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Special Issue Editorial: 7th In Sickness & In Health International Research Conference: Technologies, Bodies & Health Care

From 7-9 June 2018 we gathered on the Rozelle Campus of the University of Tasmania, in Sydney, Australia to extend the tradition of the In Sickness and In Health Conferences. These conferences were born from like-minded individuals (Helsinki-7) who were interested in creating an international network of critical health scholars and scholarship in relation to power, practice and ethics in health care. At the 7th In Sickness and In Health: Technologies, Bodies and Health Care we came from around the world to engage in critical discussions regarding technology and its interface with the social and material body in health and illness. Nowadays, technologies have permeated and contributed to an ideology of efficiency across the social, critical conversations are needed more than ever. With opportunities for critical discussions becoming increasingly rare and vitally important, I am very pleased to see us continue the conversation with an even wider audience through this special edition of Aporia – The Nursing Journal.

Thank you to all authors who have contributed to this special edition of Aporia – The Nursing Journal. I also extend my gratitude to the Editor-in-Chief of Aporia – The Nursing Journal, Professor Dave Holmes, for the opportunity to continue engaging in critical conversations about the assemblages and relations between technologies, bodies and health. I hope that each and every one of you will find the content of these papers thought provoking and inspiring.

I look forward to continuing our conversations at the 8th conference 10-12 June, 2020: People, Origin and the End of the Universe, Lleida, Spain. https://isihconference.com/isih-2020/

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Abstract
New materialism is emerging as one of the most significant developments in healthcare research in recent years, offering radical new ways to rethink our critical relationship with forms, matter, objects and things. As with any new paradigm, it can take some time for the limitations of the approach to become clear. In this article I examine some of these limitations, focusing particularly on new materialist definitions of objects and the ontology of affect. Drawing on the recent work of Graham Harman and Timothy Morton, I argue that new materialism fails the 'flat ontology test', and reinforces the kinds of idealism that it purports to critique. Object Oriented Ontology, on the other hand, may allow us to shape a radical new ethics of objects, using that to transform our abusive relationship with the ecosystem, disturb traditional enlightenment binaries and hierarchies, and to put aside human hubris.

Key Words object oriented ontology, new materialism

What's real is immaterial: What are we doing with new materialism?

DAVID NICHOLLS

There is a pleasure in the pathless woods,
There is a rapture on the lonely shore,
There is society, where none intrudes,
By the deep sea, and music in its roar:
I love not man the less, but Nature more,
From these our interviews, in which I steal
From all I may be, or have been before,
To mingle with the Universe, and feel
What I can ne'er express, yet cannot all conceal[1]

Introduction

In recent years, matter has become the focus for a range of philosophies that draw on the work of people like Gilles Deleuze and Félix Guattari, Luce Irigaray, Pierre Bourdieu, Donna Haraway, Alfred North Whitehead, Judith Butler, Bruno Latour, Rosi Braidotti, Martin Heidegger, Michel Serres, Maurice Merleau-Ponty and Michel Foucault. Frequently referred to as new materialism, this work spans a range of positions and perspectives.[2] Although many of the ideas taken up by new materialism are not new, they have provoked a significant departure from the preponderance of idealist approaches, such as social constructionism, phenomenology, and discourse analysis, in health care research and practices in recent decades.

The focus of new materialist writing has been on a new ethical relation between human and non-human worlds, especially '[o]ur habit of parsing the world into passive matter (it) and vibrant matter (us)'.[3] New materialism challenges the idea that humans are the pre-eminent entity in the universe, and introduces the possibility of a flat ontology in which all matter has access to the same virtues, capabilities, and affordances that have traditionally been reserved only for people. Part of the appeal of new materialism lies in its promise of an ethics

that puts "man" in his place and gives precedence to the materiality of every thing.

It is not hard to see why such an approach has garnered interest. We now unquestionably live in postmodern, posthuman, postqualitative times, in which, all too often, we find ourselves at odds with those who would argue that it is their moral right to bear arms, to demand a woman's right to choose, or to convert the Amazon into a palm plantation. We are bemused to find ourselves even debating whether humans are indeed the cause of climate change, whether black lives really do matter, #me too, the re-birth of fascism, human trafficking, chemical weapons in Syria, ethnic cleansing in Myanmar, and Donald Trump tweeting threats of nuclear attack from the Oval Office. "Is this really the dividend of centuries of Enlightenment and social progress", we ask ourselves?

New materialism has arrived at a time when serious questions are being asked of the idealism of the last half-century. Sitting under the looming shadow of global species extinction, surrounded by the persistent effects of human hubris, many have wondered how it can be that when you scratch the surface of a human, you still find a white guy underneath.[4] Consider, for example, this call to arms from the 2018 Congress of Qualitative Inquiry;

> These are troubled times. The global right is on the rise, north, south, east, west. It is setting the agenda for public discourse on the social good. In so doing it is narrowing the spaces for civic discourse. A rein of fear is on the rise. Repression is in the air: Brexit, the Trump presidency, global protest. Dissent is silenced. The world is at war with itself. The moral and ethical foundations of democracy are under assault. The politics may be local, but the power is global, the fear is visceral. We are global citizens trapped in a world we did not create, nor want any part of.[5]

Some have argued that new materialism is not that new, having its antecedents in the writings of Spinoza, Leibniz, Marx, Deleuze and Guattari. Many others have been working to hone some of its principles over the last decade or so. But it is perhaps the confluence of post-qualitative and post-human sentiments that has made the latest explosion of interest possible. In the health domain, at least, the groundswell is being driven by authors drawing on a diversity of approaches, including Karen Barad's agential realism, Bruno Latour's Actor Network Theory, and Fox and Alldred's affect economy.

The purpose with this article, however, is not to add to the popularity of new materialism, but rather to critique these approaches, and argue that ultimately new materialism may not offer the radical ontological turn that some suggest. To make this argument, we first have to understand how new materialism functions as a framework for thinking through matter, and to do this we need to define what are meant by objects. This will then allow an exploration of an argument that new materialism may not be the best approach for thinking through the breadth of cultural, ecological, economic, material, political and social problems that now assail us, and that a different approach to objects may hold more promise.

I will argue that Object Oriented Ontology (OOO, or 'triple O' as it is sometimes called) – a philosophically distinct and radically different approach to forms, objects and things, offers a more powerful set of philosophical and theoretical tools to reform healthcare as a human-centred practice, and radically redefine what health means. It offers a mechanism for a fully flattened ontology, and a philosophy to explain how real and sensual objects exist and interact, and it rejects the occassionalism that has allowed Gods, science or idealism to arbitrate the ordering and engagements of things in the world. OOO suggests ways to overcome the kinds of binary distinctions we have created between nature and culture, object and subject, mind and body, and it shows us how we might engage in the symbiotic real and, by doing so, avoid a species extinction that is looking ever more likely as the years go by. In this paper I introduce some of the main principles underpinning OOO and explore how it has been used by one of its main proponents, Timothy Morton, to critique our approach to nature, ecology and sustainability. I close the paper posing some of the ways I have sought to apply OOO to the work of respiratory physiotherapy. To begin with, however, we need to examine the way we are now being encouraged to think about objects.

What is an object?

Objects have held a long fascination for philosophers. Graham Harman argues, however, that most have done their best to eliminate objects as things in and of themselves from their philosophical writings, through processes that he describes as 'undermining' and 'overmining'.[6] Undermining refers to the process of reducing things to some ultimate physical element or particle; defining something by its pieces, and focusing on what a thing 'is'. Much of western science is premised on the idea that there are smaller elements forming the sub-structure of all things, and that understanding the workings of these fundamental elements lies at the heart of the scientific endeavour. But Harman also argues that the history of these efforts at undermining reach much further back than the natural philosophers of the Enlightenment, arguing that the pre-Socratic pursuit of apeiron – or the basic units that aggregated together to form the known universe

– highlights the long fascination we have had with deriving the fundamental basis of all things. For the pre-Socratics it was air, water or fire, for today's health scientists it may be DNA, atoms or electromagnetism. Overmining, on the other hand, is the upwards reduction of things, common to idealist philosophies, where there is nothing deeper than what a thing does; nothing beyond language and discourse, mathematics, power relations and effects. We see this process of overmining in the continental philosophies of the last century: in phenomenology, linguistics, critical theory and social constructionism. Critically, both undermining and overmining give an outsized role to humans.

In response to this, a great deal of recent interest in new materialism has sought to uncover how something can be more 'alive' than lifeless matter (undermining), yet more material than discourse (overmining). Jane Bennett devotes a considerable amount of space to this question in her book Vibrant Matter.[7] Drawing on the notion of vitalities, Bennett argues that we have long sought to identify the energy or force that animates living matter. Embryologist and philosopher Hans Driesch, for example, believed that there must be some 'impersonal agency' existing between things; giving life to them - something interstitial, manifold, non-material, non-spatial, and non-mechanical, neither force nor energy - a process he termed entelechy.[7 p71] And Henri Bergson's élan vital similarly corresponded with the 'internal push of life', an overflowing excess, a 'perpetual, loosely directional efflorescence of novelty'; a 'drive without design'.[7 p76-8] It is not hard to see why Bennett and others have been drawn to these accounts, as new materialists have searched for ways to imbue objects with the vitality and vibrancy that might allow us to equate the irrepressibility of matter with human existence. But, significantly, Harman argues that contemporary materialism 'does not merely undermine and overmine the object, but performs both of these maneuvers simultaneously',[8] suggesting that Bennett and others have failed to escape the legacy of the philosophies that new materialism openly appears to oppose. What is happening here then? What is happening to objects themselves in the process of new materialist rendering? And what is the status of the thing called 'matter' that new materialists refer to, that Harman and others are beginning to oppose; see, for example, references 9-12?

Nothing outside affect

One of the key principles of new materialism is that existence is relational, and governed by what Fox and Alldred called an 'affect economy'.[13] New materialism argues that there is nothing outside affect (what matter 'does', 'what capacities it has to affect its relations or to be affected by them'[13]) Echoing Alfred North Whitehead's theory that to understand an entity we must understand its relations (prehensions), and Bruno Latour's belief that 'an actor is nothing more than whatever it transforms, modifies, perturbs, or creates',[14] new materialists like Bennett, Karen Barad, Katherine Ott, Nick Fox and Pamela Alldred, Diana Coole and Samantha Frost, Mirka Koro-Ljungberg and others, argue that objects and matter only exist as confederations. As Karen Barad has said, 'Believing something is true doesn't make it true. But phenomena—whether lizards, electrons, or humans—exist only as a result of, and as part of, the world's ongoing intra-activity, its dynamic and contingent differentiation into specific relationalities'.[15] In the affect economy (the forces and relational links between matter that produce new entities, akin to a economy of trade and production), there are no real mind-independent objects pre-existing the formation of assemblages. Echoing Derrida's aphorism that 'nothing exists outside the text', Elizabeth St Pierre stated that in the 'posts' '...there is no Real - nothing foundational or transcendental'.[16] There is only 'affective-discursive practice',[17] or the 'patterned forms of activity that articulate, mobilize and organize affect and discourse as central parts of practice'.[18]

But here we arrive at the first fundamental problem with new materialism and its reliance on affect, because if there is nothing 'outside' the assemblage formed between things, then there can be no surplus; nothing beyond the boundaries of the intra-active relationship between objects; nothing more than the affect economy. If there is no residue, no excess beyond the coupling, there is no possibility for emergence, for surprise, or change. Everything that can possibly happen must be contained within the assemblage itself. Affect theory cannot allow relata to possess properties that are not enclosed in their relationship, because this would suggest that there is more than affect taking place, and this would require some explanation. We would be forced to decide how significant this excess actually was. Was it, perhaps, vastly more important than the affective relationship itself? Perhaps it is so important that it diminishes affect to a momentary aberration? In which case affect might be dismissed as insignificant. So, in affect theories, relata cannot be allowed to precede their relations, and the existence of an extrinsic reality beyond the limits of assemblages is denied. There is nothing real beyond that which comes into existence agentially. There is no essence or existence given to matter 'before' it forms a relation with another entity. There is no object 'apart from the practices that register existence'.[6] And so, as with many philosophies before it, new materialism accidentally succeeds in getting rid

of the very things it purports to champion; replacing them with a system that struggles to account for what objects really are.

But perhaps most significantly, an affect economy cannot distinguish between trivial and significant assemblages, and so labours under what Harman, after Quine 1980, calls a 'slum of possibilities',[20] in which it is almost impossible to decide whether a volcano is of greater significance than a sneeze. To resolve this, new materialists allow for a 'third party' to arbitrate what really matters. This form of occasionalism refers to the need for some sort of intermediary to 'realise' the nature of reality. Throughout history we have deployed Gods or other deities, science, or, more recently, language and discourse, as vehicles to mediate and make sense of which bits of the world's 'furniture'[20] are privileged and which are marginalised. And so it is with new materialism, where affect refers to what is meaningful to us – as humans. Despite its best intentions to challenge the human hubris of existing binary dogmas, the new materialisms position humans firmly at the top of the 'natural' order. As much is acknowledged by Jane Bennet when she concludes Vibrant Matter by saying that, 'To put it bluntly, my conatus[a] [or my will to persist and thrive as an entity] will not let me 'horizontalize' the world completely'.[7] In the same way, Karen Barad suggests that, "We have to meet the universe halfway, to move toward what may come to be, in ways that are accountable for our part in the world's differential becoming".[15][b]

The key ontological challenge therefore remains to treat 'all relations as ontologically equal translations whether humans are involved or not'.[20] Why do we persist in saying that 'the emergence of [human] thought is more important than the emergence of stars, the formation of heavier elements in supernovae, the symbiotic emergence of eukaryotic cells, or the evolution of invertebrates?'[20] But how can we do this? How can we let go of being human to engage in such a radical ontology. Even this question betrays our innate humanism, and our occasionalistic tendencies to replace God with anthropocentrism.[22,23] Surely this then is the real radical challenge offered by a new ethics of objects?

What then is radical about new materialism if it does not show us a way out of human exceptionalism, and functions as just another vehicle for a human-centric critical theory, operating within the human sphere, whilst paying cursory attention to the other things we share the cosmos with? Should we be so enamoured with new materialism if its effect is to reify classical human identity politics? As Jane Bennett says; 'The political goal of a vital materialism is not the perfect equality of actants, but a polity with more channels of communication between members'.[7] DeLanda and Harman argue however that 'Any philosophy that is intrinsically committed to human subjects and dead matter as two sides of a great ontological divide … fails the flat ontology test'.[20] So how might we approach the question of objects differently in the face of persistent human exceptionalism?

Harman's OOO

Returning to Graham Harman's argument about how philosophers – particularly in the west – have historically duomined objects, we can establish the first principle of OOO, and say that an object is that which cannot be reduced through undermining to its component atomic pieces, or conversely overmined to its discursive effects: An entity qualifies as an object as long as it is irreducible both to its components and its effects.[6,24] Harman's Object Oriented Ontology, which sits broadly under the umbrella of Speculative Realism,[25] is a realist ontology, arguing that objects of every sort exist prior to their relations.[6] Things act because they exist, not vice versa. This argument runs counter to much of the language of discourse, becoming and affect that have dominated anthropocentric idealism over the last half century, but Harman goes further. Not only is his philosophy realist, but it also accepts the reality of things that may not be materially present. For Harman, things don't have to be materially present to be real. This immaterial position opens up OOO to all forms of objects that may or may not be materially present; apples and atoms, dreams and fictional characters, governments and leaders, concepts and chest infections.

Part of the reason for Harman's anti-materialism lies in his difficulty locating where the thing called 'matter' actually resides. He asks, 'Where is this matter supposedly located? Where on earth can we find formless matter'?[20] Because matter always takes some sort of form, Harman argues that form precedes matter. But forms also exist without matter (in works of fiction, for example), so form is perhaps more useful as a way of interrogating objects than focusing on its materiality.[6] Harman also argues that forms are 'organised and structured' but 'not directly knowable', which is a key to his understanding of objects. Harman's work is heavily influenced by a radical re-reading of two pre-eminent phenomenologists - Husserl and Heidegger. From Husserl, Harman takes the notion of the Eidos – or the essence of the object hiding beneath layers of accidental effects, adumbrations, meanings and relations. From Heidegger, he takes the idea of the object always withdrawing and evading capture.

Husserl showed us that we can never fully interact with what Kant called the 'noumena', or thing-in-itself. Rather, when objects of all sorts interact with one another, they only ever encounter their respective surfaces, because objects are always encrusted with layers of accidental properties. These adumbrations, or 'shadows', hide the essence of the thing-in-itself and prevent one object from ever encountering another fully. Husserl believed that acts of imagination and cognition might allow us to strip away these adumbrations that bejewel

objects, and this formed the basis for his phenomenological method. But Husserl, like Kant before, also believed that only humans could do this. Harman, on the other hand, argues that humans are no better at knowing the essence of the thing itself than any other entity, and all entities engage in the same elusive engagement. And so humans are no more privileged in their phenomenological capacities than real trees, shabby carpets or fictional sea urchins.

A second key influence on Harman's approach to objects has been taken from Heidegger's belief that we can never exhaust the possibilities of other objects, and that they always withdraw from capture. Or, as Tim Morton prefers, objects are more 'open', meaning that they are not 'empirically shrunken back or moving behind'.[26] I might see this chair, for instance, but I can never know all of its properties or possibilities, and I will always be surprised by how it might manifest or express itself. And as with his approach to Husserl, Harman extends Heidegger's radical withdrawal to all things, arguing that it is not only humans that fail to exhaust the possibilities for other forms, but that this is true of all objects. The sun cannot exhaust the fullness of the beach towel any more than we can.

In this way, Harman brings his radical re-reading of Husserl and Heidegger into synthesis. Husserl offers the essence of an object with its surface effects and adumbrations, and Heidegger gives us the object that withdraws. Harman uses this to define an immaterial philosophy understood in two fundamental states of objects each with two possible conditions: real and sensual objects, with real and sensual qualities (see Table 1).[20] As Harman puts it;

> While there may be an infinity of objects in the cosmos, they come in only two kinds: the real object that withdraws from all experience, and the sensual object that exists only in experience. And along with these we also have two kinds of qualities: the sensual qualities found in experience, and the real ones that Husserl says are accessible intellectually rather than through sensuous intuition'.[8]

Harman argues that any significant philosophy must be able to account for all events, realities, correspondences, descriptions, knowledges, relations, and experiences, and do this for all things, not just those things that correspond to human experience. It cannot give over half of the field of philosophy to one species at the expense of all others, as has been the case for western philosophy since the Enlightenment. Nor can it accept the new materialist response to this and suggest that all things are relational. Harman shows the potential scale and reach of OOO in his discussion of space and time.

Time, for Harman, can be understood as the tension between the relatively stable sensual object and its constantly shifting sensual qualities. The experience of (lived) time, for all entities, is an experience of 'change within continuity … or the relative endurance of sensual objects amidst a constant shift of adumbrations' – an expression of the tension between a real object and its sensual qualities.[20] Space, on the other hand, is an expression of the unstable 'network of relations and non-relations between objects'.[20 p123, emphasis added] Some things are close to us, others are distant and to experience them requires work. Space reflects this distance and the 'interplay of an object's distance and nearness from me and from all other objects'.[20 p127] This is not the sensual experience of distance, but the 'real object that remains distant from us, even as its sensual qualities are accessible'.[20 p127]

Importantly, Harman reminds us that all entities engage in a continual array of encounters with the sensual qualities of other entities, and that 'although humans are of obvious interest to humans, we are really a fairly minor (if unusually interesting) sort of entity in a cosmos inhabited by trillions of other entities.[20 p2] This question has been taken up engagingly by Timothy Morton, whose OOO-inspired examination of ecology, nature and the cosmos, points to some of the ways OOO might be used by other fields in the future.

Table 1: Four conditions of Harman's OOO

Real objects	**Exist in their own right. They are mind-independent, non-relational entities, that exist in the here and now. They are always withdrawn and inexhaustible.**
Sensual objects	**Inherently relational, not real, existing here-and-now only as correlate of some real object, virtual, not existing in their own right.**
Real qualities	**Qualities that define the essence of an object without ever being exhausted by thought or praxis. The essential features without which objects would cease to be what they are.**
Sensual qualities	**Qualities that are the things we encounter when we interact with other entities. The superficial features that present themselves to us and suggest the object beneath.**

Tim Morton's OOO

Perhaps one of the best examples of how OOO can be applied to contemporary questions and concerns comes from Tim Morton's work on ecology. In a series of books over the last decade, Morton has increasingly drawn on OOO to set out a radical agenda for rethinking the historically anthropocentric relationship with ecology;

> OOO offers us a marvellous world of shadows and hidden corners, a world in which things can't ever be completely irradiated by the ultraviolet light of thought, a world in which being a badger, nosing past whatever it is that you, a human being, are looking at thoughtfully, is just as validly accessing that thing as you are.[27]

Morton argues that humanity's 12,500-year project to command the ecosystem, and bring it under our economic control, has resulted in a 'foundational, traumatic fissure between, to put it in Lacanian terms, reality (the human-correlated world) and the real (ecological symbiosis of human and nonhuman parts of the biosphere)'.[26] Morton calls this 'The Severing', and this, he argues, is the cause of our increasing anxiety and separation from all other things in the ecosystem; overlaying its superabundant 'cheapness' and openness with the 'loathsome' notion of 'Nature', that is 'a way to blind and deafen oneself to the strangeness of the symbiotic real'.[20 p62]

Morton argues that this severing is the basis of our anthropocentrism, which suppresses possibilities of solidarity with nonhumans. By contrast, 'ecology' is the cheap version of nature; an ecology that is surprisingly available and accessible to us. It is not something 'out there' to be commanded and tamed, but actually right under our nose. Drawing on Harman's re-reading of Husserl's eidos, Morton accuses us of layering ecology with adumbrations of significance and discursive meaning, so that it now feels like an inaccessible, intimidating and paralysing concept to most people. People are sitting at home looking at Pinterest images of nature rather than smelling flowers and planting lettuces;

> It is time to release the copyright control on this gap. The name of this release is ecological awareness. Ecological awareness is coexisting, in thought and in practice, with the ghostly host of nonhumans. Thinking, itself, is one modality of the convocation of specters in the symbiotic real. To this extent, one's "inner space" is a test tube for imagining a being-with that our metaphysical rigidity refuses to imagine, like a quaking peasant with a string of garlic, warding off the vampires.[26]

Morton argues that acts of ecological attunement are not grand gestures of eco-activism, but small acts of solidarity and kinship with other objects within the ecosystem. In typical jocular fashion, he tells us that 'Just as when Goebbels heard the word "culture" he reached for his gun, when I hear the word "sustainability" I reach for my sunscreen'.[26] Grand acts of eco-activism, like gestures towards sustainability, mask the fact that they are first and foremost concerned with sustaining 'the neoliberal, capitalist world-economic structure. And this isn't great news for humans, coral, kiwi birds or lichen'.[26] All too often;

> When we look to 'save the Earth' we are really saying we are '"preserving a reasonably human-friendly environment." This isn't solidarity, this is infrastructural maintenance. What is preserved is the cinema in which human desire projection can play on the blank screen of everything else'.[26 p37]

Morton encourages us to care less and to remove the layers of complexity we have fixed around the ecosystem. Every effort we make, he argues, damages our solidarity with the symbiotic 'real'. Instead, 'The point is to rappel "downwards" through the empathic part of the capitalist superstructure, to find something still more default than empathy'.[26]

Morton's work has a fascination with the gap that exists between what a thing is, how it appears, and a strange linkage between the two that defines the object. Echoing Harman's notions of real and sensual objects, Morton explores the persistent gap between what a thing is and how it appears. For Morton, the reality of an object is always open, withdrawn, and never fully accessible. What we are presented with when things interact with other objects is 'thing data'. Raindrops, using Kant's analogy, have certain properties (Harman's real qualities) that fundamentally differentiate them from blue whales and fictional characters like Anna Karenina. They are round, wet, and have a certain momentum, but, Morton argues, this isn't the raindrop we're experiencing but raindrop data, and if the raindrop could talk and express itself, it still would not be expressing the real raindrop, only more raindrop data.

If we treat all things as objects, and we know that each object is itself a confederation of other objects, then, Morton argues, it is possible to view the singular object as ontologically only one thing amongst many. It is possible, then, to argues that, contrary to conventional wisdom, that the 'whole' is not, indeed, greater than the sum of its parts – an overmining strategy par excellence – but it is instead just ontologically equivalent to all the other parts. There are, therefore, a lot more parts than there are 'wholes'. This may seem a trivial point to make on the surface, but such a simple idea can have profound implications, because traditionally we have

seen hegemonic discourses like Gaia and Mother Nature as dominant structures with many interchangeable parts. Under this schema, the loss of the coral reef, for example, is less significant because Gaia will simply replace it with something else. The parts are subordinate to the whole, and holism is a privileged discourse. This echoes our historical monotheism in which a God governs the world and intervenes for good or ill. By contrast, OOO allows for there to be more parts than wholes, and this creates the possibility for endless creativity and surplus, rather than constraint, control and subordinacy.

What, then, constitutes 'us'; human beings as a whole? By virtue of their consciousness, we say that humans are distinct from all other matter in the cosmos because we 'act', where other things merely 'behave' in response to their immediate environment. Humans, we say, are fully present to their intentions. But this differentiation is becoming harder and harder to sustain, as we struggle to distinguish between life forms and non-life forms. What, in the end, is the 'me' that is human? Morton asks, if we are made up of all kinds of things that are not 'me' (clothes, daffodil DNA, thoughts, oxygen molecules, received ideas, etc.), then there is clearly a lot less of me than I might previously have thought. And if I am ontologically real and yet only available as 'me data', I exist in the same ways as all other objects in the cosmos. This allows us to acknowledge that humans exist as distinctive objects, but that they are not human all the way down and all the way through, and that they have no more access to the world than anything else (since all objects are fundamentally open to/withdrawn from each other).

While Morton's work on ecological awareness resonates strongly with Graham Harman's writings on OOO, there has been little concerted work undertaken to apply this radical approach to health. Despite the fact that affect has become an area of significant interest to health researchers in recent years, most of the focus has been on new materialism and ideas of an affect economy. Harman and Morton's work roundly rejects this approach though, and proposes, instead, a realist ontology that should resonate strongly in the world of healthcare. For most of my professional life, I have worked as a respiratory physiotherapist and lecturer. Physiotherapists, like most orthodox western healthcare professionals, have a strong grounding in a biomedical world view, whose foundation is in realist empiricism. Notwithstanding this, I have been an avid promoter of idealism and social constructivism for more than 20 years. The two make uncomfortable bed-fellows, but my personal predilection for the Nietzshean continental philosophies of Foucault, Deleuze and Guattari, Virilio and others has, at least, allowed me to resist the urge to see one approach as good and truthful at the dismissal of the other. But it occurred to me some time ago that perhaps the problem with the contest between these competing ideologies was that advocates for either side still relied on their 'right' being greater than the other side's. So perhaps both operated along the same continuum, and so both were equally limited. New materialism and the post-inquiry work of people like Elizabeth Adams St Pierre, John Law, Annemarie Mol, Nick Fox, Brian Massumi and others[16,28-33] offered a pointer to a radical new flat ontology, that didn't so much 'allow' for a reconciliation between idealism and realism, but ultimately, for me, it re-vivified anthropocentrism. OOO, on the other hand, feels as if it might offer some really radical new ways to rethink health and healthcare. So to close the article, I will attempt to sketch out a brief vignette of OOO applied to my small area of healthcare interest, in the hope that it points to the possibilities for a radical new approach to thinking and practice.

The possibilities of OOO for health

If we first embrace Harman's realist definition of objects (neither undermined or overmined); are comfortable with the idea that real objects are radically open to us, but can never be fully captured; and that this is as true for table lamps and imagined vampires as it is for real people, then a world of possibility opens up to us. In the past, respiratory medicine has been dominated by biomedical positivism. Medical, nursing, and allied health students are taught the biological realities of respiratory anatomy and physiology, pathology, assessment, diagnostic testing, passive and active treatments, including the use of pharmaceuticals, forms of ventilation, pulmonary hygiene and exercise, designed to maximise recovery and quality of life. Until recently there has been little room in respiratory care for the more humanistic, qualitative and subjective dimensions of breathing, and still less overlap between respiratory disease and ecological, social or spiritual dimensions of health on a cosmological scale.

But if we begin from a different starting point, and take up Tim Morton's argument that there is a lot less of 'us' – in the embodied humanistic sense – than we would like to believe, then we are suddenly open to the possibility of seeing the myriad parts that make up 'me' as being fundamentally interwoven with entities spread throughout the cosmos, what Morton calls the 'symbiotic real'.[26] If we consider oxygen, air and breath – three key features of respiratory medicine – as our exemplar, we know that the human body is almost entirely made up of inorganic elements, and oxygen constitutes almost two-thirds of our body's inorganic mass (more than 3.5 times the amount of carbon). It would be reasonable to ask then, at what point my body ceases to be a collection of inorganic elements (akin to a cadaver), and when I become

me? And what role oxygen plays in this. When does the oxygen molecule floating in the air above me now actually become part of me? Is it 'me' when it is my trachea or alveoli, or later when it dissolves into the haemoglobin or catabolized by the mitochondria? Such questions are tempting to ask but, of course, they reinforce the kinds of anthropocentrism that dogs idealist, humanist and new materialist approaches.

Harman's OOO provides possibly the first approach to the inter-relationship of objects that allows us to open areas like respiratory medicine to a much wider canvas and, for the first time, embrace the full impact of oxygen, air and breath. To work with oxygen, air and breath as objects in their own right could open up healthcare work to the biology of oxygen and carbon dioxide, the physiology of gas exchange, and the pathology of dyspnoea; the human cost of breathlessness, the voice of air, and the loss of voice; trade winds, air movement and flight; the historical and cultural significance of air as miasma, and air as a vector for disease transmission and social contagion; liquid networks of air flow; the public health dimensions of environmental design, Nightingale wards and leisure tourism; air pollution and environmental legislation; air pressure and 'I can't breathe'; the medical management of respiratory failure, and the mutual dependence between lungs and machines in artificial ventilation and air conditioning; breath as metaphor – in the Māori cultural context, known as Hā, the first breath of life – and breathing in rarefied atmospheres of space and high altitude; kissing and resuscitation; breath in song and poetry; the intimate connection between the ecology of breathing, and the work of trees and algae in gas exchange; ecological consciousness and breathing as evolutionary marker of humankind's ascension from the primordial swamp, made possible by the synthesis of oxygen within the mitochondria; and so on.

How can I reasonably practice as a respiratory physiotherapist and not have a view on the interplay between the ecology of air, the biology of breathing, the lived experience of gas exchange, the spirituality of breathlessness, or the symbiotic relationship between objects that are neither defined by what they are, nor by what they do? How can I not be interested in designer face-masks, and the creative conversion of oxygen, air and breath in works of art; or be concerned for cities like Delhi, where levels of carbon monoxide were 25 times the WHO recommended level at times last year?[34,35] How can I privilege an anthropocentric view of breathing and ignore breathing as a form of anarchy, air as 'landscape', a negative space, and terra infirma? Air as terror and medium of social control? Combat breathing[36] or muscular armor[37]? My practice and thinking, surely, has to embrace the use of breathing in films and role player video games? And if oxygen is the 'fuel', how can I understand the role it will play in future robotics and space travel? I have to be interested in breathing as memory and history, in iron-lungs, ventilators and machine-assisted breathing. And I surely must want to understand why the diaphragm is the only skeletal muscle in the body that is both under voluntary control and essential to life? What of the interstitial (liminal) spaces between things – so important for the micro-anatomy of the lungs – but applied elsewhere too?

Compared with the kinds of regulated discipline that currently constitutes contemporary respiratory medicine, and much else in western approaches to healthcare, I am arguing for a new ethics of objects that embraces this superabundance of perspectives and paradigms. With the advent of 21st century technologies that will radically reshape the place of healthcare in people's lives,[38] the anthropocentrism and humanism that dominates contemporary understandings of health and illness will be harder to justify. The advent of robotic assistants, designer prosthetics and augmented reality, will make it even harder to retain the same distinction between that which is inside and that which is outside; that which is mine and that which is 'other'; that which is human and that which is nonhuman. What is needed is a radically revised philosophy of human-world relations that actually does away with the distinction between human and world, nature and culture, quantitative and qualitative, body and mind, and in doing so radically subverts the Victorian notion of professional disciplines with their impermeable boundaries and arbitrary distinctions.

The emergence of new approaches to qualitative research have opened up new ways for healthcare researchers to interrogate the meaning and significance of breathing for people.[39-48] To some extent these approaches have actively resisted the long history of reductionism and positivism that have dominated biomedical understandings of respiratory physiology and pathology. But they have also tended to promote an anti-realist, humanistic and subjective reading of breathing that has reinforced a binary position in which one either believes oxygen molecules exist and exert a significant formative influence on people, plants, air, breath, mitochondria, wind, and climates, or they do not. In the end, such an approach is as ontologically unsatisfactory as the anthropocentric scientism of western medicine.[49]

So, what is to be done? Obviously, the reach of new philosophies like OOO is far greater than just healthcare, so my focus on respiratory physiotherapy seems, on the surface at least, to be a little prosaic. But this, of course, is the point. Because orthodox, mainstream health practitioners

are largely encouraged to be reductive in their thinking, and are discouraged from seeing the work as operating on a cosmological scale for fear of seaming messianic. OOO suggests that such an attitude is redolent of the kinds of undermining and overmining that dominates our relationship with things. OOO, by contrast, offers an antidote to these persistent acts of duomining, and suggests that if we as a species are almost entirely inorganic, then focusing so much of our time and energy on ourselves might not only be wildly self-indulgent, but may also be causing many of the problems we are now experiencing as a species.

The appeal of both new materialism, OOO and the ontological turn in general, is that they open up a universe of possibilities for new kinds of research, new ways of thinking, and novel kinds of healthcare practice. But, for all its virtues, I believe that new materialism falls short of radically disrupting our anthropocentrism. New materialism's reliance on an affect economy appears radical on the surface, but in reality it is a humanistic turn on a now old qualitative theme. Clearly, removing the legacy of 12,500 years of human hubris is still the main project, but in this article I argue that new materialism fails to offer an ontology adequate for the task. OOO, on the other hand, just might.

OOO is only beginning to be recognised by scholars and, consequently, has only just begun to come under deep critical scrutiny see, for example, references 50,51. Initial indications suggest it offers us tools to reform healthcare as a human-centred practice, and radically redefine what health means; it provides a mechanism for a fully flattened ontology, and a philosophy to explain how real and sensual objects exist and interact; it rejects the occassionalism that has allowed Gods, science or idealism to arbitrate the ordering and engagements of things in the world; it shows us how to overcome the kinds of binary distinctions we have created between nature and culture, object and subject, mind and body; and it shows us how we might engage in the symbiotic real and, by doing so, avoid a species extinction that is looking ever more likely as the years go by.

Notes

a The term 'conatus' derives from Spinoza's belief that all matter possesed a living force that was its drive to persist and endure; a 'will' to express its becoming. Spinoza's exploration of conatus in the 17th century would be a significant influence on Gilles Deleuze's later work.

b A related critique, that new materialists like Jane Bennett have conveniently portrayed all matter as passive and dead substance in order that we can then demonstrate its need for human enchantment, has been made in recent years.[21]

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Abstract
In the 1970s, radical lesbian feminists identified heterosexuality as a socially glorified state of being, and organised to resist social pressure to conform to heteronorms. Decentring of radical feminist discourse has been linked to a 'shrinking lesbian world', with implications for the health and wellbeing of young women who identify as lesbian. This article employs a poststructural feminist perspective, and Foucault's notions of discourse and genealogy. Two sets of data were analysed: issues of Aotearoa New Zealand feminist periodical Broadsheet published 1972-1976, and interviews with 15 young lesbian women conducted in 2012. Findings explore how radical lesbian discourse was marginalised, and some of the implications for the health and wellbeing of young lesbian identified women. Compulsory heterosexuality persists as a health and wellbeing issue which produces 'sexual minority stress' and legitimises discrimination, violence and harassment. Marginalisation of radical lesbian discourse via compulsory family status operates to limit opportunities for collective and public lesbian resistance.

Key Words feminist discourse analysis, Foucault, young lesbian health

A genealogy of lesbian feminisms in New Zealand: Some implications for young lesbian health and wellbeing

KATIE PALMER DU PREEZ, DEBORAH PAYNE & LYNNE GIDDINGS

Introduction

Drawing from radical feminism the idea that 'the personal is political', lesbian feminist theory shaped the conditions of possibility for identifying and targeting the political and socially embedded nature of women's and lesbians' wellbeing. This lesbian feminism de-naturalised heterosexuality, analysing the oppressive effects of its systems, institutions, structures and practices on women.[eg. 1,2,3] Analysis of heteronormativity, or the ways in which heterosexuality is produced/enforced/assumed as the norm and natural in society, has thus become vital in making sense of lesbian health and wellbeing.[eg. 4,5,6] Poststructural feminist writers have been concerned with articulating how, despite the emergence of discourses of gay rights and equality,[eg. 7,8] power relations produce possibilities for, and constraints on, lesbian health and wellbeing. For example, as Kitzinger[6 p478] describes:

> While LGBT activists are campaigning against blatant oppression and overt discrimination, at the same time all around us a heteronormative social fabric is unobtrusively rewoven, thread by thread, persistently, without fuss or fanfare, without oppressive intent or conscious design.

Research shows that women who self-identify as lesbian continue to be marginalised by society.[4, 9-11] Indeed, as posed by Aotearoa New Zealand academic lesbian feminist Te Awekotuku: "Lesbians can get married, but does that make the world a safer and better place for women?"[12] Marginalisation associated with sexual minority status has been linked to lesbian women's lower levels of health and wellbeing and a higher uptake of behaviours that are injurious

to health and wellbeing.[4,5,9,11]

Recent scholarship suggests that there has been a decentering of lesbian feminisms in relation to lesbian wellbeing. Stein links this to what she calls a 'shrinking lesbian world' in the absence of feminist unifying ideology: "What we are seeing, quite possibly, is the exhaustion of particular historical construction".[13 p24] Further, young women's performances of 'feminist disidentification' have been documented internationally, and linked to processes of sociosexual power relations which reflect and reproduce male dominance.[eg. 14,15,16]. The theory and politics of trans, queer and non-binary genders/sexualities have challenged the notion of a singular truth of lesbian sexuality, bound to fixed normative characterisations of womanhood or lesbianism.[17] Vicinus[18] argues that a positioning of lesbian subjects as women, constituted through discourses of gender and sexual politics, is not adequately theorised through discourses of queerness and non-normativity. Critical race scholars have identified some lesbian and feminist identities as Western, white and exclusive standards to live up to that elide the context and culture of black and working class women's lives.[19,20]

There are many ways in which sexuality between women has been practiced and understood. These are not stable and have shifted over time according to the norms and practices prevalent at different historical moments.[21,22] The term 'lesbian' is one of many terms used by women today to position their non-heterosexuality in instances where they choose or are required to do so. Some women engage in sexual activity with women, yet refuse any form of sexual identity and may or may not be connected to a lesbian community. There is a tendency in the literature to blur lesbian identity with same-sex attraction and behaviour among women. In this paper the terms 'lesbian' and 'lesbianism' and 'lesbian sexuality' are explored particularly in relation to feminist discourse, and as deployed by women in the 1970s and 2012.

Aotearoa New Zealand is regarded internationally as a forerunner in terms of political gains in gay rights. Since the Homosexual Law Reform Act was passed in 1986 decriminalising consensual sex between men, the Human Rights Act[23] and the New Zealand Bill of Rights Act[24] have outlawed discrimination based on sexual orientation. Commensurate state recognition and protection of lesbian and heterosexual intimate relationships has taken place with the Civil Union Act[25] and the Marriage (Definition of Marriage) Amendment Act[26]. Yet health and wellbeing issues persist. For example, in recent years, young lesbians have been held to "warrant special vigilance" by health professionals and promoters in relation to suicide and depression,[27] and health risk behaviours in the areas of sexual health, smoking, alcohol and drug use.[eg. 28,29-35]

Given that particular health issues for young lesbians continue to be identified, and lesbian feminisms have historically been so integral to the articulation and practices of lesbian health and wellbeing, we asked: To what extent and how has radical lesbian discourse been marginalised in New Zealand? What are the implications for young lesbian health and wellbeing?

Methodology and method

Foucault's genealogical work used historical constructions to dissect, disrupt and render the familiar strange by interrogating truth claims.[eg. 36] Bringing historical constructions to bear on the present can function as "counter-history" opening up "critical, resistive potential".[37]) The construction of critical present-centred histories, uses what today appears "marginal, eccentric or disreputable"[38] to try and tease apart the systems of the present that have made them appear so.

This article draws on data from a recent genealogical study of young lesbian health and wellbeing in New Zealand.[39] The 1970s second wave feminism and women's health activism created conditions of possibility for the emergence of Broadsheet, a national New Zealand feminist periodical with strong health and wellbeing emphasis, which ran from 1972 until 1997. Broadsheet's early issues (published 1972-1976) provided one of the first widely accessed spaces in New Zealand that allowed lesbianism to be spoken of and acknowledged.[40,41] Hence the decision to choose Broadsheet as a key historical data source. In 2012 there was considerable national discussion and campaigning around the legalising of gay marriage, which was subsequently enacted in New Zealand in 2015. The second historical set of data are interviews with 15 lesbian identified young women aged between 18 and 24, recruited via social media in 2012. The women were predominantly white and middle class, Interviews were conducted in three major New Zealand cities, where the young women were studying at university (n=7), in fulltime work (n=7) or working and studying part-time (n=4). Most interviewees identified their ethnicity as New Zealand European (n=14), and the remaining four participants identified as New Zealand Māori, Pacific, Asian/New Zealand and Middle Eastern. The interviewees were asked by the first author (KP) to talk about how they identified as young lesbian women and their health and wellbeing. Ethical approval to conduct the interviews was obtained from the Auckland University of Technology Ethics Committee (AUTEC Reference number 11/325).

Foucault's genealogical investigations of objects and phenomena explored ruptures, sudden changes in thought and links with the maintenance and shift of power.[42] This allowed him to chart the disjointed movements of history, as neither progressive nor rational but only the "endlessly repeated play of dominations".[43] Broadsheet, and the interview encounters were considered as surfaces of emergence[44] for discourses constituting lesbian feminisms and health and wellbeing, around times of significant shift in social thought in New Zealand (the rise of feminism, the possibility of 'marriage equality'). The analysis presented was informed by feminist poststructuralist work employing discourse analysis and Foucauldian concepts of genealogy and the history of the present.[notably 45,46-48] Analytical steps taken were to identify and examine the terms and concepts that were routinely used to differentiate, delineate and impact on phenomena and practices of lesbian feminism and health and wellbeing. For example, in Broadsheet, rupture emerged between those who constructed lesbian sexuality within the minoritising terms of liberal feminism and sexological discourse, and those women who championed the relevance of lesbianism to helping transform the gendered status quo.

The subject positions and spaces created for young women by various discourses of feminism and health were defined and explored. Discourses and discursive practices were identified in the texts that construct categories such as 'lesbian' and 'straight', 'healthy' and 'sick', 'feminist' and 'square' looking for how these constructions came into being, who was authorised to speak about them and who are the subjects. Positions offered by these discourses were considered in terms of the possibilities and constraints of these for young lesbian health and wellbeing.

Findings

Broadsheet feminist magazine 1972-1976

Two dominant discourses were identified in the Broadsheet set of data. A radical feminist discourse brought a very particular and collective notion of lesbianism into being and circulation in Broadsheet at this time. Radical feminism developed a political theory of heterosexuality as a practice of patriarchal institutions of marriage and the family, and patriarchal ideologies of masculinity and femininity. Radical lesbians identified heterosexuality as a socially glorified and enforced state of being, with health and wellbeing effects on women. Simultaneously, a liberal feminist discourse operated to produce women's health issues in a heterosexual framework, as informed reproductive choice and reducing sexism, to the exclusion of identified lesbian health issues (e.g. homophobia, heterosexism). This liberal feminism constructed young women as knowing: empowered to practice a protected heterosexuality.

Radical feminist discourse

A radical feminist discourse rejected liberal notions of 'tolerance', and identified these as restricting the visibility of lesbians and their health and wellbeing issues within the women's movement. Māori women were leaders in this regard, e.g. in 1971, academic Ngahuia Te Awekotuku spoke at the first New Zealand National Women's Liberation conference, and identified herself as a lesbian by stating that she "defied the concept of submission to the inimitable cock".[49] In 1973, Sharon Alston addressed a women's liberation seminar, by identifying herself as lesbian and giving a passionate speech in favour of lesbian liberation:

> Sharon Alston attacked "straight liberals" for offering at best condescension and sympathy to female homosexuals and at worst avoiding them. She pointed out that civility [to lesbians] won't be an invitation to an attack in the ladies' loo and that what Gay Liberation was interested in were human rights and not mere tolerance.[50, Broadsheet]

Alston positioned herself within a radical feminist discourse to critique liberal notions of 'tolerance', and identify these as restricting the visibility of lesbians and their health and wellbeing issues within the women's movement. An expansion of the notion of health and wellbeing to holism, including sexism and women's social and economic oppression, created space for lesbians to begin to position themselves as subject to additional oppression as lesbian. Alston[51, Broadsheet] argued that:

> ...gay women are not subjected to exactly the same oppression as heterosexual women... and this still stands as a valid reason for allowing the lesbian to express herself and her problems in terms of her own lifestyle...

Critiquing the assumption of a rigid separation between sexuality and the public spheres of life, radical feminist discourse constructed political lesbian subjects, and a particular practice of lesbian visibility and challenge. Drawing on the writing of international feminists such as Charlotte Bunch[2], Adrienne Rich[3] and Monique Wittig[52], sexuality was seen as socially constructed, systematically and institutionally enforced, in ways that benefit men, damage women's relationships with each other, and their own self-concept:

> Many women will elect to either become celibate or

> lesbian in order to break the chains of sex domination which surround our lives. This is a perfectly valid reaction to the constant 'put downs' that women face.[53, Broadsheet]

Identifying heterosexuality with "chains of sex domination" enabled radical feminists to question, "How can heterosexual feminists maintain sexual relationships with males and stay sane?" given that "sexual behaviour is political".[53, Broadsheet] In this discourse, heterosexuality was a regulated and enforced state of mind and body, which worked to support the subordinate status of women to men.

Radical feminism legitimised the creation of women's and lesbian space – a 'room of one's own' - to contemplate, strategise and act collectively:

> Why separate from men?… [to] learn the myriad ways in which women are put down… to learn to like each other; we have to discover an essential relationship which we have been taught to deny… women have been in competition not cooperation… We can rationalise and we can explain individual cases, but no analysis of the structural position of women can reveal anything but psychological oppression.[54, Broadsheet]

In the space opened by this radical assertion, lesbianism could perform an important role in promoting women's psychological health and influencing wider social change:

> 'Lesbian Nation', subtitled The Feminist Solution, is the evolving political reactionary consciousness of an oppressed lesbian… eventually exploding into the feminist movement with the solution… Jill Johnson advocates that the only true feminist is a lesbian.[55, Broadsheet]

The notion of Lesbian Nation, articulated by Jill Johnson[56], offered practices of collective radical lesbian rebellion – demanding cultural and ideological transformation. Drawing on this framework, lesbianism took on significance far beyond the individual – becoming a practice of the feminist movement: a lifestyle opposed to liberal notions of tolerance and equality. These issues of Broadsheet actively promoted lesbianism as a political strategy in the struggle against patriarchal oppression. The Gay Feminist Collective argued in Broadsheet that: "We feel is it valid to call oneself a lesbian prior to any homosexual (sexual) experience".57 p17]

> Lesbianism is a total lifestyle that is valid in itself, not simply a matter of a sexual union…lesbians are women who survive without men emotionally, financially… who battle day by day to show that women are valid human beings, not just appendages.[53, Broadsheet]

Lesbianism held a countercultural connotation in excess of sex and desire. Lesbian separatism and heterosexual surveillance were discursive practises of radical feminism that emerged to challenge the meaning and norms of womanhood, heterosexual femininity, and female emotional and sexual dependency on men. This involved claiming public space for women and lesbians: holding conferences, meetings and rallies, drawing attention to lesbian issues. Broadsheet writers advocated lesbianism for women, and lesbian health and wellbeing. The first Lesbian Conference was held in New Zealand in March 1974, advocated publication of lesbian content to make women "aware of the validity of lesbian relationships", and actively "fighting oppression" via the media: "to publish articles we write on Lesbianism… get on talk-back radio shows" as part of a "wide-spread public re-education programme".[57, Broadsheet]

While Broadsheet offered a space for a radical feminist discourse to be articulated, it also offered a space for what we have identified as a liberal feminist discourse. However, the ways in which feminism and sexuality were constructed were quite different to those of radical feminism

Liberal feminist discourse

Radical lesbianism was strongly contested by liberal feminist discourses of human sexuality at this time. Aligned with a dominant sexological model,[21] liberal feminist discourse produced sex as an expression of individual identity, intimacy and love of the kind that is healthy for relationships and individuals. Writers argued for the sexual liberation of women, whose natural 'sexual capacity' had been suppressed by restrictive gender roles and norms:

> We must all be strong enough to examine the 'cruel and conquering' in the sexual behaviour of our bedfellows. To examine also our personal responses in terms of the myth of submission… As long as women continue to respond to men by desiring them when they force submission then we don't allow them to see their manhood defined in any other terms.[53 Broadsheet]

> … for now it is still problem enough convincing our husbands and lovers that we have sexual appetites, too, which may have a different rhythm from theirs but which are every bit as urgent.[58, Broadsheet]

Liberal feminism did offer a space for lesbian sexuality. Lesbians were produced as 'natural variants', in opposition to the prominent medical construction of female homosexuality as deviance and illness. Drawing on sexological theory and research, the liberal feminist discourse reified positions of

naturally occurring majority (heterosexuality) and minority (homosexuality) sexualities, inborn and largely fixed. The Gay Liberation University Manifesto, published in Broadsheet in 1973, argued:

> We are not going to be treated as sick, disturbed or perverted. Scientific evidence supports our claim - research has shown homosexuality is both natural and common... Society's anti-gay prejudices force thousands of us into hiding.[59, Broadsheet]

That sexual behaviour was constructed as a personal choice with reference to innate sexological sexuality, limited the positioning of lesbian identity in the women's movement to one of acceptance, rather than challenge:

> ...the feeling of some gay women that no woman can be truly feminist if she lives in a heterosexual relationship, or has any emotional relationships with men... is a demand for me to deny myself which I am unprepared to accept. To me feminism is a freedom from male attitudes...a movement to give women choice.[54, Broadsheet]

> Acceptance is acceptance... What we all do in the bedroom can then, hopefully, begin to return to being our own business.[60, Broadsheet]

While creating a space for liberal feminists to identify as lesbian, the liberal feminist discourse also placed limits around acceptable lesbianism. Liberal feminist discourse limited healthy sexuality to the breakdown of gender stereotypes and the quest for equality in heterosexual relationships. This had the effect of marginalising lesbian women and their issues within the women's movement in New Zealand. Because heterosexuality was assumed as the position of most women, within liberal feminist discourse relating to men was articulated as a key feminist project for change:

> By extending the tactic of separatism to exclude all possibility of relating with men and implicitly questioning the commitment of women who attempt such relationships, radical feminists are refusing to deal with an area crucial to the developing feminist world view of the majority of women.[53, Broadsheet]

An 'area crucial to the developing feminist world view', women must work at achieving equality in all spaces with men (e.g. sexual and intimate relations, division of housework, childcare, through to the ability to take up interests outside the home). Liberal feminism took up informed choice for women as a key point of departure for sexuality and health and wellbeing. It picked up issues of women's access to sexual and reproductive health information and empowerment in this domain. In this context abortion was discussed as the critical health issue for women. As such, a liberal feminist discourse worked to produce a dominant heterosexual position in relation to health and wellbeing. This focus effectively silenced issues that lesbians faced in relation to health at this time.

Young lesbians in 2012

The dominant subject positions taken up by the young women were informed by postfeminist and heteronormative discourses. Postfeminist discourse posits that equality has been achieved and therefore there is no need for feminist activism.[15,16,61] Certain practices and experiences the participants described were brought about by their being positioned as subjects of heteronormative discourses which produced them as women who are sexually available to men. Participants were marginalised socially and politically and, as a result, could be rendered vulnerable in social spaces and made to suffer abuse and violence.

Post-feminist lesbians: Wives, mothers and deviant others

Participants in 2012, drew on a postfeminist discourse that positions lesbians as equal to heterosexual women and men in a private sphere: emphasising finding committed love, family, marriage and having children with another woman. To position their sexualities in relation to maintaining their health and wellbeing, these women constituted acceptable lesbians as living private, quiet and domestic lives, apart from the 'spectacle' of gay pride. Broadly post-feminist discourses critiqued the relevance of visibility in lesbian lives, as Mini describes:

> I don't do much of the like rainbow flag waving and the unicorns, I just can't deal with it. The thing I try and do least is make a spectacle of myself about it... People are gonna find it less offensive if you're just two lesbian women living quietly in your own little home, you know? Just doing what everyone else does, which is exactly what you want, equal rights means doing what's equal to everyone else, not more. (Mini)

Within post-feminist discourses, Mini positioned the notion of lesbian visibility as 'excessive' and as threatening to society. Acceptable and 'equal' lesbian lives as able to be lived safely in the home, simply doing 'what straight people do'. This represents a liberal conception of equality as sameness, though it also restricts possibilities for lesbian lives to those well-worn heteronormative paths already in existence. The kind of relationship practices and families that they held to be ideal were: long term, stable, monogamous, coupled, with children. Ruby draws out a construction of long term lesbians' relationships, and notions of love, commitment (being 'long-term-lovable') as important.

> There is nothing different about me because I'm gay… I have a list of goals I have in life. I would give up the rest of them for the one thing and that's to be married and have kids (Ruby, 24).

The participants drew on notions of romantic love and relationships that were similar to those articulated by heterosexual women in other studies. For example, Hollway[62] has explicated a 'have-hold' discourse (linking to phraseology used in Christian weddings) as playing an important role in constructing women's sexuality in relation to men. This discourse constructs women as primarily interested in securing long-term commitment in relationships. Participants drew on and expanded the 'have hold' discourse to include lesbians as wives and mothers: they positioned themselves as valuing closeness and relational connection more highly than sex. One participant shed particular light on the acceptance and status within her family that she could achieve through positioning herself, through the postfeminist discourse, as a 'lesbian wife':

> Staying together kind of showed [my family] that it wasn't really a joke. We've been together for a few years now, and they like the fact that we are quite secure for our age. In their eyes, nothing bad has come out of it. (Carmen).

Postfeminist discourse also placed boundaries around acceptable feminine identities through a construction of less acceptable lesbians as 'radical' and/or 'feminist'. These positions were described as undesirable and untenable because they are anti-men. An insistence on not being anti-men was common to the talk of most of the young women interviewed who positioned themselves within this discourse:

> Lesbians can't be obsessed with politics you know? A lesbian feminist is really extreme, it's over-consuming for them. They just get too caught up in the negative views of other people… it takes a toll on their mental wellbeing. I don't think it would be good for society if you had an extreme lesbian feminist because they are anti-men. It would also create a negative stereotype in society as all lesbians being like that (Summer).

For Summer, lesbian feminism constituted a risk to individual lesbian health. A careful 'pro-men' position adopted by the women who drew on postfeminist discourse, links with McRobbie's[15] assertion that the 'post-feminist masquerade' functions to diffuse any threat posed by women and lesbians to discourses of masculinity:

> I think that truly lesbian women would rather be in a committed relationship than kind of be radical about it or like a guy, that doesn't want to be in a committed relationship, from my experience that's hurting you and other people (Carmen, 23)

Subject positions offered by dominant liberal and postfeminist discourses produced 'true lesbians' as 'definitely women'. The lesbian lifestyle discourses allowed participants to take up acceptable positions in relation to traditional hetero-feminine ideals of wife and mother. They also legitimised practices of surveillance of self and other lesbians in relation to these ideals, marginalising lesbians who were unable or unwilling to participate in heteronormative practices and relationship forms. When talking about relationship between being lesbian and health, a particular portrayal of radical lesbianism came to the fore: as unhealthy, extreme and negative. Radical lesbians were identified as man-hating-lesbians, seen as divisive trouble makers and bad for society. There was a strong rejection of lesbian practices identified as radical: e.g. feminist organisation, non-monogamy. It was striking how strongly the young lesbian women spoken to positioned themselves in opposition to a particular version of 'radical lesbian feminism'.

The young women also provided many examples of being forced to engage with negative views of lesbians, which was constructed as a drain on their wellbeing. That being 'pro-men' and 'not angry' were constructed as the healthiest subject positions to take up also reflected the power of heteronormative discourses through which femininity and homosexuality were consistently constructed as second order to masculinity and heterosexuality. A position of acceptance, as a 'lesbian wife' within one's family, was a compelling alternative to positioning outside acceptability, as 'other' lesbians were held to be. However, even as the women celebrated shifts in gay rights and increasing acceptance of lesbians in society, the women could still be subjected to exclusion, violence and victimisation when they did not fit the heteronormative mold:

> You just try to be like everyone else, but people won't let you be (Mini, 19)

> I can never hold hands in public… You just feel like a spectacle and you just want to blend in… I try not to stare at the barrel by making public displays of affection (Sally, 25)

> I said "I'm gay, I'm not interested, can you please just leave me alone," and he got really, really aggressive… I went to the bathroom and he cornered me in the bathroom he just said that he can do anything to me because I'm a waste (Summer, 22).

Compulsory heterosexuality operated in these young women's lives in a way that meant they felt extremely unsafe to identify themselves as lesbian, particularly in public spaces. They described feeling punished for identifying a lack of sexual interest in men, and lacked supportive space to be comfortable being open about their lesbian identity. A post-feminist position offered little protection for these women - try

as they might to 'not be a spectacle' they were still targeted.

Queer feminist lesbians

Two women, both university students, positioned their lesbian identities within a queer feminist discourse, drawing on poststructural notions of gender and sexuality. They drew explicitly on Judith Butler's influential book Gender Trouble,[63] cited as a key text of queer theory.[64,65] Queer discourse views homosexuality as socially constructed in a binary and subordinate relationship to heterosexuality. It also posits that this binary opposition of sexual identities is dependent on and supportive of, a culturally constructed fiction of the relationship between sex and gender.[64] These notions challenged heteronormative insistence on congruence between sex, gender and sexuality and the binary positions of male/female, masculine/feminine, homo/heterosexual that this creates. For these women, a queer lesbian feminist was a non-binary subject, capable of exploring non-normative relationship possibilities:

> For me lesbian is inclusive of multiple women in relationships as well as trans women as well, to clarify. So it's basically just people who identify as women attracted to people who identify as women ...I would say that the relationship I was in with my ex was a lesbian relationship, but then I might say that a sexual encounter I had with someone recently was a queer encounter and I don't really know why I make these distinctions, but I do (Jennifer).

A queer feminist positioning opened up possibilities for the women to shift and to play with gender identity and relationship forms.

> I'm definitely not opposed to other forms of relationship other than extended monogamy... polyamory is really interesting to me, the complexity of everything. The notion that we shouldn't necessarily, it's a lot of pressure to put on one person to say that they have to meet all our needs. (Jennifer).

> It just seems like "lesbian" and "gay" and stuff is just things you have to come out as to say that you're not straight... It seems like your sexuality is just a collection of things that you like. And of course no one's going to have the same collection of things that they like. And it's silly that it seems to always be divided along lines of gender like: "Do you like to sleep with men or women?" rather than: "Do you like to have sex with the lights on or the lights off? (Tegan)

Tegan and Jennifer positioned 'lesbians' (un-Queered) as 'cis women desiring cis women'. 'Cis-gender' is a term produced by queer discourse to position people for whom sex and gender are normatively aligned i.e. female sex plus identity as a woman. For them, heteronormative discourses had imbued the term lesbian with a 'normality', stability and permanence in relation to gender and sexuality which did not resonate with their experience or political goals.

Queer feminist discourse allowed these women to position women as subject to patriarchal oppression, e.g. they discussed as relevant to women's health: racism, imperialism, violence, strict rules about gender and sexuality, blaming and shaming of trans people, queer people, prudes, sluts, and anyone who does not fit a narrow and arbitrary body standard, rape culture, as well as a tendency to claim that liberal politics fixes all ills.

> Health is about reducing and removing oppression. That comes back to my philosophy of an intersectional feminism. I'm pretty vehemently anti-racist and anti-classist, and anti-sexist I guess, but anti-cissexist, anti-heterosexist, all those kinds of labels... they are really inherently linked into how society's structured and run... queer politics is firstly about helping queer people, but through doing that and through dismantling structures which are harmful to queer people's health, you are helping everybody else as well, because you are removing something which is harmful from society, and allowing everybody to be a bit less oppressed. (Jennifer).

Queer feminist lesbians were positioned in opposition to power dynamics that constrain or limit their wellbeing. Tegan referred to the disciplinary power that flows through heteronormative discourses to allow people to comment on, stare at and seek to re-align individuals they perceive as outside the norm with their normative understandings. She argued that the "little looks that you get from people and comments that people make" have material effects in queer people lives, because they make them feel like lesser human beings and cause them anxiety and depression. In this understanding, it is society and its promotion of heteronormative practices of violence and surveillance that are made problematic in relation to lesbian health.

The participants who drew on a queer feminist discourse, critiqued the ways in which those advocating for 'marriage equality' equated having access to the institution of marriage with 'equality'. They argued that a narrow focus on the right to marriage could obscure the broader issues of heteronormativity that are in play affecting their wellbeing:

> The other thing that annoys me about the marriage equality thing is that I know a few people who have died because they're gay or transgender and I know there are a whole lot of horrible issues with being able to be who you are... it seems like all of a sudden all of these activists are putting all their energy into being

> able to get married and it's like, well, if people are still dying because of who they are, maybe that's more important (Tegan).

Tegan and Jennifer both talked about heteronormativity as an unhealthy environment for those queer people who do not fit in. These notions resonated strongly with the radical feminist catch cry of 'the personal is political', meaning that personal issues can and do have political relevance and connection to broader social issues. Jennifer stated this explicitly:

> Being queer for me is both a personal experience and a political thing in relation to my wellbeing, because it affects and impacts so much of how I spend my time in the world and how I am treated by the world, and how I respond to the world, and so of course yeah it comes up a lot. (Jennifer).

Queer feminist discourse allowed women to articulate and critique social context, particularly heteronormativity, as a key determinant of lesbian health and wellbeing. However, the notion of 'ivory tower ideas' was repeatedly invoked to discuss how Queer feminist discourse tended to be confined to academic spaces and communities:

> You get always kind of like ivory tower ideas about gender and how to talk about people and stuff. It would be really frustrating [in a non-university environment]. I'm really used to the academic environment where everyone's either studying or teaching about a lot of critical stuff. (Tegan)

We note that both participants were white and privileged enough to be involved in university classes in specific contexts (media studies, cultural studies) where queer discourses came into play. Difficulties of translating a queer subject position into practice, and for informing collective political and progressive change, have been identified as contributing to Queer theory's limited circulation outside of the academy.[63-66]

Discussion

The results of this analysis have explored how feminisms are not monolithic or univocal.[19]

As Zita[70] holds, 1970s radical feminist discourse operated to "expand the meaning of 'lesbian' beyond genital sexuality",[p310] and produce lesbianism as "prima facie resistance to male dominance"[p312]. Broadsheet at this time, was a space where lesbians began to challenge public/private divisions of sexuality as they came to see themselves as a politicised interest group with rights to visibility, space, self-determination and difference in the interests of all women's wellbeing. A liberal feminist discourse refuted the notion that lesbianism could provide a strategic position from which to view/analyse the patriarchal power in play in heterosexuality, by upholding informed individual choice and self-expression as key to women's wellbeing. Radical lesbians could be charged with disrupting this movement for women's equality and wellbeing. Visibility of lesbians and lesbian issues could be cast as incoherent, and as misdirected.

In 2012, we found radical fervour in Queer feminist existence, where women fought to expand the boundaries of acceptable lesbian femininities and relationship forms. Queer feminism was constrained by a dominant postfeminist insistence on lesbian integration, and equality, neatly encapsulated by the aspirational position of lesbian wife and/or mother. With shifts in gay rights, family status is now possible for more lesbian women, who are offered inclusion, dignity, safety in private spaces. However inclusion seems largely contingent on de-radicalisation. The denigration of lesbian feminism has been discussed as a "cornerstone" of heteronormative dichotomies of "the good/bad lesbian"[61] Good lesbians are 'feminine chic' or 'family women', who are both defined positively against the 'masculine feminist lesbian' (61). Radical dissent is 'domesticated' when radical energy is redirected into a much more palatable and culture affirming activity: "In other words, the potential for the emergence of radical critique [can be] confined in terms of what would reinforce the status quo's most fundamental institutions and assumptions.".[71] Despite feminisms and equality gains, heterosexuality continues to be enforced on young women.[eg. 72,73-75] Lesbian women seem also to be participating in a version of McRobbie's[15] 'post-feminist masquerade' which holds that equality with men and heterosexual people has been achieved, and therefore positioning oneself within traditional femininity and relationship forms is unproblematic.

Sedgwick[76] distinguished between "minoritizing" and "universalizing" accounts of sexuality. Minoritising accounts hold that issues of sexuality are of concern to a minority of people who are not heterosexual. Universalising discourses construct issues of the divisions between sexualities as relevant to all people. In early issues of Broadsheet, ruptures emerged between those who constructed lesbian sexuality within the minoritising terms of liberal feminism, and those women who championed the relevance of lesbianism to helping transform the gendered status quo. In 2012, a dominant post-feminist discourse held that remaining differences between wellbeing for women and men, and lesbians and straight women, should be understood as a result of the free exercise of 'choice'. This discourse explicitly rendered radical challenge unpalatable. Queer feminist lesbians challenged this narrative by highlighting and resisting

structural determinants of women's wellbeing, including heteronormative expectations and practices. We have shown how modern understandings of sexuality continue to be a complex and contradictory conversation between minoritising and universalising discourses which produce different answers to the question: "In whose lives is homo/hetero definition an issue of continuing centrality and difficulty?".[76]

Considering 1970s lesbian feminisms in conversation with young women's articulations in 2012 showed how post-feminism and liberal feminism helps make heteronormative processes through which status and acceptance is achieved, invisible, even to the people who are constructed by them. Foucault cautioned us to be deeply suspicious of narrowing constructions of intimacy.[77] Feminisms have long argued that marital status should not define women's access to social justice and forms of belonging.[78] Foucault[79] suggested that struggle must look beyond the law (protection or prohibition), and address the deeper cultural norms, ethical categories, and emotional practices that ground and limit our sexual choices: "…it's not only a matter of integrating this strange little practice of making love with someone of the same sex into pre-existing cultures" it is a matter of having access to the construction of cultural forms.[79]

Expanding Queer feminist practices of lesbian space making, beyond the university environment, could hold possibilities for lesbian health and wellbeing. Queer feminisms, though hotly contested, are continuing to name heterosexuality as a political institution.[80] Women's collectives can be important spaces from which to expand relational forms and engage in practices of self-transformation in ways that are aligned with Foucault's critiques of normative power.[81,82] 1970s radical feminist discourses invoked a strategic essentialism that enabled the organisation of women's oppositional practices and communities.[70] Radical lesbian space may exist today where "a smaller minority, are nostalgic for that movement's radical imagination… who appreciate lesbian feminism for its cultural manifestations – women's land".[83] Separatism as a material, economic practice continues to produce possibilities for lesbian lives outside of structures dominated by heterosexuality and capitalism.[84] Elements of radical feminism remain useful in drawing attention to the ways in which compulsory heterosexuality continues to operate in ways which restrict women, and to support radical practices of resistance.

Conclusion

Foucault's concept of a history of the present offers the opportunity to render the present strange. This genealogical analysis has shown that a shift in that ways in which lesbian identity was constructed in the 1970s to how some young lesbian women constructed themselves in 2012 has occurred. The radical lesbian challenges and practices deployed in the 1970s regarding hetero dominance have been marginalised. Instead, compulsory family status has emerged as a normative relationship ethics, limiting some women's resistance. Bringing historical constructions to bear on the present can function as "counter-history" opening up "critical, resistive potential".[85] Rethinking radical lesbian possibilities for women's health could involve examining the political implications of 'personal issues', and supporting women's collective space-making and relational creativity.

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Abstract
Going through Research Ethics Boards (REB) and being held accountable to the highest ethical standards to conduct research with human subjects is commonplace. The goal of such a process helps ensure the selection and achievements not only of morally acceptable ends, but also of acceptable means to those ends when conducting research. Ultimately, REBs must pass judgment about the acceptability of harms and benefits to participants as they relate to research processes and outcomes. In this paper, we explore the implication of integrating "institutional reputation" as a category of analysis in the ethical review process. Informed by a recent Research Ethics Board (REB) review, we seek to engage with the readership in a constructive reflection on the concept of institutional reputation as a source of conflicting interests in research ethics review process.

Key words dual loyalties, ethics, nursing, reputational risk, qualitative research

Conflicting interests: Critiquing the place of "institutional reputation" in research ethics reviews

JEAN DANIEL JACOB & THOMAS FOTH

Introduction

Going through Research Ethics Boards (REB) and being held accountable to the highest ethical standards to conduct research with human subjects is commonplace. The goal of such a process helps ensure the selection and achievements not only of morally acceptable ends, but also of acceptable means to those ends when conducting research. Ultimately, REBs must pass judgment about the acceptability of harms and benefits to participants as they relate to research processes and outcomes. In this paper, we explore the implication of integrating "institutional reputation" as a category of analysis in the REB review process. Informed by a recent REB review, we seek to engage with the readership in a critical reflection on the concept of institutional reputation as a source of conflicting interests for REBs. Using a case report format, we provide an initial account and discussion on the subject matter, including implications for future research. To do so, the paper is divided in three sections: in the first and second sections we provide a description of the "case" by presenting a general overview of the project submitted to the REB, followed by a review of the REB process and feedback as it relates to "institutional reputation". In the third section we engage in a discussion of the "case" using current works on reputational risk,[1] dual loyalties,[2] sensitive research,[3] and current ethical standards for REBs in Canada[4].

Section 1: Project overview – Use of control measures in psychiatry

Informed by international debates on the use of control measures in psychiatry, we developed a problem statement that questioned current psychiatric practices and problematized the use of coercive interventions such as seclusion and restraints (both physical and chemical), but

also other forms of exceptional intervention such as forced hospitalization and treatment. This problem statement stemmed from well-documented detrimental effects of control measures use on patients, health care providers as well as the health care system in general.[5-7] Two recent intervention reviews from the Cochrane library assert that there is no evidence that seclusion and restraint have any therapeutic effectiveness.[8,9] By contrast, the negative effects of these interventions are well documented. Apart from various physical and psychological consequences, patient experiencing restraints/seclusion are at risk of sudden death,[10-12] increased length of stay[6] and are less likely to improve clinically than patients who experience more patient-staff interaction.[7] And even though control measures are intended to be methods of last resort for preventing self-harm or harm to others and continue to be considered controversial practices, their use remains relatively common in practice, particularly in psychiatric environments, to manage patients with challenging behaviours. For example, in Ontario, Canada, close to one in four patients admitted to mental health beds between April 2006 and March 2010 experienced at least one type of control interventions during their hospitalization.[13]

In parallel, the notion of "least-restraint" has guided contemporary healthcare policy and legislation nationally (across Canadian provinces) and internationally. In Ontario, Canada, for example, there exists a *Patient Restraints Minimization Act* that is intended to "minimize the use of restraints on patients and to encourage hospitals and facilities to use alternative methods, whenever possible, when it is necessary to prevent serious bodily harm by a patient to himself or herself or to others".[14] Although the application of legislation may vary in different organizations to the extent that "least-restraint" policies and procedures may lead to different types of interventions, it nonetheless serves as a unifying principle on which professional practices should be developed and applied. On the international scene, and of particular importance for this study, a publication in 2013 by the Special Rapporteur on Torture for the United Nations, Mr. Juan M. Méndez, condemned the use control measures in psychiatry, calling for a radical shift in current psychiatric practices.[15] This publication led to fierce debates internationally, including a revision of the original statement by Méndez,[16] albeit very little discussion in Canada. In Germany, for example, the report was integrated to ongoing critiques of coercive practices in psychiatry. As Zinkler[17] explains, moving towards a least restrictive psychiatric system in Germany was well underway in 2011, when coercive treatment in certain German states had been declared unlawful by Germany's Constitutional Court. In effect, this legislative change "effectively stopped the use of coercive antipsychotic treatment in these parts of Germany.[4] It was not the view of the Constitutional Court that coercive treatment per se was unconstitutional but rather that the criteria under which it could be given were far too wide".[17 p1] In 2012, these rulings where extended across Germany by its Federal Supreme Court, resulting in an outcry of protests from various groups, including Germany's professional association for psychiatry. This wave of protest eventually led to a softening of federal law, allowing coercive treatment to take place under strict criteria. What is important to understand here, is not so much the final outcome, but rather the debate that took place following publications of "least restrictive" legislative changes and position statements – including the report from the UN Special Rapporteur published in 2013. In light of these debates, psychiatry as an institution was forced to look inwards and engage in a debate which vehemently criticised its therapeutic foundation and the caritative nature of its interventions. The extreme changes in legislation and overall constraints on psychiatric practices as a whole created a space for dialogue and forced various stakeholders to "think outside the box", and envision the possibility of a different kind of psychiatry – as it was originally intended by Méndez[15].

Drawing on these international debates, the project aimed to

Table 1: Interview Guide - United Nations Declaration (Sample)
"The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill-treatment (A/63/175, paras. 55-56). The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-68, 78). Moreover, any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment. It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock procedure ." (Méndez, 2013, p.14)

not only try and explore how the culture of "least restraint" in psychiatry is operationalized and becomes manifest at the point of care, but also open the discussion to try and see if other ways of doing could be imagined in relation to current psychiatric practices. In other words, we not only attempted to understand the ways in which nurses operationalise and make sense of control measure in their practice, but also attempted to create a space for dialogue with respect to the ways we engage with concepts of risk, danger and violence management in psychiatry more generally. In order to do so, excerpts from the 2013 report from the United Nations' Special Rapporteur on Torture were introduced to our interview guide so it could be read by the research participants (nurses) – see Table 1.

We opted to work with the initial version of the report, as opposed to the 2014 [16] revision of the position, as it represents a radical shift in the way we think of psychiatry (i.e. move towards community resources and an absolute prohibition of restraint and seclusion) and was the initial position that fostered international debate on the question, including a joint position by the World Psychiatric Association and American Psychiatric Association [16].

After reading the excerpts from the 2013 report from the United Nations' Special Rapporteur on Torture, participants were asked questions to foster a professional discussion/ reflection – see Table 2.

As part of a reflective exercise, this section of the interview sought to create a hypothetical space from which participants, in this case nurses, would be forced to think of their practice outside the current legislative structure – try and envision a practice without control measure and see if it was even possible or feasible for them.

Section 2: REB review process and feedback

On March 22nd, 2016, our project was funded by a research institute. We subsequently submitted our protocol to the Research Ethics Board of the Hospital where the study would take place. From an ethics standpoint, the project was considered to be minimal risk given that it included interviews with health care professionals (nurses) and a separate chart review (not linked to participants taking part in the study). In short, the REB review process took 9 months, 3 resubmissions and 2 formal in-person meetings with the full REB before we obtained REB approval for the project. The following are excerpts of feedback provided by the REB on which we draw to unpack the dimensions of institutional reputation as it unfolded in the review process. All excerpts have been translated into English for the purpose of this paper.

Selective Feedback Review 1:

In a section entitled Research Protocol, the reviewers speak to the potential risks associated with the study:

Excerpt:

> 6. Risks and their management should be better explained in order to minimize their probability of occurrence. The REB has identified three risk groups: (1) those that specifically affect participants / patients; (2) those affecting the interview participants; (3) those affecting the protection of the reputation of [the Hospital]. Identification, quantification of the likelihood of these risk materialising as well as the means to reduce them, is one of the fundamental ethical responsibilities of researchers. [...]

An elaboration of these perceived risks where further detailed by the reviewers in the section that specifically addressed the Consent Form:

Excerpt:

> Research team members must identify the risks to which participants are exposed. In this case the residual risk to the institution must also be assessed, particularly when disseminating research results internally, both to institutional members and to external groups listed on page three (3) of the consent form [...]

Excerpt:

> Please specify what you will do with the various data collected particularly in the situation where they could have an impact on the employment of professionals in this care setting.

Table 2: Interview Guide – Reflective Questions
a) What are your impressions of this statement?
b) In your opinion, how would it be possible to work in psychiatry without the use of any methods of control (pharmaceutical, physical, confinement, others) or how do you imagine a psychiatric practice without the use of restraints/seclusion?
c) If you had unlimited means, financial or institutional, to change the current practice in psychiatric nursing, what changes would you makes?

The feedback provided sought to ensure that the anonymity of both participants and the institution would be protected in dissemination activities. However, a particular attention was drawn to the potential identification of reprehensive actions through the interview process and how these would be managed.

In responding to the reviewers, the research team sought to reassure the REB with respect to the explorative nature of the project, rather than being an evaluation of current institutional/professional practices derived from a normative framework. In other words, the details of our answer addressed both the interview process and the outcomes of the research; that is, how we would deal with a person reflecting on a reprehensible practice, while concurrently explaining how information would be treated in the public sphere (ex. anonymization of participants and the research site in future publications).

Selective Feedback Review 2:

In the following review, a distinct emphasis was drawn to the importance of ensuring institutional reputation, as it became very clear that the subject of the research was considered sensitive and potentially damaging to the institution, should the result of the research reveal, we can only assume, some kind of unethical/illegal practice.

> *Excerpt:*
>
> The REB would like the following documents to be modified in accordance with the indicated recommendations and to provide or clarify the explanations requested concerning the various aspects of your research project listed below:
>
> The team responded to a few questions and issues raised by the REB. However, the REB believes that there are still major issues that remain unanswered:
>
> Institutional protection (risk management)
>
> 1) The REB is concerned because the documentation submitted does not support the conclusion that the institutional risks generated by the research are being managed. Please answer the following questions:
>
> • The links that will be made between the data sources and the interpretation of institutional practices are not sufficiently discussed to allow the REB to conclude that the institution is protected.
>
> • Please indicate what steps will be taken when publishing and disseminating the results for the institution to be protected.

From a methodological standpoint, there was a direct request to remove reference to Mendez's[15] document in the interview guide:

Excerpt:

> 2) Please confirm that the extract from the text of the United Nations declaration has been removed from the questionnaire. If so, please submit a revised version of the tool.

The events that transpired during this review clarified the nature of the REB's concern. A third review specifically addressed the issues of introducing the Méndez's[15] document to the research project, questioning its validity and its potential effects on professionals (potential feeling of culpability) who would read it during the interview.

Selective Feedback Review 3:

Excerpt:

> We did not find an analysis plan that indicates how information about the response to the UN quote will be handled. It is not known if and how the identity of the institution will be protected. For example, if the publication were to lead to the conclusion that torture is being practised in [the Hospital], it would not only be the institution's reputation that would be at risk, but its ability to provide care, as potential patients might fear going there to obtain the required care, which would increase the risk for them.

Excerpt:

> The statement in section 10 indicates that the UN condemns the use of constraints while the referenced document is a report submitted by a working committee. The REB did not find the reference that supports this interpretation.

The research team was also presented with Provincial Court documentation supporting the legality of control measures in order to, somehow, counter the elements presented in the research proposal. The discomfort from the REB was most notable when the President of the REB brought the project to the CEO of the hospital, who then contacted the Scientific Director of the funding agency in order to convene a private meeting with the research team (the principal investigators). Despite being a clear transgression of REB functioning standards [4], it is at that meeting that we learned the hospital's reluctance to use a document that alluded to torture in the context of a research project being conducted in their institution and having little control over the way it would be used in the analysis. At this meeting, possible avenues requested by the institution were the censorship of the research – a declaration of non-publication - and/or a removal of any reference to the 2013 UN report [15]; requests to which the research team was firmly opposed. We continued to engage in a dialogue with the REB, by e-mail correspondence and in person, to finally receive approval of the project without censorship, but

with the addition of a preamble in the interview guide and a firm reassurance from the research team as to how the UN report[15] would be used in the analysis – see Table 3.

In hindsight, it is evident that a perceived threat to the institution and to the participants was the potential normative way in which the UN report would be used in the study. Not only did a lawyer on the committee explain that the UN declaration did not have force of law in Canada, it should not be considered as a document on which current practice could be analyzed. In other words, there were concerns about the way the UN document would be used as a normative frame to analyse the data, but more importantly, how it could potentially negatively portray the institution and the practice of its employees, should it be associated with acts of torture. Needless to say, the feedback provided gave way to constructive reflections on issues regarding sensitive research topics and role REBs play in managing reputational risk.

Discussion

It is relatively well known that before the 1950s, there were very little governmental oversight in regulating research. From the famous Tuskegee syphilis study in the 1932, to inhumane procedures in the name of clinical research during World War II, and the treatment of morning sickness and insomnia in pregnant woman with thalidomide in the 1950s, we witnessed the production of international guidelines in the conduct of research involving human subjects; that is, in response to highly publicized tragic events, often involving the rights of vulnerable people in the name of research, fundamental principles were endorsed in such documents as the *Nuremberg Code*, the *Declaration of Helsinki*, and *The Belmont Report* to ensure the protection of human subjects involved in research – notably the need for voluntary and informed consent, a favorable risk-to-benefit analysis, protection of confidentiality, etc.[18] These principles, in addition to the National Research Act of 1974 in the United States, paved the way for the regulation of research by REBs.[18] In Canada, the first attempt to produce ethics guidelines was in 1978 by the Medical Research Council (MRC), and then again in 1987, while the Social Sciences and Humanities Research Council (SSHRC) did so in 1981. It was in 1998 that the MRC, Natural Science and Engineering Research Council (NSERC), and SSHRC adopted what is now coined the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*,[4] which has becomes the official document that governs research involving humans and serves as a reference in the attainment of the highest ethical standards to conduct research.

Today, the policy statement contains clear guidelines with respect to the establishment and conduct of REBs - including the need to operate independently in their decision making; that is, be free of inappropriate influences and conflicts of interest, real or perceived. As an element to consider when reading this paper is the place in which ethics reviews are conducted. In the case reviewed in this paper, the first REB to review the project was within the hospital where the study took place, rather than within the University. Although this is not always the case, moving towards the institutions as a primary site for REB review may arguably create greater potential for conflict and new forms of power relations in the evaluations of research projects. On this particular point are the possible institutional conflicts of interest highlighted in the Tri-Council Policy that may influence the evaluation of risk, including reputational interests that may conflict with institutional obligations to prospective participants. The question of reputational risk is introduced three other times in the Tri-Council Policy, so as to ensure researchers are

Table 3: Interview Guide – Preamble
Before continuing with the interview:
Before you read the position statement of the UN Special Rapporteur, I would like to reiterate that the use of control measures in Ontario is legal. That is, they can be deployed as a last resort intervention and are regulated by law as well as your professional standards of practice. As nurses, we have all used these measures in our practice.
The purpose of this reading is to reflect on our practices. Among other things, the text makes parallels between control measures and acts of torture and ill-treatment insofar as they are imposed on a vulnerable population against their will.
The position taken by Mendez (2013) led to a heated international debate among many health professionals, psychiatrists in particular, who criticized this statement.
In the next section, we ask you to read excerpts from the statement and then give us your impressions.
It is important to note that even if the Special Rapporteur describes these acts as reprehensible, we do not in any way suggest that you took part in a non-ethical or illegal practice.

equally aware of the potential detrimental effects of their research on participants, groups and/or other entities (such as institutions). These provisions, for example, speak to the need to ensure confidentiality in cases where the research topic is considered sensitive (e.g. illegal activities) to ensure trust with participants.

In any case, it can be taken for granted that REBs display a general aversion to risk; that is, their main objective is to protect potential participants from potential harm associated with proposed research projects. Despite its common usage in healthcare,[19] however, the concept of risk, and more importantly, how it comes to be operationalized in practice remains relatively undertheorized. As Furedi[20] explains, while publications on the topic of risk proliferate, we do not have a good understanding of the concepts on which it relies, such as fear (perceived threat). The main point being, that risk has no objective meaning by itself, and must always be understood in the context in which it is being discussed/ formalized. According to Ewald, risk finds all of its meaning in cultural scripts, to the extent that 'everything depends on the shared values of the threatened group. They are what gives the risk its effective existence'.[21 p225] As such, identifying whether something or someone is at risk (or not) from an REB standpoint, must be understood as a contextually bound process. For this paper, the question of reputational risk raised by the REB cannot be overlooked and warrants further reflection. It is clear that the REB's interrogations have merit, to the extent that researchers must consider its place in the overall process and outcomes of the research project. What is less evident and somewhat silent, however, is the way reputational risk has come to take a predominant place in the REB review process and, arguably, overshadow any potential benefit to the research, such as exploring least restrictive way to engage in patient care. It further problematizes the capacity of qualitative researchers to conduct research on sensitive topics, as Perron, Jacob and Holmes[22] have previously discussed in the context of conducting critical research projects in forensic psychiatry. In effect, their work speak to an ethical problem, where REBs are becoming gatekeepers for institutions, as they envision potential threats associated with disruption of the status quo.

Here, we draw on the work of Adam Hedgecoe[1] who has come to problematize the place of reputational risk, academic freedom and research ethics reviews. Although Hedgecoe's work primarily problematizes the work of REBs within the University structure, his reflections can be applied to other contexts, as he suggests that these committees are increasingly coopted to serve as mechanisms for institutional reputation management – somewhat of a departure point from traditional ethics review, which focus on the researcher's role in protecting participants. As Hedgecoe[1] explains, the introduction of reputational risk assessments within research ethics is largely based of the influences of risk management practices from the private sector and high profile corporate scandals – where management of "reputation" has emerged within organizational practices to mitigate risks to external reputation. That is, "reputation" has come to reflect a new space of vulnerability – one that has created new demands to make it manageable from and institutional standpoint. The challenge then is to try and "understand how the logic of reputational risk management is beginning to percolate and pervade internal control and risk management agendas";[23 p4] and in so doing, look at the ways in which the REB, and to some extent the "vulnerability" of participants, are being instrumentalized in the process.

In reflecting on the role that the REB played in the current analysis, we cannot ignore the emergence of a new form of "double loyalties", where there is an emphasis put on reputational risk in relation to the risk posed to research participants. The problem of dual loyalty in this case is the fact that we are asking to weigh the benefits of the research for the participants (or patients in this case) against the objectives and reputation of the institution. For this case report, the issue of torture in mental healthcare was a sensitive topic and seen as potential threat to the institution.[3] As a result, the challenge faced by our research team was very much linked to this perceived threat where participants' interests and potential benefits to the population (i.e. patients who experience control measures) were being outweighed in favour a maintaining the status quo due to envisioned reputational risks – thus creating an issue of double loyalties for researchers, and we would argue, REBs as well. REBs are now positioned to not only take it upon themselves to protect human subjects, but also institutions, a reality that may very well highlight conflicting interests.

The concept of dual loyalty in healthcare is not new. It has taken on many forms, from critics of military physicians in complicity with abuse and torture in Guantanamo, to more common professional tensions of care and custody in the context of forensic psychiatric care.[24-26] Generally speaking, dual loyalty stems from an ethic of undivided loyalty to the welfare of the patient.[2] In practice, however, health professionals often have obligations to other parties besides their patients – such as family members, employers, insurance companies and governments – that may conflict with undivided devotion to the patient. In the context of an REB review, dual loyalties become problematic when the interests of the institution are imposed in a manner that may come to violate this devotion

to participants/potential beneficiaries. herein this context, it is not an overt ethical violation that we are talking about, but rather an insidious one - one that would ensure the status quo in avoiding to engage in a dialogue about current practices in psychiatry; one that would negate the possibility of creating an alternative discourse to the experience of being restrained; one that would perpetuate medical dominance over patients by limiting , through the REB, the production of knowledge that goes against current ways of doing.

Implications for research

Engaging in research on sensitive topics may pose a risk to host institutions in that their practices may become amenable to the scrutiny of outsiders. As a result, researchers may see the scope of their study limited, modified or even denied by research ethics boards because of the perceived threat the research may pose in challenging, disrupting or making public current ways of doing. Keeping in mind current emphasis on institutional reputation as criteria in REB reviews, it is important to consider its potential implications for research.

Engaging in research on current practices in health care is necessary; that is, there is a need for clinicians and researchers alike to be critical of current practices in order to ensure that they are, in fact, responding to their patient's needs. However, in looking at the role "institutional reputation" plays in the possibility of engaging in certain types of research, we come to question the neutrality of such an endeavour, where some topics may prove to be worth investigating, but too risky for the institution to endorse. Here, we can appreciate the complexity of opposite logics at play, where patients' best interests (the care they are provided) are juxtaposed to the institution's reputation. This may include the risk an institution sees in their employees using research projects as a means to disclose institutional issues and losing control over the messages are shared with the public sphere. In a previous publication on the politics of threat in correctional institutions, Perron, Jacob and Holmes[22] addressed ways of working within current institutional REB processes to make sensitive research possible. A large portion of their discussion had to do with maintaining independence as researchers, so as to ensure the ability to publish uncensored results – a position that may very well block sensitive research from even taking place in certain settings. This condition, however, is the result of recruitment and/or data collection needing to take place within the institution and, as result, grants the institution's review board the possibility to impose parameters on what constitutes a risk to the institution's reputation, and the ways in which researchers must mitigate this risk. However, given the evolving ways of conducting research, and if flexibility in recruitment is possible - such as engaging in recruitment outside the institution through social media, regulating bodies, public advertisement, etc. – institutional capacity to influence the research process could greatly diminished and allows for increased independence of the researcher. Evidently, this process does not negate researchers' obligations toward participants or the need for ethical review, but it nonetheless offers an opportunity to move away from conflicting interests that may be at play within institutions themselves.

The nature of any sensitive research topic gives rise to particular tensions regarding the potential threats of research to an institution. In this sense, research becomes the site of a political struggle, where ethics and politics are difficult to untangle. By exploring a case example where institutional reputation was used as a category of analysis in the ethical review process, we are able to appreciate the difficult and possible irreconcilable gap that exists between one's ethical commitment to potential beneficiaries of the research (ex. patients) and the institution's need to avoid risks to its reputation if the research was to take place and yield unfavourable results. As such, finding new ways to ensure independence of researchers and their projects may be one way to avoid the creep of institutional reputation as a deciding factor in the conduct of research.

Final remarks

In this paper, we explored how REBs are being integrated in the management of institutional reputation, creating a certain conflict of interest. That is, the REB is becoming a tool, or gatekeeper of reputation having multiple effects on the ethical process review, including potentially new forms of perceived vulnerability. In our case, the interview, where professionals where to engage with emerging "least-restraint" international discourse in relation to their practice, became a potential threat for the institution, to the extent that professional and organizational practices would potentially be subject to public scrutiny and criticism.[3] In our reflection, we are forced to ask ourselves what are the ramifications of this new form of risk management and to whose' benefit? On a larger scale, this paper adds to the body of literature documenting the difficulties of conducting qualitative research on sensitive topics, where projects are being overly scrutinized by institutions who wish to have control over its outcomes.[22]

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Abstract
This paper uses social constructionism to critically explore the social world of intensive care units, and to consider how the presence of mental health consumers impacts on nursing practice. Following a series of interviews with intensive care nurses, our analysis suggested consumers are disenfranchised through stigma, policing, and inattention to psychosocial needs. We argue that the maintenance of knowledge and power networks are fundamental aspects of reality maintenance in intensive care. The social reproduction of typifications among nurses about consumers positioned these patients as disrupting the proper business of intensive care units; a process that we argue is bound up with the imbalanced power relationships. Further, intensive care staff maintain power structures serving intensive care interests, such as physiological rescue and the preservation of biomedical authority. We conclude that the production and reproduction of intensive care nursing knowledge maintains a social-power structure at odds with the needs of consumers.

Key words intensive care, mental disorders, stigma, nursing, power

The social reproduction of difference: Mental illness and the intensive care environment

FLORAIDH CORFEE, LEONIE COX & CAROL WINDSOR

Introduction

The increasing prevalence and associated disease burden of mental distress is well documented globally.[1,2] The World Health Organisation (WHO) estimates that one in four people will experience mental distress in their lifetime,[3] and notes that mental distress represents 13% of the total global disease burden.[4] The promotion and preservation of mental health has been identified as one of Australia's National Health Priority Areas as an acknowledgement of the impact of mental distress-related disability.[5]

People living with mental health issues experience structural disenfranchisement across a number of social contexts, including health.[6] Consumer/survivors experiencing mental distress commonly face a range of physiological comorbidities resulting from the intersection of social marginalisation, self-medication though substance use, and the side-effects of psychotherapeutic interventions.[7-12] The need for physical care is at least equal to and often greater than that of the general population. Yet, as consumer/survivors access healthcare, including intensive care, they may encounter established power structures that reinforce socially-mediated stigma and deter, rather than facilitate, effective and appropriate healthcare.

A number of influences are involved when consumer/survivors are admitted into the Australian healthcare system. First, the biomedical model of health and illness forms the dominant discourse around health and is well supported in the current neoliberal/individualist political landscape. The rhetoric of neoliberalism and individualism promotes the role of managing and optimising health as a responsibility of the individual.[13,14] Second, intensive care practice is

positioned as an elite specialty within nursing, where advanced physiological knowledge and procedural skills are constructed as the pinnacle of nursing practice, and a biomedical approach to care is firmly embedded as the status quo.[15-21] This social context encompasses a number of political and social concerns related to knowledge-power and the positioning of medical and nursing staff in such power structures.

It is in this social and political landscape that the Australian health care system, including intensive care units, cares for and treats people experiencing mental distress in acute physical care settings. The research reported upon here used such a setting to explore a number of social processes associated with the positioning of consumer/survivors in Australian society.

Purpose of the research

The purpose of this research was to explore the ways in which power relationships and the persistent structural disenfranchisement of consumer/survivors contributed to the reproduction of difference. While the setting for the research was a number of Australian intensive care units, the knowledge-power structures inherent to those contexts are a replication of broader social issues related to the positioning of consumer/survivors in contemporary Australian society. We based our research on the epistemological assumption that knowledge is socially constructed, and that knowledge and power are inherent aspects of taken-for-granted social processes. This research was also informed by a conceptual review of extant literature around the construction of difference associated with mental distress.[22-25] In particular, the scholarship of stigma and othering as it related to people living with mental distress underpinned our research on how difference was constructed and reproduced through the social and political processes of knowledge and power maintenance.

Theoretical framework

Drawing primarily on the works of Berger and Luckmann,26 Weber[27] and Foucault,[28] this research sought to explore the social processes around knowledge, power and understanding in intensive care lifeworlds. We explored the reproduction of difference associated with caring for consumer/survivors experiencing severe mental distress as it manifested in the lifeworld of ICU.[29-38]

Berger and Luckmann's[26] theory of secondary socialisation posits that the internalisation of common-sense knowledge is a key social process for newcomers entering an institution. The incorporation of new knowledge into the group's everyday reality is part of the work of reality maintenance and institutional fortification, and such knowledge becomes so taken-for granted that it is regarded as 'common-sense'. Such common-sense knowledge includes the formation of typifications, much like stereotypes: accessible social 'recipes' 26 that allow group members to position and handle unknown people, without adjusting their everyday reality. Typifications function to minimise ruptures of paramount reality, preserve common-sense knowledge, and avoid the inherent chaos of social life.

From the experiences of a few nurses caring for consumer/survivors experiencing severe mental distress, the group may intersubjectively construct an explanation of what it is to care for all patients with diagnoses of mental distress. The possibility of such a social process is reflected in the literature associated with intensive care and consumer/survivors, where commentators have variously typified people living with severe mental distress as collectively dangerous, users of illicit substances, and behaviourally difficult.[39-44] Secondary socialisation into what it is to 'do' intensive care nursing related to a number of typifications of people with a psychiatric diagnosis that are also reproduced more broadly in the general community. Such typifications included the construction of consumer/survivors as responsible (and blameworthy) for their mental distress, and as inherently dangerous and unpredictable.

Social constructionism supports the notion that there is an accepted or assumed existence of power structures in everyday life. The work of both Max Weber and Michel Foucault informed the theorising of structural power and knowledge maintenance in this context. Weber's work on legitimated or rational-legal power positions a person or persons within an organisation and is structural, therefore generally unrelated to the attributes of the person exercising that power. Nurses' legal-rational power is defined and sanctioned by regulatory bodies, professional status and healthcare institutional affiliation. Foucault's work on surveillance and the relationship between knowledge and power provides a broader contextual landscape of power relationships between 'the institution', those who occupy intensive care, and the consumer/survivors who access this space.

Methods

The 17 research participants came from both metropolitan and regional cities along the Australian eastern seaboard and were practicing in a mix of level two and three intensive care units. Australian intensive care units are categorised against a number of criteria based on location, clinical capacity and acuity. Level three represents major metropolitan

tertiary referral units, and level two smaller metropolitan or large regional centres. Both tiers of acuity include units that are equipped to care for critically ill patients receiving standard intensive care interventions including ventilation, haemofiltration, and invasive haemodynamic monitoring.

All participants identified as female. The participants came from a range of career points, from graduates in their first year as a registered nurse, to senior nurses who reported practicing for over 25 years. All participants practiced in an intensive care setting that was co-located in a hospital with acute inpatient mental health services. Nurses were invited to participate in a voluntary semi-structured interview of up to one hour. Interviews centered on the participant's reflections on their perspectives and experiences of caring for consumer/survivors with mental distress in intensive care contexts. A number of prompts were employed such as 'can you share any perspectives on your role as a nurse caring for patients with mental illness?' and 'How did your experience of caring for someone with a serious mental illness turn out? Can you tell me the story of that experience?'.

The research was approved by the university's Human Research Ethics Committee (HREC). Following ethics approval, participants were recruited through nursing professional organisations, who placed an advertisement on their websites or in their digital newsletters explaining the study and inviting nurses to participate. The participants responded to the researchers by answering these advertisements in professional publications and hence, hospital ethics committees were not required in the recruitment or data generation process. Following the provision of a participant information sheet, written and informed consent was obtained from each participant, and all participants were assured they were able to withdraw at any time without prejudice. Given the geographical diversity of the nurses, all of the interviews were offered as in-person, or by video-call or telephone. All of the interviews were ultimately conducted by telephone, ran for 45-60 minutes, and were recorded and then transcribed.

The analytical framework used for this research drew on a number of theoretical sources to analyse, synthesise and build theory from multiple sources of data, including participant transcripts, existing literature, and theoretical frameworks. This form of iterative process is also known as constant comparative analysis.[45] Constant comparative analysis is a useful method in an interpretivist and critical framework because it assists in developing an understanding of individual experiences firmly situated in contextual social processes as the researcher moves between interview data, theory and literature. 45, 46 Participant interviews are acknowledged to have limitations, and this research study was strongly influenced by the scholarship of David Silverman46 in this space, who urges qualitative researchers to consider the placement, timing and inconsistencies of participant comments, avoiding a reliance on their responses as an absolute truth. By situating participant responses as one among other sources of data, we were able to avoid interpreting and presenting their responses as 'facts'.

Discussion

Power, disruption and the control of space

An air of danger and rescue are described in a number of studies concerned with space and work in intensive care.47, 48 The need to maintain safety through control of the environment is a recognised interest in the business of intensive care where patients are routinely described as critical, and hovering between life and death.48, 49 A large body of research theorises the typification of dangerousness attributed to people with a psychiatric diagnosis,50-54 and we established this analytical outcome in our research concerned with the anticipation of danger and the control of space. A participant reflected on the routines enacted prior to the arrival of a mental health consumer in her unit:

> I think safety is standard for all the patients…. but of course, mental health patients need double safety compared to other patients. So, we always agree that when the patient comes in we should be ready and more safe. There are restrainers in the trolley and we try to keep the trolley away from the room. We try to see if there is anything that will hurt the patient from inside the room and take it off. And we try to see if there are enough medications in the cupboard for this patient.

The construct of 'double safety' for consumer/survivors suggests a typification of inherent dangerousness, usually arising socially, and preceding an actual encounter with the person and, according to the study participants, devoid of any sort of formal assessment process. Control of space is enacted by removing standard patient care equipment, providing restraints, and checking sedation supplies. The presumption of dangerousness prompts policing of the space occupied by the consumer. Such policing is often extended to the consumer themselves as they attempt to enact activities of self-care such as hygiene, toileting and mobility. A participant reflected on her patient who was experiencing anxiety and wanted to walk around as a self-soothing measure:

> I can understand sometimes you just want to walk around. Sometimes you know, you are well enough to make some decisions for yourself but in that ICU

> setting we don't give a capacity for these people to do that.... if I wanted to walk around at night in my own home I would, but as they're in ICU and there lots of other sick people, that makes it dangerous at night time for them to walk around. We don't like that, so then we give them medication to force them to stay in their bed space.... I do think that's on the mean side but unfortunately due to safety we have to do it. They might self-harm.... or like the medication cupboard for the [scheduled drugs] - technically, you can just walk in there and take it.

Such language reinforces the notion that consumers are, by default, under suspicion. They are also held to a higher standard of behaviour and emotional control than the general population which means that the threshold for reacting to any emotional distress or irritability is much lower. Resistance to such surveillance and custodial acts are very likely a response to significant space restriction, feelings of shame and rejection associated with self-stigma, and the feedback loop of negativity and arbitrary suspicion during their encounters with some staff.

It is of course acknowledged that any person can be unpredictable or violent and quite frequently nurses deal with violence and agitation in their patient population.55, 56 The significance of the data above is the unquestioned assumption of dangerousness. Link and

Phelan[57] suggest there is a trajectory from attributing a label, such as mentally ill or 'schizophrenic' or 'PD' (personality disorder), through to typification formation, such as propensity to violence and inherent dangerousness. As described, typifications generally precede discriminatory behaviour at both a micro and a macro level. These acts reflect broader social processes including the involvement of police and the use of incarceration in instances of acute assessment and initial care of people experiencing acute mental distress in the community.

The nature of power relationships in the context of this research was complex and multidimensional. Turnbull, Flabouris and Iedema[58 p72] suggest [ICU] '....is a closed, intersubjective world...embodying a history and a set of roles and relationships, tensions, alliances, all contained within the semi-sealed physical space of the unit'. The relationship between policing the space occupied by the consumer/survivor and the consumer/survivor themselves is grounded in unequal power relationships. This research interrogated the processes that supported such normalised policing of consumer/survivors in this context. Drawing on the work of Weber,[27] and the social processes described by Berger and Luckmann,[26] authoritative power in intensive care settings is legitimated, objectified and normalised. The participant accounts suggest that these acts are accepted by most as beyond question. Considered through a Foucauldian lens, these social processes point to knowledge as power 28 and the ongoing maintenance of the intensive care paramount reality. Social processes of knowledge reproduction are inseparable from the reproduction and maintenance of established power structures.

Preferencing one particular body of knowledge and practice diminishes alternative bodies of knowledge. The absence of alternatives may manifest as inattention to core nursing practices such as therapeutic intervention, creating a therapeutic milieu and psychosocial care. Instead, there is an unmindful reach for chemical or mechanical restraint as a physiological solution for 'managing' consumers who are perceived as resisting (or likely to resist) the rules and rituals of the institution. Indeed, such processes reflect far broader social acts, evidenced by the descriptions of encounters between the police force and consumers,[59] and emergency services and consumers.[60] Rather than a consideration of therapeutic or treatment alternatives, such actions are a product of knowledge - power reproduction and serve to fortify and sustain established power relationships.

Concerns about anticipatory surveillance and custody are represented in the far broader context of human and civil rights,and remain contentious in both the policing and justice systems. Exercising physical power over patients for the benefit of institutional safety and the welfare of other patients, based on a number of assumptions about the person, is a form of legitimated power, sanctioned by the institution and the available legal-rational power of the nursing and medical role.[61]

The maintenance and legitimation of power structures

Individualism and neoliberalism rely on a negation of the influence of social health determinants and the briefest acknowledgement of structural disenfranchisement.[62] Situated among these social norms, as the dominant authority on what health and wellbeing looks like - or how it should be experienced - is the biomedical model.

Typification concerning those with a psychiatric diagnosis includes blameworthiness for any perceived failings around managing their own health.[63,64] Such views are reproduced in a broader social world where individualism dominates. Good health is underpinned by a series of positive and punitive government and health policies designed to remind

all citizens of our responsibility to eat well, exercise regularly, not smoke, not be overweight, and not be poor.[13,65] Such interventions are not in fact celebrating autonomy and as Foucault argued, they are a central tenet of governmentality and are 'technologies of self'.[28,65] Consumers facing multiple intersections of disenfranchisement are seen as forever failing to self-manage and rise to the obligation of good health citizenship.

We conceptualised the known authoritative dominance of biomedicine as a symbolic universe following on from the work of Dreher 67 who argued that Berger and Luckmann's symbolic universes functioned to maintain not only knowledge, but power relationships. Berger and Luckmann 26 described symbolic universes as a transcendent legitimation of knowledge and power, so objectivated and reified that it does not require scrutiny, nor alignment with the everyday lifeworld. Symbolic universes are not simply an institution, or the people in it, but a totality of theoretical tradition, philosophy, and mythology.67 The symbolic universe of biomedicine and one of its most prominent manifestations, the hospital, transcend our everyday reality. It existed before we came along and will exist long after we are gone. Such is the social, political, and intellectual power of this symbolic universe that it preferences certain types of knowledge and the freedom to determine what is important and what can be ignored or discredited. Knowledge reproduction is not only a social, but a political act, conserving and maintaining established power structures. More simply stated, by Berger and Luckmann[26 p127] 'He with the bigger stick has better chance of imposing his definitions of reality'

The negation of social determinants of health in resource allocation is one of the practical outcomes of institutional reality-maintenance in this context.[67] Habitualisation rituals such as socialisation and the reproduction of knowledge-power relationships serve the interests of the biomedical symbolic universe but may well be at odds with the experiences of nurses and consumer/survivors as they encounter each other in the ICU lifeworld. Encountering the 'institution', consumer/survivors are regarded as ineffectual stewards of their own health concerns and are frequently rejected by a system unable, or unwilling, to accommodate them beyond brief assessment and intervention. Interview participants remarked on being in 'the business of body fluids' and saving lives, continuously re-orientating themselves and our conversations to knowledge and skills associated with the business of ICU: for example, resuscitation, ventilation, haemodialysis and 'running off numbers'. Such comments suggested a complex power relationship between the socialised understanding of ICU nursing work, and stigma towards mental health consumers. Goffman68 argued that discrediting attributes are an integral aspect of the stigma experienced by people, but stigma is also a social process, infused with power inequality. In this context it is inextricably woven into concerns of maintaining and reinforcing the existing lifeworld of ICU and the established power structures contained within. The tension of a discredited person disturbing a space that has not been envisaged as accommodating them is reflected in both labelling and dehumanisation of consumer/survivors and the claims about the nature of the 'real' work of intensive care. It must be acknowledged that the while the biomedical approach is prioritised in this context, there is a clear and ongoing commitment to person-centred care throughout intensive care nursing and practice. Grappling with the inability or incapacity to consistently perform successful physiological rescue is demonstrated in some of the work around end-of-life care and palliative care in this environment.

There is a sound body of research on the nexus between end of life care and intensive care[69-73] but the existence of such work juxtaposed with the absence of work on consumer/survivors and intensive care is itself interesting data. The reflection from intensive care personnel on the success/failure binary is limited to death. The literature on palliative care and end of life care in this context suggests that success and failure are well established as a cultural norm and the literature merely encourages nurses to reconceptualise death as a lesser failure, or a good death through palliation as a success.[74-75] This in itself is reasonable: the critical importance of informed, sensitive end of life care is not in question. However, this binary continues to reinforce acute discomfort about patients including mental health consumer/survivors who are not perceived as success stories. Rather these cases are condemned to the status of failures instead of allowing for mental distress and chronicity to be explored as a complex experience, part of which may involve the care of intensive care nurses from time to time.

The experiences of palliative care advocates[76-77] demonstrate an existing tension between the taken-for-granted business of intensive care and patients who disrupt this context. However, the literature on the palliative care - intensive care nexus highlights just one aspect of the displacement experienced by consumer/survivors, because palliative care patients are not known to be subject to stigma and disenfranchisement. This consideration of palliative care in an intensive care setting has been offered as a point of reference in an attempt to explore people with an alternative illness-label (palliative care patient) who are also conceptualised as types

of interlopers, in an environment ostensibly set up to accept any patient. The key point of difference here is the presence of stigma in the encounters between intensive care staff and patients, and we propose that stigma is an integral contributor to the sense of disruption that consumer/survivors bring to the social context of intensive care.

The disentitlement to consistent, equitably-realised and appropriate healthcare afforded to people with repeated admissions in particular is reflected in broader literature around people who repeatedly present to acute inpatient facilities, and draws on historical constructs of moral decrepitude and unworthiness.[78] A notable comment came from an experienced intensive care nurse, reflecting on a consumer/survivor who had a number of admissions to the intensive care unit:

> "...this is like double digit figures for this patient and they'd done a pretty good job, they weren't successful, but they'd done a pretty good job. And....the senior nurse is saying 'You know, this is the *whatever* attempt for this person. I don't even know why we keep trying to bring her back. People should just let her go. She should just do a good job; it's really not that hard to kill yourself. She's taking up bed space. We've got six people who need this bed'

The dehumanisation of people who enact self-harm to such an extent that their death is perceived as preferable to timely and appropriate health care, is a profound reproduction of the disenfranchisement experienced by people with psychiatric diagnoses. The concepts of unworthiness, resource-wasting and the notion that consumers are responsible for their own mental distress underpinned fundamental concerns of reality maintenance around intensive care business.

Conclusion

This paper sought to explore a number of social processes associated with the positioning of consumer/survivors in the everyday lifeworld of intensive care and in broader Australian society. Using Berger and Luckmann's 26 social constructionist theory, we argued that through social processes of typification formation and knowledge reproduction, a series of socially sanctioned assumptions are legitimated and reified among intensive care nurses as they encounter consumer/survivors in the course of intensive care work.

These social processes are underpinned by the everyday business of intensive care, which includes the preservation of the symbolic universe of biomedicine. The encounters between intensive care staff and consumer/survivors do little to ameliorate the social stigma experienced by this group, as they are positioned as unworthy, blameworthy, and disrupting the proper business of intensive care.

Further, given the focus of biomedical-model nursing in intensive care settings, such disruptions to the everyday lifeworld appear to consolidate and reinforce established power disparity through acts of policing and restriction of movement. The structural inattention to therapeutic nursing work, both at macro (social) and micro level displaced by the gaze of biomedicine, and a reflexive suspicion of consumers, leaves intensive care staff with limited options beyond the physiological 'solutions' of chemical and mechanical restraint.

Many questions have been asked in this research about the ways in which encounters with consumer/survivors in this context are reproduced through typifications of unworthiness, blame-worthiness, and dangerousness. It is unlikely that alternative constructions of health and illness will displace the symbolic universe of biomedicine. Further, dismantling structural disenfranchisement for consumer/survivors is unlikely to occupy Australian social and political discourse any time soon, given the dominant social and political ideology of individualism and neo-liberalism – however, there is scope to reflect on opportunities for emancipatory change.

Harnessing the high value placed on education in the lifeworld of intensive care is a possible mechanism for reflecting upon and appreciating the prevalence of mental distress and the inevitability of mental health consumer/survivor presence in intensive care. Although shifting the nursing gaze away from biomedicine to a bio-psycho-social model of care is far beyond the scope and influence of this study, our hope is to start a conversation about making space, both intellectually and physically, for the effective and appropriate care of consumers who are admitted to an intensive care unit.

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