

In Sickness and In Health: Governing the self in the hospital and the clinic

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Care & Patienthood in the Era of the Gene

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Plenary Talk

What I am going to do in this paper is think through the contemporary landscape of health care, or what Adele Clarke calls a healthscape, one that makes explicit the problems and the issues for care in a frank and provocative way. With Foucault I am going to focus on some effects. These effects may be intermittent in their operation, but they are, I suggest, systematic and systemic because they extrude so many possibilities: too many body-persons seem, like dirt, to have become out of place in the modes of ordering I am about to describe. And as Mary Douglas helps us to understand, where there is dirt there is system.

On mentioning that I am going to give a paper on care & patienthood in the Era of the Gene colleagues in nursing have responded with – ‘Oh we are not teaching any of that yet’. But I am not going to talk about that – nursing care knowledge and know-how in the context of advances in bio techno-sciences. Rather I want to think about what has been happening to care in medicine more generally, and what the connections are between transformations in care and the extraordinary explosion of interest and research in the genetic and biological bases of diseases and other bodily troubles.

So my talk here today in part draws out of and on from my many studies of medicine, nursing and health care organization, including those with many colleagues and with my PhD students. But it also draws out of what I have called in Jay Gubrium and Jim Hostein's *Handbook of Constructionist Research*, an emergent critical tradition in research on medicine, nursing and health care organization. As such I do not speak so much as an individual but out of and as a part of this emergent tradition, some of whose founding authors are here today: Carl May, Mary Ellen Purkis, Trudy Rudge, Siobhan Nelson, Maxine Mueller.

So let us think about the scale of the effect. When I was a practising Ward Sister in the mid 1980's at the Edinburgh Royal Infirmary, the clinical home of a world-renowned British Medical School, no-one that I can remember, and I was in charge of a professorial ward with all my consultants doubling up as clinical scientists, ever discussed the gene, or the molecular origins of any particular disorder. The exception was a haematologist whose research specialism was the hereditary condition haemophilia. Now, wherever I look, the gene, and other microbiological processes are being explored for their involvement in pathology, and for their potential in relation to medical interventions. This is particularly, if not exclusively, true of the degenerative and chronic diseases of Euro-American countries, the diseases of the wealthy, such as dementia, the cancers, and so on. Even ageing itself as a micro-biophysiological process is being reconsidered more and more as a 'part of the problem', and as playing an important role in the aetiology of many pathologies. May be soon it will even be possible to put on a death certificate that

someone has died of old age. This represents a huge shift for medicine: 20 years ago no-one could be seen to die of old age, it wasn't considered a pathology in its own right.

I want to think then about this huge shift, what some have described as the biomedicalization or genetization of the clinic, for its significance, particularly in relation to care.

The Curecare Binary

Let me begin with something I think you will all recognise. A key discourse within the landscape of medicine revolves around the tropes of cure and care. In particular what I want to point to here is the 'carecure' binary.

Figure 1



Curecare – a binary with system properties

A binary consists of two parts or components; a 'twofold'. A binary is different from a polarity or dualism – a binary implies partial connection and interdependence: critically, a binary implies *relationality*. For example, a binary star is a system of two stars that revolve around each other under their mutual gravitation.

I am using the term binary very deliberately here. The term binary is from the Latin *binarius*, meaning having two parts. A binary is thus characterized by or consists of two parts or components; a 'twofold'. I like this idea of a two fold because it connects to Deleuze's conceptualization of the fold, and how we are folded into different discourses and truth regimes. A binary is different from a polarity or dualism – a binary implies connection and interdependence: critically, a binary implies *relationality*. For example, a binary star (Figure 1) is a system of two stars that revolve around each other under their mutual gravitation. So rather than care and cure being understood as a dualism, we can think of it as a relation that works institutionally as well as discursively.

The binary 'curecare' thus helps inform a set of practices that we can understand loosely as 'medical', and that circulate around the body, the mind, and matters of life and death. In many ways this working between carecure offers a way to travel across and bring into play the life-worlds of patients and of practitioners.

So care and cure can be understood as two major tropes, tropes in circulation and that could be reached for and that have the power to 'call'. With Foucault I want to stress how it is the very mysteriousness and elusiveness of these terms, and their relation, that gives them their potency – and that this binary relation of care and cure, has important organizing effects. This includes making it much more difficult to say precisely where a division of labour lies. Let me elaborate what I mean here:

2 stories

1st story

I am just tidying up at the desk having taken the handover from the night nurses. It is about 8 am when Ms Sparrow arrives to visit her post-op patients from yesterday. I go over to join her at the bedside of one patient who has had a pneumonectomy. Miss Sparrow kneels down on the floor next to the patient's chest drain, stands up and tells me it has been incorrectly set up, with the end of the drainage tube sitting just above the water level, thus allowing the possibility of air entering the pleural space. She is furious, and I am mortified. I apologise profusely and arrange for the drain to be changed immediately. As well as ensuring that the night staff are retrained with regard to chest drain care I make sure that in future on taking the hand over from the night staff, the nurse in charge and the night nurse check all the chest drains together. (Life stories of a lapsed nurse, Latimer, in process).

2nd story

It is Professor Petrie's ward round and we travel from patient to patient in the usual way. We arrive at the bedside of a very frail elderly lady, Mrs Gallacher, admitted with collapse, heart failure and severe anaemia. The house doctor has presented a history of the patient in the doctor's room prior to coming onto the ward. From the medical history the patient is not apparently on any anti-inflammatory medication. I have not met Mrs Gallacher before as I have only just come back from some days off. I sit down next to her and take her hand while the doctors are talking to her. I notice that she has very arthritic hands, swollen and red. I ask her if she takes anything for the pain. She says she takes lots of aspirin. Professor Petrie orders a barium meal. Of course, Mrs Gallacher probably has not thought that aspirin is a medication. (Life stories of a lapsed nurse, Latimer, in process).

Figure 2

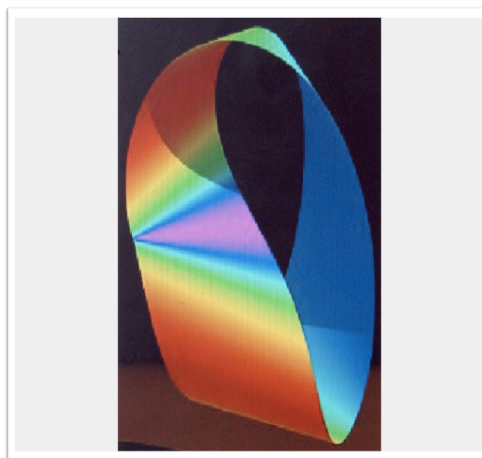
In these two mundane ordinary stories (Figure 2), who is doing the caring and who is doing the curing – the doctor or the nurses? Each action slips and slides across and between the binary care/cure.

So I want to clarify that within this perspective of the binary care/cure, medicine emerges as all the practices and processes, people and technology involved in the performance of *medicine*: medicine appears as distributed across many kinds of

practitioner, including nurses and doctors, physios, radiologists, and so on and so forth.

We can think of the binary curecare in terms of a Möbius strip¹ (Figure 3). A Möbius strip is made by taking a strip of paper, twisting it once and joining the ends. Now the strip has only one side and one edge. This can be demonstrated by putting a pencil down on the strip, turning the strip under the pencil until the pencil line returns to its starting place. The pencil line will appear on both sides of the strip, which means, in effect, that it has only one side. In the carecure binary, care and cure travel along planes that end up as connected and on the same side.

Figure 3



The CareCure Binary

Like a Möbius Strip where care and cure travel along the same plane – they are on the same side

As we have seen from my two stories there are possibilities for chiasms and crossings here. The ambiguity and ambivalence over what counts as curing or caring, allows for great motility and keeps open possibilities for shifts in perspectives and

justifications. For example, how an activity constituted as care can so easily also be seen to have other potential in terms of cure.

Figure 4



‘Care after Cure’ in a leprosy hospital

<http://www.stlukesleprosyhospital.org/9A.Care After Cure.jpg>

For example, in figure 4 according to the title of the image, a man with leprosy is weaving as a part of his care *following* his cure. But of course from the perspective of occupational therapy, occupation in the form of weaving itself has affects in terms of enhancing well-being. Weaving in this context is in a sense curative.

Now of course I am offering the binary ‘curecare’ as in a sense an ideal type, but one that has its organizing effects. It is one I think that even if we don’t long for it, we at least recognise it.

There have always been problems for care where a body-person cannot be held on the medical ground of cure, where they can be figured as Becker's 'crocks', or Jeffrey's 'normal rubbish': as people for whom nothing can be done, as trivia, or as having as what one nurse in one of my studies called 'no prospect ahead of them'. Dame Ciceley Saunder's hospice movement in the 1980's and Ingunn Moser's talk yesterday about dementia care, and what she called 'a logics of rehabilitation', are examples that help expose how any body-person's ills can be subject to care practices that contain within them a possibility for enhancement. How for so many body troubles, particularly in relation to those deriving from chronic illnesses, cure is itself is an unobtainable ideal if too narrowly conceived. Critically, in the curecare binary even with a so-called incurable disease someone can have a life, they can do more than merely exist, including the process of dying being itself a part of that life.

Now I want to suggest that we can review the landscape of social transformation in health care systems in terms of dividing practices that have inserted and worked a rift in the binary 'curecare', and that undermine its organizing properties. And I want to suggest that these dividing practices align and overlap to perform conditions of possibility for the chasm between cure and care that we are currently struggling with.

Dividing Practice 1: Medical Dominance

The first of these dividing practices that I want to point to is what has been termed in the literature 'medical dominance'. What everyone knows and understands is

that through processes of appropriation and closure the term medicine has become reserved for what doctors do.

Here then the two entirely mysterious conceptions, care and cure, in a binary relation to one another, through the dividing practice of medical professionalization begin to become separated, disconnected. Specifically, in the reserving of the term 'medicine' for what doctors do there is a subsequent division between curative and caring practices, between cur-iosity and carefulness.

We can see in Foucault's *Birth of the Clinic* that the emphasis on knowledge and the performance of medicine as science pushes and presses this dividing work of care from cure, so that cure becomes the prerogative of the doctors, while care at first seems to be relegated to the 'para'-medicals, particularly to nurses. And in particular there is a possibility of making it seem that there is a separation of the work of *representing* (as saying what is) from the work of intervening and treatment, as well as from the work of caring.

And this division between care and cure can be played across other divisions. The division offered to us by Mike Featherstone (1992), for example, between the heroic and the mundane, with cure being associated with the heroic life, while care becomes associated with the everyday life. And across other divisions: such as the division between cure as masculine work, and care as feminine work; or across a division between what Drew Leder distinguishes as the object body (*corps*), and the

lived body (*lieb*), with the object body the concern of cure and the lived body as relegated to the work of care.

But as Ann Marie Rafferty helps illuminate in her book *The Politics of Nursing Knowledge*, these practices of care and cure divide particularly over the issue of claims to knowledge and the problem of what counts as knowledge.

Critically, what governs the space of medicine as cure, is knowledge as science: science as of a particular kind, associated with the scientific method. And this governing of the domain of medicine by knowledge as science, means that other practitioners, such as nurses, to make their work visible as professional work, are called to make explicit how their work is also knowledge based. Here there is a proliferation of research into the 'care' part of the 'clinical' domain – pressure area care, wound treatment, infection control and so on and so forth. Within this perspective and rendering, care begins to be reconstructed, and effaced, as 'intervention'.

What is much more difficult in the space of knowledge governed by ideas of science is research on those activities, processes, effects and affects that are invisible to the scientific method, those aspects of the medical world that are invisible to so-called 'normal' science.

Where knowledge as science governs the ordering of relations of representation, the clinic comes to be organized hierarchically, in the Foucauldian sense. Thus what was once a binary, curecare, under these kinds of dividing practices begins to be played out in a hierarchical relation, relations of what Marilyn Strathern (1997) calls

comparison. So that care begins to emerge as the supplement of, or even as an inferior substitute for, cure. I am thinking here of all those situations in which cure, increasingly narrowly defined, is not possible, so that all that is possible is that a condition is managed. Here, minimal care may arrive in the form of a differential diagnosis. But as will be seen in the next section, increasingly the management of conditions constituted as incurable (such as diabetes, asthma, dementia, arthritis, and so on) is being passed on to technologies of care, or what Bruno Latour would call *machines*.

Dividing Practise 2: Accountability as Transparency

I want to turn now to the matter of accountability, in the guise of transparency, and the dividing practices of what Strathern and others have called audit cultures.

What starts to emerge in analyses here is that management science does not believe in knowledge in the same way as we have seen above. Rather, I want to suggest, that managerialism wants to *change* cultures. Here, the need to change culture in the domains of care and cure, partly arises from the elision between culture and tradition, ideology and ideas that the professions, particularly doctors, are organized along tribal lines: it is the ceremonial order of the clinic that is the drag on modernization of health care. Managerialism thus finds an alignment with the social science critique of medical domination. We can see this in Phil Strong and Jane Robinson's analysis of the NHS under new management.

Now what I want to suggest is that because of the displacement and hierarchy between cure and care effected through the dividing practices of medical dominance discussed earlier, transparency over what has been set aside as curing has been different from what has been set aside as caring. The dividing practices that we have already encountered thus creates an archaeology, a set of seams and foundations, along which accountability travels to create further rifts and cracks in the binary carecure.

Put under the microscope of transparency medicine, governed by knowledge as science has to go off somewhere else – far from the bedside – to reassert itself in relation to knowledge as science. Otherwise it is on very shaky ground.

Here we can imagine that the first space for medicine as cure to retreat to is the technology of the Randomised Control Trial and evidence-based medicine: here everything to do with intervention can be trialled. But what trials don't help medicine-as-cure to do is perform itself as beyond the pale of ordinary accountability, that is as *representing*, as engaged in normal science: RCT's do not do the work of making medicine-as-cure visible as science, as discovery, as 'real' science. As Ian Hacking's work has helped to show, the strongest grounds for legitimating the need for intervention are those routed through the mode of ordering offered by representing: only when medicine can be shown to be engaged in representing 'what is', as engaged in normal science can it make itself (un)transparent, and fend off calls to account.

So medicine as cure needed to perform itself as representing, not just intervening: doing this can make medicine as cure (un)transparent. So medicine needed harder science to that offered by RCT and the technology of evidence based medicine. It is here I want to suggest that medicine has realigned itself with the gene and the new biology.

My argument is then that it is a managerial need for accountability as transparency that has sent medicine back to the basic sciences: alignments between the clinic and the new molecular and reproductive biology offers firmer ground for medicine to make itself (un)transparent as knowledge. In its realignment with the basic biosciences, and a return to biomedicine, medicine returns cure to the well-travelled way of scientific method or normal science.

Lets stop to think for a moment here how much easier it is to claim revelation in the laboratory than in the clinic. Here there is promise, or as other commentators have suggested, hope, not for present interventions, but for *a future* of knowledge. Bio-medical knowledge promises not just a future knowledge of the origins of illness and disease but of the *stuff of life itself*.

What the alignment of the clinic with the new biomedical sciences does is effect an even more intense reduction, as Emily Martin has elaborated, of not just illness and its origins, but of persons, to ever smaller body parts. This reduction is of course the seduction: because it focuses on the stuff of life the new biomedicine draws the gaze away from the complexity and mess of, for example, social medicine. This is not just

to recognise that there is also a complex universe there, at the molecular level of interacting stuff, but this complexity and unravelling at the molecular level helps perform biomedicine as mastering nature, and the universe within. And as transparency and the demands of audit culture drive medicine back to science, there is reinforcement and intensification of knowledge *as* normal science.

Back in the laboratory, medicine as biomedicine appears more real, and more transparent. And within this view, the clinic and the bedside itself are a key part of the laboratory, as I have shown in my work on clinical genetics. But back here in the laboratory, we are in a state of anticipation, standing once again in what Heidegger calls advance of the world. And here, in the laboratory, cure, thrust into the future, is a millions miles away from care. But what for the moment seems to be being accomplished is the rebirth of the clinic (Latimer et al 2006) as a site for the production not just the consumption of knowledge.

Within this view accountability serves as a dividing practice so that we can understand biomedicalization not so much as a cause but an effect of accountability regimes coming into the clinic, regimes of truth that intensify the division between cure and care, so that the fissures and rifts become chasms: abysmal rather than chiasmic.

So what happens here – to the other kinds of medical practitioners associated with care, and the sick, rather than cure, and to the people who are here, now, back in the present?

Now if we remember with Strathern that culture, in the culture of enhancement, is seen as a drag, and with medical sociologists and managerialists, that it is institutions such as medicine that are at fault, then what is needed under regimes of accountability as transparency are technologies that can deliver interventions as standardised and measurable. So that back here in the day to day, as cure has gone off to RCT's and the laboratory, care has become increasingly technologised, demoralised, and deskilled.

Accountants and economists keep saying how expensive care is, and how we face a future of more and more need for care as populations age. So transparency calls for care not to make itself visible as *knowledge* based, this is the mistake of nursing and other care associated disciplines. Rather care needs to be made visible as efficient, so that care gets reconfigured as provision and intervention. Here the management of care is heavily invested in the notion of planning – protocols and procedures that can stand in advance of their delivery, and a distribution of care work amongst persons who at the point of delivery, reconfigured as providers, are merely following orders prescribed elsewhere. Staff follow procedures and implement plans. So care is relegated to what Latour in his book *Science in Action* nominates as machines. Indeed, what care, reduced to provision and intervention, needs now are more machines.

Care increasingly divided from cure needs to make itself visible against measures of efficiency specified far from the space of care. Within this context care,

reconfigured as *intervention* and *provision*, can be increasingly technologised, made lean and efficient, independent of the practitioners who deliver it. Here I am thinking then that we can see the effects of accountability and transparency and the division of care from cure, in the endless proliferation and pursuit of technologies to make care manageable: such as care pathways for specific diseases or treatment regimes, the nursing process, collaborative care planning and so on and so forth.

Care reconfigured as provision and intervention has been taken over by the machines: machines that can be understood as programmes for conduct. There are even machines that act as centres of calculation for the need for care: scales and assessment tools for weighting the need for care. One such is the triage system.

Care machines supposedly obviate the need for discretion. Within this view conduct – that, has as I have shown in my earlier work, has a moral or spiritual linking – and the mystery of care – is sidelined.

More and more of this routinised medicine-as-intervention can be passed on to GP's and nurses, while the work of providing for the body now almost completely amputated from the work of cure gets passed on to paid and unpaid carers and more and more to patients themselves. GP's and nurses pick up more and more of the medical work once it has been embedded in the machines as pathways, procedures and protocols. And care gets reconfigured as illness management, with intervention distributed across many different agencies. Ontologically, practitioners are refigured as providers and patients as recipients. Except of course patients

themselves are increasingly implicated in health care work, not just as carers, nor even as Carl May has shown in his studies of telecare, as recipients, but with the work of what once used to be associated with cure: the work of medical examination and diagnosis. Rather this separation of cure and care, of diagnosis from intervention and so on and so forth, and the proliferation of machines, has intensified and proliferated moments of assessment and access for patients and staff alike. And this the crippling mess.

From the perspective of patients there is a proliferation of thresholds. Here patients can not rely on the machines, medical and administrative, to act as their allies and spokespersons, rather they are called to the work of negotiation and justification, particularly in circumstances where their bodies and troubles do not fit the configuration of the systems as they find them. For example, Alexandra Hillman in her work on Emergency medicine shows how patients must perform themselves as careful in relation to how they use services and as needing to have the resources to mobilise accounts that will help negotiate their access to care. Within this rendering apart of cure and care patients get refigured as the potential enemies of the system, while the system itself requires care. But there are other insidious ways in which the apparatuses of accountability and transparency are transforming patienthood.

Patient hood: The jointing of efficiency and morality

Strathern suggests that what audit cultures do is joint efficiency and morality. Alongside the reconfiguration and demoralization of professional work the culture of individual lives at home has been charged to avert or at least postpone the need for

care or cure. Here the exercise of choice comes into play as a site for the performance of a particular kind of moral order, one that concerns itself, like the genetics clinic, with a future of health and wellbeing. Remember, present action aimed at the future is very difficult to render visible.

Individuals are called to perform themselves as *choosing* health. Here they are made responsible for health in relation to both the stuff of life as well as the style of life. So that care shifted into the home, reemerges as choice. On the one hand transparency calls for people to perform themselves as good citizens where care of self involves choosing a style of life in anticipation of a life of health: live well now and be healthy later (figure 5).

Figure 5



Reconfiguring patienthood:
Choosing a style of life



are as socially constructed as anything else that we make. Here, the genetic clinic is a site of social engineering: helping to excite a sense of the riskiness of reproduction.

Figure 6

The Sunday Times, January 11, 2009
Gene parents plan more breast cancer-free babies
Sarah-Kate Templeton Health Editor

The parents of the first British baby screened to be free of a breast cancer gene have spoken publicly about their “beautiful” daughter - and revealed that they plan to have more children free of the hereditary condition. “She is a beautiful, healthy baby girl,” the child’s mother told The Sunday Times in her only interview. “She has 10 fingers and 10 toes. She’s 100% healthy.”

The parents are remaining anonymous to protect the baby, who was born last week. They are pioneers of a breakthrough in the fight against “hereditary” cancer. Though the parents could conceive naturally, they underwent IVF and genetic screening because three generations of women in the husband’s family had suffered from breast cancer. The procedure ensured that a gene associated with the cancer would not be present in the baby.

The 26-year-old mother said: “To be able to look at our daughter and to know that she doesn’t have the gene is a massive sigh of relief for us. We have eliminated that risk and that is priceless.”

Reconfiguring patienthood: Choosing the stuff of life

From chiasm to chasm: where to now

The mystery of the curecare binary seems to me to be increasingly in the dark.

Accountability as transparency inserts the new rationalism into practices of care and cure in ways that operate along the fracturing already engendered through the dividing practices of medical professionalization and dominance. Transparency intensifies the trajectory of cure and medicine towards biomedicalization. So there is genealogy here on how managing through notions of accountability come in on

existing divisions around knowledge, and the division between medicine and other practices.

Biomedicalization within this perspective is an effect of regimes of accountability and transparency that have drive medicine back to the laboratory and a million miles away from care. At the same time as care has been transformed into provision and intervention, distributed through the development of technologies of care and the machines of calculation. Discretion gets reinvented as negotiation, with a proliferation of thresholds through which patients have to pass to access care and interventions. As at the same time as more and more health care 'work' passes to patients and their families, people are being incited to perform themselves as moral in their choices over their style of life and the stuff of life that they choose to reproduce.

So that it seems that accountability as transparency, has acted as a dividing practice to reinforce the rift between care and cure in ways that obliterate any hope of a return to the curecare binary. Rather the care-cure binary having chiasmic properties, my fear is that there is no return, that an unbreachable chasm has been produced. So questions arise as to where can we go from here.

Are there possibilities for breaching the chasm – building bridges that bring the two banks back into view as what Heidegger would call a locale – a place for the carecure binary to dwell? What objects can be put into circulation to retranslate the effects of what I have been describing above? Davina Allen in her work on Care Pathway

development seems to be suggesting that in the work of their construction care pathway seem to act as boundary objects that do some work of reconfiguring the kinds of breaches and chasms that I am describing here.

Or with Anna Marie Mol and Ingunn Moser, we can keep to the local and specific descriptions of how a multiple logics of care is at work in the ordering of health care environments and make more visible when and how these are out of balance: when choice or efficiency or somatic medicine, for example, becomes too greedy and dominates, to extrude other possibilities for interpretation and conduct. My problem here is gracing the administrative nonsense of technologies of care and calculation, or a biomedicine oriented to the future, with an idea of logic, seems to be too generous. My suspicion is that this is a gloss of social science, and that from a patient's, and perhaps even some practitioners', perspectives, there is very little that is logical about how contemporary health care organization is working. My question really pertains as to whether we can begin to think of the breach itself as a space of possibility?

Figure 7



Leaping into the chasm made by the separation of cure and care

In particular how can we revive *medicine*, wrench it back from the future, and interest it in the here and now, however distributed its practice? Help it remember itself as a part of life, as never just work, or functional, but as world-forming?

While not wishing to undermine the suffering and pain sometimes involved, I do want to stress that the figuring of sick and ill bodies is itself relational, an interaction between certain kinds of bodies and their cultural and social worlds. So for example, people with so-called dementia find themselves in social worlds that they do not fit (Schillmeier 2009), and this lack of fit between how they are, their body and the world means that they find themselves as out of line (Munro and Belova 2009), all of which does not just intensify the experience and the condition (Schofield 2008) but, I would aver, partly constructs the condition itself (see also Kraeftner and Kröell 2009). This relationality also applies to the health issues of the third world: is aids a problem that inheres in specific bodies or a relation between poverty, culture, global economics and the flesh and blood of individuals?

Questions arise then as to how we can bring into view methods, narratives and discourses that circulate difference in ways that help deconstruct the old hierarchies: ways of imagining that revalue both the sick and the frail, and the care that some of us require? I am thinking here of Fleming and May's (1997) paper in which they stress the importance of imagining.

While there has been an emphasis on exploring ways of thinking of 'spaces' of care, in ways that privilege attention to issues of self-determination, dignity, individuality, privacy and choice, these do not address how care itself is relational and world-forming. The starting point then for reimagining could be to posit a different, less functional notion of care and the involvement of practitioners and patients as

embodied persons in relations (e.g. Rudge 2009, Savage 1995). Here we need to undo all the problematic of the dividing practice of work-life balance: the work people do is as much a part of their life as anything else they do or make. Margaret Mead suggests that the very notion of leisure is a dominating trope that upsets the idea that how we work also decides our lives.

Specifically, we could begin to imagine forms of organization embedded in a view of care routed in 'body-world relations' (Latimer 2009). Here spaces of care can bring being-with (*mitsein*) alongside being-in-the world (*dasein*), to think of spaces of care in terms of locale, materiality and relationality, rather than just in terms of individualisation, face and self, as important as these are. But there are many possibilities here. Let's talk more about them. Thank you.



Yes we can

ⁱ The Möbius strip was named after August Möbius in 1885.