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## **The Coproduction of Moral Discourse in U.S. Community Psychiatry**

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*Anthropologists often criticize the discipline of bioethics because its remote, abstract theories fail to capture how front-line clinicians experience and resolve moral uncertainty. The critique overlooks, however, the ways that everyday, emergent moral discourse is influenced—over time and through several mediations—by formal ethical notions. High-order ethical pronouncements become sedimented into the conditions of work, illustrated in this article by a two-year ethnographic study of Assertive Community Treatment (ACT), a popular mode of outpatient psychiatric services. ACT clinicians’ moral unease when they break the confidentiality of patients is connected to high-order debates, dating back 35 years, about ensuring patients’ autonomy without abandoning them. These debates originally spurred the invention of ACT, and they get braided into today’s moral discourse through several mediations: regulatory paperwork, the mandates and micropolitics of staff–patient interactions, and the idealized self-image of front-line staff. This article shows how everyday moral talk is coproduced by both the immediate contexts of clinical work and the categories of formal bioethics.*

Keywords: [bioethics, case management, Assertive Community Treatment, community psychiatry, coproduction]

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### **Advancing the Anthropological Critique of Bioethics**

Over the past 20 years, social scientists have launched a broad, ethnographically based critique of conventional bioethics. It claims that people engage with the ethics of medical care not by invoking abstract principles and values (autonomy, utility, care, etc.) but rather through local idioms and reflections on their immediate, practical activities. According to this critique, people’s moral perspective on medical treatment emerges from the concrete details of inequality and local notions of suffering, not high-order virtues or rules of conduct (Kleinman 1995). Emotional experience and local institutional arrangements drive many of the social conflicts that later get formally labeled as bioethics disputes (Anspach and Beeson 2001). Ethical discussions by both staff and patients are thus inseparable from their immediate life circumstances, social roles, political interests, and cultural beliefs (Marshall 1992; Marshall 2001; Muller 1994).

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On this basis, social scientists have criticized the experience-distant language of formal bioethics for misrepresenting the ways clinicians actually think about their conduct and obligations (DeVries and Subedi 1998; Fox and Swazey 1984; Hoffmaster 2001; Kleinman et al. 1999). Conventional bioethics in the United States is committed to liberal individualism, contractual relations, and core principles such as autonomy, beneficence, nonmaleficence, and distributive justice. It prescribes rational and systematic deliberation as the proper response to moral uncertainty (Beauchamp and Childress 2001). But its logic and vocabulary do a poor job of analyzing how medical workers actually reflect on ethical problems in the midst of practice. For the latter task, according to this critique, ethnography is the preferred method. Long-term qualitative research has shown that clinical and ethical issues become inevitably entangled and that ethical decision making is a shifting, shared, and implicit process, not the premeditated action of autonomous individuals, as envisioned by mainstream bioethics (Kaufman 1997). Ethnographies replace the remoteness of abstract moral theory with accounts of short-term decisions made in the face of local constraints (e.g., Bosk 1992; Chambliss 1996). They explore how medical professionals identify certain social conflicts, but not others, as ethical dilemmas. They demonstrate that clinicians talk about ethics in specific cultural idioms, framed by their own gender, class identities, and institutional loyalties, and rooted in a historical context (see Cohen 1999; Walker 2007; among many others).

The anthropological critique of bioethics relies on a categorical division between “moral discourse” and “ethics.” For the above authors, moral discourse is the framework used by ordinary front-line practitioners as they handle particular illness episodes. Ethics, by contrast, is the codified, reflective language of elite experts, situated far from the scene of clinical action (Kleinman 1999). Moral discourse addresses everyday experience and gets expressed idiomatically in the midst of practical activities. Ethics is based on the human capacity for reasoning and gets expressed through formal systematic theory (see Hoffmaster 1992; Jennings 1990). The categorical division itself sums up the anthropological critique. Conventional bioethics, as a discipline, offers an inadequate and misleading representation of the ordinary moral discourse of practitioners. Ethnographic research, by contrast, is uniquely fitted to the task.

The critique is compelling, and it demonstrates the distinctive contribution of ethnography to the study of moral uncertainty in health care. However, the critique also threatens to block interdisciplinary dialogue between anthropologists and clinical bioethicists, because it challenges the status of the latter group as professionals in their own right. Different types of experts with diverse training participate in the bioethics enterprise, including academic philosophers, theologians, lawyers, and medical educators. Clinical bioethicists, however, have the greatest professional stake in the type of theorizing targeted by the anthropological critique. Clinical bioethicists occupy distinctive roles as members of ethics committees and consultants to health care providers, and they are expected to define and resolve disputes, or at least help to build consensus (Churchill 1999). They are called on when clinicians and policymakers get tangled up in crises of incommensurate values, medical urgency, frustrating social conflict, and legal and financial risks. The forward motion of clinical care or research comes to a halt, and bioethicists are called in

to restart it. They must justify their intervention somehow, and in medical institutions founded on expert knowledge, the most effective way is to refer to high-order, systematic theories. When one's professional service is providing moral advice and adjudicating disputes, general theories become psychologically attractive and rhetorically persuasive (see Chambers 1999). They promise clarity, rigor, and coherence, even if (indeed, precisely because) they obscure the local texture and richness of moral life. Clinical bioethicists depend on their specialized theoretical knowledge to legitimize their professional identity. Undercutting the primacy of systematic ethical theory is tantamount to stripping full-time bioethicists of their source of expertise.

Ethnographers' strong critique—that disciplinary bioethics as such cannot account for moral discourse—will therefore likely remain marginal to the bioethics enterprise. The social power of clinical bioethicists—the likelihood that others will follow their advice—depends on their cultural authority, their ability to establish convincing definitions of fact and value. This is a tight power/knowledge link, in which bioethicists' political defensiveness against ethnography is braided with philosophical arguments. One cannot deduce a normative "ought" from a factual "is," writes Daniel Callahan (1999:286), a founder of the Hastings Center (one of the oldest bioethics think tanks). His response to social science draws on canonical bioethics scholarship, in particular the distinction between normative and descriptive ethics made by Beauchamp and Childress (2001:2). Callahan welcomes ethnography if it illuminates existing values or shows how they cross-cut different settings and clinical issues. But given the work imperatives faced daily by practicing bioethicists, even the finest ethnographic argument seems beside the point. For example, Hoffmaster (1992) eloquently demonstrates that ethical decision making in health care is a culturally embedded process, attuned to people's life experiences and shifting over time. It thus cannot possibly conform to the dictates of prescriptive theory. But clinical bioethicists intervene in the short term, typically at a late stage of conflicts, and to stabilize their authority they need a more efficient and univocal method than ethnography (Bosk 2001). Knowing the contexts and idioms for ethical concerns does not buttress bioethicists' authority either in the short run (at the bedside, in the committee room) or the long run (in the drive to establish professional sovereignty). For these reasons, bioethicists easily shrug off the ethnographers' critique.

To advance the dialogue with bioethics, medical anthropology should move beyond its oppositional strategy (which threatens to become a permanent critique with meager outcome). In this article, I suggest instead that moral discourse is coproduced by formal bioethics, on the one hand, and the circumstances of everyday clinical practice, on the other hand. The idiom of coproduction comes from science and technology studies, and it illuminates the connections between things usually regarded as ontologically distinct (see Jasanoff 2004 and the conclusion, below). This idiom offers a clear alternative to categorizing formal ethics and moral discourse as two separate worlds of thought. Undeniably, the authors of bioethics texts—physician educators, jurists, philosophers, and so forth—comment on clinical work from a distance. Moral discourse, by definition, is produced by front-line workers immersed in their routine tasks. These two commentaries on right and wrong come cloaked in different rhetorics, circulate in different institutions, and exert different

effects. For clinicians, formal bioethics may indeed seem remote and even irrelevant to their experience-near dilemmas. But to insist on their absolute difference is to grant ultimate analytic primacy to the clinician's point of view. From a more expansive ethnographic and historical perspective, bioethics and moral discourse do not exist in separate universes.

The practical horizon of ordinary clinicians—the problems they face and the tools at hand to solve them—was created in part by prior ethical decisions made by other actors, responding to different circumstances and demands at an earlier historical period. The “shape of action” for front-line practitioners is a *pentimento*, a layered domain where the outcome of prior ethical debates is woven into the terms and the tools used by today's clinicians (Rhodes 1991). Over time, bioethics decisions (systematic, explicit, and made by experts) become sedimented into the very conditions of work for front-line practitioners. They help create the roles that clinicians play, the guidelines and goals for interventions with patients, and their moral perspective on everyday work. In this sense, moral discourse—the emergent, experience-near commentary on the rightness and wrongness of clinical action—is coproduced by formal bioethics and by the daily contingencies of work.

### Confidentiality as Moral Discourse

Vignettes from fieldwork in a U.S. community psychiatry agency will illustrate the process of coproduction. They show that high-order ethical notions structure the terrain where front-line practitioners speculate about the moral stakes of their job. The vignettes trace the steps by which this structuring occurs, and they focus specifically on the coproduction of confidentiality. The first case connects clinicians' grounded experience of moral uncertainty with the formal, regulatory ethical apparatus that shapes interactions with all patients. Analysis of this case unfolds entirely within the physical and temporal boundaries of everyday work routines. It shows that spontaneously voiced moral concerns, generic paperwork about patient rights, and the micropolitics of clinician–client relations coemerge as parts of a single network. The later cases offer a different type of coproduction account, emphasizing deeper historical processes. They suggest that decades-old mental health reforms undertaken with explicitly ethical aims create the conditions of possibility for both clinical action and moral unease in the present.

The data come from a two-year ethnography of an intensive case management team, founded on the principles of Assertive Community Treatment (ACT), in a midwestern city.<sup>1</sup> The 10-person work group comprises social workers, psychotherapists, and psychiatrists, and it is part of Eastside Services (a pseudonym), which is a large, multispecialty medical clinic serving the city's poorest neighborhood. The team's mission is to bring all needed medical, psychiatric, and social services to 75 clients who have severe, chronic mental illness (primarily schizophrenia). All the clients have extensive prior hospitalizations, but they currently live in the community, and many would have great difficulty obtaining medical and social services on their own. On the basis of their history, they risk becoming more psychiatrically unstable, homeless, rehospitalized, or incarcerated (typically for nonviolent offenses such as loitering, disorderly conduct, and drug charges). The program staff

members are primarily social workers and master's-level counselors who go to clients' homes and deliver medications, watch clients take them, and assess their symptoms. Staff also take clients shopping, help them find new apartments when they get evicted, control their money and write their budgets, broker for services with other providers, negotiate with their probation officers and landlords, testify at commitment hearings, and do whatever else is necessary to help them succeed in community living.

Complaints like the following often come up during daily 8 a.m. staff meetings. Robin, the program director, gives an update on her client Bob:

Bob's parents called me again last week. They say they just want to know where he's living. I tell them, I'm sorry, I don't have permission to give you his address. . . . I feel so bad, they must be 80 years old. So, I told them that I saw Bob, and he's doing fine. . . . But I really shouldn't say that I even know anyone named "Bob."

Robin later explained the problem to me. Bob is a client with schizophrenia who consistently refuses medication. He has not given his consent to release any information to his parents, whom he thinks are trying to poison him. The case managers therefore cannot tell the parents anything, including the reason why Bob withholds his consent. "If we talk to the parents," Robin continues, "our rapport with Bob is destroyed. But we don't want to annoy the parents too much, because the next time Bob is evicted, they'll refuse to talk to us. So, what do we do?" she concludes. "Ethically, it's a gray area."

Robin's uncertainty about the right course of action resonates with textbook bioethics rules for confidentiality and disclosure. But as a clinician, she does not engage with these rules at a conceptual level. She instead treats them as a given feature of her work environment, and her commentary picks up where the rules leave off. Exemplifying the emergent moral discourse of front-line clinicians, it stays firmly within the horizon of practical action. Robin has worked at this agency for six years: long enough to witness several of Bob's cycles of stability and decompensation. Bob collects things in his apartment, especially bicycles, empty cans, and old newspapers. As they pile up, his apartment becomes a fire hazard and infested with vermin. He gets evicted every few years, and the Eastside Services team has enormous difficulty finding new housing for him.

Following the standard guidelines of ACT, Robin must keep in contact with Bob and provide the medical and social services that he needs. With most other clients, Robin does not bother to articulate these overarching clinical goals, but in this case, they conflict with each other. On the one hand, she must maintain rapport with Bob (and thus not talk to his parents), and on the other hand, she must keep him housed (and thus she should talk to his parents). Fulfilling one clinical goal imperils the other. Meeting one social obligation (to Bob or to his parents) betrays the other party. In this zone of ambiguity, the flow of work is blocked, and she cannot restart it without doing the forbidden and ignoring the obligatory. Robin cannot break the impasse by relying on either normal clinical routines or normal rules of social conduct. That is what she signals by calling it an ethical gray area.

## Confidentiality and the Objects of Bioethics

The above account stays within Robin's immediate frame of reference and reveals how local contexts and long-term relationships produce her moral discourse about confidentiality. The entire discourse, however, is coproduced by certain "objects of bioethics." An object of bioethics is a document, rule, or regulatory apparatus that reshapes routines of clinical care and research in line with an explicitly ethical rhetoric (see Brodwin 2005). Histories of bioethics explore why and how such objects arise, get refined, and then diffused to new sites where they alter people's conduct and inform their conceptions of right and wrong (e.g., see Rothman 1991:148ff on the history of hospital ethics committees). Over time, an object of bioethics can become a background feature of clinical work. It establishes the limits of allowable conduct, but from behind the scenes. It eventually starts to function as a "black box"; clinicians do not need to know its history and internal complexity to use it for the routine tasks of patient care or research (cf. Latour 1987).

Two objects of bioethics—in this case, written documents—help to produce Robin's dilemma about talking to Bob's parents. The first is a list of "consumer rights" shown to all new clients during their intake to the agency. This one-page document begins, "It is the policy of Eastside Services to support and protect the fundamental human, civil, constitutional and statutory rights of each consumer," and then lists 15 discrete rights. Some are lofty ideals ("to be treated in a fashion which recognizes your personal dignity in all aspects of care"). Others refer to operational details ("to participate in developing an individualized treatment plan") and some incorporate mainstream safeguards common nowadays throughout U.S. health care (the right "to confidential handling of disclosures and records of your treatment and status, and the right to refuse such information"). Case managers are supposed to read these rights yearly to all clients and have them sign to indicate their understanding.<sup>2</sup> The second document is the "Authorization to Use or Disclose Health Information," stored in the back of clients' charts. This federally mandated document asks clients to indicate which types of health information (psychiatric evaluation, MD progress notes, lab results, etc.) they wish to release to which specific individual. The case manager is supposed to ask clients to update the authorizations each year.

To label these texts as objects of bioethics does not mean they derive solely from formal bioethics scholarship. The texts contain several broader notions of rights and obligations that far predate the birth of bioethics as a discrete discipline. The texts draw from many historical sources, including debates about the treatment of the mentally ill and the legitimate reach of professional medical power. Nonetheless, the patient rights document and the authorization to release health information represent a special kind of literature generated by the 40-year rise of bioethics as a regulatory feature of health care practice. They gather together many different notions of rights on a single piece of paper. They operationalize the rights by specifying exactly what case managers must do and must avoid doing for their conduct to count as respecting clients' autonomy. The texts thereby constrain the course of clinical work. Moreover, the texts enable the surveillance of case managers by their direct supervisors at the agency as well as the state Department of Mental Health (see below). In a literary and functional sense, therefore, the documents are

the objective tools by which the bioethics enterprise regulates work at the clinical front line.

The explicit objects of bioethics, laced with abstract language about rights and duties, shape the landscape of practice by making certain clinical gestures possible and others impossible, and sometimes blocking the forward motion of everyday work. Most of the time, they do so without leading clinicians to think in formal, systematic “ethical” terms. Indeed, case managers regard the forms as an annoying and time-consuming burden. They direct clients to flip through and update the authorizations on their own, typically while driving them to an appointment or at the tail end of a home visit as they gather up their other paperwork and medication bottles. Even when case managers find time for a face-to-face conversation about release of medical information, clients’ attention often wanders and they have trouble understanding the legalistic language. The ethical ideal of voluntary, free, and informed consent is undercut by the reality of clients’ isolated, disenfranchised lives, which offer no experience with contracts, lists of rights, grievance procedures, and the like. At times, clients’ understanding of their “rights and responsibilities” is also hampered by their slowed thinking (both a negative symptom of schizophrenia and a side effect of medication).

Nonetheless, these objects of bioethics affect the balance of power where clinical work takes place. First, they are a rare medium for political negotiation between client and case manager. The clients of this agency resemble the individuals in Estroff’s account of the original ACT program (Estroff 1981). Immersed in their roles as objects of psychiatric intervention, they depend on the agency for access to key resources, such as money, housing, food, medical care, social contact, and even clothing. The ability to control the circulation of personal information is one of the few ways clients can limit clinicians’ power. As demonstrated by Bob’s refusal, taking control over information immediately makes the staff’s job harder. Second, the documents enact the state’s regulatory power over the agency as a whole. Every few years, an employee from the state Department of Mental Health audits the program, mainly by reviewing patient charts. Continued funding depends on meeting the regulations written into the state’s Mental Health Act, which mandate this paperwork. In the case of Bob and his parents, Robin’s moral discourse of confidentiality is thus coproduced by the immediate impasse she faces as well as the high-order ethics of confidentiality.

The ethics of confidentiality exists on several different registers. For philosophical bioethics, confidentiality is an ideal component of all medical encounters, justified by reference to patients’ autonomy and the fiduciary relation between patient and health care provider (see Beauchamp and Childress 2001:303–312). As a guideline for mental health clinicians, confidentiality is an “essential ethics skill” that can be summarized by a “do and don’t” chart covering eight areas (patient information, medical records, disclosure to family, etc.; see Roberts et al. 2004:112). In the register of U.S. legal bioethics, confidentiality is a rule backed up by case law with well-rehearsed exceptions in areas such as treatment of minors and dealings with insurance companies or workplace injury compensation boards (American Medical Association 2006:136–162). In the register of governmental statutes relevant to Eastside Services, “confidentiality to treatment records” is one of 24 discrete patient rights guaranteed by the state.

The objects of bioethics represent the final common pathway for all these registers of confidentiality to enter everyday clinical work. Via the list of patient rights and the authorization to disclose information, the ethics of confidentiality regulate face-to-face relations between case manager and client. These documents create blockages in work that provoke moral commentaries, even though no one engages with the high-order notions that lie behind the rules. They produce the exasperation and bewilderment of front-line practitioners who struggle through an “ethical gray area” to meet the demands of the day, juggle their obligations to clients, and at the same time obey the annoying, legalistic paperwork.

To represent this process ethnographically, the idiom of coproduction works better than the stark, ontological opposition between “ethics” and “moral discourse.” The ethics and moral discourse about confidentiality remain analytically distinct, but in practice, the former helps to produce the latter. We can contrast them as written rules versus unwritten tactics, formal versus idiomatic expressions, and generic versus situated knowledge. Moreover, most front-line clinicians in this agency have a very hazy understanding of the philosophical arguments about patient autonomy or the proper way to use principles in adjudicating disputes. When case managers discuss confidentiality, they refer only to their immediate context of action and decision making. Nonetheless, when ethical concepts gain regulatory power and help to shape the work environment, they become braided into the moral discourse of front-line practitioners. A coproduction account illuminates the untidy process by which idealist commitments and the texture of local social life interact to generate expressions of moral unease. In this case, the commitment to patient autonomy and the situated encounter between particular case managers and clients creates the recurrent moral discourse about confidentiality.

### Confidentiality in the Street

The following vignettes suggest another way that moral discourse is coproduced by high-order ethics and the immediate demands of clinical work. Ethical ideals are not only explicitly stated in documents that regulate face-to-face interactions but are also sedimented deeply and implicitly into the very rationale for treatment. As we have seen, documents about patients’ rights set limits on the way that clinicians do their job. At a more fundamental level, however, ethical ideals help determine what constitutes the job in the first place. In both cases, the ethnographic task remains the same: to describe how front-line practitioners encounter and talk about moral dilemmas and then to connect their moral discourse to both the local context and more encompassing ethical ideals. The goal is to trace the mediations between ethical ideals and their objectification (into mandates, documents, roles, and prohibitions), and between ethical ideals and their effect on the shape of action and clinicians’ emergent moral commentaries.

The bulk of daily work at Eastside Services involves driving around the city visiting clients. Each case manager has a case load of ten clients, some of whom require visits seven days a week. Although most clients want to live in independent apartments, not all do. The team places them in different accommodations (such as group homes and supported living facilities) on the basis of their ability to care for themselves, their eviction record, income, and the sheer availability of low-cost

dwellings. Most clients end up living in poor neighborhoods neglected by the city and with high rates of crime and gang activity. Their marginal housing adds to the frustration and danger for front-line staff. One day, I accompanied Tom, the most experienced case manager on the team, for his appointment with Larry, a middle-aged man with schizophrenia and an occasional cocaine habit who lived in his brother's basement apartment across from an auto mechanic's garage. As he does on all home visits, Tom hauled with him a heavy backpack filled with paperwork, his cell phone, pager, and Larry's "med bag" and "money bag" that he prepared that morning. These two zippered pouches contain the minimal medium of exchange between case manager and clients. Larry's med bag contained seven bottles of medication and a plastic cassette or "med minder" with slots for individual daily dosages. His money bag contained his entire monthly Social Security Disability Insurance (SSDI) payment in cash, along with pay slips and accounting sheets.

Larry answered the doorbell just as he finished mopping the floor, so he asked to meet with us back in Tom's car. Sitting down on the passenger side, Larry passed over the previous week's med minder, which Tom inspected for missed doses. Tom then fished out from his bag all of Larry's medication pills and an empty cassette, and led him through the process of filling it for the coming week. With most clients, Tom adds some "medication education" lessons during this procedure, such as quizzing them to see if they know why they take certain medications or checking up on side effects. But today, in the cramped car and in clear view of all passersby, Tom hurried on to the next required task: giving Larry \$50 and having him sign the pay slip. Their conversation was brief and to the point. Tom asked about symptoms (How are your voices?), medications (I see you skipped a few days of Risperdol?), and current issues in Larry's life (Did you get that job at the sports arena? How many hours is it per week?). The visit lasted no more than ten minutes, and as we drove away, Tom complained to me,

Confidentiality went out the window. And if someone wants to know when Larry has his money, they can just observe it. I am like clockwork; I'm there at the same time every Monday. They could be asking, "Is it a drug deal? Does he have money?" and he'll be robbed. All because of a washed floor.

I heard more complaints about lost confidentiality from Jean, another case manager. She was working closely with Tyrell, a man diagnosed with schizophrenia and borderline personality disorder who had more than ten psychiatric hospital admissions in the past year. A few days earlier, Tyrell was banned from the convenience store near his apartment after causing a disruption. He wanted Jean to explain his illness to the store owner so Tyrell would be allowed to shop there again, and Jean agreed. This sort of request is not unusual for intensive case management services. Staff routinely interact with roommates, landlords, neighbors, police, and family members to advocate for clients and intervene in disputes that might escalate to eviction or arrest. But as they were waiting in the crowded store to speak to the owner, Jean found herself criticizing Tyrell in public about an entirely unrelated issue. She asked what he had gone there to purchase. He answered, "A cake."

[Jean:] But Tyrell is a diabetic, and he should not be eating cake. So I started to tell him, there and then, that he shouldn't be eating cake, that he should buy cigarettes, instead. . . . Tyrell told me that I shouldn't have done that. Wow, I could not believe that I had said all this! I apologized. I said to Tyrell that we had just lost another client, Sam, to a medical condition, and that I knew I was out of line. I said to Tyrell, "You've been honest with us, so I'll be honest with you. I was just so upset about Sam."

What provoked these concerns about confidentiality? From the case managers' perspective, the answer is clear. They got caught up in contradictions while carrying out the basic tasks of the job. The minimal home visit—providing meds and money—exposed Tom's client to the risk of robbery or worse. Jean's effort to help her client succeed in community living and improve his health led her to berate him in public, and to broadcast to other shoppers that he "has a worker." (Most clients vehemently do not want neighbors or strangers to know they have a case manager.) Ordinary clinical routines, carried out to help people, ended up potentially harming them (their well-being or reputation), and to articulate this situation, case managers complained about lost confidentiality. Such talk communicates the case managers' worry and even shame when their well-intentioned perspective is thwarted (see Rowe 1999). Case managers hold to a self-image as advocates who protect vulnerable clients and give them resources and personal support to manage independent living. However, providing services in clients' own living spaces (in accord with ACT principles of *in vivo* treatment) can have unintended harmful consequences. Case managers' moral discourse about confidentiality expresses the slippage between their preferred self-image and the real demands of their job. They frame confidentiality not as a high-order ethical mandate (a general good), but as a quality of particular interactions that, when absent, endangers clients as well as their own idealized identity.

### From Ethical Plateau to Moral Discourse in ACT

Everyday comments about confidentiality are thus produced when front-line clinicians confront the contradictions built into standard work routines. But the routines themselves have a history that connects them to ethical controversies dating back 30 years in the United States about the proper treatment for people with serious mental illness. Case managers' moral discourse is coproduced by everyday work situations as well as with high-order ethical debates that have become sedimented into the specific guidelines for their job. The debates are mostly invisible in case managers' talk about confidentiality, but they fundamentally set the terms for emergent moral discourse.

ACT arose in the wake of deinstitutionalization: the massive shift in the locus of care for people with severe, persistent mental illness from hospitals to community settings that occurred in the United States in the 1960s and 1970s. The downsizing of large state-run mental hospitals had ideological causes, as well as the oft-cited medical and economic ones.<sup>3</sup> Critics of the status quo imagined deinstitutionalization as an ethical imperative and revolutionary advance over the dark ages of psychiatric confinement (Mechanic and Rochefort 1990). Influential attacks from psychiatry and sociology (see Goffman 1961; Szasz 1974; among many others) argued that

long-term institutionalization was an assault on human dignity that produced passivity and social withdrawal. Deinstitutionalization thus became a moral ideology, not only a public policy (see Mechanic 1989). At a broad cultural level, it was driven by an ethic of personal freedom and the valorization of autonomy and choice. Independent living in community settings became a prime goal for reformers of the mental health system as well as patient-advocates (Cockherham 1996:287).

The shortcomings of deinstitutionalization soon became well known (see Bassuk and Gerson 1978; Gruenberg and Archer 1979). By 1975, only one-third of the necessary number of community mental health centers were operational. The inpatient population at state and county mental hospitals sharply declined, but admissions rose just as sharply. This trend signified the new norm for treatment of people with serious psychiatric illness in the public mental health system. From the 1970s to the present, such individuals are hospitalized for short-term stabilization, then discharged to a ramshackle and inadequate network of nursing homes, substandard apartments, halfway and rooming houses, and shelters. The resulting isolation, despondency, and fragmented medical and psychiatric services often leads to relapse and rehospitalization. An ethical rhetoric has driven the vast literature about the failures of deinstitutionalization.<sup>4</sup> It claims that psychiatry, law, and U.S. society at large have created a nationwide “crisis of abandonment” (Gruenberg and Archer 1979:486). Professions and individual practitioners are guilty of shirking responsibility for an entire class of patients. Social welfare agencies, medical professionals, and families reject outright these unattractive, marginal patients and hope that someone else will find the resources to solve the problem. Critics take aim at wishful thinking about the curability of chronic mental illness as well as misinformed zeal about the civil rights of patients that allows them to “die with their rights on” (see Isaac and Armat 1990; Johnson 1990). In this rhetoric, irresponsibility and neglect are the core ethical failings of deinstitutionalization, and the blame rests squarely in the shoulders of the helping professions and mental health bureaucrats (Torrey 2001:24).

Two clusters of values—ensuring patients’ autonomy and freedom, on the one hand, and not abandoning them, on the other hand—now constitute the ethical plateau (Fischer 2003) for mental health services after deinstitutionalization, including ACT. An ethical plateau is a particular conjuncture of technologies, institutions, and ideologies that shape how clinicians perceive their obligations and the limits of acceptable conduct. Fischer develops the notion in the context of new biotechnologies (genetic engineering, organ transplantation, and xenotransplantation), but the term is also crucial for the anthropology of bioethics in general. An ethical plateau operates as a legacy of the past in the present. It extends its influence forward in time by establishing an armature of notions about right and wrong that subsequently gets reproduced in other settings, in other registers, and in the voices of actors (clinicians, patients, advocates, policymakers, etc.) who enter the scene long after the original debates fade away (see Fischer 2003:175). An ethical plateau thus represents the starting point in the chain of mediations between high-order pronouncements and local, contextualized moral discourse. Objects of bioethics (such as the authorization to release medical information) as well as guidelines for a particular treatment mode emerge later in the same chain. In terms of their effects, such mediations stabilize and regulate clinical conduct. In terms of their origins, they

concretize the general ideals and prohibitions laid out in the relevant ethical plateau. They structure the landscape of practice for case managers, and they precondition certain tensions, blockages, and frustrations of everyday work. In the end, front-line practitioners articulate these conditions through experience-near moral commentaries on the impasses they encounter with particular patients.

To apply this model of coproduction to ACT, we must trace its genealogy, which starts in the 1970s at Mendota State Hospital in Madison, Wisconsin (see Dixon 2000; Stein and Santos 1998; Thompson et al. 1990). A group of psychiatrists and psychologists at Mendota State decided to address the “revolving door” pattern of discharge, psychiatric crisis, and readmissions by visiting patients at home after discharge, working with their social networks, and being available around the clock to respond to crises. Over time, the group radicalized its clinical research project and renamed it “Total In-Community Treatment.” In line with the general critique of institutional psychiatry, they claimed that community-based services could succeed where hospitals failed. Living in ordinary neighborhoods, they claimed, provided individuals with serious psychiatric illness a set of healthy role models, more efficient learning of skills of daily living, and more rewards for appropriate behavior. They subsequently developed a third version of their intervention, “Training in Community Living” (Stein and Test 1985), which was the template for today’s ACT. ACT has proven hugely influential in mental health services research and has diffused nationally and abroad.<sup>5</sup> ACT is essentially a “hospital without walls” that replicates the range of medical, psychiatric, supportive, and rehabilitative services once provided by large state hospitals. Preventing hospitalization and maintaining people in community settings is the single most important, and most often replicated, outcome of ACT. Successful community dwelling is the major goal of ACT, not cure, greater insight, or psychotherapeutic progress (Thompson et al. 1990). Indeed, ACT does successfully maintain more people out of the hospital for longer periods of time, compared to other mental health services, according to decades of empirical research (Stein and Santos 1998).

ACT rests on the same ethical plateau as all mental health services in the aftermath of deinstitutionalization: the twin values of ensuring patients’ autonomy and freedom while not abandoning them. However, the historic tension between these values—born in successive moments of reaction and counterreaction to the dominance of large state psychiatric hospitals—has never quite disappeared. It gets reproduced in the general mandates for ACT and finally the specific guidelines for front-line staff. The founders of ACT hold that enabling people to lead a stable life in the community is the best guarantee of their rights and dignity. They explicitly cite the concern for patients’ civil liberties as a key influence for developing the model (Stein and Santos 1998:17). To assure stable community residence for people with serious, persistent mental illness, ACT staff provide services for as long needed, often for the rest of a person’s life.<sup>6</sup> In practice, Eastside Services rarely discharges a client. The few clients who leave the program do so either by dying, going to jail, or moving to another state. The program director told me,

People sign on the dotted line [to receive our services] because they are in the hospital, and they want housing and want to be out of the hospital. But once you sign, we’re like gum on your shoes. . . . Some agencies drop clients if,

after six months of trying to contact them, they do not respond at all. You have to document that you really went out there, not that you just stayed in the office, waiting for them. . . . But we are more flexible. If a hand reaches out to grab a Gatorade, we consider that a contact, and we reset the six-month clock.

During staff meetings, case managers devote much time to clients who are “missing in action” and devise ways to find them: checking shelters, calling case management programs in other counties or states, driving to their relative’s homes, and so on. Holding on to clients for as long as possible is considered simply part of the job, and doing it well is a point of pride.

The other way to assure stable community residence is to provide services in clients’ own living space and to do so “assertively.” The latter term is defined in a popular ACT training manual:

Use an assertive approach. . . . This principle infers acting quickly to avert negative consequences for clients, which, of course, requires careful client monitoring. . . . It dictates that the team must be assertive about knowing what is going on with clients and acting quickly and decisively when action is called for. ACT continually does what it can to increase client independence. The major goal of ACT is to help clients live successfully in the community, and the beauty of living in the community, as contrasted with living in an institution, is that clients are in control of their own lives. [Stein and Santos 1998:75]

This directive, which is arguably the pillar of the treatment mode, is echoed in multiday training sessions for ACT staff organized by the state office of mental health as well as on-the-job coaching for new case managers. Translating the guideline into everyday clinical routines involves informal practices of surveillance, such as counting the number of beer cans in the trash or asking directly about drug use, prostitution, and drinking. It involves keeping up to date with virtually every aspect of clients’ lives—who they visit, what they eat, where they spend their days—through observation or direct questioning. It demands dogged persistence to maintain contact with clients who do not meet their appointments, who sometimes disappear for days or weeks into a hospital or prison bureaucracy, or who simply want to escape the agency and its intrusions.

The high-order ethical imperatives that spurred the development of ACT thereby get translated into a recipe for everyday clinical work: Case managers are trained to do everything possible to keep in touch with clients and deliver medical and social services in their own living spaces. The tension inherent in that ethical plateau also gets transmitted to front-line practitioners, and it appears, for example, in the training manual definition of the “assertive approach.” Practices of monitoring, surveillance, and intrusion do succeed in keeping clients out of the hospital. To claim, however, that they “increase client independence” and render them “in control of their own lives” flies in the face of case managers’ experience (see also Estroff 1981; Floersch 2002). The tension between the founding imperatives of ACT—to ensure patients’ autonomy but not to abandon them—becomes an insupportable

contradiction for the front-line staff. Case managers find they are massively controlling their clients, supposedly to guarantee that clients control their own lives. Of course, most ACT staff never articulate the contradiction directly. The mandate is too hegemonic, and directly questioning the core clinical guidelines is inconceivable in the midst of a busy workday spent rushing from client to client.

Through their moral discourse about confidentiality, however, case managers do refer precisely to this contradiction. They accurately sense that they have stumbled into an ethical gray zone when they must speak to a client's parents without his permission, hand over money and meds in a busy street, and criticize a client's eating habits in front of other shoppers. Not only is textbook confidentiality impossible once mental health professionals leave their offices and deliver services *in vivo* (Diamond and Wikler 1985), but front-line staff find that the same clinical gestures required, per ACT guidelines, to prevent hospitalization (the prime clinical and ethical ideal) can also decrease clients' independence, threaten their well-being, and humiliate them in public. Case managers articulate this double bind through their talk about confidentiality. They worry about the double bind—and express their worries in a moral register—but not because they are trying to finesse a legal document or to work through a philosophical dilemma. Looking inward, they find their good intentions are thwarted even as they fulfill the guidelines for continuous, lifelong, assertive delivery of services. Looking at the client, they find that ACT actually can endanger clients and hamper their freedom. Their moral discourse about confidentiality thus articulates a double bind, and it is coproduced by their daily interactions with clients and the ethical plateau that spurred the creation of ACT in the first place.

## Discussion

This article presents a new framework for understanding moral uncertainty among health care professionals. Instead of opposing high-order ethical concepts to moral discourse, the framework traces how the former influences the latter through specific mediations. The approach taken here differs from the important study of ethics and moral discourse among hospital nurses by Chambliss (1996). The U.S. hospital is a rigid occupational hierarchy, and Chambliss shows how nurses face the contradictory demands to be competent professionals but also subordinate members of the organization. The very structure of the hospital creates recurring conflicts between nurses, on the one hand, and doctors and administrators, on the other hand. According to Chambliss, nurses frame such conflicts as ethical problems, whereas at root they are political conflicts and turf wars.

By contrast, political and organizational problems play a much smaller role in the genesis of moral discourse for intensive case management programs.<sup>7</sup> The front-line staff work by themselves in the community about 80 percent of the time (according to my data, Floersch 2002, and Stein and Santos 1998). After the two-week training period for new employees, there is very little direct observation or on-the-spot supervision of case managers. Moreover, such teams do not have steep hierarchies. At Eastside Services, for example, the three supervisors are also case managers, albeit with a reduced load, and both supervisor and ordinary case manager typically have master's degrees. The consulting psychiatrist spends only eight hours per week at the agency, and most of that time he sees individual clients for medication checks.

During my research, I documented discussions about only two clients (out of the total agency case load of 75) in which case managers deployed moral discourse to advocate for their own clinical decisions against recommendations by supervisors and psychiatrists. In one case, the client in question had severe alcohol addiction but without a definitive psychiatric diagnosis. His case manager's religious values drove his opposition to the team leaders, who wanted to cut back services to this client to the bare minimum. In the other case, the client was on probation from a prior criminal offense, and the team needed to decide whether to inform police that she had started using cocaine. The supervisor had strong sentiments about harsh sentencing and racism in the criminal justice system, whereas the woman's case manager believed that criminal behavior merited punishment, no matter what the circumstances. In both cases, the ethical debates were driven, in part, by political dynamics within staff meetings. But these were the only two cases of moral discourse in which staff members (1) elaborated their personal values and (2) used moral framings chiefly to advance their occupational interests (as case managers as opposed to supervisor or psychiatrist).

Moral discourse in intensive case management services does not, therefore, derive from occupational hierarchies. It is instead coproduced by the details of clinical work—carried out alone in the community—and the mediations of high-order bioethics notions. The model of coproduction is an idiom, not a theory (Jasanoff 2004). Deriving from Science and Technology Studies (STS), it expresses certain types of relationships especially well, no matter what the theoretical issues at hand. The following section briefly reviews the idiom in its original STS context and modifies it for use in the anthropology of bioethics.

The coproduction framework within STS seeks to understand how scientific knowledge and the social order emerge simultaneously and in mutual dependence. It cautions against polarized narratives that either celebrate science as the apotheosis of reason (and the ideal model for social arrangements) or demonize science because it strengthens oppressive social hierarchies (Reardon 2005). In this article, by contrast, I do not take up the relations between science and the social order writ large. I instead focus more narrowly on the relation between formal bioethics and moral discourse that emerges in specific, historically contingent, and fleeting face-to-face social relations. The ethnographic analysis requires an account of mediations between abstract principles, on the one hand, and spontaneous expressions, embedded in social action, on the other hand. The case of ACT shows that spontaneous commentaries about the obligatory and the forbidden from front-line staff index the situation immediately at hand but are also prestructured by ethical ideals, via the mediations of objects of bioethics and the very treatment model. In this sense, moral discourse is coproduced.

The idiom of coproduction in STS focuses on the connection between things usually regarded as existing in entirely separate spheres. For example, scientific facts and the rules for verifying facts are said to be coproduced. From this angle, a fact is not an objectively true statement about the world, irrespective of time, place, and social context. A fact is instead “‘true to’ a set of self-authenticating techniques” (Hacking 1992) located in particular worlds of practice (see Fujimura and Chou 1994). For example, accepted laboratory methods and rules of legitimate evidence are techniques that authenticate and stabilize scientific facts. Each world of practice, in turn, is historically located and depends on particular work routines

(see Fujimura and Chou 1994:1020). A statement is rendered true, therefore, not by its veridical relationship to a universe outside of human discourse, but instead by the self-stabilizing techniques of a given world of practice.

The idiom of coproduction invites suspicion about all transcendent truth claims. Worlds of practice are contingent, historically located, and built up from innumerable microsocial interactions and negotiations (see Hacking 1992). The truths proclaimed by scientists thus bear all the marks of a certain time, place, research tradition, institutional politics, and so forth. Scientists nonetheless try to place their statements about the truth in an immutable realm outside of politics and culture (Jasanoff 2004:18–19). They give their scientific pronouncements a transcendent aura by cleansing their work of all references to its local context and to the contingent ways that experiments proceed and results accumulate (Latour 1986). To analyze the coproduction of scientific facts and the rules for verifying facts means to reverse this process. It means reconstituting the “hybrid network” (Latour 1993) that preexisted the framing of scientific knowledge as placeless and transcendent.

The anthropology of bioethics should acknowledge a similar hybrid network connecting local moral discourse to formal, textbook ethics. In the standard anthropological critique, moral discourse is categorically distinct from ethics. The former is historically located, culturally contingent, and dependent on collective work processes, whereas the latter announces itself as universally true across all contexts. Nonetheless, local moral discourse and the high-order notions of virtue and value about a particular clinical realm—ACT, for example—can both be placed in the same ramifying network of actors, relationships, institutions, and meanings. They are not fundamentally different types of statements, although they bear the marks of their origin at different social locations. The coproduction of moral discourse is difficult to perceive for two reasons. First, the discipline of bioethics is very successful in purifying and standardizing its knowledge; in this regard, it resembles mainstream natural science. Like theoretical physics, bioethics portrays its core principles as universally applicable, transcending local worlds of practice and the immediacy of particular cases. Professional bioethics operates through a standardized bureaucratic apparatus (IRBs, regulations, professional codes, etc.) that establishes “ethical procedures” and makes them portable from site to site. Analyzing the coproduction of moral discourse recovers the connections that were rendered invisible by the transcendentalizing strategy of bioethics. In the case of ACT, autonomy and the professional obligation to provide care are abstract renderings of historically specific imperatives, embedded in a distinctive technological, institutional, and cultural milieu.

Second, the coproduction of moral discourse is difficult to see in daily clinical life. In many respects, an item of moral discourse—what gets said in a staff meeting or in the car after seeing a patient—does seem categorically distinct from a formal ethical pronouncement. The two differ as the ephemeral to the enduring, the spoken to the inscribed, the personal to the impersonal, and the local to the universal. Busy clinical work rivets the practitioner to problem-solving in the short term with the resources at hand. The frustrations and blockages that generate moral uncertainty remain tied to practical activities. Most practitioners do not know (because they do not need to know) that ethical controversies carried out long ago and in another place continue to structure their encounters with patients. Those unresolved tensions between competing ethical ideals help to create the immediate experience of moral uncertainty, but the distant connections are difficult to perceive.

To summarize: Moral discourse, by definition, is produced out of the hands-on engagement with clinical tasks. It is also produced by formal ethics, but this is difficult to see for two reasons. Professional bioethics self-consciously places its products in a realm outside of history and practice (a transcendentalizing strategy). Moral discourse and bioethics emerge at different nodes in a same network, separated from each other space, time, and the relative weight given to reflection versus practice. Nevertheless, high-order ethical discussions about right and wrong hover above the site of clinical action, leaking into the words people use, constraining people's actions without their knowing it, and sometimes entering their most personal anxiety about the obligatory and the forbidden. An important goal for the anthropology of bioethics is to trace a historical line from a particular ethical plateau to objects of bioethics and guidelines for practice, and finally to local moral commentaries. This article uses a retrospective method for that goal. Ethnography in a single work group revealed which circumstances provoke clinicians to talk about confidentiality. The research process then had to track backwards, away from the clinical front line, to the documents and guidelines that regulate action, and then to the historically contingent rhetorics about patient autonomy and professional responsibility that influenced the very development of ACT. This method emphasizes the sedimentation of yesterday's high-order ethical debates into today's clinical routines and the sharp moral unease that results. The coproduction framework can thus provide a conceptual bridge between local moral experience and systematic ethical reflection (Kleinman 1999) and allow more fruitful interdisciplinary work between medical anthropology and bioethics.

## Notes

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1. Participant-observation research took place for two years at an intensive case management program for people with severe mental illness. Although based on the principles of ACT (see Stein and Santos 1998), "Eastside Services" does not meet the formal fidelity standards for ACT currently used by certain states to authorize, evaluate, and fund community psychiatric services (see Teague et al. 1998). I attended 120 staff meetings and accompanied six case managers, for approximately four months each, on their daily visits to clients' homes and meetings with psychiatrists, lawyers, and family members. I observed ten sessions of counseling and medication management between the consulting psychiatrist and clients. Other sources of data include 30 semistructured interviews: 20 with case managers, five with the program director, and five with the psychiatrist. During fieldwork, I documented both the ongoing moral commentaries made by clinicians in the midst of seeing clients and the use of more abstract ethical language during staff meetings and research interviews. I also attended training sessions for new case managers run by the state

Department of Mental Health, as well as four regional continuing education seminars for social workers about ethics and boundaries. Transcribed interviews and field notes were coded with Nvivo 2.0 software for qualitative data analysis. Institutional Review Board approval from the University of Wisconsin–Milwaukee was obtained before beginning research.

2. The actual informed consent document is a much shorter form, on which clients indicate their agreement to be admitted and (again) their understanding of their “rights and responsibilities as an Eastside Services consumer.”

3. Psychiatrists had access to newly discovered psychotropic medications to lessen the most florid symptoms of schizophrenia and bipolar disorder. The establishment of Medicaid and Medicare meant that federal dollars could replace state dollars to care for people with mental illness. The Community Mental Health Center Act of 1963 envisioned a 50 percent reduction in the number of patients in custodial care within one decade, who would then be served by a network of neighborhood-based clinics.

4. This literature, of course, also explores structural reasons for the failure of deinstitutionalization: insufficient political will to pay for community services, the continuing stigma attached to serious mental illness, the resulting economic and residential marginalization of individuals, poor coordination between hospitals and community-based services, the unwieldy mental health bureaucracy, and juridical limits on commitment (see Brown 1985).

5. In 1974, ACT won the Gold Achievement Award from the American Psychiatric Association. In 1996, the National Alliance for the Mentally Ill (NAMI)—the leading lobby for mental illness research in the United States—devoted resources to promote ACT as a best practice. In 1999, Medicaid began reimbursing ACT services (Bond et al. 2001). By the mid-1990s, almost 400 ACT teams operated in 34 states (Bond et al. 2001). The model has been successfully diffused to Canada, especially Ontario; the United Kingdom; and several European countries. Professionals and mental health advocates can easily obtain manuals to set up new ACT teams (e.g., Allness and Knoedler 2003; Stein and Santos 1998). A vast technical literature explores its efficacy, its key ingredients, and its adaptations to specific sites and populations (see the bibliography maintained by the ACT Center of Indiana, at <http://psych.iupui.edu/ACTCenter/Biblio.htm>, accessed August 2006).

6. The empirical literature shows that when ACT is stopped, patients return within a year to the revolving-door pattern of frequent decompensation and hospital admission (Stein and Test 1985).

7. A full understanding of the production of moral discourse for relatively low status health workers awaits more studies in the anthropology of social work, such as Carr n.d.

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