmly. He seems genuinely pleased to see her. Diane talks to Simon in a slow and steady way, unhurried and gentle. Although everything is pre-arranged, she explains clearly what we are doing: she'll drive him to see Dr Woolf 'because we're all worried about you.' They'll 'have a chat and decide what to do.' Diane deftly inserts the idea that a decision must be made, and that something needs to be done. Simon says he is worried about being sectioned. Diane replies that this isn't a mental health act assessment, that he won't be sectioned today, but that he may have to take his medication more and that, regrettably, there may be an assessment coming up. She presents herself as Simon's advocate, acting on his behalf as an interface with 'the doctors.' She talks of 'doctors' as if they are slightly distant, kind and well-informed experts who are trying to help. Simon is suspicious. He knows other patients who he feels were 'tricked' into attending mental health act assessments and whose legitimate wishes were ignored.

As we walk to the car Simon sees someone he knows. It is a man of a similar age to Simon, who is similarly dressed. Unlike Simon, he is overweight in a way suggestive of antipsychotic medication. Simon stops to talk. He glances across to us and, with a flick of the

wrist, informs us that we can wait for him by the car for a few minutes. I express surprise. Simon seems suddenly rather supercilious. Diane said she had seen it before. She says that patients find many ways, some of them ingenious, to keep members of staff waiting. It is a kind of power, she speculates. She says that patients have so few arenas where they are powerful, both in their day-to-day lives and in the world of mental healthcare. I found it hard to imagine Simon being so dismissive of Dr Woolf, however. I ask Diane about the person Simon is speaking to. Is he another patient? Diane thinks so, by his appearance, including his body shape, but doesn't recognise him. She says that patients often get to know each other. This made me recall her remarks in the clinic about Simon being socially isolated. His manner here was of a socially rather connected person. Had Diane assumed Simon was isolated because this is part of a recognized set of typical features of people with psychosis? It was unclear, and the uncertainty became greater as the encounter went on.

After few minutes, Simon rejoins us and we get into the car. Diane talks carefully. She speaks calmly and slowly, always giving time for Simon to talk, and expressing her concern or sympathy when he describes something painful. Part of Diane's clinical skill is that she is able to maintain the same tone and pace however shocking, distressing or strange the conversation. Her casual manner belies the methodical nature of her enquiries. There is a degree of dissonance here. Diane's tone implies a casual, unstructured chat, but in fact she expertly directs Simon towards topics that will be of use in the forthcoming assessment with Dr Woolf. Simon might have good reason to be suspicious, but he clearly likes Diane and enjoys their interaction.

The use of the car as a clinical environment was raised several times during fieldwork. A number of members of staff have said to me that they 'do their best work' whilst driving with patients. They say there is something about sitting in a car that leads to better conversation. This doesn't appear to be an official technique or component of expertise that might be formally taught in training, but a kind of informal savoir-faire, picked up on the job. Staff members who like to drive patients have commented that they suspect that it might be helpful not to be looking at each other whilst talking. In the car, a member of staff can ask intimate questions without the inhibiting effects of eye contact. Perhaps it is helpful that the staff member is partially occupied with the task of driving, and the motion of the car presents an ever-changing sensory environment. Pauses and breaks in conversation in a car feel natural and unproblematic whilst in most face-to-face contact they do not. One care co-ordinator told me he saw an affinity with the confessional in a Catholic church, in that it enabled patients to say awkward, embarrassing or shaming things. Whatever the reason, Simon did open up in the car.

Simon sat in passenger seat, pulled his seatbelt into place and began to talk. As Diane started the car, and backed out of the parking bay, he explained that: 'things are ok' and 'I'm ok, really, you know.' He went on: 'people are bad to me, don't understand me, they are, Diane, they are, and I don't deserve it.' He went on: 'I don't like it and I want to get away.' He said he wants 'be in nature' and to 'commune with nature.' I am struck that 'communing' is an odd term, one seldom heard. It was used by Diane and Dr Woolf in the clinic kitchen, and now I hear Simon using it himself. I am unsure whether it is coined by Simon, or used by Diane and adopted by Simon. It is good concise general description of Simon's wishes that would be suitable to be entered in notes as evidence of psychosis. Simon talks a bit about communing with nature. It appears to involve Simon getting into the countryside, especially

woods, and removing all his clothes. This communing he describes as a ‘spiritual experience’ and ‘really beautiful.’ He smiles as he talks about it.

The dynamics of the situation were delicate. Simon appears to like aspects of generic ‘support.’ Diane is kind and supportive. She listens and understands in a ‘non-judgemental’ way. She often repeats back to Simon a simple paraphrase of what he’s been saying. Part way through the journey, Simon remarks that Diane ‘really understands him’ and contrasts her capacity to understand with some of his friends and family. This might be flattering to Diane. Simon says he feels ‘isolated’ and ‘lonely.’ I felt very unsure about this. Was Simon reflecting back to Diane aspects of her interpretation of him? Was it a means of strengthening their relationship? Or, was it unstrategic and sincere? Simon’s experiences, however construed, are, at best, idiosyncratic and difficult for others to understand or empathise with. Perhaps talking to Diane is a rare opportunity for him to feel human connection. As an observer, I was left in the dark.

Diane encouraged Simon to stay away from houses and people if he intends to commune with nature and be naked. She mentioned some nearby woods where he might be unobserved. She tried to remind him that other people wouldn’t see it the same way that he does. Simon laughs. He doesn’t seem to worry about other people’s responses. One of the questions Diane was unsure about was whether Simon’s indecent exposure was basically an extension of his communing with nature. She asks if he’s communing with nature when he’s naked in the town.

At this point, Simon's conversation begins to become disjointed. He becomes difficult to follow. At times he smiles obscurely in response to things he has said ('inappropriate affect' it might be called in notes). It looks like these are responses to personal meanings hidden from us. I wonder if his lapses into more disjointed and allusive speech are strategic, a way of not answering Diane's questions. Perhaps he is using psychosis as a disguise. If this interpretation is right, Simon plays the role of psychotic mental patient to his advantage, in an attempt to steer the conversation away from uncomfortable sexual topics and back to more comfortable ground. But, if this is a strategy, it is double-edged. Simon could be successful in maintaining his privacy, perhaps even promoting an impression of his innocence, but it comes at the price of asserting his madness.

Diane draws the conversation towards Simon's purchasing of flights. She mentions that Simon has twice bought travel tickets to the Andaman Islands. 'They are a good place to go' he says in reply. He said he wants to find a place where he can be naked and explained that the Andaman Islands are a suitable place for nakedness. He says that on the Andaman Islands his wish to be naked might be 'understood for what it is.' He sees them as a place 'where I can be free.' Diane warns him against this in a tone that makes these ideas seem quite natural and normal, as if they are simply inadvisable holiday plans. She guides him through the backstory: that the first time he bought tickets and then cancelled the flights. The second time he boarded the plane at Heathrow but then got off. But Simon then goes on to say that a few weeks ago he flew as far as Mumbai, where it appears that the authorities discovered he didn't have a suitable visa and he was put on a return flight. This was new to Diane. She goes over the details with him. Simon seemed sad that he couldn't complete his journey.

In the car, Diane's concern is to be comprehensive, rather than to go too deep. She doesn't want to miss out things that she ought to know and tries not to be distracted by knowledge she doesn't need to know. Having discussed communing with nature and flights to India, she asks Simon about his 'intrusive thoughts.' Simon says that he continues 'to have the thought, and to hear the idea 'rape' in my head.' The topic upsets him. 'I hear it again and again. Rape, rape, rape.' Diane probes this. She asks: 'are you hearing the word now?' He says: 'no.' She asks: 'when you do hear it, is it more like an idea that comes into your mind, or is it more like something that you hear?' Simon is unclear and Diane asks 'is it like when you hear my voice now?' and then 'does it seem like a command, like you've got to do it?' Simon is emphatic to both questions: 'no.' He becomes distressed. He repeats that he is good, that he's 'not like that at all. I am so gentle, I'm very gentle, I understand how wrong it is. I would never do it, the word just comes into my mind.' Diane reassures him. She says 'I know you are a good person, I really I do. I know that about you.' Diane later explained that she couldn't decide whether it counts as a voice or not. In other words, she wasn't sure whether it should be recorded as an 'auditory hallucination', a less serious 'pseudo hallucination' or, a more innocuous 'repetitive intrusive thought.'

7.5 Simon, Diane and Dr Woolf

When we arrive at the clinic, Diane asks Simon to sit in the waiting room and then she and I go to find Dr Woolf. We find him in the team room, where Dr Woolf and Diane then briefly confer. Dr Woolf says that he hasn't got the time to 'do the meeting properly.' He asks Diane: 'How is Simon today?' Diane describes Simon as being 'just as before.' They talk for a few minutes. We are joined by a junior doctor and go in to talk to Simon. Simon's

appointment with Dr Woolf thus begins. This appears to be where the action is, where decisions are made and the future direction of treatment determined. But, in a sense, this impression is misleading. A lot of the action is offstage, in hurried conversations in the clinic's kitchen, in Simon's electronic record on RiO, and the virtual audience towards whom Diane and Dr Woolf are accountable.

Dr Woolf begins by asking Simon how he is. Simon says he is fine and starts to talk about how things had been 'getting better' after a 'bumpy patch.' Dr Woolf doesn't respond to this, and after a few moments interjects: 'People are getting concerned Simon and it is understandable they get concerned. You are frightening people. I know you are a gentle person, but what you do is scary. I have a responsibility to the public, and it isn't good for you either, being like this.' He goes on to explain that Simon is unwell and that he has 'a psychotic illness.' This, he says, explains why Simon has been 'acting out of character.' He says that this should be treated with injections of antipsychotic medication. 'You're not really taking your medication, are you, not properly' says Dr Woolf. He says it will be 'better' for Simon to have regular injections, given by a member of the team in the clinic will help him 'get better' and 'feel more yourself again.'

He does not ask Simon about his ideas regarding communing with nature, or with the ideas about rape. He knows enough already from what Diane has told him. Simon talks about feeling 'stressed' in his day to day life. Dr Woolf responds by saying that he understands that Simon feels stressed. He warns that smoking cannabis will make it worse. Simon returns to talking about his feelings of sadness, and how he gets 'close to despairing, giving up hope.' He says he feels particularly bad about the thoughts of rape. Dr Woolf isn't drawn in. In his

records it states that Simon experiences ‘low mood’ and ‘anxiety’, but in the appointment Dr Woolf directs Simon away from talking about these experiences. Dr Woolf talks sympathetically about how Simon feels misunderstood and stigmatized, and then moves the conversation on.

Dr Woolf presents Simon with two options. ‘For both your own good and for the good of the community,’ he has to either accept monthly injections of antipsychotic medication, or Dr Woolf will arrange a section, known formally as a Mental Health Act assessment (MHA). Simon becomes anxious. Simon said that antipsychotics make him feel ‘heavy and slow.’ He adds: ‘I’m only starting to feel my body again. I don’t want to go back to that.’ But he doesn’t want to be admitted to a ward either. Dr Woolf says that if the ‘independent psychiatrists agree with me’ in the assessment they will either section him or place him under a compulsory treatment order, compelling Simon to receive the injections. In fact, a Mental Health Act assessment is carried out by two doctors and an Approved Mental Health Professional (AMHP) who must all agree for a patient to be detained or treated compulsorily. AMHPs are not doctors. However, Dr Woolf here fails to mention the AMHP, perhaps maintaining the rhetorical distinction between kindly nurses and stern doctors.

Simon asks about his chances of getting through the MHA without any compulsory treatment. Dr Woolf replies that he thinks it is likely they will agree with him, but it is not certain. ‘You could win it, but it isn't likely’ he says. He sympathises with Simon, he says he knows that injections are not pleasant, but that the side effects ‘are worth it’ because the medicine is effective. But also he said that no decision has to be made immediately. Dr Woolf gives him a leaflet about Clozapine and says that he has ‘a couple of days to decide.’

As the appointment ends and Diane leaves the room with Simon, Dr Woolf pauses in the consulting room to write a prescription of Clozapine that Diane will later use to get Clozapine for Simon. Simon is able to choose to take Clozapine, but it looks like he will not be able to choose not to take it.

Simon walks back to the car dejectedly. His upbeat demeanour is gone. He complains to Diane that he doesn't want to go to hospital and doesn't want the injections. As we drive off, Diane creates intimacy with Simon, a sense they have shared interests and can trust each other. She comments on 'the doctor's decisions' but she does so as an outsider, as Simon's advocate. She reiterates Dr Woolf's position and the two options he has given Simon as if no other options were possible and no other way of framing the situation is viable. Simon is unwell, he poses a risk to the community. He needs treatment, treatments are effective even if they have unfortunate side-effects. Reducing the risk Simon poses to the community is the same thing as promoting Simon's health. Simon must either accept injections or face a Mental Health Act assessment. Simon asks her views on the likely outcome of an assessment. She replies: 'Dr Woolf said you could win the Mental Health Act assessment and that is right. You could. But I don't think it is very likely. It doesn't usually happen. The two doctors who would assess you are independent of Dr Woolf. The might disagree with him. But they might want to section you. That could happen. And you don't want that. In the years to come, you don't want that in your records. It has a lot of consequences down the line, consequences you can't imagine now.'

We drop Simon off outside the café. We are on time to drive straight to the next patient. As we drive, I ask Diane how she felt the appointment had gone. She said she was pleased, and

thought that it helped that Dr Woolf had been 'decisive.' I asked what she thought Simon might decide. She thinks, and hopes, that he will accept the injection. I ask if she thinks that Simon wants to be taken care of, or is perhaps being instrumental in some way. Diane replies that she doesn't really think about patients in as much detail as she used to and as much as some of her colleagues do. 'It doesn't help' she says, to 'overthink it.' She has a big caseload and thinking in too much depth increases stress, Besides, she says, and a lot of it is 'irrelevant' to her work.

7.6 The Advantages to an Accountable Clinician of Not Knowing Too Much

This is a deeply complex encounter, full of uncertainty, ignorance and ambiguity. These are unique events, and the gaps in knowledge are substantial. Uncertainty about Simon seems almost total. He seems to get a great deal out of what look like mystical activities, consisting of experiences of union with nature. How are Diane and Dr Woolf to understand these events? Whether or not he is hearing voices, whether to construe his nakedness as indecent exposure or not, and whether he is really suicidal is all unclear. We might feel that, in a perfect world, no decisions involving Simon would be made until more information were available.

As the narrative unfolds, highly unusual events and individuals are nonetheless incorporated into routinized practice. This isn't a haphazard process. Diane and Dr Woolf do not agonise over what to do, or struggle to deal with the pressures under which they are placed. They are calm and composed throughout and are able to keep precisely to time. This is because, as it turns out, reaching a decision about Simon is not difficult at all. The appointment takes just fifteen minutes. Nothing that happens during the drive to

the clinic, in the appointment itself, or on the drive back again surprises Diane or Dr Woolf. This isn't because, perhaps though training, experience or superior cognitive gifts, they are able to unlock the secrets of what is going on. They are profoundly uncertain about nearly everything. It is just that this doesn't prevent the sequence of events from seeming completely routine.

In The Importance of Knowing about not Knowing, Last describes a world of multiple medical styles in Nigeria from the late 1960s onwards (Last 2007). He finds that not knowing was quite common amongst his medical practitioner informants. One way of interpreting it is as a decline: 'the origin of not knowing lies in the breakup of traditional medicine as a system.' (ibid.: 11). The material rehearsed above suggests a quite different reading: not knowing is strategic and essential to the functioning of NHS mental healthcare.

Risk and uncertainty are both longstanding subjects of academic interest. Ignorance is a more recent concern. Two early sources are essays by Luhmann, Describing the Future and The Ecology of Ignorance (Luhmann 1998: 63-74; 75-111). Luhmann presents ignorance as distinctly modern, arising out of the immense complexity of the world we now live in. Interest in many aspects of ignorance is now growing (Gross and McGoey 2015). A new term, 'agnotology' has been coined (Proctor and Schiebinger 2008; Croissant 2014).

McGoey has shown how not knowing can be useful, for example to tobacco companies who deploy 'strategic ignorance' to protect themselves (McGoey 2007). For Diane and Dr Woolf, ignorance offers only a degree of protection from accountability. They are

likely to be held responsible for not knowing that Simon was psychotic, for example, if he became involved in some misadventure. In fact, not knowing this could make them vulnerable to censure, perhaps even guilty of negligence or misconduct. Their clinical expertise consists, in part, of being aware of what they need to know and what they don't need to know, and then making sure they either know, or can document reasonable efforts to try to get to know, all that they should know.

One way of thinking about ignorance and clinical knowledge is to understand clinical terms as 'black boxes.' Latour borrows the phrase black box from cybernetics, where it is used whenever 'a piece of machinery or a set of commands is too complex…[then]…no matter how controversial their history, how complex their inner workings, how large the commercial or academic networks that hold them in place, only the input and output count.' (Latour 1987: 2–3). Black boxes make not knowing unproblematic. In this case, the inputs are things like symptoms, disorders, risks, side effects and disability; whilst the outputs are increases or decreases in medication, increases or decreases in the level of care, stopping or starting medications, ordering Mental Health Act assessments. Black boxes enable efficiency and co-operation by means of simplification and concealment. They make it possible for experts to make predictions without an understanding of the processes involved. In a bureaucratic system, simple black box terms and rules are able to symbolise clinical reason, satisfy the need for accountability and reflect sensitivity to policy and strategy.

In a paper on ambiguity in the World Bank and IMF, Best suggests that not knowing can be a 'coping mechanism' for a bureaucracy (Best 2012). Best finds that the machinery of the office is often not equal to the task of accurately describing the world. She remarks:

‘we know that not everything can be measured, and that those things which resist classification or definition are often the most vital’ (ibid.: 85). The solution is for bureaucracies to adopt categories, metrics and other forms of knowledge that are less clear, less informative and more ambiguous. Imprecision can help practical action.

Pickersgill makes a related argument about the concepts of anti-social personality disorder and psychopathy (Pickersgill 2011). In both cases the categories are uncertain, slippery and vague. According to Pickersgill, this gives them some of their value. Ambiguity is put to use, promoting knowledge production and professional habits. Ontological ambiguity is often greater than epistemological uncertainty. The reference of terms is often more clear than their sense. In other words, it is often difficult to tell what a mental disorder is, but possible, and sometimes quite easy, to guess which patients have it.

In chapter six I tried to show how the conceptual flexibility of clinical terms enabled Olivia to produce justifications for treatment decisions. The ethnographic material above suggests a second aspect of clinical knowledge. Diane and Dr Woolf use the ideas of ‘the illness’ and ‘risk’ as black boxes that contain uncertainty and ignorance. These terms are not clearly defined but neither are they without any semantic precision at all. Categories like this are essential to an accountable bureaucracy. For mental healthcare professionals to be accountable for the health of their patients, and the risks they may pose, they need to be seen to be able to make appropriate responses to ill-health and risk. Given the complexity, uncertainty and ignorance faced by Diane and Dr Woolf, it may seem impossible. Black boxes contain ignorance such that not knowing is not an impediment to being accountable. Knowing more, introducing further doubt and complexity, would,

institutionally, be a problem, as it would open up more possible choices, and undermine decisions. The rigidity of the office is helpful to Diane and Dr Woolf because it gives them very little discretion regarding Simon. This is why his case, however puzzling, is clinically unproblematic.

7.7 The Role of Canonical Texts

Rule-bound working practices prompt an interest in rule-books. But as Diane and Dr Woolf interact with Simon, it became clear that although they are concerned that he is becoming psychotic, their use of the term 'psychosis' is not precisely delineated by the diagnostic manuals and protocols that seem to guide mental healthcare. Their working definition of psychosis could not be inferred from the texts. Neither do Diane and Dr Woolf exercise discretion by picking and choosing from texts. The detail of formal expressions of psychiatric knowledge simply aren't important to their daily work.

Textbooks and clinical guidelines consider delusions to be a 'distortion of thinking' amounting to a variety of intellectual error. This is how the DSM 5 puts it:

> Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence…Delusions are deemed bizarre if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences…The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity. (American Psychiatric Association 2013: 87)

Delusions appear to be interpreted as a failure of reason, characterised by errors, factitiousness, fixity and a poor relationship to the available evidence. In a manual designed

to help mental health professionals understand key terms and make diagnoses, the idea is expressed even more strongly: 'Delusions are erroneous beliefs that usually involve a misinterpretation of perceptions or experiences. Delusions are considered bizarre if they are clearly implausible, not understandable, and have no connection to ordinary life experiences' (Munson 2001: 152). If these ideas formed the basis for Diane and Dr Woolf's care of Simon, we might anticipate considerable attention given to the quality of his thinking. Perhaps Diane might test the degree of conviction with which Simon holds his views on nakedness, or his openness to counter-evidence.

This is not how Diane and Dr Woolf proceed. Simon's beliefs about communing with nature do not seem problematic to Diane because they are fixed, or weakly supported by evidence. She is not concerned to establish what beliefs lie behind Simon's unusual behaviour. Neither does she seek to test the flexibility or evidence base, or otherwise investigate the credibility of Simon's ideas. The term 'delusion' and 'Delusional Disorder,' found in Simon's records, does not mean that the team are concerned that Simon has a number of strongly held beliefs that are difficult to defend. Terms like 'delusion' relate to a larger estimation of how severe Simon's psychosis is, and so what level of antipsychotics might be appropriate. Diane and Dr Woolf are not interested in the detail of the DSM discussion.

However, both Dr Woolf and Diane are influenced in a looser way by official texts and rulebooks. The shape and form of official thinking does inform their working knowledge. They think of psychotic illness as a 'disturbance,' for example, a deviation from how a person usually is. It has to do with 'abnormalities' that interfere with 'functioning.' A disorder might explain why a person is, in some sense, not themselves. This is seen in how

Diane describes Simon to me at the beginning of the ethnography. She talks of the illness as displacing and disabling Simon. Diane and Dr Woolf feel quite confident in establishing a dichotomy between Simon as a heathy young man, and Simon suffering the effects of a biological illness in the brain. As they discuss Simon, Diane and Dr Woolf talk of 'the illness' as having existed before symptoms were detected. The process of getting worse they describe as the illness 'emerging' and 'coming to the surface' or 'coming out.' In their talk, 'the illness' is both distinct from Simon, and has causal properties of its own.

Diane and Dr Woolf talk as if they see the illness as wholly destructive and Simon as intrinsically functional and rational. This reveals a new aspect of the relationship between expert knowledge and common sense. In his discussion of the intellectual background of the discipline of psychology, Reed notes that psychology researchers tend to assume that by their very nature, people are not self-destructive, and that self-destructive behaviour must arises out of some defect, deficit or aberration (Reed 1997: 7). For Reed, what is odd about this assumption is that it stands in opposition to common sense. It recalls the 'faith in information' shown by the clinicians who designed True Colours, who assumed that better informed patients would make better health-related decisions. In casual conversation, my clinical informants understood people in general as being at least sometimes weak, confused and on occasion resolutely self-destructive. If a colleague takes up smoking, sometimes drinks too much, endangers his or her family life with an affair, or insists on playing squash even if it risks damage to his or her spine, it would not be assumed that they were ill. Foolishness, rashness, and imprudence are taken as normal constituents of character. In chapter six I presented Olivia as drawing on her locally constituted common sense. A different relationship is indicated here. When they are on the job, Diane and Dr Woolf reject their common sense in favour of expertise.

7.8 Psychosis as a Disguise

Diane and Dr Woolf don't want to know all that much about Simon's psychosis. Why this seems unexceptionable to them might in part be explained by the way that mental healthcare professionals conceptualise psychosis. When I asked clinicians about psychosis I was often told it is inaccessible and muddled, or, even, unintelligible and meaningless. It is like an externally imposed and involuntary burst of intellectual malfunctioning, white noise that interrupts and overpowers the smooth functioning of our cognitive equipment. These ideas form part of their expert knowledge, and have a long history.

One of the formative early theorists of psychiatry was Jaspers. In 1913 he published the seminal General Psychopathology in which he built the notion of non-understandability into the concept of psychosis (Jaspers 1997). For Jaspers, if a patient's experiences arise meaningfully from their personality and life history, they are not psychotic. A necessary condition of psychosis is that a person's subjective world is beyond empathetic understanding. No amount of time or background research will unlock it. And if they can't be understood by the usual means, then the experiences must have a different cause. For Jaspers, and for some but not all the generations of mental healthcare professionals who followed him, abnormal experiences that can't be explained by personality or life must be caused by their biology. Biological abnormalities cause involuntary and meaningless psychotic experiences. That is broadly the approach taken by Diane and Dr Woolf in 2014. Simon's experiences are understood as biological, and, therefore, external, unwilled and unwanted.

During fieldwork I found it hard to square biological accounts of psychosis with some of the patient memoirs I read, as described in chapter one. For some writers at least, their psychotic experiences are strange and exotic but not completely discontinuous with normal experience. There is nothing so unusual, after all, about experiences that are difficult to understand and involuntary. They are a part of everyday life. Behrman's psychotic episodes, for example, sound like hedonism gone too far, frightening and unpleasant, but hardly beyond the ken of an empathetic reader (Behrman 2002). Saks is diagnosed with Schizophrenia and experienced long periods of severe psychosis (Saks 2007). But these periods were not always as baffling as they might have looked from the outside. For example, she says 'Psychotic people who are paranoid do scary things because they *are* scared (ibid.: 97, italics in original). At times, she had the capacity to control her psychoses. If there is a difference between psychotic and normal experience, it seems as much a difference of degree than of kind. Likewise, in a paper called Not What the Textbooks Describe, Jones, a psychologist with first-hand experience of psychosis, describes a dramatic misfit between her experiences and the descriptions in the medical texts (Jones and Shattell 2016).

As I chatted with patients, I was able to test these competing claims. The conversation of people who were described by staff as psychotic could be challenging. In the early months of fieldwork, I got to know a patient diagnosed with Bipolar Disorder who was described by his clinicians as psychotic. His speech was extraordinary. He was prone to discourse on topics, talking rapidly, sometimes quite loudly, in a colourful, allusive style, more akin to modernist poetry than everyday speech. It was certainly a challenge to record in field notes. I once met with him in a coffee shop in central Oxford. He arrived looking rather tense and, having lit up

a cigarette, immediately began talking. According to my notes, he said: ‘my hope is made of rope, of rope, they are ropes, my hopes, ropes, cobras, hopes, cobras that do the rope trick, cobras that dance, trick cobras, tricky cobras, titchy cobras, I play the flute and they dance.’

A first I thought the doctors might be right. Utterances like this seemed too outlandish and disconnected to be intelligible. But the patient’s sister told me otherwise. She said that if I take the time to listen to her brother, I will be able to make sense of what he is saying. She was right. It took time, however and some patience. I had to learn ‘to tune in’ to her brother, rather than enter into a reciprocal or symmetrical dialogue. After this I found nobody wholly unintelligible. I couldn’t revisit previous exchanges, however, and I never got to the bottom of the rope and hope remarks quoted above. But on other occasions apparently opaque statements became accessible with a little thought. For example, a patient held on a section on an acute ward told me she was afraid because there was a vampire who visited the hospital. She said the vampire would bite her and suck her blood to take away her humanity. Later that day I reflected that she was receiving injections of antipsychotic medication. These injections are described by patients as profoundly numbing or sedating. What more vivid metaphor could there be for the deadening effects of antipsychotic injections than a vampire?

Some commentators might suspect that my anthropological training was helpful. Corin and Larsen make the case that anthropological tools are well suited to the understanding of the lifeworld of a person who experiences psychosis (Corin 1990; Larsen 2004). I am not so sure. My experience did not suggest that expertise or specialist knowledge is necessary to understand the conversation of people with psychosis, or understanding their lifeworld. Much of what I heard was accessible to simple common sense.

Some patients told me that they enjoyed their psychotic experiences, and said they could usually start them and, less often, stop them at when they wanted to. Some of my informants would drink or take drugs, listen to loud music and go without sleep with the intention of inducing psychosis. In her ethnography of patient experience Making it Crazy, Estroff seems to take the same view (Estroff 1981). Estroff suggests 'rules for making it crazy.' The first rule is to 'Have the ability to experience psychosis voluntarily or experience psychosis involuntarily' (ibid.: 189). Estroff finds that patients strategically deploy craziness (ibid.: 229). The clinicians that take care of Estroff's informants seem to largely unaware of this. Indeed, disguising preferences can be part of a patient's survival strategy. In a paper on homeless people in Los Angeles, Cohen also finds very recognizable motives and strategies lying behind what might otherwise be the incursions of an impersonal disorder, such as resorting to fantasy and delusion to 'construct positive self-images and meaningful lives' (Cohen 2001: 285).

Jones et al. make a similar claim (Jones et al. 2016). Patient informants report a subjective sense of being fully or partly responsible for psychosis. They describe their psychotic experience as 'interesting,' as an 'escape' or as a form of 'wish fulfilment' (ibid.: 6). For some it was like a captivating puzzle or a game. The sense of control was often described by informants as being reduced over time, such that psychosis began as a conscious diversion but later became involuntary. The idea of being mad is appealing to some, who see themselves as having 'intentionally pushed themselves over the edge' (ibid.: 6). The subjective experience of psychosis emerges as sensory and embodied, a mix of thinking,

feeling and intuiting that breaches the frontiers of clinical terms like ‘hallucination’ which refers only to sensory experience, or ‘delusion,’ that refers to beliefs.

Some of the attractions of psychosis are hinted at in the ethnography of Simon. There seem to be aspects of his abnormal experiences that he likes, such as communing with nature. At times his psychosis becomes like a bargaining chip. Staff members are obliged to respond to psychosis, and he trades talk about his experiences for support and advice. The conceptual repertoire used by Diane and Dr Woolf seems not well suited to describing Simon’s strategies. Psychosis is a potential shield. Staff are not curious about the content. Underneath the apparently meaningless or muddled words, personal intentions, motives and strategies may be concealed.

Despite this, contact with the team might impact on Simon’s capacity for empowerment. Diane’s sometimes rather leading questions require Simon to divulge intimate thoughts and experiences in a structured and repetitive way. As I tried to show above, this helps a clinician deliver accountable care. Simon seems remarkably open in his talk with Diane, vulnerable, happy to talk about his innermost thoughts and feelings. Simon knows nothing of Diane and displays no curiosity about her. He seems attuned to her responses, of the genuineness of her compassion, but there is no reciprocity in their interaction.

Mental health professionals can be concerned where they feel patients fail to detect and follow social norms regarding intimacy and social boundaries. For example, Simon has visited his ex-girlfriend’s parents to talk about his sex life with their daughter, which Diane

regarded as a loss of 'boundaries' and 'insight' associated with the advancing illness. In her interpretation, Simon was unable to detect the unwritten rules of social interaction because of the impact of the illness. But in his interaction with staff Simon is encouraged to disregard social rules concerning intimacy and reciprocity. Simon is now comfortable breaching familiar social boundaries, where intimate revelations are usually reserved for close friends and family members. Staff members sometimes report concerns about how patients 'lose social skills' or are 'deskilled.' This is a way in which services are said to be disempowering, leading to social isolation and a dependency on staff members for social contact. Perhaps the rather odd social role required of Simon might promote such a process. If so, it is an example of a contradiction between accountability and empowerment.

7.9 Sinclair's Concepts of Audience and Staging

In an ethnography of medical training, Sinclair develops Goffman's notion of social space as a theatre to understand the way that the behaviour of student doctors changes according to where they are (Goffman 1959; Sinclair 1997). Sinclair pays particular attention to way that the presence of people (the 'audience') influences the junior doctors' presentation of self. When official staff are present, for example during ward rounds, or in lectures, the junior doctors are 'onstage'. When they are unobserved, for example in libraries, they are 'offstage.' The social roles played out offstage frequently contradict the impression created front stage (Sinclair 1997: 15).

Sinclair makes a further, cross cutting, distinction between the official and unofficial. Work that is official is linked to the functioning of the teaching hospital. Activities that are unconnected to this function, such as sports, theatrical performances and social activities in the student bar, may take place on the hospital site, but are unofficial. Some of these unofficial activities are carried out in public, and so front stage, such as rugby matches. Others are hidden from the view, such as drinking games that form part of the initiation of many student doctors.

Transitions between domains are marked by changes in deportment, and, most notably, in language. A formal clinical language is used on ward rounds, for example, and patients are sometimes addressed in a distinctive argot that is oddly dated and euphemistic. Sinclair observes doctors ask patients about their 'ticker' or 'waterworks' for example. Once offstage, and amongst themselves, the trainees shift to a more robust style of talk, peppered with humour. A severe haircut may be described as 'a radical rugectomy' and a difficult consultant classed, like a tumour, as malign (ibid.: 227). Sinclair argues that humour is a means by which junior doctors try to deal with conflicts between their clinical ideals and the compromises necessary in a pressured and limited work environment.

The above ethnography suggests there might be several ways to further develop Sinclair's approach, such that the concepts of staging and audience cast further light on mental healthcare as an accountable bureaucracy. The first development concerns the notion of audience. Sinclair treats the medical trainees as being the actors on the stage, and other staff, plus patients and members of the public, as the audience that helps determine the role the trainees must play. I suggest two developments to this. On the one hand, the patient becomes

the actor, responding to an audience of staff members. On the other hand, stakeholders constitute a kind of virtual audience, for whom clinicians must perform. Finally, I refine the distinction between official and unofficial to incorporate that which is recorded and that which is not recorded.

Staff members serve as an audience for patients just as much as the patient or members of the public are the audience for staff members. Looked at from this perspective, the composition of the audience has a number of consequences. For Simon, speaking to a psychiatrist is very different from speaking to a CPN. Diane seeks to use this to create a kind of intimacy with Simon whilst driving him to the clinic. This constitutes an informal offstage in which Diane hopes that Simon might divulge more than when sitting in a more front stage formal consultation with Dr Woolf. In the car, Diane creates the impression that she is having a relaxed chat with Simon, as if they were friends and the content of their talk was off the record.

However, in an offstage conversation between Dr Woolf and Diane that takes place in the clinic's team room immediately prior to the appointment, we see that this is not really the case. Diane summarises for Dr Woolf the content of her exchange with Simon. In the appointment it emerges that Dr Woolf wants Simon to consent to injections of antipsychotic medication. Simon is reluctant. As she drives Simon back to his home town, Diane is able to create a second informal offstage. On this occasion she offers what sounds like an informed, independent commentary on what Dr Woolf told Simon. Her aim is to get Simon to agree, but the tone is suggestive of being on Simon's side and simply being helpful. Overall, Diane is adept at using staging as an opportunity to gain more information, and perhaps a different

perspective, on Simon's health, as well as a chance to reinforce the message that Dr Woolf has delivered.

A lot of the work of mental healthcare appears to take place on these various offstage locations. Diane gathers information about Simon whilst driving him to the appointment. Diane and Dr Woolf talk things through first in the clinic's kitchen and then the team room. It isn't possible to know at exactly which point the decision is made regarding Simon. Perhaps it is wrong anyway to imagine decisions as discrete processes that are fixed in time. In this case, it seems that Dr Woolf is more or less clear what he will decide by the end of the offstage conversation. So by the time Simon is onstage, in sense, it is all over. In medical records, decisions are usually presented as being the outcome of appointments. Here, in the appointment, Dr Woolf appears to do little more than double check his impression of Simon. The appointment really appears to be a formality, required by documentation, and also a chance for Dr Woolf to give Simon information about his options to encourage him to agree to injections of Clozapine.

Diane and Dr Woolf are always aware that their decisions, and the record they produce, may be scrutinised. In Dr Woolf's deliberations regarding Simon, this virtual audience is just as important as Simon himself. Staff members sometimes say that when a difficult patient is heavily sedated by strong antipsychotic medication, the main beneficiaries can be their family and neighbours. In this case, Diane and Dr Woolf need to consider the interests of people who are inconvenienced, disturbed and potentially put at risk by Simon. A number of consultant psychiatrists have independently said to me that when they face difficult clinical decisions, they imagine 'what it might sound like in a headline in the Daily Mail.' In this

case, the unwritten headline might be ‘Sex Attacker Left Untreated by Local Psychiatrist.’ As well as the local community, Diane and Dr Woolf have to consider a virtual audience that includes, but is not restricted to, Simon’s GP, the local priest, the police and the immigration and airport authorities in Mumbai.

7.10 Discussion

In a paper on scientific knowledge and ignorance of obesity, Sanabria remarks that: ‘Existing forms of scientific evaluation make it impossible for certain things to be known’ (Sanabria 2016: 153). With Simon, medical terms organised around bureaucratic evaluation make it difficult to think of Simon as an agent. Psychosis is meaningless, and knowing too much just complicates decision making and threatens routinization. Diane and Dr Woolf work smoothly and efficiently precisely because their knowledge is limited and their ethos and expertise is bureaucratized. It is unclear to them what Simon’s desire to commune with nature really means. They do not know if he is hearing voices commanding him to rape, or experiencing the thought in a repetitive involuntary fashion. They can’t tell how serious he is about killing himself. Is he really best understood as a dangerous flasher or a confused innocent? Simon has come to the attention of the police, the local GP and a priest, towards whom they now have to satisfy obligations of accountability. But this does not mean they find it difficult to reach a decision.

Diane and Dr Woolf sincerely want to help Simon, but as they go about their work, acknowledging more than a small set of simple qualities is cumbersome and obstructive. It reintroduces complexity and ambiguity that may be hard to contain. Engaging Simon as an agent in his own health care makes the situation more unpredictable and more risky. It is a

barrier to accountable practice. As time-pressured professionals, dealing with patients experiencing intense anguish, deep suffering and sometimes baffling sensory experiences, whilst also causing what appear to be quite reasonable concerns in others, Dr Woolf and Diane have to conform their observations, deliberations, documentation to what helps to get the job done.

From their point of view, Simon is clearly in some generic sense psychotic. Although their conduct is routinized, they do not think in terms of the detail of diagnostic manuals. What is important to them is not the meaning or nature of the psychosis, but its scale. They decide the magnitude of Simon's psychosis is quite severe. The psychosis is associated with the risk and disturbance he is creating in his home town. So it is in everyone's interests that Simon is treated with antipsychotic medication. Currently he is not taking his tablets. Dr Woolf has simply to decide if this is the moment to make a clear decision, or whether to wait a bit longer. He decides that now is the time. So they offer Simon a choice of antipsychotic medication administered by injection in the clinic, or a section that is likely to lead to hospitalisation and enforced treatment with the same antipsychotic.

This is a bureaucracy in action. The team is strategic in its use of staging and audience composition. In particular, Diane creates an informal offstage where she can elicit information and reinforce Dr Woolf's message. As clinicians, they find themselves as actors on a virtual stage, in which their actions may be observed and scrutinised by others towards whom they have ties of accountability. This creates other factors that they need to consider, and adds to the need to act according to simple standardised rationales.

As a part of the same process of care-receiving, Simon is encouraged to develop a very particular social persona. He is asked to divulge his secrets, treat his personal pain as a matter of public interest, be comfortable in asymmetrical relationships, and dismiss people who query his actions as prejudiced. We might wonder whether the social role of the mental patient necessary for the delivery of accountable healthcare erodes the conditions required for the development of personal empowerment.

CONCLUSION

This thesis is an ethnography of NHS mental healthcare. I try to understand my empirical evidence by thinking of Oxford Health as an accountable bureaucracy. This theoretical frame suggests a particular understanding of mental healthcare. Clinicians go about their work in a highly bureaucratized manner. Features of care that are deemed good clinical practice are, simultaneously, good bureaucratic practice. Good quality care is care that can be justified according particular documentary practices that demonstrate accountability. Analysing Oxford Health as an accountable bureaucracy also gave me a platform to think about what I didn't observe. Absences and omissions are important to my argument. Oxford Heath staff members talk about their work in terms of effectiveness, expertise, good practice, and efficiency. Omissions disappear as care seems to arise naturally out of research evidence, professionalism and goodwill. At times it even appears to be inevitable. My thesis suggests otherwise. There are many other directions that mental healthcare might have taken. Indeed, one of the surprises of fieldwork was that many staff regret, oppose and even resist the bureaucratization of their work.

A focus on the clinical goal of patient empowerment arose out of my entry to the field, and brings theoretical clarity to my argument. Patient empowerment is a widely discussed, recognised goal. It is endorsed by central government and the Department of Health. It receives more or less unanimous commendation from the mental healthcare professions. Empowerment is seen as dovetailing with other policy goods such that they form a single synergistic set: efficiency, safety, transparency, uniformity, and quality. The self-

management technology True Colours, which formed the heart of my fieldwork, is designed to promote patient empowerment.

I argue that empowerment is inconsistent with the processes of an accountable bureaucracy. The relationship between them might be seen as a zero-sum game. More of one means less of the other. Making care accountable means simplification, routinization, the use of explicit, standardized treatment rationales, and the forging of a particular kind of clinical relationship. Promoting patient empowerment falls against the grain of such practices. It is unstandardized, care is hard to control and hard to document, risky and based on therapeutic relationships as much as interventions.

In making this argument, I raise a number of themes that run throughout the thesis and cumulatively build from chapter to chapter. One of the main themes is knowledge. I investigate the nature of the expert knowledge of mental healthcare professionals. My analysis considers key clinical categories, patterns of reasoning and forms of justification for treatment. I consider what kinds of phenomena are attended to and what tends to be side-lined, ignored or erased. I describe how the shortcomings of expert knowledge play out in the clinic. The ethnographic evidence suggests, for example, that patients find strategic uses for clinical blind-spots. I also look at the relationship between expert knowledge and untutored common sense. I argue that there are the advantages to non-specialist approaches to distress. This raises a question: is expert knowledge or common sense better suited to the project of patient empowerment?

Ethical concepts formed a key part of my analysis. I present the office as an ethical domain, use the analytic concept of 'ethos.' I consider audit cultures, conceived of in the literature as

an ethical project tied to various technologies of monitoring and documentation. The flavour of everyday life in mental healthcare is created by the ethical demands on staff members. Ethics shapes the formation and use of expert knowledge. Staff feel bound to the bureaucratized ethos of the office, and accountable to patients, to their families and friends, to the wider community, and to bodies internal and external to the Trust that scrutinize care. Loyalty to the office is part of its ethos. In this context, scepticism on the part of staff members, or views critical of the status quo are forms of dissent. As a result, much of what staff told me was secret, revealed in moments of complicity.

One of the purposes of this thesis is to investigate the notion of empowerment. The various goals and ideals associated with empowerment emerge as heterogeneous and not well defined. Underlying attractive clinical goals are some deep conceptual issues. The concepts of freedom and autonomy, the relevance of choice, the significance of reasons for action, the notion of externalised perspectives on oneself and second-order preferences, all formed part of my discussion. Part of my task is to apply these potentially slightly abstract, even rarefied, concepts to mental healthcare. Conceptions of empowerment that focus on freedom of choice, or enter into a pre-set universe of clinician-guided self-management seem rather narrow. Anthropological and philosophical literature suggest strategies to approach this, differentiating potential ingredients of empowerment and suggesting ways to make important distinctions between them.

The themes of knowledge construction, ethics and professional ethos, and the concept of empowerment combine in concerns about the overall effects of mental healthcare. Contributors to the literature on mental healthcare from a number of disciplines are sceptical about the benefits of care. It is notable that writers who describe themselves as having

personal experience as a patient are prominent amongst critics. The worry is that care is at best ineffective and at worst, harmful. Much of the putative harm can be read as forms of disempowerment. During fieldwork I met a number of current and ex-patients who expressed dissatisfaction with the care they received. To my surprise, I met and spoke to many staff members who expressed similar views.

In this work, I do not take a view on clinical matters. Questions about treatment evaluation are not anthropological questions. This means I do not seek to measure the benefits of treatments or the harms of being a patient. However, I hope that my analysis of mental healthcare contributes to the understanding of both why and how mental healthcare might be disliked by patients. My findings suggest why it could have adverse effects, and why this receives little official recognition. The ethos of staff, and their bureaucratized expertise, promote a style of care in which accountability is the primary good. Care that is directed towards patient empowerment is likely to be harder to bureaucratize.

Each of the theory chapters begins with an ethnographic vignette that seeks to root the discussion in the local, particular, empirical world. In chapter one, I described an encounter I had with a group of mental health professionals in which I tried to explain my research. I said that I had been struck that clinicians believe that certain character traits or values in patients predict better outcomes, but nothing is done to promote those qualities. It seemed puzzling that these healthy qualities fall into a clinical blind-spot. Next I discussed my fieldwork question. My research formed part of the 'qualitative evaluation' of the True Colours technology, which was being introduced into standard care for the patients of Oxford Health general adult mental health teams. True Colours promotes patient empowerment through self-quantification. It prompts patients to complete health-related questionnaires and gives access

to the results. Despite being timely, well-funded and vigorously promoted, it was unpopular with staff and patient alike. This thesis seeks to understand why, in general terms, this was so.

My argument is that any attempt to promote patient empowerment is likely to face barriers in an accountable bureaucracy. True Colours itself reflects a rather limited version of empowerment. For some staff members, empowerment has no role in mental healthcare. For these people, True Colours is irrelevant. I quoted a sceptical psychiatrist who said to me: 'I can tell when the medications are working.' Other staff members have a broader vision of mental healthcare and are more committed to empowerment. They see it as central to their role. But for them, True Colours represents too narrow an understanding of empowerment to be of value. They seek to inspire hope, give patients the confidence to make and follow through plans, or find ways for patients to understand their distress. True Colours doesn't help with any of that.

In the opening chapter I also discuss my methodology. My methods centred on participant observation, and included reading patient notes, conducting recorded interviews, and immersing myself in the wider cultural world of mental distress. This latter aspect proved important. Plays, films, novels and life-writing cast light on aspects of distress and madness not considered by Biomedical approaches. It struck me that non-specialist or non-Biomedical readings of distress do not share the blind-spots discussed in the opening vignette. For example, it was clear from these sources that madness and distress hold a certain appeal that was difficult to mental healthcare professionals to acknowledge or understand. Knowing more about mental disorders and their symptoms, seemed to be a way of knowing less about the inner lives and motivations of distressed people. This provided the background to my

discussion of why, although it can be appealing to be mentally unwell, it is rather less appealing to be a mental health patient.

Next, I turned to the idea of bureaucracy. Weber's ideal type of the structured, routinized and rule-based office resembles the teams I observed (Weber 2009). Several scholars were reviewed who stressed the limits to bureaucratization. There are warnings from Scott and Graeber, amongst others, that the schematic, simplified and standardised forms of knowledge required by bureaucracies have limitations both practical and epistemological (Scott 1998; Graeber 2015). Lipsky showed how street-level bureaucrats exercise discretion in how they apply the rules. He argued that this is necessary if they are to deal with complex human encounters. Discretion seems to be a counterweight to routinization. For Lipsky and others, rules and routines alone are impractical (Lipsky 2010). Commentators detect a tendency over the last few decades to give officials less scope for discretion. O'Neill described it as arising out of a crisis in trust (O'Neill 2002). However, the notion of ethos suggests that even if left to their own devices, officials might replicate the workings of the office. Nonetheless, the literature on bureaucracy provokes a concern about the drawbacks and even the suitability of bureaucratizing mental healthcare.

Chapter two investigates the notion of accountability. It began with a vignette describing the Oxford Health AGM. What struck me about the AGM was that budgetary concerns, safety issues and patient grievances were all on the same, unified agenda. I wondered what accountancy and patient participation had in common. The answer was accountability. Making financial accounts public and hearing patient feedback are both ways that Oxford Health makes itself accountable. The political science literature suggests that accountability can be a quality or virtue of officials, but, very often, it also involves institutional devices that

may scrutinise work, investigate deficiencies and reward or punish. Accountability emerges as a goal towards which a bureaucracy can be orientated.

The history of the NHS can be understood as a transition from a rather hierarchical and inflexible, top-down bureaucracy to an accountable bureaucracy. In the early decades, government ministers did not gather data about outputs or performance. They trusted medical staff to do their job with the resources provided. But, in two waves of reforms starting in the mid 1980s, accountability was introduced alongside the introduction of features of the market. Competition between providers required the production of information about care quality. NHS institutions gained autonomy, but were made accountable. Some accountability was 'upward,' directed towards regulatory bodies that inspect financial status and care quality. Accountability was also downward, to the local community. Oxford Health is an example of an accountable NHS institution. Although it has a degree of autonomy, it is responsive to policy goals, such as patient participation and transparency.

Understanding the appeal of accountability is not straightforward. Some commentators point to quantitative evidence that market and accountability reforms have improved care quality or increased efficiency. Other dispute these claims with equally convincing counter evidence. Evidence alone does not settle the question. I reference anthropological work on the role and use of quantitative research. Ulucanlar et al. describe how the tobacco industry sought to further its interests by actively engaging in quantitative research, a process they call 'evidential landscaping' (Ulucanlar et al. 2014). Accountability is linked by some with neoliberalism. For Harvey, Graeber and Glyn, neoliberalism is linked to class interests (Glyn 2007; Graeber 2010; Harvey 2007). From their perspective, debates about 'the evidence' appear to be disguises for power.

Strathern argues that auditing is not neutral (Strathern 2000). Her work on audit cultures stresses that monitoring is linked to evaluation, which, in turn, is linked to improvement. Auditing reshapes the way that professionals go about their work, in part because of the difficulties of representing and quantifying what is important about a particular occupation. In many cases, external interests are embedded within audit technologies. Yet, however flawed, unpopular and partisan audit cultures may be, Strathern and others remark that their spread seems irresistible.

One way that the medical professionals I observed internalised the values of auditing is via the philosophy of evidence-based medicine. EBM authorises simple, standardised, repeatable care that may be easily documented. It enables communication across professions and international cooperation. Some of the criticism of EBM from within Biomedicine and by philosophers resembles the concerns anthropologists expressed about audit cultures. EBM seems narrow, limited and simplistic. The role of the clinician in EBM resembles the official in Weber's ideal type: both seek be impartial and disinterested, to work with a view to easy cooperation with colleagues, and to be guided by protocols and rules. The question that begins to emerge is: how appropriate are these skills and practices to mental healthcare?

Chapter three examines the notion of patient empowerment. The chapter begins with an ethnographic vignette in which a clinician informant, Claire, describes her work. She talks about how 'target-driven' mental healthcare work has become. She differentiates between her actual job, her idealised job and the way her job might be characterised 'for promotional purposes.' She says that these jobs all conflict and that, as a result, she feels compromised and worries that her work, and thus her patients, suffer. She is concerned to empower patients. I

use the term patient empowerment as an umbrella term to refer to a set of overlapping and interlocking clinical goals. These goals are not clearly defined, but concern more open and equal clinical relationships, a greater role for patient preferences and decisions, and service designed to reflect patient experiences and needs. They are the subject of strong support across Biomedicine.

I compare the concept of patient empowerment to consumer choice and find, with Mol, shortcomings in the conception of patients as consumers of services and of empowerment conceived of as an expansion of choice (Mol 2008). Next I looked at some philosophical work on the concept of autonomy. Following Dworkin, I found that autonomy is multifaceted and particularly desirable when it contains preferences about oneself, known as second-order preferences (Dworkin 1988). O'Neil's Kantian approach found autonomy to be a quality of reasons rather than of persons (O'Neill 2003). Medical anthropologists working on narrative find healing to consist in personal transformation which may be achieved as a feature of emplotment, or in the ownership and sharing of personal stories. All these ideas emerge at points to bring focus to my analysis in the ethnographic chapters.

Many commentators on mental healthcare regard it as disempowering. This may or may not be seen to outweigh any positive effects. Lurhmann writes of how people with Schizophrenia in the US experience 'social defeat,' an experience that is reinforced by healthcare (Luhrmann 2007). For some, distress and madness are themselves constitutive of disempowerment. Scheper-Hughes, working in a Durkheimian tradition, finds social reasons for failures of personal agency, leading to mental illness Scheper-Hughes (Scheper-Hughes 2001). However, there are reasons to be cautious about the promotion of empowerment in mental healthcare. Empowerment can lead to an excessive sense of personal responsibility.

This is particularly the case where structural factors that cause distress are erased by an individualistic focus on the patient as agent. Furthermore, as Laidlaw argues, there are bad reasons to favour empowerment, for example as the unthinking defence of the individual against the group (Laidlaw 2013).

Chapter three ends with a discussion of monographs by Luhrmann and Lakoff (Luhrmann 2000; Lakoff 2005). Luhrmann presents mental healthcare as being unbalanced by the primacy of biological care over psychodynamic approaches. A largely medication-based care leaves the patient without agency. She argues that the shift towards medications occurred in part as a result of the informational demands of insurance companies. Treatments targeted at specific disorders look good on paper. Lakoff presents a different picture. He describes how, in Buenos Aires, psychiatrists prescribe antidepressants without diagnosing depression. They use pharmaceuticals, but without the reasoning that lies behind it. Lakoff accounts for this in terms of the absence of regulatory demands for targeting and specificity and a local epistemic milieu that is hostile to biological psychiatry and friendly to psychodynamic thinking. But he takes issue with Lurhmann on her argument that biological psychiatrists deny their patient's agency. He describes how patients receiving treatment for a specified mental disorder may be asked to self-monitor. This is a moral project that resembles the kind of self-care envisaged by the True Colours team. Whatever their disagreements, Lurhmann and Lakoff both see the content of care being determined by forces external to medicine, notably bureaucratic forces.

Chapter four is the first ethnographic chapter. It begins, as seems fitting for a thesis about bureaucracy, with documentary practices. I reproduce and discuss a number of letters and notes that I selected to convey a sense of typical documentation that enable me to develop my argument. Medical documentation consists of simple, clear descriptions of people and

problems, tied to calm, confident decisions about treatments. Staff told me they aimed to write in an 'objective' way. As a result, decision-making appears natural and inevitable, such that the clinician is almost erased and the decisions are made by facts, evidence and rules. Montgomery argued that medical narratives are incommensurable with a patient's own narrative (Montgomery 2013). They cannot co-exist, or be given an equal footing. Instead, the medical narrative supersedes the patient's. Medical narratives are standardised, composed of simple flexible terms that justify decisions. It is striking that genre conventions suggest the effectiveness of treatments: in medical documentation, treatments are often the only active ingredients mentioned. Other potentially relevant factors are usually excised. So if a patient improves, it appears to be because of the medication he or she was taking.

Elements of patient empowerment are to be found throughout medical documentation. Patients are given a choice of medication. Their preferences regarding side-effects are taken into account. Aspects of lifestyle are mentioned as potentially contributing to health or detracting from it. For example, committing to relationships or being involved in voluntary work are noted approvingly. The final piece of documentation I discuss is a letter by a psychiatrist to a GP about a patient diagnosed with Schizophrenia. The letter commends the patient for his efforts and attitude, and notes the personal progress he has made. It appears to represent a very rich appreciation of patient empowerment. But one of my clinical informants, Aisha, is sceptical. She sees the patient as having been made 'docile' by services. She thinks that he is now dependent on services where before he was autonomous, albeit, for services, a handful. He has lost the 'fight' he might need to recover. Aisha's account showed how much is left unsaid in medical letters. The positive remarks looked very impressive, but may be little more than spin, as if the psychiatrist is serving the 'promotional' purposes of the Trust as outlined by Claire in the vignette in chapter three.

To investigate the kinds of things that might not be included in official documentation, I ended the chapter with a case study. During fieldwork I had found that partners of patients provided detailed evidence on the sorts of things that clinicians ignore, neglect or simply fail to notice. Cathie regards her Bipolar husband, Don, as being the victim of his own character, ethics and goals. For Cathie, Don seeks value from success, feelings of superiority and dominance. He alienates people with his ruthlessness, manipulative charm and lack of integrity. In Cathie's view, it is no wonder he is unhappy. For her there is no need to think in terms of dysfunctions in the brain to account for his troubles. But Don's psychiatrist thinks very differently. He tells Don he has an inherited vulnerability. As well as taking medications, he should self-monitor and self-manage in the light of this vulnerability. As a part of his Bipolar, he is liable to distorted cognitions, such as thinking people don't like him.

The two understandings conflict. My analysis seeks to show how incommensurability in manifest in the details of care. Don's sense of loneliness might be informative, giving valuable hints as to the shortcomings of his social style, or it might be a cognitive distortion. Thinking in terms of disorders in the brain means not thinking in terms of personal character. Cathie's thinking may or may not be correct. But it is clear that her approach lends itself to patient empowerment. The way she thinks about Don's distress could lead to him taking on an active role in his healthcare. The psychiatrist's version of events helps him to deliver accountable care, but restricts Don's role to being the psychiatrist's eyes and ears.

Chapter five examines complexity. I noticed during fieldwork that certain patients would be described by staff members as complex. This seemed noteworthy because of my theoretical frame. If bureaucracies require simplicity, occasions of complexity are of interest. Complex

patients were indeed understood to be a problem. Complex patients are people whose character, ethics, worldview or social style are impossible to ignore. When a clinician says a patient is complex, they widen their gaze to include the very features that, in the interest of routinization, clinicians typically try to exclude.

The chapter contains two case studies. The first is a description by Moira of her dealings with Chloe. The second is an encounter between Giles, Diane and Viv. In both cases, we see clinicians struggling to deal with complex patients. Staff members are sceptical about complex patients. The care that different teams provide appears to be rather uneven. The ethnographic material about complex patients contributes to an understanding of the notion of empowerment. It is striking that both Chloe and Viv appear in some sense, to be highly empowered. They have distinct needs and preferences and communicate these effectively to staff. They are highly engaged in their own health. When in contact with staff, there seemed to be a kind of exchange going on, as if, like good consumers, complex patients are getting the best healthcare deal they can. However, to staff members they seem to be empowered in the wrong way. Staff regard the preferences of complex patients as being part of the problem. Teams actively seek to resist complying with complex patients requests because they believe doing so would be anti-therapeutic. For staff at least, this is not real empowerment.

Complex patients also reveal a little more about the potential harm of contact with services. Staff worry that complex patients become dependent. Their capacity to cope with their feelings, make important decisions or engage with others in equal, reciprocal, rewarding relationships is eroded. Polly suggested that distressed people choose to become patients, often as an escape from responsibilities that are hard to face up to. She presents the need of staff to maintain relations with patents, and to promote treatment adherence, as encouraging a

rather uninspiring, risk-averse and non-empowering clinical style. She presents staff neediness as a driver, too, of a disempowering clinical approach that rewards docility and penalises autonomy. To investigate this further I discussed the work of Pickard and Pierce on responsibility without blame (Pickard and Pierce 2009). The distinction they draw illuminates why bureaucratized teams struggle to deal with complex patients. They see health and ethics as tied together. But it is difficult to envisage a bureaucracy of personal ethics, in which responsibility were asserted and blame denied. The distinction they suggest might be clinically valuable, but it is hard to routinize. Indeed, much of the clinical talk described in this thesis pulls in the opposite direction. It serves to de-ethicize and to deflect responsibility from patients.

In chapter six I described Olivia's clinic. I describe Olivia at some length to try to show how she reconciles the competing demands of accountability and empowerment. I document the detail of how she talks with patients. Her clinical language is simple and leads straight on to familiar and justifiable decisions. The terms are flexible enough to be in soft focus when describing the patient and then hard focus as they become part of the justification of care. Changes in the degree of symptoms can be responded to by changes in the scale of treatments that target that symptom. One of the advantages of medication over competing treatment methodologies, including talk therapies, is that they are highly adjustable. There is a lot of scope for adjusting doses up and down. Large increases in symptoms can be met by large increases in dosages, and signs of the attainment of stability can be met with small, cautious reductions in dosages. I show how Olivia weighs up pro and cons, risks and rewards, to reach a decision or to give advice. Her lifestyle advice is of the same form as deliberations about medications drawn from RCTs. In this case, however, there is evidence to refer to. Indeed, what counts as local common sense shapes Olivia's scientific deliberations.

Olivia's relationships with her patients represent what I suggest is a 'routinized intimacy.' She has to ask repeated, standardised questions about very private and sometimes very painful topics. There is no reciprocity. Olivia has to extract standardised information, and convert her patient's distress into a reductive clinical narrative. The foundations of trust, empathy, and empowerment seem diminished, even absent. But in some ways, the effects of bureaucratic mechanisms on clinical relationships are helpful to Olivia. She is able to cite rules and regulations that force her to ask difficult questions. She can side with her patients when delivering bad news about diagnoses and treatments: it isn't Olivia herself deciding, but the 'evidence.' She can offer a kind of absolution for patient whose behaviour might have been criticised by their peers. For Olivia there is no blame and limited responsibility for her patients. Indeed, she can unite with patients against members of the public that don't understand, and stigmatise mental illness.

In the final chapter I describe an encounter between Simon, Diane and Dr Woolf. Simon is a patient diagnosed with Delusional Disorder, which is expected to develop into full Schizophrenia. Diane emerges as an expert in the strategic use of staging. In the car with Simon she creates a kind of intimacy in which she is rhetorically united with Simon against the stern doctors. She gathers information on the way that means Dr Woolf has little to decide in the appointment itself. On the way back, she reinforces Dr Woolf's message and encourages Simon to be compliant with treatment.

I try to stress in the ethnography how little Diane and Dr Woolf really know. They can't tell if Simon is hearing voices or not. They are unsure about whether he poses a risk of sexual assault. It is unclear whether he really took an overdose of medication. They can't tell if

Simon is a 'normal' flasher or confused innocent. They were even unaware that Simon recently took a flight to India, only to be returned because he lacked a visa. It might seem impossible to deliver care in the face of such uncertainty. It isn't. My ethnography shows Diane and Dr Woolf proceeding in a methodical and untroubled way. Not knowing is not a problem. In fact, I argue that it helps them, in ways that are revealing about how bureaucratized care functions. Routinization, coupled with limited knowledge, enables healthcare to run smoothly. Knowing more would simply muddy the waters and introduce complexity. Given their limited choices, Diane and Dr Woolf don't need more knowledge. Lipsky and others assumed that flexibility or discretion was needed for bureaucracies to deal with human complexity (Lipsky 2010). In this case, routinized working practices are what make decision-making relatively easy. More discretion would be an obstacle to getting the job done.

The ethnography reveals more about the workings of bureaucratized mental healthcare. Rule and rule-following are central to the notion of the office. It might be supposed that canonical texts such as the DSM 5 might be such a rule book. I find that although the way basic concepts are presented in the DSM do resemble the way staff talk and think about mental disorders, the detail is ignored. A very different model of care might be inferred from the way that delusions are defined in the DSM. Some popular criticism about psychiatry is directed at diagnostic manuals. This finding suggests that texts cannot be considered without taking into account the way they are used.

Diane and Dr Woolf are not curious about Simon's psychosis, and think of it as wholly separate from Simon. Psychosis is understood by professionals to arise out of dysfunctions in the brain and to be meaningless. When psychotic people talk, it can certainly be baffling and

demand some patience. However, I was warned against thinking of 'disordered speech' as being without meaning by the sister of a patient. Life-writing, novels, films and plays suggested the same thing. With Diane and Dr Woolf, Simon appears to deploy his madness. He tries to parry Diane's questions about the thought or idea of rape, whilst securing her support. Simon is more empowered, perhaps, than it appears. However, the role he is encouraged to adopt, of divulging secrets, ignoring the usual social norms and boundaries might have a role in reducing his capacity to interact with others as an autonomous social being.

Thinking of Oxford Health as an accountable bureaucracy explains much of my ethnographic data. A great deal of expertise, professionalism, and care quality can be read as the workings of an office. The need to be accountable, to produce a certain kind of justification for care, to be an impartial, objective clinician allowing the facts to decide, trumps other considerations. The principle finding of my research is that thin empowerment may be fully compatible with the bureaucratization of mental healthcare, but thick empowerment is not. Much of what clinicians and patients value about thick understandings of empowerment pulls against accountability. The contradiction is found in many places: in key concepts, in patterns of reasoning, in clinical relationships and in attitudes to risk. But the benefits of accountability should not be ignored. Even if it leads to less than fully empowering care, there are good reasons to prefer healthcare delivered by an accountable bureaucracy. The problem is one of conflicting goods.

Bureaucratization has contrary effects on patients. By decontextualizing a person's distress, external factors tend to be given little prominence and may even be erased. For example, structural inequalities and unfairness rarely find their way into medical notes. The individual

is, to a large degree, seen in isolation. However, because mental disorders are separated from the person, the patient is not held to be causally implicated either. Mental disorders themselves cause distress. Because mental disorders are province of experts, the patient is more or less a spectator, with little to do, but wait for treatments to work, perhaps whilst being vigilant and taking simple self-management steps.

My suggestion is not that the victims of mental disorders should now simply think of themselves as responsible for their problems. Rather, I argue that as a result of bureaucratization, a baby has been thrown out with the bathwater. Ethics, values and character are thought of by many mental healthcare professionals as implicated in distress and recovery, but, to bureaucratized clinical expertise, they have a very limited role in care. Excluding them from care helps routinization and is part of how Oxford Health achieves accountability. But empowerment and responsibility are connected. If patients are genuinely to be given a bigger role in their care, this entails greater responsibility.

Many commentators are concerned that mental healthcare is disempowering. It seems wrong to ignore disempowerment as a health outcome. The benefits of treatments, whether medications or talk therapies, need to be weighed against any negative effects such as disempowerment. It would be possible to orient care towards a greater role for patients. However, attempts to rebalance care in this way are likely to come at a cost. Care oriented towards patient empowerment may or may not be successful, but we are likely to know less about it. If it is harder to routinize, it will be harder to get a sense of care quality, or evenness, or safety. If the patient of an institution less orientated towards audit trails commits suicide, we are likely to know less about it, and have less sense of what might be done. If we are

serious about empowering mental healthcare patients, we may have to live with this uncertainty and, perhaps, replace documentation with trust.

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