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Reflections on Ethics and Values from the Public Hospital

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"The work of thought is not to pose answers but to problematize them; it is to respond to a situation not with a solution that might end discussion or action but with a question that might open up new possibilities [1]."

Socrates: "Is a doctor in the precise sense … a money-maker or someone who treats the sick? [2]"

Abstract

The public hospital has long been besieged by a politics of fabricated scarcity. This study of San Francisco General Hospital shows how its functioning is driven by value-complexes or "models" that are inflected by the dynamics of U. S health care. Four models of hospital operations -- normalization, compassionate care, trauma and management – contend and conflict in substantive patient care situations. The political refiguration of values that occurs when these models interact provides a critique of how health care, widely endorsed as an ascendant (or meta-) value, is implemented yet eroded, challenging caregivers and citizens to advocate policy reform in the interest of maintaining a safety net and bringing about health equity. Can a politics of clever opportunism be replaced by a value-driven ethics of care aligned with social good and human thriving?

Keywords: Public hospitals; Critique; Ethics; Advocacy

David Newton is a white man in his late 20s who has a generous mop of sandy blond hair and likes to ride around San Francisco on his bicycle. He works at a neighbourhood hardware store and people who come into the store often ask him to tell them the story of the scar on his face. He is happy to do so and sings his praises for San Francisco General Hospital[1].

He was riding his bike one afternoon in the Mission when a car stopped abruptly in front of him. He knew immediately that he would not have time to stop before running into the rear of the car, so he veered to the side to avoid a collision, only to find himself flying at top speed. He had avoided the first vehicle only to collide with the second vehicle just in front of him.

When his bike hit the rear bumper of the car, he was launched off his bike and smashed through the car's rear window. When he came to, he was in the back seat of the car. Blood was everywhere, but the paramedics had already arrived and shipped him directly to the Emergency Room at San Francisco General Hospital.

1 San Francisco General Hospital was renamed Zuckerberg San Francisco General Hospital and Trauma Center in 2016, after the founder of Facebook made a substantial contribution to the institution. I have, however, retained the hospital's official name as the ethnographic present I knew during my time working there. As represented in this essay. SFGH is an historical entity. It remains an exemplar of issues that continue in the present.

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The rest is history. David was lucky to be near the hospital when the accident occurred. He was also lucky that San Francisco General specializes in treating trauma patients. As a souvenir from the accident, he has a crescent-shaped scar, very even and clean, from the corner of his mouth to his right ear. He lost three teeth and had experienced considerable blood loss. The fracture of his mandible took a while to heal, but miraculously, he did not sustain a major head trauma.

Since the accident, I often see him on the street near the hardware store, but he is never riding his bicycle. He goes on with life, knows how fortunate he was and tells how the hospital made the conclusion of his story a victory. David has every reason to be a happy-go-lucky kind of guy.

Introduction

Dramatic as it is, David's story is not unique, which demonstrates SFGH's promotion of well-being for the public. The layered, institutional, political and social conditions that make for the positive outcome of David's case may not be immediately apparent, but they comprise a politicized assembly of values, dispositions and technical expertise that bring about care. SFGH as well as David's experience as a patient is implicated in that system, which is less systematic than it is a zone of competition for fiscal resources and social legitimacy, and a venue for debates over values and applicability. Care at SFGH and elsewhere is a problem to be addressed more than as an achieved public good. This essay examines how care at SFGH is negotiated through diverse value and models of care, as they are implemented in the clinical arena. I will reflect here on the problem of an ethics of care as both essential and as problematized by the politics acted out at SFGH and beyond. David's narrative of healing must be understood in that broad institutional context. What his story does not disclose is the paradox of care as an institutional mission at SFGH but undercut by its institutional situation. How this paradox is realized at SFGH and defines the politics of care is a constant challenge to caregivers.

SFGH provides care to more than 100,000 patients a year, many of whom are uninsured, due to expanding inequalities [3, pp. 12-13; 4, p. 135]. The hospital serves a beleaguered, underserved population for whom life is less readily livable, given over-taxed social services, shelters and soup kitchens, long waiting lists for low-income housing and clinic appointments, and budget cuts from city hall [5][2]. At the hospital, I worked as nursing supervisor, doing participant observation along the way; in this essay, my critical voice overlays that of a practitioner[3]. From this dual perspective, I portray the politics of care at the hospital, reflecting health as a meta-value but not always a societal norm; perhaps a growing pragmatism has diminished the "value of values [6, p. 316]."

The language of values in the hospital's day-to-day functioning is variously expressed in the process of care at the bedside. "The bedside" is both a zone of engagement of the caregiver with the patient and a metaphor for implementation and practice in other settings; full treatment of the macro-issues that face health care is beyond the scope of this essay. However, I must acknowledge that the hospital is a microcosm of the politics and pathologies of a society that makes promises it does not keep and a symbol expressive of the contradictory altruism and exploitation of the health care system; such is the paradox lived out in that setting. In the last part of this essay, I therefore venture to outline an ethics of care as I observed being pursued at the bedside, an ethics that may begin to address these larger realities.

In her ethnography of a psychiatric emergency room, Lorna Rhodes demonstrates that contested values is an ongoing issue for hospital functioning. In that setting, caregivers "discharge patients quickly and yet treat them adequately." Rhodes [16, p. 1] found that "contradictions in the situation of the hospital" made the emergency room "a site of both acquiescence to the institution's constraints and a complex and strategic resistance." Her description could be of the Psychiatric Emergency Service (PES) at SFGH. Tanya Luhrman [17, p. 97] gives a more pointed description of such settings in which, she says, caregivers have "to fight to keep their compassion" as clashing values have to be negotiated in the clinical arena.

John Murray [18], a specialist in pulmonary medicine in the ICU at SFGH, gives a nuanced portrayal of his work at the bedside. He is an expert in normalizing patients' complicated medical conditions, a priority that makes the contradictions of care less visible than in the psychiatric emergency room. Critical care patients are easily traumatized by that experience, a problem that may be eclipsed in that setting. Murray's description suggests that the pressing psycho-social needs of patient and family may be overshadowed as caregivers, prioritizing the so-called medical model, attend to unstable vital functions. Compassionate care and support in the face of such trauma can be short-changed, causing

2 Boehm [7, p. 50], Rylko-Baur and Farmer [8, p. 482], Hoffman [9] and others have demonstrated changes in health care economics brought about by a politics of scarcity, that have seriously compromised the health care and social services providing a safety net for the disenfranchised [10; 11, p. 744; 12, p. 7].

3 It is neither necessary nor possible to give a "complete" description of the hospital. I focus on the problematics and paradox of bedside care, in reference to an "assemblage" [12, pp. 54-56] of "heterogeneous elements, techniques and concepts," the hospital one among them, threading together various practices, radiating through local, national and global processes [14,15].

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implicit care rationing. In PES and in the ICU, explicating and working through such challenges makes critique essential to caregivers' strategizing on behalf of patients and their families.

Clinical Thinking is Critical Thinking

Since Boas, anthropology has countered ethnocentrism and so has encompassed critique as a feature of its ethos. Observing social realities that noticeably deviate from claimed values, ethnographers are de facto, if not always overt practitioners of critique. As Marcus and Fischer [19, p. 167] acknowledge, "advocacy or assertion of values against a particular social reality is the primary purpose of critique." As analyst and practitioner, I undertake critique as a prescriptive as well as a descriptive project, advocacy thus complementing description. The "should" and the "is" are not polar endpoints, but shifting perspectives that imply the necessity of advocacy, reform and a priority on an ethics of care.

While critique inclines toward the political and criticism toward the literary, the terms are broadly interchangeable. Foucault [20, p. 176] gives the concept a provocative, rhetorical impetus: "I'd like a criticism of scintillating leaps of the imagination. It would not be a sovereign or dressed in red. It would bear the lightening of possible storms [21, pp. 175-176]." As not sovereign, critique must be linked to description and truth-telling, particularly when institutional self-description does not, as at SFGH, fully explicate the norms and values reflective of day-to-day practices [22, pp. 148,157]. Critique has a clear alliance with social description and social thought, but it goes further. It entertains "the possibility of no longer being, doing, or thinking as we are, do or think [23, pp. 315-316][4].

Arendt understands critique as built into thinking and rooted in the concept of humans as "question asking beings [24, p. 62]. Critique "inevitably has a destructive, undermining effect on all established criteria, values, measurements of good and evil, in short on those customs and rules of conduct that we treat in morals and ethics [24, p. 175]." Clinical thinking worthy of the name must embrace Arendt's understanding of critique not only in focusing clinical judgment – on what the patient needs in relation to what the "system" allows – but when the "system" does not allow what the patient needs, on pitting the former against the latter. Critique embraces pushback. In doing so, it moves beyond abstract norms and values that make up the context of clinical thinking: In implementing care, caregivers' use of critique revises and redefines their relation to such values.

Foucault's [25, p. 265] notion of critique as "not being governed quite so much" underwrites this understanding of clinical thinking. Critique reserves "the right to question truth" [25, p. 266], both the truth of the patient as defined by clinical assessment and especially the truth of the system or institution in regard to what it allows and what it values, specifying the problem of relating one to the other. In Foucault's terms, critique is "a question of attitude" [25, p. 278] which I translate as caregivers' questioning of institutional protocols and standards. This orientation may require "leaps of imagination" to think differently in order to assert alternative approaches to care.

Butler [4] interprets this orientation as a critical relation to existing norms that requires caregivers to remake themselves in such a way as to expose the truth of the patient over alleged "truths" of the institution. The caregiver's skepticism of institutional norms and values derives from putting patients' interests first, foregrounding "the truth of the patient" which encompasses both subjective self-understandings and preferences and the facts of his clinical status [26, p. 91]. Care may have to question some norms to implement others.

Models of Care

Bedside care at SFGH is defined by an interplay of four models of and for care. As I describe them below, these models or value complexes organize caregivers' "sphere of action," laying out the "conditions of possibility" for accomplishing care [27, pp. 121,124]. However, as Weber [28, p. 147] pointed out, such models may conflict, requiring caregivers to practice ethical deliberation rather than following a standard recipe. This situation of contending models is comparable to Paxson's [29] description of Athenian women's deliberative practice through which they achieve full womanhood by negotiating among ideal type models: an ethics of service, whereby a value of responsible, feasible childrearing is highlighted; an ethics of well-being whereby women appropriate selected medical technologies for managing their health as well as motherhood; and an ethics of choice whereby they have to balance childbearing and opportunities in the labor market. They orchestrate these models through exercising a logic of modernity through which they fashion themselves, a process nevertheless subject to "increasing conflict and contradiction." Paxson describes Athenian women as "modern subjects who 'think for themselves [29, p. 32].'" Her description is strikingly similar to how caregivers think through caregiving in relation to the conceptual models that are tools for care but must be

4 Advocacy and reform do not define a precise target, endpoint or utopian state of affairs, but an ongoing process of critique and revision [23, pp. 303-319; 1, pp. 244, 247, 280-281]. But when reform is tied to a politics of scarcity, budget cuts and an obsession with "small government," the erosion of services is factored out of the health care equation. That is a cynical inversion of the meaning of reform.

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orchestrated anew for each clinical situation. Caregivers' self-fashioning requires "rational deliberation" [29, p. 36] as Paxson calls it, in order to manage the interplay of models that are the given value-complexes defining care.

At SFGH, these models co-exist uneasily; yet the institution functions well enough for a precarious integration to prevail, despite what Robbins [27, p. 130] calls a "pluralistic value conflict." The paradox of care, as an expression of health as a societal meta-value confronting the dominance of a profit-driven economy of health, expresses itself decisively at the bedside. Caregivers must make it work, in some cases as remediation and sometimes as "being governed a little less" as their clinical thinking takes hold. The rough and tumble of day-to-day hospital operations shows that models of care may check or reinforce one another, but they remain mutually contested idioms for negotiation and improvisation as well as of rhetoric and contradiction. After an overview of these models or ideal types, I will suggest how they direct or impede care and, taking a cue from Florence Nightingale, how they can point to an ethical practice that enecompasses direct patient care as well as broader health care advocacy.

The Normalization Model

Normalization claims to provide neutral and impersonal techniques for controlling social forms, functions and institutions. In the hospital, this model defines variables that must be kept "within normal limits," in reference to a distinction between the normal and the pathological [30]. The omnipresence of normalization at the hospital is inscribed in the floor plan of the new hospital, built to meet state-mandated earthquake safety standards [31, p. 10]. The lay-out of patient rooms and central nursing stations resemble Jeremy Bentham's Panopticon, a prison designed for "perfect" surveillance [32][5].

Controlling critical variables targets a wide range of signs and symptoms, from the agitation or combativeness of the psychiatric patient to the blood glucose level of the diabetic. If a patient suffers an episode of psychotic agitation and becomes a danger to others, does she need medication and should hospital security be called for assistance[6]? If a patient in the Emergency Room or on an acute medical unit is found to have a blood glucose level that is "critical" or not "within normal limits," has the patient been given orange juice or started on intravenous 50% dextrose, and does he need an endocrinology consult[7]? Caregivers monitor patients' blood pressure, their input-output as an indication of their fluid balance, their recent laboratory values and their level of pain and consciousness.

Normalization is key to the language of care and is pursued on patients' behalf as a step to health restoration. The language of normalization is deeply inscribed in caregivers' assessment of patients' clinical status. The normalization model also applies to caregivers' practice. However, there is an implicit tension between normalizing methods of data acquisition, surveillance and intervention, and caregivers' self-directed practice. This contradiction can be distracting and stressful, at times an impediment to care and inimical to caregivers' professionalism.

The Compassionate Care Model

In the clinical arena, compassion is a primary value of caregivers [34,35]. According to the official Philosophy of the SFGH Nursing Service, nurses must "practice with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attitudes, or the nature of [his or her] health problems[8]." Like the preservation of life itself, – compassion puts the patient's status as a person first [37, p. 187-188]. I am suggesting that this value can put caregivers' ethics in a paradoxical situation.

Respect and openness are basic to this idealized stylizing of interaction, summarized by Arthur Kleinman [38,39] as "empathic listening." Caregivers listen closely to how patients define their own needs and anticipate their unexpressed difficulties[9]. Generally, patients obtain comfort from knowing they are being listened to. Nurses should pay attention to the "whole person," not just whether her electrolytes are "within normal limits" or his hematocrit (red blood count) has improved after a transfusion. The nurse is a "therapeutic presence" who engages in an interpersonal process of partnering with the patient that is ideally characterized by caring[10].

5 The hospital is not a panopticon tout court. Lorna Rhodes [33] provides a nuanced ethnographic portrayal of panopticism and normalization in action, "haunting" (an apt term, indeed) the high security prison.

6 Compassionate care mandates that calling hospital security to manage difficult psychiatric patients be avoided whenever possible. SFGH no longer uses physical restraints to control psychiatric patients. Sears [34, p. 62] describes non-aggressive, compassionate modes of intervention.

7 A "MERT" (Medical Emergency Response Team) is called when a patient's clinical status unexpectedly deteriorates. Like Code Blue for respiratory or cardiac arrest, a critical care nurse, physician, respiratory therapist and nursing supervisor arrive immediately at the patient's bedside.

8 Compassionate care assumes "patient-centered" care [36].

9 While attempting to contain costs, SFGH treats all patients regardless of their ability to pay [40, p. 15]. This is the paradox that the hospital embodies in its operation, as I attempt to describe it in this essay. How management addresses this challenge is not always transparent to hospital staff. A weekly "Management Forum" features the hospital CEO presenting "budget updates," but they are often issue-oriented rather than comprehensive overviews.

10 The public hospital has absorbed escalating administrative costs [9, p.

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This "rule" of compassion is a relentless challenge to the nurses' theatrical skills as well as to their therapeutic and technical expertise. The nurse must always "arrange his face" in the patient's presence [41], making a point of being there for that person in the moment, regardless of storms of paper work or time-consuming computer glitches. Nursing judgment must also include continuous self-assessment in relation to this key value, along with continuous assessment of the patient [42, p. 446].

The Trauma Model

SFGH is a regional trauma center, as reflected in its official name, San Francisco General Hospital and Trauma Center. The hospital's Emergency Room receives trauma patients at any time of the day or night. The most frequent diagnoses for trauma patients include MCAs (motorcycle accidents), GSWs (gunshot wounds), SWs (stab wounds) and PVAs (pedestrian versus automobile accidents), and for the elderly, "falls from standing." SFGH is nationally recognized for its innovations in the clinical management of traumatic injuries and has been at the forefront in developing resources and techniques tailored to the specific needs of trauma patients [43, p. 211-212].

The trauma model includes both standard protocols for providing care to patients with traumatic injuries and psycho-social interventions for trauma that can easily be neglected or denied in managing the immediate clinical consequences of an injury[11]. The presence of social workers in the ER day and night is critical in beginning to address such issues. Many frightening, even haunting histories – the man who fell on a glass coffee table and was admitted to the ICU with a large shard of glass embedded in his kidney or the Mexican migrant worker who became quadriplegic after a scaffolding collapsed under him – may be veiled in denial. Trauma is therefore as much a challenge to the psychiatrists and social workers as it is to the surgeons on the trauma service or nurses in the ER and the ICU[12].

The trauma model utilizes the clinical efficacy of bearing witness, debriefing and storytelling, formally or informally, as hospital staff who are repeatedly exposed to injured patients try to overcome their own burn out, compassion fatigue and secondary or vicarious trauma. Support systems and empathy are key resources for caregivers as well as for victims [45, p. 190]. Processing trauma moves it from the intra-psychic domain into a social, intersubjective space where it can be shared and its effects attenuated[13].

The Management or Business Model

Like all hospitals, SFGH is challenged to provide cost effective care, which is, arguably, its key managerial value. The hospital's patient population is decisively "down-scale," under-insured or uninsured ("medically indigent adults") who are frequently unable to pay their hospital bills. The hospital relies on revenues from patients (especially trauma patients) as well as on yearly appropriations approved by the city's Board of Supervisors. Ever-escalating budgetary constraints make such appropriations uncertain, and they must be re-negotiated each fiscal year.

Cost-containment is taken as a self-evident value by hospital management. However, from the perspective of compassionate care, the effective management of cost may be bought at some cost to care itself. For many nurses, care is unduly bureaucratized, encumbered by tasks such as charting or running down supplies and physicians, which take time away from being with patients; in their view, care is gutted of compassion or heart. "Cost effectiveness" may undercut itself, although management does not acknowledge this downside[14].

Precise adherence to this management model makes the hospital look carefully managed. In key political venues, cost effectiveness translates directly as the virtue of effective management. This leaner and meaner approach (in caregivers' terms), means that nurses have to be "flexible" and "creative," conditions that can make it difficult to develop therapeutic alliances with patients. Such costs are left out of management's cost-benefit equation.

The management model as played out at SFGH is caught between city hall politics and the demands of patient care, a political dynamic that has plagued the institution since it opened its doors in 1850 [43, p. 26]. Cost containment, is a dominant value that is self-justifying and rationalized as budgetary constraint, which does not shut down public debates about cuts in public health appropriations

741] and restricted Medicaid (Medical in California) as well as a decrease in the number of patients, since some go to other hospitals for care once they are insured. The result is an "intensification of already existing barriers" [9, p. 735] to care. These forces have pushed public hospitals to adopt an increasingly corporate, market-drawn management culture [43, p. 739]; SFGH is no exception.

11 PTSD, post-traumatic stress disorder is a diagnosis that has become commonplace in public discourse, and ts actualities are tragically commonplace in the clinical arena.

12 For patient and caregiver, trauma is "a shattering, a sudden obsolescence of one's old self" [44, p. 150], and defines the victim's experience of loss. "Traumatic experience is not [simply] a story but a cascade of experiences, eruptions, crevasses, a sliding of techtonic plates that undergird the self [45, p. 181]."

13 Clinical research on secondary trauma among caregivers shows that similar interventions work for them as for victims of primary trauma [46].

14 In the view of one nurse, "instead of documenting what we do, documenting is what we do [15, p. 203]."

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[47]. Hospital workers' unions, citizens' committees and community groups as well as nurses and physicians attend hearings at city hall to make their voices heard[15].

Cost-containment is not applied without regard to patient care, whatever the perspective of caregivers to the contrary, although the management model is obliquely related to the care of individual patients, instead focused on systems issues. Management reminds caregivers that patients cannot get care if the institution is not also cared for. Practically speaking, care of patients and care of the institution itself have to be balanced, in delicate, precarious equipoise through cost-effective management. This process clearly leaves room for disagreement and controversy. Management's balancing act induces caregivers' vigilance and advocacy. Push back of caregivers' advocacy against managerial normalizing points out how cost-containment can compromise both care and public health as a society-wide meta-value. In the contentious environment of health politics, at SFGH the management model therefore becomes subject to caregivers' insistence on remediation and on critique in Foucault's sense of being governed less.

Case Vignettes

The following case studies[16] illustrate the remedial and critical dynamic among the above models of care. The case of Brian Austin shows how an initial failure to activate the trauma model resulted in a delay in treatment and avoidable pain for the patient. Naureen Mizra's case indicates a complicated, ultimate synergy between compassion and normalization. Manual Castillo's case suggests how the management model can get in the way of normalization.

Brian Austin, a 23-year-old white male, was admitted to the SFGH jail unit for treatment of burns; another inmate had thrown hot coffee on him in the county jail. He was initially seen in the ER for burns on his chest, abdomen and thighs. He was in custody for driving his car while intoxicated and hitting a bicyclist. The jail unit admits acute medical and psychiatric patients from the city and county jails. The presence of sherrif's deputies, the architectural containment of the unit and the illness of the patients make it one of the safest unit in the hospital. Deputies do frequent rounds on the patients from their "capsule" just outside the unit's entry-controlled, double doors. When I came on duty as charge nurse, Mr. Austin was lying quietly in bed, with a distressed look on his face. His burns would require pain management, wound care, antibiotics and fluid management. As reported, his care was presented as business-as-usual, rather than as trauma.

I managed his pain medication and intravenous fluids and administered antibiotics. As the night progressed, Mr. Austin's complaints of pain increased despite repeated doses of morphine. I became increasingly uncomfortable about his condition. I paged the resident to re-evaluate his pain medication. Soon after, we transferred him to the ICU for more aggressive clinical management. My questioning of his initial treatment plan was critical in getting him the care he needed. The resident managing his case had little disagreement with my assertion that Mr. Austin needed a higher level of care.

Because he had come from jail, I wondered if Mr. Austin was not treated in the ER like a non-custody patient, resulting in the questions I had to ask later. His evaluation in the ER minimized the severity of his condition and the level of care he needed. A more detailed evaluation would have led to the trauma model being activated earlier and his to admission directly from the ER to the ICU. My critique after his admission to the jail unit belatedly allowed normalization (managing his pain) and compassion to work together.

When John Perry, the charge nurse in the Psychiatric Emergency Service (PES), paged me about a Pakistani family who wanted to bring in a family member for treatment, I knew it would be complicated. Naureen Mizra's family had taken her to the university medical center. They were referred to SFGH because the university medical center does not provide crisis intervention for psychiatric patients. The Mizra family had advanced degrees and were employed by a major software firm; unlike most PES patients, Naureen had full insurance coverage. Her treatment could therefore be managed efficiently, compared to the long waits for publicly funded acute beds or outpatient referrals needed by many SFGH patients.

At home, Naureen had become preoccupied and agitated, expressing fears that people were invading her house. In the hospital parking lot, she said she was afraid of the nurses and doctors and refused to come into the building. Her sister explained that she had been hospitalized previously for mental health problems, though not in San Francisco. John thought the young woman should be placed on an involuntary hold for evaluation and treatment. He knew he could not send the nurses to the parking lot to bring her in. Only the police could do that. I walked to the ER where a number of police officers had gathered after arriving with a trauma case. I spoke with three of them, one of whom was female. A woman officer would be a better person than a man to talk

15 The hospital contracts with the University of California for services and human resources, including the hospital's medical (physician) staff.

16 These case studies are composites of actual patients. Names, background information and clinical details have been altered in order to insure patient confidentiality and in conformance with federal (HIPPA) regulations and anthropological practice. Any resemblance between them and real persons is coincidental.

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with Naureen. We discussed the necessity of setting the right tone for approaching her. The officers took charge, using a kinder, gentler approach (a phrase PES nurses often use to describe compassionate intervention) in talking with her. The policewoman took the lead, and soon she and Naureen were walking together through the hospital entrance. Later in the shift, John informed me that an acute inpatient admission had been arranged for her at a private hospital.

Normalization, a cessation of Naureen's delusions, was what her family were asking for and what the nurses knew she needed. At first, Naureen was unwilling to submit to that regime. Yet, everyone wanted to act compassionately. In this case, compassion and normalization were initially in conflict. The challenge was to harmonize these potentially conflicting approaches: Normalization became possible at a macro-level because compassion could be instituted at the micro-level of nuanced interaction with the patient. Normalization was implemented by giving it a spin, re-casting it symbolically, as caring and compassion; it was coded or represented as compassion in initially approaching the patient. This rhetorical slight-of-hand between normalization and compassion – this interpolation -- was what made effective clinical management possible.

Manual Castillo, a 38-year-old Spanish-speaking man, had been admitted to an acute medical unit for treatment of bacterial pneumonia. He also had long-standing kidney disease; he had a supportive family and managed his illness effectively at home. He also had durable therapeutic alliances with caregivers at a city outpatient clinic in the Mission, a neighborhood near to SFGH which has a diverse, but largely Latino, population.

In addition to IV antibiotics for pneumonia, Manual needed peritonial dialysis for his kidney disease. He was capable of doing this procedure on his own, but in the hospital, the nurses performed the procedure, which requires meticulous sterile technique in order to prevent peritonitis. Fluid is introduced into the peritoneum through a tube that has been surgically inserted in the abdomen, and after the diffusion of toxins, the fluid is drained out.

Priscilla, the charge nurse on his medical unit, paged me after making a number of in house telephone calls to locate the correct dialysis fluid. She had been unable to do so. She had already spoken to the medical resident about the issue; he did not want Manual's dialysis to be delayed. Manual told his nurse that his family had a supply of the proper dialysis fluid at home. I sent a taxi to his home to pick up the dialysis fluid after he telephoned his family to inform them of our plan.

I met the taxi driver at the hospital's main entrance. He handed me a heavy backpack full of bags of dialysis fluid which I lugged up to Manual's unit and gave to Priscilla. Manual was soon started on dialysis. I made an exception to hospital policy in using his own dialysis fluid; medications other than those supplied by the hospital are not usually administered. After the situation was resolved, Priscilla filed an Unusual Occurrence Report with Risk Management for "delay in treatment," and I reported the problem by email to the Director of Materials Management.

For Mr. Castillo's clinical management, normalization (keeping blood levels within normal limits) was the priority. But the management value that drives the provisioning of supplies by maintaining a tight inventory implied a different priority: cost containment. The incident indicates a conflict between normalization as a dominant value for patient care and patient safety, and cost-containment being given priority, a contradiction in models or values that is elided in official self-descriptions of hospital operations[17].

According to caregivers, management does not value compassion, whatever management's rhetorical truth claims to the contrary. Manual's case shows that at the level of direct care, what worked was an approach based on negotiation; the nurses made it work (as they often do), sometimes despite constraints from management. That style of improvisation remains un-institutionalized as a valued modus operandi that is re-invented through critique, "thinking out of the box," on a case-by-case basis. Management does not include in the cost of treatment extra staff time and effort that is often required,

Ethics as Process

These cases indicate how the four models of care, plural [48, p. 5] and diverse as they are, do not always directly motivate practice [49, p. 52]. The models make a disharmonic aggregate that complicates as well as coordinates clinical practice [4, p. 319]. With ant-like industry, caregivers may disrupt the logics of a particular model to delineate a logic of care necessary in particular clinical circumstances.

The Code of Ethics for Nurses, published by the American Nursing Association [50], establishes precepts and premises for nurses as they define and implement care. This code is closely allied to the compassionate care model and mandates collaborative, "compassionate and transparent" practice [50, p. 4]. Care is characterized as inherently personal and intimate

17 To highlight these contradictions, I mention the one between being generous with patients in order to provide compassionate care and being ungenerous with resources in order to contain costs. Beyond SFGH, cost containment promotes excessive profit-taking by health care insurance companies, the pharmaceutical industry and for-profit health care corporations.

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[50, p. 7], yet acknowledges that nurses face "competing loyalties" and even "conflicts … between their own personal and professional values" [50, p. 5], and those of other health care professionals and of healthcare organizations.

These precepts are a prelude for ethics, a prerequisite or theory for ethics, or a substrate for ethics; ethical practice must fit them to clinical particulars. Ethical practice is located not in abstract premises and propositions, but in the process of negotiating care. As process, ethics is therefore the change caregivers come to in attitude, concept and self-regard, stylizing their actions and self-presentation to fit particular occasions of care.

A number of steps must therefore be taken beyond the ANA's precepts for ethics to be enacted. An ethics of care becomes real through being melded into the caregiver's thinking. It relies on mutual awareness and shared interaction that, however provisional, fragmentary and encumbered, is part of being with the patient. As an orientation to clinical thinking, ethics is necessarily dialogic.

That orientation will already have been part of cultivating an ethical disposition in the education of budding caregivers. It reinvents itself in the thinking-on-your feet that caregiving demands. The effective caregiver is never task-oriented or a worker-bee who pushes IV antibiotics and then runs out of the patient's room or who suctions a tracheostomy without further ado. In the ethics of care, there is no separation between theory and practice or between thinking and doing. For the caregiver, thinking as the work of ethics is by its necessity thinking with the patient, utilizing a mélange of conceptual norms and values contained in the models of care. Annamarie Mol [51] describes this collaborative process, making clear that "care is not a well-delineated product, but an open-ended process" that demands "a stop-and-think" [24, p. 78, italics in original]: The "truth of the patient" begins in dialogue, finding common ground for understanding clinical particulars.

Mol [51, p. 20] idealizes this interaction as "a calm, persistent effort to improve the situation of the patient," in which the caregiver's listening "frees the patient from passivity [51, p. 79]." The handshake becomes a powerful gesture for denoting and symbolizing negotiation. The formation of an intersubjectivity of caregiver with patient also involves a process of the self-formation of caregiver and her "external expression, its enactment over and with others [51, p. 75]." Essential to its built-in pedagogy is a reflexive process of explicating and inspecting this process, as I am doing here. The developmental cycle of caregiver-patient intersubjectivity involves an "improvisational pedagogy that resolved itself into a more routine pedagogical partnership [52, p. 265]." But it is never completely routinized. Always learning is both a matter of disclosure and of shifting, experimental perspectives; the caregiver not only puts herself partly aside, but also embraces "the personalism of ancient ethics" [52, p. 49] which did not press to standardize ethical practice, but to improvisation and self-scrutiny. Always seeking re-orientation and re-definition, devoted to thinking differently, the endpoint of this process is to engage with the patient in the situational production of care.

The caregiver is on a learning curve all the time, one that I suggest encompasses self-formation. Arendt [24, 38] does refer to tools and instruments that allow the "it seems to me" to be corrected and updated. Like the letters and confessions recommended by Stoic philosophers, the clinical status of the patient is re-examined in case conferences, progress notes written in the patient's medical record and process narratives the clinician writes in consultation with colleagues. In these and related venues, pedagogy invokes autopoiesis [42, p. 86], an art of self-formation that reforms the caregivers' perspective, not only regarding the patient and her clinical issues but regarding herself and her capacity to think differently about intervention. In the intersubjective zone of care that replaces the separate subjectivities of patient and of caregiver, the tools of self-reflection and autopoiesis synergize, enrich and focus care.

Clinical thinking, as I delineate it here, brings the ANA values of care into concordance with the particulars of the clinical situation. The caregiver's "it seems to me" regarding the patient is critically redefined and revised through this process, in order to implement care as a social good. Clinical thinking about patients may have to segue into push back against "the system." Practice moves into a broader, political domain. Ideally, caregivers become exemplars of an art of advocacy.

Advocacy, an Ethical Project

Ethics is what we owe one another, a defined orientation to values and virtues. Good health defines the ethics of care that caregivers strive to implement. But the politics of care revealed by the interplay of models institutionalized as the system can degrade as well as promote practice. Within the hospital as well as beyond it, these models can function as disingenuous rhetorical forms [53], misrepresenting and co-opting compassion as they prioritize one model over another, such as cost-containment over compassion[18]. Under such conditions, ethical practice must extend beyond the bedside where the dissemination of issues such as the politics of scarcity compromise care. Within the hospital

18 "Cost containment" is a cover term for a restrictive politics of care. In this "language of euphemisms" [6], "cost" masks profit as a major element of health care financing.

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and beyond, caregivers are not only responsible for patients, but according to the AMA Code of Ethics [50, p. 28], they are also responsible to society at large. Patient care and health diplomacy, advocacy in the public sphere, seamlessly define practice. "Formal and informal dialogue with Society" and the exercise of "critical thought" [50, p. 32] are part of engaging in the political process as key to promoting a robust environment of care.

While an understanding of the conflicting models of care described in this paper requires critique, critique can be difficult to exercise at the bedside and in health care politics[19]. Can contending models and values be coordinated? Comparison and advocacy prevail, when they do prevail, in spite of conflict among them. Hospital administrators can be politically enmeshed so as not to be reflective or candid about their priorities. Caregivers can be on autopilot at the bedside and unprepared for serious reflection on the issues as well. Yet, paradoxically, their practice of critique, however implicit, is what helps them use these models to produce care. In this respect, caregivers' critical reflection and self-reflection potentially positions them to manage a comparable politics in the interest of public health. The caregivers' ethical project is an art of crafting a compassionate self on behalf of patients and so practicing advocacy.

The irony for us now is that health as a meta-value remains fundamental in theory but problematic in practice. The challenge is how to re-implement health care in order to synergize robust institutional practice. I propose caregivers' management of contending models of care as a skill-set for promoting advocacy, and even activism for health equity and compassionate care, as opposed to for-profit health care driven by market fundamentalism [55, p. 5][20]. Florence Nightingale's charge to nurses, "you must inform public opinion,"[21] therefore defines an ethics for caregivers and for social analysts as well [60]. In the interest of patients, it mandates an involvement in public dialogue. Caregivers' ethics of professional self-formation can be exercised in both personal and public venues. Nightingale's ethical challenge is a clamorous imperative motivated by compassion [61]. In meeting this challenge, the virtue of critique must seriously inform the care of the self, the care of others and to care of the polity.

19 Advocacy impelled by careful field research and critique is not new news in medical anthropology [54].

20 I agree with Arnold Relman who argues for the following solution to the American health care crisis: "a single-payer financing system, like Medicare, with no investor-owned private insurance companies; and a non-profit delivery system, consisting of multi-specialty groups of doctors paid by salary within a set budget [56, p. 32; 57]".

21 Florence Nightingale's advocacy and activism is deeply inscribed in her biography and in the culture of the nursing profession. Nightingale is an exemplar of compassion [58, p. 11] and professional self-development. Her work makes nursing a paradigm for advocacy for other caregivers. On the implementation of compassion, see Fassin [59, pp. 70-71].

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