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From the manager's point of view: work intensification, posthuman ethnography, and healthcare in England

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Drawing on fieldwork conducted in a hospital in Greater Manchester, England in 2016–17, we describe how a set of national health priorities were translated into work for hospital managers and clinicians during a period of significant organizational pressure. Departing from the focus on practice and posthuman relations in many recent ethnographies of healthcare, we attend to inequalities between perspectives on organizational change, exploring the hidden work involved in producing improvements to care quality in a public general hospital. Putting practice in perspective, we shed light on relations between the emergent politics of bureaucracy and more contentious politics of healthcare. Reflecting on connections between the posthuman turn and rationales of management, we emphasize the need to view social science theory in its broader social context, and examine practices of work, care and management from bottom-up points of view.

Introduction

Management first captured anthropological attention a few decades ago as new structures of audit and accountability were introduced to universities and other public institutions (Strathern 2000). While anthropologists long had been interested in formal organization (S. Wright 1994), the encroachment of new commercial style management in public sectors in the 1980s and 1990s renewed interest in questions of institutional power and authority (Shore & Wright 1997). Bureaucratic practices such as mapping, measuring, documenting, and accounting are central to how people, institutions, and territories are made administratively visible (Mitchell 2002; Riles 2006; Scott 1998). Framed by broader discussions of governmentality and structural adjustment (Foucault 2002 [1978]; Gledhill 2007), anthropological accounts of bureaucracy during this

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period tended to emphasize processes of knowledge production as intrinsic to the projection of state power (e.g., Ferguson 1994).

As ethnographic research on bureaucracy has developed, increasingly fine-grained understandings of bureaucratic interests, ethics, and authority have emerged (Brown 2016; Gupta 2012; Petryna 2002). Public bureaucracies are sites of 'subtle negotiation of power' (Bear & Mathur 2015: 19) where the wills of governments and politicians are frequently thwarted as well as enacted (Timmermans & Berg 2003). In healthcare, as in other areas of government policy, managerial interventions are shaped by local institutional processes, professional agendas, resources, and maintenance of coalitions of support (Bear & Mathur 2015; Mosse 2005; Pinder, Petchey, Shaw & Carter 2005). Ethnographic attention to the work of managers in public institutions sheds light on broader questions of political agency and the contingencies of social and economic change.

In this article, we draw on fieldwork conducted in a general hospital in Greater Manchester, England, in 2015-17 as effects of the UK government's post-financial crisis austerity drive circulated through public systems (Clarke, Kellner, Stewart, Twyman & Whiteley 2016; Lorne 2022). We describe how a set of national health priorities concerning patient safety and acute kidney injury were translated into work for hospital managers and front-line clinical staff during a period of significant organizational pressures. Focusing on questions of responsibility and resources, we explore the project's rationales and practices, highlighting the hidden work and demands for additional time and attention involved in producing organizational change in public healthcare.

The project we explore involved techniques and tools of bureaucratic knowledge production but also interventions in established care processes and routines aimed at improving medical outcomes for patients. This hybridization of bureaucratic knowledge and medical practice is characteristic of contemporary healthcare. The rise of evidence-based medicine (Lambert 2006), the spread of uniform clinical recommendations and guidelines (Timmermans & Berg 2003), and the incorporation of these standards into other bureaucratic structures and technologies (patient pathways, performance review, electronic algorithms, and patient records, etc.) have brought far-reaching changes to healthcare (Bailey, Pierides, Brisley, Weisshaar & Blakeman 2020*a*; Checkland 2004; Greenhalgh, Potts, Wong, Bark & Swinglehurst 2009; Harrison & Dowswell 2002; Pinder *et al.* 2005). Studies of this process in medical anthropology have explored how universalized medical knowledge is made to fit in institutional setting in the Global South, 'like a round peg to a square hole', as Julie Livingston puts it (2012: 25). With some notable exceptions (Lambert 2006), however, few anthropologists have attended to this process in places like the United Kingdom where bureaucratic changes to health systems have been transformative.

By contrast, healthcare bureaucracy is written about extensively at the intersections of the social sciences and the multidisciplinary field of health service research (Checkland 2004; Harrison & Dowswell 2002), where the introduction of new managerial systems has provided fertile ground for ethnographers interested in organizational change and improvement (Allen 2009; Bailey *et al.* 2020*a*; Berg 1997; Dixon-Woods *et al.* 2013; Greenhalgh & Swinglehurst 2011; Pinder *et al.* 2005). Influenced by actor network theory (ANT) and the broader posthuman turn in the social sciences (Latour 1993; Mol 2002), these accounts often centre on bureaucratic technologies, exploring tensions that emerge within institutions as these non-humans alter organizational relations.[1] Timmermans and Berg (2003) argue that bureaucratic technologies in healthcare are inherently political because they change the 'practices in which they become embedded', repositioning 'relations of accountability' and 'emphasizing or deemphasizing preexisting hierarchies' (2003: 22).

We, too, are concerned with politics as everyday relations within institutions, rather than something that exists solely in the 'regulatory-political environment' (Timmermans & Berg 2003: 22). However, we are minded by debates in anthropology about the increasing universalization of posthuman theory in the social sciences. Several anthropologists argue that by focusing on human/non-human relations – and abandoning more conventional ethnographic concerns with human perspectives and inequalities – scholars in ANT and similar traditions uncritically reproduce basic assumptions about reality and politics of the people they study (Graeber 2014; Gregory 2014; Martin 2014; 2020). In ANT-inspired ethnography, these tend to be managers, bureaucrats, scientists, businesspeople, and other professionals.

These accounts echo long-standing critiques of lack of attention to questions of human interest and political economy in ANT-inspired scholarship. Early writing on ANT was often accused of flattening social hierarchies by focusing on entanglements of people and objects in heterogeneous networks (for discussion, see Candea 2018). Concepts like 'emergent politics' (Timmermans & Berg 2003) and 'ontological politics' (Mol 2002) are in part responses to this flat ontology critique. By attending to how realities of medicine and disease are made *in practice*, politics returns as tensions concerning, for example, the reordering of professional roles in institutional settings (Timmermans & Berg 2003). However, concepts like emergent politics tend to result in rather harmonious accounts of healthcare where fraught questions about the economics and politics of health systems are made to seem incidental to ethnographically salient 'logics of care' (Mol 2008) and management (Berg 1997).

Our fieldwork took place against a backdrop of renewed public debate over the future of the National Health Service (NHS) in England. Cuts to public spending introduced following the financial crisis affected health budgets (Clarke *et al.* 2016). By 2016, stories about a crisis in the NHS were common in UK media (Triggle 2016). As fieldwork progressed, organizational pressures became apparent in the hospital. While many ethnographies of healthcare focus on practice (Berg 1997), we take a different approach. Rather than 'putting practice into theory' (Mol, Moser & Pols 2010), we instead attend closely to different points of view on organizational changes. To put something in perspective is to broaden its context, to adjust the aperture. By putting practice in perspective, we signal both the need to view social science theory in its broader social context, and understand practices (of work, care, and management) from hierarchically ordered points of view.

The issues we discuss concerning resource pressures and work intensification are common in accounts of healthcare workers (Irons 2024; Pasquini 2023). However, they are often externalized or treated as analytically uninteresting by researchers (Brisley, Lambert & Rodrigues 2023). Exploring healthcare management from different perspectives, we shed light on relations between the emergent politics of bureaucracy and more contentious politics of healthcare (Lorne 2022; Pushkar 2019). By foregrounding pressures on systems of care, our work sits among anthropological studies that in recent years have called attention to broad challenges to relations of care and social reproduction in Europe (Brisley *et al.* 2023; Narotzky 2020).

Fieldwork was conducted by the first author over 18 months, covering the planning and implementation phase of the hospital project. Our wider research team was part of an applied research collaborative with the hospital (hereafter, Hospital A) which provided privileged ethnographic access to the hospital (see Bailey, Pierides, Brisley, Weisshaar & Blakeman 2019). Fieldwork comprised participant observation of project meetings and events, document analysis, visits to wards and clinical areas, and 24 semi-structured interviews with project leadership and participants.

In the first section of the article, we trace the development of bureaucratic changes in the NHS. The following two sections present our main ethnographic description of the hospital project. First, we explore how questions of resources, work, and responsibility were framed by the 'patient safety' and 'quality improvement' rationales of the project. We then explore the work that the project involved, conflicting priorities of care, and broader challenges the hospital faced. In the final section, we situate our approach to healthcare ethnography in debates about bureaucratic good, posthumanism, and perspective in ethnographic writing.

Medical and managerial authority in the NHS

Introduced in 1948 during a period of post-war welfare consolidation, the NHS was established as a universal service funded by general taxation. The first decades of management in the NHS were characterized by self-governance by the medical profession. The Department of Health was composed of medics and bureaucrats in equal proportions. Physicians held sway over hospitals and local statutory bodies which ran the NHS, exercising control over service development and organization (Harrison 2009).

New structures of general management were introduced to the NHS in 1984 following a review by chief executive of the supermarket chain Sainsbury's (Dopson 1994). Subsequent decades were marked by market-orientated structural reforms intended to introduce competitive pressure to the English NHS system. Hospitals were disaggregated and encouraged to form NHS Foundation Trusts: groupings of hospitals that would in principle compete in an NHS 'internal market'. Changes to the structure of the NHS were profound, resulting in various new layers of management in hospitals, as well as regionally and nationally, while also introducing new forms of market bureaucracy (Pollock & Price 2011). However, NHS trusts, the bodies responsible for the delivery of most services, remain public organizations under the ultimate statutory authority of the Department of Health. Claims about effects of market incentives on the day-to-day running of hospitals and broader delivery of services are hotly contested (Pollock *et al.* 2011).

The rise of markets and management in the NHS coincided with broader bureaucratic changes to the nature of medical and clinical practice globally. The movement to standardize criteria used in clinical decisions and procedures began to gain traction in the early 1990s in response to the problem of variance between hospital outcomes in the United States. Uniform guidelines based on evidential review and professional consensus were proposed as a solution (Timmermans & Berg 2003). Guidelines for health and care in England and Wales are published by the National Institute of Clinical Excellence (NICE). Since the 1990s, standards have been embedded in management and funding structures in the NHS, becoming benchmarks for performance evaluation of clinicians and organizations (Checkland 2004).

The arrival of standards in the NHS was viewed by many as further attenuation of medical professional autonomy; 'the co-optation of core medical ideas by government and health service managers' (Harrison 2009: 184). However, the need to improve the evidence base of medical practice did not first emerge in the state, but from increasing recognition from around the 1960s onward (including in medicine) that many medical decisions were 'based on tradition or preference, unsupported by any evidence of benefit other than the conviction of the administering practitioner' (Lambert 2006: 2634). While themes like 'de-professionalization' often appeared in early literature on bureaucracy in the NHS (e.g., Haug 1976), research also shows how these changes helped solidify medical authority. Some scholars argue that by repositioning responsibility for medical decision-making at the professional institutional level, rather than with individual clinicians, processes of evidence-based standardization allowed medical elites to exert 'control over the rank and file in order to protect the profession as a whole' (Harrison & Dowswell 2002: 208).

External bureaucratic oversight of medicine has a similarly complex history. Calls for greater medical accountability emerged mid-century in the United Kingdom and United States in response to high-profile medical controversies – the atrocities revealed by the Nuremberg doctors' trail, the Tuskegee Experiment, the Karen Quinlan case, to name some examples (Wilson 2012). Critical scholars like Michel Foucault (1994 [1973]) not only inspired a generation of anthropologists but also key figures in the bioethics movement. In the 1980s, prominent public intellectuals drew on work by Foucault and Ivan Illich (1976) to argue for external oversight of medical research and practice. In the UK, these demands dovetailed with the desire of Margret Thatcher's government to render public sector professions and services more 'accountable' to their end-users by exposing them to outside scrutiny and the 'discipline of the market' (Wilson 2012: 196).

The rise of management in the NHS is a constituent of a broader social transformation – the emergence of 'audit culture' (Strathern 2000) or 'audit society' (Power 1997) – but it should not be reduced to mere neoliberal bureaucracy or 'corporate mentality' (Irons 2024). These concepts rightly connect the rise of managerialism in public sectors to the promotion of markets as a solution to social policy problems. The subordination of the medical profession to structures of general management was a precondition for the introduction of the NHS internal market (Harrison & Dowswell 2002). However, wills of governments are met in organizational contexts where other forms of professional and institutional power exist. The fall of traditional medical governance in the NHS appears to have been overdetermined by critiques from the political right and left (as well as patient activist groups and healthcare professionals) converging on change in an era when public attitudes were turning against traditional forms of authority (Lambert 2006; Pickstone 2012; Wilson 2012). On one hand, standards and guidelines can be understood as forms of medical professional 'bullet proofing' (Strathern 1996), that is, the adoption of internal bureaucracy to defend external bureaucratic attacks. On the other hand, standards work as 'boundary objects' (Allen 2009) that link the work of clinical professionals to systems of managerial scrutiny. As the emergence of AKI as a policy priority between 2014 and 2016 exemplifies, existing structures of NHS governance and policy reflect this balance of professional and administrative powers and values.

Acute kidney injury

Formerly classified as 'acute renal failure', the term 'acute kidney injury' (AKI) resulted from attempts at an international medical consensus conference to consolidate older definitions of the syndrome (Bellomo, Ronco, Kellum, Mehta & Palevsky 2004). AKI is defined as a potentially fatal medical problem characterized by sudden reduction in kidney function. AKI often happens to patients who are already unwell and receiving medical care. It is regarded as an issue of patient safety because many incidents of AKI are considered 'predictable and avoidable' (NCEPOD 2009: 5) if certain standards of care are followed such as ensuring patients are adequately hydrated and performing blood and urine tests and pharmacy reviews when patients are at risk of developing AKI.

Although always a concern of healthcare, patient safety during clinical processes and procedures was traditionally seen as the responsibility of individual doctors. In recent years, however, there has been growing recognition that safety of patients reflects wider organizational and governance issues in hospitals and health systems (Waring, Allen, Braithwait & Sandall 2016). The political prominence of patient safety in the United Kingdom is in part a result of the fallout from the 'Mid Staffs Hospital Scandal'. Broadly associated in UK media with 'target culture', in 2013 a public inquiry into excess deaths at Mid Staffordshire NHS Foundation Trust found 'appalling suffering' caused by an 'insidious negative culture' that prioritized meeting national targets and achieving 'financial balance' over 'standards of care' (Francis 2013: 3).

AKI became a major patient safety concern in the United Kingdom around the same time. In 2009, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) published a highly critical report about AKI in the UK health system. The report highlighted 'systematic failings' in the recognition and clinical care of AKI. It estimated only 50 per cent of AKI patients received a 'good' overall standard of care and 20 per cent of deaths associated with AKI were 'avoidable' (NCEPOD 2009). New guidelines for prevention, detection, and clinical management of AKI were published in 2013 (NICE 2019). In 2014, economic analysis found that AKI was more common than previously thought, affecting approximately 15 per cent of hospital admissions in England. Kerr, Bedford, Matthews and O'Donoghue (2014) estimated the annual cost of AKI inpatient care to be £1.2 billion per year and savings to the NHS 'in the region of £200 million a year' if avoidable cases of AKI were prevented (2014: 1367). The same year, NHS England issued a 'patient safety alert' aimed at standardizing the early identification of AKI and mandated all hospitals under its authority to adopt 'an automated computer software algorithm to detect AKI' by March 2015 (NHS England 2014: 1). In addition, NHS England included AKI in its Commissioning for Quality Improvement (CQUIN), a financial incentive scheme that hospital foundation trusts volunteer to adopt and receive 'bonus' payments from NHS England for meeting certain annual targets.

Patient safety priorities like AKI attract the attention of politicians, bureaucrats, and medical professionals because they speak to multiple registers of value simultaneously. Rather than 'efficient delivery of services at minimum cost' (Gledhill 2007: 340), AKI improvement is better understood as an attempt to realize multiple 'public goods' (Bear & Mathus 2015) associated with harm and cost reduction. Framed as a preventable issue of patient safety, AKI resonates with core medical values of care and professional responsibility while marking out £200 million in potential savings, thereby offsetting any additional time and resources invested in organizational improvement. However, as we explore below, new demands for improvements in patient safety enter contexts of severe strain, competing with other priorities, and adding to existing demands for time and attention.

Systems thinking and the resources of improvement

Hospital A had already begun a programme of work on AKI when we began fieldwork in late 2015. A year earlier, the hospital had established an AKI steering group composed of a quality improvement manager, administrative support, project managers, nursing and pharmacy representatives, and a pre-existing group of senior physicians who had been working on AKI.

In 2015, the hospital enrolled in the national CQUIN, which required information about AKI to be communicated to patients before discharge and included in discharge notes (NHS England 2015). At the same time, the hospital adopted the mandatory electronic alert and algorithm. NHS England's (2015) mandate required the introduction of a phased approach to AKI detection. In phase one, blood samples sent to the hospital labs show acute changes to serum creatinine, a sign of AKI. In phase two, an alert is communicated to clinicians, leading to phase three, the clinical response phase. Taking advantage of its integrated IT system, Hospital A embedded the algorithm in electronic patient records so that AKI e-alerts were generated on screens and interfaces used by clinicians on the wards (Bailey *et al.* 2020*a*). To cement the organizational change, the hospital launched the AKI Collaborative, a programme of work with staff from eleven wards and clinical areas. The collaborative aimed to reduce the overall incidence of AKI in participating areas by 10 per cent, incidence of hospital acquired AKI by 25 per cent, and the progression of AKI from stage 1 to more severe stages 2 or 3 by 50 per cent.

The collaborative was based on a management approach called 'quality improvement' (QI). Several years earlier, the hospital had established a dedicated QI directorate and adopted QI methodology from the influential US-based Institute of Health Improvement (IHI). QI has grown in popularity in healthcare alongside increasing focus on patient safety as a way of preventing 'avoidable harm' to patients. It represents something of a zenith in the broader standardization movement, seeking to standardize not only criteria used in key decisions (assessment, prescription, treatment, etc.) but also working processes and techniques (Waring *et al.* 2016).

IHI collaboratives are made up of a series of six 'learning events' spaced across 12 months (IHI 2003). In Hospital A, the events were attended by members of the steering group, designated link nurses from each of the participating wards and departments, care assistants, nursing ward managers, pharmacists, and junior doctors. Learning events usually began with a senior physician from the steering group presenting an emotive real-life case of an AKI patient who suffered poor standard of care in the hospital. Craig, a quality improvement manager who chaired the steering group, typically led the rest of the day which consisted of presentations and discussions of AKI in the hospital and QI methodology.

Much of the learning events was dedicated to discussing the 'care process bundle' and 'change package'. The former (see Table 1) was a series of standards that had been adapted by the steering group from national AKI standards. The change package comprised techniques and tools, so-called 'tests of change', for embedding change in wards and clinical areas. Once complete, the collaborative planned to share the change package with the rest of the hospital. In learning events and other

Table 1. The AKI care process bundle

Investigate for cause of AKI, e.g., sepsis or obstruction
Urine dipstick test within 24 hours of first AKI alert
Fluid balance assessment
Stop ACE inhibitors and ARBs, and pharmacy medication review within 24 hours of first AKI alert
Serum creatinine test repeated within 24 hours of first AKI alert
Ultrasound scan of urinary tract within 24 hours of first AKI alert
Specialist renal or critical care discussion within 12 hours of first AKI alert
Written self-management information prior to discharge

collaborative meetings, care processes were mapped out step by step: 'where was the phone call to the pathology lab made, who made it', and so on (Bailey *et al.* 2020*a*). Once visualized in this way, tests of change were developed. The collaborative members then trialled the new techniques in between the events, abandoning ones that were ineffective and sharing useful ones with the rest of the group. For example, low output and non-passage of urine are symptoms of AKI that are sometimes overlooked. Improvement of this care process hinged on increasing the visibility of patients' fluid intake and output. Suggested tests of change included keeping fluid balance sheets at the end of patients' beds, asking patients to fill in their own fluid balance sheets (a strategy that had the additional advantage of increasing awareness about hydration among at-risk patients), and putting AKI risk stickers on the boards above the beds as a reminder to clinical staff.

Craig was something of a devotee of QI methodology and spoke animatedly about the success of the approach in the history of the hospital. He often talked about 'systems thinking' which, he explained, had emerged in the aerospace industry, where there are few human errors in systems owing to very high degrees of reliability. He contrasted QI with 'top-down' approaches to healthcare management that he associated with the Mid Staffs Hospital Scandal (Francis 2013). In QI collaboratives, he said, clinicians developed their own techniques and took ownership of the improvement. There was also enthusiasm among the ward staff for the QI work, especially during the first learning sessions. In late 2016, the first author interviewed Mark, a senior nurse, who described how learning about QI led him to develop a more efficient sample labelling system, which had improved 'patient flow', the tricky process of moving patients between wards so that beds become available for new patients.

As Casper Jensen (2008) observes, QI methodologies encourage clinicians to view care as a 'system' that is 'amenable to intervention and control' (2008: 311). This allows QI managers to internalize critiques about 'top-down targets' and 'cultures of blame' by refocusing attention from the individual actor to the system. QI collaboratives are intended as platforms for the open discussion of errors in patient safety. They thus provide answers to the kinds of concern raised by the Mid Staffs Hospital Scandal, namely, that clinicians hide errors for fear of damage to their professional reputation. By focusing on the system, it is claimed, cultures of blame can be replaced with cultures of safety.

Reflecting this logic, Craig often emphasized that he did not want 'anyone to act like a hero'. Heroes, he said, worked as hard as they could until the improvement was realized and then, exhausted, returned to previous working patterns. By contrast, QI was about improving reliability and making sustainable changes. AKI, understood as preventable occurrence, fed into this way of thinking about care. As a physician from the steering group put it, AKI could be understood as 'the end result of a failed care process'. Framed through notions of systems thinking, this failure was not attributed to individuals but to 'the system', and the many potentially inefficient and unreliable material practices that comprised it. As we discuss in the following section, however, while discourses on patient safety and QI are adept at avoiding individual attribution of blame, they nevertheless position clinicians as responsible for fixing failing systems.

Responsibility, work, and care

The first author occasionally accompanied members of the steering group on visits to the clinical areas involved in the project. On the doors of the wards were often signs displaying words like '362 days since the last fall on this ward'. There were equivalent signs for bed sores. Both are problems of patient safety that had previously been subject to quality improvement work. The group was usually greeted by enthusiastic link nurses and members of the collaborative keen to show the tests of change they had introduced to their clinical areas. On one occasion as the group was entering a ward, they caught the eye of a busy-looking nurse as she hurried between patient bays. The nurse was familiar to the group having been involved in the collaborative for several months, but on this occasion, she appeared annoyed: 'I can't do this AKI stuff today, we've got too much on'. Continuing her journey into the bay and out of sight, she added, 'sorry, but sometimes we actually have to prioritize patient care'. An offhand remark, it nevertheless reflected a broader set of tensions around work, priorities, and the demands of the AKI improvement collaborative that appeared during fieldwork.

As we argue elsewhere (Bailey *et al.* 2019), despite broad assumptions about the role of technology in organizational change, electronic patient records, alerts, and algorithms do not substitute human work but require and direct it. For example, when blood samples were sent to pathology for analysis, the algorithm embedded in the electronic patient system alerted staff if changes to blood chemistry indicated AKI. But the baseline for these changes had to be taken from a previous blood result. Only if previous results were on record would the alert work. If not, staff were required to manually search paper notes, follow up with phone calls to other NHS hospitals and clinics, or estimate a baseline using population data. As comments made by one of the senior doctors from the steering group illustrated, qualitative judgement was required to interpret numerical data in the context of patient care:

> *Alan*: So we use a reference, for instance, of 80 to whatever, but there are a lot of people with creatinines of less than 80 who aren't unwell, so you've got to take into account the patient in front of you as well … If they're unwell and have got low blood pressure and then their creatinine comes back and it's over 200/300 you could be thinking, well its [AKI] is normally related to that as well … The whole thing is about not treating somebody just on numbers but actually trying to get as much information about them as possible, but if it looks abnormal and it smells abnormal, it probably is abnormal.

Participation in the collaborative, implementing the care package, and trialling the tests of change also produced extra work. The division of responsibility for this work was a question that had to be decided in the collaborative events, but while the first events had been well attended, as the project year progressed, fewer people in general and no junior doctors turned up. To compensate, the steering group arranged additional link nurse meetings, thereby adding to the demands placed on the nurses. In one meeting, after Mike appeared to suggest that much of the care bundle could be done by nurses, several of the audience members were infuriated that it seemed they were being made solely responsible for the improvement work.

Falling engagement among collaborative members was attributed to two main causes. The first was in March 2016, NHS England updated the national CQUIN, no longer listing AKI. While in principle CQUIN financial incentives are extra payments, in practice, participation in the scheme over time tends to mean 'bonus' money is absorbed into expectations about operational budgets (Bailey *et al.* 2019). When AKI 'fell off the CQUIN', as our informants put it, focus among some clinical staff shifted to other priorities.

The second was growing resource pressures in the organization. Talk of a crisis in the NHS caused by rising patient numbers and falling budgets was rife in the media in 2016. In April, the national junior doctor's union took industrial action (Pushkar 2019) and picket lines were formed in front of Hospital A. In the collaborative events, members of the steering group acknowledged that it was 'really tough out there' but reassured the audience they believed improvements could 'still be made'. In interviews, however, they spoke of never seeing it 'this bad before', and the AKI collaborative 'feeling different from previous times'. Other clinical staff supported this perspective, discussing shortages of beds, human resource pressures, and patients left with inadequate clinical oversight.

In an interview conducted shortly after finishing a shift, Mark, a senior nurse in charge of a team in an emergency unit, provided further insight into relationships between these pressures and the priorities of QI. He attributed organizational pressures to 'staffing', explaining that there were many vacancies in the hospital. Mark said nurses who wanted to leave their clinical area to attend AKI meetings were often unable to do so because they had 'breaches coming up'. By breaches, he was referring to a national NHS regulation which mandates all patients to either be discharged or referred to another department within four hours of attending an NHS hospital's emergency department. Frequent 'crisis talk' (Masco 2017) in UK media about NHS 'missed waiting times' concerns these breaches (e.g., Triggle 2016). In Hospital A, the four-hour time limit was embedded in electronic patient record systems and interfaces, creating a direct link between the temporality of these broader crises and the work of the ward staff. He went on to explain how pressures on the wards affected quality and safety directly:

> *Mark*: When you get down there, you'll see that there's cups of tea strewn around the place because that's how people are having their breaks. And yet policy says you don't eat or drink on the shop floor. So, people try to work to the rules as much as they can, but things get done because they have to. And when people are tired, stressed, and they want these bloods to be done because they can't physically do it. They're really physically upset because I asked … well, that's me three or four hours ago … to take the bloods. I've not physically had time to get there because I've got to manage the boards, keep the throughput coming, making sure patients are okay. Trying to give people breaks. Well, the law says we've got to give breaks, but you try to get those breaks for people and still manage to keep their team safe.

After the interview, Mark took the first author to see the emergency medical unit where he worked. Recalling his earlier comment, he pointed to the illicit, half-drunk drinks containers scattered about the station's desktops. He said the prohibition on drinking water and non-stop demand during working hours meant nurses could work 12-hour shifts without having a drink. He speculated that such long periods of dehydration meant the ward nurses would likely set off an AKI alert were their serum creatinine levels to be tested. But this, he added, was a 'story no one wants to hear'.

QI is attractive to health professionals and managers because it appears to provide pragmatic solutions in difficult material circumstances. Despite the challenges we describe, Hospital A's AKI collaborative resulted in decreased incidents and progression of AKI in participating wards. However, the claim that improvement can be achieved by standardization of practice, rather than 'heroic' individual effort, underplays the work that lay behind these 'numbers of improvement' (Bailey *et al.* 2019). As anthropologists have noted in other institutional contexts (Bear & Mathur 2015; Mosse 2005), the success of managerial and policy interventions depends on the ability to hold together coalitions of professional interests by appealing to different forms of social value. Improvements to hospital systems appeared to rely on a similar kind of resource. E-alerts, AKI stickers, tests of change, and training all alter priorities, directing the work and attention of clinical staff (Bailey *et al.* 2020*a*). Despite assumptions about the role of technology in driving organizational efficiency, successes in patient safety appeared to depend on extra attention and work mobilized in tight economies of time.

Feminist scholars long have drawn attention to unpaid work. The exploitation of women in the domestic sphere depends on an 'ethics of care' that, through relations of dependency, obliges women to work – that is, to care for *their* children, households, husbands, etc. – without pay (Federici 1975; Green & Lawson 2011; Narotzky & Pusceddu 2020; Tronto 1993). Evoked in collaborative meetings and literature on patient safety, the image of *the patient failed by the system* is carefully constructed not to blame nurses and doctors. However, like much of the imagery in patient safety discourse, it appeals to a professional ethics of care that positions clinicians as responsible for fixing failing care systems. While QI permits discussion of safety errors without individual clinical blame, it says nothing about actors elsewhere in the broader health systems. Yet, as Jensen points out, adverse events are not only or primarily due to 'human error on the ward level' (2008: 322) but are rather 'systemic consequences' (this time, in the social science meaning of the term) of the way that health services are governed, resourced, and funded. Mark's comments illustrate the cost of continual demands for improvement. Fine-grained distinctions between clinical 'blame' and 'responsibility' dissolve in his description of being physically upset in frustration at not being able to test blood samples. In their place is instead the image of the clinician failed by the system.

From the manager's point of view: health service ethnography

Writing at a time when patient safety and QI were first beginning to gain traction in healthcare, Timmermans and Berg (2003) argued for positive engagement from social scientists. They viewed QI's model of the system as a refreshing alternative to the overly individualizing focus on clinical knowledge that characterized the first era of guidelines and standardization in healthcare. Departing from the critical tone of many contemporary accounts of management, they argued that merely highlighting hidden work and bureaucratic intensification failed to respond to the key problem that QI addresses: 'unnecessary deaths and organizational failure' in hospitals (2003: 200). Evoking Bruno Latour's image of the patronizing 'critical scholar', they suggested such critique had 'outlived its usefulness' (2003: 199) and offered an ANT-inspired focus on emergent politics and distributed agency as an alternative.

In the intervening years, quality and safety have risen in prominence in healthcare policy debates, while the line between health research and management has become increasingly blurry (Dixon-Woods *et al.* 2013; Jensen 2008; Sykes *et al.* 2018; Waring *et al.* 2016). Hospital A's AKI collaborative and our research are part of this history. Our team was part of an institutional 'collaborative' between our university and Hospital A, which aimed to apply research to the improvement of organizational practices and care. Questions of usefulness also preoccupied us as we conducted fieldwork and were asked by the steering group to provide practical feedback. Elsewhere we have written in a register better suited to academic debates about improving policy and practice (Bailey *et al.* 2020*b*). In this article, however, we have tried to emphasize a sense that was often apparent during fieldwork, that it was not critique but promises of cost-saving improvement that seemed to have 'run out of steam' (Latour 2004).

Our approach in this article was inspired by work on emergent politics but also critiques of this kind of position (Jensen 2008). The image of the 'critical scholar' is based on Latour's (1993) claim that most social science follows the same basic analytical operation, namely, the denunciation of the agency of objects and non-humans. According to Latour, when presented with the everyday belief in the power of money, or God, or art (or claims about cost-saving technologies), the response from the critical scholar is the same. These forms of non-human agency are explained away as mere projections of whatever 'real' social force the critical scholar happens to believe in (e.g., capitalism, patriarchy, etc.).

It is argued that underlying this 'double denunciation' is a pluralist ontology: the belief that reality is singular but there exist multiple, more or less true perspectives on it. The images of the actor-network and, later, multiple ontologies were offered in place of pluralism. In *The body multiple*, for instance, Annemarie Mol (2002) refuses to take shortcuts by assuming underlying biomedical or economic realities can explain the entities (diseases, care) she encounters in a hospital. Rather than using one perspective (e.g., Marxist political economy, feminist arguments about unpaid care work) to critique another (biomedicine, hospital managerialism, etc.), Mol ethnographically traces how *multiple realities* (or 'enactments') of disease are performed through situated knowledge practices in laboratories, clinics, and other settings.

By contrast, theory in anthropology is often built by evoking the concepts, perspectives, world views, or ontologies, etc., of the groups being studied and bringing them into conversation with anthropological, Marxist, feminist, modernist, capitalist, or managerialist (etc.) perspectives.[2] The gift in economic anthropology is a classic example (Gregory 1982; Strathern 1988). Chris Gregory (2014) argues the same is true of all social theory even though relationships between analytical concepts and the perspectives of particular social groups are not always foregrounded. For instance, Marx's reformulation of classical political economy was historically contingent on how economic value appeared to be produced from the point of view of the industrial working class (as a particular arrangement of labour exploitation). As such, Marx's labour theory of value privileges the point of view of workers. Gregory and others (Graeber 2014; Martin 2014) call for careful examination of the links between the posthuman turn in social science theory and changes to universities and academic life associated with the rise of audit culture. Highlighting the lack of interest shown by ANT scholars in questions of inequality, political economy, and mechanisms of physical cohesion, they argue post-structural (Graeber 2014) and posthuman (Gregory 2014; Martin 2014) social theory privileges various kinds of bureaucratic perspective.

Like others who have commented on this debate (Kipnis 2015), we find nothing inherently contradictory about political economy and posthumanism. Ethnographers have found various ways to incorporate a focus on non-humans with political economic concerns (Bailey *et al.* 2020*a*; du Gay, Millo & Tuck 2012). However, it is important to recognize that assumptions on which ANT scholarship is based were initially reflections made about academia in France in the 1970s and 1980s, when scholars 'lived, spoke, breathed Marxism' (Hacking 1992: 511, quoted in Candea 2018). In *We have never been modern*, Latour estimates that 'double denunciation' accounts for 99 per cent of social science critique (Latour 1993: 54). He repeated the claim in his 2004 paper on critique but reduced the number to 90 per cent (2004: 237). These figures may have been intended as rhetorical flourish rather than descriptions of reality, but in any case, they bear no relation to the social sciences today.

In the United Kingdom, health service research is larger than anthropology and an increasingly important employer of ethnographers. Research in this field draws on a range of quantitative, psychological, and social science approaches. ANT and ethnography are popular among researchers in more interpretivist and sociological as opposed to positivist traditions (Greenhalgh *et al.* 2009). The ethnographic value of these approaches is in highlighting what otherwise might be ignored. Object-centred analyses, exemplified by Latour and Mol, provide a model for revealing emergent institutional politics and the distributed agency of bureaucratic technologies that are hidden by positivist accounts (Timmermans & Berg 2003). However, posthuman approaches increasingly predominate in this multidisciplinary space (e.g., Allen 2009; Berg 1997; du Gay *et al.* 2012; Greenhalgh, Darbyshire, Ladds, Van Dael & Rayner 2024; Pinder *et al.* 2005), just as they do in anthropology (Gregory 2014; Martin 2020).

While posthuman approaches do not preclude focusing on political economy and human inequalities, they make these concerns seem analytically optional in a way they never were in the work of so-called critical scholars. Like managerial discourses, ANT provides a conceptual language in which practices of care, work (Mol 2008), and management (Berg 1997) can be discussed and theorized independently of their broader historical, economic, and political context. For instance, Mol's (2008) work on care has helped shift the dial from talking about care as labour, and a potential source of exploitation, to exploring 'care work' (Mol, Moser & Pols 2010) as a practice that appears in clinics and other settings (e.g., Cowan 2024). There are many reasons for the growth in popularity of these approaches in the social sciences. Social theory which allows criticism to be carefully directed is perhaps more amenable to interdisciplinary and interinstitutional collaborative building than approaches which draw unflinching attention to issues of managerial authority, labour intensification, resource pressures, and unpaid work. In any case, few recent ethnographies of healthcare bureaucracy explore concerns raised by previous generations of Marxists and critical scholars.

As Marilyn Strathern (2011*a*; 2011*b*) observes in her exchange with Mol (2014), taking positions in academic debates 'sits side by side with the apprehension that the world is full of persons, known or unknown to one another, who all have their own view-points' (2011*a*: 91). In other words, it belongs 'to the epistemic universe' (2011*a*: 88) of pluralism. 'There are many contexts in which one does not need to share points of view in order to interact'. It is when caught up in the 'apparatuses of description' that we are 'stuck in "points of view"' (2011*b*: 125).

Mark was caught up in the apparatuses of description when he evoked a perspective that belonged to the front-line clinical staff on the wards. His comments were the initial inspiration for our interest in resource pressures and work intensification. We have avoided using language like 'management perspective' and 'nursing perspective' because these categories are incapable of expressing the hybridized knowledge practices and roles typical of contemporary healthcare. Members of the steering group would often consciously switch from speaking as a doctor or nurse to speaking as a manager, as exemplified in the above quote from Mark, where he begins commenting on the needs of his team before changing tack to speak from the point of view as a frontline nurse (see also Bailey *et al.* 2019).

At the same time, we have tried to maintain Mark's focus on hierarchal relations and pressures that often appear as concrete realities in accounts of care and work that privilege bottom-up points of view (Narotzky 2020). In a sense, we borrowed Mark's 'binary licence', as Strathern (2011*a*) might have it, and presented our argument as a contrast between hierarchically ordered perspectives on the project. While this might not allow us to escape Latour's double denunciation critique entirely, at least we can locate the ontological move. As Keir Martin (2020) observes, claims about 'real reality' (and the pluralist ontology they evoke) are not the preserve of patronizing 'critical scholars' but an everyday mechanism for understanding and resisting power. Claims about the real reality of work and resource pressure often arise when attending to bottom-up perspectives on organizational change and are, we suggest, fundamental for understanding contemporary public institutions.

Hospital management during fiscal austerity does not simply entail administering the wills and budget discipline of governments. Clinicians and managers in Hospital A worked hard to improve care and prevent further decline of public services in trying material circumstances. However, managerial public goods reflect broader economic realities (Bear & Mathur 2015). The image of 'the system' amenable to cost-neutral improvement and efficiency savings sits side-by-side with the image of public sectors as wasteful and inefficient. A 'bottomless financial pit' (Lapsley & Schofield 2009: 369) was how Margret Thatcher described the NHS when general management was introduced in the 1980s. Despite statistical evidence pointing to economic efficiency (Anandaciva 2023), this trope remains popular in UK media and politics. Patient safety agendas and organizational budgets are shaped by economic and political narratives of austerity (Bailey *et al.* 2019). As we have illustrated, despite assumptions about technology, efficiency, and productivity, these managerial-medical public goods mobilize and disguise the additional work of health professionals. Management is a subjective identity (Brown 2016), but it is also a perspective and practice that professionals with other identities (nurse, anthropologist) adopt. While management in public sectors may not be perceived as encroachment from the epistemological or institutional outside (Brown 2016), it is often experienced as the relentless demand for additional work and attention (Bailey *et al.* 2020*a*; Pasquini 2021).

The pressures described in this article are common in accounts of health service workers (F. Wright 2022). For a variety of reasons, however, they are frequently externalized or seen as analytically uninteresting by researchers (Brisley *et al.* 2023). This article sits among ethnographic accounts that in recent years have explored challenges to basic relations of care and social reproduction in the context of fiscal austerity in Europe (Brisley *et al.* 2023; Narotzky 2020; Pasquini 2023). Like these other ethnographies, our account emphasizes that public sectors are not rich treasuries of potential efficiency savings and cost-neutral improvements. The kind of resource pressures we encountered in 2016 intensified and returned to national attention four years later as the Covid-19 pandemic hit. Crises are not only preformed through statistical knowledge practices (Cozza 2024) and the 'crisis talk' of media pundits (Masco 2017), but also in the exhausted bodies of clinicians and carers – as Mark's comments about finding AKI in nurses provoke us to consider. Today it seems important to be able to say something not only about 'problems of unnecessary deaths and organizational failure' (Timmermans & Berg 2003: 200) but also about relations of political responsibility that stretch beyond the hospital.

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NOTES

[1] Our focus in this paper is posthumanism in relation to healthcare. To our knowledge, other versions of posthumanism in anthropology (e.g., Henare, Holbraad & Wastell 2007; Viveiros de Castro 1986) have had no direct impact on these debates and fall outside the scope of this article. The title of the article is inspired by Viveiros de Castro's (1986) *From the enemy's point of view*, an ethnography which explores complexities of perspective in Amerindian cosmology.

[2] Posthumanisms more centrally located in anthropological debate tend to attribute the ontological shift away from pluralism to their ethnographic interlocutors (e.g., Henare *et al.* 2007). Whereas in ANT, the same kind of operation is framed as assumptions that are not made about the entities – e.g., diseases (Mol 2002) – that ethnographers encounter during their fieldwork (Candea 2018).

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Du point de vue des managers : intensification du travail, ethnographie post-humaine et soins de santé en Angleterre

Résumé

À partir d'un travail de terrain mené dans un hôpital de l'agglomération de Manchester, en Angleterre, en 2016-2017, les auteurs décrivent comment un ensemble de priorités nationales de santé ont été transformées en travail pour les gestionnaires des hôpitaux et les praticiens hospitaliers au cours d'une période de forte pression organisationnelle. Au lieu de mettre au centre du débat la pratique et les relations post-humaines, comme beaucoup d'ethnographies récentes sur les soins de santé, l'article examine les inégalités entre les points de vue sur le changement organisationnel, en explorant le travail caché qu'implique l'amélioration de la qualité des soins dans un hôpital général public. Mettant la pratique en perspective, il fait la lumière sur les relations entre la politique émergente de la bureaucratie et les politiques plus contentieuses des soins de santé. Par leur réflexion sur les liens entre le virage post-humain et les raisonnements du management, les auteurs soulignent la nécessité d'envisager la théorie sociologique dans un contexte social élargi et examinent les pratiques de travail, de soin et de management de bas en haut.

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