

Facing Facts: what's the good of change?

by
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1. Introduction

What kind of practice am I talking about?

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

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

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

What am I going to be talking about?

My colleague Tom Flynn and I have been working within the British National Health Service (the NHS) since 2000, examining the way orthotic clinics treat their patients. Orthotists are a type of clinician who prescribe 'orthoses', working not only with orthopaedic and paediatric patients, but also preventatively with diabetic patients, osteo-arthritic patients, and so on. These orthoses are artificial external devices, such as a brace or a splint or special footwear, which prevent or assist relative movement in the limbs or the spine. And the characterisation I gave you of the orthotist's experience within the NHS is not an unfair one, including the gender characterisation.

To cut a long story short, we found that focussing on the early and sustained treatment of conditions involved initial investment and a significant increase in orthotic budgets, but within five years saved more than five times the initial investment in reduced need for the acute care and social costs associated with immobility in later life; and a great deal more than that over the longer term. And, of course, an enormous gain in the quality of patients' lives. It was as if the system had been set up to deal with acute conditions, if necessary by waiting until conditions became acute!¹

What kind of challenge did this face the clinicians with?

I want to talk about a kind of *Faustian pact* that clinicians enter into with their host systems that, while not explaining why change does not happen, does highlight something about what makes change difficult. The Faustian pact is an unholy alliance between the clinician and the system, in which the deal is: "As long as you give the system what it needs, you can do pretty much as you like, so long as the patients don't complain." A kind of 'we'll leave you alone if you leave us alone'. And of course there is the other side of this: the clinician going to great lengths to keep obscure what he or she is actually doing for his or her patients not only because he or she considers it to be no-one else's business, but also because the less anyone else knows, the less likely they are to find a basis for interfering with their practice, something that he or she would always consider to be for the wrong reasons or against the patient's interests.

I want to argue that the alternative to this involves the clinician having to take up a kind of *double challenge*. This double challenge, on the one hand involves clinicians questioning the nature of their own practices in relation to their consequences and outcomes in the patient's life. And on the other hand it involves challenging the host system, insofar as that system creates contexts that act against the needs of the patient – a kind of constructive disobedience not only given force by the challenge of the case, but also supported by the evidence of the case. This is what is implied by the idea of 'facing facts'.

What is the relevance of this to us all?

What has this got to do with us, I hear you say? The way of the clinician stands for a particular desire to address the needs of the patient, however cynical we may become about how clinicians fall short of this in practice (Boxer and Palmer, 1997). I want to extend this ethic from the 'clinician' in particular to the 'professional' in general. In some sense we all of us here are professionals who will have had

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some direct experience of this double challenge. Furthermore, as members of ISPSO, we are uniquely placed to understand it because of the nature of the Freudian insight. So in unpacking something of what this double challenge might mean for us, I will also be saying something about the form of leadership it implies. And in not taking up this double challenge? I will be arguing that failure to do so leads to a kind of *evacuation* of the public realm, which is to the detriment of us all. By this I mean that there comes to be no way of speaking about, let alone protecting the public good. Everything is rendered 'private'.

What is the plan for the paper?

The paper is in two halves. The first half starts with the case itself, what we tried to do in response to it, and what kind of double challenge the case represented for the orthotists. It will then talk about the wider context of the NHS system itself, and how the double challenge facing the orthotists could be taken as being symptomatic of the difficulties facing the state itself in its approach to reforming its public services. This will lead me to the question of what appears to be happening to our relationship with the state as citizens, and the way in which the double challenge at the level of the orthotist is repeated at the level of the state as a question of what properly belongs in the public realm. The point about the Faustian pact is that it describes the process by which the evacuation of the public realm takes place.

The first half concludes by considering what kind of dilemma this double challenge presents us with as clinicians or as citizens. The second half then looks more closely at what is happening at the individual level in all of this. Firstly, it looks at how we approach the question of our own authorisation as citizens; then at what is going on when we 'face facts', in particular the role ideology plays in this, insofar as the force ideology has for us is derived from the valency it has with our own unconscious phantasies. This leads me to consider how anxiety gives us the clue for what happens when this valency is put into question, how anxiety strikes us personally, and where we can then find ourselves looking for the good of change.

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

2.1 The case itself

What was the original presenting problem and our proposed approach to it?

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

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

What did we learn from the pathfinder projects?

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

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

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

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

We found this a very difficult project. In effect, we were taking up the double challenge on behalf of the clinicians in the dual disruptive and reflexive approaches that emerged - creating its own dynamics within our team which reflected the difficulties the clinicians themselves faced in taking on the double challenge. These dynamics are not the prime focus of this paper, so I will not pursue them here, but suffice it to say that the way we handled them was critical to our ability to sustain the momentum of the intervention itself as a whole.^{iv}

What we had identified were the benefits of a systemic change to referral protocols and pathways in the interests of patients' long term care needs. It was not surprising that the clinicians and their professional association were themselves strongly supportive of these changes.^v The difficulty was that the service was located in the Acute System, the costs were carried by the Primary Care system, and the benefits fell very largely in Social Services. There turned out to be no mechanisms and no sponsorship for making these kinds of systemic change, despite the fact that we were now a project under the Modernisation Agency, and the Treasury modellers had endorsed the level of benefits identified as having been understated. Our experience was showing just how difficult it was for the clinicians to argue these changes themselves.^{vi}

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2.2 The challenge to NHS reforms

What changes were going on in the NHS context?

I have laboured the detail of the case somewhat, in order to convey something of the dead weight of the NHS context within which the orthotists were working. So what was going on in this context?

A major change was going on which removed direct funding from the Acute System and channelled it via the Primary Care System. This was equivalent to channelling all funding through managed care or insurance organisations in the USA, although using government funds rather than insurance funding.^{vii} At the same time, the Acute System was subjected to a vast number of targets, most famously relating to waiting lists, that had the perverse effect of diverting both management's attention and government funding to short term fixes in order to meet those targets, taking attention away from the systemic changes needed to achieve long-run improvements. Here is the chairman of the Audit Commission, which audits UK Government expenditures:

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

How are we to think about what is going on here? We are looking at something that is not peculiar to the NHS, but is symptomatic of a way of doing business in a complex service environment.

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

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

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

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

2.3 The emergence of the market state

What is the government is trying to do with the NHS?

What we have, then, is a N-S dominant model of the NHS run by the State, with its heavy dependence on its Faustian pacts with the medical profession; and a modified version of this, still N-S dominant with the Faustian role intact, but control of spending moved into the Primary Care System. What we appear not to be getting, yet, is an E-W dominant model, built around the Primary Care System being able to secure the delivery of through-life health care to the individual. Nevertheless, this is the vision of New Labour's policies for modernising government:

"Modernising Government is about government for people - people as consumers, people as citizens... we will make sure that government services are better - that they reflect real lives

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and deliver what people really want... To improve the way we provide services, we need all parts of government to work together better. We need joined-up government. We need integrated government.” (Jack Cunningham, 1999)

What we are seeing, nevertheless, is evidence of a fundamental shift in the role of the State, in which it is no longer a matter of what benefits we get in return for being loyal citizens, but rather what support we citizens have a right to expect in return for the taxes we pay.

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

We appear to be living through a profound transition from the *nation state* of the twentieth century to the *market state* of the twenty-first century (Bobbitt, 2002). In essence the state withdraws from being a provider in the market state, drawing its legitimacy from its ability to create opportunity for its citizens. Philip Bobbitt argues that this transition is reflected by changes in the technology of warfare and of commerce, and ultimately in the way the state's citizens cede powers of life and death over them, currently very much in evidence through the impact of terrorism. And why terrorism? The point is that very small acts of violence can have a totally disproportionate impact on the state because of the complex interrelationships between everything, and because such acts are so difficult to anticipate because they are such individual acts. The effectiveness of terrorism shows the other side of this different economic basis for the state – namely one dependent not only on securing the economic autonomy and initiative of its citizens, but also on having its citizens accept the risks of so doing. And by 'risks' here I mean personally accepting responsibility for the opportunities as well as for the dangers.

This shift in economic basis is occurring precisely because of the success of the dominant approach to doing business, established during the course of the twentieth century following the innovations of mass production, called *managerial capitalism* (Zuboff and Maxmin, 2002), with its much-criticised side-effects associated with globalisation (Stiglitz, 2002). This form of capitalism assumes that value is lodged in the products and services the enterprise sells. The success of this form of capitalism is leading to the emergence of new forms associated with the market state, in which the growth in value to the supplier becomes subordinated to growth in value to the client citizen. This is more than a service economy. It must be concerned with addressing the demands of the client citizen that are particular to the client citizen's context-of-use. So, for example, getting the computer or the documents home is not enough – the valuable bit is knowing how to make effective use of them! Put another way, the value shifts from being in the product or service to being in the relationship through which the product or service becomes useful. How much more does this apply to public services such as health and education.

Do we need a new concept here to make sense of this?

Managerial capitalism serves its own interests by targeting those elements of demand that are common across consumers and thus are symmetrical with its own capabilities. In contrast, I want to introduce the concept of *asymmetric demand*. Asymmetric demand is that component of demand, which is particular to the client's context-of-use. It is about wanting to embed the 'thing' bought in the client's life in a way that is effective and useful. With it goes the concept of a *value deficit*, which arises insofar as there is a gap between buying something and being able to make effective use of it.

We have all experienced this at the level of the product that we can't work out how to use, and we have all experienced how difficult it is to get builders to do what we want, rather than what suits them. But we experience it too every time we ask for 'customer service', or worry about what we are actually eating! The increasing frustration with managerial capitalism and its attendant effects of globalisation can be explained by its inability to address the value deficit. People get fed up with getting ripped off by suppliers, endless customer service queues, and so on. In the terms used earlier, managerial capitalism reflects N-S dominance, whereas asymmetric demand requires E-W dominance. The Faustian pact, then, at least means that the patient's demands get dealt with to some extent, depending on who the patient knows, even if it does leave the N-S axis unchanged. But is this going to be adequate within the market state?

In what sense does the Faustian pact involve turning a blind eye?

Where is the corollary of the Faustian pact at the level of the state? We see it in what John Kay (2003) calls 'the american business model' (ABM). This, I must emphasise, refers not to how american business works, but to an overseas rendering of it as per Margaret Thatcher, based on four claims: that self-interest should govern our economic lives; that markets should operate freely without regulation; that government's economic role should be kept to the minimum, and not include providing goods and

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services or owning assets; and that taxation should be as low as possible and not seek to bring about redistribution.

You will recognise the politics of this position as those associated with the minimal state. Kay explains that it does not describe the way the US economy works because it ignores the social institutions within which 'markets' are embedded, which are in fact highly developed. These define the nature of the *public realm*, and determine the nature of such things as who can know what, who bears risk, corporate cultures and ethical values, and the standards, knowledge and information in the public domain.

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

So what is the connection between the 'Faustian pact' and the 'evacuation of the public realm'?

Is this evacuation of the public realm a necessary characteristic of the Market State? The Continental European vision of a Federated Europe is based on something rather different: social regulation, redistributive taxation, and public provision of services and welfare, although the challenges it faces over low growth and high unemployment appear to be forcing it to consider, however reluctantly, at least elements of the ABM (Menendez, 2000). What makes the NHS particularly interesting as a case is the fact that we see there what happens when these two models collide, reflected in the choice between N-S and E-W dominance, and the difficulties of securing a transition from the one to the other.

But I am not here to argue that one or the other is right, because that truth will only emerge through the way the double challenge is taken up. Rather I agree with Will Hutton (2002) that what we are encountering in these times are choices about the nature of the public realm and our attitudes towards property, equality, and social solidarity. The important point is that these choices show that the double challenge exists as much in relation to the state as within our particular institutional contexts, in either case challenging not only our practices, but also our relationship to the system. My argument is that the evacuation of the public realm occurs because of the Faustian pact – it encourages us to withdraw from the public realm in order to protect our own interests.

2.4 What kind of dilemma is this?

Are we not talking about on what basis we make choices?

The market state may be about having personal choices, but in what ideological frame are these choices to be formulated? Eric Miller (2002) spoke about the vicissitudes of identity that we face in these times: "People are experiencing devaluation or removal of identities they thought they had, while at the same time there is a lack of identities that might reflect and express our increasing global interconnectedness...". If the *a priori* public good is being dismantled around us, what does this throw us back on. Within what personal frameworks are we to make our choices? How are we to make sense of what is 'good' for us?^{ix} Is it to be emergent from our very practices, and will this emergence be unaffected by the superstructures within which they take place? I think not.

If choosing in a market state is not to be about maximising our private choices, what is it to be in relation to? It is here that we find ourselves facing the double challenge at the most intimate level of asserting an identity day-to-day while simultaneously having called into question the very contexts within which we weave those identities (Boxer, 1994).^x We have to find our own particular way of making claims about what is true for us, which means questioning the truth claims offered by the superstructures within which we live and work in terms of a dilemma over how we manage our relation to truth – a dilemma between affiliation to a received wisdom concerning the truth; and alliance around the formation of emergent wisdom (Boxer, 1999). This was what Winnicott meant in his formulation of the 'challenge of the case' as the necessity to go beyond what we knew if we were to be able to meet the specific need of the patient (Boxer and Palmer, 1994). We have to be able to hold a relation to both forms of truth, and find ourselves somewhere in between.

The clinician might not use the concept of asymmetric demand, but finding ways of responding to the particular context of the patient is the basis of their daily bread-and-butter. How, then, does the daily reality of the clinician relate to that of being citizens?

3. The challenge posed to those working within the system

3.1 Reflexive modernisation

How has the basis of our relationship with the state has changed?

Ulrich Beck saw the shift towards a market state as a shift to a *risk society*, which had as its corollary the idea of *reflexive modernisation* (Beck, 1992). Previously, simple modernisation had meant improving things in relation to the past in a way that took for granted the truth claims made about 'progress' by a liberal democratic society. Reflexive modernisation called this very direction into question: a questioning of truth claims that was undertaken not only at the level of the individual, but which extended to apply at the level of institutions as well (Beck et al, 1994). The point about this reflexivity, as with the earlier process of reflexive change, was that it involved individuals or institutions questioning their own ways of framing progress.

Thus, whereas the 'modern society' of managerial capitalism had been about the distribution of goods, the risk society became about the distribution of opportunities and dangers. In this risk society, each of us became increasingly concerned about what might go right or wrong for us, rather than with what we had; and social change became a matter for us as individuals, rather than being defined by our membership of a social class. And these risks covered all aspects of our lives - ecological, medical, psychological, social, financial etc - impacting on us on a daily basis. The central characteristic of the market state therefore became that it was the citizen who was responsible for the risks of not being able to live the 'happy life' - a responsibility that had rested with the state in its previous form as the nation state.

This did not make the truth claims of modernisation wrong, so much as too unidirectional. Reflexivity, then, is what gives rise to Eric Miller's vicissitudes of identity. But on what basis then is the individual to do this questioning? How is he or she to author-ise his or her truth claims?

In a risk society, are not our demands then necessarily asymmetric?

Beck saw this authorisation arising through the emergence of a sub-politics, based on communities of interest. Thus politics were no longer equated with the state, but with the pressure group, as the relative immobility of the state gave rise to a sub-political domain of self-organised activism.^{xi} We see this evidenced in voter apathy in national and even local elections, suggesting that voting has become an inadequate response to the changing economic basis of the state, with the growing significance of asymmetric demand - not surprising when we consider that no amount of voting is going to be able to determine how an institution responds to my particular context-of-use: voting leaves N-S dominance intact, and does not mean that the value deficit will be reduced, as we learn from the NHS.

Scott Lash (Beck et al, 1994) takes this question of authorisation further, grounding it ultimately in a reflexivity in how we give meaning to our experience. He makes authorisation emergent, grounded in the practices we choose to construct and share as communities through which we make our living-together, and which go beyond the mere sharing of interests. But whatever form our reflexivity takes, we find ourselves on the ground mapped out by Foucault (1974), describing the *discursive formations* through which an account of the effects of power knowledge can be provided that is properly reflexive, enabling us to reveal the outlines of our own processes of authorisation.

But what makes the notions of the risk society and reflexivity particularly relevant to us here is that it brings the question of authorisation home to us, rendering our demands necessarily asymmetric insofar as we respond to the question in a way that is particular to ourselves. In these terms, asymmetric demand is demand that is not just for a 'customer-centric' rhetoric, but that is for actual behaviours that are responsive to ourselves as contexts-of-use. To 'face facts', then, is to ask to what extent this responsiveness to the context-of-use is actually happening, and the double challenge is in relation to any value deficits that might emerge as a result.

3.2 Facing Facts

What is the relation between discursive formations and ourselves in particular?

In 'facing facts' we are always already personally implicated, because to 'face a fact' is not to discover something already there, waiting to be named.^{xii} Rather, it is to encounter our particular relation to what-is-going-on through our discursive formations. Thus the particular way a clinician identifies a patient's condition may, on the face of it, describe certain objective features of the patient's aetiology.

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But it also structures a particular relation to the patient through which the clinician may fulfil himself or herself as such – there is nothing like a really interesting case!

A discursive formation is characterised by its objects, concepts, enunciative modalities and strategies. These locate the objects and ways of operating on those objects in relation to the particular positions from which they can be spoken of authoritatively. We have heard about this concept of discursive formation from Barry Palmer, in describing the Tavistock Paradigm (2000), and Susan Long (2001) in considering the practice of a psychoanalytic study of organisations. But it is the strategies that I want to pay particular attention to here, since it is they that convey the aura of authority. Foucault approached these through what he called ‘the points of diffraction’ in a discursive formation:

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

Thus strategies were the themes or theorems that gave the appearance of unity and coherence to the field of the practice. So while facing facts presents the subject with incompatibilities or gaps in formations – reveals formations as lacking – strategies organise and systematise them in a way that gives them unity and coherence. This is why it is so difficult to work with evidence. It disrupts.

The psychoanalyst approaches the discursive formation as a reflexive formation, speaking of it as unconscious phantasy, that through which we become the subject of the unconscious. And it is the unconscious phantasy that not only organises our desire, but at the same time, through enabling us to be someone in particular, protects us from the unconscious. I say “protects” because insofar as we are open to the gaps and inconsistencies in our own way of being – to our own lack, we expose ourselves to anxiety. Note that unconscious phantasy in this sense is not the formations themselves, so much as the axioms on which those formations appear to be founded.

So can we try to be good, with all the unity and coherence that goes with living in relation to an Ideal construction and its pleasures; and can we be open to the gaps and inconsistencies in ourselves, exposing us to another good constituted through our relation to the unconscious – a particular good that only emerges when we are in a position of not-knowing, of being lacking? ^{xiii}

How are we live between two ‘goods’?

When we take our reflexive formations into the social domain, strategy becomes ideology – the effects of unconscious phantasy structuring the nature of social reality itself (Zizek, 1989). In this way we can see the American Business Model or the Continental European vision of a Federal Europe as ideologies. And at the level of the formation of the institution, we encounter it as David Armstrong’s institution-in-the-mind (Armstrong, 1997). Again, ideology is not the formulation itself, but the axioms that anchor the way it constructs our social reality; and with ideology comes an understanding of a good rooted in the axioms of the ideology.

So how do we, as both citizens and subjects, live between these two ‘goods’? How do we live not only in relation to the good offered by ideology, but also in relation to the good we constitute for ourselves as subjects of our unconscious? This is a good neurotic question that goes to the heart of the ethic of psychoanalysis. We can approach it by focussing on the valency that each has for the other. Thus the social phantasy provides us with a way of living in relation to our unconscious phantasy in the sense that the one supports the other. This way we can be happy enough, and insofar as we are not, we can consider change by putting into question the relation of the one to the other (Arnaud, 2002).

Consider the metaphor of the coral reef. Take the coral reef to be the ideology that forms a habitat, which can be colonised by a wide spectrum of life forms – fishes, seaweeds, crustaceans etc – all of which find a way of accommodating themselves to each other’s niche within the eco-system. In my metaphor these different life forms are different forms of unconscious phantasy. Thus we can understand ‘valency’ as the capacity of any given life form to find a niche for itself within the eco-system supported by the coral reef.

What happens, then, if the coral reef itself undergoes significant change? This is what we have been describing as happening to the NHS, and this is what is implied in the transition from nation state to market state. All those life forms will have to find different ways of accommodating themselves, to re-invent themselves or to die. In these terms, reflexivity means not only being able to address the question of how the valency can be made to ‘work’ for each of us, but also means being brought up against our particular relation to the unconscious – and thereby to anxiety. Here, then, we have how the double challenge implicates us through its questioning of the two ‘goods’.

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How, then, does anxiety become the index of where we place ourselves between the 'two goods'?

The difficulty is that we are used to deriving the good from the ideology itself – a kind of off-the-peg solution. Reflexive modernisation describes what happens when we derive it directly from our particular relation to unconscious phantasy. This is where reflexivity takes us, introducing us to this other notion of the good, which emerges through the way we struggle with the gaps in ideology, and which stands in contrast to the good offered by ideology. But how are we to bear the anxiety that is the necessary corollary of this?

3.3 Anxiety and the question(ing) of the good

How do we get our bearings from anxiety?

The valency between ideology and phantasy therefore means that the gaps that appear in ideology expose us to anxiety. That is, the gaps expose us to fear without an object. Such anxiety is difficult to arrive at, because we are usually pretty good at putting an object in the way. Of course when our clients do it, we call it a symptom, but when we do it we prefer to call it a reason! Those introducing change call this 'resistance', although what is going on is the conservation of relations on the side of those being asked to change, through the conservation of relations to the object. Nevertheless, the emergence of such gaps exposes us to the possibility of a lack in our very formation as subjects of the unconscious, and therefore to anxiety. My favourite metaphor here is of A.A. Milne's Christopher Robin taking particular care not to step on the cracks between the pavement stones, lest the bears from London Zoo come to eat him up. Although 'not stepping on the cracks' is presented as a reason, it is not that, but a symptom that protects us from something that would otherwise be much more terrifying.^{xiv}

What happens when we step on the cracks?

Lacan, in his seminar on anxiety (Lacan, 1962), considers the relation of symptom to inhibition and anxiety down the diagonal of a matrix. This matrix has two axes, the first relating to movement towards 'care', as in "taking great care". This idea is derived from Heidegger (1978), and means paying particular attention to how we bear the embodied nature of our being – that is, the fact that our destinies are somehow bound up with the body through which we find our being, and with which we are somehow thrown into this world. In its extreme corner of the matrix, this taking care involves the introjection of an Ideal under which we can know ourselves to be good. This is the corner in which ideology is at its most effective, providing us with the justification within which to act through providing ourselves with the sense that we are acting in the name of a good cause.

The other axis is towards increasing difficulty, in which, at its extreme corner of the matrix, the subject "suffers the greatest difficulty in what is implied by a successful outcome to the obstacle presented." (Harari, 2001). In other words, if this thing that I would like to happen were actually to happen, then what would be the consequences? What if the result then was that these other things happened? But what if I do nothing, what will happen then? And so on. This idea is derived from Kierkegaard's 'concept of anxiety' (1980), in which freedom appears before itself as a possibility. You don't get more reflexive than that. Ideology, in the particular form it takes as the host system that governs us, but from within which we derive support for our identity, provides us with a way in which we can know what will happen. 'Freedom', then, involves calling this ideology into question, its valency with our own unconscious phantasy, therefore opening up an awareness of our own lack. This is the axis of the concept of anxiety, in which we can become immobilised by our considering of 'freedom's possibilities'. This way lies an intensification of anxiety. But it can also be our guide. To quote Kierkegaard:

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

So inhibition involves no movement along either axis, whereas anxiety involves the greatest movement, placing symptom in the middle of the matrix. Anxiety therefore involves combining taking the greatest care with anticipating the greatest difficulty – the double challenge. But what is important here is to recognise the nature of this double challenge, this time at its most particular to our personal experience of being-in-the-world.

How does this alter our understanding of the double challenge?

So where does this lead us? The familiar notion of leadership is associated with embodying an Ideal, not only for ourselves, but for others too. But here we are arguing for a different form of leadership that is reflexive in nature and capable of challenging the system rather than embodying the system –

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not only a leadership that accepts its lack, but a followership that accepts it too. This requires Keats' negative capability of which Robert French speaks:

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

This might also be thought of as a constructive disobedience to 'preconceived certainty', insofar as it can bear the anxiety that arises with it, and use it 'against its will'. What makes this difficult is that we must not only bear the 'performance anxiety' associated with the dangers of implementing change; but we must also bear the 'primary anxiety' that we experience in considering 'freedom's possibilities'.

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

4. In Conclusion

What new things does all this demand that we learn?

We look with disdain at ideologies whose truth claims are based on theocratic or blood legacies, but our own truths based on democracy are not looking so hot either. We are living in times where none of us can feel secure within the institutions that employ us. It is as if we are all self-employed now, having to live in relation to a new kind of truth born out of the asymmetric nature of our demands.

Asymmetric demand is particular to ourselves in the way our desires are constituted, and while the market state is requiring us to assert them, the ready-made definitions of the ideological good are not working so well, so that we must not only find new truths, but find them in new ways. To face facts is to understand that these truths are to be found in amongst the ready-to-hand fabric of our day-to-day lives, to know that the facts matter, and to use them as evidence.

But it is no accident that the phrase "what's the good of change" has another meaning: "let's be realistic, no amount of change is actually going to change things. They are not going to want to change their underlying behaviours." Just the other side of that active engagement with what-is-going-on is the despair that leads us to make do with a Faustian pact!

So we need to use ways of understanding the complex systems within which we live and work, which can honour the asymmetric nature of the demands placed on them; and we need to intervene in ways that draw strength from the anxiety that goes with those ways. Precisely because of the E-W nature of the challenge asymmetric demand poses N-S dominant institutions, it turns out that the very professionals who historically have despaired of changing anything are now not only the ones who are closest to what needs changing, because they are closest to the demands being made; but they are also the only ones who understand what changes are needed. This is what the NHS case taught Tom and I. Without helping the clinicians to develop East-West dominant forms of organisation, we had no chance of enabling them to address the asymmetric demands on their practices in a way that could be sustained by the systems within which they worked. And to achieve that, the clinicians had to learn to work in ways that were both disruptive and reflexive.

If ideology is not to be primary, what then does the unconscious requires of us?

Clinicians can not do this in isolation from each other. The demands on them are too complex for that. Patients' conditions increasingly require that many different kinds of clinician work together effectively for the good of the patient over extended periods of time. So it is for any complex system facing asymmetric demand. It is nevertheless true that we each face anxiety alone. But knowing this admits a different kind of ethic in how we approach the good of change, an ethic that we can share, and an ethic that is predicated on there being an unconscious.

So what has all this to do with us? Well, we do have some understanding of what these changes are about. We may be no different in our predilection for the Faustian, but at least we know how to question on what basis the good of change is constituted for ourselves.

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Glossary

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

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

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

Castration: part of the series frustration, privation, castration. Frustration is based on the presumption that we can have it all, but that we are not getting it. Privation is based on the acceptance that although we cannot have it all, another can. So the father has the mother even if the child does not. Castration, then, is the realisation that no-one can have it all – that it is in the nature of the human condition to be lacking. Thus it is in castration that we are exposed to our condition as lacking – as both inconsistent and incomplete.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Endnotes

ⁱ You can perhaps tell from this that we are trying to bring about a change in how the system works, with its associated changes in how clinicians work in relation to each other. But in case you think that I am here with some kind of this-is-how-you-bring-about-change, we are still on the case, and we are not sure that our work with orthotists will not also become a monument to people's failure to change the system.

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

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

^{iv} The issue of how to work with these dynamics will be taken up in a subsequent paper.

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

^{vi} Our experience was of the enormous commitment of orthotists to their patients. But at the same time, there were bottomless sources of resistance to changes in those practices; and an administrative and budgetary system that recognised the problems, but appeared either blind to the need for change or unable to authorise changes in the ways the resource cake was carved up in the interests of the patients. Striking too was the extent to which the clinicians appeared to have no ways of thinking about the way this context worked. Rather they suffered its effects on their day-to-day practice with stoic resignation. So what chance did they have of arguing these changes for themselves?

^{vii} Following this change to funding via the Primary Care system, the Acute Trusts within the Acute Care system would eventually become 'foundation hospitals', governed through locally elected representatives and able to raise money for investment purposes in their own right; and the Primary Care System would buy individual services from Acute Trusts on a centrally priced basis. To give you a feel for what is thought about these changes, here is the Economist (a British weekly magazine) on the subject:

"As part of its rethink, the government is reintroducing an internal market, through Primary Care Trusts, which now manage three-quarters of the country's health budget... This is fine in principle, but there are two problems... First, for competitive pressures to work, purchasers need to be just as powerful as providers. But PCTs are sad neglected creatures that may not be a match for foundation hospitals. While foundation hospitals will be able to make their own

decisions and will derive some legitimacy from their locally elected boards, the PCTs answer directly to the men in the ministry. Second, the new system will sharpen hospitals' performance only if the PCTs' power bites.... The rumpus over foundation hospitals will be as nothing to the row that will erupt when the internal market starts to put the squeeze on bad hospitals." (The Economist, 2003)

^{viii} Much of the government's current reforms are driven by the fact that the Faustian pact appears to have become an end in itself for the doctors, keeping the system focussed on acute responses, and making the NHS too expensive to run. But the government's response has been to increase N-S dominance with all the target-setting, and to change the manner of subordination of E-W through the shift of funding via the Primary Care System (Timmins, 2001). The alternative response proposed by the pathfinder was an East-West dominant approach based on a properly demand-driven role for the PCTs, empowered to make systemic changes in the interests of providing better through-life care. To take up the double challenge at the level of the state, then, would be to engage with the requirements of both axes in the interests of the whole.

^{ix} The argument for the foundation hospitals was to reduce the *democratic deficit* by increasing local representation ('Democratic deficit' refers to a gap between the powers of an institution and the processes through which those powers are bestowed on it by those affected by it). But will this close the *value deficit* experienced by citizens in how institutions respond to them, however locally governed they become?

^x This is what the Archbishop of Canterbury had to say about it:

"The market state it seems is here to stay. But - here is the difficult point - if we ask about its legitimacy, its claim on us as citizens, we need to come up with a better answer than we've had so far if we are to avoid the reduction of politics to instantaneous button-pressing responses to surface needs.... In the marketised world, so we're led to believe, we're left to make the best decisions for ourselves; but what does a reasonable decision look like in this context? It isn't easy to justify choices at the present moment that don't have an impact on an immediate future that I am going to experience personally, choices that will secure something beyond maximising my freedom to go on freely choosing.... For the religious believer each of us, and each item in our environment, exists first in relation to something other than me, my needs, my instincts. They are related to a life or agency quite independent of any aspect of how things happen to be or happen to turn out in the universe. They are related to the eternal, to God." (Archbishop of Canterbury, 2002)

The Archbishop argues that what this means in practice is an engagement with the traditional religious communities in a new way, as he puts it: "not in a bid for social control, but as a way of opening up some of the depth of human choices, offering resources for the construction of growing and critical human identities. And this also means, incidentally but not insignificantly, that religions have work to do intellectually and imaginatively to defend their basic credibility, their truth claims."

^{xi} In the UK, an attempt has been made to respond to this democratic deficit through devolving powers more locally (Prescott and Byers, 2002); and, with the foundation hospitals, through the 'public interest company' with locally elected members on its board.

^{xii} I am approaching this 'facing of facts' through a Lacanian understanding of naming, in which the unity of the object named is a retroactive effect of the act of naming itself. The relationship we have to our experience is retroactive, and always mediated by the effects of language and culture – effects that in Lacanese are 'effects of the Symbolic'. In this understanding, the object is a discursive formation that refers to that 'something in the object that is more than the object itself', that is to say the Lacanian *objet petit a*. This *objet petit a* is a 'more' that shows us our desire in relation to the particular other of the object, so that the act of naming both structures the particular form of this 'more', and also establishes our particular relation to it.

^{xiii} The 'effects of the Symbolic' governing the act of naming are understood by the Lacanians as a relation to the (big) Other. This (big) Other is our experience of the already-thereness of the Symbolic medium in which we constitute our being, and it too is incomplete, inconsistent and lacking. An encounter with this lack of the Symbolic is an encounter with the Lacanian Real, and it provokes anxiety – hence the Lacanian wordplay that anxiety is the only real emotion.

This idea of the (big) Other is a difficult concept to grasp, but if we listen carefully to the Archbishop's words, remembering that he is dressing the (big) Other in the clothes of a particular ideology that conceals its own lack, then we can grasp some sense of it in how he speaks of God: "... each of us, and

each item in our environment... (is related to an) agency quite independent of any aspect of how things happen to be or happen to turn out in the universe. They are related to the eternal, to God.”

The important idea here is that, just as our objects are subjected to our desire, so too are we subject to the desire of the (big) Other. Just as our particular objects show us our desire, so too do we, as the object of the (big) Other, show the (big) Other's desire through our formation as its subject.

^{xiv} The realisation of this lack in our very formation as subjects is *castration*. This concept occupies a particular place in the series frustration, privation, castration. Frustration is based on the presumption that we can have it all, but that we are not getting it. Privation is based on the acceptance that although we cannot have it all, another can. So the father has the mother even if the child does not. Castration, then, is the realisation that no-one can have it all – that it is in the nature of the human condition to be lacking. Thus it is in castration that we are exposed to our condition as lacking – as both inconsistent and incomplete. And it is castration that makes us anxious!

Remembering that the object is a discursive formation, and that these objects are constructed by the effects of phantasy on our relation to our embodied being, we find that the unconscious phantasy itself is constructed from proto-phantasies built around the Freudian objects - Freud's original list of three, that is the oral, anal and phallic, to which Lacan adds two further objects - the gaze, relating to the scopic or spatial; and the voice, relating to the insistent action of the superego. These proto-phantasies provide ways of mediating the particular forms of anxiety that would arise if we were without an object: annihilation (oral), object loss (anal), castration (phallic), possession (gaze) and the persecuting superego (voice). These particular forms of anxiety are to be found put together in a way that is particular to our unconscious phantasy in forming ourselves as symptom of our particular relation to the desire of the (big) Other.