Facing Facts: what's the good of change?

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Abstract

Tony Blair defines the role of Government as creating the conditions in which individuals can pursue fulfilment in their own lives to the fullest extent possible. This evidences a new form of compact between the State and the citizen that is only just coming fully into view – one which at the same time demands that the individual accepts responsibility for taking on risks that in the post war years the State sought to conceal if not remove in the name of a different kind of compact – one in which the State acted as guarantor of the individual. The vicissitudes that the individual is faced with as a consequence reflect distinctly different approaches to what can be expected from the State, in which the UK finds itself somewhere between the USA and continental Europe - but between what?

Thought of as a dilemma, the choice is between a presumption of the State knowing versus not-knowing best – a dilemma that in the UK can be seen clearly in the approach being adopted to the reform of the UK's National Health Service. Within the NHS, both horns of the dilemma jostle for attention through a heady mix of top-down driven versus locally-enabled interventions. Working within this context, what is most striking is what gets ignored in the process of holding steady in the face of such a confusion of directions pressing for change. Understood as a demand for negative capability – the capacity to hold still in relation to ignorance for long enough to allow learning to take place, it requires a capacity for containing anxiety that stretches managers and clinicians alike beyond reason. The question then becomes one of how to render such anxiety bearable in the interests of change.

The Lacanian perspective addresses this question in terms of the particular valency that insists between individual phantasy and the organisational architectures of power. The paper will use case material from a major intervention in the UK's National Health Service that made use of disruptive processes and supporting IT innovation, the aim of which was to put this valency into question in order to bring about change. The paper will explore the ways in which facts were not faced, and a blind eye was turned to the complexity surrounding the improvement of patients' access to health care. It goes on to consider how these processes for rendering anxiety bearable are replicated more generally within the wider context of society.

How is this to be theorised, and what consequences does this have for understanding 'resistance'? These questions are approached through the presumption that anxiety operates like a geiger counter in bringing manager, clinician and change agent alike to the question of the good of change. This approach mirrors the new form of compact with the citizen, having at its base a changed presumption of the good of anxiety, which constitutes a different basis for authority and leadership.

The paper concludes that it is paradoxically in the moments of disobedience to the architectures of power that the good emerges. This presents a new kind of challenge to leadership.

1. Introduction

The clinician is highly paid, because there are not many of them. He turns up at the clinic and sees the patients in appointments organised for him by the administrator. He reads the case notes, speaks with the patient, examines her condition, makes a prescription, sends her on her way, and completes the paperwork. And what is wrong with that?

The clinician will tell you that he has no time to think, has no chance to discuss cases with colleagues, and is on an endless treadmill as he tries to do his best for each patient as she appears in front of him in the limited time available. But what can he do about it? There have been many reports pointing out that patients are not getting the quality of treatment that they need, and that the focus on managing the costs by increasing throughput makes it impossible for the clinician to sustain a focus on outcome, beyond the moments in which the patient appears in front of him. But nothing seems to have happened as a result. The system grinds inexorably on with its priorities, in a way that seems oblivious to the actual suffering of his patients.

So he continues to do his best by the patients he sees. He is grateful for the living he is able to make. And he waits for the powers that be to change things for the better. After all, there are only so many times he can point out what is wrong, and have nothing be done about it. Better to get on with doing what you can where and when you can.

The challenge of the case

This paper is about work done by a team within the British National Health Service (the NHS) since 2000, examining the way *orthotic* clinics treat their patients. Orthotists are a type of clinician who prescribe 'orthoses', who work not only with orthopaedic and paediatric patients, but also preventatively with diabetic patients, osteo-arthritic patients, and so on. These orthoses are artificial external devices, such as a brace or a splint or special footwear, which prevent or assist relative movement in the limbs or the spine. The characterisation of the orthotist's experience within the NHS is not an unfair one, including the gender characterisation.

The team discovered that focussing on the early and sustained treatment of conditions involved initial investment and a significant increase in orthotic budgets. However, within five years this change of focus saved more than five times the initial investment in reduced need for the acute care and social costs associated with immobility in later life. Of course, a great deal more savings occur over the longer term, not to mention the enormous gain in the quality of patients' lives. It is as if the system had been set up to deal with acute conditions, if necessary by waiting until conditions became acute!

The challenges facing the clinicians and the Faustian Pact

There is a kind of *Faustian pact* that clinicians enter into with their host systems that, while not explaining why change seems impossible, does highlight what makes change difficult. The Faustian pact is an unholy alliance between the clinician and the system, in which the deal is: "As long as you give the system what it needs, you can do pretty much as you like, that is, as long as the patients don't complain." This pact silently declares 'we'll leave you alone if you leave us alone'. And of course, on the other side, the clinician goes to great lengths to keep obscure what he is actually doing for his patients. He behaves this way because he believes that the less the powers that be know, the less likely they are to find a basis for interfering with his practice for the wrong reasons or against the patient's interests.

The alternative to this Faustian pact confronts the clinician with a kind of *double challenge.* Clinicians have to question the nature of their own practices in relation to the consequences and outcomes in the patient's life, and simultaneously challenge the host system, insofar as that system creates contexts that act against the needs of the patient. This represents a kind of insistence, or even a form of constructive disobedience, that is supported by the evidence of the known facts and the challenge of the case that these facts reveal. This is what is implied by the idea of 'facing facts'.

What is the relevance of this to all of us?

The clinician stands for a particular desire to address the needs of the patient, however cynical we may become about how clinicians fall short of this in practice (Boxer and Palmer, 1997). In some sense, all practioners who have direct responsibility for patient or client welfare within institutions and organisations have some direct experience of this double challenge – a challenge that extends to all of us within the context of the wider society. The refusal to acknowledge and take up this double challenge leads to a kind of evacuation of the public realm, which is to the detriment of us all. Every client interaction becomes 'privatised', subject only to the vicissitudes of whatever Faustian pact it falls within – if you know your way around the system, this may suit your interests, but if not, then too bad.

2. What is going on if we look at the system as a whole?

2.1 The case itself

The original presenting problem and the proposed approach

Our original clients were the Purchasing and Supplies Agency of the NHS. We had been asked to help them develop an approach to purchasing derived from the nature of demand, as an antidote to the supply-side approach they had been using to date (Rosen et al, 2001).

The original problem related to the way orthoses were purchased by the NHS. Orthotics was largely a service contracted in by Acute Trusts, the orthotist having originally been provided to fit the supplier's orthoses. The clinician's time was therefore charged as an overhead to the cost of manufacture. Our clients were responsible for NHS purchasing, and the introduction by them of a national approach to procuring orthoses and orthotists' services separately had resulted in the unbundling of product and service and the aggressive pricing of contracts, but had also left the continuing cross-subsidisation of the cost of clinicians' time unchanged. As a result of the unbundling, budgets had been cut back by Acute Trusts, but so too had the investment and cross-subsidisation by the industry, ultimately reducing the quality of service to patients.

The approach we proposed was in three stages: firstly, a pilot stage of about 3 months to establish if we could indeed come up with a viable way of intervening on the demand side. Secondly, a pathfinder stage of about 12 months, using the approach developed in the pilot; and working with orthotic clinics within six Acute Trusts, chosen to represent the variety of contexts within which change would need to take place, in order to work out how to intervene in a way that could produce sustainable change. Thirdly, we proposed a 'roll-out' stage, aimed at spreading the benefits of the learning gained from the pathfinders across the NHS as a whole (Fitzgerald et al, 2002). We are presently between the pathfinder and roll-out stages (PASA, 2004).

What did we learn?

What we learnt from the pilot was the need to distinguish the *referral pathways* from the *care pathways.* A care pathway describes all the steps in a patient's treatment, but a referral pathway describes the pathway of referrals from clinician to clinician as the patient's presenting condition becomes progressively structured in the form of requirements for different kinds of treatment. We needed to understand how those referral pathways governed the ways in which patients' needs became demands for treatment, and in particular how those referral pathways had become *colonised* by clinicians' often tacit ways of organising patients' needs. This colonisation appeared to reflect more the custom-and-practice in the organisation of medical specialisms than the provision of the most appropriate forms of access to care. Intervening on the 'demand-side' meant challenging and changing these referral pathways.

Two different approaches to change emerged from the pathfinders, both working directly with the clinicians, and both depending critically on the use of data to enable the clinicians to develop an output-based approach to their clinics (Prahalad and Krishnan, 2002). Thus, both approaches involved us building a data platform that could enable the clinicians to see the characteristics of the episodes of care they were providing, distinguished by types of condition, and relating data across multiple appointments and multiple episodes. Fundamental in this was enabling the clinicians to relate their immediate experience of their patients to the patterns of care outcome they were achieving across the clinic as a whole – what might be called "facing facts".

One approach introduced *disruptive change* to the service (Christensen et al, 2000), developing protocols for direct referral from the *Primary Care System*, aiming to expand the service and transfer it as a whole from within the *Acute Care system* into the Primary Care system. It was disruptive because it used the needs of patients, presently discriminated against by the existing referral pathways, to establish a fundamentally different role for the clinic – preventative rather than acute.

The other approach was *reflexive change*, establishing clinical review processes which could use the data platform to provide the clinicians with the means to argue for change themselves, not only in relation to their own practices, but also in their clinician-to-clinician relationships within the larger context of Acute and Primary Care systems, separating out the primary and acute care roles of the clinic so that they could be funded differently. It was reflexive because it demanded leadership from the clinicians themselves in engaging critically with the organisation of their own practices.

What benefits were established as emerging from changing the way orthotists worked?

We found this a very difficult project. In effect, we were taking up the double challenge on behalf of the clinicians through the dual disruptive and reflexive approaches that emerged - creating its own dynamics within our team which reflected the difficulties the clinicians themselves faced in taking on the double challenge, and for which we needed our own supervision processes (Boxer & Eigen, 2003). The nature of this double challenge will be characterised below in terms of the relationship between two axes of organisation, represented by the points of the compass.

What we had identified were the benefits of a systemic change to referral protocols and pathways in the interests of patients' long term care needs. From the point of view of the clinicians, achieving changes depended on their leadership being prepared to open up their own practices to change. Not all of them were. Achieving changes in referral pathways meant renegotiating with other clinicians the basis on which referrals were made. Many had no time for doing this, or would use case instances to block any discussion of change. And always we were up against the inertia of budgets and administrative procedures. Nevertheless, in all cases very significant benefits were identified at all levels of change, impacting on the efficiency of the clinic itself, the quality of care to patients, the removal of unnecessary delays in accessing the clinic and the ability to respond to patients before their conditions became acute. Furthermore, when the economic impact of these benefits was modelled, it became clear that the long term cost benefits of increased mobility, particularly in the elderly, enormously outweighed the short-term investment costs needed to bring the changes about. It was not surprising that the clinicians' professional association was itself strongly supportive of these changes.

The difficulty was that the service was located in the Acute System, the costs were carried by the Primary Care system, and the benefits fell very largely in Social Services. There turned out to be no mechanisms and no 'sponsorship' for making these kinds of systemic change, despite the fact that we were now a project under the Modernisation Agency, and the Treasury modellers had endorsed the levels of benefit identified as having been understated. 'Sponsorship' is used here to distinguish the processes whereby change is authorised from the clients in relation to whom changes are made, again highlighting the nature of the double challenge.

2.2 The challenge to NHS reforms

The NHS context within which changes were being made

We were surprised to find no mechanisms and no sponsorship for making systemic change. In fact the NHS context within which the orthotists were working was something of a dead weight. So what was going on in this context?

A major change was being undertaken, which removed direct funding from the Acute System and channelled it via the Primary Care System. At the same time, the Acute System was subjected to a vast number of targets, most famously relating to waiting lists, which had the perverse effect of diverting both management's attention and government funding to short term fixes in order to meet those targets, while simultaneously taking attention away from the systemic changes needed to achieve long-run improvements. Here is the chairman of the Audit Commission, which audit's UK Government expenditures:

> *"There is a growing realisation that centralist command and control supported by a plethora of targets is as counterproductive as it was in the former Soviet bloc. Take, for example, the NHS, where many complain of over-management. In fact the NHS is not so much over-managed as destructively over-bureaucratised.... At the heart of our political system is a culture which cares more about the right process than the best outcome." (Strachan, 2003)*

How are we to think about what is going on here? We are looking at something that is not peculiar to the NHS, but is symptomatic of a way of doing business in a complex service environment. In what follows, a model is put forward through which to think about this larger challenge to service organisations.

How does this relate back to the challenges facing the clinician's practice?

I want to invoke the metaphor of the points of the compass to understand this. To the North we have the owners and directors of the institution; to the South we have all the infrastructure, capabilities and competencies available for use in satisfying client demands; to the East we have the client's needs in all their particularity; and to the West we have the know-how which brings what is to the South to bear on the demand to the East in a way that is effective in satisfying the client's demand. Thus the clinician's practice must work West-East in relation to the patient, while administrators work North-South in determining the use of resources.

A *North-South dominant approach* to running the institution subordinates what happens East-West to its requirements. This is what we are observing happen in the NHS, even though the reforms make this more difficult to see because of the way the pricing of healthcare is being imposed through the Primary Care system. Thus although control of expenditure is made more local, the relation to demand is still determined administratively. In contrast, an *East-West dominant approach* would subordinate the N-S supporting infrastructures to the requirements of satisfying the demand. This would involve a cumulative approach to funding patients' healthcare, based on direct management of the patient's through-life costs, thus taking into account the benefits of reducing healthcare risks. The outcomes of the pathfinder project showed that this was a less costly way of delivering better quality care to the patient than the N-S dominant approach.

So what happens when the East-facing demand is beyond the ken of those in command of the N-S axis, and the N-S axis remains dominant? Insofar as the demand gets satisfied, an 'informal' response emerges within the context of the formal organisation. Clinicians will go the extra mile to bridge the gap personally. Indeed clinicians may be paid a lot of money to do this if it is a regular requirement for the success of the organisation as a whole. The informal East-West space will then get colonised by clinicians who can provide the missing know-how and responsiveness; and if this informal organisation becomes established over time in co-dependency with the N-S axis, then we have the conditions for a Faustian pact, in which N-S says 'we will leave you free to do what you will E-W, so long as you provide us N-S with the behaviours and performance we need to maintain our dominant position.' This was the original pact made between the doctors and the government when the NHS was founded in 1948, and it remains intact today.

Questioning the government's response

In fact much of the government's current reforms appeared to be driven by the fact that the Faustian pact had become an end in itself for the doctors, keeping the system focussed on acute responses, and making the NHS too expensive to run. But the government's response has been to increase N-S dominance with all the target-setting, while changing the manner of subordination of the E-W axis through the shift of funding via the Primary Care System (Timmins, 2001).

The learning from the pathfinder suggested that an East-West dominant approach would be more effective, both in terms of cost as well as for the quality of care. But it would have to be based on a properly demand-driven role for the Primary Care Trusts, empowered to make systemic changes in the interests of providing better through-life care – they would have to meet a double challenge. In what follows the ways in which current changes fall short of this are taken as being symptomatic of the difficulties facing the State itself in how it authorises change, At the heart of these are the difficulties of meeting the 'asymmetric' demands of citizens – demands that expect responses that are particular to each individual citizen. The NHS shows these difficulties very clearly, since the more successful it is at treating general conditions, the more it faces these asymmetric forms of demand.

3. The Double Challenge posed to the State

3.1 The emergence of the Market State

The underlying intention of the Government

What we have, then, is an original N-S dominant model of the NHS run by the State, with its heavy dependence on its Faustian pacts with the medical profession; and a modified version of this model, still N-S dominant and still with the Faustian pacts intact, but with control of spending moved into the Primary Care System.

What we appear not to be getting, yet, is an E-W dominant model, built around the Primary Care System being able to secure the delivery of through-life health care to the individual. Nevertheless, this is the vision of New Labour's policies for modernising government:

> *"Modernising Government is about government for people - people as consumers, people as citizens… we will make sure that government services are better - that they reflect real lives and deliver what people really want… To improve the way we provide services, we need all parts of government to work together better. We need joined-up government. We need integrated government." (Jack Cunningham, 1999)*

Should we be cynical, or are we in fact seeing evidence of a fundamental shift in how we think about and envision the role of the State, in which it will ultimately no longer be a matter of what benefits we

get in return for being loyal citizens, but rather what support we citizens have a right to expect in return for the taxes we pay.

What does this say about changes in the economic basis of the State itself?

We appear to be living through a profound transition from the *Nation State* of the twentieth century to the M*arket State* of the twenty-first century (Bobbitt, 2002). In essence the State withdraws from being a provider in the Market State, changing instead to being an enabler of services, and drawing its legitimacy from its ability to create opportunity for its citizens.

This transition in economic basis is occurring precisely because of the success of the dominant approach to doing business, established during the course of the twentieth century following the innovations of mass production, and called *managerial capitalism* (Zuboff and Maxmin, 2002). With its much-criticised side-effects associated with globalisation (Stiglitz, 2002), its assumption is that value is lodged in the products and services the enterprise sells. It is the success of this approach that has led to the emergence of the new forms of capitalism associated with the Market State, in which the growth in value to the supplier becomes subordinated to growth in value to the client citizen. Thus as goods get cheaper and more commodified, so value shifts to the ways in which those goods can be used to create value. This is more than a service economy. It must be concerned with addressing the demands of the client citizen that are particular to the client citizen's *context-of-use*. The value shifts from being in the product or service to being in the relationship through which the product or service becomes useful – from the fitting of an orthosis to the provision of effective orthotic treatment over time.

This transition is reflected by changes in the technology of warfare as well as of commerce, as digitisation changes the economics of both forms of organisation. And ultimately it is reflected in changes to the way the State's citizens cede powers of life and death over them, currently very much in evidence through the impact of terrorism on 'homeland' security. Terrorism here is the small act of violence that can have a totally disproportionate impact on the State, because of the complex interrelationships between everything, and because such acts are so difficult to anticipate precisely because they are such individual acts. The effectiveness of terrorism shows the other side of this different economic basis for the State – namely one dependent not only on securing the economic autonomy and initiative of its citizens, but also on having its citizens accept the risks of so doing.

The emergence of asymmetric demand

Managerial capitalism serves its own interests by targeting those elements of demand that are common across consumers and thus are 'symmetrical' with the supplier's own capabilities. In contrast, *asymmetric demand* is that component of demand which is particular to the client's context-of-use. It is about wanting to embed the product or service bought in the client's life in a way that is effective and useful. The patient needing treatment for the nature of their particular condition presents an asymmetric demand.

With asymmetric demand comes a gap between buying something and being able to make effective use of it. We have all experienced this gap at the level of the product that we can't work out how to use, or getting the builders to do what we want, rather than what suits them. In the case of orthotics it is the shoe which fits, but which is not worn because, despite its remedial benefits, it is too uncomfortable to walk in. The increasing frustration with managerial capitalism, and its attendant effects of globalisation, is precisely because its strengths in providing us with mass produced goods (i.e. responding to 'symmetric' demand) are also a reflection of its weakness in addressing this gap.

In the terms used earlier, managerial capitalism reflects N-S dominance, whereas asymmetric demand requires E-W dominance. In these terms, it is the Faustian pact that allows the patient's demands to get dealt with to some extent, depending on who the patient knows, while leaving the N-S axis unchanged. But this is not going to be adequate within the Market State, organised as it is in relation to the asymmetric nature of demand. This is what makes the NHS particularly interesting. We see there what happens when these two models collide, reflected in the choice between N-S and E-W dominance, and the difficulties the State faces in securing a transition from the one to the other. In what follows, we will consider this choice as being ideological in nature, implying different forms of relation between citizen and State.

3.2 The double challenge at the level of the State

The effects of the Faustian Pact at the level of the State

We see the effects of the Faustian pact at the level of the State in 'the American Business Model' (ABM) (Kay 2003, pp307ff). This is based on four claims: that self-interest should govern our

economic lives; that markets should operate freely without regulation; that government's economic role should be kept to the minimum, and not include providing goods and services or owning assets; and that taxation should be as low as possible and not seek to bring about redistribution. The politics of this position are those associated with the minimal State. This position does not describe the way the US economy actually works because it ignores the social institutions within which 'markets' are embedded. These are in fact highly developed, and define the nature of the public realm, determining the nature of such things as who can know what, who bears risk, corporate cultures and ethical values, and the standards, knowledge and information in the public domain. (Kay 2003, pp318-319)

The Faustian pact at this level leaves us free to go about our business *as if* the ABM is true, thus leaving the social institutions out of it, provided that we conform to the behaviours they require. This *as if* has the effect of evacuating the public realm of debate about what should be in it, by rendering everything as private. Needless to say this serves particular kinds of vested interest, particular those associated with incumbent wealth and the status quo.

The evacuation of the public realm

But is this evacuation of the public realm a necessary characteristic of the Market State? The Continental European vision of a Federated Europe is based on something rather different: social regulation, redistributive taxation, and public provision of services and welfare, although the challenges it faces over low growth and high unemployment appear to be forcing it to consider, however reluctantly, at least elements of the ABM (Menendez, 2000). What we appear to be encountering therefore are choices not only for ourselves, but also about the nature of the public realm and our attitudes towards property, equality, and social solidarity (Hutton, 2002). Thus we see these issues arising not only in relation to the NHS, but with transport, utilities, pensions, care of the elderly, and so on. These choices show that the double challenge exists as much at the level of the State as within our own particular institutional contexts, in either case challenging not only our practices, but also our relationship to the systems within which we live. Thus the evacuation of the public realm is an effect of the Faustian pact – it encourages us to withdraw from the public realm in order to protect our own interests, and in so doing to serve others' interests.

3.3 Reflexive modernisation

On what basis is the individual to establish what is true?

We can see the shift towards a Market State as a shift to a *risk society*, which has as its corollary the idea of *reflexive modernisation* (Beck, 1992). Thus previously, simple modernisation meant improving things in relation to the past in a way that took for granted the claims made about 'progress' by a liberal democratic society. Reflexive modernisation calls this very direction into question: a questioning that has to be undertaken not only at the level of the individual, but at the level of institutions as well (Beck et al, 1994).

Thus, whereas the 'modern society' of managerial capitalism has been about the distribution of goods, the risk society becomes about the distribution of opportunities and dangers. In this risk society, each of us becomes increasingly concerned about what might go right or wrong for us, rather than with what we have; and social change becomes a matter for us as individuals, rather than being defined by our membership of a social class. And these risks cover all aspects of our lives - ecological, medical, psychological, social, financial etc - impacting on us on a daily basis. The central characteristic of the Market State therefore becomes that it is the citizen who is responsible for the risks of not being able to live the 'happy life' – a responsibility that had previously rested with the State in its Nation State form. Thus New Labour's vision as expressed in the NHS reforms can be understood as seeking to create the institutional conditions in which this transfer of responsibility to the citizen can ultimately take place, and the pathfinder projects pointed out another step along that way.

The Market State, then, is not only about having personal choices, but also about choosing within what ideological frame these choices are to be formulated. But if we think of this ideological frame as an individual formation within which we formulate our choices, then if the *a priori* public good is being dismantled around us, what does this throw us back on? Within what personal formations are we each to make our choices? How are we to make sense of what is 'good' for us? We find ourselves facing vicissitudes of identity in which people experience "devaluation or removal of identities they thought they had, while at the same time there is a lack of identities that might reflect and express our increasing global interconnectedness…" (Eric Miller 2002). If choosing in a Market State is not to be simply about maximising our private choices, what is it to be in relation to? How are we to authorise our truth claims if not in relation to a received wisdom?

Authorising truth

We find the double challenge at the level of the State appearing therefore at the most intimate level of day-to-day identity, through the way we question the very contexts within which we weave those identities. We have to find our own particular way of making claims about what is true for us, which means questioning the truth claims offered by the systems within which we live and work (Boxer, 1999), at the same time as facing the necessity to go beyond what we know, if we are to be able to meet the specific need of the patient (Boxer and Palmer, 1994).

This grounds the question of authorisation ultimately in the reflexivity within which we give meaning to our experience (Beck et al, 1994). Authorisation becomes emergent, grounded in the practices we choose to construct and share as communities through which we make our living-together, practices that go beyond the mere sharing of interests. This leads us to the *discursive formations* (Foucault 1974; Palmer 2000; Long 2001) through which we can reveal the outlines of our own processes of authorisation. It is this formation that renders our demands necessarily asymmetric through their embeddedness in ourselves as contexts-of-use, and not just 'customer-centric'. To 'face facts', then, is to question the extent to which this responsiveness to context-of-use is actually happening.

4. The double challenge posed to those working within the system

4.1 Facing Facts

The discursive formations within which we constitute our 'truths'

In 'facing facts' we are always already personally implicated, because to 'face a fact' is not to discover something already there, waiting to be named. Rather it is to understand naming as an act, in which the unity of the object named is a retroactive effect of the act of naming itself. That is, the relationship we have to our experience is retroactive, always mediated by the effects of language and culture. In these terms, the object is an effect of a discursive formation that refers to that 'something in the object that is more than the object itself'. This 'more' shows us our desire in relation to the object, so that the act of naming structures the particular form of this 'more', as well as establishing our particular relation to it. Thus, for example, the particular way a clinician identifies a patient's condition may, on the face of it, describe certain objective features of the patient's aetiology. But it also structures a particular relation to the patient through which the clinician may fulfil himself or herself as such.

To 'face facts', then, is to encounter our particular relation to what-is-going-on through our discursive formations. A discursive formation is characterised by its objects, concepts, enunciative modalities and strategies, but it is the strategies that give the aura of authority to our formations, locating the objects and ways of operating on those objects in relation to the particular positions from which they can be spoken of authoritatively. Foucault approached these strategies through what he called 'the points of diffraction' in a discursive formation:

> *"These points are characterised in the first instance as points of incompatibility: two objects, or two types of enunciation, or two concepts may appear, in the same discursive formation, without being able to enter the same series of statements under pain of manifest contradiction or inconsequence." (Foucault, 1974, p65)*

Thus strategies are the themes or theorems that give the appearance of unity and coherence to the field of practice, in this way defining the 'good' of the whole as an Ideal formation. So while facing facts presents the subject with incompatibilities or 'gaps' in a formation, revealing the formation as lacking, strategies organise and systematise a formation in a way that gives it unity and coherence, rendering it Ideal. This is why it is so difficult to face facts. They disrupt the Ideal formation.

The formation of our relation to desire

The psychoanalyst approaches this discursive formation as a reflexive formation, speaking of its basis in unconscious phantasy, through which we become the subject of our unconscious. This phantasy provides the underpinning for our Ideal formation, not only organising our desire, but also enabling us to be someone in particular through the way we live as its subject. The protection this gives us from the unconscious protects us because, insofar as we are open to the gaps and inconsistencies in our own being – to our own lack , we expose ourselves to anxiety. Here, then, is a notion of the 'good' expressed as a relation to an Ideal formation that reflects our particular relation to desire.

When we take our reflexive formations into the social domain, however, strategy becomes ideology – the structuring of the nature of social reality itself (Zizek, 1989). In this way we can see the

American Business Model or the Continental European vision of a Federal Europe as ideologies. And at the level of the formation of the institution, we encounter it as the institution-in-the mind (Armstrong, 1997).

Living between two 'goods'

So how do we, as both citizens and subjects, live between these two 'goods', between the good offered by ideology and the good constituted by our particular relation to desire? How we do this depends very much on the nature of the valency that each has for the other – the ways in which ideology provides us with a way of living in relation to the particular nature of our desire. Given such valency, even if it takes the form of a Faustian pact with ideology, then we can be happy enough; and insofar as we are not happy enough, we can consider change by putting the valency into question (Arnaud, 2002).

In terms of the N-S-E-W model, privileging the 'good' of ideology implies North-South dominance, while privileging the 'good' that emerges from our particular relation to desire implies East-West dominance. Here we see the double challenge re-emerging as a challenge of two 'goods', each privileging one of the axes over the other. Of course to privilege the E-W axis sounds 'selfish' in terms of ideologies of the good, but reflexivity means considering such prohibitions as themselves ideological, serving to deflect us from facing the question of authorisation and its double challenge.

So what happens if the ideology itself undergoes significant change? This is what is implied in the transition from Nation State to Market State, and in the associated changes being faced by the NHS. This means not only having to address the question of how the valencies presently available can accommodate each of us, but having to develop new accommodations to our particular relation to desire, with all the attendant anxiety that this gives rise to. The difficulty is that we have become habituated to privileging the ideological axis. Reflexive modernisation is what happens when we are forced to reverse this, and work directly from our particular relation to desire. This brings us face-to-face with the good that can appear in the gaps in ideology – in its 'points of diffraction'.

4.2 Anxiety and the question(ing) of the good

The two axes of anxiety

The gaps that appear in ideology expose us to anxiety, experienced as fear without an object. Such anxiety is difficult to arrive at, because we are usually pretty good at putting an object in the way of fear. Thus, when the client of a psychoanalyst puts an object in the way, the psychoanalyst calls it a symptom. But when people being asked to change within the NHS give their reasons for not changing, as they seek to conserve their identity through the conservation of their relations to their objects, we call it resistance to change. Either way, the emergence of such gaps exposes us to the possibility of gaps in our very formation as subjects of the unconscious, therefore exposing us to anxiety.

Lacan, in his seminar on anxiety (Lacan, 1962), considers the relation of symptom to inhibition and anxiety in terms of two axes. The first relates to movement towards 'care', as in "taking great care". This idea is derived from Heidegger (1978), and means paying particular attention to how we bear the embodied nature of our being – that is, the fact that our destinies are somehow bound up with the body through which we find our being, and with which we are somehow thrown into this world. In its most extreme form, this taking care involves the introjection of an Ideal under which we can know ourselves to be good. This is the use of ideology at its most extreme, providing us with the justification within which to act, through providing ourselves with the sense that we are acting for a good cause. It is the North-South Axis, which, if pursued to the total dominance of the other axis also leads to an extreme of right indicative of Heidegger's relation to National Socialism (Farias, 1989).

This other axis is a movement towards increasing difficulty in knowing what to do, which is what implicates our desire, and which in its most extreme form, involves the subject "suffering the greatest difficulty in what is implied by a successful outcome to the obstacle presented." (Harari, 2001). In other words, if this thing that I would like to happen were actually to happen, what then would be the consequences? What if the result then was that these other things happened? And yet, what if I do nothing? What will happen then? And so on. It is the East-West axis.

This East-West axis of difficulty is derived from Kierkegaard's 'concept of anxiety' (1980), in which freedom appears before itself as a possibility. Every case presents the clinician with a challenge to address its singular nature in a way that is particular to the case. Ideology, in the particular form it takes as the host system that governs us, but from within which we derive support for our identity, provides us with a way in which we can know what will happen. 'Freedom', then, involves calling this ideology into question, through questioning its valency ultimately with our own unconscious phantasy, through the way it opens up an awareness of our own relationship to our 'lack'. This East-West axis is

where we can become immobilised by our consideration of 'freedom's possibilities'. This way lies an intensification of anxiety.

But it can also be our guide. To quote Kierkegaard:

> *"… whoever is educated by possibility remains with anxiety; he does not permit himself to be deceived by its countless falsifications and accurately remembers the past… for him, anxiety becomes a serving spirit that against its will leads him where he wishes to go." (ibid, p159)*

While inhibition involves no movement in relation to either axis, anxiety involves the greatest movement, with the role of the symptom being somewhere in between. Anxiety therefore involves combining taking the greatest care with anticipating the greatest difficulty – the double challenge again.

Using anxiety 'against its will'

The familiar notion of leadership is associated with the North-South axis embodying an Ideal, not only for ourselves, but for others too. East-West dominance argues for a different form of leadership that is reflexive in nature and capable of challenging the system rather than embodying the system – not only a leadership that accepts anxiety, but a followership that accepts it too. This requires Keats' negative capability:

> *"… effective leadership involves seeing moment by moment, day by day, what is actually going on, in contrast with what was planned for, expected or intended…. leaders must put themselves to one side, in order to allow their minds to be changed by 'truth-in-the-moment'… the heart of the paradox is that it may only be by changing and re-visioning the organization's reality as it evolves that a leader can preserve the focus on the task." (Simpson et al, 2002).*

This is a constructive disobedience to 'preconceived certainty', that bears the anxiety that arises with it, and uses anxiety 'against its will'. What makes this difficult is that it involves bearing not just the 'performance anxiety' associated with the dangers of implementing change, but also the 'primary anxiety' that we experience in considering 'freedom's possibilities'.

No wonder, then, that we opt for the Faustian pact. In avoiding the double challenge we are also avoiding placing something of ourselves in question. But no wonder, too, that we live in anxious times, in which our supporting ideologies are themselves in question, with or without our involvement (Boxer, 1994). Although our encounter with these dangers keeps us rooted to our particular inhibition or symptom, it is only by loosening their grip over the particular form of our desire that we can encounter anxiety in a way that can be constructive.

5. In Conclusion

What new things does all this demand that we learn?

Asymmetric demand is particular to ourselves in the way our desires are constituted, and while the Market State is requiring us to assert them, the ready-made definitions of the ideological good are not working so well, so that we must not only find new truths, but find them in new ways. To face facts is to understand that these truths are to be found in amongst the ready-to-hand fabric of our day-to-day lives, to be built in a way that must be particular to ourselves and our context – home-cooked so to speak. But it is no accident that the phrase "what's the good of change" has another meaning: "let's be realistic, no amount of change is actually going to change things. They are not going to want to change their underlying behaviours." Just the other side of that active engagement with what-is-going-on is the despair of alienation that leads us to make do with a Faustian pact!

Clinicians can not do this in isolation from each other. The demands on them are too complex for that. Patients' conditions increasingly require that many different kinds of clinician work together effectively for the good of the patient over extended periods of time. So it is for any complex system facing asymmetric demand – an individual cannot make the system's responses effective on his or her own. It is nevertheless true that we each face anxiety alone. In knowing this, we must therefore admit a different kind of ethic enabling us to take up this double challenge: an ethic that is predicated on assuming responsibility for the particular form of our relationship to desire as well as questioning our relation to the architectures of power.

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Glossary

Acute System: medical and surgical treatment and care provided typically in hospitals.

Asymmetric demand: that component of demand, which, being particular to the client's context-of-use, is about embedding the 'thing' in the client's life in a way that is effective and useful. Contrasted with symmetrical demand, being those products or services that are symmetrical to the suppliers capabilities and are common across consumers.

Care pathway: describes all the steps in a patient's treatment.

Colonisation: the way referral pathways were organised by clinicians' often tacit ways of organising patients' needs, reflecting more the custom-and-practice in the organisation of medical specialisms than the provision of the most appropriate forms of access to care.

Context-of-use: in considering the relationship of a supplier of a product or service to a customer, that customer will incorporate the product or service into the context of his or her own practice of living. This practice of living forms the context-of-use for the product or service.

Discursive formation: a formation defined by its objects, concepts, enunciative modalities and strategies. These locate the objects and ways of operating on them in relation to the particular positions from which they can be spoken of authoritatively, while the strategies convey the aura of authority itself through giving the formation the appearance of unity and coherence.

Disruptive change: a change in which the needs of patients presently discriminated against by the existing referral pathways are used to establish a fundamentally different role for the clinic – in this case preventative rather than acute.

Double challenge: on the one hand it involves clinicians questioning the nature of their own practices in relation to their consequences and outcomes in the patient's life. And on the other hand it involves challenging the host system, insofar as that system creates contexts that act against the needs of the patient.

Faustian pact: an unholy alliance between the clinician and the host system, in which the deal is: "As long as you give the system what it needs, you can do pretty much as you like, so long as the patients don't complain." A kind of 'we'll leave you alone if you leave us alone.

Gap or Lack: a point of incompatibility or manifest contradiction in a formation. When the formation is reflexive, such a gap is a failure of unity or coherence in relation to our unconscious, exposing us to anxiety.

Informal organisation: That organisation which is not formally authorised by the 'powers that be', but rather by the personal or private authority of those who work within the formal organisation.

Managerial capitalism: capitalism based on the assumption that value is lodged in the products and services that an enterprise sells.

Market State: the emerging constitutional order that promises to maximise the opportunity of its people, tending to privatise many State activities and making representative government more subject to the market.

Nation State: the dominant constitutional order of the twentieth century, promising to improve the material welfare of its people.

North-South vs East-West dominance: Using the metaphor of the points of the compass, to the North are the owners and directors; to the South is all the infrastructure, capabilities and competencies available for use in satisfying patients' demands; to the East are the patients' needs in all their particularity; and to the West is the know-how which brings what is to the South to bear on the demand to the East in a way that is effective in satisfying the patient's demand. A North-South dominant approach to running the institution subordinates what happens East-West to its requirements. In contrast, an East-West dominant approach subordinates the N-S supporting infrastructures to the requirements of satisfying the demand.

Orthosis. Artificial external devices, such as a brace or a splint or special footwear, which prevent or assist relative movement in the limbs or the spine.

Primary Care System: the general medical services, community health services and wider primary care services responsible for a resident population.

Referral pathway: describes the pathway of referrals from clinician to clinician as the patient's presenting condition becomes progressively structured in the form of requirements for different kinds of treatment, which in turn require care pathways.

Reflexive change: change demanding leadership from the clinicians themselves in engaging critically with the organisation of their own practices.

Reflexive modernisation: a questioning of truth claims about the nature of modernisation itself as 'progress', not only at the level of the individual, but at the institutional level as well. The point about this reflexivity, as with the earlier process of reflexive change, was that it involved individuals or institutions questioning their own ways of framing progress.

Risk society: a society in which each of us becomes increasingly concerned about what might go right or wrong for us, rather than with what we have; and social change becomes a matter for us as individuals, rather than being defined by our membership of a social class. This contrasts with the 'modern society' of managerial capitalism being about the distribution of goods. These risks cover all aspects of our lives - ecological, medical, psychological, social financial etc - impacting on us on a daily basis.

Sponsoring System: The authorising context within which the legitimacy of change is established. To be distinguished from the client system, which benefits from the effects of change.

Valency: the commensurability of ideology and unconscious phantasy, enabling the one to create the conditions in which the other may be sustained.

Value deficit: the value gap that arises between the symmetric and asymmetric components of demand, between buying something and being able to make effective use of it.